

The Role of Civil Commitment in the Opioid Crisis

Ish P. Bhalla, Nina Cohen, Claudia E. Haupt, Kate Stith, Rocksheng Zhong¹

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As the opioid crisis deepens, a particularly controversial policy response is gaining traction: civil commitment. Civil commitment refers to the involuntary detention of individuals with substance use disorder (SUD), without resort to the criminal justice process, in order to separate them from access to the general population (including that population's access to illicit opioids) and, in some instances, to offer some form of treatment.² The medical, ethical, and legal questions surrounding civil commitment remain under-examined. Most importantly, this practice raises major issues related to civil liberties and public health.

This article seeks to shed light on civil commitment in the context of the opioid crisis, to sketch the existing legal landscape surrounding civil commitment, and to illustrate the relevant medical, ethical, and legal concerns that policymakers must take into account as they struggle to find appropriate responses to the crisis. Presently, thirty-seven states and the District of Columbia have civil commitment laws that appear to encompass involuntary confinement of persons with SUD, alcoholism, or both.³

In short, the medical benefits of being forced to undergo treatment for opioid addiction are uncertain, and the legal and ethical concerns regarding civil commitment of those with SUD are substantial. The constitutional and other legal rules governing civil commitment were not developed in the context of SUD, and did not anticipate application to individuals with SUD. Nor have the statutory standards for civil commitment been developed in contemplation of the medically appropriate treatment for SUD, which is most often a combination of medication assisted treatment (MAT) and psychosocial treatment. In scope and kind, the opioid crisis appears to be beyond what the traditional legal framework of civil commitment has contemplated. The tensions among the values of individual civil liberty, societal public health, autonomy of the individual to choose treatment or decline it, and the state's interest in protecting the welfare of its citizens give rise to difficult questions that require careful reflection and research. At the very least, the complexity of these questions ought to counsel policymakers against reflexively adopting restrictive, potentially draconian, and likely ineffective measures that may well do more harm than good.

I. Civil Commitment in the United States

The legal basis for civil commitment laws generally lies in the *parens patriae* doctrine or the states' police power to protect their citizens' health and safety. In the public health context, the Supreme Court held that the states' police powers may be used to limit individual autonomy.⁴

Historically, civil commitment for use of dangerous substances began with efforts to control alcohol abuse.⁵ The first substance abuse commitment laws in the United States were adopted in the second half of the nineteenth century.⁶ Modern commentators note that "[n]ineteenth-century debates over the role of coercion, the nature of the underlying disease, and the efficacy of treatment are stunningly similar to present-day policy arguments."⁷ Indeed, they highlight controversies surrounding the lack of judicial review of admission decisions, the initial absence of due process,

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and persisting medical doubts about the efficacy of involuntary treatment.⁸ Early legal challenges reflect those concerns; for example, New York’s law, “[t]he nation’s first identifiable substance abuse commitment code,” enacted in 1864, was found to violate due process principles.⁹

Of the thirty-eight jurisdictions that permit involuntary commitment for substance abuse, two (MT, RI) only allow involuntary commitment for alcoholism, while one (VT) only allows involuntary commitment for SUD, not alcoholism.¹⁰ Five states (IN, ME, NE, TN, VA) include SUD and alcoholism in their statutory definition of “mental illness.” Most states, however, do not classify SUD or alcoholism as mental illnesses (possibly to avoid the availability of the insanity defense), and may have different criteria and procedures for (1) civil commitment of persons with mental illness, and (2) civil commitment of persons with alcoholism or other substance abuse.¹¹

There is some variation among the states as to who may initiate civil commitment proceedings for persons with SUD or alcoholism. Petitioners may:

include the person’s spouse, guardian, relative, or health care professionals, including a physician, physician assistant, advanced practice registered nurse, or psychologist. In some states, any responsible adult with knowledge of the circumstances may petition to have the individual committed for treatment. In other states, commitment proceedings may only be commenced by the administrator or director of a treatment facility or hospital where the individual has been receiving treatment on an emergency basis.¹²

