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Ethical Considerations in Civil Commitments for Substance Use Disorders

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Cynthia Nichols, MSW, Ph.D. (Candidate)
University of Connecticut
Cynthia.nichols@uconn.edu

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Abstract

In the wake of the opioid epidemic, involuntary civil commitments (ICC) for substance use disorders (SUDs) are becoming common practice. Despite SUDs being classified as a mental health condition, they are often treated differently, leading to ambiguity among states regarding the regulations and treatment of civil commitments. Although ICC is deemed to be legal, the ethics of ICC for SUD requires further consideration. Research has suggested that ICC for SUD may not be as effective as initially thought. Moreover, ICC practices among courts and treatment centers perpetuate the criminalization of substance use. Drawing on a case example from Massachusetts, this article discusses ICC using utilitarian and deontological ethical frameworks.

Keywords: Involuntary civil commitments, substance use disorders, opioid use disorder, social work ethics, utilitarian framework, deontological framework

Ethical Considerations in Civil Commitments for Substance Use Disorders

Multiple states have enacted laws that allow the use of involuntary civil commitments (ICC) for individuals diagnosed with substance use disorders (SUDs) (Cavaiola & Dolan, 2016). Civil or involuntary commitment is a legal process involving individuals with mental illness, SUD, or both, who are court-ordered to inpatient or outpatient treatment programs (Cavaiola & Dolan, 2016). ICC can be initiated by family members, health care practitioners, or other individuals for a person with a SUD (Jain et al., 2018). Although social workers are often on the frontlines of making these decisions, few studies have explored the ethical dilemmas for social workers who are initiating ICC (Taylor, 2006). While ICC can serve as a protective factor in reducing the immediate threat of overdose, ethical concerns continue to exist (Cavaiola & Dolan, 2016; Jain et al., 2018).

Previous research has primarily focused on social workers' experiences when initiating ICC for mental health reasons rather than substance use (Maylea, 2017); however, they share similar themes of ethical issues surrounding coercion (Gomory & Dunleavy, 2018; Maylea, 2017; Taylor, 2006). Although the National Association of Social Workers (NASW) (2024) ethical values provide social workers with the ideals to practice by, ethical dilemmas persist, with scholars arguing the NASW Code of Ethics is rooted in contrasting moral theories, specifically deontological and utilitarian perspectives (Bryan et al., 2016; Gomory & Dunleavy, 2018). This article aims to add to the growing body of literature addressing ICC for SUD, as well as provide social workers with a better understanding of the history of ICC and the complexities of making such decisions. Massachusetts (MA) is used as a case example to emphasize the positives and negatives of ICC for SUD. This article discusses the differences between deontological and utilitarian ethical perspectives and provides recommendations for how to balance both frameworks and manage conflicting perspectives when initiating ICC. Although all healthcare professionals do not share the same code of ethics,

utilitarian and deontological frameworks are applicable and drive many decisions made in healthcare; hence, understanding these frameworks is particularly important for social workers working with other public health professionals (Tseng & Wang, 2021).

History of Substance Use Treatment and Civil Commitments

Substance use treatment options have grown since the mid-1800s, contributing to changes in commitment laws. The Temperance Movement literature, written during the mid-1800s, began the discussion of addiction being viewed as a disease rather than a moral failure (Hall & Appelbaum, 2002). This prompted at least 14 states to pass commitment statutes for addiction between the 1860s and 1890s, in addition to 50 "inebriate hospitals" being constructed across the United States (Hall & Appelbaum, 2002). During the 1910s, there was increased interest in persons with SUD being committed and cared for within inpatient settings, prompting the creation of a national treatment facility in Lexington, KY in 1935 (Williams et al., 2014). The emphasis on inpatient settings changed during the 1960s and 1970s when states began to separately consider commitment laws for persons with SUD, causing ICC for SUD to be in outpatient or residential treatment settings (Gostin, 1991). Concurrently, states were narrowing the criteria for ICC, with greater emphasis placed on the danger posed by an individual rather than their need for treatment. In the 1980s, the American Psychiatric Association (APA) countered this change with the 1983 Model State Law, arguing for the need for treatment, which led states to widen their criteria to include risk of severe deterioration and the inability to care for self (Williams et al., 2014).

Initial ICC laws emphasized the importance of a supportive, long-term treatment environment to allow individuals to stabilize. One of the first civil commitment laws to address individuals with SUD was the Marchman Act, passed in 1993 in Florida (Cavaiola & Dolan, 2016). The Marchman Act provided civil commitment for up to 7 days or longer-term treatment for those with severe SUD (Cavaiola & Dolan, 2016). This law allowed for mandatory

treatment where individuals could be assessed and stabilized through detox, medication-assisted treatment, and medical stabilization, as well as encouraging longer-term treatment (Cavaiola & Dolan, 2016). The Marchman Act contended that treatment may provide time for individuals to regain rational decision-making, which may be lacking due to the nature of SUD (Cavaiola & Dolan, 2016).

