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Committed to Treatment?: The Potential Role of Involuntary Hospitalization in West Virginia's Response to the Opioid Epidemic

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COMMITTED TO TREATMENT?: THE POTENTIAL ROLE OF INVOLUNTARY HOSPITALIZATION IN WEST VIRGINIA'S RESPONSE TO THE OPIOID EPIDEMIC

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I. INTRODUCTION

“‘People are dying everywhere,’ one caller said.”¹

“They were all dropping the same time, like boom boom boom boom boom.”²

“It’s a revolving door. We’re not solving the problem past reviving them.”³

“At the end of the day, we gave 26 people another chance at finding recovery. . . . Hopefully, maybe they’ll all live.”⁴

At about 3:25 p.m. on August 15, 2016, an EMS supervisor administers life-saving naloxone to a woman who would have died in just minutes from an opioid overdose.⁵ At just that moment, his radio blares with reports of more overdoses, and at the 911 dispatch center, the phone lines fill with reports of opioid overdoses around the city.⁶ Ambulances and patrol cars zoom around the town responding to the calls.⁷ Officers and responders have just enough time to attempt to revive one overdose victim before jumping back in their vehicles and speeding off to save another life.⁸

In Huntington, WV, over a four-hour period on August 15, 2016, 28 people overdosed from opioid drug use.⁹ On that particular day, the large number of severe overdoses resulted from the heroin being laced with potent synthetic opioids such as fentanyl and carfentanil.¹⁰ Of those 28 people, 26 were saved by first responders, several of whom used the opioid antagonist naloxone.¹¹

Shortly after the incident, a Huntington EMT director indicated that the department had already administered 307 doses of naloxone that year, a substantial increase from the 130 doses administered the previous year.¹² As a result of the increased need for and use of opioid antagonists, citizens were being

¹ 28 ODs in 4 Hours: *How the Heroin Epidemic Choked a W.Va. City*, CBS NEWS (Sept. 4, 2016, 11:37 AM), <https://www.cbsnews.com/news/4-hours-in-huntington-va-how-the-heroin-epidemic-choked-a-city/> [hereinafter 28 ODs in 4 Hours].

² *Id.*

³ Andrew Joseph, *26 Overdoses in Just Hours: Inside a Community on the Front Lines of the Opioid Epidemic*, STAT (Aug. 22, 2016), <https://www.statnews.com/2016/08/22/heroin-huntington-west-virginia-overdoses/>.

⁴ 28 ODs in 4 Hours, *supra* note 1.

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

trained in using naloxone, police officers started carrying the opioid antagonist, and the mayor even began keeping a dose of naloxone with him.¹³ In light of the increased need for naloxone and the new procedures aimed at making it more readily administrable, reporters covering the incident gave attention to the people being administered the drug after overdosing, and it was reported that because many of the people who overdose have no place to go for help, “[m]edics revive the same people, again and again and again.”¹⁴ Therefore, people who have been saved using the opioid antagonist often go back to drug use, and saving those individuals’ lives on those particular occasions does not ultimately solve the problem and lead to recovery because it does not address and resolve the issues at the root of their addiction.¹⁵

The opioid epidemic is a critical public health issue in the United States today.¹⁶ In fact, on October 26, 2017, President Donald Trump declared the opioid crisis a national Public Health Emergency under federal law.¹⁷ The opioid epidemic has ravaged communities and devastated families, especially in Appalachia, including states such as West Virginia.¹⁸ Though the causes of the opioid epidemic can be traced, in part, to changes in the prescription of opioid painkillers in the 1980s, the budding opioid problem drastically escalated in the 21st century and has become a devastating epidemic in the most recent decade. Nationally, according to a report of the Center for Disease Control (“CDC”), an average of 115 Americans died every day from an opioid overdose in 2017.¹⁹ And in West Virginia, where the opioid crisis is particularly severe, approximately 1,000 people died from an opioid overdose in 2017, and opioid overdose rates have generally increased over the past two decades.²⁰ With lives being lost on a daily basis, and the epidemic only becoming more severe, immediate and meaningful action is necessary.

¹³ *Id.*

¹⁴ *Id.* For example, from 2008 to 2016, for patients admitted to any WVU Medicine facility for an opioid-related overdose, the percentage of repeat overdose increased 175%, from 10.2% to 28.0%. Sara Warfield et al., *Opioid-Related Outcomes in West Virginia, 2008–2016*, 109 AM. J. PUB. HEALTH 303, 304 (2019).

¹⁵ Joseph, *supra* note 3; *see also* Warfield et al., *supra* note 14.

¹⁶ *The Opioid Crisis*, WHITE HOUSE, <https://www.whitehouse.gov/opioids/> (last visited Sept. 27, 2019).

¹⁷ *Id.*

¹⁸ *See, e.g., Drug Overdose Deaths in Appalachia*, APPALACHIAN REGIONAL COMMISSION, <https://overdosemappingtool.norc.org/> (last visited Sept. 27, 2019).

¹⁹ *Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/epidemic/index.html> (last updated Dec. 19, 2018).

²⁰ Lara Trump, *On Opioid Crisis, WV Needs Action, Not Talk (Gazette Opinion)*, CHARLESTON GAZETTE-MAIL (Aug. 20, 2018), https://www.wvgazette.com/opinion/gazette_opinion/op_ed_commentaries/lara-trump-on-opioid-crisis-wv-needs-action-not-talk/article_298a632e-a6d3-51e4-9f0c-72f453b513ca.html.

While the particular severity and complications of today's opioid epidemic may be new challenges, problems of addiction and overdose are not new, and many actors have already taken action to combat the opioid epidemic. At the national level, Congress has passed bills and allocated billions of dollars to combat the opioid epidemic.²¹ Additionally, the U.S. Department of Health and Human Services ("HHS") and the CDC have outlined programs and guidelines for other organizations to follow and administer in hopes of curbing the destruction of the opioid epidemic.²² Some states have followed and implemented the suggested federal programs and guidelines, and other state legislatures have created and implemented their own responses.²³ Additionally, efforts at the local community level, such as diversion programs and support and recovery groups, have also taken place in hopes of mitigating the detrimental effects of the opioid epidemic.²⁴ In West Virginia's response thus far, the state has implemented the use of data collection tools such as Prescription Drug Monitoring Programs ("PDMPs") and has placed limitations upon pharmacies and opioid prescriptions.²⁵ Additionally, the West Virginia legislature passed the Access to Opioid Antagonists Act in 2015, which requires first responders to carry and administer opioid antagonists for overdoses, which increased the availability and use of overdose-reversal agents such as naloxone.²⁶ More recently, in January of 2018, House Bill 4215²⁷ ("the Opioid Overdose Involuntary Hospitalization Bill") was proposed, which would have amended the

²¹ Timothy Swope, *Congressional Actions to Address the Opioid Crisis*, BIPARTISAN POL'Y CTR. (Aug. 16, 2018), <https://bipartisanpolicy.org/blog/congressional-actions-to-address-the-opioid-crisis/>; see also John Fritze & David Jackson, *What's Included in the Opioids Bill Signed by Trump*, USA TODAY (Oct. 24, 2018), <https://www.usatoday.com/story/news/politics/2018/10/24/donald-trump-opioids-bill-includes-changes-trafficking-treatment/1752329002/>; Geoff Mulvihill, *Federal Budget Deal Includes \$4.6 Billion to Combat Opioid Epidemic*, WASH. POST (Mar. 25, 2018), https://www.washingtonpost.com/politics/federal-budget-deal-includes-46-billion-to-combat-opioid-epidemic/2018/03/25/0c65bd16-3082-11e8-94fa-32d48460b955_story.html?

²² See, e.g., *Prevention Programs & Tools*, U.S. DEP'T HEALTH & HUM. SERVS., <https://www.hhs.gov/opioids/prevention/prevention-programs-tools/index.html> (last reviewed Nov. 21, 2018); *CDC's Response to the Opioid Overdose Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/opioids/strategy.html> (last reviewed Jan. 11, 2019).

²³ See Shalini Wickramatilake et al., *How States Are Tackling the Opioid Crisis*, 132(2) PUB. HEALTH REP. 171 (2017); *50 State Review on Opioid Related Policy*, ARIZ. DEP'T HEALTH SERVS. (Aug. 18, 2017), <https://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/50-state-review-printer-friendly.pdf>.

²⁴ Allison Peterson et al., *State Legislative Responses to the Opioid Crisis: Leading Examples*, 11 J. HEALTH & LIFE SCI. L. 30, 40–41 (2018).

²⁵ *Here's What West Virginia Is Doing to Address the Opioid Crisis*, WBUR (May 11, 2018), <http://www.wbur.org/hereandnow/2018/05/11/opioid-crisis-west-virginia> [hereinafter *What West Virginia Is Doing*].