The Supreme Court has said that the standard of “clear and convincing” evidence is required for involuntary hospitalization of a person who has a psychiatric illness and poses an imminent risk of danger to himself or others.¹³ All states that permit civil commitment of those with substance use disorder have likewise adopted this standard, which is less than the standard used in criminal cases (proof beyond a reasonable doubt) and greater than the standard used in most civil cases (proof to a preponderance of the evidence).¹⁴

II. Expanding Civil Commitment in Response to the Opioid Crisis: The Case of Massachusetts

In many states, there is growing recourse to civil commitment to coercively secure treatment of SUD. In Massachusetts, for example, 6,500 individuals were involuntarily committed to treatment in 2016,¹⁵ under Section 35 of the state’s mental health code.¹⁶ The state’s modern civil commitment regime was originally enacted in 1970, applied only to “alcoholics,” and allowed commitment for a maximum of fifteen days.¹⁷ In 1987, the regime was expanded to permit involuntary commitment of “substance abusers,”¹⁸ and in 2012, the maximum period of commitment was extended to ninety days.¹⁹

Under current Massachusetts law, “[a]ny police officer, physician, spouse, blood relative, guardian or court official may petition in writing any district court or any division of the juvenile court department for an order of commitment of a person whom he has reason to believe has an alcohol or substance use disorder.”²⁰ In practice, family members are the most common petitioners.²¹ The statute allows the court to issue a warrant for the individual’s arrest if he or she does not voluntarily appear upon receipt of a summons, and the individual has a right to counsel—including state-appointed counsel if indigent.²² After a court-ordered examination by “a qualified physician, a qualified psychologist or a qualified social worker,” and other testimony (which may include an expert testimony introduced by the individual), the court issues an order of committing

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the individual for up to ninety days upon a finding that he or she has “an alcohol or substance use disorder and there is a likelihood of serious harm as a result of the person's alcohol or substance use disorder.”²³ “Likelihood of serious harm,” in turn, may be proved in three different ways; that is, under any one of the following three prongs:

(1) a substantial risk of physical harm to the person himself as manifested by evidence of, threats of, or attempts at, suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or (3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.²⁴

The third prong appears to be an especially common approach to civil commitment of those with SUD. One important question facing courts administering statutory regimes like that in Massachusetts is the significance of widespread illicit fentanyl, a highly potent opioid,²⁵ if the individual brought before the court not only has pronounced opioid use disorder but has in recent months overdosed one or more times. The fact is that in some parts of the country the illicit opioid market is much more dangerous than it used to be. Concomitantly, individuals who a decade ago might not have presented “a very substantial risk of physical impairment” may be found by courts to meet that threshold today. This is disconcerting in its own right, and also because, as we discuss in Part III, there is little evidence that such individuals would receive effective treatment if confined, and would likely face a marked risk of overdose upon discharge.

In 2015, Massachusetts’ highest court, the Supreme Judicial Court, considered at some length the requirements for civil commitment under Section 35. In addition to reaffirming that Massachusetts requires only the “clear and convincing” standard of proof (not the higher criminal standard of proof beyond a reasonable doubt), the court held that a showing of “substantial risk of physical harm” under the first two prongs requires a showing of “imminent” harm because “an assessment of a substantial risk of harm diminishes the farther out one projects as to when the harm is likely to materialize.”²⁶ “Imminent,” however, does not mean “immediate” but rather “in the reasonably short term—in days or weeks rather than in months.”²⁷

