Experiences of Court Clinicians Who Perform Civil Commitment Evaluations for Substance Use Disorders

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Civil commitment for substance use disorders is an increasingly used intervention to mitigate the risks associated with severe substance use. Although court clinicians play a vital role in helping courts determine whether respondents meet statutory requirements for commitment, little is known about their experiences conducting these evaluations. In this pilot study, we surveyed all court clinicians who perform evaluations for civil commitment for substance use disorders in Massachusetts, a state with one of the highest rates of such commitments nationally. Court clinicians reported that these evaluations are most frequently ordered for individuals who use heroin and other opioids, alcohol, and cannabis. They reported a recent suicide attempt or drug overdose, intentional physical harm to another, use of dangerous weapon, and driving while intoxicated as the behaviors most likely to satisfy the statutory requirement of imminent risk. At the same time, many court clinicians consider a much broader range of behaviors as constituting imminent risk, and many reported having endorsed commitment on one or more occasions in the absence of statutory criteria being satisfied. These findings underscore the need for additional research on the performance of civil commitment evaluations for substance use disorder and standards for such evaluations.

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From 2013 to 2017, deaths from overdoses involving opioids rose by 90 percent, with an increasing portion attributed to fentanyl and fentanyl analogs, and a majority involving concurrent use of benzodiazepines, cocaine, or methamphetamine.[1,2] Meanwhile, a majority (> 85%) of the 17 million Americans with a substance use disorder fail to recognize the need for specialized treatment.[3] Such low recognition of treatment need in the context of an epidemic of drug overdoses has increasingly prompted policymakers to consider civil commitment for substance use disorders.[4] Civil commitment laws give judges the authority to order individuals to receive treatment when their substance use poses a high likelihood of serious harm to themselves or others. Civil commitment for substance use is legally and procedurally distinct from emergency hospitalizations (which do not generally require court authorization) and court-mandated substance abuse treatment that is ordered in the context of adjudicating criminal charges (e.g., drug courts). As of 2018, 38 states allow for substance-related civil commitment,[5] with wide variability between states in their frequency of applying their statutory guidelines.[6]

In Massachusetts, petitions for substance-related civil commitment have nearly doubled since 2010, with nearly 11,000 petitioned in 2018.[7] In Massachusetts, as in other states, when a court receives a valid petition for civil commitment of a person because of substance use, a judge orders the

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individual to undergo an evaluation conducted by a court clinician with expertise in substance use disorders.[8] In Massachusetts, civil commitment for substance use (also referred to as Section 35) is initiated when a qualified petitioner (e.g., a family member, health care professional, or police officer) requests that a court rule on whether a respondent (the individual for whom the evaluation is being requested) has an alcohol or substance use disorder and whether that disorder is likely to result in serious harm to self or others. If a judge determines that both criteria are met, the respondent can then be committed for up to 90 days to a designated facility. In practice, the length of commitment is generally much shorter than this maximum period and is determined by the individual's treatment needs. Court clinicians assist the court in determining whether a person has a substance use disorder and if the disorder has resulted in a likelihood of serious harm. Court clinicians operate in every district court in the state eligible to consider a commitment petition. They provide expert testimony during commitment hearings and submit written reports for the court record. In other words, they play a central, indispensable role in helping the court fulfill its societal and legal mandate to arrive at valid decisions regarding need for civil commitment for substance use disorders.

Little is known about how court clinicians conduct evaluations and make determinations about the need for civil commitment. Because civil commitment statutes are vague in specifying what constitutes "serious harm" in the context of substance use disorder and when the risk of such harm is sufficiently high to justify commitment,[6] court clinicians potentially have broad latitude when interpreting statutory language. Given their psycho-legal training and experience, these clinicians may have developed a relatively narrow and consistent set of risks that tend to support commitment; conversely there may be considerable heterogeneity across clinicians when performing such assessments. Given the controversy surrounding the merits of civil commitment for substance use disorder,[9,10] the empirical uncertainty regarding its outcomes,[11] and the potential for procedural injustices described by some individuals subject to substance use-related commitment,[12] a better understanding of how court clinicians arrive at formal commitment opinions seems warranted. This study seeks to address that gap by examining pilot data, which is necessary as a steppingstone to examine decision-making systematically in evaluations of civil commitment for substance use disorders.

Methods

We invited all court clinicians from Massachusetts to participate in a pilot study using a brief, anonymous, online survey about their experiences conducting civil commitment evaluations for substance use disorders.