The Opioid Epidemic

Presently, substance use is one of the leading causes of morbidity and mortality in the US (Christopher et al., 2015). Increases in prescription opioid use, heroin, and fentanyl have contributed to a rise in overdose deaths. Drug overdoses have claimed over one million lives since 1999, with opioids involved in 80,411 overdose deaths in 2021 (Centers for Disease Control and Prevention (CDC), 2023). In addition to substance use being a significant public health and safety issue, it poses economic consequences (Christopher et al., 2015). In the US, substance use is believed to have an economic impact ranging from $193 billion for illicit drugs to $223.5 billion for alcohol (Bouchery et al., 2011).

An increase in opioid prescriptions can be traced to the 1990s when two critical shifts in practice occurred: (1) the use of opioids for pain management expanded to non-cancer patients, and (2) Purdue Pharma received Food and Drug Administration (FDA) approval for Oxycontin (Krans & Patrick, 2016). As opioids were over-prescribed, patients became addicted, leading to an increase in heroin use and overdose deaths (Krans & Patrick, 2016; Rudd et al., 2016). Other factors contributing to opioids being more accessible were black tar heroin being less expensive on the illegal market, and the creation of "pill mills" by corrupt doctors who dispensed prescriptions for cash and other goods (Quinones, 2015). Since 2013, overdose deaths involving synthetic opioids have been on the rise, particularly those involving fentanyl (O'Donnell et al., 2017).

For many years, voluntary treatment for SUD has been the only option for individuals struggling with substance use outside of the context of the

criminal justice system (Cavaiola & Dolan, 2016). Although voluntary treatment for SUD is often more desirable due to increased patient autonomy, mandated treatment is effective in certain instances (Farabee et al., 1998; Kelly et al., 2005). Research has found that offenders mandated to SUD treatment demonstrated similar or improved substance use outcomes as well as crime reduction, compared to those who entered SUD treatment voluntarily (Kelly et al., 2005). Drug courts, which are specialized dockets for criminal offenders with SUD, are a common example of mandated treatment, with SUD treatment often required to avoid incarceration (Cavaiola & Dolan, 2016). Drug courts have been useful in diverting nonviolent offenders away from the criminal justice system and into SUD treatment; however, drug courts are, in many jurisdictions, only applicable for individuals who have been convicted of a drug-related charge (Fulton Hora, 2002). ICC for SUD is another type of mandated treatment with similar aims of reducing risks related to substance use, including overdose and criminal involvement.

Civil Commitments for Substance Use Disorders

Many states are turning to ICC as a solution in addressing the opioid epidemic and increasing access to treatment. In 2017, the President's Commission on Combating Drug Addiction and the Opioid Crisis issued a report providing recommendations on how to address the addiction crisis (Christie et al., 2017). This report revealed that 90% of people with SUD (including 17 million American adults) did not believe specialty substance use treatment was needed (Christie et al., 2017). Furthermore, of the more than 20 million Americans diagnosed with a SUD under the Diagnostic and Statistical Manual of Mental Disorders (DSM), only two percent of that number have received substance use treatment, with under one percent receiving care from a facility that specialized in substance use treatment (Christopher et al., 2015). These statistics suggest that many individuals do not recognize the importance of substance use specific treatment, or do not wish to pursue treatment (Christopher et al., 2015; Jain et al., 2018).

Given the low rates of interest in treatment, external influences are often involved in treatment initiation, including family pressure, mandates by work or legal influences, including jail diversion and drug courts (Christopher et al., 2015). ICC for substance use occurs when an individual is court-ordered to a period of treatment, which occurs separately from criminal confinement and other forms of civil commitments (Klag et al., 2005). ICC laws have been enacted by several states in response to the concerns of family, significant others, and friends when a loved one is using substances (Cavaiola & Dolan, 2016). Family and friends of those misusing opioids are often faced with the difficult reality that if they wait until their loved one is willing to voluntarily enter treatment, their loved one may face overdose and death (Cavaiola & Dolan, 2016). ICC laws for substance use have been adopted in 38 states as a way of mandating individuals with severe SUD to enter treatment (Cavaiola & Dolan, 2016; Slocum et al., 2023).

In ICC cases, concerned individuals may petition the court to enforce a mandate for a person with a severe SUD to enter treatment (Christopher et al., 2015). Rather than a criminal charge, the petition allows the court to issue a ruling (Walton & Hall, 2017). The petition process is started by a concerned person providing supportive information that justifies reasons the defendant's substance use is severe enough for emergent treatment to be warranted, and they are at risk of harm to themselves or others (Walton & Hall, 2017). Typically, statutory requirements include that a medical professional evaluate the person with the SUD and certify, in writing, that the person needs intensive treatment, accompanied by the commitment petition (National Judicial Opioid Task Force, 2019). The status governing ICC vary by jurisdiction, with criteria commonly including dangerousness to oneself or others, grave disability, lack of decision-making capacity, inability to manage personal affairs and take care of basic needs, and loss of control due to addiction (National Judicial Opioid Task Force, 2019).