Greater immediacy of harm is required to commit a person pursuant to the third prong, which requires a “very substantial risk” of harm. However, it is sufficient to prove that the individual’s “judgment is so adversely affected by the abuse of alcohol or drugs that [he or she] cannot protect himself or herself from physical harm” and that the individual’s “community does not include any reasonably available external source of adequate protection.”²⁸ The court noted that merely proving that the individual “was addicted to heroin and had not been able successfully to control the addition . . . d[oes] not appear to satisfy the requirements” of the Massachusetts civil commitment statute.²⁹ The year after the Supreme Judicial Court’s decision, an appeals court in Massachusetts upheld the commitment of an individual who had intravenously used heroin for several years, had overdosed the night before his commitment hearing and after being revived had refused medical treatment, and had twice previously been committed for threatening to kill himself and his mother.³⁰ At the commitment hearing, the individual’s girlfriend testified that until the night of the overdose, the individual had “not ‘used[d] for so many months and then he did use, he ended up overdosing.’”³¹

The Massachusetts regime is controversial also because of the apparently inadequate standard of medical care that individuals are provided after they are confined. The Massachusetts regime specifically requires that the residential commitment “shall be for the purpose of inpatient care for the treatment of an alcohol or substance use disorder in a facility licensed or approved by the department of public health or the department of mental health.”³² Many male SUD commitments in Massachusetts are to a facility that previously served as an all-male minimum security prison. The statute provides for such commitment “if the court makes a specific finding that the only appropriate setting for treatment for the person is a secure facility.”³³ A former prison is, by definition, a “secure facility.” As Boston radio station WBUR reported in September 2017:

Enter the former Massachusetts minimum security prison in Plymouth and you might think it’s still a prison. Men arrive in handcuffs, they wear orange jumpsuits, and they’re monitored by correction officers.³⁴

Moreover, it is not clear what kinds of treatment these civilly committed individuals in Massachusetts actually receive. A committed individual is initially placed in a “detoxification unit” and then is counseled “about addiction, sobriety, and how to prevent relapse.”³⁵ The state provides no MAT at Plymouth, even though access to MAT has been shown by evidence-based studies to be more effective for many persons with SUD than abstinence-based treatment,³⁶ as we discuss in the next section. The superintendent of the facility may release the individual before expiration of the 90-day period “upon written determination . . . that release of that person will not result in a likelihood of serious harm.”³⁷

Several legal challenges have been filed in recent years against commitment under Massachusetts Section 35. A class action lawsuit challenging the civil commitment of women in a wing of a state prison was filed in 2014. The suit alleged that no “inpatient care” is provided. Instead, those committed were “put through a brief detoxification, and then they are simply incarcerated.”³⁸ A similar suit was filed last year challenging the confinement of men in the former minimum security prison in Plymouth.³⁹

In late 2017, Massachusetts Governor Charlie Baker proposed expanding the state’s civil commitment regime in the “Act Relative to Combatting Addiction, Accessing Treatment, Reducing Prescriptions, and Enhancing Prevention” (CARE Act).⁴⁰ The proposed legislation would permit medical professionals—in an emergency department, for instance—to “restrain or authorize the restraint” of a patient for transportation to a licensed treatment facility and confinement for up to 72 hours in such facility “where a patient poses an immediate risk of harm” but does not agree to “voluntary treatment.”⁴¹ The individual may seek a judicial hearing, and “[t]he superintendent of the faculty, if he or she seeks to retain the person for treatment, shall at the time of the hearing file a petition for commitment under section 35.”⁴²

III. Medical, Ethical, and Legal Questions

A. Medical Concerns

Perhaps the most fundamental medical question—which must in turn inform ethical and policy determinations—concerns effectiveness. Simply stated, if involuntary treatment for SUD is ineffective from a medical perspective, the entire debate over whether involuntary civil commitment should be used for those with SUD is over. Unfortunately, there is no uniformly agreed upon answer to the question of effectiveness.

