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Civil Commitment: An Assessment of the Alcohol and Drug Statute in Mississippi

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CIVIL COMMITMENT: AN ASSESSMENT OF THE ALCOHOL AND DRUG STATUTE IN MISSISSIPPI

by
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DEDICATION

This thesis is dedicated to my uncle, Craig Foley, and my grandfather, Peter Foley. I hope this thesis conveys my admiration for your strength and perseverance.

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ABSTRACT
ELIZABETH LOUISE FOLEY: Civil Commitment: An Assessment of the Alcohol and Drug Statute in Mississippi
(Under the direction of Dr. Melissa Bass)

This thesis assesses the alcohol and drug commitment statute in Mississippi. Substance use disorder has impacted millions of people around the world, including within the U.S. Civil commitment is one of the many policies aimed at helping those with substance use disorder; however, it is highly debated and under researched. This thesis looks specifically at the alcohol and drug commitment statute in Mississippi, interviewing legal and medical professionals who are responsible for implementation of this statute. The findings of this thesis include a lack of uniformity in the implementation of the statute and several areas where procedures can and ought to be improved to yield better results. Policy recommendations include streamlining the commitment process, reallocating funding, and improving education regarding substance use disorder.

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LIST OF ABBREVIATIONS

SUD	substance use disorder
OUD	opioid use disorder
DMH	Department of Mental Health
CMH	community mental health center
MAT	medication assisted treatment
MS	Mississippi
SABG	Substance Abuse Block Grant
NIDA	National Institute on Drug Abuse
FDA	Food and Drug Administration
MSH	Mississippi State Hospital
SAMHSA	Substance Abuse and Mental Health Services Administration
LPC	Licensed Professional Counselor
LCPC	Licensed Clinical Professional Counselor
ASAM	American Society of American Medicine
MSW	Masters of Social Work
CPSS	Certified Patient Service Specialist
CSU	Crisis Stabilization Unit
NIMH	National Institute of Mental Health

Chapter 1: Introduction

Substance use disorder, or addiction, affects thousands of families across the U.S. and the world, and my family is no exception. I've spent much of my academic career learning more about this topic, and I always wanted my senior thesis to delve more deeply, particularly into opioid use disorder. The opioid epidemic was in part created and perpetuated by poor public policy, and thus, I am eager to assess public policies the government has enacted to fix the problems they helped create. One of those public policies is civil commitment; however, I've learned that this policy is not without its problems either.

Recovery Research Institute estimates that 20 million individuals in the U.S. have a SUD (Research Recovery Institute, 2017). Furthermore, three million individuals in the U.S. "have had or currently suffer from opioid use disorder" (Azadfard, 2021). Despite these high numbers, the statistics regarding those who receive treatment are much lower. In 2017, four million individuals received treatment, which was only "19% of those who needed it" that year (American Addictions Center, 2022), and furthermore, only one million of these actually "felt that they needed treatment" (American Addictions Center, 2022). In regards to drug overdose deaths, over 100,000 Americans died from April 2020 to April 2021, "an increase of 28.5%" from April 2019 to April 2020, and overdose deaths from synthetic opioids increased in this time period (CDC, 2021). Specifically in Mississippi, reported drug overdose deaths rose by 22.5% from September 2020 to September 2021 (CDC, 2022).

Civil commitment is one of many public policies whose purpose is to provide treatment to those with substance use disorder. The legal definition of civil commitment is "court-ordered

institutionalization of a person suffering from mental illness, alcoholism, or drug addiction upon a finding that the person is dangerous to himself or herself or to others" (Merriam-Webster, 2022). Thus, this policy provides for involuntary treatment. All 50 U.S. states have a civil commitment statute; however, they all differ (Snook, et al., 2014). Some states have civil commitment statutes that only address those with mental illness, while others include for those with substance use disorders as well. Furthermore, states differ in their civil commitment processes, in terms of the standard needed to commit someone (Snook, et al., 2014).

The utilization of civil commitment, when used as involuntary treatment for those with SUD, differs, sometimes drastically, among states (Christopher, et al., 2015). Furthermore, one research team that studied the use of civil commitment for SUD in every U.S. state found that Mississippi's use was unknown (Christopher, et al., 2015).

The purpose of my research paper is to contribute to the scholarly conversation regarding Mississippi's civil commitment statute. Commitment, both for alcohol and drug disorders as well as mental disorders, is heavily debated in the literature. There are many arguments for and against this policy, both ethically and legally. Furthermore, the effectiveness of the alcohol and drug commitment process is also unclear due to the lack of systematic data collection, and the limited nature of the data that is collected. My initial research was focused on identifying in what instances civil commitment is a worthwhile and effective policy, specifically contrasting Mississippi alcohol and drug commitments at public versus private facilities. Additionally, I aimed to pay particular attention to the experience that those committed for opioid use disorder (OUD) have in the civil commitment process, in Mississippi. As I conducted my research, my research question and purpose evolved. Through my research and learning more from the professionals who deal with the commitment process daily, I learned that there are more pressing

questions relevant to the policy implementation in Mississippi. My research question then shifted to *how is the alcohol and drug commitment statute in Mississippi implemented, and how can it be improved to be more effective and ethical for those with SUD, and specifically, OUD?*

In the following chapters, I will provide background on this subject, the literature regarding commitment, the research design I followed, the results of my research, my thoughts on these findings, and finally, my policy recommendations. In chapter two, I explain the origins of the civil commitment statute, its intended purpose, background on SUD in the U.S., as well as background on SUD and SUD policy in Mississippi. In chapter three, I review the literature on civil commitment and SUD, and I explain how my research builds on and fills gaps in existing knowledge. In chapter four, I present the research design I aimed to follow, as well as how my research design evolved. You will learn why I chose the research design I did, what problems and struggles I confronted while conducting my research, and why I had to adapt my research design. Next, in chapter five, I report my findings from my interviews, and in chapter six I discuss those results. In chapter seven, I then lay out my recommendations for what policymakers should do to improve the alcohol and drug commitment process, as well as improve treatment for substance use disorder in general, in Mississippi. In chapter eight I conclude my thoughts on this research process and provide guidance for future researchers. Through this thesis you'll learn more about how the alcohol and drug commitment process is being implemented in Mississippi, the flaws in this process, and what treatments for alcohol and drug commitments are actually being used. Hopefully you'll walk away convinced that this policy is important, and that improving the alcohol and drug commitment process ought to be prioritized.

Chapter 2: Background

"Common sense tells us that no disease, social problem, or public health problem can be remedied, reduced, or solved simply by treating its victims" (Hancock, 1974). Not only does common sense tell us this, but so do statistics, especially in the case of SUD. SUD is a major public health problem in the United States and has been so for a long time. Nineteen point seven million Americans over the age of 12 had a substance use disorder in 2017, according to the National Survey on Drug Use and Health ("Alcohol and Drug Abuse Statistics," 2021). Furthermore, approximately 8.5 million American adults battled both SUD and mental health disorders at the same time ("Alcohol and Drug Abuse Statistics," 2021). In Mississippi, in 2004, one-third of nearly 500 incarcerated juveniles reported co-occurring mental and substance use disorders (Robertson, et al, 2004). SUD cost many lives, as nearly 841,000 Americans have died from drug overdoses since 1999 ("Drug Overdose Deaths," 2021), and the NIDA has found "increases in substance use and drug overdoses in the United States since the COVID-19 pandemic" began ("Covid-19 & Substance Use, 2022). Opioids specifically have posed major problems. From 1999-2019, there were just under 500,000 deaths due to opioid overdoses, including legally prescribed opioids ("Understanding the Epidemic," 2021). More recently, opioid-involved deaths have increased from year to year. From 2010 to 2017, the number of opioid-involved overdose deaths more than doubled (NIDA, 2021). Additionally, in 2020, 93,331 Americans died of drug overdoses, a record high and over 20,000 more deaths than in 2019 (Baumgartner, 2021). 69,710 of those deaths were due to opioids, also a 20,000 death increase from 2019 (Baumgartner, 2021).

As the scholar Dr. David Hancock notes, simply treating the victims of addiction (SUD) will not truly solve the problem of addiction (SUD). However, our treatment procedures still can and ought to be improved until we find a successful method to minimize the causes of SUD, and more particularly, OUD. Civil commitment is one of those procedures enacted, in part, to bring treatment to those with SUD.

2.1 History of Civil Commitment

Civil commitment originated in the 4th century B.C., as Hippocrates is believed to have suggested that individuals with mental disabilities or illnesses should be housed in institutions for their safety (SAMHSA, 2019). Historians then trace civil commitment to 13th century English law, where they had laws regarding the custody of individuals labeled as "idiots" and "lunatics" (SAMHSA, 2019). This language, clearly not appropriate for those with mental disabilities or illnesses, exemplifies how individuals with mental illnesses were treated in this time. Similar statutes were instituted in the American colonies, but with a lack of support for the health sector and a lack of hospitals designated for those with mental disabilities or illnesses, many individuals with mental health issues were sent to jail, until the mid-1800s (SAMHSA, 2019). Reform movements changed the public opinion of individuals with mental illnesses, and thus they began to be sent to hospitals rather than jail (SAMHSA, 2019). However, there were still instances of wrongful commitment due to the leniency of commitment statutes, and the statutes were eventually tightened after the National Institute on Mental Health recommended medical professionals play a larger role (SAMHSA, 2019). Thus, civil commitment originated with the purpose of institutionalizing individuals with mental illnesses (Testa, et al, 2010).

Similar to individuals with mental illnesses or disabilities, individuals with drug and alcohol disorders were historically also persecuted, being accused of lacking character (Wood,

2020). Drug addiction (SUD) is one of "the most stigmatized…behaviors cross-culturally" (Roberts, 2021). While SUD is still stigmatized (Wood, 2020), attitudes are slowly changing. One indicator is that several states now have civil commitment statutes that include individuals with SUD, signifying the recognition that they ought to receive treatment rather than a prison sentence. If an individual with a serious drug or alcohol disorder is not willing to get treatment themselves, then some routes, other than civil commitment, include criminal prosecution or drug courts (Abishek, et al, 2018). One study noted that with civil commitment, "loved ones don't have to wait for an individual to 'hit rock bottom,' face criminal charges, or experience other dire consequences before substance abuse treatment can be imposed" (Abishek, et al, 2018). Thus, civil commitment allows individuals to have a chance at rehabilitation, without facing the criminal justice system. Interestingly, the inclusion of drug and alcohol commitment does not follow party lines: some of the most conservative states, like Texas, include substance and alcohol use disorders as reasons for civil commitment, as do some of the most liberal states, like Massachusetts (Abhishek et al, 2018).

Mississippi, specifically, has a civil commitment statute that applies to those with mental illness as well as substance use disorders (MS Code § 41-30-27 (2013)). Mississippi's statute, for individuals with SUD, has a few key components. First, an individual has to submit an application to the chancery court for the civil commitment of another individual. This application can be filed by a physician, the patient's spouse or guardian, a relative, or anyone responsible for the individual's health. Along with this application, called an affidavit, the judge, or special master, may require medical review of the individual; however, while this is required for mental commitments, it is not required for alcohol and drug commitments in Mississippi. Once the chancery court accepts the application, a hearing can take place with or without the individual

named for commitment; however, the individual named for commitment will receive a notification of when the hearing is and have the opportunity to attend. The individual will be represented by an attorney, and counsel may be given to them regardless of their ability to pay. After the hearing, should the judge decide that the person should be committed, the individual then is escorted to the facility to which they were assigned (MS Code § 41-30-27 (2013)).

2.2 History of SUD and OUD

Substance use disorder, in general, has a long history in the United States, and researchers and historians trace its origins both to the emergence of the hypodermic syringe, and to the Civil War (Lewy, 2014). The hypodermic syringe made it easier and faster for drugs to enter the system compared to powders and pills (Lewy, 2014). The hypodermic syringe grew in use during the Civil War, allowing doctors to treat pain more quickly (Lewy, 2014). Furthermore, at the time of the Civil War, while medical professionals were aware of the dangers of drugs such as opium and morphine, addiction or SUD was not yet seen as a potential dangerous cost (Lewy, 2014). Addiction was not even a commonly used word and was not recognized, on a national level, as a disease; it was not "generally understood that drugs could cause a morbid craving" until 1877 (Lewy, 2014). Historian David Courtwright believes that the Civil War did indeed cause mass addiction, and "that the addicts… were hidden from the historical radar because of incomplete data" (Lewy, 2014). Other researchers have noted that wars, in general, indirectly cause drug addiction and SUD because war induces trauma, which increases the likelihood of SUD, especially when addictive drugs are being readily administered as a way to treat soldiers (Lewy, 2018). This claim has been corroborated by the drug problems that have ensued nearly every major American war (Lewy, 2014). Thus, drug addiction, and its more modern term "substance use disorder," has its origins with, ironically, medical innovation,

specifically the hypodermic syringe, and the Civil War, and has continued in part due to the wars America has fought since (Lewy, 2014).

During and after World War II and the Vietnam War, heroin, an opioid, became a common drug of choice, leading to widespread SUD (Lewy, 2014). Opioids are drugs that interact with opioid receptors in the brain, thus creating a feeling of euphoria; it includes drugs such as heroin, fentanyl, morphine, and oxycontin (National Institute on Drug Abuse, 2020). With the reintroduction of opioids in the 1990s, the opioid epidemic began to grow largely because of poor public policy making. When "pain" became prioritized as a major health concern in the 1990s, doctors began to over prescribe pain medication, of which opioids were common (Macy, 2018; ASPA, 2021). Pharmaceutical companies also pressured healthcare providers to prescribe their new opioids, claiming they were not addictive, which in fact led to widespread opioid addiction (ASPA, 2021). The lack of accountability for pharmaceutical companies, especially Purdue Pharma, downplayed the dangers of and perpetuated misinformation about opioids (Macy, 2018).

In 2017, the U.S. Department of Health and Human Services officially declared a public health emergency as a result of widespread opioid addiction and overdoses (ASPA, 2021). Since 1999, over 760,000 people have died from a drug overdose, and two-thirds of overdose deaths in 2018 resulted from an opioid (ASPA, 2021). From 2002-2017, "there was a 22-fold increase in the total number of deaths involving synthetic opioids, and more than a 7-fold increase in the number of deaths involving heroin" (APA, 2021). In Mississippi specifically, almost 60% of drug-related deaths in 2018 involved opioids, and Mississippi health care providers wrote "76.8 opioid prescriptions for every 100 persons compared to the average U.S. rate of 51.4 prescriptions," which was one of the top ten rates in the U.S. (NIDA, 2020). While different

policies contributed to the severity of the epidemic, the irresponsibility of the pharmaceutical companies, as well as the lack of restrictions and regulations on companies and prescribers are among the largest causes (Macy, 2018).

Now, thousands of Americans, as well as people all over the globe, suffer from OUD. Opioid use disorder is defined as "a problematic pattern of opioid use leading to problems or distress," (APA, 2021), with at least two of the following symptoms occurring within one year: taking larger amounts or taking drugs over a longer period than intended, persistent desire or unsuccessful efforts to control opioid use, problems fulfilling obligations at work/school/home, giving up or reducing activities because of opioid use, and more (APA, 2021). There are several different recommended treatments, although only one-fourth of people with OUD "receive specialty treatment" (APA, 2021). One of the most effective treatments for OUD is medication-assisted treatment (MAT), which is the use of medication, paired with therapy, to reduce the craving for opioids, alter brain chemistry, block the euphoria felt because of opioids, and more (APA, 2021). Treatment usually also involves behavioral approaches and therapy, but MAT particularly "has been shown to help people stay in treatment and... reduce opioid use" (APA, 2021). In general, the main treatments for those with SUD are psychosocial intervention, which is counseling or therapy, and "medical intervention," referring to medication (Miller, 2009).