If a judge grants the petition, the ICC process would occur, meaning the individual would be mandated to SUD treatment (Walton & Hall, 2017). To protect the civil rights of the person with the SUD, every state allows the right to an attorney during the commitment process, and the right to

petition the court for a writ of habeas corpus, which is a right that protects against unlawful and indefinite imprisonment (American Civil Liberties Union, 2007; National Judicial Opioid Task Force, 2019). Statutes vary in the type of punishment imposed for individuals resistant to treatment, as well as ICC commitment length and location (Walton & Hall, 2017).

Presently, disagreement exists regarding the nature and treatment of SUD within the medical community, leading to variability among state statutes of ICC laws for SUD (Williams et al., 2014). Every US state has adopted laws that allow individuals with mental health issues (those at risk of harming themselves or others, or danger to self as a result of a grave disability) to be involuntarily committed; although, specifics regarding these laws are variable by state (Williams et al., 2014). Despite SUD being classified as a mental health condition, SUD ICCs are often addressed differently, meaning the commitment process is different from commitments for other mental health reasons, which are typically carried out in an inpatient psychiatric unit (Testa & West, 2010). Whereas some states, such as Maine, have already included SUD under their eligibility criteria in ICC laws for mental health issues, others, such as Kentucky, have specifically created separate ICC laws for those with SUD (Walton & Hall, 2017).

Furthermore, civil commitment laws differ in the length of confinement and the type of treatment setting, either outpatient or inpatient (Cavaiola & Dolan, 2016). For example, Arizona has commitment durations of 90, 180, and 365 days, while Massachusetts has a 90-day duration (Cavaiola & Dolan, 2016). In addition to having a 90-day duration, MA utilizes settings outside of typical therapeutic environments for substance use ICC.

Massachusetts Case Example

Opioid-related overdose deaths rose in MA in 2022 by 2.5% compared to 2021, with 2,357 deaths in 2022 and the largest increase in deaths occurring among Black and non-Hispanic residents (MA Department of Public Health, 2023). Non-Hispanic Black residents had the highest opioid-related

overdose death rate increase from 2021 to 2022, from 56.4 to 79.6 per 100,000, while non-Hispanic women increased from 17.4 to 25.5 per 100,000 (MA Department of Public Health, 2023). Furthermore, in 2020, opioid related deaths in MA were 33% higher than the national average (Slocum et al., 2023).

In MA, petitions for ICC are under the MA General Law Chapter 123, Section 35, commonly called "Section 35 Petitions" (Munichiello, 2019). Section 35 was enacted in 1970 which allows a qualified person (i.e. physician, police officer, court official, or blood relative) to petition the court to have a person involuntary committed for SUD (Slocum, 2023). Individuals are sectioned into various facilities overseen by the Department of Public Health (DPH), the Department of Mental Health (DMH), and the Department of Correction (DOC) (Becker, 2019). MA is the only state that uses correctional institutions for ICC when no crime is involved (Becker, 2019). As of 2019, if there are not any suitable licensed or DPH or the DMH approved treatment facilities available, and if the court finds the only appropriate setting is within a secure facility, then a person may be committed for "(i) a secure facility for women approved by the DPH or the DMH, if a female; or (ii) the MA correctional institution at Bridgewater or other such facility as designated by the commissioner of correction, if a male; provided, however, that any person so committed shall be housed and treated separately from persons currently serving a criminal sentence." (The General Court of the Commonwealth of MA, 2023, para. 7). Previously, women also had the potential to be committed to a correctional facility, but this changed in 2019. Currently, all the facilities women are committed to are overseen by either DPH or DMH, whereas two of the three facilities for men are overseen by DOC (Becker, 2019).

In 2019, MA Governor Charlie Baker created a Section 35 Commission to evaluate the efficacy of ICC for SUD (Munichiello, 2019). According to this report, the Men's Addiction Treatment Center (MATC) in Brockton was the only Section 35 facility overseen by DPH and MA Alcohol and Substance Abuse Center (MASAC), and the largest men's facility was run by the DOC (Munichiello, 2019).

The Commission's report revealed stark differences between these two settings, including differences in types of medications for opioid use disorder (MOUD) offered. MOUD is an evidenced based treatment for individuals with opioid use disorder (OUD) (Degenhardt et al., 2011; Larochelle et al., 2018; Ma et al., 2019). Commonly used MOUD include buprenorphine, methadone, naltrexone, and injectable options (Sublocade and Vivitrol) (Substance Abuse and Mental Health Services Administration (SAMHSA), 2022). The use of MOUD has been shown to increase treatment retention and employment, and decrease criminal behaviors (SAMHSA, 2022). Although all four of the Section 35 facilities offer buprenorphine and naltrexone, MATC was the only facility licensed to offer methadone (Munichiello, 2019). According to a 2018 study in MA, only 19% of individuals who had been civilly committed for OUD received MOUD (Christopher et al., 2018).