²⁶ W. VA. CODE ANN. §§ 16-46-1–7 (West 2019).

²⁷ H.D. 4215, 83d Leg., Reg. Sess. (W. Va. 2018).

Access to Opioid Antagonists Act to provide that any person administered an opioid antagonist by a first responder would be subject to the state's involuntary hospitalization procedure.²⁸ The passage of this Bill would have represented a significant change to the state's involuntary hospitalization law and a consequential addition to the state's response to the opioid epidemic.

This Note will argue that a law implementing a procedure for involuntary hospitalization for opioid overdoses, such as that proposed in the Opioid Overdose Involuntary Hospitalization Bill ("the Bill"), would likely be upheld against legal challenges and could be an effective addition to West Virginia's response to the opioid epidemic. In making that argument, this Note will examine the issues involved in the opioid epidemic and analyze the involuntary commitment and hospitalization laws that currently exist in West Virginia and other states. Though use of involuntary hospitalization raises serious concerns because it infringes upon important rights, a legal framework exists in support of this type of addition to the state's response. Despite the existence of a legal framework and precedent that could support the implementation of involuntary hospitalization for opioid overdoses, because it would be a drastic remedy, the potential legal consequences and complications for all parties affected and involved must be thoughtfully considered.

At this point, it is necessary to acknowledge that the issues involved in the opioid epidemic and this particular response involve more than just issues of a legal nature. Rather, a complete discussion and consideration of involuntary hospitalization as a response to the opioid epidemic also involves medical, psychological, social, and economic concerns that would influence how such a law could be practically and effectively implemented. While consideration of those issues is necessary for a complete analysis of such a law, they will only be addressed briefly in this Note and should be investigated and analyzed by scholars in those fields. Accordingly, the scope of the analysis of this Note will be focused primarily upon the legal framework, consequences, and concerns raised by involuntary hospitalization and its potential place in West Virginia's response to the opioid epidemic.

In Part II, this Note will provide background information on the opioid epidemic and the actions that have been taken in response. Part III of this Note will suggest that a law applying involuntary hospitalization to opioid overdoses, such as was proposed in the Bill, is recommended because a legal framework and precedent exist under which it would likely be upheld against challenges. Additionally, the application of involuntary hospitalization in this situation could be an effective addition to the state's response to the opioid epidemic by providing a vehicle for treatment, support, and assistance to those who suffer from addiction and a form of accountability for the state. In the course of the analysis, this Note will raise several legal and practical concerns involved in involuntary commitment and hospitalization laws and, where applicable, suggest

²⁸ *Id.*

ways to improve the law or system to provide more effective assistance and support. Because a legal framework and precedent for involuntary commitment, generally, already exists, and such a law would communicate to West Virginians the importance of combating the opioid epidemic and taking action to help connect those addicted to opioids with treatment, West Virginia's lawmakers should again consider the addition of an involuntary hospitalization procedure specifically in the context of the opioid epidemic.

II. BACKGROUND

Nationally, but especially in Appalachia, including states such as West Virginia, the opioid epidemic has devastated communities and resulted in the premature deaths of thousands of people. This Part will provide information on the origins of, consequences of, and responses to the opioid epidemic, both nationally and specifically in West Virginia. Section II.A will provide a broad overview of the context for the opioid epidemic, both nationally and specifically in West Virginia. Section II.B will detail the various and specific ways in which the United States, West Virginia, and other states have responded to, and attempted to provide a solution for, the opioid epidemic. Finally, Section II.C will introduce and provide context about the Bill proposed in 2018 that could have added involuntary hospitalization to West Virginia's legislative response to the epidemic. Only with an understanding of the sources and consequences of the opioid epidemic can the proposed solutions be appropriately considered.

A. *The Opioid Epidemic: A National Public Health Crisis*

Though particular parts of the country may have garnered more media attention, the opioid epidemic is truly a national problem. This Section will explore the beginning of the epidemic and trace its growth and outcomes on broader and narrower scales. First, Section II.A.1 will explain what opioids are, how the opioid epidemic came to be, and what its consequences are on a national scale. Second, Section II.A.2 will examine the consequences and outcomes of the opioid epidemic specifically in West Virginia.

1. The Birth and Growth of a National Epidemic

Opioids consist of a broad group of pain-relieving drugs.²⁹ Opioids were originally derived from the poppy plant, but, in recent years, the pharmaceutical industry has turned to also artificially synthesizing the drug in laboratories.³⁰

²⁹ Carrie Krieger, *What Makes Opioid Medications So Dangerous?*, MAYO CLINIC (Mar. 21, 2018), <https://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/expert-answers/what-are-opioids/faq-20381270>.

³⁰ *Id.*

Opioids work by interacting with opioid receptors in a person's cells: the opioids travel through the blood and attach to opioid receptors in the brain cells, which, in turn, release signals that inhibit the person's perception of pain and increase feelings of pleasure.³¹ Although, when used as directed by a responsible physician, opioid medications can be helpful to control acute and severe pain in various contexts, there are many severe risks when opioids are used incorrectly.³² While lower doses of opioids make a person feel tired and lethargic, higher doses can slow breathing and heart rates, which can ultimately lead to death.³³ Additionally, the positive feelings that opioids produce often lead to addiction and dependence.³⁴

The opioid class of drugs includes (1) pain relievers available by prescription, such as oxycodone, hydrocodone, codeine, and morphine; (2) the illegal drug heroin; and (3) synthetic opioids, such as fentanyl.³⁵ The first relevant type of opioids, prescription opioids, are used to treat moderate or severe pain after a surgery or injury or in the course of serious health conditions such as cancer.³⁶ The prescription opioids most commonly involved in opioid overdoses, and thus relevant to the opioid epidemic, are methadone, oxycodone (for example, OxyContin), and hydrocodone (for example, Vicodin).³⁷ The second type of relevant opioid is heroin. Heroin is an illegal and highly-addictive opioid drug, which is typically injected but can also be smoked and snorted.³⁸ Finally, synthetic opioids are the third type of relevant opioids, of which fentanyl is perhaps the most relevant to the epidemic. Fentanyl is a synthetic opioid that has both pharmaceutical and illegally-made versions.³⁹ Pharmaceutical fentanyl, which is 50 to 100 times stronger than morphine, has been approved for treating severe pain, usually associated with advanced cancer, and is prescribed in the form of transdermal patches or lozenges.⁴⁰ Illegally-made fentanyl, which is

³¹ *Id.*

³² *Id.*

³³ *Id.*

³⁴ *Id.*

³⁵ *What Are Opioids?*, U.S. DEP'T HEALTH & HUM. SERVS., <https://www.hhs.gov/opioids/prevention/index.html> (last reviewed May 15, 2018).

³⁶ *Prescription Opioids*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/opioids/prescribed.html> (last updated Aug. 29, 2017).

³⁷ *Id.*

³⁸ *Heroin*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/opioids/heroin.html> (last updated Aug. 29, 2017).

³⁹ *Fentanyl*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/opioids/fentanyl.html> (last updated Aug. 29, 2017).

⁴⁰ *Id.*

more often linked to overdose and death, has a heroin-like effect, is sold in illegal drug markets, and is often mixed with other drugs such as heroin or cocaine.⁴¹

Although, traditionally, opioids were prescribed with reservation due to the likelihood of addiction caused by even short-term use, a series of publications released beginning in the 1980s suggested potentially safe long-term use of opioids and provided support for increased opioid prescription.⁴² Opioid producers accordingly began marketing campaigns, including incentivizing doctors to prescribe opioids, to increase opioid prescription for extended and chronic pain.⁴³ This marketing campaign resulted in doctors beginning to prescribe opioids more frequently.⁴⁴ As a result of the increased pharmaceutical advertising efforts and physicians' increased prescriptions, patients came to view opioids as an appealing treatment option.⁴⁵ Based upon the accumulation of these changes with regard to the understanding and availability of prescription opioids, the number of adults prescribed an opioid increased from 3% in 1994 to 7% in 2006, and by 2012, there were 282 million prescriptions written for opioids, which would have been enough prescriptions for every adult in the United States.⁴⁶

Eventually, in response to increased availability of prescription opioids and the illegal activity surrounding their distribution and use, authorities around the country began to crack down on pill mills, which are physicians and pharmacies that distribute inordinate amounts of opioids without proper medical purposes,⁴⁷ and physician opioid-prescription practices; but when the opioid pills became more difficult to obtain, people turned to heroin.⁴⁸

The opioid epidemic, which resulted from the course of events discussed above, has been described and summarized as occurring in three distinct waves. The first wave, beginning in the 1990s, involved the increased prescription of opioids and an increase in overdoses involving prescription opioids.⁴⁹ The

⁴¹ *Id.*

⁴² Andrew White, *Pain Management & Opioid Abuse in America: Causes, Solutions, and a Policy Prescription Worth Writing*, 26 ANNALS HEALTH L. ADVANCE DIRECTIVE 84, 86–87 (2017). Those studies have since been refuted by recent studies, and some of the physicians responsible for the studies advocating increased opioid prescription have also since spoken out against the use. *Id.* at 95.