2.3 Background on Medication and Funding for SUD and OUD

The Food and Drug Administration has approved three medications to treat OUD: methadone, buprenorphine, and naltrexone (APA, 2021). There are two categories of treatments: agonists and antagonists. Agonists "activate the opioid receptors in the brain, fully resulting in the full opioid effect," and antagonists are drugs that "block opioids by attaching to the opioid receptors without activating them, [thus causing] no opioid effect" (USDHHS, 2022).

Methadone is an agonist, buprenorphine (suboxone) a partial agonist, and naltrexone an antagonist (USDHHS, 2022). While these drugs are used to treat the same condition, different patients may require different medications. For example, patients are required to undergo detox to use naltrexone, and not all patients are able to do this (Millett, et al, 2018). This shows the need for all three of these drugs to be available as much as possible, at as many facilities as possible. However, some people believe individuals who use these drugs are simply replacing one addiction with another, a stand the National Institute on Drug Abuse has repeatedly denied, since medications are not used at a dosage that produces a high (APA, 2021). While different individuals need different treatments, or different levels of treatment, MAT overall is shown to be effective through empirical studies (SAMHSA, 2021).

Despite this medical consensus, not all OUD treatment facilities utilize MAT as a treatment option. In Mississippi, there is only one substance abuse treatment center that offers all three forms of MAT for OUD (amfAR, 2022). Only 31 substance abuse treatment centers offer at least two forms, and only 53 offer MAT services at all (amfAR, 2022). Given that Mississippi has 90 substance abuse facilities (amfAR, 2022), not every facility offers the services that are recommended to treat OUD. Furthermore, this data is as of 2022. Just ten years ago, Mississippi only had 15 facilities providing substance abuse treatment, and only one offered at least two forms of MAT (AMFAR, 2022). Furthermore, only 58 of the 90 facilities currently offering substance abuse treatment accept Medicaid, only 32 of those 58 facilities offer one form of MAT, and 18 of those offer two forms of MAT (AMFAR, 2022). The sole facility that offers substance abuse treatment and all forms of MAT does accept Medicaid (AMFAR, 2022).

In Mississippi, Jackson, Hinds, and Harrison counties had the most overdose deaths each, contributing to 35% of the overdoses in 2020 (“Mississippi Opioid and Heroin Data

Collaborative," 2021). Furthermore, of the 1,772 unique patients admitted to the Department of Mental Health in Mississippi in 2020 that were opioid-related admissions, 63.1% were admitted with opioids as their primary substance of use ("Mississippi Opioid and Heroin Data Collaborative," 2021).

According to the Mississippi Bureau of Alcohol and Drug Addiction Services, the funding for SUD treatment comes from the federal government, specifically the Substance Abuse Block Grant (SABG), and the state government, specifically the three percent alcohol tax that was enacted in 1977 (Malkin, et al., 2022). This tax is not levied on beer. These sources are outlined in the Bureau's State Plan for 2022-2023: the SABG is the primary funding source, with funds from the alcohol tax used to fund treatment for alcohol use disorders specifically (Malkin, et al., 2022). Approximate funding for alcohol and drug treatment in Mississippi for 2022-2023 is $33,162,426, with $10 million from the alcohol tax, and $13,804,875 projected from SABG (Malkin, et al., 2022). The additional funding is from the federal government, due to COVID-19.

The Bureau lists ten priorities for this SABG funding, specifically responding to the opioid crisis as its first priority, co-occurring disorders as its seventh, adolescents and prescription drug use its ninth, and adolescents and alcohol use its tenth (Malkin, et al., 2022). This report also updates the number of beds available in Mississippi for substance use treatment, with a caveat that bed capacity may have decreased due to COVID-19. Thus, according to this report, Mississippi has 32 beds for adolescents, specifically at the community-based residential treatment level (Malkin, et al., 2022). These beds are all housed at one facility in region one. For adults, there are 219 beds at community-based primary residential treatment programs, 216 beds at community-based residential treatment programs (non-primary), 86 beds at free standing primary residential treatment programs, 95 beds at transitional residential treatment programs, 24

beds at free standing transitional residential treatment programs (Malkin, et al., 2022). Not all 13 regions in Mississippi have the same resources. For example, there are eight community-based primary residential treatment programs for SUD, in eight regions; thus, five regions in Mississippi do not have this specific type of program (Malkin, et al., 2022). In total, the maximum number of SUD treatment beds in Mississippi, at varying types of state-programs for adults, is 640. This number does not include Mississippi State Hospital, private facilities, or account for reductions in bed numbers since the COVID-19 pandemic began. These beds are available not only for those who are admitted through the commitment process, but also those who are admitted on their own accord or through drug courts. About 1% of Mississippians report struggling with substance abuse, which is approximately 227,000 residents; not all may need treatment, but this does not include those who do not admit to struggling (Vertava, 2019).

In Mississippi, the use of the civil commitment substance use statute is unknown (Christopher, et al, 2015). Nowhere in the Bureau's State Plan for 2022-2023, which is 160 pages long, is the alcohol and drug civil commitment statute mentioned. Civil commitment, in general, is mentioned once, with no description of the process.

Chapter 3: Literature Review

There were three areas of literature I needed to survey to understand what research has already been conducted on my topic, and to help me identify gaps in the literature. Those three areas are: research into treatment options for substance use disorders and their accessibility, research into voluntary and involuntary treatment, and research regarding one involuntary treatment method in particular: civil commitment.

3.1 Treatment Options and their Accessibility

While many Americans suffer from SUD, there are some treatment options that the literature addresses, with the literature first finding that treatment differs based on drug (NIDA, 2022). The National Institute on Drug Abuse states that counseling, medication, evaluation, and long-term follow-up are key to preventing relapse (NIDA, 2019). All these components are important, but of most interest to me, due to the controversy surrounding it, is medication. The NIDA states that medication assisted treatment (MAT) is only available for opioids, tobacco, and alcohol, but medications for cocaine, methamphetamine, and cannabis are currently in development (NIDA, 2019). The Food and Drug Administration has approved three types of medications, as well as forms of these medications, to treat OUD: buprenorphine, methadone, and naltrexone (Center for Drug Evaluation and Research, 2019).

Many studies have assessed the effectiveness of certain medications for those with OUD. The U.S. National Library of Medicine reported in 2019 that treatment using medication like methadone or buprenorphine results in a 50% mortality rate reduction among people with OUD (National Academies of Sciences, et al., 2019). The Library did note that there is less data about

naltrexone to suggest that it results in a mortality reduction (National Academies of Sciences, et al, 2019).

A study by Bonhomme, et al., (2012) published in the *Journal of the National Medicine Association,* compared methadone and buprenorphine, and it provides some key insights about the drugs and how they treat OUD. These specifically include how dosage, length of treatment, and drug choice can impact their effectiveness for those with OUD. The study drew on other studies for their data, and after analyzing the results from 37 studies, involving 3029 individuals, they found that "high doses of outpatient methadone had greater efficacy than lower doses in sustaining heroin abstinence" (Bonhomme, et al., 2012). The researchers also found that tapering off the drug, whether buprenorphine or methadone, does not lead the individual to "easily remain drug-free" (Bonhomme, et al., 2012), as they did not find data to suggest that patients are able to sustain abstinence after they stop utilizing buprenorphine or methadone as treatment (Bonhomme, et al., 2012). Furthermore, methadone was found to be preferable for those who are more severely addicted, while buprenorphine is less likely to create "dysphoria," (Bonhomme, et al, 2012) than methadone. Thus, both methadone and buprenorphine were found to have strengths and weaknesses, and the decision of which drug to prescribe depends on "unique addiction history, personal characteristics, life situation, and therapeutic responsiveness of the patient" (Kaltenbach, et al., 2018), thus demonstrating the need for multiple FDA-approved MAT drugs to be available at all substance use treatment centers. The study by Bonhomme, et al., also suggested that the risk of death "is usually lowest during treatment but increases substantially in the first year after discontinuing either methadone or buprenorphine," thus showing that these medications are most effective while they are still in use.

An article written by Dr. Williamson, reviewed by Dr. Nguyen, and published on *Medical News Today* provided insight into naltrexone. These doctors recommended that an individual with OUD "should go through opioid detoxification" before taking vivitrol, the brand name of naltrexone (Williamson, 2021). Individuals can experience "severe opioid withdrawal" if they take vivitrol while still having opioids in their body (Williamson, 2021). However, it is not always possible for an individual with OUD to stop using opioids for seven to 14 days at a time. This information supports treatment centers offering multiple medications, as not all are suitable for all patients.

Bonhomme et al.'s study (2012) also found that access to OUD medications can be difficult due to informal and formal restrictions. In regards to informal restrictions, these researchers found that "reducing stigmatizing experiences may improve treatment outcomes" when patients use MAT, and "public and media concern" was a large reason why there is stigma against the use of MAT, specifically against the more widely known methadone (Bonhomme et al., 2012). Volkow et al. (2014) found that it is common for people to believe that MAT replaces one addiction for another addiction (Volkow et al., 2014), thus contributing to the stigma. These researchers even found that some treatment staff prefer not to use MAT and this "provider skepticism may contribute to low adoption of MATs" (Volkow et al., 2014). Furthermore, Blendon and Benson's study found that as in 2017, less than half of all Americans believed there is treatment that is effective long-term for "prescription-painkiller addiction," (Blendon and Benson, 2018). Kennedy-Hendricks et al. conducted a national survey in 2014, and 78% of the 1,071 respondents stated that they believe individuals with OUD "are to blame for [their] problem" (Kennedy-Hendricks et al., 2017).

In regards to formal restrictions, Bonhomme's study found that individuals who use methadone for OUD must "show treatment compliance for 2 years" before they can go home with a month's supply of methadone, whereas individuals who use buprenorphine are allowed "home treatment sooner" (Bonhomme, et al., 2012). Furthermore, the article "Why There's Still A Medication Assisted Treatment Debate" (2021) reported that Medicaid does not always fund MAT for OUD, and private insurance companies do not cover certain medications ("Why There's Still a Medication Assisted Treatment Debate," 2021). Another study, by Honerman, et al., (2018), found that as of 2016, only 41% of the 12,029 substance abuse treatment facilities offer a form of MAT for OUD (Honerman, et al., 2018). Of those that offered a form of FDA approved MAT for OUD, fewer than 70% accepted Medicaid to pay for it (Honerman, et al., 2018). Honerman et al.'s study also found that the treatment facilities that offered all three types of MAT-approved medications were mostly located in the southwest or northeast (Honerman, et al., 2018), suggesting that the southeast is lacking MAT availability. Finally, George's 2018 article in *MedPageToday* reported that only about 5% of physicians in the U.S. have "the waivers to prescribe buprenorphine" (George, 2018).

3.2 Voluntary and Involuntary Treatment

There are two pathways to a treatment facility for SUD: voluntary or involuntary. Drug courts and civil commitment are two policies constructed to force individuals to receive treatment, and the latter is the focus of this thesis. There is literature discussing whether involuntary, or compulsory, treatment is effective in helping those with substance use disorder achieve remission. A study by Wild, et al., (2002), published in *European Addiction Research,* surveyed 170 other research studies on "the area of compulsory substance abuse treatment" (Wild, et al., 2002). These researchers found that compulsory treatment had "superior

participation… relative to non-compulsory treatment" (Wild, et al., 2002). However, only 25% of the studies that focused on "substance abuse outcomes" found better outcomes from compulsory treatment, while 75% "reported no difference" (Wild, et al., 2002). One of the studies that Wild and the other researchers examined assessed 64 individuals with alcohol use disorder at an in-patient treatment program through civil commitment; this study concluded that compulsory treatment was "less helpful" in maintaining high retention rates (Wild, et al., 2002). Another study that Wild's team examined surveyed 101 heroin users receiving court-ordered treatment and found they had "fewer hospital admissions" than those that did not receive court-ordered treatment (Wild, et al., 2002). Thus, there are diverging findings on the effectiveness of involuntary commitment, according to Wild et al.'s study. This study did not address whether the effectiveness of court-ordered treatment depends on the type of SUD (AUD, OUD, etc.).

Before surveying the literature specifically on civil commitment, it is important to highlight another form of involuntary treatment: drug courts. Drug courts "[operate] by initially screening recent arrestees for program eligibility," and eligible arrestees for the program are offered "reduced or dismissed" charges if they complete the treatment program successfully (Sevigny, et al., 2013). Thus, the process is different from civil commitment in the sense that drug courts involve those who have been charged with non-violent felony crimes in a court of law. Doernberg, et al., (2021) published the report "Substance Use Treatment Quality in United States Adult Drug Courts," specifically analyzing adult drug court research evaluations between 2008 and 2018. Doernberg et al. found that "less than 10% of evaluations" of drug courts included measures such as "service utilization, overdose death, and mortality" (Doernberg, et al., 2021). These researchers note a lack of "high-quality data on participants' access to substance use treatment and the success of drug courts [in stemming] the harmful health outcomes of

substance use disorders" (Doernberg, et al, 2021). Doernberg et al. noted that the United States Government Accountability Office also had "concerns about the quality of drug court evaluations" (Doernberg, et al., 2021). Further, the data they did find found that "less than half of adult drug courts provide access to… buprenorphine and methadone," and overall, those with OUD have "reduced odds" of receiving medicated-assisted treatment through drug courts (Doernberg, et al., 2021). Thus, the literature suggests that drug courts may not be a reliable conduit for proper treatment or yield consistent positive health outcomes. Civil commitment may be a viable alternative to drug courts, if the process allows those with SUD, and more specifically OUD, to receive proper medication.

My research will focus on the alcohol and drug civil commitment statute, specifically in Mississippi. Two specific studies addressed the opinions of patients on civil commitment. Paul Christopher et al. (2020) interviewed patients, entering inpatient opioid detoxification, at the time of their admission to the SSTAR treatment program in Massachusetts. These researchers asked the patients for their opinions on civil commitment for drug abuse and mental illness and found that the patients "were more likely to support civil commitment for psychiatric disorders than for drug misuse" (Christopher et al., 2020). However, of the 254 patients interviewed, only 75 were ever civilly committed (Christopher et al., 2020). Christopher et al. also found that "individuals previously committed for opioid misuse were less likely to support drug misuse-related commitment" (Christopher et al., 2020). The second study, however, came to a different conclusion. Bourquin-Tièche, et al., published a study that found that commitment for alcohol dependency was seen as "justified and generally useful" by many, but not all, patients they surveyed (Bourquin-Tièche, et al., 2001). This information was collected from the committed individuals during follow-up interviews, which were conducted a median of 500 days post

commitment period (Bourquin-Tièche, et al., 2001). However, this same study did note that civil commitment of alcohol or drug dependent patients is "far less frequently examined" by researchers (Bourquin-Tièche, et al, 2001) than drug courts. Thus, patient opinion on involuntary treatment appears to vary. My research will aim to understand how Mississippi's legal and medical professionals view the civil commitment process and how it is implemented in this state.

3.3 The Ethics of Civil Commitment

In regards to ethics, civil commitment can be analyzed using consequentialist and non-consequentialist theories. Using these frameworks explained by Bonde et al. in "A Framework for Making Ethical Decisions," one can argue civil commitment is ethical or unethical. Consequentialist theories are most relevant for analyzing civil commitment, as consequences of public policies are a primary measure of assessing their success. However, aspects of non-consequentialist theory, such as autonomy, will be addressed as they become relevant to my analysis of civil commitment.