Additionally, one-third fewer therapy services were offered at MASAC compared to MATC (Munichiello, 2019). Furthermore, correctional procedures at MASAC interfered with a treatment-centered approach; this included patients being instructed to stand at the foot of their bed and remain standing while officers counted them (Munichiello, 2019). The treatment at MASAC and MATC has also been described as "night and day," with MASAC staff consisting of 100 correctional officers (with no special training), and only 17 substance use counselors (Munichiello, 2019, para. 10). MASAC patients also experience strip searching upon admission, solitary confinement for punishment, and report officers using abusive language, threats, and intimidation, all of which were not reported at MATC (Munichiello, 2019).

Since the Commission's report, in November 2022, Section 35 regulations were amended to mandate access to MOUD in any civil commitment facility in MA; however, there have been no studies assessing implementation of these changes (Slocum et al., 2023). Other reports have revealed that individuals committed to carceral settings have been placed in solitary confinement for refusing food, lost access to psychiatric medications, and experienced irreversible trauma from these experiences (Slocum et al., 2023).

Ethical Legislative Precedents

ICC laws have originated from two roles or functions of the state, specifically police powers (meaning the government's ability to enact laws to coerce citizenry for public good) and *parens patriae* (meaning "parent of the fatherland") (SAMHSA, 2019). Police powers protect citizens from harmful substance-related behaviors (driving under the influence), while *Parens patriae* is a legal doctrine that allows the state to act *in loco parentis,* meaning "in place of a parent", when citizens are incapable or lack capacity to act on their behalf (Walton & Hall, 2017). Essentially, the court can suspend an individual's right to freedom and require that they enter treatment so they may recover, in order to protect the safety and health of individuals and communities (Walton & Hall, 2017).

Several cases have formed the legal basis for ICC laws. Lawmakers have decided that specific health conditions are dangerous enough to permit nonconsensual intervention, including mental illness, tuberculosis, and guardianship (Bayer & Dupuis, 1995; Monahan et al., 1995; Teaster et al., 2007). A set of provisions ensures that authorities do not abuse their authority in ICC cases, including prioritizing the least restrictive means, entailing strict time limitations on ICC, and requiring the burden of proof from the petitioner (SAMHSA, 2019; Walton & Hall, 2017).

Previous legal cases have shaped ICC laws, including *Robinson v. California, 370 U.S.660 (1962)*, *O'Connor v. Donaldson, 422 U.S. 563 (1975)*, and *Addington v. Texas, 441 U.S. 418 (1979)* (*Addington v. Texas, 441 U.S. 418*, 1979; *O'Connor v. Donaldson, 422 U.S. 56, 1975*; *Robinson v. California, 370 U.S. 660, 1962*). In each of these cases, the rulings offered guidance about what constitutes a person being at harm to themselves, and when it is no longer appropriate for them to remain in treatment.

In *Robinson v. California, 370 U.S.660 (1962)*, Lawrence Robinson was convicted and sentenced to 90 days after being pulled over by the police who noticed marks on Robinson's arms from substance use; however, this was struck down based on the conviction being a violation of the Eighth Amendment and Fourteenth Amendment due to their being insufficient

evidence of harm (Walton & Hall, 2017). In this case, Justice Tom C. Clark began the discussion of there being two stages of drug use, including voluntary use and then involuntary use (Walton & Hall, 2017). He advocated for state laws to begin transitioning laws from treating individuals as criminal to sick once they are unable to control their substance use, suggesting that the state use its police powers to protect individuals from becoming involuntary drug users (Walton & Hall, 2017).

Furthermore, *O'Connor v. Donaldson, 422 U.S. 563 (1975)* and *Addington v. Texas, 441 U.S. 418 (1979*) rulings emphasized the importance of there being clear and convincing evidence that a person is at harm to themselves for the state to enforce an ICC (Walton & Hall, 2017; SAMSHA, 2019). *O'Connor v. Donaldson, 422 U.S. 563 (1975)* occurred when Kenneth Donaldson was involuntarily committed by his parents for a delusional disorder from 1957 to 1971. He petitioned the court 18 times arguing that he was not a danger to himself or others (Walton & Hall, 2017). The Supreme Court eventually ruled in favor of Donaldson, stating that the requirement of imminent threat of harm to self or others is necessary for a state to enforce future ICC laws, and that states have the ongoing responsibility to defend the commitment (SAMHSA, 2019).