We distributed the survey to 175 court clinicians using a private email distribution list through the state agency for which they worked. The online survey was administered through Research Electronic Data Capture (REDCap) software. Participants received an initial email invitation and two follow-up emails. In the invitation, the court clinicians were informed that participation was voluntary, that they could skip items as they chose and discontinue at any time, that their responses were anonymous, and that the survey was estimated to take no more than 10 minutes to complete. This study was approved by the institutional review boards of the University of Massachusetts and the Massachusetts Department of Mental Health.

Survey

Respondents were asked a series of questions about their experiences conducting evaluations for civil commitment of substance use disorders, including the number of years of experience they had, the percentage of their professional time devoted to such evaluations, and the frequency of performing such evaluations (Table 1).

Respondents were asked to estimate the percentage (0–100%) of cases in which the presiding judge agreed with their recommendation regarding the need for civil commitment for substance use disorders. In addition, they were asked whether (yes/no) and, if so, how often they had recommended commitment when an individual did not technically meet the full statutory criteria. They were further invited in an open comment section to describe the circumstances that led to such cases. They were also asked to estimate, among the individuals they evaluated who were committed, the percentage (0–100%) who used various substances (Table 2).

Using a Likert scale of 1 (not at all) to 7 (extremely), respondents were asked to rate the extent to which the presence of various individual risk behaviors would create a likelihood of serious

Table 1. Respondent Characteristics

Respondent Characteristics	Response	Did Not Respond
Female	22 (78.57)	4
White	27 (81.82)	5
Profession		5
Social work	8 (28.57)	
Psychologist	20 (71.43)	
Experience performing commitment evaluations, years	10.42 ± 10.99	3
Professional time performing commitment evaluations, %	89.50 ± 16.38	5
Frequency of performing commitment evaluations, *n*		3
Past week	3.50 ± 2.35	
Past month	11.60 ± 7.81	

Data are presented as mean ± SD or *n*. *n* = 33 respondents.

Table 2. Characteristics of Civil Commitment Cases Seen by Court Clinicians

Characteristics	Response	Did Not Respond
Respondent substance use, %		
Heroin	61.18 ± 19.51	5
Fentanyl	43.76 ± 24.44	4
Other opioid(s)	22.40 ± 17.89	3
Alcohol	59.90 ± 20.94	4
Cocaine	36.25 ± 22.16	5
Stimulants	19.27 ± 14.21	7
Benzodiazepines	36.55 ± 21.91	
Cannabis	69.73 ± 28.69	7
Other	17.33 ± 13.79	
Respondent risk behaviors, %		
Imminent danger to self	5.73 ± 0.84	
Imminent danger to others	5.26 ± 0.70	
Inability to care for/protect self	4.34 ± 0.84	
Miscellaneous/unclear	4.20 ± 1.02	
Concordance between judicial decision and evaluator recommendation, %	89.66 ± 7.48	
Ever recommended commitment without full criteria met? (yes), *n*	19 (65.52)	4

Data are presented as mean ± SD or *n*. *n* = 33 respondents.

harm needed to justify civil commitment (Table 3). Respondents were instructed to consider each risk factor alone and to assume it had occurred in the last week and was causally linked to the person's substance use. The survey items used to assess risk behaviors were either drawn from the behavior section of the Alcohol Use Disorder and Associated Disabilities Interview Schedule associated with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,[13] or were developed specifically for this study.

Using a Likert scale from 1 (completely disagree) to 7 (completely agree), respondents were asked 6 items to assess their opinions about the utility and efficacy of substance-related civil commitment and their confidence and preparedness in performing evaluations (Table 4). For select comparisons, responses were collapsed into three categories: "disagree" when respondents answered with 1 (completely disagree), 2 (mostly disagree), or 3 (somewhat disagree); "neutral" when respondents answered with 4 (neither agree nor disagree); and "agree" when respondents answered with 5 (somewhat agree), 6 (mostly agree), or 7 (completely agree). Finally, respondents were asked to provide demographic information (Table 1).

