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ETHICS CASE
Civil Commitment for Substance Abuse
Commentary by Jeffrey C. Eisen, MD, MBA

Mr. Robinson arrived at the emergency room in the middle of the night after crashing a car through a glass storefront. Luckily for him, he hadn't been going very fast, but had a large cut on his hand. He was not an easy patient; he swung at a nurse who was cleaning his wound, yelled obscenities at the doctor who was trying to get a history, and urinated in his cubicle. His hand required 20 stitches. His blood alcohol level was 400.

When Mr. Robinson's daughter Margaret arrived at the hospital, she was frantic with worry, not only about the health of her father but also about her own family. The car was hers and she needed it to get to work. She was the single mother of two young children, whom she'd had to leave with a neighbor. Her father had come to live with them in the Boston suburbs a year earlier after going through a messy divorce. He'd struggled with alcohol throughout his life, but had started drinking heavily again soon after moving in with Margaret. This was his third visit to the emergency department for an alcohol-related crisis. Margaret was at her wit's end. She asked to see Dr. Diallo, a psychiatrist who had been called in to interview Mr. Robinson during a previous hospitalization.

"We've tried everything—individual therapy, group therapy, AA, outpatient full-day programs. It just isn't enough for him. He's wonderful when he's sober, but drunk is another story."

Dr. Diallo agreed that Mr. Robinson needed more intensive care to achieve sobriety. He decided to admit Mr. Robinson to the hospital for detoxification and to broach the subject of longer-term inpatient treatment with him that afternoon when he had sobered up and Margaret got out of work.

Mr. Robinson was a completely different person in the afternoon. He gave Margaret a hug when she came in and asked about his grandchildren, but he was less pleased to see Dr. Diallo. "I just got a little too drunk last night," he said impatiently.

Margaret reminded him that they had been through similar episodes three other times. "You're an alcoholic, Dad. You scare me when you're drunk."

Dr. Diallo told him about the advantages of ongoing hospitalization for substance-abuse treatment, but Mr. Robinson shook his head. He wasn't interested. Margaret

begged Dr. Diallo to intervene. “He got into a car in that state! He’s a menace to himself, my family, and the whole community,” she argued.
Unlike many states, Massachusetts allows for involuntary civil commitment for patients with substance use issues if they are at risk of “serious harm” to themselves or others as a result of their use of substances. Though a judge ultimately determines whether or not a patient can be involuntarily committed for substance-abuse treatment, the psychiatrist must make the decision whether or not to petition the court for such an order.

The decision weighed heavily upon Dr. Diallo. On the one hand, Mr. Robinson had come into the ED three times with dangerously high levels of alcohol. On the other hand, infringing someone’s freedom demanded strong justification, especially when that person had, so far, not harmed anyone or been accused of harming anyone. Dr. Diallo wondered if mandating inpatient treatment for substance abuse was in his patient’s best interest.

Commentary
The case of Mr. Robinson describes the complexities associated with treating the substance dependent patient. Dr. Diallo’s desire to motivate this patient to seek treatment, and the worry expressed by his daughter, stand in great opposition to a patient who denies both the problems and consequences of ongoing substance use.

The concerns of Dr. Diallo and Margaret are further heightened by Mr. Robinson’s potential for harm to himself, and others as well, due to his alcohol dependency. He could have injured or killed others when crashing his car. Following this event, he attempted to assault a nurse in the Emergency Department (ED), yet again endangering the life of another.

Mr. Robinson’s actions affect Dr. Diallo and Margaret considerably. Margaret exemplifies the range of conflicting and often confusing emotions felt by family members attempting to reach their substance-abusing loved ones. Margaret expresses worry, frustration, hurt, and, importantly, a sense of helpless and desperation. Similarly, Dr. Diallo feels compelled to intervene, yet may feel helpless to change a dire situation and frustrated when the patient does not adhere to treatment recommendations.

Given that Mr. Robinson risks significant harm to himself and others due to substance dependence and has not been helped by other treatment modalities, Dr. Diallo ponders an important question, namely if mechanisms exist to mandate substance-abuse treatment against the will of the patient. In the state of Massachusetts, Chapter 123, Section 35 of the Massachusetts General Laws allows spouses, blood relatives, guardians, physicians, and police officers to petition the court to commit substance-dependent patients for up to 90 days of treatment in a locked facility. This suggests that Dr. Diallo or Margaret may petition the court to commit Mr. Robinson to inpatient substance-abuse treatment.

Between 2004 and 2008, up to 5,000 Section 35 civil commitment cases were considered per year in Massachusetts [1]. Nationally, 38 states have laws that permit civil commitment to inpatient or outpatient substance-abuse treatment programs. Of the remaining states, 8 permit some form of involuntary treatment that does not include civil commitment, such as emergency hospitalization due to substance-use concerns. Alabama, Pennsylvania, Virginia, and Wyoming do not offer any legal provision for involuntary treatment [2]. Notably, Massachusetts law authorizes commitment to inpatient programs only and does not include an outpatient option.

Clinicians may express interest in this modality of treatment but are often uncertain about whether or not a particular patient is appropriate for mandated treatment, and many may not even be aware of the existence of such laws. Dr. Diallo seems uncertain in both of these regards—whether or not mandated treatment is even possible and, if so, to what extent Mr. Robinson might meet the criteria for commitment.

Determining which patients are appropriate candidates for mandated substance-abuse treatment remains controversial and complicated. Dr. Diallo must be aware of the criteria for commitment under the Massachusetts law. First, the individual under consideration must be a substance abuser, which is defined in the law by chronic or habitual ingestion, the loss of power of self-control over the use of substance(s), and interference with social and/or occupational functioning. Second, likelihood of "serious harm" as a result of the substance use must exist [3].