Gerald Dworkin's article on paternalism (2020) explains that paternalism is "the interference of a state or an individual with another person, against their will, and defended… by a claim that the person interfered with will be better off or protected" (Dworkin, 2020). Thus, civil commitment can be viewed as a paternalistic policy and thus argued as ethical. Dworkin explains that paternalism can be justified because long-run autonomy is more valuable than short-term autonomy (Dworkin, 2020). Thus, using consequentialism, one could argue that civil commitment is ethical because the long-run benefits outweigh the short-term harms: civil commitment is able to give a patient autonomy in the long-run, while only taking it away in the short-run.

There are also consequentialist arguments that suggest that civil commitment is unethical. Jonathan Cantarero argues in "The Ethics of Civil Commitment" that civil commitment is only ethical when an individual is a harm to others, from a utilitarian consequentialist perspective (Cantarero, 2020). Thus, from this standpoint, civilly committing an alcoholic who has not been shown to be a threat to others, but solely to themself, is unethical. This view would assert that civil commitment being a paternalistic policy is not enough to make it an ethical policy, as there must be a harm shown to others, not just the individual in question, to make commitment ethical. A consequentialist might also argue that civilly committing someone to a treatment center that does not meet accepted standards of care is also unethical. Since civil commitment facilities are often not equipped with the proper medications to treat patients (Evans, et al., 2000; Bhalla, et al., 2018), a consequentialist could argue that commitment statutes today may be unethical based on how they are implemented.

From a consequentialist perspective, the ethics of civil commitment are open to debate. To address this, Bourquin-Tièche, et al., calls for more studies to "better define… which kinds of residential facilities may increase the likelihood of recovery from dependence" (Bourquin-Tièche, et al., 2001). My study aims to better define in what situations civil commitment is ethical under the framework of consequentialism.

There is also literature regarding the use of non-consequentialist theory with regard to health care settings. Specifically, deontology can be applied to the idea of civil commitment. Deontology is "an ethical approach centered on rules and professional duties," and this theory judges "actions based on what most people consider to be morally correct, regardless of actual consequences" (Barrow & Khandhar, 2021). Barrow and Khandhar (2021) explain that using this theory, a research study that involves minors is unethical if the child does not consent to

participate, regardless of whether the parents or guardians consent; however, this same scenario could be seen as ethical under the utilitarian ethical framework, a consequentialist theory, if the research study is aimed to "advance the 'greater good'" (Barrow & Khandhar, 2021). This analogy can be applied to civil commitment, which involves the consent, via an affidavit application, of a guardian or loved one to have an individual committed, without the individual's consent. Thus, deontological theory would classify this as unethical. However, Barrow and Khandhar also note the limits of deontology, as it does not always "provide answers to guide practice" (Barrow & Khandhar, 2021). If an individual with SUD does not want to be committed, but they are actively a danger to themselves and others, would commitment still be unethical? Perhaps in the view of deonotology, but through consequentialism, commitment would be justified. Thus, while it is important to account for these deontological ethical considerations when discussing my results and drafting policy recommendations, my focus remains prioritizing consequentialist theory within this thesis.

3.4 The Effectiveness of Civil Commitment

Similar to the ethical analysis of civil commitment, the effectiveness of civil commitment, from the current literature, is largely debated. Nearly all of the studies found a need for treatment for those with SUD, but also found a lack of widespread treatment. A 2018 report by Jain, et al., published on *Psychiatric Online* found that only about "10% of the nearly 21 million Americans with a substance use disorder in 2015 received any type of specialty treatment" (Jain, et al., 2018). Thus, civil commitment ought to be effective in bringing treatment to people who need it and don't realize, as the same study noted that "approximately 90% of the remaining persons … did not think [treatment] was needed" (Jain, et al., 2018). However, while

in theory civil commitment should be effective at curbing SUD, the reality is that its effectiveness is questionable, a claim supported by almost all studies on civil commitment.

The study by Wild, et al., (2002), aforementioned in this literature review, "documented inconsistencies and variability in how civil commitment cases were handled - even within one jurisdiction" (Wild, et al., 2002). These researchers found this lack of consistency "undermines the strategy of examining the efficacy of compulsory treatment" (Wild, et al., 2002). Jain's team found that many states do not systematically collect data, and the states that do collect data found little evidence that civil commitment is effective, or that it is ineffective (Jain, et al., 2018). Numerous studies note the lack of empirical evidence that can be applied broadly to assess the effectiveness of civil commitment, specifically "Civil Commitment for Opioid and Other Substance Use Disorders: Does It Work?," "The Role of Civil Commitment in the Opioid Crisis," and "Perceived Benefits and Harms of Involuntary Civil Commitment for Opioid Use Disorder." Morris's 2020 study, "Detention without Data: Public Tracking of Civil Commitment," noted that the lack of data regarding civil commitment can lead to confusion among patients and their families, as they may ask important questions, and "first responders, clinicians, judges, and other authorities may not have accurate answers" (Morris, 2020).

Bourquin-Tieche's study did find that civil commitment was quite effective for those with AUD, specifically stating that "involuntary residential treatment of alcohol-dependent patients… is… a life-saving measure" (Bourquin-Tièche, et al., 2001). However, this study is not only dated, but also, 11 of the 17 commitment cases, that had detailed follow up data, had a median duration of residential commitment as 29 weeks and the maximum 198 weeks (Bourquin-Tièche, et al., 2001). These commitment lengths are far longer than Mississippi allows, as Mississippi's inpatient alcohol and drug commitment length ranges from 30-90 days.

Thus, the findings from this study are not necessarily generalizable to civil commitment in Mississippi.

From these studies, I can conclude that the effectiveness of alcohol and drug civil commitment statutes is currently unknown, especially in Mississippi, because of the lack of data and the fact that many civil commitment facilities do not even have the resources to properly execute the statute. My research hopes to illuminate the implementation of the current statute in order to better evaluate its effectiveness.

3.5 Procedural and Legal Concerns

Finally, the third broad area that much of the literature addresses is the procedural and legal concerns of civil commitment. This literature finds that civil commitment poses a serious problem for policymakers; even though the Supreme Court has ruled that civil commitment is permissible under the right circumstances, its legality can still be questionable depending on its implementation. According to the authors of "The Role of Civil Commitment in the Opioid Crisis," there are legal arguments for and against civil commitment (Bhalla, et al., 2018). It is important to note that many of the legal concerns came from analyzing civil commitment as a whole, not necessarily the specific statute that allows for civil commitment of individuals with substance use disorder. Nonetheless, the Supreme Court has long recognized the constitutionality of civil commitment, but creates specific conditions for when it is permissible, which is important to understand prior to analyzing Mississippi's implementation of its statute.

The Substance Abuse and Mental Health Services Administration explained that in *Humphrey V. Cady (1972),* the Supreme Court held that an individual being committed must pose a "degree of dangerousness… great enough to justify such a massive curtailment of liberty" (SAMHSA, 2019). This decision also states that the danger must be immediate and proven

beyond a reasonable doubt, with potential evidence for such danger being "recent overt act, attempt, or threat to do harm to oneself or another" (SAMHSA, 2019). Thus, only under these conditions is civil commitment constitutional. The Supreme Court established in *O'Connor V. Donaldson* (1975) that "a state cannot constitutionally confine… a non dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends" (O'Connor v. Donaldson, 422 U.S. 563 (1975)). In *Youngberg V. Romeo* (1982), the court noted that "the state concedes a duty to provide adequate food, shelter, clothing, and medical care" for those who are constitutionally confined, as well as to "provide needed training" to professionals (Youngberg v. Romeo, 457 U.S. 307 (1982)). This case also confirmed the notion that patients are entitled to "reasonably nonrestrictive confinement conditions" (Youngberg v. Romeo, 457 U.S. 307 (1982)).

Winick's 1999 article, "Therapeutic Jurisprudence and the Civil Commitment Hearing," noted that for civil commitment to be legally viable, a civil commitment hearing is necessary, to protect the individual's right to due process (Winick, 1999). However, Winick found that in 79-100% of civil commitment hearings, the judge sides with the expert witness's opinion (Winick, 1999), which brings into question whether there is bias in civil commitment hearings, depending on who the expert witness is. Furthermore, Winick also found problems with lawyers not adequately representing the person who may be committed (Winick, 1999).

My conclusion from the literature I surveyed is that the Mississippi Alcohol and Drug Civil Commitment statute's legal status is currently unknown based on available research, and my research will look into how this statute is implemented, and how it can be improved to be more ethical and effective.

Chapter 4: Research Design

I am particularly interested in civil commitment for individuals with OUD in Mississippi. I chose Mississippi to keep my study manageable, and as well, in order to give back to the community I've lived in for several years. Furthermore, I chose to target individuals with OUD because, unfortunately, the opioid epidemic is still affecting so many lives, and furthermore, it began partially due to public policy error and negligence (Macy, 2018).

My research design evolved as my research progressed and my research question changed; however, the overarching structure of a two-part analysis, including an analysis of the legal process of civil commitment for individuals with SUD, and more specifically OUD, and an analysis of the civil commitment experience in treatment facilities, remained the same. I focused on these two areas to understand the process of civil commitment more fully and try to assess how it can be improved.

In Mississippi, civil commitment falls under the chancery circuit, and thus I originally planned to interview 10 chancery judges, with a promise of confidentiality, to better understand the legal process. After applying to IRB and receiving approval, I narrowed the 20 chancery districts in Mississippi to 10 through a coin-flipping process. I then selected chancery judges from each of these districts to contact, aiming for diversity across gender, race, experience, and geography. I was able to select five female judges, five male judges, seven of which were white, and three remaining black, with chancery judge experience ranging from one year to 26 years. The next part of my research design was to contact them via email, or reach out to their district to

ascertain their email and inquire about being interviewed for my project. At this point, my research design began to adapt, due to difficulty getting in touch with chancery judges, difficulty garnering interest in participating in my study, as well as learning that there are other legal professionals who serve in different roles but still have valuable expertise on the subject of civil commitment. Thus, at this point, I applied to IRB with an amendment to expand my interviewees to special masters, chancery clerks, and lawyers. I contacted special masters and lawyers that I had been referred to. I selected chancery clerks to contact based on their location, in order to achieve regional diversity, and based on their connection to the chancery judges I originally intended on interviewing. Lastly, I also selected my chancery clerk contacts based on their gender and race to ensure diversity in those capacities. After receiving approval from IRB, I contacted special masters, chancery clerks, and lawyers, particularly those referred by chancery judges, while still hoping for 10 interviews among a diverse group of legal professionals.

After contacting these individuals for interviews, I waited for approval or sent follow-up emails. Once a legal professional agreed to participate, I conducted the interviews via Zoom. These interviews were audio recorded and notes were transcribed, for interviewees who consented. Recordings were kept in a private file on my iPhone, accessible only to me, and notes were taken in a notebook as well as in an online folder, also only accessible to me.

For my interview questions, I developed a semi-structured protocol. I did not base my interview questions on another study; instead, I developed my own questions. I began with background questions, assessing how often the legal professional has dealt with civil commitment, and how much experience they have with SUD and OUD. After understanding the individual's experience, I then asked about statistics on civil commitment: how prevalent are alcohol and drug commitments, how often are SUD or OUD civil commitment cases referred to

public treatment programs, how often to private treatment programs, how often were the cases thrown out and thus did not result in civil commitments, and more. I asked these questions to understand how much this statute impacts Mississippi and to assess if civil commitment is even a regularly used policy, and if it is, what the tangible outcomes are. Over time, my research design shifted more towards an assessment of the alcohol and drug commitment statute broadly rather than a comparison of commitments at public and private treatment facilities more narrowly. Thus, as my research continued, my questions on civil commitment tended to be in regard to the whole process, rather than specific to public or private treatment programs.

The rest of my interview questions were more analytical, such as how does a judge decide what facility or program a civilly committed individual should be sent to. I ask this to understand if the decision process is handled on a case-by-case basis, or if individuals are sent to a specific facility due to the particular drug they are addicted to. Additionally, I asked this because while MAT is the national standard, not all facilities in Mississippi utilize MAT. Thus, understanding where individuals in Mississippi are being sent is vital to understanding if they are receiving the nationally recommended treatment.

I planned to conclude the interview by asking the legal professionals their personal opinions of the statute, to assess expert opinions about its practicality and effectiveness. I assured again that their identities will not be revealed.

After my interviews, I re-listened to them, taking notes and writing down quotations, which I sent to interviewees in case they wanted to clarify anything they had said.

After finishing with the legal professionals, I planned to move onto the second part of my research design: the actual experience of being civilly committed to an institution. While I planned to interview medical professionals after my legal interviews were complete, in order to

interview medical professionals at institutions that my legal interviewees referred me to, the difficulty of securing interviews led me to modify my research design. Thus, I began contacting treatment facilities in Mississippi prior to all my legal interviews being complete and regardless of whether the facilities or interviewees had been referred to me. I contacted these facilities and inquired about interviewing medical professionals experienced with alcohol and drug commitments. I hoped to interview five health workers each from publicly and privately funded facilities.

After contacting these health workers and finding those who agreed to participate, I scheduled Zoom interviews. I modeled the questions similarly to those I asked to the legal professionals. I began by asking the health workers how long they had worked in this field, and how long they had worked with civilly committed patients, specifically with SUD and OUD, to gauge their experience and reliability. I also asked how many civilly committed patients, committed for OUD or just generally for SUD, they had treated. Next, I asked what the process is like after someone is civilly committed for OUD—how patients are transferred to the facility, how long the process takes, what the patients are allowed to take to the facility, how involved the family is, and other details. I was especially keen to see how public and private health workers answer this question differently. However, due to the difficulty of securing the interviews, as well as learning public facilities usually receive commitments, I only interviewed medical professionals at publicly funded treatment facilities.

Next, I inquired about the type of care and treatments the facilities provide. Specifically, did they utilize MAT or not? One study I read found that one of the benefits of civil commitment was the guarantee of treatment, but one of the harms was a lack of proper treatment, specifically MAT for OUD (Evans, et al, 2020). Thus, I asked the healthcare workers about the availability

of MAT, to gather whether or not Mississippians committed for OUD are being committed to institutions with the proper resources.

Finally, I concluded my interviews by asking the medical professionals for their personal opinion of the civil commitment statute and how it operates, because they are truly the experts: they see what their patients undergo every day, and they are the ones who can tell me the different effects civil commitment has on individuals with OUD. My goal was to identify differences at publicly-funded institutions and privately-funded institutions, and to identify where the gaps in care are; however, as my research design evolved, this was less relevant than simply assessing the treatment and care available at Mississippi facilities in general.

After finishing my interviews with medical professionals, I followed the same process as I had with my legal interviews, relistening, note taking, and following up on questions. I did not interview individuals who had undergone civil commitment due to concerns over IRB challenges.

After collecting my data, the next part of my research design is to separate my notes into two categories: legal professional interviews and medical professional interviews. I planned to analyze the data from these two groups separately, in order to separate the civil commitment process from the civil commitment experience. My goal was to identify problems or solutions in both areas of civil commitment and separating the data into these two groups allows me to better review my data, as well as draw better inferences and conclusions from the data.