The current standard of care for opioid use disorder is a combination of MAT with psychosocial interventions. The problem with involuntary commitment schemes like Massachusetts' is that they may involve neither form of treatment, or are not set up to do either well. Thus, they may be ineffective responses (or worse) to the problem they are trying to address. The first phase of treatment, withdrawal or detoxification, can last up to 10 days after the last opioid use and involves a period of sometimes extremely uncomfortable but not life-threatening physiologic symptoms such as anxiety, pain, diarrhea, and nausea and vomiting.⁴³ Medications in the acute withdrawal phase target symptom relief and can include opioid derivatives with a specific rapid taper protocol. Non-opioids, such as clonidine, loperamide, and ibuprofen, may also be used. The present standard of care for most patients would then be long-term maintenance treatment with opioid derivatives or naltrexone, an opioid antagonist, prescribed using long-term protocols with close monitoring.⁴⁴ Opioid-derived maintenance medications (generally methadone or buprenorphine) have the most evidence but can be stigmatizing in settings when opiate replacement therapy may be viewed as substituting one addiction for another.⁴⁵ Clinicians must also prescribe opioid derivatives cautiously because co-ingestion with other substances can be dangerous or fatal. Many MAT programs require frequent in-office follow-up visits, random urine testing, and monitoring of controlled prescriptions to prevent doctor shopping, that is, seeking medications from multiple prescribers.⁴⁶

Psychosocial interventions are important adjuncts during the maintenance phase of opioid use disorder treatment and can be administered in acute inpatient, residential, or outpatient settings, depending on a person's level of impairment. These services address underlying impediments to recovery and connect people with OUD in a structured support network that provides guidance and mentorship for people at various stages of the recovery process. For example, people with OUD are encouraged to attend self-help groups, such as Alcoholics Anonymous and Narcotics Anonymous. Additional services may include contingency management, vocational rehabilitation, psychoeducation, and cognitive behavioral psychotherapy to prevent relapse.⁴⁷ Since many patients with opioid use disorder may be ambivalent or resistant to change, motivationally-enhanced psychotherapy or motivational interviewing is the preferred method to guide patients to gain insight into the illness. Motivational interviewing is a type of client-centered psychotherapy that promotes behavior change by exploring and resolving ambivalence.⁴⁸

Like most medical treatment, addiction treatment depends on the patient's voluntary cooperation. Although some evidence suggests that certain types of people might benefit from involuntary treatment, a 2016 review of available data concluded that evidence does not suggest improved outcomes of compulsory treatment, and some studies suggested potential harm resulting from such treatment.⁴⁹ Even studies written from a perspective more sympathetic to involuntary treatment express significant doubts about effectiveness:

[T]he most important question to be answered is whether or not compulsory treatment is effective in the rehabilitation of substance addicted offenders. Regrettably, three decades of research into the effectiveness of compulsory treatment have yielded a mixed, inconsistent, and inclusive pattern of results⁵⁰

The resulting uncertainty ought to counsel policymakers to proceed with caution.

B. Ethical Concerns

Assuming, for the sake of argument, that there might be some medical value to involuntary commitment and treatment, ethical and policy questions loom large. Bodily integrity and decisional autonomy interests are implicated quite dramatically when it comes to involuntary commitment and treatment. While civil commitments for mental illness and dangerousness are relatively common in the United States (though with deinstitutionalization, “[t]he number of psychiatric inpatients declined precipitously from a high of more than 550,000 in 1950 to 30,000 by the 1990s”), that is not true of dangerous substance abuse.⁵¹ “[T]he practice of committing addicted individuals who have not broken laws is rare.”⁵² The limited literature on this subject ascribes the infrequency of civil commitment for SUD to (1) societal reluctance to restrict autonomy through non-criminal mechanisms of social control, (2) reluctance on part of clinicians and others to expend funds on involuntary interventions when access to voluntary addiction treatment is so limited, and (3) genuine societal ambivalence over whether substance abuse should be viewed as willed conduct or the consequence of unwilled affliction.