⁴³ *Id.* at 87–88.

⁴⁴ *Id.* at 88.

⁴⁵ *Id.* at 88–89.

⁴⁶ *Id.* at 89.

⁴⁷ See, e.g., Laurel Wamsley, *Drug Distributors Shipped 20.8 Million Painkillers to West Virginia Town of 3,000*, NPR (Jan. 30, 2018), <https://www.npr.org/sections/thetwo-way/2018/01/30/581930051/drug-distributors-shipped-20-8-million-painkillers-to-west-virginia-town-of-3-00>.

⁴⁸ Joseph, *supra* note 3.

⁴⁹ *Understanding the Epidemic*, *supra* note 19.

second wave, beginning in 2010, involved a rapid increase in heroin overdose deaths, resulting from increased use of heroin.⁵⁰ And the third wave, beginning in 2013, involved an increase in overdose deaths from synthetic opioids, especially illegally-manufactured fentanyl.⁵¹ To truly consider and understand the problem, therefore, the opioid epidemic should be viewed as a long-term problem that has resulted from numerous medical, governmental, social, and economic influences and has involved various forms of opioids.

On October 26, 2017, HHS issued a statement declaring a nationwide public health emergency regarding the opioid crisis.⁵² According to the CDC, an average of 115 Americans die each day from opioid overdoses.⁵³ And it has been estimated that 580 people begin to use heroin every day.⁵⁴ In 2016, the number of overdose deaths involving opioids was five times higher than it was in 1999.⁵⁵ In that time, heroin use has increased in the United States across most population classification groups.⁵⁶ Part of the uniqueness of the opioid epidemic is that it generally does not only affect a particular subset of the population but, rather, affects both men and women, low- and high-class communities, and urban, suburban, and rural communities.⁵⁷ In particular, however, drug overdoses are now the leading cause of death for Americans under the age of 50.⁵⁸ In 2016, it was reported that overdose deaths from opioids were reaching similar levels as those of the H.I.V. epidemic during its peak.⁵⁹

Although the abuse of other drugs and illicit substances is certainly a problem, heroin and opioid use can be distinguished from that of other addictive substances because of the frequency with which recreational use results in

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis*, U.S. DEP'T HEALTH & HUM. SERVS. (Oct. 26, 2017), <https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html> [hereinafter *HHS Acting Secretary*].

⁵³ *Understanding the Epidemic*, *supra* note 19. It is likely, however, that many of these statistics do not accurately capture the scope of the epidemic, as there have been instances of underreporting the cause of death as well as inconsistencies in toxicology tests to determine whether opioids were involved. Peterson et al., *supra* note 24, at 32.

⁵⁴ *United States v. Walker*, No. 2:17-cr-00010, 2017 WL 2766452, at *3 (S.D. W. Va. June 26, 2017).

⁵⁵ *Understanding the Epidemic*, *supra* note 19.

⁵⁶ *Walker*, 2017 WL 2766452, at *3.

⁵⁷ White, *supra* note 42, at 84.

⁵⁸ Peterson et al., *supra* note 24, at 32.

⁵⁹ Haeyoun Park & Matthew Bloch, *How the Epidemic of Drug Overdose Deaths Rippled Across America*, N.Y. TIMES (Jan. 19, 2016), <https://www.nytimes.com/interactive/2016/01/07/us/drug-overdose-deaths-in-the-us.html>.

death.⁶⁰ For example, from 2012 to 2014, the CDC found that heroin caused the most overdose deaths of any drug.⁶¹ Specifically, in 2016, more than 66% of drug overdose deaths involved an opioid.⁶² Today, as discussed above in the discussion of the epidemic's history, opioid addiction and overdose involves not only painkillers and heroin but also fentanyl and other synthetic opioids, which have greatly contributed to the increased death rate.⁶³ And compounding the problems of drug abuse and overdose involved in the opioid epidemic is the fact that many people who suffer from opioid addiction face barriers to obtaining the treatment they need.⁶⁴ Because of the stigma around addiction, the lack of available and effective treatment services, and the inability for people with a substance use disorder to voluntarily seek treatment, there is a wide gap between the need for treatment and actual treatment received.⁶⁵

2. The Opioid Epidemic Brings Its Worst to West Virginia

Even outside the opioid epidemic, West Virginia, as well as the rest of Appalachia, experiences a general health disparity in comparison with the rest of the country with regard to health issues and opportunities for treatment.⁶⁶ Appalachia trails the rest of the United States with regard to most health measures, including mortality rate for poisoning, which includes drug overdoses, rate for years of potential life lost, and infant mortality.⁶⁷ In assessing the disparities in Appalachian healthcare, patients in coal mining areas, a historically-important industry in West Virginia, are more likely to need treatment for opioid usage.⁶⁸ Additionally, issues regarding privacy and family and cultural barriers prevent Appalachians from accessing treatment for substance abuse and mental health concerns.⁶⁹ Furthermore, analysis of opioid users in West Virginia has identified risk factors such as being within the age

⁶⁰ Walker, 2017 WL 2766452, at *3.

⁶¹ *Id.*

⁶² *Understanding the Epidemic*, *supra* note 19.

⁶³ Walker, 2017 WL 2766452, at *3.

⁶⁴ Peterson et al., *supra* note 24, at 48 n.57.

⁶⁵ *Involuntary Commitment for Substance Use Disorders*, HAZELDEN BETTY FORD FOUND. (July 2017), <https://www.hazeldenbettyford.org/education/bcr/addiction-research/involuntary-commitment-edt-717>.

⁶⁶ See Robert R. Davis & Shelly Cole, *Healthcare in Appalachia and the Role of the Federal Government*, 120 W. VA. L. REV. 1001, 1001–02 (2018).

⁶⁷ See *id.* at 1007.

⁶⁸ *Id.* at 1005.

⁶⁹ *Id.*

range of 35 to 54, being high-school educated or less, being single, working in a blue-collar industry, and having a history of incarceration.⁷⁰

More specific to the effect of the opioid epidemic on West Virginia, West Virginia has the highest rate of fatal drug overdoses in the United States.⁷¹ As of 2015, for every 100,000 people in West Virginia, 41.5 died from a fatal drug overdose, which was much higher than the national average of 16.3 fatal drug overdoses per 100,000 people.⁷² In 2016, 818 West Virginians died of a drug overdose, with at least 703 of the deaths involving an opioid,⁷³ and in 2017, that number increased to a total of almost 1,000.⁷⁴ Those numbers are up from 212 drug overdose deaths, 147 of which involved opioids, in 2001.⁷⁵ From just 2014 to 2015, the rate of drug overdose deaths involving synthetic opioids increased 76.4%, and fentanyl use alone increased tenfold from 2014 to 2017.⁷⁶ Moreover, opioid addiction does not only affect the individual users of the drugs; for example, West Virginia has the highest rate of any state of babies that are born with a dependence to opioids.⁷⁷

Based upon these drastic and harmful effects of the opioid epidemic in West Virginia, at least one West Virginia court has demonstrated an awareness of the opioid epidemic in the state and how it intersects with the broader legal system.⁷⁸ This demonstrates that the opioid epidemic is understood as being a major concern of the general welfare for the state of West Virginia, beyond just the harm it causes to those addicted to the drugs.⁷⁹ Accordingly, West Virginia courts have taken the seriousness of the opioid epidemic into consideration in making their decisions.⁸⁰ Accordingly, the opioid epidemic and its consequences have influenced many aspects of West Virginia communities and systems.

⁷⁰ *What West Virginia Is Doing*, *supra* note 25.

⁷¹ Joseph, *supra* note 3.

⁷² *United States v. Walker*, No. 2:17-cr-00010, 2017 WL 2766452, at *6 (S.D. W. Va. June 26, 2017).

⁷³ Wendy Holdren, *Although Overdose Deaths Up, WV Health Officer Cautiously Optimistic About Future*, REGISTER-HERALD (Mar. 7, 2017), http://www.register-herald.com/news/although-overdose-deaths-up-wv-health-officer-cautiously-optimistic-about/article_eb38b7df-09b3-52ac-b3a0-4811c2347f62.html.

⁷⁴ Trump, *supra* note 20.

⁷⁵ Holdren, *supra* note 73.

⁷⁶ *Walker*, 2017 WL 2766452, at *7.