After separating these notes, I then planned to use these notes to compile the results chapter of my thesis. I originally planned to separate the results of my legal professional interviews into two subgroups: civil commitment to public institutions and to private institutions. In regards to the medical professionals, I also planned to divide the results of these interviews

into two groups, specifically information from medical professionals at private treatment programs and medical professionals from public treatment programs. However, after receiving the results of my interviews, I learned that this was not an effective or relevant strategy to organize the information, and thus, I instead planned to organize the results based on various themes that were present among the responses of several or all the interviewees. This organizational strategy will help me understand the entire process of alcohol and drug commitment in Mississippi, compare how medical professionals perceive the process differently than legal professionals, and assess how the process may differ by region in Mississippi. While this analytical strategy was not modeled after another specific research study, many research studies follow the idea of "comparative research," whereby the researcher compares the data across two or more groups. My plan was to attempt to use this research style, to draw conclusions and provide room for ethical analysis.

After compiling my notes into the results of my research, I planned to analyze these results. I originally planned to analyze the results, via the discussion and policy recommendations chapters, through a similar fashion as I planned to compile the results: separating the analysis into information from the legal professionals, followed by analysis of the information from the medical professionals, and ending with an overall assessment of the information. However, after adapting my plan for organizing the results of my thesis, via themes, I then adapted my plan for the discussion chapter to mirror the results chapter.

I am looking for answers on how to assess the hotly debated topic of civil commitment. Analyzing this statute within the small lens of civil commitment for individuals with SUD and OUD in Mississippi allows me to attempt to provide new understandings, as well as comment on this statute.

Chapter 5: Results

While I had hoped to interview ten legal and ten medical professionals, I was only able to interview five each. Prior to conducting these ten interviews, I researched and read literature on the topic of civil commitment, including literature that was specific to the alcohol and drug civil commitment statute. At this point, I estimated I was well versed in the details of the statute. However, after conducting interviews with professionals who deal with the statute on a daily basis, I realized that there are so many areas of concern I never considered. These professionals were forthright in their beliefs and generous in sharing their views of the statute and its problems. This chapter is focused on conveying this information, specifically how the statute is implemented and how these professionals view the process. I followed up with every interviewee to confirm the information and quotes I utilized from the interview, and nine of the ten interviewees responded, corroborating the information or amending some notes.

5.1 Clerical Information

I conducted ten interviews over the course of my research, all of which were with professionals in Mississippi, five medical and five legal. I had hoped to achieve diversity of location, gender, race, and experience. In regards to location, my interviewees were diverse, representing eight of the Mississippi Department of Mental Health's 13 regions. In the identification chart, I list the mental health regions that my interviewees worked in, but I did not assign regions to each individual for the purposes of anonymity. In regards to gender, seven of my interviewees were women, and three were men. In regards to race, all my interviewees were white. While I attempted to achieve racial diversity during my outreach process, securing

interviews proved difficult. I eventually had to proceed with any interview I was able to secure, regardless of the person's race. Lastly, in regards to experience, I was able to achieve diversity. The average number of years of experience, in their current job, for each individual is 12.3 years. The years of experience ranged from less than one year in their current role to 24 years in their current role. In the identification chart, I list the various years of experience each interviewee had in their current job, but I did not assign years of experience to each individual for the purposes of anonymity. Regarding professions, my legal interviews were with one chancery court judge and four chancery clerks. My medical interviewees all dealt with civil commitment, specifically: two licensed professional counselors, one licensed clinical professional counselor, one forensic psychiatrist, and one certified patient service specialist of a free-standing treatment agency. It is important to note that all the legal professionals were elected to their job, as chancery judges and chancery clerks are elected positions in Mississippi. However, the medical professionals were hired through a job application and selection process.

I conducted eight of the interviews over Zoom, and the other two interviews by phone for the convenience of the interviewees. I recorded the Zoom interviews for the purposes of note taking. The phone interviews were not audio recorded. One was not audio recorded because they did not consent to recording, while technical difficulties with the recording equipment prevented recording the other phone interview. The interviews were intended to be approximately 45 minutes long, but they ranged in length, lasting from 26 to 54 minutes. I began the interviews with introductions, and then proceeded to inquire about audio recording the interview. For the individuals who consented to being audio recorded, I then began recording, read the verbal consent script, and upon verbal confirmation of consent, I then proceeded with the interview and

the audio recording. The process was the same for those who were not audio recorded, minus the recording aspect.

My interviews discussed many themes. Some themes were present across all interviews, whereas other themes were limited just to the legal or medical interviewees. There were also some themes mentioned only by a handful of interviewees but were important enough to be mentioned in my results. There I identified seven major themes from the interviews. Exploring these themes will help in understanding how the alcohol and drug commitment statute is utilized in Mississippi.

IDENTIFICATION CHART*

Designation/Title/Name	**Gender**
Chancery Judge	Female
Chancery Clerk #1	Female
Chancery Clerk #2	Male
Chancery Clerk #3	Female
Chancery Clerk #4	Female
Forensic Psychiatrist	Male
Licensed Professional Counselor #1 (LPC #1)	Female
Licensed Professional Counselor #2 (LPC #2)	Male
Licensed Clinical Professional Counselor (LCPC)	Female
Certified Patient Service Specialist at a Free-Standing Program (CPSS)	Female

***Mental Health Regions represented (in no particular order):** 12, 10, 3, 2, 14, 9, 4, 7

***Years of service in current job at their facility (not necessarily their years of medical certification):** 24, 11, 2, 14, 18, 5, 9, 7, 8, 1>

5.2 Regular Use of the Civil Commitment Statute

The first major theme is the regularity of use of the civil commitment statute, for both the mental health and the alcohol and drug statutes. There are two general topics within this theme: first, which commitment process is more regularly used, and second, how often the alcohol and drug civil commitment statute is used specifically.

In regards to the first topic, for the most part, the mental health commitment process seems to be more utilized in Mississippi, although that may change from region to region within the state. Chancery clerks #1 and #2 noted that they see more mental commitments than alcohol and drug commitments; however, chancery clerk #2 added that alcohol and drug commitments have been rising in their county in recent years. The chancery judge noted that they had mostly seen mental commitments, also indicating that alcohol and drug commitments are less common than mental commitments in Mississippi. However, chancery clerk #4 estimated that, while the number of mental commitments and alcohol and drug commitments are close to equal in their county, they still deal with more alcohol and drug commitments overall. Additionally, chancery clerk #3 stated that in their county, when people want to file an affidavit for civil commitment, for someone with a dual diagnosis, most want to file for alcohol and drugs. However, they often change their mind and file on the mental commitment side because the control the state has over mentally committed individuals is more strict, suggesting a possible explanation for the higher numbers of mental commitments. This idea is discussed more in depth in section 5.8.

In regards to the second part of this theme, it seems that the regular use of the alcohol and drug commitment statute also varies around the state. LPC #1 noted that they receive about six alcohol and drug civil commitments a month at their community mental health center, while LPC #2, who also works at a community mental health center, receives only about 15-30 alcohol and

drug civil commitments a year, usually having one to two at any time in a month. Furthermore, chancery clerk #2 mentioned that their county had approximately 220 civil commitments in total for 2021, and while mental commitments made up the majority, alcohol and drugs commitments have been rising in their county. Based on chancery clerk #2's county population, this would put the percentage of commitments in their county as about 0.3% of their population. Chancery clerk #4 mentioned that they deal with civil commitment daily, with their county receiving two to three mental and alcohol and drug commitments each per week. This suggests that chancery clerk #4's county receives approximately 104-156 alcohol and drug commitments a year. Based on chancery clerk #4's county population, this would put the percentage of their population that are committed for alcohol and drugs each year as 0.1-0.2% of their county.

The main findings from this theme are that the mental civil commitment statute is more regularly used than the alcohol and drug commitment statute; however, the alcohol and drug commitment process is used regularly enough for it to be a major part of the duties that chancery judges, chancery clerks, and treatment professionals take on in Mississippi.

5.3 Waiting Period

The waiting period refers to the time between the signing of the commitment order by the chancery judge and the admittance of the individual to a treatment center. The Mississippi Department of Mental Health runs a diversion program in an attempt to decrease waiting times. So, while individuals who have been legally committed are waiting for a bed at their respective facilities, the state screens individuals to see if they would qualify to have their treatment completed at a different center—specifically one that has a bed available sooner. Even with this diversion program, all my legal professional interviews noted that there is still usually a waiting period, whether it's just for a few days, or for several weeks. Chancery clerk #4 stated that the

waiting period for alcohol and drug commitments can be two to three weeks for their county. However, chancery clerks #1, #2, and #3 also noted that the waiting period for alcohol and drug commitments can be months, with chancery clerk #3 mentioning that in their region it has been as long as one year. As of November 2021, the waiting period for a bed at MSH, for those committed for alcohol and drugs, was six to eight months, according to chancery clerk #3. Thus, in general waiting periods are the norm for civil commitments, and they can often be especially long for those committed for alcohol and drugs.

LPC #2 and LCPC, both from community mental health centers in different regions, gave similar information regarding the waiting periods. Both mentioned that waiting periods can be quite long, with LCPC mentioning that four to six weeks is the longest that their facility's waiting period may be. However, they do work with other centers to find an open bed for those on the commitment waiting list. The forensic psychiatrist noted that due to the length of waiting periods, there are situations where someone committed for alcohol and drugs has already started their dedication to sobriety, and thus they enter the facility already having been sober for some time. However, they do note that most often people arrive actively addicted. Thus, three of the five medical professionals mentioned that waiting periods for those civilly committed, particularly for alcohol and drugs, can be more than just a few days, corroborating the information given by the legal professionals.

Beyond length, the theme of waiting periods also includes what happens to the committed individual during that period. Through my interviews, I found a lack of agreement on where alcohol and drug committed individuals are legally allowed to be held during the waiting period. Some of my interviewees stated that they are allowed to be held in jail designated as a certified holding facility, whereas others stated that they cannot legally hold anyone who has been civilly

committed for alcohol and drugs and is waiting for a bed. According to chancery clerk #4, jails designated by the state as certified holding facilities have been inspected to receive this classification. Chancery clerk #2 further noted that their certified holding facility has two nurses and a doctor. Certified holding facilities, or evaluation centers as chancery clerk #2 called them, usually have cells separate from the rest of the jail, according to chancery clerk #4. It is important to stress that while these holding facilities have a different label, many interviewees referred to them as simply "jail."

The forensic psychiatrist noted that the question regarding the legality of placing civilly committed individuals in jail while they wait has been posed to the Attorney General of Mississippi, who concluded that they should not be held in jail during their waiting period. It is unclear whether that referred to all jails or just jails that are not certified holding facilities. LPC #1 noted that in their region, mental and alcohol and drug commitments are indeed held in jail for the duration of the waiting period, which could range from a week to a month. LPC #1 confirmed this further, stating that when her facility receives alcohol and drug civil commitments, they arrive at their community mental health center from the county jail. LPC #2 stated that some counties hold their commitments in jail, whereas others do not. Whether or not an individual is held in jail for this period can be dependent on "family connections," according to LPC #2, suggesting that not all civil commitments are treated the same and that networking may play a role in this aspect of the statute. Finally, the CPSS said that it is up to the court to decide if an individual committed for alcohol and drugs is held at a certified holding facility, or if they can just wait at home.

There was disagreement among the legal professionals regarding use of jails. Chancery clerk #2 stressed the Attorney General's opinion that alcohol and drugs commitments cannot be

held in jail during their waiting period. Despite this language, chancery clerk #3 knew of counties that use jail during waiting periods, which I expect must be certified holding facilities. However, when I asked chancery clerk #1, they stated that neither type of commitment is held in jail unless the judge deems that there is a major concern due to risk of imminent harm to either the individual themself or others. Unless the judge deems that there is a need for the commitment to be held during the waiting period for safety concerns, alcohol and drug commitments are in "limbo" until a treatment facility bed opens up and they are free to reside wherever they like. Chancery clerk #2 noted that their county has an "evaluation center," referring to the jail classified as a certified holding facility, where alcohol and drug commitments can be held. Finally, chancery clerk #4 mentioned that their county holds all commitments in their certified holding facility. However, chancery clerk #4 professed that they do not support holding the commitments in jail, explaining that it's "really no place for them." However, without a more appropriate location, they are forced to hold them in jail. Furthermore, when I followed up with chancery clerk #2 to inquire more about where there is information regarding certified holding facilities in Mississippi, specifically how a jail can become one, chancery clerk #2 was not able to answer my question or refer me to sources with more information regarding this subject.

Thus, it is clear there is still some confusion among medical and legal professionals regarding where alcohol and drugs committed individuals are supposed to be held—if held at all—during the waiting period. Additionally, it is clear that, at least regarding the waiting period, that the alcohol and drug commitment statute is being implemented differently around the state.

5.4 Differences between Mental Commitment and Alcohol and Drug Commitment

Another theme was the differences between the mental commitment process and the alcohol and drug commitment process. There are many similarities: both involve the filing of an

affidavit by a family member or loved one, both go through the chancery court, and both involve hearings. However, there are some differences, and one in particular is quite significant.

First, the uniform civil commitment procedure, which handles those with mental disorders, states that a hearing must be set within seven to ten days after two doctors (or one doctor and one healthcare professional) evaluate the individual and deem civil commitment necessary. However, the alcohol and drugs commitment statute states that a hearing must be set between five and 20 days after the affidavit is filed and the fee paid.

A second difference is that after the commitment order is signed by the judge, mental commitments are committed to a state behavioral health program, including a crisis stabilization unit, while alcohol and drug commitments are committed to the state hospital, or another state program through the diversion process, not including crisis stabilization units. Both commitments can be made to private treatment facilities, but the government does not pay. In the case of commitments to a private facility, the individual or affiant will pay out-of-pocket, through insurance or through another funding source they personally secure.

The third, and perhaps the most significant, difference is the level of involvement medical personnel have in the legal processes. The statute for mental civil commitment in Mississippi requires a pre-evaluation screening from a medical professional, as well as review by two doctors, or by a doctor and another healthcare professional. However, the alcohol and drug civil commitment process does not require counties to request medical professionals to review the case or to diagnose the person being civilly committed, although my results showed that some counties do anyways. Chancery clerks #2 and #3 noted that their counties require alcohol and drug commitments to be evaluated by a doctor or doctors, prior to the judge making a ruling of commitment. Chancery clerk #1's county does not involve any doctor in the legal process for

alcohol and drugs commitments, nor do they require a drug test. Thus, for their county, and many others around the state that follow the basic requirements of the statute and do not include medical review of the person being civilly committed prior to a ruling, the entire process relies upon the honesty of the affiant, as well as any witnesses brought to the hearing. Thus, there are some significant differences between the processes, as well as differences in how alcohol and drug commitments are processed around the state.

5.5 Treatment

Another major theme was the treatment those who are civilly committed for alcohol and drugs receive at their respective facilities, focused on two main areas: the length of care and the types of treatment. Most of this information came from the medical professionals, as both legal and medical professionals noted that once someone has been transferred to a facility, the work of the legal professionals is done. For example, the chancery judge stated that they do not check up with committed individuals once they are sent to their facility, and there is no follow-up court date. Additionally, chancery clerk #1 stated that they have "no control over how long they stay," within the 30-90 day time frame set by the statute, and that treatment is up to the "treatment team" at the treatment center. Chancery clerk #3 noted that their court does not follow up with civilly committed patients either, and even if an individual is noncompliant, they only intervene in mental commitments. Chancery clerk #4 stated that if a committed individual does not complete treatment, they will contact the sheriff's department to return them either to the treatment center or jail, until the commitment period has ended. However, treatment length and type is left up to the medical professionals.