Ordinarily, patient autonomy is the key concern in healthcare delivery. It forms the basis of such central doctrines as informed consent and the fiduciary duties that obtain within the doctor-patient relationship. In the context of civil commitment, the interest in patient autonomy is overridden by asserted public health interests. To what extent striking this balance is justified depends on the harms that may be caused by a lack of treatment. Indeed, the U.S. Supreme Court, with respect to involuntary commitment in the context of mental illness, held that “a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”⁵³

Therefore, many states (including, as we have seen, Massachusetts) require that

the petitioner must allege circumstances beyond just that the individual sought to be committed has a substance use disorder or is an alcoholic. Typically, there must also be evidence that the individual has threatened, attempted, or inflicted physical harm on himself or herself or another, or proof that if the individual is not detained, he or she will inflict physical harm on himself, herself, or another, and/or that the individual is incapacitated by drugs or alcohol such that he or she cannot provide for his or her basic needs, including food, shelter, and clothing, and there is no suitable adult willing to provide for such needs.⁵⁴

Remarkably, several states “allow commitment on the basis of substance abuse alone—that is, in the absence of additional clinical, legal, or social factors.”⁵⁵ As noted above, however, such commitments are rare.⁵⁶

A major ethical issue for the medical professional in states permitting civil commitment for SUD is whether to cooperate in imposition of involuntary treatment of individuals who have already been involuntarily confined by court order. When civilly committed patients refuse MAT, clinicians may not simply and automatically prescribe involuntary MAT. The general clinical standard of care reserves involuntary medications for those persons presenting a risk of imminent harm.⁵⁷ Because they are confined away from the general population and access to opioids, civilly committed individuals are generally not understood to be in imminent harm.

Another likely scenario in many states is that there will be a group of civilly committed patients who *are* willing to take maintenance medications, but state law or practice does not include access to MAT; Massachusetts is currently such a state with respect to its men’s facility in Plymouth. In these circumstances, medical professionals are in an ethically challenged position. If they participate in the coercive achievement of abstinence during confinement, they are not only acting outside of the ordinary standard of care for SUD, they also are participating in creating the risk that the individual will accidentally overdose when discharged. As is noted in other contributions,⁵⁸ the discharged individual may consume his or her pre-treatment dose, not realizing that their tolerance decreased during the period of abstinence, with potentially tragic results.⁵⁹ Involuntary commitment can also provoke patient disengagement and negative attitudes toward mental health treatment, discouraging people from seeking treatment later in life.

C. Legal and Policy Concerns

Civil commitment of those with SUD “blur[s] the lines between health care and incarceration.”⁶⁰ Moreover, the infringement on personal autonomy that occurs with involuntary commitment is not checked by the strong procedural and substantive safeguards that exist in the criminal context. There may be involuntary confinement and treatment subsequent to a criminal conviction,⁶¹ but the civil commitment regime differs markedly from the criminal justice framework. The U.S. Supreme Court has held that “[p]ersons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.”⁶² It is not clear that this constitutional standard is met when individuals with SUD are held in a prison setting under conditions virtually equivalent to those of convicted offenders.

Moreover, despite being held in institutions that may be indistinguishable from prisons, civilly committed individuals did not receive procedural protections in the commitment hearing that were equivalent to the protections afforded in criminal trials. While individuals are provided with an attorney, the standard of proof, as we have noted, is not “beyond a reasonable doubt,”⁶³ and the rules of evidence do not apply (so that hearsay, for instance, is permitted).⁶⁴ More fundamentally, the issue in a civil commitment proceeding involves *predicting the future* (whether the individual is at risk of harming himself or others), rather than ascertaining *what happened in the past*—i.e., whether the defendant committed a crime specified in the state’s penal code. The American Psychological Association and the American Psychiatric Association have long warned of the perils, uncertainty, and ultimately the unreliability of predictions of future dangerousness.⁶⁵ To be sure, the U.S. Supreme Court has declined to transform “the view of the [American Psychiatric Association]. . . into a constitutional rule barring an entire category of expert testimony.”⁶⁶ But the question facing states considering the use of civil commitment of those with SUD is not only a question of constitutional law. The question is what is the best policy. The state must consider whether such coercive restrictions on liberty are justified by the likelihood of harm reduction to the individual and the larger community.