⁷⁷ Joseph, *supra* note 3.

⁷⁸ *See Walker*, 2017 WL 2766452, at *3.

⁷⁹ *Id.* at *7.

⁸⁰ *Id.*

B. A Multi-Faceted Problem Requires a Multi-Faceted Response

Because the opioid epidemic is severe and multi-faceted, the responses to the epidemic have varied in an attempt to address the many and varied aspects it presents. This Section will provide an overview of the various responses to the opioid epidemic. First, Section II.B.1 will outline the federal responses as well as responses, generally, in states besides West Virginia. Second, Section II.B.2 will detail the responses to the epidemic thus far in West Virginia.

1. The Big Picture Responses

The response to the opioid epidemic has been multi-faceted. Based upon use of PDMPs (used for prescription data-collection), increased scrutiny from the Drug Enforcement Agency, and CDC regulation, responses have, to begin with, generally discouraged physicians from over-prescribing opioids.⁸¹ In addition to government responses and interventions, research, anti-opioid advocacy inside and outside of the medical community, and litigation against opioid-producing pharmaceutical companies have all offered different forms of responses to the epidemic.⁸²

On the national stage, Congress and federal agencies have been active in their responses to the epidemic. In 2016, for example, Congress passed almost 20 bills related to the opioid epidemic.⁸³ One of those bills was the Comprehensive Addiction and Recovery Act of 2016, which was designed to expand addiction treatment programs and increase the availability of overdose reversal medications such as naloxone.⁸⁴ Additionally, as part of the response to the opioid epidemic, HHS, in April 2017, unveiled a five-point Opioid Strategy with priorities to (1) “[i]mprove access to prevention, treatment, and recovery support services”; (2) “[t]arget the availability and distribution of overdose-reversing drugs”; (3) “[s]trengthen public health data reporting and collection”; (4) “[s]upport cutting-edge research on addiction and pain”; and (5) “[a]dvance the practice of pain management.”⁸⁵ In addition to outlining this combative strategy, HHS also invested almost \$900 million in 2017 alone for funding a response to the opioid epidemic through various measures.⁸⁶ Funding has also come from other national-level and federal sources, such as Congress, which in

⁸¹ White, *supra* note 42, at 94.

⁸² *Id.* at 94.

⁸³ *Id.* at 95.

⁸⁴ Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198, 130 Stat. 695; *see also* White, *supra* note 42, at 96.

⁸⁵ HHS Acting Secretary, *supra* note 52.

⁸⁶ *Id.*

2015, through the 21st Century Cures Act, made approximately \$1 billion available to the states to respond to the opioid epidemic.⁸⁷

Also on the national front, the CDC has issued, for use as a model for the states, opioid-prescription guidelines that focus on determining initiation or continuance of opioid treatment; selection, dosage, duration, follow-up, and discontinuation of opioid treatment; and assessment of risk factors and dangers of opioid usage.⁸⁸ In particular, the CDC's guidelines suggest a careful risk-benefit assessment at the outset of opioid therapy, careful ongoing monitoring during the therapy, and generally lower dosages of the opioids for all patients.⁸⁹ The CDC, in addition to constructing those practice guidelines, has attempted to combat the epidemic through regulation by limiting how many opioids can be prescribed to particular patients and during particular time periods and by requiring physicians to consider alternatives to prescription opioids.⁹⁰ Despite the variety and scope of these federal actions discussed above, however, many opioid-related bills and actions are stunted by disagreements over federal spending, and Congress has denied over \$600 million in funding for treatment programs.⁹¹

In addition to the federal initiatives and actions responding to the opioid epidemic, other sources of response have come from organizations distributing overdose-reversal medication, health care organizations providing guidance to physicians and other healthcare personnel, and state legislatures.⁹² Several states, in fact, have followed the CDC's model guidelines discussed above.⁹³ However, for the most part, the responses of the states have varied, with some laws being more comprehensive and others being more specific, providing for particular limits to be placed upon the prescription of opioids.⁹⁴ States have also utilized PDMPs as a means of collecting and reporting data to better address opioid abuse by means of prescription medication.⁹⁵

Many state and local communities have also employed various diversion programs in their efforts to respond to the opioid epidemic.⁹⁶ "Diversion," when used in the context of responses to the opioid epidemic, can connote "unlawful,

⁸⁷ Peterson et al., *supra* note 24, at 68.

⁸⁸ *CDC Guideline for Prescribing Opioids for Chronic Pain*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/prescribing/guideline.html> (last updated Aug. 28, 2019); *see also* Peterson et al., *supra* note 24, at 33.

⁸⁹ Peterson et al., *supra* note 24, at 34.

⁹⁰ White, *supra* note 42, at 94.

⁹¹ *Id.* at 97–98.

⁹² Peterson et al., *supra* note 24, at 32–33.

⁹³ *Id.* at 35–40.

⁹⁴ *Id.*

⁹⁵ *Id.* at 40–41.

⁹⁶ *Id.* at 47.

high risk behavior that dictates a quick response that relies on regulatory and police powers in the interest of public safety and patient well-being,” but it can also define “a community initiative or state policy that attempts to ameliorate some of the devastating effects of opioid addiction by providing treatment as an alternative to incarceration.”⁹⁷ These diversion programs, while often part of the criminal justice system, are typically patient-centered and often have aims to decriminalize opioid addiction and to reduce the likelihood of recidivism while providing treatment and resources for people to rebuild their lives.⁹⁸

2. Addressing the Problem Close to Home

Many of West Virginia’s initiatives and actions to combat the opioid epidemic overlap with those of other states and the federal government. Just as other states and the national government have done, one of the ways in which West Virginia has responded to the opioid epidemic is by developing more comprehensive data-collection systems such as PDMPs.⁹⁹ Furthermore, similar to other states, West Virginia is also limiting the number of pharmacies at which people can have opioid medication prescriptions filled.¹⁰⁰

In 2015, the West Virginia Legislature passed the Access to Opioid Antagonists Act (“the Act”).¹⁰¹ The stated purpose of the Act is “to prevent deaths in circumstances involving individuals who have overdosed on opiates.”¹⁰² That purpose was based on legislative findings that “permitting licensed health care providers to prescribe opioid antagonists to initial responders as well as individuals at risk of experiencing an overdose, their relatives, friends or caregivers may prevent accidental deaths as a result of opiate-related overdoses.”¹⁰³ As part of the Act, as codified under section 16-46-4 of the West Virginia Code, local and state government agencies are required to provide opioid antagonist rescue kits to their initial responders for use in response to and prevention of opioid overdoses.¹⁰⁴

⁹⁷ *Id.* at 47.

⁹⁸ *Id.* at 48–51.

⁹⁹ *What West Virginia Is Doing*, *supra* note 25.

¹⁰⁰ *Id.*

¹⁰¹ W. VA. CODE ANN. § 16-46-1 (West 2019).

¹⁰² *Id.* § 16-46-1(a).

¹⁰³ *Id.* § 16-46-1(b).

¹⁰⁴ *Id.* § 16-46-4.

C. *2018 WV H.B. 4215: Relating to the Involuntary Hospitalization of Persons Administered Opioid Antagonists*

On January 19, 2018, the Opioid Overdose Involuntary Hospitalization Bill was introduced.¹⁰⁵ The Bill proposed that the Access to Opioid Antagonists Act be amended to add a section requiring the involuntary hospitalization, in accordance with section 27-5-3 of the West Virginia Code, of persons administered opioid antagonists by initial responders.¹⁰⁶ In particular, the bill proposed the following changes: as a new section 16-46-7(a), that “[a]ny person who has been administered an opioid antagonist by an initial responder shall be subject to the involuntary hospitalization provision of section 27-5-3 of this code”; as a new section 16-46-7(b), that “[a]dministration of an opioid antagonist shall constitute a waiver of the requirements for a probable cause hearing under section 27-5-2 of this code”; and, as a new section 16-46-7(c), that “[f]urther proceedings involving an individual involuntarily hospitalized under the provisions of this section shall be consistent with the remaining provisions of section 27-5-1 et seq. of this code.”¹⁰⁷ The Bill was referred to the Committee on Health and Human Resources¹⁰⁸ before referral to the Committee of the Judiciary with a recommendation that the bill pass.¹⁰⁹ Unfortunately, with a busy legislative session,¹¹⁰ the session ended before the Bill could pass. The Bill received limited media and news attention.¹¹¹

¹⁰⁵ H.D. 4215, 83d Leg., Reg. Sess. (W. Va. 2018).

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ H.D. JOURNAL, 2018 Reg. Sess. (W. Va. Jan. 19, 2018).

¹⁰⁹ H.D. JOURNAL, 2018 Reg. Sess. (W. Va. Feb. 16, 2018).