The alcohol and drug civil commitment statute states that an individual can be committed to an inpatient facility for a period of no less than 30 days and no more than 90 days, at

government expense at a public facility. This time frame does not include the waiting period. The medical professionals explained that most alcohol and drug commitments fall on the shorter end of the time frame. For example, chancery clerk #4 and LPC #2 stated that in general, commitment to a state institution for alcohol and drugs is 30 days. LCPC stated that a lot of health facilities cut alcohol and drug commitment off at 30 days, despite the fact that they could keep individuals longer and provide more treatment. However, the forensic psychiatrist stated the average length of stay at MSH for someone committed for alcohol and drugs is approximately six weeks, so 42 days.

One of the more interesting findings is that the diversion program actually limits the length of treatment paid for by the government. When someone is on the waiting list to be civilly committed to the state hospital for alcohol and drug use, they can be diverted to another publicly funded facility, like a community mental health center, to decrease their waiting time. Those who are diverted only have funding for a 30 day commitment, according to CPSS, unless they receive an extension. This would explain why many community mental health and other centers do not extend civil commitment past 30 days. This connects to another theme, funding, that I will address later. Thus, while the diversion program shortens the waiting period for treatments, it also shortens the length of treatment.

What is most striking about these findings is that these average lengths of treatment are completely contradictory to what medical professionals recommend. Four of the five medical professionals I interviewed noted that the longer someone can be in treatment, the better. LPC #1 stated that a "30 day program is the old school of thought." LPC #2 stated that in regards to alcohol and drugs patients, committed or not, they prefer to have someone with OUD be on MAT for a full year, via inpatient or outpatient treatment, before they consider weaning off the

medication. The CPSS used an analogy to basketball to explain why longer treatment is better: "if you practice 60 days, you're going to be better than if you practice 30 days." Finally, the forensic psychiatrist also mentioned that after people complete their commitment at MSH, some go to a secondary facility to receive more treatment, demonstrating that there is a need for longer treatment. Thus, my findings showed that the length of treatment that is legally afforded or provided to those who are civilly committed for alcohol and drugs in Mississippi is not as long as what medical professionals recommend.

The second part of the treatment theme is the type of treatment alcohol and drug commitments receive. I want to note that generally, the type of treatment individuals receive will *not* depend on whether they were civilly committed or not: three of the medical professionals stated that there is no difference. LPC #2 did disagree, stating that treatment differs slightly because civil commitment changes how the facility approaches the patient. However, my findings suggest that treatment does not significantly change based on commitment status. Another important note is that all alcohol and drug civil commitments are classified together; there is generally no further classification based on what drug or drugs the person is addicted to.

My findings suggest that two types of treatments are the norm for alcohol and drug addicted patients: therapy and MAT. In regards to therapy, the CPSS explained that the Mississippi DMH mandates a minimum of one hour individual therapy and 20 hours of psychoeducational group therapy per week. LPC #1 stated that their facility follows the guidelines provided by the American Society of Addiction Medicine when determining the care for each individual. ASAM's guidelines include six dimensions used to properly assess an individual and prepare a treatment plan, and those six dimensions include: acute intoxication and/or withdrawal potential; biomedical conditions and complications; emotional, behavioral, or

cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and recovering/living environment. LCPC also mentioned that therapy is a part of their treatment for alcohol and drugs patients, civilly committed or not. Thus, the medical interviews demonstrated that therapy is a regular part of treatment for those with SUD. However, my interest in treatment is more focused on MAT, where the findings from the medical interviews get more interesting.

All of the medical professionals mentioned that their facilities, five different facilities in five different regions, utilize MAT, with LPC #2 noting that all community mental health centers are required to offer MAT. However, the practical use of MAT varies. The FDA has approved three medications to treat OUD: buprenorphine, methadone, and naltrexone. These drugs are also used as ingredients in other viable medications like suboxone, which includes both buprenorphine and naltrexone. All of the medical professionals stated that they utilize naltrexone or an equivalent (ex: vivitrol) at their facility, four stated that they use buprenorphine or an equivalent (ex: subutex), and four stated that they use suboxone. However, none stated that they utilize methadone, with the forensic psychiatrist specifically stating that methadone is not offered at MSH for treatment maintenance. LCPC explained that a possible reason for the low use of methadone is that it requires individuals to come to the facility every day for their daily dose; however, this would only explain the low use of methadone for outpatient care. In regards to suboxone, the forensic psychiatrist also stated that suboxone is not offered at MSH for treatment maintenance. LPC #2 also noted that suboxone is not always used properly, stating that "a lot of places find a way to use MAT without using suboxone the way research says you should," specifically in regards to how long one should be on suboxone. While LPC #2 recommends that, generally, patients who have OUD should stay on suboxone for approximately a year, they stated

that there are still medical professionals who will taper patients off suboxone after as little as 15 days of treatment. LPC #2 noted that "the most dangerous thing you can do with someone in active opioid use disorder is to detox them."

Another finding regarding MAT is that the patient has to consent, and some patients do not. The CPSS noted that it is always "50-50" whether a patient consents to taking the available form of MAT, as some do not want to take a form of a drug they may have abused. Thus, my main findings regarding the type of treatment is that while MAT is a medically endorsed method of treatment, not all Mississippi treatment facilities, specifically where individuals are civilly committed for alcohol and drugs, offer all forms of MAT or the proper conditions under which MAT is recommended.

5.6 Ideological Differences

Another important theme that emerged through my interviews was ideological differences. I found there is still some disagreement within the medical community and among some in the legal community as to how to view substance use disorder. The medical community has advanced with the notion that addiction, the medical term being substance use disorder, is a mental disorder, not a "moral disorder" as some people still believe, according to LPC #2. However, my interviewees disagreed about the level of autonomy that individuals addicted to alcohol or drugs have, and what that means for their treatment. For example, chancery clerk #3 stated that "until they decide they want help, you can't do anything." This view was in direct opposition to what LPC #1 stated, who stated that the idea that "'you have to want it [i.e. treatment] for yourself' is old and worn out. That's not true." LPC #2 stressed the importance of not putting blame on the individual and discouraged using the term "addict," as it can "dehumanize the individual." LPC #2 also noted continued debate over MAT, especially

buprenorphine, since it allows individuals to get "high" to a certain extent and is often abused on the street. However, LPC #2 noted that people on buprenorphine, for treatment, stay alive at a much higher rate while taking it. In LPC #2's words, "with so many people dying, what's the big deal with somebody being on medication?" However, it is clear that there are still ideological differences on SUD, including among some of my interviewees.

5.7 Dual Diagnosis

Dual diagnosis is also another theme that was prevalent throughout all my interviews, and one I did not anticipate. Dual diagnosis means that an individual has been diagnosed with both a mental disorder and a SUD. The Mississippi commitment statute separates the process of commitment into two avenues: Mississippi uniform civil commitment, and Mississippi alcohol and drug commitment. The former deals with mental and behavioral issues, where someone can be committed if they, for example, are having hallucinations that make them a danger to themselves or others. The latter deals with commitment of those addicted to alcohol and drugs. There is no aspect of the statute that accounts for the situation where one has both. Thus, a family member who wishes to commit a loved one with a dual diagnosis has to choose which commitment process to go through: mental or alcohol and drugs.

Four of the legal professionals, including the chancery judge, cited the need for some type of dual diagnostic process, or mentioned the difficulties they face without a dual diagnosis process. Chancery clerk #4 mentioned that "in Mississippi, we can't treat for dual" diagnoses, and chancery clerk #2 went further, saying that the state hospitals aren't able to deal with dual diagnoses well, and that there needs to be a facility that does. Chancery clerk #2 also stated that it is difficult for them when someone has a dual diagnosis; if the family decides to change from one commitment process to the other, the chancery clerk has to start the administrative procedure

all over again. Chancery clerk #4 explained that they have seen patients who will complete one form of civil commitment, and then go through civil commitment again on the other path, to get treatment for both disorders. Bolstering the need for a dual diagnosis process, the medical interviewees explained how prevalent dual diagnoses are in this state. LPC #1 explained that most of the civil commitments they receive are individuals with co-occurring disorders, which is another term for dual diagnosis. Over 90% of the people LCPC treats have both mental disorders and substance use disorders. Thus, given how prevalent dual diagnoses are in civil commitments, it is important to understand how treatment facilities deal with these cases.

My findings suggest that some facilities are better equipped to deal with dual diagnoses than others. The forensic psychiatrist mentioned that at MSH, someone who is committed for alcohol and drugs but has an underlying mental issue can be sent to inpatient psychiatric service. However, when someone has a severe personality disorder, they may threaten staff and thus criminal justice has to intervene, which is exactly what civil commitment tries to avoid. However, the only publicly funded inpatient psychiatric facilities in Mississippi are at the Mississippi State Hospitals, specifically MSH and East MSH, and their satellite programs: Specialized Treatment Facility, North MSH, South MSH, and Central Mississippi Residential Center. Thus, other publicly-funded treatment centers that receive alcohol and drug commitments, like community mental health centers, do not have inpatient psychiatric resources for individuals with dual diagnosis.

LCPC noted that their facility is technically a co-occurring facility, meaning that they have the ability to treat someone who is civilly committed for alcohol and drugs for any ailment they have; however, they, like many other facilities, do not have inpatient services for mental commitments. The CPSS has a lot of experience with individuals with co-occurring disorders.

They noted that many of these individuals turn to alcohol and drugs to cope with their underlying mental disorder, and thus sometimes treating the individual for alcohol and drug addiction first can exacerbate their mental disorder. Interestingly, chancery clerk #1, noted that their strategy is, in fact, to treat SUD before treating mental disorder, which serves in contradiction to the previous assertion by the CPSS. This same medical professional also noted the frustration they feel when they are able to help an individual get off alcohol and drugs, but they can't provide proper medication or treatment for their underlying mental disorder. This medical professional stated that they can provide lower severity mental health care, such as renewal of medications, but not anything more. All the care provider can do is "the best you can." The same medical professional stated that a "vicious cycle" can start when an individual with a dual diagnosis is discharged to an outpatient facility after their in-patient alcohol and drug addiction treatment or commitment period has ended. Because this individual has not been properly treated for their psychiatric needs, they may turn to alcohol and drugs again to cope, and thus the cycle continues.

5.7 Funding

The last major theme is funding, or rather a lack thereof. All of the legal professionals cited the need for more funding not only to improve the alcohol and drug commitment process in Mississippi, but to just generally better treat individuals needing treatment for alcohol and drugs. Their priorities included funding for more treatment facilities, more beds, more long term treatment, more follow-up care, and more alcohol and drug education. Chancery clerk #4 noted that funding has been cut for mental health services in the past few years, which has led to a decrease in beds at treatment facilities. It also may lead to the lengthy waiting periods.

Funding was discussed in all of the medical interviews as well. LPC #2 and LCPC mentioned the lack of funding for treatment facilities in general. LCPC cited a need for more

beds throughout the state, as well as more therapists. LPC #2 was more specific, explaining that their facility receives only $146 a day from the government to care for alcohol and drugs commitments—reimbursement that they assume is much higher at MSH. The same medical professional stated that their facility only has enough funding for MAT to help 15 people at a time, each for three to six months. LPC #1 stated that "the commitments are outdated," adding that some people abuse the system to get free treatment when they could apply for financial aid.

Furthermore, the CPSS mentioned that the funding for MAT only covers medications for OUD, even though the FDA has approved MAT for AUD as well. Furthermore, their funding only covers forms of buprenorphine and naltrexone, but not methadone. This same medical professional also noted the need for more funding to allow longer treatment periods, especially for those who are a part of the diversion program and only receive funding for 30 days. Lastly, the forensic psychiatrist had a different perspective on funding, stating that they had never known anyone who wanted more treatment and was not able to figure out a way to pay for it. Still, funding is an unresolved issue within the sphere of alcohol and drug civil commitment.

5.8 Minor themes

Beyond the major themes presented above, the results of my study touched on a few other subjects worth noting, the first of which is drug courts. In drug court, avoiding prison is used as an incentive for individuals to obtain treatment for SUD. No such incentive exists in civil commitment. Drug courts technically allow for more autonomy and consent, as the individual can choose to forego the drug court process and accept prison time. Two medical professionals, LPC #2 and the forensic psychiatrist, spoke about drug courts in our interviews. LPC #2 was wary of the process, having been told that "these people are inmates, they just don't happen to be in prison," as the patient checks in weekly with a judge, and the judge has the final say on the

treatment. The forensic psychiatrist spoke more positively about drug court, as the drug court patients that he has dealt with are "extremely successful." This medical professional believes that the people at highest risk should receive the most intense treatment, and usually the addicted individuals with the highest risk "come from the criminal justice system." The forensic psychiatrist also added that civil commitment offers a "perverse incentive," meaning that individuals are basically rewarded with free treatment. He believes it is important to figure out a "way that the civil commitment arm continues a relationship with the drug court." Thus, my research found that drug court is a similar public policy to civil commitment; however, medical professionals disagree on which is better for those who need alcohol and drug treatment.

Another subject was the difference between public and private treatment centers related to civil commitment. When beginning my research, I planned to focus primarily on this topic. As my interviews progressed, I realized that there were several more relevant aspects of civil commitment to research. However, I did learn some interesting information on this subject. First, the legal professionals noted that individuals civilly committed for alcohol and drugs can go to private institutions, but as the chancery judge stated, only "if they have their own money." Chancery clerk #1 noted that a lot of people don't have health insurance, so commitment to a public treatment facility is their only option. Attending a private treatment center may lessen the waiting period, but it is not viable for many people. Chancery clerk #1 also noted that some private treatment centers don't take court orders. Lastly, chancery clerk #3 noted that most people follow the civil commitment route precisely because they can't afford to pay for treatment at a private facility and need government funding. This raises the question of whether civil commitment for alcohol and drugs is really providing treatment to the unwilling as it was intended, or if it is mostly just a way for people to receive free treatment.

Regarding my medical interviewees, no one I interviewed worked at a fully privately funded medical institution, so their insights were limited. LPC #2 reiterated that commitment to a private facility is allowed, and that individual just has to pay on their own or via insurance. However, LPC #1 stated that they "don't know any private [facility] that takes commitments," which reinforces what chancery clerk #1 said about some private facilities not taking court orders.

The last topic I will address is the ability of a facility to hold someone against their will. The basic premise of civil commitment is to force treatment upon someone, with either a mental or substance use disorder, who is not voluntarily receiving treatment. However, after conducting my interviews, it seems as though the practical use of the civil commitment statute does not have the same control and jurisdiction over patients as the basic premise of the statute implies. First, beginning with the legal professionals, chancery clerk #4 mentioned that in their county they have the authority to have the sheriff's department pick up and hold a committed person who has not completed treatment. Chancery clerk #3 stated that their county has the power to commit someone for treatment; however, if they have been committed for alcohol and drugs, they cannot order that person to stay. Chancery clerk #3 even went so far as to say that when people are filing an affidavit for commitment of an individual with dual diagnosis, they'll often switch from the alcohol and drugs process to the mental process once they find out that only mental commitments can be forced to stay at their treatment center. This same chancery clerk said that their county can issue noncompliance orders if someone civilly committed for a mental disorder is not complying with treatment; however, they issue no such order for non-compliant alcohol and drugs commitments. Several of the medical professionals corroborated this information. LPC #2 stated that they do not hold anyone against their will; since community mental health centers

are not locked facilities, patients can leave their facility if they want. LCPC, also from a community mental health center, confirmed that while they have a residential level of care for individuals committed for alcohol and drugs, their facility also is not locked. The forensic psychiatrist stated that MSH does have locked doors, but patients who demonstrate a willingness to receive treatment are let outside.