Lastly, in *Addington v. Texas, 441 U.S. 418 (1979*), Frank Addington was indefinitely confined to a psychiatric hospital after he threatened his mother. Although Addington was diagnosed with schizophrenia, he contested that his providers had not provided sufficient burden of proof (Walton & Hall, 2017). Ultimately, the courts decided that an intermediate condition of proof (clear and convincing evidence), should be applied versus a stringent condition (beyond a reasonable doubt) (Kaplow, L., 2011). Hence, the courts acknowledged that even highly trained and skilled mental health professionals cannot predict future dangerous behaviors (Ross, 1979).

Overall, these judicial rulings supported the notion that citizens' rights should temporarily be suspended to protect themselves and others from harm, but only when there is clear and convincing evidence (Walton & Hall, 2017). These cases also emphasize tendencies to involuntarily commit a

person when there is fear of a future incident or concern of a person being dangerous.

Utilitarian and Deontological Ethics

Although ICC laws may be legal, the pathways and settings in which they occur are not always ethical. Arguments that oppose ICC tend to focus on individual rights-based assertions grounded in classical libertarian ideology (Walton & Hall, 2017). Libertarian ideologies tend to stress individual rights, specifically that each individual should have freedom unless their behavior violates other individuals' freedoms (Walton & Hall, 2017). Conversely, arguments that favor ICC tend to share beliefs with communitarian ideologies, which emphasize the importance of protecting the rights of communities and other social groups (Walton & Hall, 2017).

The libertarian and communitarian ideologies of ICC are similar to the utilitarian and deontological theories of ethics frequently discussed within medical decision-making. Like communitarian ethics, in the utilitarian approach, decisions are based on the calculated harms or benefits of action to have the most significant benefit for the greatest number of individuals (Mandal et al., 2016; Osmo & Landau, 2006). Conversely, similar to libertarian ideology, deontology theory suggests a patient-centered approach, where harm is unacceptable regardless of consequences (Mandal et al., 2016). Although healthcare providers typically aim to follow deontological ideologies, systems and administrators are likely to encourage using a utilitarian framework to avoid and reduce consequences to as many individuals as possible (Mandal et al., 2016).

Research has also shown that although social workers are more deontological in principle, they tend to utilize a more utilitarian approach in practice situations (Osmo & Landau, 2016). For example, NASW (2024) social work ethics speak to the importance of prioritizing clients as evidenced by the social work value of service, and dignity and worth of a person; however, social workers also have a responsibility to society. Hence, in healthcare settings, social workers are balancing person-centered approaches and broader concerns, including the potential impact of the harm

that a person's SUD can create for a community and other individuals. Concerns about liability may be a potential reason for this.

There are benefits to utilizing both deontological and utilitarian approaches in making ICC decisions, as both patient and societal needs should inform providers and courts when debating ICC decisions. Understanding the concerns and justifications of ICC is valuable in making an ethical decision about when to use an ICC for SUD. The remainder of this article will apply utilitarian and deontological ethical frameworks to clarify the ethical concerns and justifications for ICC. Finally, an ethical solution that balances these concerns and justifications will be offered.

Ethical Concerns

The use of ICC for SUD can violate ethical principles outlined within the NASW Code of Ethics (2024); specifically, the core ethics of respecting and promoting a clients' right to self-determination, non-maleficence, beneficence, and justice. Given that not all ICC settings are therapeutic, particularly carceral settings, social workers may do more harm than good by initiating an ICC. Furthermore, ICC can be coercive and negatively impact a person's autonomy, particularly if other treatment options have not been explored. Lastly, gender and racial disparities exist among ICC that can perpetuate structural inequities. Social workers must consider these principles in upholding NASW core values, including the value of integrity. A deontological framework can be useful in encapsulating the multiple ethical principles and values contemplated by social workers when deciding if an ICC is needed or when working with other providers initiating an ICC.

Using a deontological approach when considering ICC for SUD is valuable due to the treatment setting variability among ICC sentences, as seen in MA. Research suggests that social workers and other healthcare providers in MA may already be using a deontological framework as they have expressed concerns over current ICC pathways and locations (Walt et al., 2022). For example, a study by Walt et al. (2022), interviewing clinicians in MA, revealed that the majority of clinicians experienced some or high levels

of moral distress when utilizing Section 35 (ICC for SUD) for involuntary commitment. These clinicians expressed concerns about systemic treatment failures, and believed SUD should be viewed through a harm reduction framework (Walt et al., 2022). They also expressed concern about the treatment settings employed in the Section 35 process, including criminal justice settings (Walt et al., 2022). These findings suggest providers are inclined to take a patient-centered approach that considers the potential consequences of ICC to the individual with SUD in concert with the individual's preference to remain in the community over the potential, albeit unpredictable, harm of not using ICC.

