

Financial Equity in Involuntary Treatment for Substance Use Disorders

Jacob M. Appel, MD, JD, MPH, HEC-C

Involuntary civil commitment for individuals who are chronically impaired as a result of their substance use remains highly controversial. At present, 37 states have legalized this practice. Increasingly, states are allowing private third-parties, such as friends or relatives of the patient, to petition courts for involuntary treatment. One such approach, modeled on Florida's Marchman Act, does not determine status based on the petitioning party's willingness to commit to pay for care. In contrast, Kentucky's approach, widely known as "Casey's Law," predicates such involuntary commitment on the third party's willingness to commit in advance to pay for the patient's treatment. This article reviews the history and current status of existing law on this subject and then argues that psychiatrists should advocate strongly against involuntary substance treatment laws that rely upon third-party pledges of payment.

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Substance use disorders are a significant cause of both morbidity and mortality in the United States with deaths from drug overdoses exceeding 100,000 per year for the first time in 2021.^{1,2} These disorders have long been known to affect both the physical health and psychological wellbeing of individuals.³ Increasingly, evidence has also shown their devastating impact upon the relatives of those afflicted.⁴ Not surprisingly, family members of individuals living with alcohol and drug dependence often want them to obtain treatment, and if they will not seek treatment voluntarily, may push for involuntary interventions. Thirty-seven states and the District of Columbia allow for such involuntary treatment under some circumstances, while thirteen do not (see Table 1). Whether such forcible treatment laws are effective remains unclear and the attitudes of experts vary considerably.⁵

As Jain *et al.* note, "commitment may achieve the immediate goal of preventing an overdose or related danger, but whether it leads to sustained recognition of treatment needs by the affected person, engagement in care, and improved decision-making remains to be demonstrated" (Ref. 6, p 375). The debate over the merits of involuntary treatment laws has been discussed extensively elsewhere and is beyond the scope of this article.⁷ Yet, whether or not involuntary treatment for substance use disorders is effective, principles of justice and equity demand that the law treat both financially empowered and indigent patients and families similarly. Increasingly, with regard to involuntary substance use treatment, that is not the case. Rather than having financial status merely reflected in the quality of care offered, itself an ethical shortcoming replicated in many aspects of the health care system, legislatures are considering, and in several cases have enacted, statutes that predicate involuntary commitment upon the ability and willingness of family members to pay for the care of their substance-dependent loved ones.^{8–10} The National Judicial Opioid Task Force has also suggested that courts consider whether they "may or should direct others (e.g., family member petitioners) to pay for the costs of the commitment and of treatment" (Ref. 11, p 11).

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Dr. Appel is Associate Professor of Psychiatry and Medical Education, Director of Ethics Education in Psychiatry, Assistant Director, Academy for Medicine & the Humanities, Icahn School of Medicine at Mount Sinai, New York, NY. Address correspondence to: Jacob M. Appel, MD, JD, MPH, HEC-C. E-mail: jacobmappel@gmail.com, jacob.appel@mssm.edu.

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Table 1 State Statutes on Involuntary Substance Use Treatment