IV. Conclusion

The opioid epidemic is of such a scale as to require significant intervention. Civil commitment and involuntary treatment present an extraordinary way of addressing the crisis. In the name of

protecting the public health, however, not every perceived solution is legitimate or desirable, no matter the scope of the crisis.

Health law scholars are deeply skeptical of most states' SUD civil commitment regimes, suggesting that "[t]he prospects for positive outcomes . . . are especially bleak, given the standard of care currently available [in these facilities]."⁶⁷ One core criticism of civil commitment for opioid dependence, in particular, is lack of access to MAT and to appropriate psychosocial interventions.⁶⁸ Rather than offering evidence-based treatment, "the treatment provided is often not rooted in science at all."⁶⁹

Before policymakers embrace involuntary commitment and treatment as a viable solution, they ought to carefully examine the medical, ethical, and legal uncertainties, as well as competing social and civil liberties interests.

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¹ **Ish Prasad Bhalla M.D.**, is a fellow in forensic psychiatry in the Department of Psychiatry, Yale School of Medicine. He received his B.S. from Case Western Reserve University and his M.D. from University of Toledo College of Medicine. **Nina Cohen** received her A.B. from Bryn Mawr College and her MSc from the University of Oxford. She will receive her J.D. from Yale Law School in May 2018. **Claudia E. Haupt, Ph.D., J.S.D.**, is a Resident Fellow at the Information Society Project and a Research Fellow at the Solomon Center for Health Law & Policy, both at Yale Law School. She received her first law degree and Ph.D. from the University of Cologne, her LL.M. from George Washington University, and her J.S.D. from Columbia Law School. **Kate Stith, J.D.**, is the Lafayette S. Foster Professor of Law at Yale Law School. She received her B.A. from Dartmouth College, and her M.P.P. and J.D. from Harvard University. **Rocksheng Zhong, M.D., M.H.S.**, is a fellow in forensic psychiatry in the Department of Psychiatry, Yale School of Medicine. He received his A.B. from Harvard College and his M.D. and M.H.S. from the Yale School of Medicine.

² Compare D. Shesgreen, "Families seek involuntary commitment laws as key tool in saving opioid addicts," *USA Today*, Aug 23, 2017, <https://www.usatoday.com/story/news/politics/2017/08/23/families-seek-involuntary-commitment-laws-key-tool-saving-opioid-addicts/594423001/> with M. Cramer, "Worse than jail? Addicts civilly committed say DOC abused them and failed to treat them," *Boston Globe*, July 14, 2017, <https://www.bostonglobe.com/metro/2017/07/13/worse-than-jail-addicts-civilly-committed-say-doc-abused-them-and-failed-treat-them/1kzQdRdO6F4QeQuYUiP54J/story.html>.

³ National Alliance for Model State Drug Laws (NAMSDL) (2016), *Involuntary Commitment for Individuals with a Substance Use Disorder or Alcoholism* 3; Christopher, P. P., Pinals, D. A., Stayton, T., Sanders, K., Blumberg, L. (2015), Nature and utilization of civil commitment for substance abuse in the United States, *Journal of the American Academy of Psychiatry and the Law*, 43(3):313-320, at 314.

⁴ See, e.g., *Jacobson v. Massachusetts*, 179 U.S. 11 (1905).

⁵ K. T. Hall, P. S. Appelbaum, "The Origins of Commitment for Substance Abuse in the United States," *Journal of the American Academy of Psychiatry and the Law* 30(1) 2002, pp. 33-45.

⁶ *Id.* at 37.

⁷ *Id.* at 42.

⁸ *Id.* at 35-37.

⁹ *Id.* at 38-39 (citing *In the matter of Adrian Janes*, 30 How. Pr. 485 (N.Y. Sup. Ct. 1866)).

