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Perspective

Will Emergency Holds Reduce Opioid Overdose Deaths?

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The opioid overdose crisis has claimed more than 400,000 lives in the United States since 1999. As part of efforts to reduce overdose deaths and increase enrollment in treatment, lawmakers in some states are contemplating enacting or expanding emergency hold laws that permit some patients with severe substance use disorder to be involuntarily detained for short-term observation and, in some cases, treatment. A bill introduced in Rhode Island during the past two legislative sessions, for example, would allow physicians to request that a court order a 72-hour hold for inpatient treatment for a person with substance use disorder who "presents a danger or threat of danger to self, family, or others, if not treated." Similar statutes have already been enacted in other states, including Minnesota and Washington.

Emergency hold laws are modeled after, and often extensions of, existing measures that permit short-term evaluation and treatment of people in mental health crisis. Using short-term emergency holds in the context of opioid use disorder presumes that a person's risk of overdose will be mitigated by a brief, involuntary hospitalization. But the efficacy of emergency holds for substance use disorders hasn't been evaluated. Their use in this context raises ethical, legal, medical, and practical questions that merit careful consideration, given the profound effects that holds would have on individual liberty, relationships between patients and physicians, and the health care delivery system.

For medical providers, the ethical justification for restricting a person's autonomy rests primarily on the principle of beneficence, according to which clinicians should act in their patients' best interests. Courts consistently support nonvoluntary medical interventions when at least one of two conditions exists: dangerousness and decisional incapacity. The state's authority to intervene in these circumstances, which it may extend to medical professionals, derives from its *parens patriae* duty to protect vulnerable people and prevent harm.

Emergency hold laws for mental illness, which exist in every state, all require some finding of dangerousness, either to self or to others.[1] Since emergency hold laws for substance use disorder would presumably rely on this standard as well, a crucial question is whether these holds would attenuate the dangerousness, particularly to people with substance use disorders themselves, that would justify restricting individual liberty.

The increase in opioid overdose deaths over the past two decades is largely the result of unintention-

al overdoses, not suicides. It's not clear that emergency holds would prevent these deaths. Certainly, people who experience an overdose are at high risk for subsequent overdose and death. In the year after a nonfatal opioid overdose, rates of fatal overdose range from 1% to 5%[2,3] and about one in five people has another nonfatal overdose.[3] Research doesn't support the notion that short-term treatment during involuntary holds would reduce these risks, however. In cases in which people with substance use disorder express suicidal intent or have coexisting psychiatric disorders that create imminent safety concerns, existing mental health laws provide well-established mechanisms for involuntary observation and treatment.

Substance use disorders impair people's decision making to varying degrees. Craving and withdrawal symptoms after an opioid overdose can be quite severe, for example, particularly if naloxone is administered, and can compromise a person's ability to make rational decisions — as can intoxication. Still, emergency holds are unlikely to fully restore competent decision making, since substance use disorders are chronic, recurring conditions. Effective treatment typically requires long-term medication therapy, harm-reduction services, behavioral counseling, and recovery support. None of these services are likely to be provided during a short-term emergency hold. Moreover, for ethical reasons, health care providers eschew restricting individual autonomy for purposes other than the prevention of imminent harm, even when people's choices adversely affect their health.

Medical emergencies in which patients temporarily lose decisional capacity after an opioid overdose most often result from severe respiratory depression. Intervention in these cases doesn't require an emergency hold, since according to existing statute and case law, it can be presumed that people would consent to lifesaving care if they were able to express their preferences.

Emergency holds for opioid use disorder would most commonly be used in cases of nonfatal opioid overdose. The standard for treating moderate-to-severe opioid use disorder is voluntary, outpatient, medication-based treatment.[4] The limited research evaluating involuntary treatment for substance use disorders is inconclusive,[5] and no data exist in support of emergency holds. Furthermore, forced abstinence during emergency holds may increase the risk of overdose once a person is released, just as people with opioid use disorder who don't receive medication treatment during incarceration or inpatient detoxification have continued cravings for opioids but lower tolerance to their effects.

Voluntary treatment with medications for opioid use disorder reduces cravings, opioid use, and the risk of fatal and nonfatal overdoses and improves long-term outcomes.[4] Yet these medications are not widely available, particularly to low-income people, people with criminal-justice involvement, people of color, and people living in rural areas. Nor do all communities have uniform access to other services proven to reduce drug-related harm — specifically, naloxone distribution and syringe-services programs. Involuntary holds may exacerbate existing inequities by disproportionately affecting people in communities with poor access to voluntary services. Furthermore, fear of involuntary holds may undermine patients' trust in clinicians, increase skepticism of the medical system, and deter patients from voluntarily seeking care after an overdose or for injection-related complications (e.g., soft-tissue infections, HIV, hepatitis C, and vascular injuries). Policymakers' help is needed to address barriers to evidence-based treatment and other factors that disproportionately affect groups already subject to social injustices.

Emergency holds would also have a substantial impact on health care delivery. People currently obtain access to voluntary outpatient and inpatient treatment for opioid use disorder by means of community treatment programs, office-based practices, acute behavioral health services, or referral from emergency departments or other health care providers. Most states don't have enough inpatient units designed for voluntary inpatient treatment of substance use disorders. To meet the increased demand for acute, inpatient services created by emergency holds, states would need to allocate substantial funding to expand inpatient addiction treatment, which they are unlikely to do, given the budgetary challenges most face. Without an expansion of inpatient treatment, however, emergency holds would increase rates of boarding of patients in emergency departments and exacerbate shortages of inpatient treatment beds, particularly for patients voluntarily seeking treatment, since involuntary admissions would be prioritized. Furthermore, emergency holds might be overused, given the legal authority such laws confer and the demand

for clinicians to "do something" for high-risk patients who present to emergency departments but then decline voluntary care. Making emergency holds routine may divert focus from the complicated social factors that contribute to opioid overdoses and the need to expand effective outpatient treatment and harm-reduction services.

It is important to reduce drug-related harms, and emergency holds have intuitive appeal for lawmakers and other concerned parties. However, the adoption of emergency hold laws as they are currently written isn't an evidence-based or justifiable strategy for meeting this end. We believe that addressing the substantial challenges associated with obtaining access to voluntary treatment for opioid use disorder, particularly medications, should instead be the priority and that harm-reduction services, including easy access to naloxone, syringe-services programs, supervised consumption spaces, and fentanyl test strips, should also be aggressively pursued. Confronting the opioid overdose epidemic will require increased access to and funding of these proven interventions as well as policies addressing the social and medical determinants of addiction. There is no shortage of opportunities to meet these objectives. We just need the required resources and political will.

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