State	Involuntary treatment	Third-party pays	Criteria
			In addition to meeting the criteria for involuntary civil commitment, the patient must also meet the conditions listed:
Alabama	No	—	None
Alaska	Yes ⁶⁷	Maybe ⁶⁸	"Incapacitated by alcohol or drugs" ⁷⁰
Arizona	No	—	None
Arkansas	Yes ⁶⁹	No	"Addicted to alcohol or other drugs" ⁶⁹
California	Yes ⁷⁰	No	"Impairment by chronic alcoholism or the use of narcotics or restricted dangerous drugs" ⁷¹
Colorado	Yes ^{72,73}	No	"Substance use disorder" and "that the person has threatened or attempted to inflict or inflicted physical harm on himself or herself or on another and that unless committed the person is likely to inflict physical harm on himself or herself or on another or that the person is incapacitated by drugs." ⁷³
Connecticut	Yes ⁷⁴	Some ⁷⁴	Alcohol dependency or drug dependency ⁷⁴
Delaware	Yes ⁷⁵	No	"Those who abuse substances such as alcohol, drugs or inhalants" ⁷⁵
D. C.	Yes ^{76,77}	No	"Drug user" ⁷⁷
Florida	Yes ("Marchman Act") ⁷⁸	No	"Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that he or she is incapable of appreciating his or her need for such services" ⁷⁸
Georgia	Yes ⁷⁹	No	"Alcoholic, drug dependent individual, or drug abuser" ⁷⁹
Hawaii	Yes ⁸⁰	Maybe ⁸⁰	"Conduct of the respondent that indicates substance abuse or addiction" ⁸⁰
Idaho	No	—	None
Illinois	No	—	None
Indiana	Yes ⁸¹	No	"An alcoholic" or "incapacitated by alcohol" or "a drug abuser" ⁸²
Iowa	Yes ⁸³	No	"Substance-related disorder" defined as "diagnosable substance abuse disorder of sufficient duration to meet diagnostic criteria specified within the most current diagnostic and statistical manual of mental disorders published by the American Psychiatric Association that results in a functional impairment" ⁸³
Kansas	Yes ⁸⁴	No	"Person with an alcohol or substance abuse problem" ⁸⁴
Kentucky	Yes ("Casey's Law") ⁸⁵	Yes (85)	"Individual suffering from alcohol and other drug abuse" ⁸⁵
Louisiana	Yes ⁸⁶	No	"Person suffering from a substance-related or addictive disorder" ⁸⁶
Maine	Yes ⁸⁷	No	"Persons suffering effects from the use of drugs, narcotics, hallucinogens or intoxicants, including alcohol" ⁸⁷
Maryland	No	—	None
Massachusetts	Yes ("section 35") ⁸⁸	Maybe ⁸⁹	"Alcohol use disorder" and/or "Substance use disorder" ⁸⁹
Michigan	Yes ⁹⁰	Fee ⁹¹	"A substance use disorder as verified by a health professional" ⁹¹
Minnesota	Yes ⁹²	No	"Chemically dependent person" defined as any person "determined as being incapable of self-management or management of personal affairs by reason of the habitual and excessive use of alcohol, drugs, or other mind-altering substances" ⁹³
Mississippi	Yes ⁹⁴	No	"Periodic, constant or frequent use of alcoholic beverages or habit-forming drugs" ⁹⁴
Missouri	Yes ⁹⁵	No	"Alcohol or drug abuse, or both" ⁹⁵
Montana	No	—	None
Nebraska	Yes ⁹⁶	No	"Substance dependence" ⁹⁶
Nevada	No	—	None
New Hampshire	No	—	None
New Jersey	No	—	None
New Mexico	No	—	None
New York	No	—	None
North Carolina	Yes ⁹⁷	No	"Substance abuser" ⁹⁷

Continued

Table 1 Continued

State	Involuntary treatment	Third-party pays	Criteria
North Dakota	Yes ⁹⁸	No	"Substance use disorder" ⁹⁸
Ohio	Yes ⁹⁹	Yes ¹⁰⁰	"Suffering from alcohol and other drug abuse" ⁹⁹
Oklahoma	Yes ¹⁰⁰	No	"Drug or alcohol dependency" ¹⁰⁰
Oregon	No	—	None
Pennsylvania	Yes ¹⁰¹	No	"Drug dependent person" defined as "a person who is using a drug, controlled substance or alcohol, and who is in a state of psychic or physical dependence, or both, arising from administration of that drug, controlled substance or alcohol on a continuing basis. Such dependence is characterized by behavioral and other responses which include a strong compulsion to take the drug, controlled substance or alcohol on a continuous basis in order to experience its psychic effects, or to avoid the discomfort of its absence. This definition shall include those persons commonly known as 'drug addicts.'" ¹⁰²
Rhode Island	Yes ¹⁰³	No	"An alcoholic who habitually lacks self-control as to the use of alcoholic beverages" (alcohol only) ¹⁰³
South Carolina	Yes ¹⁰⁴	No	"Chemical dependency" defined as "a chronic disorder manifested by repeated use of alcohol or other drugs to an extent that it interferes with a person's health, social, or economic functioning; some degree of habituation, dependence, or addiction may be implied" ¹⁰⁴
South Dakota	Yes ¹⁰⁵	No	"Abusing alcohol or drugs" ¹⁰⁵
Tennessee	Yes ¹⁰⁶	No	"Alcohol dependence" or "drug dependence" ¹⁰⁷
Texas	Yes ¹⁰⁸	No	"Chemical dependency" defined as "(a) the abuse of alcohol or a controlled substance; (b) psychological or physical dependence on alcohol or a controlled substance; or (c) addiction to alcohol or a controlled substance." ¹⁰⁸
Utah	Yes ¹⁰⁹	Yes ¹⁰⁹	"Sufferer of a substance use disorder" ¹⁰⁹
Vermont	Yes ¹¹⁰	No	"Drug addict" (alcohol possibly excluded) ¹¹⁰
Virginia	Yes ¹¹¹	No	"Substance abuse" ¹¹¹
Washington	Yes ("Ricky's Law"; "Joel's Law") ¹¹²	No	"Chemical dependency disorders" ¹¹³
West Virginia	Yes ¹¹⁴	No	"Substance abuse" ¹¹⁴
Wisconsin	Yes ¹¹⁵	No	"Drug dependent" ¹¹⁵
Wyoming	No	—	None