5.9 Conclusion

Prior to conducting these interviews, I read literature on the topic of civil commitment, both as a whole and literature specific to the alcohol and drug statute. Much of this literature spoke about the ethics of civil commitment, its effectiveness, and the legal concerns of the statute, with most of the conclusions unclear. My interviews demonstrated that, at least in Mississippi, the alcohol and drug commitment statute is not being utilized properly, meaning there is room for improvement in various aspects of the statute. I discuss these findings and what should be done to improve the statute and its use in the next chapters.

Chapter 6: Discussion

The majority of my results are qualitative in nature; how legal and medical professionals view civil commitment, how they see the process functioning, and their recommendations for the statute, specifically. One may consider what the value of such information can be, as quantitative data, such as treatment completion rates and percentage of individuals who reach sobriety, may be seen as a more effective data set to evaluate the commitment statute. The nature of my research, a senior undergraduate college research thesis, inevitably limited the amount of time and resources I could devote to this project. The amount of time required and the number of hurdles that would need to be overcome to reach out to former patients who have been civilly committed and collect data from them, would be nearly insurmountable. Thus, I settled for interviewing the professionals who deal with this statute daily, and the results gained from these interviews proved very useful. The following chapter analyzes and discusses the results of my study.

6.1 Diversity

Interviewing a diverse group of professionals was very important to my research. I hoped to maintain diversity among my interviewees, so the results from this study could be reliable, all encompassing, and representative of the entire state of Mississippi. I had an even distribution between medical professionals and legal professionals, however, within those subgroups, there was less diversity of job titles and placements. Among the medical interviewees were two LPC from community mental health centers, one LCPC from a community mental health center, a forensic psychiatrist who treats patients with SUD, and a CPSS from a free-standing chemical

dependency treatment center. I had originally intended my research to focus on the different experiences of alcohol and drug commitments at public and private treatment facilities; however, while conducting these interviews I learned that most alcohol and drug commitments go to publicly funded institutions, and furthermore, some private treatment facilities refuse to take commitments. Thus, I quickly learned that private treatment facilities were not a significant part of the commitment process in Mississippi. Thus, my interviewees were all from state treatment facilities, except for the CPSS, whose facility is technically a free-standing program certified by DMH. This facility still receives some funding from the state and thus is not classified as a purely private treatment facility.

While the medical interviews lacked diversity of job placements, the results from these interviews were critical, as all the medical interviewees had vast experience with the commitment process.

Within the legal interviews, I expanded my interviews to include chancery judges, chancery clerks, special masters, and attorneys. I learned that each of these individuals play an important role in the commitment process. However, I quickly learned that chancery clerks were not only the easiest to get in touch with, but they also play a huge role in the administrative processes that allow the commitment statute to function. Thus, while my legal interviews were predominantly chancery clerks, with one chancery judge, the results from these interviews still proved very useful due to the expansive knowledge chancery clerks have on this topic.

Regarding gender, while most of my interviewees were women, I did have a few male interviewees who provided gender diversity. I don't believe that gender biases played a large role in influencing my results as I did not see any patterns of responses that followed along gender

lines. Thus while the ratio of women to men was not equal, I don't believe this disrupts the results.

One of the parts of my research that I'm most proud of is the diversity of experience my interviewees had, as well as geographic diversity. My interviewees represent the majority of the Mississippi Department of Mental Health regions. Since I only had ten interviews, I am proud that eight regions were represented. In regards to the diversity of experience, I felt this was important to ensure that the results represented varying levels of exposure to this statute. Luckily, I was able to interview individuals with a range of experience in their current job, ranging from less than one year to 24 years. Some of the medical professionals were not identified by this job title, and instead identified by one of their medical certifications, for the sake of anonymity.

While I was able to achieve a level of diversity in all the aforementioned categories, I was not able to achieve racial diversity. All of my interviewees were caucasion, and I do believe this limits the results of my study. According to the 2018 National Survey on Drug Use and Health which surveys U.S. citizens over age 12, 7.7% of White, 7.1% of Latinos, 6.9% of Black or African Americans, 10.1% of American Indian or Alaskan Natives, 9.3% of Native Hawaiians or other Pacific Islanders, and 4.8% of Asian Americans have SUD (Close, 2020). With SUD impacting so many different races and ethnicities, and many with a higher proportion of their population diagnosed than the Caucasian race, my research is limited by only interviewing Caucasian/white professionals. Race and ethnicity were not a major topic in my interviews, but perhaps it would have been had I interviewed a more racially diverse group of professionals. A racially diverse group of professionals would have ensured that my results were more representative of the professionals that implement this statute, as well as the demographics that

are impacted by SUD. Thus, I keep this limitation in mind while analyzing the results of this study.

6.2 Use of The Civil Commitment Statute

The first theme mentioned in the results chapter was the regularity of the use of the civil commitment statute, both as a whole and specifically the alcohol and drug statute. The initial results suggested that mental commitments are more prominent in Mississippi. However, upon further analysis, this statement may be too broad to fully encapsulate the approximated use of these statutes. Chancery clerk #3 stated that while most commitments in their county may begin as alcohol and drug commitments, the family often changes their mind to instead file a mental commitment when they learn that the state has more control over the individual in this process. I also learned that a vast majority of alcohol and drug commitments also have dual diagnoses, meaning they have both a SUD and a mental disorder, and thus the family has to choose which process to navigate. Thus, the question is whether or not alcohol and drug commitments are truly less prevalent, or if the level of jurisdiction and control the state has over mental commitments simply entices those with dual diagnoses into the mental commitment route. Furthermore, LPC #1 and #2 both hail from community mental health centers, and they both noted that they receive fewer than ten alcohol and drug commitments each month, with LPC #1 estimating six and LPC #2 estimating one to two. While these numbers may seem low and may indicate that the alcohol and drug commitment statute is not often utilized, putting this information in the context of the diversion program challenges this conclusion. Alcohol and drug commitments are admitted to community mental health centers through the diversion program, which not all patients will qualify for if the Department of Mental Health believes the state hospital would be better for

them. Thus, this data could be more representative of how often the diversion program is utilized, rather than how often the alcohol and drug commitment statute is utilized.

Furthermore, these numbers don't take into account the fact that there are very limited beds available for commitments. Chancery clerk #2 mentioned that at one point in 2020, there were only 25 beds each for women and men for alcohol and drug treatment available at state facilities in Mississippi. These numbers have since increased, but it demonstrates the very limited resources that have been available in Mississippi. Furthermore, chancery clerk #2 also noted that only nine beds were available at their county's certified holding facility, also demonstrating the limited resources. So, the number of alcohol and drug commitments in Mississippi may be less representative of the use of the statute, and more representative of the number of commitments that these facilities can handle at a time. Thus, an argument using this data to discourage funding towards alcohol and drug treatment would be, in my estimation, invalid.

6.3 Waiting Periods

I did not expect to find waiting periods particularly significant to my research, as the literature I analyzed did not address it. However, it quickly became one of the most glaring problems with the commitment statute. My interviewees identified two issues: length of the waiting period, and where committed individuals spend the waiting period. A waiting period of weeks, months, or even a year long, calls into question the purpose of the commitment statute, which is to get treatment to individuals, who do not want it, as soon as possible. Substance use disorder has killed tens of thousands of Americans, and as LPC #1 noted, this makes treatment time-sensitive: "if we wait around for them to want it [i.e. treatment], they're probably going to die." It is a major concern that all five legal professionals I interviewed noted that there is usually

a waiting period after a commitment order is signed. The solution would be more treatment facilities with more beds or less use of the commitment statute, the latter leaving limited avenues for families to help their loved ones who suffer from substance use disorder.

As discussed in chapter three, the policy of commitment can be seen as ethical based on paternalism, in which the state acts to protect the citizens from themselves. However, if this policy includes a lengthy waiting period, one could argue that the state's intended purpose is not actually being produced, as a long waiting period does not benefit the individual, or protect those with SUD from themselves. This leads into the second issue, which is where committed individuals reside during the waiting period. My results show that some counties hold alcohol and drug commitments in jails that have been certified as holding facilities by the Mississippi Department of Mental Health. This policy raises ethical concerns. Since waiting periods can often be lengthy, individuals can be held for weeks in a jail with no criminal charge, and no access to treatment. For individuals with AUD, withdrawal begins to emerge a few hours after their last drink, and can last up to eight days (Sharp, 2022). For individuals with OUD, withdrawal begins to emerge between eight hours to four days after the last use, and can last up to ten days (Sharp, 2022). Thus, individuals forced to wait weeks in jail can endure incredible pain and suffering. While chancery clerk #2 noted that their holding facility has two nurses and a doctor on call, the extent to which they give medication to those experiencing withdrawals is unclear. Thus, by forcing individuals to reside in jail for a lengthy period, the state is inflicting more pain and punishment on them for having a disorder. This brings about both consequentialist and non-consequentialist ethical concerns. Consequentially, this practice would only be deemed as ethical if the long-term effect of commitment is proper, effective treatment. However, as discussed in section 6.5, the notion of proper treatment being provided to these individuals is

questionable. Non-consequentially, specifically through a deontological perspective, this practice of holding someone against their will is unethical regardless of the consequences. It is also a concern that there is no information on certified holding facilities on the Mississippi Department of Mental Health's website, as well as the fact that chancery clerk #2 could not direct me to any source with information regarding certified holding facilities. One of the key parts of the process of commitment in Mississippi is nearly impossible to find information on.

Consequentialist theory would find that holding commitments in jail without access to treatment is ethical if the commitment process is successful in providing the individual with proper treatment and helping the individual maintain sobriety. Non-consequentialist theory, which focuses on an actor's intentions, could find placing individuals in certified holding facilities without their consent to be unethical specifically through the deontological perspective. The consequences of public policy matter and must be considered in this field; however, in situations in which consequences are unknown, such as the effectiveness of treatment through civil commitment, it is important to also consider non-consequentialist ethical theory to evaluate a practice. Thus, in my estimation, and following the aforementioned ethical frameworks, holding alcohol and drug commitments in jails classified as certified holding facilities during the waiting period without access to SUD and withdrawal treatment is an unethical practice. It is ethical if there is SUD and withdrawal treatment at the certified holding facilities, and if the care at treatment facilities includes the most effective and modern care practices for those with SUD.

6.4 Discussion on the differences between the two commitment processes

Several differences between the mental commitment and the alcohol and drug commitment processes in Mississippi are worth discussing. One of the major differences is that the alcohol and drug commitment process does not require any diagnosis or medical evaluation

prior to the judge signing the commitment order. While the Department of Mental Health does provide instructional manuals on how each commitment process works, I could not fathom that there would really be no medical evaluation before someone is court ordered for alcohol or drug treatment. Thus, I did not fully understand this notion until I was in the midst of interviewing the legal professionals, who confirmed that a chancery judge or special master can sign a alcohol and drug commitment order, for inpatient or outpatient treatment, without a medical evaluation of the committed individual and without a recommendation from a doctor or medical professional. The effectiveness of the alcohol and drug commitment statute is debated in literature, due to a lack of data needed to assess the statute as a whole. Not having medical professionals assess individuals and recommend them, or not, for commitment further calls into question the statute's ethics and effectiveness, especially if the omission of medical evaluation allows individuals who do not need it, or will not succeed in it, into the process. The results did show that some judges in some counties require evaluations by physicians prior to signing the commitment order; however, the statute does not require this, and more than one of the counties represented in my research do not require medical evaluation on their own. While it is unimaginable for someone to be wrongfully committed for alcohol and drugs, not requiring medical review as a part of a legal process allows for that possibility.

Another major difference is the difference in the timeline of procedures. The results showed that mental commitments must have their hearings seven to ten days after medical professionals evaluate the individual and recommend commitment. The alcohol and drug commitment statute requires that a hearing is five to 20 days after the filing of the affidavit. Thus, the time frame is much longer. Twenty days is nearly three weeks—nearly as long as some commitment periods. It also raises the question as to why there is a difference at all, if the goal is

to get treatment to both individuals with mental disorders and those with SUD. The results of my study found that many civilly committed patients have dual diagnoses. My study also found that when someone is dually diagnosed and is being committed, the family must choose between mental and alcohol and drug commitment. With a shorter time frame until the hearing, it would make sense for these families to choose the mental commitment process, adding another possible explanation to why there are more mental than alcohol and drug commitments. Furthermore, with people dying from overdoses daily, Mississippi having 400 overdose deaths in 2019, having a possible twenty-day time period before a hearing is more than enough time for an overdose death to occur (CDC, 2019). The statute for alcohol and drug commitment seems to be written with a lack of urgency compared to the mental commitment statute.

Lastly, another key difference between the statutes is the location of treatment. Mental commitments have a few possible locations where they can go, one of which is crisis stabilization units. CSUs "provide stabilization and treatment services to persons who are in psychiatric crisis" ("Crisis Services," 2019). CSUs aim to "more quickly" treat these individuals, rather than just allowing them to be "held without treatment" ("Crisis Services," 2019). My results found that crisis stabilization units are not available for alcohol and drug commitments. Thus, there seem to be more resources available for mental commitments. Lacking stabilization units as a possible treatment location just further hinders the ability of the alcohol and drug statute to be an effective public policy.

6.5 Treatment

Treatment is one of the largest, and most important, themes present in my results. Within this theme were two subtopics: length of care and type of treatment. The results found that the length of alcohol and drug commitments to inpatient programs in Mississippi is usually 30 days,

with just one of my interviewees stating an average of 42 days for patients they have dealt with. The alcohol and drug commitment statute in Mississippi allows for inpatient commitments to last anywhere from 30-90 days, and the state will pay for treatment for the entire commitment period, whether 30 days or 90 days, or somewhere in between. It is concerning, then, that state treatment facilities will often end the commitment period early, rather than utilizing more time. This is especially concerning when my medical professional interviewees stated that longer treatment is more effective for those with substance use disorder. LPC #2 spoke in depth about medication-assisted treatment, specifically about how several medications are the most effective while the person is still taking them or still in treatment. Thus, while any treatment for SUD is beneficial, the fact that most commitments end after 30 days demonstrates that this policy is not as effective as it could be.

Several of the medical professionals did note that they work with individuals to transfer them to a new treatment provider after the commitment period has ended; however, the individual has to find their own payment source, which can be very difficult, as many people utilize the commitment process to receive free treatment. Furthermore, while the diversion program seems well designed to shorten waiting periods, the drawback is that those who are diverted only have funding for a 30 day commitment, unless DMH grants an extension. One potential result of this too-short treatment is commitment recidivism. One chancery clerk specifically mentioned that they have "repeat offenders," individuals who go through the alcohol and drug commitment process several times. This demonstrates that in its current state, this statute is not fully helping individuals achieve long term sobriety.

In regards to the type of treatment, therapy and medication are the main treatment methods for those committed for alcohol and drugs. With my particular interest in OUD, I was

very interested in learning about medication assisted treatment for this disorder. The literature concluded that MAT, specifically buprenorphine, methadone, and naltrexone, can be extremely beneficial to those with opioid use disorder. However, my study's results showed that methadone is not as regularly offered or used at treatment facilities in Mississippi housing committed individuals. One might think that with three different medications available for those with OUD, having at least one medication available would be enough. However, the literature on MAT shows that not every medication is appropriate for every individual. For example, naltrexone produces severe withdrawal for individuals who have opioids already in their system, so it can't be used for patients who have had an opioid within the past two weeks. This example demonstrates the need for multiple medications; however, methadone is clearly not available to the extent that buprenorphine or naltrexone are. This is unfortunate, as one study found that methadone is "preferable to buprenorphine" for heroin abstinence, and further that methadone was a more effective medication for the severely addicted (Bonhomme et al., 2012). If this statute were providing patients with the proper care, in the proper time frame, an assessment on its effectiveness would be more reliable. Additionally, ensuring that all possible medications are available for alcohol and drug commitments would make this statute more ethical from a consequentialist and non-consequentialist perspective. However, in Mississippi, this statute is not providing patients with the full potential of proper medication, for those with OUD specifically, and thus its administration needs to be improved.