Concurrently, another concern of ICC for substance use is that providers and court systems may have different thresholds in deciding what types of behaviors warrant an ICC. Subjectivity in providers' feelings about SUD, and the inability to predict future behavior, can contribute to individuals facing an ICC sentence when other treatment options have not been exhausted (Walton & Hall, 2017). Specifically, the stigma of SUD has contributed to providers resisting harm reduction practices that have been shown to save lives, including syringe exchange programs, safe consumption sites, and naloxone kits (Messinger & Beletsky, 2021; Walton & Hall, 2017). A study surveying emergency room providers in three New England academic care centers found that although providers reported an interest in engaging patients in harm reduction services, less than 10% did so in practice (Samuels et al., 2016). Provider resistance to harm reduction treatments may contribute to some pursuing an ICC sentence to coerce clients to engage in abstinence-based treatment.

Other literature has demonstrated inconsistencies in the efficacy of ICC for SUD, revealing that involuntary commitment may create unintended consequences (Evans et al., 2020; Messinger & Beletsky, 2021). For example, in 2019, the MA DPH found that individuals subjected to involuntary treatment were 2.2 times more likely to die from overdose than those who attended voluntary treatment; however, it is unknown how these results compare with those who did not receive any treatment (Messinger & Beletsky, 2021). Furthermore, the criminalization of ICC has become a

growing concern due to ICC patients being detained by the police, handcuffed in courtroom proceedings, or held in lockup (Christopher et al., 2020). The safety of ICC facilities has also been questioned, with there being recent findings of escape attempts, suicides, and other tragic events (Messinger & Beletsky, 2021). This suggests that ICC facilities may be retraumatizing a population that frequently has comorbid Post Traumatic Stress Disorder (PTSD), and significant trauma histories (Gielen et al., 2012). Lastly, issues related to ICC facilities have been exacerbated by the COVID-19 pandemic and the elevated risk of COVID-19 transmission in these settings (Sinha et al., 2020).

Another ethical concern of ICC is that variability exists in treatment among ICC treatment settings. No statutes are established that serve as precedence for ICC facilities' standards of care during treatment, with many ICC facilities neglecting to use empirically validated treatments (Messinger & Beletsky, 2021). The majority of ICC facilities fail to provide FDA-approved MOUD, and do not connect individuals to community-based treatment upon release (Evans et al., 2020; Messinger & Beletsky, 2021). A study by Christopher et al. (2018), found that less than 20% of individuals in ICC facilities received MOUD, and only 7% followed up with treatment after their release. Additionally, it was found that 34% of respondents reported relapsing to drug use the day they were released from ICC, further emphasizing the need for relapse prevention treatments, including MOUD (Christopher et al., 2018).

Literature has revealed that former patients of ICC are aware of its short-comings and may be more likely to avoid treatment in the future. Christopher et al. (2020) found that individuals previously committed for opioid misuse were less likely to support drug misuse-related ICC due to its perceived lack of efficacy, and had more favorable views toward ICC for mental health reasons rather than for drug misuse. Similarly, previous studies have suggested that ICC for mental health reasons may impact future help-seeking behaviors; for example, Swartz et al. (2003) found that individuals with a history of involuntary hospitalization for mental health issues were less likely to seek out outpatient treatment in the future due to fear of

coercion. This may also be true among individuals with SUD; however, further research is needed.

Lastly, ICC for SUD raise multiple social justice issues (McLeod, 2024). Differences between state ICC statutes, practices, and settings are likely to contribute to health inequities, including discrepancies in future substance use treatment utilization. As discussed previously, women are no longer sectioned to carceral settings in MA; hence, differences in treatment settings are likely to contribute to gender disparities. Furthermore, a recent study in MA found men civilly committed for opioid use reported longer wait times between ICC hearing and treatment setting transfer compared to women (Hayaki et al., 2023). Men also had longer wait times for opioid withdrawal management compared to women (Hayaki et al., 2023). These findings suggest the treatment of men and women is different throughout the ICC process, potentially contributing to worse outcomes among men.

Although there is limited literature addressing racial disparities in ICC for SUD, research has found that Black, Indigenous, People of Color (BIPOC) are more likely to be subjected to involuntary psychiatric hospitalization compared to white patients (Shea et al., 2022). More research is needed to understand racial disparities in ICC for SUD commitment process and practices. Given that substance use has historically been criminalized more among BIPOC populations receiving drug charges, social workers must be weary of differences in treatment among racial groups and pause before initiating ICC for SUD (Rosino & Hughey, 2018).

Ethical Justifications

Utilitarian frameworks are beneficial in understanding the possible benefits linked with an ICC admission, particularly due to the harms associated with ongoing substance use. Justifications for ICC are concurrent with NASW ethical principles of non-maleficence, beneficence, as well as values of dignity and worth of the person, and integrity (NASW, 2024).