This article reviews the history and current status of existing law on this subject. Then it examines the ethics concerns raised by involuntary substance treatment laws that depend upon financial resources, and argues that psychiatrists, both individually and through their organizations, should advocate strongly against them.

Background

The practice of involuntary commitment related to substance use in the United States dates back to the second half of the 19th century. Following the establishment of the New York State Inebriate Asylum at Binghamton in 1864, that state's judges were empowered to involuntarily commit "inebriates" for compulsory medical care, but this well-known example proved the exception.¹² Only 14

states managed to pass involuntary treatment laws for substance users prior to 1900.¹³ By contrast, voluntary treatments thrived, leading to a two-tiered system of care. In 1883, "94 percent of all patients treated in American inebriate asylums were treated voluntarily," but "treatments such as these were reserved for people who could afford them" (Ref. 13, pp 55–56). Involuntary commitment laws ultimately "faded from use with closure of inebriety asylums in the wake of prohibition of alcohol and criminalization of narcotics" (Ref. 12, p 41), and forcible treatment for substance use disorders did not become a widespread option again until the 1960s. Too often, the so-called "paddy wagon" and the county jail became the involuntary methods of detaining individuals without substantial resources experiencing alcoholism and substance use disorders.¹⁴

The U.S. Supreme Court ruling in *Robinson v. California* (1962) has been linked to the decision of states to revisit rules regarding the compulsory treatment for substance use disorders.^{15,16} In that case, the defendant was convicted of a misdemeanor for violating a state statute that rendered it illegal “either to use narcotics, or to be addicted to the use of narcotics” (Ref. 17, p 662). The key finding here was that the status of being a substance user could not result in criminal sanction. In contrast, the Supreme Court ruled six years later in *Powell v. Texas* (1968)¹⁸ that the act of being publicly intoxicated could result in criminal charges. In striking down the law in question in *Robinson* as unconstitutional, Justice Potter Stewart offered *dicta* proposing alternative state regulations that would pass Constitutional muster, among these that “a [s]tate might establish a program of compulsory treatment for those addicted to narcotics . . . [that] might require periods of involuntary confinement” (Ref. 17, p 665). Such programs were consistent with then recent recommendations of a joint panel of the American Medical Association and the American Bar Association,¹⁹ and with a 1957 report of the Council on Mental Health,²⁰ which counseled that “civil involuntary commitment for addicts without criminal backgrounds be encouraged” (Ref. 16, p 11). Such involuntary commitment was possible under California’s Civil Addict Program (1961)²¹ and New York’s State Civil Commitment Program (1966),²² but both organizations were largely dismantled in the 1970s.²³ By 1966, half of the states had enacted some form of civil commitment for substance users, but many of these statutes offered diversion and treatment only to individuals criminally charged for other offenses.¹⁶ The first legislative entrance into this arena at the federal level, the short-lived Narcotic Addict Rehabilitation Act,²⁴ proved similarly constrained.²⁵ When involuntary civil commitment did occur, it was often imposed at the behest of public authorities upon individuals with limited social capital.