6.6 Ideological Differences

Ideological differences was one of my results' smaller themes, but still interesting and useful in my analysis. My results showed that among my interviewees there was some diversity of ideology when it comes to addiction. The relevance of this depends on whether or not these

diverging ideologies impact the use and effectiveness of the statute. The execution of a public policy is most successful when the professionals actively involved are in agreement about the goal and direction of the policy. There were a few instances in my results where a chancery clerk and a medical professional had differing opinions, whether on the level of autonomy of individuals with SUD, or the appropriateness of jailing these individuals. To properly assess this statute's effectiveness, it should be done so when it is operating at its best. When professionals have different viewpoints on parts of the statute, it can be difficult to assess the policy on a wider scale. For example, chancery clerk #3 believes that there is little one can do for those with SUD if they don't want treatment. This ideology manifested into real policy: their county does not require alcohol and drug commitments to stay at their commitment facility, their county does not issue a noncompliance order for noncompliant alcohol and drug commitments, and does not hold alcohol and drug commitments during the waiting period, which allows them free access to drugs on the street. Thus, this ideology manifested itself into a lack of urgency in terms of how the alcohol and drug commitment statute is used. Different chancery clerks with different ideologies have a slightly different process in their counties, and these differences create a statute that is not used in a uniform manner across the state. This impacts the actual individuals being committed, as it seems that mere luck of residence can impact how one experiences the commitment process—a process that is supposed to be uniformly available for all Mississippi residents. A lack of uniformity in implementation can be argued as an unethical practice.

A few of the medical interviewees expressed a different ideology than chancery clerk #3, for while chancery clerk #3 is unsure of what more "can be offered to [individuals with substance use disorder] right now," LPC #1 noted the importance of acting quickly and LPC #2 stated that treatment availability and usage of the statute is not yet where it needs to be. The legal

professionals play a huge role in how this statute is implemented daily, and thus, their diverging understandings of how the process should look, compared to the opinions of the medical professionals, inevitably will limit how effective this statute is.

6.7 Discussion on Dual Diagnosis

My results found that dual diagnoses are quite common, albeit more common in some regions than others. Nevertheless, given their prevalence, it was surprising to me that dual diagnoses did not arise in my survey of the literature on civil commitment. When questioning my interviewees, many of them cited the lack of a dual diagnosis commitment process as their biggest concern. Not only is Mississippi lacking a legal process for dual diagnosis commitments, there is also limited care for individuals with dual diagnoses in Mississippi. This severely limits the ability of this statute to be effective, as the resources and practical processes needed to carry out its intended purpose are lacking. If a large portion of commitments have dual diagnoses, but are only receiving inpatient treatment for one of their disorders, “a vicious cycle” can ensue, as stated by the CPSS. Additionally, I found that mental disorders and substance use disorders are often linked, with one disorder triggering the other. Thus, if someone copes with their mental disorder through substance use, and only receives proper treatment for their SUD and not their mental disorder, then it is probable that they may turn again to substance use to cope with their untreated mental disorder. Furthermore, chancery clerks are not allowed to recommend one commitment process over the other, and thus it is up to the family to decide which commitment path to use. With different resources and timelines, it is understandable for families to favor the mental commitment process, as it requires medical evaluation prior to commitment and also has crisis stabilization units available. The results also demonstrated that families may change commitment processes; however, this makes it difficult for chancery clerks who have to start the

commitment process over. For individuals who have dual diagnoses, it would be easier and more efficient if there was one process that allowed them treatment for both their mental and substance use disorders at one facility, during one commitment period. Both legal and medical professionals supported and proposed the idea of a dual diagnosis process.

6.8 Funding

While analyzing my results, I realized that a lot of the issues present in the current civil commitment process in Mississippi could be solved with more funding and better allocation of funding. With civil commitment not being a widely known public policy, it can be hard to argue for more funding. However, it is clear from my results that the professionals who deal with this public policy daily believe it needs more funding to properly function. It is also vital that funding be allocated properly. More funding for longer commitment periods is not useful if it is not allocated to treatment facilities, so they can have enough beds, medication, and treatment available. LPC #2 mentioned that their capacity for treating individuals with OUD with medication assisted treatment is 15 people at a time, for three to six months each. This is the capacity at just one of 14 community mental health centers in Mississippi. If there is more funding for commitments, but not more funding for treatment facilities, therapists, and medications, then the funding will prove ineffective. With more funding to facilities, waiting periods could shorten, and the need to hold alcohol and drug commitments in jail could decrease. Furthermore, more funding to community mental health centers would allow alcohol and drug commitments who receive treatment through the diversion program to receive longer treatment than the 30 day limit. Individuals who participate in the diversion program have to forgo a longer treatment period to receive treatment quicker, and this is not a concession these individuals should have to make. More funding for the diversion program would allow all alcohol and drug

commitments, regardless of location, to receive inpatient treatment for as long as doctors recommend within the 30-90 day time frame. This would likely increase the effectivness of the commitment process, thus justifying the statute as ethical under the consequentialist framework.

6.9 Minor Themes

Drug courts were also a minor theme in my research, and since they serve a similar purpose to the alcohol and drug commitment statute, they are worth analyzing. Because drug courts are available to individuals who are convicted of nonviolent felony drug charges, they could apply to many alcohol and drug commitments. The only difference between individuals in drug courts and those who are committed is that individuals in drug courts have already been charged with a non violent felony drug charge, which could include for drug possession. Thus, committed individuals do not have prison time used against them as leverage if they do not complete treatment. In a way, committed individuals benefit from the luck of having family members who take control of the situation and file an affidavit to commit them, prior to the individual being caught by law enforcement and charged. It is intriguing to me that there are two policies with the same intended purpose for helping the same population, yet, often by pure luck, some go through the criminal justice system to receive treatment, while others do not have to go through the criminal justice system. My results show that, similar to the commitment statute, drug courts are heavily debated. Ethically, drug courts can be seen as the better policy, as they give patients the option to forego treatment for prison time, allowing the patient some form of autonomy. However, from a consequentialist perspective, this may not be more ethical, as an individual who forgoes treatment via drug courts for prison time does not receive the rehabilitation and care needed to have a chance to live sober after the prison sentence and have long term positive consequences. Having two processes, both heavily debated, for practically the

same purpose is inefficient and leads to two poorly executed policies, rather than, potentially, one properly executed.

The second minor theme was the difference between public and private treatment centers. The premise of the civil commitment statute is to bring involuntary treatment, either at public or private facilities, to individuals who need it. However, I learned that commitments mostly will go to public, state-funded institutions, so inquiring into private treatment centers was not the best use of my research time. Thus, it seems as though this policy is less centered around forcing involuntary treatment, and more so about giving free treatment. While this is not necessarily a problem, it is important that lawmakers understand how this policy is being implemented, and if its practical use is different from the lawmakers' goal, there either needs to be a re-education of the professionals dealing with this statute, or adjustments to the statute to ensure that the intended purpose is being brought about. This invokes the larger conversation of access to treatment in Mississippi. A tendency for individuals who are open to treatment to use the commitment process to receive free treatment suggests that other avenues to treatment, one being paying out-of-pocket, are quite difficult. This notion speaks to the state of treatment for SUD in general in Mississippi.

The last minor theme is the ability of a facility to hold someone against their will. While the statute is premised on the government forcing individuals to receive treatment, my interviews found that some facilities are not locked, making it possible for committed individuals to leave treatment when they choose. Furthermore, some counties implement the statute more aggressively than others, as chancery clerk #4 stated that their county will pursue and hold a committed person who fled their treatment facility, whereas the county where chancery clerk #3 resides will not. Thus, it seems as though whether or not the statute fulfills its intended purpose

of giving involuntary treatment to individuals who have been legally committed actually depends on what county one resides in. This leads into another point of discussion, which is a lack of agreement, understanding, and education surrounding civil commitment, further questioning the ethics of this implementation.

6.10 Uniformity

It is clear from my interviews that both the legal professionals and the medical professionals had slightly different understandings of how the commitment process works. While the basic premise was understood and agreed upon, there are some key parts of the statute where there is a lack of uniformity around the state. One instance is that some counties hold alcohol and drug commitments in certified holding facilities, whereas other counties do not. Another instance is that some counties do not require medical evaluation before the judge signs the alcohol and drug commitment order, whereas some counties do. These are only two of several examples in my results. When there is a lack of uniformity around the state, the experience that individuals have in the commitment process differs, and thus, it is more difficult to assess if the commitment statute is effective and worthwhile on a state level. This lack of uniformity, in addition to the lack of systematic data on race and economic class, makes it difficult for any detailed assessment on a broad scale. Furthermore, a lack of uniformity calls into question the ethics of commitment. Individuals having different commitment experiences or different care provided to them, based on where their residence is, can be seen as unethical through both the consequentialist and the deontological views, as both the lack of uniformity and the consequences of the lack of uniformity can be negative.

Chapter 7: Policy Recommendations

My conclusion from my research, including both a survey of the literature and the results from my interviews, is that the premise of the alcohol and drug commitment statute has merits; however, the implementation of the statute in Mississippi flawed and needs correction. These corrections are needed to improve the ethics and efficiency of the process, and so a future researcher, with more time and resources, can do a more comprehensive assessment of the Mississippi statute, when it is operating at its maximum potential uniformly around the state. The following recommendations include suggestions proposed by the interviewees, as well as my own suggestions. These recommendations will improve the process of alcohol and drug commitment, and prepare the statute to be more thoroughly assessed at a later date.

7.1 Improved Data Collection

Part of the reason that commitment is heavily debated is because there is a lack of data collection in general, and data that is collected is not a wide enough sample to allow policymakers draw conclusions. The alcohol and drug commitment process needs to be assessed for trends regarding race, gender, age, and other demographic identifiers. While medical professionals are required to conduct an intake assessment that collects biographical information from committed patients, it is my understanding that there is no statewide analysis of this information. The Mississippi Department of Mental Health ought to start collecting the demographic information of all alcohol and drug committed individuals, as well as the time of year of commitments. Furthermore, knowing who goes through the alcohol and drug

commitment process more than once is another important data point. Hopefully, one report analyzing the demographics of those committed for alcohol and drugs can help the state properly assess if the process is effective, who it is effective for, and if this process has any biases. Then, if necessary, Mississippi policymakers can consider making the commitment process more accessible to certain populations, and also decide whether or not it is a worthwhile policy in general.

7.2 Streamline the Process

I believe the commitment process should be streamlined, so that the two commitment processes we currently have—mental commitment and alcohol and drug commitment—are combined into one. Streamlining will make funding easier to allocate, and make this process less confusing for both chancery clerks and the families of individuals with dual diagnoses. One process will also solve the issue of a lack of a clear path for individuals with dual diagnoses. Furthermore, one process would promote the narrative of SUD being another type of mental disorder, as the NIMH deems it so ("Substance Use and Co-Occurring Mental Disorders," 2021). The commitment process should combine elements of both current processes, as well as suggestions from my interviewees and my own suggestions. The alterations, other than streamlining the process, include minor changes, in part due to the fact that sweeping changes all at once are not feasible. The steps to commit an individual should be as follows:

1. Family, loved one, or friend submits an affidavit to request an individual being committed, and they state the reason why (behavioral and/or mental concerns, alcohol and drug concerns, or dual diagnoses).
    a. The current affidavit forms on the DMH website should continue to be used. There are three forms: civil commitment affidavit, uniform alcohol and drug

commitment affidavit, and private treatment uniform alcohol and drug commitment affidavit. The only change would be if someone is committing an individual for dual diagnosis; they must submit both the civil commitment and uniform alcohol and drug commitment affidavits and submit them together.

b. The civil commitment affidavit should be edited. The following statement *to my knowledge the recent behavior described herein is not caused by any of the following: epilepsy; intellectual disability; brief periods of intoxication, dependence upon or addiction to alcohol or drugs; or senile dementia* should be edited to *to my knowledge the recent behavior described herein is not caused by any of the following: epilepsy; intellectual disability; brief periods of intoxication, or senile dementia*.

2. Within 48 business hours of the affidavit being filed, the sheriff's department should locate the individual and bring them to the region's community mental health center, where two doctors, or one doctor and one healthcare professional of a master's level education, should evaluate the individual and assess whether the information on the affidavit seems credible and diagnose the disorder(s) the individual has.

    a. The two evaluations should take place independently. The evaluators should not be allowed to influence each other's opinion.

3. If both evaluators agree that the individual ought to be committed, for dual diagnosis or for just one disorder, they will give their recommendations to the chancery judge. If they are not in agreement, the commitment process ceases.

4. Then, the chancery clerk will set a hearing for the commitment case, no less than five and no more than seven days out from the date of the evaluation by the doctors and/or healthcare professional.
5. The Sheriff's department serves the individual with the papers summoning them to appear in court.
    a. Steps two through five must occur within the same 24 hour period.
6. Between the date that the individual is served, and the actual hearing date, the individual in question is allowed to reside wherever they please.
7. The court will appoint a public prosecutor and a public defender to the case, if both individuals need one.
    a. The defendant may waive their right to a hearing if they choose to.
8. At the hearing, the affiant and the two doctors, or doctor and medical professional, who evaluated the individual must testify to why they believe the individual should be committed, and what disorder(s) specifically they are suffering from. The defendant will also have the opportunity to speak for their defense if they choose.
    a. The doctors must be asked what their recommendation is: inpatient, outpatient, or otherwise.
9. The judge, or special master, will decide if commitment is necessary, and if so, they will commit them to the Mississippi State Hospital(s). The judge will also make a decision on whether or not this individual qualifies for the diversion program, based on the recommendation of the doctors and/or health care professional, and based on guidelines provided to the judge, or special master, from the Department of Mental Health.
    a. Inpatient commitment length:

i. Mental: The person should be discharged when he or she no longer meets commitment criteria and can return to live in the community with adequate support services (same as the current statute).
    1. The treatment center should be required to send bimonthly updates to the court who ordered the commitment regarding these commitment patients.

ii. Alcohol and Drug: No less than 60 days and no longer than 90 days.
    1. The NIDA recommends that the best treatment length for an individual with addiction (SUD) will vary from person to person. However, they find that most individuals with addiction (SUD) need “at least three months in treatment” and that “the best outcomes occur with longer durations of treatment” (NIDA, 2020). So, I recommend that the minimum commitment length was increased to 60 days, to allow for better treatment outcomes.
    2. If the treatment providers believe that an individual does not need more treatment, and the commitment period has not reached 60 days yet, a doctor or physician may discharge the individual after submitting a written and signed statement, explaining the reasons for discharge, to the chancery judge who ordered commitment.

iii. Dual Diagnosis: The individual should be treated for their substance use disorder at the same time they are treated for their mental disorder, at facilities that have both inpatient psychiatric and inpatient alcohol and drug treatment. The person should be discharged when he or she no longer

meets commitment criteria and can return to live in the community with adequate support services.

1. The treatment center should be required to send bimonthly updates to the court who ordered the commitment regarding these commitment patients.

b. Outpatient commitment length:

   i. Mental: The person should be discharged when he or she no longer meets commitment criteria and can return to live in the community with adequate support services (same as the current statute).

