Clinical Considerations When Developing Substance Use Legislation

(*Feedback from Pennsylvania Psychiatric Society's Executive Committee, Clinical Committee and Government Relations Committee; American Psychiatric Association's Council on Addiction Psychiatry*)

SOCIETY POSITION/BACKGROUND:

The Pennsylvania Psychiatric Society (Society) has taken a position that we will oppose all proposed legislation that mandates involuntary commitment under the Mental Health Procedures Act (MHPA) for those individuals with substance use needs.

Although we remain opposed to all proposed legislation that mandates involuntary commitment under the MHPA for those individuals with substance use needs, we stand willing to assist with re-writing the bill and/or drafting a comprehensive evidenced based substance use treatment and services approach to address this public health epidemic.

We are keenly aware of the urgency/pressure to "do something" to slow down substance use misuse and diversion across the Commonwealth. We remain concerned that policy decisions are being made quickly without evidence-based practice and sound clinical research.

CONSIDERATIONS WHEN SEEKING INVOLUNTARY COMMITMENT FOR SUBSTANCE USE TREATMENT

Involuntary commitment for substance use emergencies and involuntary commitment for mental health needs must be kept separate as, unless the individual has co-occurring needs, treatment is distinctly different as are which services will be needed to assist individuals to thrive in their recovery. Amending the MHPA to include involuntary commitment for those in need of emergency substance use treatment would not only cause additional confusion/barriers to care but blurs the distinction between these two separate types of treatment modalities.

Reasons Why Substance Use and Mental Health Treatment is Distinctly Different/Suggestions

1) Treatment for substance use includes detoxification/rehab which would not be necessary for those individuals petitioned for an involuntary 302 commitment for serious mental illness.

2) Detox/rehab are not secure units. Since many overdose victims present in emergency departments where the individual is often taken there by law enforcement or as unwilling participants for treatment, the lack of secure units is of utmost concern.

3) The length of stay/duration of treatment for those with substance use needs (especially within an inpatient setting) often varies greatly from those involuntary committed solely for mental health needs. The array of services needed after a mental health involuntary commitment varies greatly from what would be vital to ensure recovery from misuse, abuse or diversion from a controlled substance or illegal substance(s). We can provide additional clinical resources upon request.

4) Current funding streams separate mental health and substance use treatment and services. The current mental health system is underfunded and lacks enough resources to be fully effective without adding an additional burden for involuntary commitment for those individuals presenting at emergency departments with substance use needs. Psychiatric hospital units capable of caring for civilly committed individuals are not prepared to manage an influx of individuals with substance use disorders, lacking excess capacity or programming ability to provide appropriate treatment.

5) Current licensure standards acknowledge the difference in treatment and service needs and require separate licenses for treating mental health and substance use needs. We suggest that those facilities with both licenses (considered dual programs) could be authorized to take either or both kinds of commitments.

Concluding Thoughts:

Experience/research shows that involuntary commitment for those individuals who overdose on controlled substances does not necessarily facilitate treatment and will overtax the already overburdened system.

This is a complicated issue with no simple solution, with a risk of overwhelming demands on resources without clear gain. Bottom line is that forcing someone into 72 hours of "treatment" is unlikely to change course of addiction for many, while the ability to provide meaningful interventions for those who are open to such is a much more realistic approach.

The idea that involuntary treatment for substance use has any value at all comes from a small literature related to treatment in lieu of incarceration, a totally different scenario. It is very difficult to treat addiction with a willing person; to treat with an unwilling person is likely impossible (unless the threat of jail looms). In such cases as these, we are mindful of the question "whom are we treating?" If the person overdosing, even repeatedly, is not interested in stopping his drug use, is there really anything which we can do, aside from intervening for a few days with the intention of effecting real change under limiting circumstances? We are not necessarily opposed to such efforts, since families are often desperate, but there will be an incredible cost which is not likely to be made up by new money or facilities.

Although we remain opposed to all proposed legislation that mandates involuntary commitment under the MHPA for those individuals with substance use needs, we stand willing to assist with re-writing the bill and/or drafting a comprehensive evidenced based substance use treatment and services approach to address this public health epidemic.