A different framework for involuntary civil commitment emerged in Florida as a result of the Hal S. Marchman Alcohol and Other Drug Services Act of 1993.^{26,27} The legislation, initially proposed by Republican Representative Stephen R. Wise, combined state laws regarding alcohol misuse and the use of other illicit substances, and, in a break with prior practice, established a streamlined procedure for third parties to petition the courts for involuntary commitment. Those third parties who were permitted to apply for the civil commitment of adults were defined

broadly to include a “spouse or legal guardian, any relative, a service provider, or an adult who has direct personal knowledge of the respondent’s substance abuse impairment and his or her prior course of assessment and treatment.”²⁸ The law was named after Rev. Hal Strickland Marchman (1919–2009), a minister from Daytona Beach who had spent his retirement advocating for the welfare of individuals addicted to alcohol and drugs. The Marchman Act was modeled, in part, on the Florida Mental Health Act of 1971,²⁹ better known as the “Baker Act,” which permitted involuntary civil commitment of individuals with mental illness. Although other states had permitted third-party applications in the past that provided for such petitions (e.g., New York had enacted a statute in 1914, and repealed it in 1921), the Florida law established a modern precedent.³⁰ The Marchman Act did not significantly distinguish on its face between wealthy and indigent patients, nor did it impose any pecuniary burden upon the petitioners, except in the rare cases where such petitioners were already financially responsible for the economic wellbeing of the patient.

A decade later, Kentucky adopted a fundamentally different approach to petitioning for involuntary commitment for individuals with substance use disorder. In April 2004, that state enacted the Matthew Casey Wethington Act for Substance Abuse Intervention.³⁰ The law, named after a 23-year-old man who died from a heroin overdose on August 19, 2002, was the product of intense lobbying by his parents, Jim and Charlotte Smoot Wethington.³⁰ Similar to Florida’s Marchman Act, Kentucky’s “Casey’s Law” allowed for petitions to “be filed by a spouse, relative, friend, or guardian of the individual” (Ref. 31, Sec. 222.432). Yet in contrast to the Florida statute, Kentucky’s law also required that the petition “be accompanied by a guarantee, signed by the petitioner or other person . . . obligating that person to pay all costs for treatment of the respondent for alcohol and other drug abuse that is ordered by the court” (Ref. 31, Sec. 222.432). While “free long-term inpatient recovery centers” do exist in Kentucky, cost is reportedly “the single biggest inhibitor scaring loved ones of addicts from filing.”³² In practice, one’s legal right to care or right to refuse care (depending on one’s perspective) is dictated, in part, by the economic circumstances (and the financial generosity) of one’s friends or family members. That approach to a significant social or medical problem, favoring the well-off *de jure*, appears to be unique in

American law. Ohio enacted its own version of Casey's law³³ in 2012, and advocates have pushed for such laws in a range of other states including Georgia,³⁴ West Virginia,³⁴ and New York.³⁵

Classification of Laws

At present, 37 states and the District of Columbia offer some form of involuntary commitment for substance use disorders. In contrast, 13 states do not allow for such involuntary commitment based upon the dangerousness of substance use alone (see Table 1). It should be noted that the standard of impairment required for involuntary commitment may vary significantly between jurisdictions. Multiple efforts have been made to catalogue these state laws regarding such variables as frequency of use³² and level of disability required for commitment.³⁶ In fact, both the Marchman Act and Casey's Law have many common features that render them more similar to each other than the rules in many other states, especially the ease with which third-parties can file petitions. Where they differ substantially is in their financial underpinnings. To date, no effort seems to have been made in the literature to classify such statutes based upon financial obligations, although this feature of the laws likely has a substantial impact upon their use.³⁷ This omission is unfortunate, as such classification not only serves to raise ethics concerns, but also might stimulate further research comparing such programs between states that have adopted different payment regimes.