¹¹⁰ See Hoppy Kercheval, *Observations at the End of the 2018 Regular Session of the Legislature*, METRONews (Mar. 12, 2018), <http://wvmetronews.com/2018/03/12/observations-at-the-end-of-the-2018-regular-session-of-the-legislature/>; Rusty Marks, *Winners and Losers of the 2018 Legislative Session*, WVNEWS (Mar. 13, 2018), https://www.wvnews.com/news/wvnews/winners-and-losers-of-the-legislative-session/article_d9efe3d3-0c4c-5a1f-bb0d-58b087a358b0.html. In particular, the 2018 West Virginia school employees strike garnered a large amount of attention during the 2018 legislative session. See Ryan Quinn, *A Look Back at the 2018 WV Public School Employees Strike*, CHARLESTON GAZETTE-MAIL (Mar. 24, 2018), https://www.wvgazette.com/2018_wv_teachers_strike/a-look-back-at-the-wv-public-school-employees-strike/article_c0dcd2db-4017-5bcd-b433-6b3afb6c3d57.html.

¹¹¹ See Kelsey Hoak & Kaitlynn LeBeau, *Update: W.Va. Overdose Bill Raises Red Flags for Some First Responders*, WSAZ (Jan. 25, 2018), <https://www.wsaz.com/content/news/WVa-House-Bill-would-require-hospital-trip-for-people-administered-naloxone-470206663.html>.

III. ANALYSIS

The 2018 Opioid Overdose Involuntary Hospitalization Bill proposed an addition to West Virginia's legislative response to the state's opioid epidemic. The Bill drew upon a legal framework established by both the state's Access to Opioid Antagonists Act and its established involuntary commitment and hospitalization laws. Because a legal framework exists upon which such a legislative addition could be situated, legal precedent generally supports the constitutionality of involuntary hospitalization procedures, and hospitalization procedures such as those proposed in the Bill could provide a means through which individuals suffering from addiction could get access to treatment, this Note suggests that the West Virginia Legislature again consider the addition of a procedure for involuntary hospitalization after opioid overdose as part of the state's legislative response to the opioid epidemic. This Part will offer this suggestion through an analysis of West Virginia's and other states' involuntary commitment and hospitalization laws and procedures, both generally and in the context of the opioid epidemic. Section III.A will examine the general laws and procedures involved in involuntary commitment and hospitalization and the laws of West Virginia. Section III.B will then consider and discuss, with specific reference to the 2018 Bill, potential issues and concerns that are raised by involuntary commitment and hospitalization which must be considered and addressed in order for a law such as that proposed by the Bill to be upheld against legal challenge and become an effective addition to West Virginia's response to the opioid epidemic.

A. *Interpretation and Analysis of Involuntary Commitment and Hospitalization Laws*

Civil involuntary commitment procedures are not new, but rather have historical roots and have been consistently in use up to present day. Involuntary civil commitment laws and procedures can be traced back to the development of the government's *parens patriae* power in the English law of the Middle Ages.¹¹² Though earlier involuntary commitment procedures were most often applied to help those with mental illnesses, the laws have evolved and broadened in scope. Today, in the United States, involuntary commitment laws for individuals suffering from drug or substance abuse have been passed and implemented in many states as an alternative for drug-related criminal convictions and incarcerations and as a means for drug abusers, regardless of criminal charges, to be moved into a course of treatment.¹¹³ Generally, across state programs for

¹¹² Mara Lynn Krongard, *A Population at Risk: Civil Commitment of Substance Abusers After Kansas v. Hendricks*, 90 CALIF. L. REV. 111, 118 (2002).

¹¹³ Thomas L. Hafemeister & Ali John Amirshahi, *Civil Commitment for Drug Dependency: The Judicial Response*, 26 LOY. L.A. L. REV. 39, 42 (1992).

involuntary commitment for drug dependency and abuse, two primary purposes have been identified: (1) to benefit the individuals dependent on drugs with treatment in order for them to become productive members of society, and (2) to benefit society by protecting people unable to help themselves and by protecting the general public from potentially dangerous people suffering from substance abuse.¹¹⁴ Although involuntary commitment laws have been applied to situations involving drug abuse, dependence, and addiction, such as within the context of the opioid epidemic, courts have still varied as to whether such drug abuse and addiction falls within the scope of “mental illness,” which is often part of the statutory language of such laws, or whether a specified requirement of addiction is necessary to apply these laws in drug addiction situations.¹¹⁵

1. West Virginia’s Involuntary Hospitalization Law

Under section 27-5-1-11 of the West Virginia Code, a person may be involuntarily hospitalized for examination if that person is believed to be addicted or mentally ill and, because of that addiction or mental illness, is likely to cause serious harm to himself, herself, or others.¹¹⁶ For purposes of the statute, addiction is defined as “a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one or more of the following occurring within thirty days” prior to the filing of a petition for involuntary hospitalization: (1) “[r]ecurrent substance use resulting in a failure to fulfill major role obligations at work, school or home”; (2) “[r]ecurrent use in situations in which it is physically hazardous”; (3) “[r]ecurrent substance-related legal problems”; or (4) “[c]ontinued use despite knowledge of having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.”¹¹⁷

With regard to the process and steps involved in the involuntary commitment procedure, according to section 27-5-2 of the West Virginia Code, any adult person may make the

application for involuntary hospitalization for examination of an individual when the person making the application has reason to believe that the individual to be examined is addicted . . . or is mentally ill and, because of his or her addiction or mental illness, the individual is likely to cause serious harm to himself, herself,

¹¹⁴ *Id.* at 45–46.

¹¹⁵ *Id.* at 48.

¹¹⁶ W. VA. CODE ANN. §§ 27-5-1–11 (West 2019).

¹¹⁷ *Id.* § 27-1-11.

or to others if allowed to remain at liberty while awaiting an examination and certification by a physician or psychologist.¹¹⁸

In each judicial circuit, the chief judge must appoint an attorney to serve as mental hygiene commissioner and preside over involuntary hospitalization hearings.¹¹⁹ The application must be made under oath,¹²⁰ made to either “the circuit court or a mental hygiene commissioner of the county in which the individual resides or of the county in which he or she may be found,”¹²¹ and provide the information and facts required by the involuntary commitment form.¹²² Thereafter, the circuit court, mental hygiene commissioner, or designated magistrate may enter an order for the named individual to be detained in order to hold a probable cause hearing for the purpose of an examination of the individual by a specified healthcare professional.¹²³ Then, a probable cause hearing must be held before the mental hygiene commissioner, circuit judge, or designated magistrate, in accordance with sections 27-5-2(e)–(j) of the West Virginia Code, in which the named individual has the opportunity to present evidence, confront all witnesses and evidence offered against the individual, and examine all testimony offered.¹²⁴ If, in accordance with the procedure laid out in section 27-5-2 of the West Virginia Code, probable cause is found, the “individual may be admitted to a mental health facility for examination and treatment.”¹²⁵

If the individual is admitted to a mental health facility, the Code provides for notice requirements and time limitations for the examination, certification, and commitment proceedings.¹²⁶ After the examination, final commitment proceedings are conducted in accordance with section 27-5-4 of the West Virginia Code.¹²⁷ And at the end of those proceedings, the circuit court or mental hygiene commissioner will make findings as to the following: “[w]hether the individual is mentally ill or addicted”; “[w]hether, because of illness or addiction, the individual is likely to cause serious harm to self or others if allowed to remain at liberty”; “[w]hether the individual is a resident of the county in which the hearing is held or currently is a patient at a mental health facility in the county”; and “[w]hether there is a less restrictive alternative than commitment appropriate

¹¹⁸ *Id.* § 27-5-2.

¹¹⁹ *Id.* § 27-5-1.

¹²⁰ *Id.* § 27-5-2(b).

¹²¹ *Id.* § 27-5-2(c).

¹²² *Id.* § 27-5-2(d).

¹²³ *Id.* § 27-5-2(e).

¹²⁴ *Id.* § 27-5-2(f).

¹²⁵ *Id.* § 27-5-3(a).

¹²⁶ *Id.* § 27-5-3.