The scientific community has argued that SUD is a chronic condition with biological, genetic, and neurological mechanisms (Leshner, 1997). In

most civil commitment laws, the rationale is that it is unreasonable to expect individuals with severe SUD to provide informed consent to enter voluntary treatment due to negative effects of ongoing substance use, including impaired insight and compromised capacity to make rational decisions (Cavaiola & Dolan, 2016). One of the criteria for SUD is that substance use continues despite awareness of recurrent physical or psychological problems that have been caused or worsened by the substance (American Psychiatric Association, 2022). Hence, it is argued that individuals with SUD may lack the ability to recognize their level of impairment and enter treatment, as the individual can perceive this as interfering with short-term gains of substance use (Cavaiola & Dolan, 2016). Furthermore, research has revealed that individuals with OUD may not have the ability to provide voluntary informed consent to treatment due to the disorder progressing and individuals losing the ability to make rational decisions (Charland, 2002).

Hence, ICC may be considered a step that generates motivation for a person to continue their recovery following a period of stabilization where they are unable to use substances. A period of stabilization has the potential for individuals to make more rational decisions regarding future treatment (Cavaiola & Dolan, 2016). Positive experiences within ICC, and the procedural process, can impact post-commitment abstinence length. For example, Christopher et al. (2018) revealed that when individuals have positive ICC experiences, including higher perceived procedural justice during the commitment hearing, and have post-commitment medication treatment, they tend to have more extended periods of abstinence.

Others argue that ICC prevents overdose, saves lives in the short term, and protects vulnerable and underserved populations (Evans et al., 2020). Specifically, Evans et al. (2020) found that ICC provided immediate access to OUD treatment, which was not readily available in community-based treatment due to long wait lists, strict treatment policies, and lack of long-term care. Participants also reported arranging involuntarily commitment themselves for the support and treatment engagement (Evans et al., 2020). Lastly, a recent study in Australia revealed that individuals receiving involuntary and voluntary treatment had the same reduction in emergency

department visits a year following admission for severe alcohol use disorder (Vuong et al., 2022). Although this study revealed positive outcomes for involuntary treatment, it is unclear what type of settings Australia commits individuals to, and how this may impact their experiences and healthcare utilization.

Finally, ICC has been identified as helpful in diverting individuals with SUD from the criminal justice system (Cavaiola & Dolan, 2016). Christopher et al. (2018) found that most individuals receiving ICC were considered high-risk, reporting histories of intravenous heroin and fentanyl use, as well as overdose and current criminal justice involvement. Seeing that many of the individuals with an ICC are in danger of continued criminal justice system involvement with other risk factors, therapeutic ICC may reduce high-risk behaviors perpetuating this cycle. Avoiding criminal convictions can also reduce barriers to employment, credit, and housing (Clark, 2007; Henderson, 2005; Saxonhouse, 2004). Other research has revealed additional communal and individual benefits associated with ICC, including increased patient gratitude, increased treatment options for families, increased treatment access, and promotion of public health and public safety, such as the prevention of Hepatitis C and other infectious diseases (Evans et al., 2020). Hence, it can be argued that there are more benefits associated with ICC admissions than consequences.

Ethical Solutions

As fatal overdoses increase, and as ICC becomes a common practice among providers and courts, additional education and careful ethical considerations must occur. And, while scholars frequently discuss utilitarian and deontological frameworks in contrast to one another, in practice, the two are used in conjunction depending on the circumstance. For instance, the provider and patient relationship is deontological, but providers are often forced to utilize a utilitarian framework during times of crisis to reduce potential consequences to as many individuals as possible and increase safety (Vearrier & Henderson, 2021). For example, the individual using substances

may continuously commit acts that are potentially harmful to the community while intoxicated, such as operating automobiles or other potentially dangerous behaviors, and the provider feels obligated to initiate an ICC for SUD due to protect others from harm. On the other hand, providers often adopt a utilitarian approach when facing pressure to reduce the likelihood of overdose and other dangers of substance use through ICC, but do not realize the negative impact this may have for patients' future mental health symptoms and healthcare utilization behaviors. Reducing the harms associated with both continued, unabated substance use and ICC requires that these frameworks be used concurrently. Table 1 below outlines the considerations from each framework and the balance point between the two that offers an ethical solution for determining the use of ICC.

Justification	Concern	Potential Solution
Can provide a period of stabilization (Cavaiola & Dolan, 2016).	Can exacerbate symptoms for individuals with trauma histories (Gielen et al., 2012).	Utilize both utilitarian and deontological approaches in ICC decision making, ensuring all other treatment options have been exhausted and individual factors are considered.
Can provide immediate access to OUD treatment (Evans et al., 2020).	Variability in ICC laws among states with some neglecting empirically validated treatments (Messinger & Beletsky, 2021)	Creation of ICC standards of care, including ICC providing MOUD.
Can reduce risks of SUD, including overdose (Evans et al., 2020).	Can contribute to increased risk of overdose following discharge (Cavaiola & Dolan, 2016).	Ongoing research investigating efficacy of ICC.
Can be a motivating factor for continued treatment (Christopher et al., 2018).	May reduce future healthcare utilization (Christopher et al., 2020; Swartz et al., 2003).	Continued education and supervision from healthcare settings and supervisors about ICC.
Can divert individuals away from criminal justice system (Cavaiola & Dolan, 2016).	Variability in ICC settings, specifically the use of criminal justice systems (Evans et al., 2020; Messinger & Beletsky, 2021)	Continued guidance from states about how to construct, implement, and enforce ICC laws; including, ICC settings only being in healthcare and therapeutic settings.