As it turns out, states have adopted one of five different approaches to involuntary civil substance use commitment. The first group of 13 states have not yet adopted such legislation at all or, like New York, have previously adopted and since repealed involuntary commitment for substance users. A second group of 29 states and the District of Columbia have statutes that provide involuntary civil commitment at no cost to the petitioning parties; these include both Florida's Marchman Act²⁶ and Washington State's well-known "Ricky's Law" (2018),³⁸ named after suicide survivor Ricky Garcia, who has championed this approach. That is not to say that patients do not face financial burdens as a result of involuntary care in these states, but rather that the costs fall only upon the patient and not upon the petitioning party. This mirrors approaches to involuntary civil commitment for psychiatric illnesses more generally, where the patient may be expected to pay after

hospitalization, but where friend and family are generally not expected to commit to payment or to offer a deposit in advance.³⁹ As with involuntary civil commitment for other psychiatric illnesses, third-party payors such as insurers often do cover a portion or all of the patients' charges under such circumstances.

Among the remaining eight states, one jurisdiction, Michigan, statutorily imposes a filing fee upon third parties. (Of note, other jurisdictions that do not charge filing fees may nevertheless require minor charges for sheriffs or process servers, but these *de minimus* costs are excluded from this analysis.) Four states (Alaska, Connecticut, Massachusetts, and Hawaii) may impose costs upon third party petitioners under some circumstances but appear to afford significant judicial discretion and to waive costs for indigent third parties. To what degree, if ever, costs are recovered in these states remains unclear. What should be emphasized is that third-party ability to pay in these jurisdictions remains entirely independent of the judicial decision regarding civil commitment. Finally, three states (Utah, Ohio, and Kentucky) not only impose costs upon third-party petitioners but require a pledge of financial commitment to pay as a prerequisite for honoring the petition. Activists, including family members of individuals who have died from the effects of substance use disorders, are now making considerable efforts to convince additional legislatures to adopt statutes similar to these three laws in other states, suggesting that Casey's Law may be a harbinger for the spread of financial barriers more broadly.^{34,35}

Jurisdictions that have adopted statutes like Casey's Law often do offer many patients free or low-cost care options for involuntary substance use care. For instance, Recovery Kentucky has established 14 sites for free treatment that serve up to 2,000 state residents each year.⁴⁰ The program is jointly funded by the state's Department for Local Government, the Department of Corrections, and the Kentucky Housing Corporation.⁴⁰ In Rowan County, Kentucky, the county attorney's office was able to obtain a grant from an addiction resource nonprofit, PATHWAYS, that enabled them to cover the costs of Casey's Law applications, which can reach \$500 and that the assistant county attorney reported are "too expensive for many" families to afford.⁴¹ Other substance users who seek care may have their care covered by private insurance, Medicaid⁴² or Medicare, depending on their eligibility. The Kentucky legislature has considered modifications to Casey's Law that would limit the obligation of petitioners to pay for

treatments “not covered by a third-party payor” and prevent requiring deposits or charging for services available at no cost but has not yet adopted them.⁴³ In the absence of such changes, family members of patients covered by third-party payors such as Medicaid might still be responsible for the entire cost of care.^{8,44} Families may also need to pay for expert witnesses and legal counsel for patients objecting to treatment.⁴⁴ Similarly, fear of costs played a large role in deterring family members from petitioning for care in Ohio.⁸ Notably, during the first three years after Ohio enacted a statute modeled on Kentucky’s Casey’s Law,³³ only seven of 81 probate judges in the state reported such petitions (although far more had inquired about them), a phenomenon that experts attributed to the economic burdens imposed by such petitions.⁴⁴

Equity and Ethics

Statutes that impose financial pledges upon petitioners are an outlier in American law and American health care. Disparities in social and economic capital affect access to a wide range of essential goods and services, including medical treatment and psychiatric care. In addition, sometimes an individual’s legal status stems from that person’s financial status. For example, whether or not one can afford bail, or whether one’s relatives can pay on one’s behalf, may determine whether a detainee is subject to pretrial incarceration.⁴⁵ Laws that tie legal status to economic condition, common in the United States until the mid-20th century, have increasingly been challenged by both the public and by the judiciary. For instance, vagrancy statutes in a number of jurisdictions have been overturned by the courts^{46–50} since the unanimous Supreme Court decision striking down a Florida ordinance for vagueness in *Papachristou v. Jacksonville* in 1972.^{51,52} Although many individuals accused of crimes remain jailed because they cannot afford bail, several large jurisdictions, including New York State⁵³ and California,⁵⁴ have significantly curtailed cash bail. The Supreme Court has also ruled that convicted offenders cannot be incarcerated solely because they cannot afford to pay fines^{55–57} and that “in criminal trials, a [s]tate can no more discriminate on account of poverty than on account of religion, race, or color” (Ref. 58, p. 17). Similarly, opportunities for civil engagement, historically tied to economic status, have increasingly been opened to all regardless of their finances. For instance, the 24th Amendment