¹²⁷ *Id.* § 27-5-4.

for the individual.”¹²⁸ Based upon those findings, the court may dismiss the proceedings, order the individual to a temporary observatory period not exceeding six months, or order the individual to a mental health facility for an indeterminate period, which expires two years from the date of the last order unless extended by the Department of Health and Human Resources.¹²⁹

From the statutory language outlining the involuntary hospitalization proceedings, the courts have interpreted the statute as requiring two steps for lawful temporary commitment: “(1) a facially valid certificate of an examining physician or psychologist . . . expressing the judgment that such person is mentally ill and likely to harm himself or herself or others, and (2) a facially valid finding of probable cause . . . to the same effect.”¹³⁰

Generally, for purposes of involuntary commitment, the likelihood of serious harm to self or others does not necessarily have to be imminent but must be within the reasonably foreseeable future.¹³¹ Based upon the detailed procedure outlined by the West Virginia Legislature and addressed by the state’s highest court, there is a clear and definite framework and procedure for involuntary hospitalization into which a law requiring involuntary hospitalization following an opioid overdose, such as that proposed in the Bill, could fit. Thus, though such a law alters the procedure to an extent and calls for its application in a much narrower circumstance, the involuntary hospitalization procedure is generally well-established in West Virginia.

In *In re C.M.*,¹³² the Supreme Court of Appeals of West Virginia upheld the constitutionality of the state’s involuntary commitment statutes against several challenges.¹³³ Additionally, the court found that evidence that a person attempted suicide, intentionally overdosed on a medication, was addicted to a prescription drug, and would attempt suicide again was sufficient evidence to sustain an involuntary commitment on the ground that the person was addicted, suicidal, and a danger to herself.¹³⁴ West Virginia’s current involuntary commitment law and procedure has also been previously applied in the context of substance abuse in *State v. Armstrong*.¹³⁵ In *Armstrong*, the court reasoned that where the record clearly reveals probable cause to believe a person suffers from alcohol addiction, and that person’s history of automobile use shows

¹²⁸ *Id.* § 27-5-4(k).

¹²⁹ *Id.* § 27-5-4(l).

¹³⁰ Syl. Pt. 11, *Riffe v. Armstrong*, 477 S.E.2d 535, 540 (W. Va. 1996).

¹³¹ *See State ex rel. Pifer v. Pifer*, 273 S.E.2d 69, 71 (W. Va. 1980); *Hatcher v. Watchel*, 269 S.E.2d 849, 850 (W. Va. 1980).

¹³² No. 15-0997, 2017 WL 1347709 (W. Va. Apr. 10, 2017) (memorandum decision).

¹³³ *Id.* at *3–5.

¹³⁴ *Id.* at *2–3.

¹³⁵ 332 S.E.2d 837 (W. Va. 1985), *overruled on other grounds in State v. Hopkins*, 453 S.E.2d 317 (W. Va. 1994).

probable cause to believe that person poses a substantial threat of harm to himself and others, the State has a duty to provide and mandate appropriate rehabilitation of that person by means of an application for involuntary commitment to an appropriate mental health facility.¹³⁶ West Virginia's highest court, therefore, has upheld the constitutionality of West Virginia's involuntary hospitalization statute and its application in the context of substance abuse. Accordingly, even though a law requiring involuntary hospitalization following an opioid overdose may be met with due process and other legal challenges, the existing precedent likely supports the law being upheld.

2. How Other States Have Applied Involuntary Hospitalization in the Context of the Opioid Epidemic

All states have statutes under which, according to particular procedures and evidentiary standards, people may be involuntarily committed for treatment when those people present a threat of significant harm to themselves or others.¹³⁷ In most cases, those statutory schemes were originally intended to provide involuntary commitment proceedings for people with mental health disorders and have not been often used in the specific context of substance abuse disorders.¹³⁸ Further, some states' statutes do not include substance abuse within the definition of mental illness.¹³⁹ Thirty-seven states, however, as well as the District of Columbia, now do have laws in place that allow for the involuntary commitment of individuals with a substance abuse disorder or alcoholism.¹⁴⁰ These laws vary from state to state with regard to who can petition the court, the likelihood of a petition being granted, the length of commitment, and the type of treatment mandated.¹⁴¹ In some of these states, in the particular context of substance abuse and addiction, the dangerousness criteria required for commitment has been held to be satisfied by actual attempted harm of self or others, inability to care for oneself, or failure to take care of an immediate and dangerous medical issue caused by the drug use and addiction.¹⁴² However, even though it has been recognized that several courts have been willing to find that substance abuse, as a type of harm to self, satisfies the dangerousness requirement, the satisfaction of the dangerousness criteria by drug abuse self-

¹³⁶ *Armstrong*, 332 S.E.2d at 844–45.

¹³⁷ Peterson et al., *supra* note 24, at 52. In addition to civil involuntary commitment laws, there are other means by which individuals with substance abuse disorders may be involuntarily committed for treatment. *Involuntary Commitment for Substance Use Disorders*, *supra* note 65.

¹³⁸ Peterson et al., *supra* note 24, at 52.

¹³⁹ *Id.*

¹⁴⁰ *Involuntary Commitment for Substance Use Disorders*, *supra* note 65.

¹⁴¹ *Id.*

¹⁴² Hafemeister & Amirshahi, *supra* note 113, at 52.

harm has also been recognized as a potential slippery slope.¹⁴³ Despite the availability of such routes to hospitalization for drug abuse, many families, healthcare professionals, and legal professionals are unaware of the options provided by these laws, so they are rarely used.¹⁴⁴

Generally, in a similar manner as the procedure in West Virginia, an involuntary commitment based on a substance abuse disorder requires a petition for commitment by another individual, which varies according to state but may include a spouse, guardian, relative, medical professional, or other responsible person.¹⁴⁵ Next, the commitment process generally requires an evaluation by a physician, or, for some states, another type of healthcare professional, prior to commitment.¹⁴⁶ If committed, the individual will be committed for a certain amount of time, which varies greatly from state to state, but a third of the states have a maximum length of commitment of 30 days.¹⁴⁷ During that time of commitment, an individual will receive treatment for the substance abuse disorder.¹⁴⁸ Generally, after the period of commitment has ended, the statutes do not require or account for any additional treatment for the individual.¹⁴⁹

Now, in the context of the opioid epidemic, just as West Virginia did in 2018, several states have considered new involuntary commitment laws or changes to existing laws that would make commitment less difficult for those addicted to and abusing opioids.¹⁵⁰ The aim of these laws designed to make involuntary commitment easier in the context of opioid addiction and abuse is to provide families and other interested parties with the tools needed to act in the best interest of the afflicted individuals, especially in light of the nature of substance abuse disorders and the stigma attached to addiction that inhibits many from seeking out and obtaining the necessary treatment.¹⁵¹ Massachusetts, for example, based upon increased use of its involuntary commitment law for alcohol or substance use disorder due to the opioid epidemic, updated and clarified its involuntary commitment law in a variety of ways.¹⁵² For example, the changes to Massachusetts law in this area included a promulgation of new trial court rules, the Supreme Judicial Court of Massachusetts issuing a decision

¹⁴³ Krongard, *supra* note 112, at 147–48, 153–54.

¹⁴⁴ *Involuntary Commitment for Substance Use Disorders*, *supra* note 65.

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

¹⁵¹ Peterson et al., *supra* note 24, at 53.

¹⁵² See Crystal Lyons, *A Fairer Approach in Addressing the Opioid Epidemic: Recent Changes to the Law Regarding Involuntary Commitment for Alcohol and Substance Use Disorders Under M.G.L.C. 123, § 35*, 60 Bos. B.J. 16 (2016).

addressing the operation of the rules, and the Massachusetts Legislature passing two bills that address particular changes regarding the operation of the state's involuntary commitment procedure.¹⁵³

Additionally, three states, New Hampshire, Maryland, and Washington, have adopted new involuntary commitment laws that specifically apply to opioid use.¹⁵⁴ New Hampshire's Senate Bill 220 proposed to amend its definition of mental illness for the purpose of its involuntary commitment statute to include any person who "has ingested opioid substances such that the person's behavior demonstrates that he or she lacks the capacity to care for his or her own welfare and that there is a likelihood of death, serious bodily injury, or serious debilitation if admission is not ordered."¹⁵⁵ In Maryland, House Bill 499 proposed specific involuntary commitment and treatment procedures for individuals who have experienced a drug overdose.¹⁵⁶ Finally, Washington's Senate Bill 5811 proposed that, in expanding its involuntary treatment statutes, "[a] person is gravely disabled due to a substance use disorder when the person has an opioid use disorder characterized by active use of heroin and, within the prior twelve-month period, the person" has met other related criteria demonstrating the detriment of the drug use on that person's life.¹⁵⁷ Based upon the actions of the states discussed above, it is clear that West Virginia was not alone in considering to attempt to adjust and utilize its involuntary commitment procedures to provide a means of helping those who are addicted to and have overdosed from opioids. Accordingly, West Virginia lawmakers, courts, and healthcare professionals would be able to look to the successes and failures of other states to fine tune its own use of involuntary hospitalization in the context of the opioid epidemic.