Table 1: Justifications, Concerns, and Solutions of ICC for SUD

Although there is more evidence suggesting ICCs for SUD to be unethical in certain settings, steps can be taken to increase efficacy and improve patient outcomes. First, ICC recommendations should never be initiated without careful consideration by a provider, and should only be made as a last resort after all other options have been exhausted (Cavaiola & Dolan, 2016; Evans et al., 2020). Utilizing a deontological approach and considering each client's values and preferences is critical in developing a therapeutic relationship and understanding whether ICC is the most appropriate choice for an individual. Due to biases among mental health professionals and other providers, supervision should be sought prior to a provider making an ICC recommendation. Additionally, providers should regularly attend ICC educational trainings, which include information about the ethics of ICC, the chronic nature of addiction, and harm reduction practices (Jain et al., 2021).

ICC programs should not occur in criminal justice settings and should instead occur only in healthcare settings (Evans et al., 2020). Research has shown that abstinence occurs for more prolonged durations following ICC when individuals report positive experiences within ICC settings, which is often lacking within correctional facilities (Christopher et al., 2018). Treating SUD within correctional facilities also clashes with many healthcare professionals' codes of ethics, including social work's ethic of respecting the inherent dignity and worth of a person (Evans et al., 2020). Furthermore, ICC standards of care should be created to support the use of FDA-approved MOUD, as individuals using approved medications have lower mortality, less opioid use, and less infection disease risk (Evans et al., 2020). The use of FDA medications within ICC would also have the potential to reduce the risk of overdose following ICC admissions.

Other systemic changes should occur to increase access to evidence-based approaches prior to an ICC for SUD. It would be valuable to increase accessibility to other substance use treatment options, as this may decrease the number of ICC recommendations and improve outcomes upon discharge from ICC (Reif, 2017). Increasing access should include using harm reduction strategies and expanding the number of treatment venues to emergency and primary care settings (Sinha et al., 2020). For example,

creating "bridge clinics" in Boston has been valuable in allowing clinicians to initiate buprenorphine treatment in emergency departments and connect patients to follow-up care (Sinha et al., 2020).

Additional research addressing the efficacy of ICC for SUD is needed, given the insufficient knowledge regarding how states should construct, implement, and enforce ICC laws, as well as the variability between state ICC laws (Walton & Hall, 2017). It would be valuable for researchers and policymakers to identify a measurable goal of the ICC, which would help frame how states should implement ICC laws and duration (Walton & Hall, 2017). Other questions must be examined, including what type of individual benefits from an ICC, whether ICC has better outcomes than other policies, and the short- and long-term accumulative effects of an ICC (Evans et al., 2020). Recent literature has assessed practices within certain states, specifically MA; however, more research is needed to understand the type of treatment provided in other states for ICC and the coordination of care between providers in these settings and outside of these settings (Christopher et al., 2015; Christopher et al., 2018, Slocum et al., 2023). Lastly, past research has primarily explored family, police, and some healthcare providers perspectives of ICC for SUD; however, more research is needed to understand the perspective of social workers and the specific dilemmas they face in making these decisions (Husted & Nehemkis, 1995; Slocum et al., 2023).

Each of these factors should be considered when social workers recommend a civil commitment to a physician or family member. While many of these ethical concerns are related to systemic issues, it is important that social workers are aware and have education around these issues to make informed decisions when weighing the harms associated with ongoing substance use for a client and the community versus the potential harms of ICC practices and settings. Social workers must continue to practice the NASW value of competence and develop their professional expertise of ICC as literature about this process increases. Lastly, social workers must continue to advocate and challenge the social injustices occurring among ICC settings which violate a person's dignity and worth and perpetuate gender and racial inequalities and inequities.

Conclusion

Overall, ICC for SUD has the potential to be a valuable lifesaving recovery resource for individuals with severe SUD who are at risk of harmful behaviors and criminal justice involvement. Despite the justifications for ICC, variability in ICC laws and settings are cause for concern and may reduce future healthcare utilization, exacerbate mental health symptoms, and increase the risk of overdose. To reduce these risks, utilitarian and deontological approaches should be used in conjunction among healthcare providers and social workers, in order to make ethical decisions regarding the utility of ICC for individuals and the surrounding community. Ongoing research regarding the efficacy of ICC is warranted, as well as continued guidance from states regarding ICC laws, settings, and standards of care.

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