banned the poll tax in 1964 and has been interpreted broadly, making clear that the right to vote cannot be significantly constrained by ability or willingness to pay.^{59,60} Restrictions upon jury service based on property ownership have largely been repealed or struck down by the courts.⁵⁹ Even Florida’s decision to compel released felons to pay their fines before voting, upheld by the closely divided 11th Circuit Court of Appeals, stands out as an exception to the general trend.⁶¹ In short, statutes like Casey’s Law reflect an approach to legal status that has increasingly been challenged in other areas of American law and that stands out as different from *de facto* disparities in health care treatment. If involuntary civil commitment for substance use disorders is of individual benefit, then patients are being denied care based upon the limited economic means of their relatives. Alternatively, if involuntary civil commitment for substance use disorders is not of individual benefit, then patients are being denied autonomy based upon the wealth and largesse of their relatives. In either case, the law acts unjustly by treating similarly situated individuals differently.

Only extraordinary circumstances might justify such a radical approach. Arguably, the severity of the ongoing substance use crisis, which claimed more than 100,000 American lives between May 2020 and April 2021, is an exigent situation.² Laws that require third-party payments could be considered a first step toward mitigating this crisis, especially if the political will did not exist to cover expenditures for such treatment through public funds. To what degree one tolerates inequity to save lives, even if disproportionately wealthy ones, is in itself a challenging ethics question. Yet, the current crisis does not require society to address that question, because no evidence exists for an absence of such political will. In fact, the available real-world evidence suggests precisely the opposite. That thirty jurisdictions pay for such involuntary commitment without placing a burden upon third parties indicates that such an approach might also prove politically palatable in Utah, Ohio, and Kentucky. At a minimum, advocates should demonstrate that efforts to adopt a Marchman-like financially neutral system have failed before pursuing an approach that burdens third parties. Yet, even should such efforts fail, placing a financial burden upon third-party petitioners proves hard to justify. All considered, this may be a situation where something is not better than nothing.

The direct consequence of requiring third-party petitioners to pledge to cover financial costs is that such requirements may deter potential petitioners from action. This deterrence may have an increased impact as the proximity of the relationship to the addicted individual decreases. Few potential petitioners may be willing to risk bankruptcy for a distant relative or friend. Of course, such dissuasion could, in theory, serve the purpose of discouraging less invested parties from acting, increasing the likelihood that petitioners are informed and valid. Yet, such a blunt tool for deterring ill-informed petitions seems injudicious, especially so when its consequences disproportionately burden the indigent. Undoubtedly, the financial barrier will exacerbate existing inequities in access to substance use care, recreating the two-tiered system of the nineteenth century. Free care options may mitigate this impact to some degree, but the very act of signing such a pledge in advance may deter many third-parties of lesser means from committing themselves to payment, thereby depriving their loved ones of needed care.

The second danger of such an approach is that it perpetuates and aggravates perceptions of inequity in the health care and substance use treatment systems. Many aspects of our health care system (from solid organ allocation to involuntary civil commitment) are predicated upon widespread public support. This support is certainly essential if the general public is expected to sustain treatment for substance use disorders. The perception that the law applies differently to those with and without means risks undermining public approval not only for civil commitment for substance use disorders, but for treatment for substance use disorders more generally. Furthermore, such legal disparities have a broader optical impact in that they risk branding some substance users as second-rate citizens. As a result, both supporters and opponents of civil commitment for substance use disorders should be concerned by these disparities. In light of the already existing economic, racial, and cultural biases that have historically led to the mistreatment of individuals dependent upon alcohol and drugs, avoiding even the appearance of injustice or discrimination seems essential for the long-term welfare and public embrace of treatment programs.