In addition to such legislative adjustments as discussed above, and as exemplified by the series of legislative actions and ongoing responses to the opioid epidemic taken by the state of Kentucky, any response to the opioid epidemic should involve ample discussion involving all types of stakeholders, a willingness to make necessary legal changes, and a flexibility and open-mindedness to amend laws and regulations as problems arise and in the course of evaluating actions already taken.¹⁵⁸ In the context of a crisis as complex and multi-faceted as the opioid epidemic, there is not going to be one clear and final

¹⁵³ *Id.*

¹⁵⁴ MD. CODE ANN., HEALTH-GEN. § 10-101 (West 2018); H.D. 499, 438th Sess. Gen. Assemb. (Md. 2018); S. 220, 165th Sess. (N.H. 2017); S. 5811, 65th Leg., Reg. Sess. (Wash. 2017); *see also Involuntary Commitment for Substance Use Disorders*, *supra* note 65.

¹⁵⁵ S. 220, 165th Sess. (N.H. 2017).

¹⁵⁶ H.D. 499, 438th Sess. Gen. Assemb. (Md. 2018).

¹⁵⁷ S. 5811, 65th Leg., Reg. Sess. (Wash. 2017).

¹⁵⁸ Peterson et al., *supra* note 24, at 59–60.

solution.¹⁵⁹ Instead, the approach is better viewed as a system or series of responses that considers the many aspects of the problem and their impacts upon those suffering from addiction and the wider communities.¹⁶⁰ The Bill proposed in West Virginia in 2018 built on prior legislation and responded to new issues that had arisen based on previous responsive actions. Therefore, in a similar fashion, and as demonstrated by other states, West Virginia law- and policy-makers, if they were again to consider a law requiring involuntary hospitalization after an opioid overdose, will need to remain open-minded and to continue to adjust and build upon previous actions already taken to continue to fight the multi-faceted epidemic.

B. Potential Issues Involved in the Application of Involuntary Hospitalization to Opioid Overdoses

In expanding the scope of a state's civil involuntary commitment procedures, specifically when addressed to opioid use and overdose, as was proposed in West Virginia in 2018, there are many factors that need be considered. Those considerations include developing specific implementation procedures, enforcing compliance, anticipating risk mitigation, determining the levels of training and licensure required to evaluate individuals for involuntary commitment and treatment, creating mechanisms to ensure protection of privacy and confidentiality as much as possible, identifying persons able to petition the court for involuntary commitment, and specifying recording standards in support of involuntary commitment in light of the sacrifice of freedom.¹⁶¹ States will have to deal with serious issues involving confidentiality, consent, types of care, and continuity of care in effectuating these procedures in the context of the opioid epidemic.¹⁶²

1. Legal Issues: Balancing Safety and Treatment Against Rights and Privacy

In any situation of drug or substance abuse, emphasis has often been placed on the importance of providing treatment, which drug abusers often do not seek voluntarily and which involuntary commitment laws aim to provide.¹⁶³ While involuntary commitment laws for substance abuse, such as opioid overdose, might be a way to get those addicted to opioids the treatment they need

¹⁵⁹ *Id.* at 60.

¹⁶⁰ *Id.*

¹⁶¹ *Id.* at 54–55.

¹⁶² *Id.* at 55. In light of some of these concerns, some states have attempted to protect patients' procedural and substantive due process rights by providing a right to counsel and a right to receive the petition and be present at the hearing. *Id.*

¹⁶³ Hafemeister & Amirshahi, *supra* note 113, at 41.

to avoid death and reestablish their lives, there are also concerns for the privacy and freedom of people with substance abuse disorders.¹⁶⁴ Some argue, for example, that treatment should remain a choice for people unless they have committed a crime.¹⁶⁵ Thus, West Virginia's lawmakers should consider the potential concerns discussed below in order to ensure the proper safeguards and policies are in place for a law requiring involuntary hospitalization for opioid overdoses to be implemented legally and effectively.

With regard to involuntary commitment and hospitalization laws, generally, there has been disagreement between states and courts about the type and degree of procedural safeguards guaranteed to the individual named in drug-based involuntary commitment and hospitalization proceedings.¹⁶⁶ It has previously been noted that, in the context of drug-related cases, courts, as well as Congress and legislatures, have shown a willingness to limit constitutional protections in efforts to combat drug use and abuse.¹⁶⁷ One important and contentious issue that influences how those protections are viewed has been the treatment and consideration of the proceedings as either criminal or civil.¹⁶⁸ These concerns and confusions stem, in part, from the dual purpose of such procedures to both serve as protection to the general public and as assistance to obtain treatment for the individual.¹⁶⁹ Accordingly, for an opioid overdose involuntary hospitalization law to be sound and effectively implemented, lawmakers should provide clarity as to the nature of the proceedings specific to commitment based on opioid overdose. Clearly defining the nature of the involuntary hospitalization proceedings will do much to clarify the types and degree of protections guaranteed to the person sought to be hospitalized.

Another important legal issue raised in the context of involuntary hospitalization is the right to counsel in such proceedings.¹⁷⁰ While most states provide for a right to counsel at the final commitment proceeding, the right to counsel is not always necessarily guaranteed at the earlier stages of the proceedings, such as the medical examination.¹⁷¹ Related to the right to counsel, there are also concerns that where counsel is appointed for such involuntary commitment proceedings, the representation is not always necessarily as zealous

¹⁶⁴ *Involuntary Commitment for Substance Use Disorders*, *supra* note 65.

¹⁶⁵ *Id.*

¹⁶⁶ Hafemeister & Amirshahi, *supra* note 113, at 68.

¹⁶⁷ Krongard, *supra* note 112, at 135–36.

¹⁶⁸ Hafemeister & Amirshahi, *supra* note 113, at 68–69. Along similar lines, considering such involuntary commitment proceedings as criminal matters raises potential issues regarding right to a jury trial. *See id.* at 69–70.

¹⁶⁹ *Id.* at 69.

¹⁷⁰ *Id.* at 71–72.

¹⁷¹ *Id.*

as it should be.¹⁷² Accordingly, in order to ensure that this type of law could be enacted and implemented in a way likely to be effective and upheld against legal challenges, lawmakers should be sure to clarify at what points in the involuntary hospitalization proceedings the individual has a right to counsel. Further, emphasis should be placed on ensuring that appointed West Virginia lawyers represent these inflicted individuals with zeal.

Four other issues likely to arise in the context of the involuntary hospitalization proceedings include the following: (1) whether the right against self-incrimination is applicable in involuntary commitment procedures;¹⁷³ (2) whether any aspects of patient-physician privilege apply;¹⁷⁴ (3) whether the individual suffering from a drug addiction would be competent to make a waiver of his or her rights;¹⁷⁵ and (4) whether a “clear and convincing” standard or “beyond a reasonable doubt” standard should be employed as the burden of proof in such proceedings.¹⁷⁶ In light of the concerns discussed above, West Virginia lawmakers would have to consider these rights and potential protections of the individual named in the proceedings. The lawmakers would then have to decide what protections should be provided for that individual, whether they should be different than those generally guaranteed under the state’s standard involuntary commitment law, and whether those protections are sufficient.

Another important consideration in the context of involuntary commitment proceedings is the principle of the least restrictive alternative.¹⁷⁷ According to the principle of the least restrictive alternative, the “individual’s liberty should be restricted only to the extent necessary to effectuate treatment.”¹⁷⁸ It may be argued that there are alternatives to involuntary hospitalization, such as some sort of outpatient service, that would be less restrictive while providing necessary treatment. Therefore, West Virginia lawmakers should be prepared to justify why an overdose and resuscitation necessitates such a restrictive response in order to support a law requiring involuntary hospitalization after an opioid overdose.

Finally, beyond the medical examination and commitment process, there are also concerns to be addressed with the actual treatment once the individual has been involuntarily committed. First, there is an issue as to whether individuals that are involuntarily committed or hospitalized for drug abuse or

¹⁷² See Deborah L. McHenry, *The Duty of Counsel in Civil Commitment Cases*, 9 W. VA. LAW. 12 (1995).

¹⁷³ Hafemeister & Amirshahi, *supra* note 113, at 74.

¹⁷⁴ *Id.*

¹⁷⁵ *Id.* at 78.

¹⁷⁶ *Id.* at 81–82.

¹⁷⁷ *Id.* at 84–85.

¹⁷⁸ *Id.*

addiction have a right, either constitutionally or statutorily, to treatment.¹⁷⁹ Accordingly, in order to be effective, the Legislature should ensure that the statutory language proposed for the law, whether it be that of the 2018 Bill or otherwise, guarantees a right to treatment to an individual once he or she has been involuntarily hospitalized after the opioid overdose. Furthermore, even though the purpose of involuntary commitment or hospitalization in these situations is to provide the individual with effective treatment for his or her drug dependence, that treatment may end up being ineffective for reasons such as the individual not cooperating with or participating in the treatment, the individual not being motivated to ultimately change his or her behavior, or the particular treatment program being ineffective for that particular individual.¹⁸⁰ Accordingly, West Virginia law- and policy-makers will need to account for these problems likely to be encountered in the treatment portion of the hospitalization process.