      1. The treatment center should be required to send bimonthly updates to the court who ordered the commitment regarding these commitment patients.

   ii. Alcohol and Drug: No less than 90 days and no longer than 120 days.

      1. Mississippi DMH website currently does not specify the length of outpatient commitment. I've selected this time frame because the NIDA finds that most individuals with SUD need "at least three months in treatment" (NIDA, 2020).

   iii. Dual Diagnosis: The individual should be treated for the alcohol and drug disorder at the same time they are treated for their mental disorder. The person should be discharged when he or she no longer meets commitment criteria and can return to live in the community with adequate support services.

1. The treatment center should be required to send bimonthly updates to the court who ordered the commitment regarding these commitment patients.

10. For those on the waiting list for commitment to the MSH but also qualify for the diversion program, the Mississippi DMH should start conducting outreach to community mental health centers, community-based residential treatment programs, and stabilization units in each county, to inquire about the availability of beds (as they do so now). If there is available space at both a diversion program certified facility, in the individual's home county or otherwise, as well as the MSH, eligible individuals should be sent to the diversion program certified facility, in order to allow more space at the state hospital for those who do not qualify for the diversion program, such as those with dual diagnoses who need inpatient care for both SUD and mental disorder.
    a. Commitment lengths should be funded the same at diversion program facilities as they are at the MSH. There should be no 30 day limit on commitment lengths for alcohol and drug commitments at diversion program facilities.
11. It is at the discretion of the judge, based on the recommendation of the medical professionals, whether an individual committed by court order should reside in certified holding facilities until they are placed in a treatment program. Every seven days, the judge should re-examine the individual who is waiting in a certified holding facility, to see if they are eligible to no longer reside there. The basis on which they examine the individual is based on guidelines given to the judge by the medical professionals that initially reviewed the individual and recommended commitment. If an individual has

been waiting for more than 21 days, they should be released and be free to reside wherever they choose until a bed opens up.

    a. Individuals cannot be placed in certified holding facilities until the commitment order has been signed. Access to treatment that reduces withdrawal pain should be available at these holding facilities.

12. Private facilities are only eligible to house commitments if they have the same treatments available as public treatment facilities.
13. Any committed individual who leaves treatment early should be returned to the certified holding facility for the duration of their commitment period, until they agree to go back to their treatment facility or until the commitment period ends.

The changes proposed to the Mississippi commitment process are aimed to make the process more efficient and more ethical. The changes reflect both consequentialist and non-consequentialist considerations.

Regarding consequentialism, the change to make commitment periods longer allow for the consequences of commitment to be more effective, as medical professionals deem longer treatment as better and more effective than shorter treatment. The requirement for two medical professionals to recommend the commitment process continue, before an individual can be committed for any disorder, also reflects consequentialist concerns, as it would ensure that only those who truly need commitment are proceeding with the process. The recommendation for a shortened period before the commitment hearing, as suggested by one of my interviewees, also has more positive consequences than negative, as it will ensure that we are getting treatment to those who may need it as soon as possible.

Regarding non-consequentialism, the change to one commitment process, rather than two, follows deontological considerations as it ensures fairness, as all commitments are treated the same and experience the same commitment process. Additionally, the requirement that commitments to private institutions are only allowed if the private institutions have at least the level of care as an alternative public facility is also supported by deontology as it ensures a uniform experience of commitment throughout Mississippi. The change that all commitments, regardless of the facility of residence, will have a minimum 60 day commitment period, as one interviewee recommended longer commitment periods, fully paid for by the government, also ensures that all commitments are being treated uniformly, and thus fairly. Lastly, the requirement that all individuals should reside in certified holding facilities, for a maximum of 21 days, also reflects some deontological and consequentialist considerations. From a consequentialist perspective, holding an individual to prevent harm to the individual or others is ethical. From a deontological perspective, it violates the autonomy of the individual and thus is unethical; however, putting a limit on the length of being held, prior to being admitted to a bed, allows for a return to autonomy for the individual. Thus, this change also invokes some deontological considerations.

7.3 Funding Changes

My research shows there needs to be more funding directed towards the commitment program to ensure that it runs in an ethical and efficient way. Specifically, there is a need for more beds and more treatment for SUD in Mississippi, as shown through my interviews. While some may argue that the commitment statute is not used at a level that would warrant more funding, I believe it is important to provide enough funding to ensure that statute is operating at its fullest potential, ensuring ethical and effective considerations are taken into account, so future

researchers can fully assess whether commitment is worthwhile in Mississippi and is aiding those with SUD.

According to the Bureau of Alcohol and Drug Addiction Services, funding for substance use disorders treatment comes from two main sources: Substance Abuse Block Grants (SABG) from the federal government, and the three percent alcohol tax enacted by the state government (Malkin et al., 2022). As mentioned in chapter two, the approximate funding for alcohol and drug treatment in Mississippi for 2022-2023 was $33,162,426, with $10,000,000 from the alcohol tax, $13,804,875 projected from SABG, and additional funding from the federal government due to COVID-19 (Malkin et al, 2022). However, it is important to recall that the $10,000,000 from the alcohol tax is set aside for treatment of alcohol use disorder only (Malkin et al, 2022). I propose that the $10,000,000 alcohol tax revenue be used to fund all SUD treatment, including MAT for OUD. Furthermore, as the alcohol tax does not apply to beer, I propose that a 0.1% tax be placed on beer, at the point of sale, and that the revenue be allocated to substance use disorder treatment.

Specific goals ought to be set out in order to assess whether the government is implementing the funding for this statute appropriately. Firstly, in total, the maximum number of beds available for treatment for substance use disorder in Mississippi, for adults, is 672, although it is possible this number may have decreased since COVID-19 began (Malkin et al., 2022). Mississippi ought to increase this to 772 beds over the next two years. This would require each of the twenty primary residential substance abuse treatment programs outlined in Mississippi's DMH Bureau of Alcohol and Drug Addiction Services State Plan for 2022-2023 to each increase their capacity by five beds. Funding from the alcohol and new beer taxes should help achieve that goal. With more beds, there is hope that lengthy waiting periods will shorten.

Another benchmark goal is to make methadone available at the twenty primary residential substance abuse treatment programs in Mississippi. The NIDA approximates that the per-patient cost of methadone, for providers, is $4700 yearly (Brico, 2017). Funds from the alcohol tax can help fund the cost, by starting small: within two years, there ought to be enough methadone at each of these twenty facilities to treat one individual with OUD consistently for a whole year. This would cost approximately $94,000, which can be funded through the alcohol tax, beer tax, or the SABG.

The Bureau of Alcohol and Drug Services lists the ten priorities for SABG funding; responding to the opioid crisis is the first. Making methadone more readily available would align with this priority.

Funds also should be allocated to create more certified holding facilities, as well as modernizing these facilities. Not every county has a certified holding facility, as one chancery clerk noted it requires review from the state government, as well as taxpayer money, for a jail to become a certified holding facility. My proposal would require every chancery court district to have a certified holding facility, and that a nurse or doctor from a community mental health center be present at the holding facility anytime a patient is there. Furthermore, as current certified holding facilities hold their commitment patients away from the general jail population, this practice should be continued. It is imperative that committed individuals be treated like patients, not inmates. Withdrawal medication should also be available at these certified holding facilities, if it is not already, which includes buprenorphine, methadone, and naltrexone for those with OUD.

With the process of holding alcohol and drug commitments in certified holding facilities followed uniformly across the state, a more in-depth research project can better assess the

effectiveness of the statute and apply conclusions to the entire state, rather than just the few counties that follow the same process. With each county having a certified holding facility, the counties should have a better capacity to keep alcohol and drug commitments from continuing to abuse drugs and overdosing before they are sent to their treatment facility. Chancery clerk #3 stated that certified holding facilities cost approximately $200,000 a year to manage. However, I could not corroborate this information through existing research or on the Mississippi Department of Mental Health website. Additionally, I could not find information regarding why certified holding facilities might be so expensive, specifically if they cost more from salaries, treatment, or building expansions. If this chancery clerk's estimation is correct, certifying a jail in every county will be expensive. The state government ought to continue certifying jails as holding facilities and slowly allocating funding to these counties, over a ten year period.

With funding allocated towards more certified holding facilities, more beds, and making methadone accessible, hopefully the alcohol and drug commitment statute can be modernized and run more effectively, making the process better and easier for all involved. Should there not be enough space at certified holding facilities in Mississippi, committed individuals will be held in crisis stabilization units with available space until space at a certified holding center arises, until the 21 days holding period ends, or until the individual receives an actual location of commitment. This is an existing practice, although not for those with SUD in Mississippi. CSUs should be available to those with SUD as well.

Hopefully, these funding changes will allow the commitment process in Mississippi to be more effective at helping individuals receive quality treatment, thus improving the ethics of the statute as well, from a consequentialist perspective.

7.4 Improved Education

My last policy recommendation is improving education on the alcohol and drug commitment statute. My research into the alcohol and drug commitment statute, as well as information from the legal and medical professionals, has informed my thoughts and recommendations in this subsection.

From my personal experience, the commitment process in Mississippi is not well known to the average individual, and further, information on the topic is difficult to find. The Mississippi DMH website has a page that outlines the current commitment processes in Mississippi, and one can also access the actual text of the statute online. However, specific information is harder to find. I was unable to find any literature or a website explicitly explaining the Department of Mental Health's diversion program or certified holding facility qualifications, as well as which counties have certified holding facilities. Lastly, there is a lack of online literature and information regarding waiting periods. It seems as though this information is distributed through channels that are not readily available to the public, including those family members of individuals with SUD who are trying to get their loved one into a treatment facility. This information needs to be made more accessible and clearer to the public, so they can understand the resources available to them and fully understand how the statute is implemented if they want to pursue this process. My recommendation is that the DMH should add to the civil commitment webpage brief descriptions of issues relevant to the commitment process, including: certified holding facilities, the diversion program, treatment available, and waiting periods. In addition, this same information needs to be added to the websites of every chancery court in Mississippi. These two steps would be small, but helpful, improvements towards making information on the alcohol and drug commitment process more accessible.

Not only is there a need for increased education, but also re-education for those who do know the statute and work with it. Among my interviewees, there were misunderstandings of the statute and its implementation. The DMH needs to re-educate all individuals involved in the commitment process, and ensure that the process is being uniformly implemented. In order to do this, the revised commitment statute needs to be distributed to all chancery courts, Mississippi State Hospital staff, community mental health centers and other treatment programs that participate in the diversion program. Furthermore, one month after the statute is revised and passed by the legislature, I recommend that representatives from the Mississippi DMH visit every chancery court in Mississippi, as well as every treatment center, to speak in-person and answer any questions. This process may take up to two years, but it is vital in ensuring that the new process is implemented and enforced. When chancery courts report demographic information regarding committed individuals, they ought to include proof of the court's following of the new implementation process for the first two years post the statute's revisions. Should the evidence reflect a failure to follow the new implementation process, representatives from DMH ought to check in on those counties more routinely and ensure proper implementation.

A more difficult part of the education campaign is promoting understanding of addiction as a disorder, as well as promoting the medical term "substance use disorder" in place of the term "addiction." The more people view it as a disorder, separate from the individual, and less as a part of someone's identity, the more willing Mississippi's citizens will be to help these individuals. It is clear that the public still operate under the ideal that addiction is a moral failing, not a medical problem. However, our medical professionals, with the proper expertise, suggest otherwise, and furthering this ideal will foster greater support and awareness around addiction

and substance use disorder. Promoting the idea of addiction as a disorder, rather than as a moral failing and a representation of one's character, can improve treatment, given the finding that "reducing stigmatizing experiences may improve treatment outcomes" for those with OUD specifically (Bonhomme et al., 2012). I propose that the Mississippi DMH, the Bureau of Alcohol and Drug Services, and the Mississippi legislature eliminate the term "addict" from their language, as LPC #2 noted that such a term can "dehumanize" the individual. Language can impact thought, and eliminating this term can influence people to view those with substance use disorders as humans with a disorder, rather than as the disorder itself. Furthermore, I recommend that education in public schools be altered to reflect this change. Health classes in public schools ought to teach SUD and addiction as disorders, and ensuring that this language and thought is taught to young Mississippians can yield great results in modernizing our treatment methods for years to come.

Chapter 8: Conclusion

In this thesis, I covered the purpose and aim of my research, the reality of how my research proceeded, the results of my research, and finally, my thoughts and recommendations for how the alcohol and drug commitment process ought to be improved in Mississippi.

In the beginning, I thought my research was going to focus on the difference between alcohol and drug commitment at public treatment facilities versus private treatment facilities. However, as my interviews progressed, I learned that the most relevant research product would be an assessment of the alcohol and drug commitment statute in Mississippi as a whole, including an assessment on the implementation at every step of the process. The real question of the alcohol and drug commitment statute is not whether it is more effective at public or private facilities, but rather whether the way the process is being implemented in Mississippi is proper at all. I've learned that it is not, and through a detailed analysis of the thoughts, opinions, and recommendations of the legal and medical professionals I interviewed, I proposed a restructuring of the commitment statute, as well as other initiatives that will allow this statute to function at its best, while maintaining ethical standards.

While I do believe the results of my interviews convey a wide range of ideas, and credible information, there was still more I would have liked to do. Firstly, if I had much more time, I would have liked to interview a chancery clerk, chancery judge, lawyer, or special master, from every chancery court in Mississippi. Doing so would have allowed me to gain a full picture of how legal professionals around the state are implementing the alcohol and drug commitment statute. With my limited time and resources, I was only able to interview legal professionals

from five different counties. Likewise, I would have liked to interview medical professionals from all facilities that treat alcohol and drug commitments, including state and non-state facilities. However, this would have also been very difficult, for two reasons. The first is that finding information about the diversion program and identifying participating facilities is difficult, so finding all the participating facilities in the entire state would be a challenge. The second reason is the sheer number of interviews required. However, these interviews would have provided a comprehensive picture of how the alcohol and drug commitment process works in Mississippi.

Another way my research could have been improved is accessing more statistical, quantitative data, via other sources than interviews. Humans have biases, as is our nature, and accessing quantitative data regarding commitment in Mississippi—how often it is used, what counties use the process the most, what the demographics of alcohol and drug commitments are—would have been useful. However, much of this data has not been collected or organized. I encourage future researchers, if they have the time and resources, to build upon this research by expanding the number of legal professionals to reach out to, specifically from as many counties in Mississippi as possible, as well as expanding the number of medical professional interviews from as many different facilities that treat alcohol and drug commitments. In addition, I encourage these researchers to spend some of their resources to get access to demographic data and to draw conclusions from this data, as well as contrast against the information given by the professionals. Furthermore, I also encourage future researchers to interview the individuals who have gone through the alcohol and drug commitment process in Mississippi. Their experiences would add to a much more comprehensive analysis.

In regards to my next steps, I plan to share this report with my local representative in Massachusetts. Opioid Use Disorder is quite severe in Massachusetts, more so than in other states in the U.S., and combatting this epidemic is a priority of several policymakers. In addition, I plan to share this information with Mississippi policymakers, to share my findings and recommend they invest time and resources towards expanding the scope of my research, in order to address how the commitment process is being implemented across the entire state. Hopefully, these leaders will see the value in improving this process and the value in investing in the lives of individuals with substance use disorder.

Substance use disorder is not a moral failing, but rather, a community failing. We owe it to these individuals who suffer with this disorder to build, improve, and modernize the processes intended to support them and help them assimilate back into society; we can start with the alcohol and drug commitment statute.

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APPENDIX

Mississippi Department of Mental Health Regions - DMH Website