Even in many states that do not charge third-parties to petition, nonindigent patients are themselves often still charged for their care. Such is the case, for instance, in Florida. Moreover, while one can, in theory, file a petition without legal counsel,

many petitioners choose to hire attorneys at an estimated cost of \$7,500 to 9,500.⁶² Doing so arguably increases the likelihood of a petitioner's success. Commitment in private facilities, while often an option, is also a significant expense and generally only available to those with insurance or personal funds. To some degree, the practical economic consequences of commitment in states that do not require third-party pledges may still prove a deterrent in many cases, such as when spouse-petitioners will have their own resources depleted as a result of holding joint assets. In the long term, efforts should be made to ensure that, if involuntary care is an option, it be offered at low cost or free to anyone in need, so as to guarantee access and encourage appropriate petitions. Until that day comes, however, preventing a *de jure* system of economic segregation in involuntary substance use treatment is essential for ethical care.

That is not to say that those who advocate for statutes modeled upon Casey's Law do not offer a rationale for their approach. One significant argument in favor of such legislation is that substance use treatments must be funded from some source, either public or private, and state legislatures, reflecting the sentiments of taxpayers who elect them, may not have the political will to spend state funds on such programs. The continued stigmatization of substance use disorders may make generating public support for such funding difficult. In the absence of such support, private funding by families may be considered by some a first step that can help some, even if only a few wealthier, substance users.⁸ This rationale was noted by the sponsor of Ohio's statute, State Senator Bill Seitz, who explained that the advance deposit was "integral to getting the bill passed" and who "reasoned it was better to have some relief than none."⁸ Yet, this limited benefit for the few must be weighed against both the symbolic and practical consequences of an inequitable system. Evidence suggests that the requirement for family members to pay results in a very small number of such petitions.⁴³ Whatever benefit accrues to this small number of well-off beneficiaries does not justify the damage that results from policies that further structural inequities in the American behavioral health system.

Psychiatrists have an essential role to play in shaping the law in this area. Both forensic and addiction specialists, with expertise in the areas of civil commitment and substance use, respectively, have an ethics duty to press for laws that are equitable and just. Such an

obligation has been recognized by multiple professional organizations, including the World Psychiatric Association in its Code of Ethics for Psychiatry, which requires psychiatrist to pursue “equity in the prevention, treatment and diagnosis of psychiatric disorders” (Ref. 63, p 2), and the American Psychiatric Association in its “Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health.”⁶⁴ In a recent editorial in *The Journal*, Chaimowitz and Simpson noted that forensic psychiatrists have the power to “raise [their] voices and demand improved care for the marginalized” (Ref. 65, p 160). Challenging policies that treat patients differently based upon their relatives’ abilities to pay is consistent with these goals. Historically, physicians have often proved to be trusted authorities who have played a role in influencing legislation related to their professional domains.⁶⁶ Psychiatrists are uniquely situated to advocate in this area as they have the professional expertise to convey to policymakers the medical consequences of health care inequities and to do so with authority and gravitas.

Psychiatrists who object to financially biased rules might wish to disengage themselves from the process entirely, but doing so would prove fraught on ethics grounds as it would come at the expense of individual patients in need who can afford the care. In essence, opting out of the process, however biased, would unjustly harm patients with means to mount resistance to unjust policies. That approach appears both radical and ill-advised. In contrast, psychiatrists involved in formulating policy in this area, or advising legislatures, should make clear to lawmakers that *de jure* discrimination in this area is unethical. This is a distinct matter from involuntary treatment for substance use disorders, for which clear evidence for efficacy remains unavailable and upon which persons of good will, including physicians, may disagree. When states offer the option of involuntary commitment to third parties, psychiatrists should adopt a consensus understanding that such an approach should treat wealthy and indigent petitioners identically under the law.

Conclusions

Jurisdictions that have adopted statutes like Casey’s Law have, to their credit, made considerable efforts to expand access to free care.³² While those efforts deserve commendation, *de facto* access is not a

substitute for eliminating *de jure* discrimination. Moreover, there is no guarantee that if other states were to adopt similar statutes, they would also strive to ensure access to care. Commitment rules that depend either on the ability or willingness of petitioning family members to pay for their loved ones’ care are deeply troubling. By drawing attention to this concern, which has received minimal attention in the literature, the hope is that this article will increase awareness among psychiatrists as they are asked for guidance regarding legislation in this field.

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