In this case, determining the seriousness of harm at time of initial presentation is not particularly difficult, given the dramatic events leading to Mr. Robinson's arrival in the emergency department and the behavior following it. However, the evidence shifts over time. Once admitted to a detoxification unit and sober, the patient becomes "a completely different person," described as "wonderful" by his daughter. A clinician evaluating the patient at the time of ED arrival might conclude that the imminence of risk supports civil commitment for substance-abuse treatment, whereas a clinician evaluating the pleasant, sober patient may have less urgent concerns about seriousness of harm. Mr. Robinson's actions while intoxicated are clearly serious, but, as it pertains to the civil commitment statute, clinicians may interpret the definition, timing, and imminent nature of "serious" differently.

Dr. Diallo's review of the legal criteria only represents the beginning of this process. Even if Mr. Robinson appears to meet the legal standard for civil commitment, many clinician-, patient- and systems-based factors can affect the commitment process and may limit access to mandated treatment. Dr. Diallo will also consider the efficacy of such treatment and his own ethical framework as he decides whether or not to file a petition.

The complexity involved in pursuing an order for mandated treatment could create a significant barrier for Dr. Diallo or Margaret, who have limited knowledge of the petitioning process. Typically, in my experience, the physician must provide written

documentation in support of the petition, present data at court in front of a presiding judge who will decide the case, and otherwise coordinate patient discharge, among other tasks, all of which are time consuming and take away from time with other, perhaps more urgent, patient needs. As this case continues, Dr. Diallo will have to determine whether the time and effort involved in the process is prohibitive, given the many responsibilities involved in managing a multitude of complicated patients on his detoxification unit. In essence, Dr. Diallo must feel compelled enough to take the time away from other responsibilities to focus on this endeavor.

Patients with medical or psychiatric comorbidities can be challenging for substance-abuse commitment facilities, which may not have staff with the necessary expertise to manage these additional concerns. In some cases, physicians must also assert that the person being committed will remain medically stable throughout the holding and transfer process until reaching a facility. This case does not suggest that Mr. Robinson has acute medical or psychiatric problems that would affect the civil commitment process, but it would be important to consider the possibility that he may experience the physical effects of withdrawal during the holding and transfer period.

The nature of the legal system may also complicate a petitioning effort. In my experience, judges can hold a higher threshold for commitment if a patient has been previously committed. While this has not been documented in the case, it is an important detail not to be overlooked. If a prior commitment is found, Dr. Diallo may need to explain his rationale for pursuing this treatment modality, given that prior commitment did not result in ongoing sobriety.

The timing of the petition requires consideration as well. In Massachusetts, petitions for civil commitment for substance abuse are filed and heard by judges only when the court is open [4]. If Mr. Robinson arrived in the emergency department on the weekend or overnight, for example, clinicians would be limited in their ability to pursue the petition when the need and evidence for containment was greatest. The petition would originate from Mr. Robinson's location in the detoxification unit, which allows more time to prepare the petition, allows Mr. Robinson to detox safely, and reduces the risk of his going through a withdrawal event during the process. Nonetheless, the petitioning effort should still begin at the start of the business day so that the petition and the patient arrive at court early enough for the case to be heard.

As Dr. Diallo evaluates this case, he will certainly ask whether mandated treatment for substance abuse works. A review of 30 years of research into the efficacy of coerced substance-abuse treatment reveals an inconsistent and inconclusive pattern of results [5]. Several of the studies cited in this review found that treatment outcomes for mandated and nonmandated clients did not differ. While certain studies found that voluntary clients had better treatment outcomes, others asserted that legal pressure was negatively related to treatment outcomes. Similarly, studies of the sobriety retention rates of mandated and nonmandated clients reflected mixed

outcomes [5-9]. A number of factors account for the varied conclusions, including small sample sizes, the lack of group differences at baseline, the challenge in comparing mandated to nonmandated treatment programs and differences in outcome measures [5].

A clinician's interpretation of the appropriate outcome measures associated with substance-abuse treatment by civil commitment complicates the decision-making process. If basic survival for 90 days represents a successful outcome because risk of imminent harm or death is averted during the commitment period, then a clinician may support pursuing civil commitment as a treatment option. Other clinicians may assign a period of postcommitment sobriety as the appropriate measure of success.

With scant data to support or refute the efficacy of mandated substance-abuse treatment, the decision will fall to Dr. Diallo's clinical judgment, which incorporates the factors associated with this specific case and his own ethical framework. Ethical considerations weigh significantly in the decision to commit a patient for substance-abuse treatment [5]. A review of 850 papers related to coerced substance-abuse treatment noted that 81 percent were nonempirical in nature, reflecting that the discussion of civil commitment for substance abuse emphasizes the significant ethical, legal, and policy issues involved in such treatment [5]. Dr. Diallo must consider the extent to which society should curtail the liberty of substance users and, as such, if he should take away Mr. Robinson's freedom to protect his life and the well-being of the greater community.

Despite agreement between Dr. Diallo and Margaret that that Mr. Robinson often places himself in serious risk of harm to himself and others as a result of ongoing substance use, the question remains whether or not civil commitment for substance-abuse treatment is appropriate for him, particularly when taking into account the multifaceted commitment process and the lack of clarity from the perspectives of efficacy and ethics. As is common in such cases, Dr. Diallo will likely to continue the discourse and debate with his peers, with the family of Mr. Robinson, and with the patient himself.

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Further Reading

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