¹⁰ NAMSDL, *supra* note 3, at 4.

¹¹ *Id.* at 3.

¹² *Id.* at 5. See also P.P. Christopher, et al., *supra* note 3.

¹³ *Addington v. Texas*, 441 U.S. 418 (1979)

¹⁴ NAMSDL, *supra* note 3, at 5.

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- ¹⁵ L. Beletsky, E.L. Ryan, W.E. Parmet, “Involuntary Treatment for Substance Use Disorder: A Misguided Response to the Opioid Crisis,” Harvard Health Business Blog Jan 24, 2017, <https://blog.content.health.harvard.edu/blog/involuntary-treatment-sud/>
- ¹⁶ Mass. Gen. L. ch. 123, § 35.
- ¹⁷ Act of Sept. 1, 1970, ch. 888, § 35, 1970 Mass. Acts 830, 855.
- ¹⁸ Act of Nov. 17, 1987, ch. 500, 1987 Mass. Acts 886.
- ¹⁹ Act of Oct. 27, 2011, ch. 142, § 18, 2011 Mass. Acts 691, 705.
- ²⁰ Mass. Gen. L. ch. 123 § 35.
- ²¹ See C. Slayton, “Maximum Sentencing Under Section 35” 15 (2015). *Honors Theses*. 57. https://digitalcommons.salemstate.edu/honors_theses/57
- ²² Id.
- ²³ Id.
- ²⁴ Mass. Gen. L. ch. 123 § 1.
- ²⁵ See R. Rothberg & K. Stith, *Fentanyl: A Whole New World?* (in this volume).
- ²⁶ In the Matter of G.P., 473 Mass. 112, 137 (2015).
- ²⁷ Id. at 128.
- ²⁸ Id. at 128-129.
- ²⁹ Id. at 130.
- ³⁰ 2016 Mass. App. Div. 74 (2016).
- ³¹ Id.
- ³² Mass. Gen. L. ch. 123 § 35.
- ³³ Id. (providing, inter alia, that men may be committed to “the Massachusetts correctional institution at Bridgewater”).
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- ³⁵ Department of Health and Human Services, Section 35 – FAQ about Civil Commitment of those with Substance Abuse problems and other Options, <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/addictions/drugsand-alcohol/section-35-faq.html>.
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- ³⁷ Id.
- ³⁸ Doe v. Baker, <https://aclum.org/wp-content/uploads/2015/06/s35-complaint.pdf>
- ³⁹ See M. Cramer, *supra* note 2.
- ⁴⁰ <https://www.mass.gov/files/documents/2017/11/14/TheCAREAct.pdf>
- ⁴¹ Id., § 38 (proposing new § 35A after current Mass. Gen. L. ch. 123, § 35).
- ⁴² Id., proposed § 35A (b).
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- ⁵² Id., p. 37.
- ⁵³ O’Connor v. Donaldson, 422 U.S. 563, 576 (1975).

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- ⁵⁴ NAMDSL, *supra* note 3, p. 6.
- ⁵⁵ Christopher et al., *supra* note 3, p. 318.
- ⁵⁶ See Testa and West, *supra* note 53, p. 37 (in states permitting commitment solely on the basis of substance abuse, “only 20% of psychiatrists believed that substance dependence as a diagnosis fulfilled criteria for civil commitment”).
- ⁵⁷ Fischer, J., “A comparative look at the right to refuse treatment for involuntary hospitalized persons with a mental illness,” *Hastings Int’l & Comp. L. Rev.* 2005;29:153, 165-167.
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- ⁶⁶ *Barefoot v. Estelle*, 463 U.S. 880, 899 (1982); see also *Estelle v. Smith*, 451 U.S. 454, 472 (1981); *Addington v. Texas*, 441 U.S. 418, 429 (1979).
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- ⁶⁸ *Id.*
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