2. Practical Issues: Multiple Components to Effective Implementation

Beyond the potential legal concerns discussed above, there are a number of other practical concerns that should be considered and addressed in the course of considering and potentially implementing an opioid overdose involuntary hospitalization law. For example, studies based on the efficacy of forced or involuntary commitment and treatment, as compared with voluntarily-sought treatment, have produced inconsistent results, and much of the research on the results of involuntary commitment is limited.¹⁸¹ Some have raised concerns that involuntary commitment and forced treatment for opioid abuse is ineffective in the long-term and results in infringements upon liberty; lack of high-quality, evidence-based treatment; and a higher risk of overdoses.¹⁸² As a result of lowered tolerance during involuntary commitment, in combination with a lack of follow-up and treatment after the involuntary commitment, it has been shown that individuals have an increased risk of overdose when re-entering their previous lives after involuntary commitment.¹⁸³ In fact, Massachusetts data

¹⁷⁹ *Id.* at 95–96.

¹⁸⁰ *Id.* at 87. Further, even if an individual is involuntarily committed, that individual may still have the right to refuse the treatment provided during that commitment. *Id.*

¹⁸¹ *Is Involuntary Treatment the Next Tool in the Fight Against the Opioid Epidemic?*, GUARDIAN RECOVERY NETWORK (Feb. 27, 2018), <https://www.guardianrecoverynetwork.com/2018/02/27/is-involuntary-treatment-the-next-tool-in-the-fight-against-the-opioid-epidemic/> [hereinafter *The Next Tool*]; *Involuntary Commitment for Substance Use Disorders*, *supra* note 65.

¹⁸² See Leo Beletsky et al., *Involuntary Treatment for Substance Use Disorder: A Misguided Response to the Opioid Crisis*, HARV. HEALTH PUB. (Jan. 24, 2018), <https://www.health.harvard.edu/blog/involuntary-treatment-sud-misguided-response-2018012413180>; *The Next Tool*, *supra* note 181.

¹⁸³ See *Involuntary Commitment for Substance Use Disorders*, *supra* note 65.

demonstrated that “people who were involuntarily committed were more than twice as likely to die from an overdose than those who completed treatment voluntarily.”¹⁸⁴ Though such findings may be discouraging, they are not decisive. Accordingly, West Virginia should consider innovations and different approaches to make involuntary treatment more effective than it has previously been shown to be.

Another concern related to that of the effectiveness of the care during the involuntary commitment or hospitalization is that of outpatient or follow-up treatment. Courts, in the context of general substance abuse-based involuntary hospitalization, have upheld the use of outpatient placements and programs to gauge whether a committed individual should return to society.¹⁸⁵ On a related matter, the type and degree of due process protections guaranteed to individuals after inpatient commitment, but before the end of outpatient treatment, is an issue of contention across courts.¹⁸⁶ So West Virginia’s law- and policy-makers should also consider how to effectively account for individual’s rights and protections and combine hospitalization, outpatient, and follow-up services to provide a more holistic and long-term source of assistance and treatment to those that need help.

Taking a step back from the individual people sought to be helped by the hospitalization and potential treatment programs, the implementation of involuntary hospitalization measures for opioid overdoses will likely raise concerns involving the capacities of health care facilities to handle the involuntarily hospitalized patients, as available hospital beds and addiction treatment facilities are already low in numbers.¹⁸⁷ There is already a concern that the infrastructure of the addiction-treatment system, including treatment centers, hospitals, and detox and rehabilitation centers, may not have the resources and capacity to handle the influx of patients likely to result from the increased use of the civil involuntary commitment statutes.¹⁸⁸ Furthermore, there are several economic and social concerns that could halt the effectiveness of such a law if passed and implemented. For example, the Department of Health and Human Resources has estimated that the fiscal impact of the proposed 2018 Bill would have been approximately \$211.2 million, with the potential to increase until the opioid epidemic was under control.¹⁸⁹ Furthermore, the hospitalized individuals and their families, many of whom are already living in poverty, will likely feel economic and social harms because involuntary hospitalization could result in lost income and hospital bills. These types of concern are the type of real-world

¹⁸⁴ *The Next Tool*, *supra* note 181.

¹⁸⁵ Hafemeister & Amirshahi, *supra* note 113, at 92.

¹⁸⁶ *Id.* at 93–94.

¹⁸⁷ *See Involuntary Commitment for Substance Use Disorders*, *supra* note 65.

¹⁸⁸ *Id.*

¹⁸⁹ FISCAL NOTE, H.D. 4215, 83d Leg., Reg. Sess. (W. Va. 2018).

factors and limitations that, even if such a bill was passed into law, would prevent the law from having any productive effect upon the opioid problem. Accordingly, though outside the scope of this Note, lawmakers, as well as other stakeholders in this system, must ensure that there is infrastructure and economic and social resources in place that would allow an involuntary hospitalization law for opioid overdoses to actually be used as a means of helping the people of West Virginia.

3. What Else Could West Virginia Lawmakers Consider?

While a law requiring involuntary hospitalization for opioid overdoses would likely be upheld against legal challenges and could be a potentially effective addition to West Virginia's response to the opioid epidemic, there are other potential responses that should be sought out and considered in addition to the actions already taken, a few of which are discussed below. One of the other potential responses to the opioid epidemic could involve a change to the healthcare system. In a fee-for-service healthcare system, in which physicians are paid a fee per visit rather than based on health outcomes, physicians are pressured and incentivized to prescribe opioids because prescribing the patient what the patient wants, in combination with the short-term treatment nature of the opioid, will keep the patient returning for further visits.¹⁹⁰ Transitioning out of such a fee-for-service healthcare system could take some pressure off of physicians to prescribe opioids and ultimately help, by way of the providers, to fight against the opioid epidemic.¹⁹¹ A comprehensive care payment system would allow physicians to focus more on long-term health improvement rather than visit rates, which would likely encourage physicians to utilize different resources in patient care before resorting to opioids.¹⁹²

Relatedly, determination and application of viable and effective alternatives to opioids is key to ending the opioid epidemic.¹⁹³ Combinations of other drugs have been proven to be just as effective in pain relief, but without being addictive.¹⁹⁴ Accordingly, the government should consider funding and granting research of such alternatives. Finally, responses to the opioid epidemic are costly in many ways.¹⁹⁵ A major cost is connected to naloxone, which has become increasingly more expensive.¹⁹⁶ If the government can intervene to artificially reduce the price of, or provide additional funding for, naloxone, and

¹⁹⁰ White, *supra* note 42, at 94.

¹⁹¹ *Id.* at 94–95.

¹⁹² *Id.* at 95.

¹⁹³ *See id.* at 99.

¹⁹⁴ *Id.*

¹⁹⁵ *Id.* at 98.

¹⁹⁶ *Id.*

other key response expenditures, then communities can get the supplies they need, and the opioid overdose problem may be able to be reduced.¹⁹⁷

IV. CONCLUSION

A law requiring involuntary hospitalization following an opioid overdose, such as that proposed in West Virginia's 2018 House Bill 4215, would not be enacted without concerns and would not be the ultimate solution to the problems of the opioid epidemic, but such a law would likely be upheld against legal challenges, could build off of the state's existing laws, and may provide a route to treatment for many people suffering from opioid addiction in West Virginia. The law would build off of a legal framework previously in place in two ways. First, the law would build off of the state's established involuntary commitment laws and procedures, and second, the law would build off of the Access to Opioid Antagonists Act, which is part of the state's response to the opioid epidemic. Because these laws already exist and, especially with regard to the involuntary commitment laws, are supported by court decisions and legal precedent, such a law appears likely to be upheld against legal challenges on its face. This type of law would also provide a system of follow-up and accountability for the administration of opioid antagonists and a procedure for getting people who have suffered an opioid overdose into treatment. As discussed in this Note, there are concerns about the long-term effectiveness of involuntary treatment, the available infrastructure and resources that implementation would likely require, and the legal rights and protections afforded to individuals sought to be involuntarily hospitalized. These are concerns that lawmakers and state officials must consider and address, and there are likely other issues and concerns that would arise both as such a law was implemented and as the opioid epidemic evolves over time. However, West Virginia's citizens, especially those suffering from opioid addiction, need help, and this type of law has the potential to be an effective means to get them on the track to the help they need.

*Quentin T. Collie**

¹⁹⁷ *Id.* at 99.

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