Data Analysis

Quantitative data were analyzed used SPSS 25 (IBM Corp., Armonk, NY). Data on participant demographics, types of substances used by individuals who are evaluated for commitment, risk behaviors that substantiate commitment need, and opinions about civil commitment for substance use were analyzed using frequencies and means with standard deviation. Based conceptually on clinical experiences of the authors, risk behaviors were grouped into four categories: Danger to self (7 items), Danger to others (12 items), Inability to care for or protect self (11 items), and Miscellaneous (6 items). The first three categories are well-established bases for all types of civil commitment[6] and the miscellaneous category captures items that did not directly fit into the first three. A repeated measures ANOVA with Holms-Bonferroni adjustment was used to identify significant differences ($\alpha = 0.05$) in support for civil commitment across categories of risk behaviors. Pairwise *t* test comparisons were used to examine group difference between the four types of risk behaviors.

Results

Descriptive

Thirty-three respondents completed the survey (response rate of 18.8%). A majority of the respondents identified as female (79%) and white (82%). Twenty (71%) work as psychologists and 8 (29%) as social workers; 5 respondents did not indicate their profession. Respondents reported an average of 10.4 years (SD = 11) conducting civil commitment evaluations for substance use disorders, with a mean ±

Table 3. Risk Behaviors That Potentially Support Need for Civil Commitment

Risk Behaviors	Response	Did Not Respond
Danger to self		
Attempting suicide	6.60 ± 0.89	3
Overdosing on drugs (e.g., losing consciousness or collapsing)	6.37 ± 1.03	3
Using fentanyl or fentanyl analog	5.90 ± 1.40	3
Mixing different kinds of drugs	5.53 ± 1.31	3
Thinking about suicide without a specific plan	5.30 ± 1.15	3
Coming close to being struck by a vehicle while walking or biking	5.07 ± 1.41	4
Using higher amounts of drugs than before	4.50 ± 1.53	3
Danger to others		
Physically hurting another person in any way on purpose	6.27 ± 1.08	3
Using a weapon like a stick, knife, or gun in a fight	6.17 ± 1.23	3
Driving or using heavy machinery while drunk or high	6.17 ± 1.12	3
Starting a fire on purpose	5.97 ± 1.88	3
Having trouble caring for one's child because of drug or alcohol use	5.77 ± 1.31	3
Threatening to physically harm someone	5.60 ± 1.07	3
Pressuring someone to engage in sexual activity against their will	5.27 ± 1.84	3
Stealing from someone directly, like mugging or snatching a purse or wallet	4.30 ± 1.69	3
Breaking into someone else's house, building, or car	4.17 ± 1.64	3
Having a driver's license suspended or revoked for moving violations	4.00 ± 2.24	3
Thinking about hurting someone else without acting on it	3.97 ± 1.35	3
Damaging someone else's property	3.59 ± 1.18	4
Inability to care for/protect self		
Starting a fire accidentally (e.g., leaving a burning cigarette unattended)	5.73 ± 1.44	3
Being pressured by someone to engage in sexual activity against one's will	5.62 ± 1.64	4
Not keeping up with necessary medical treatment	5.33 ± 1.21	3
Being physically hurt by another person in any way	4.97 ± 1.67	3
Sharing needles with others	4.83 ± 1.55	3
Not keeping up with necessary mental health treatment	4.83 ± 1.28	4
Being malnourished	4.23 ± 1.57	3
Being threatened by someone to do something one didn't want	3.61 ± 1.64	5
Having a loved one express general worry about one's safety	2.90 ± 1.79	3
Neglecting personal hygiene (e.g., bathing, brushing teeth, clean clothes)	2.70 ± 1.71	3
Having trouble keeping one's home/apartment clean	2.27 ± 1.48	3
Miscellaneous		
Hurting or being cruel to an animal or pet on purpose	5.20 ± 1.96	3
Having sex to get money, drugs, clothes, food, transport, a place to stay, or other things	4.67 ± 1.54	3
Being threatened or losing legal custody of one's child	4.57 ± 1.87	3
Experiencing a major loss (e.g., job, housing, close relationship)	3.43 ± 1.72	3
Witnessing someone else overdose on drugs	3.30 ± 1.51	3
Engaging in minor criminal behavior (e.g., shoplifting, vandalism, trespassing)	3.10 (1.58)	3

Data are presented as mean ± SD or *n*. *n* = 33 respondents.

Table 4. Opinions Regarding Civil Commitment[a]

	Disagree	Neutral	Agree
Civil commitment is an appropriate intervention for managing substance use and its associated risks.	16.7 (5)	6.7 (2)	76.7 (23)
I would favor legislation that allowed certain health care workers to hospitalize patients involuntarily for short periods (e.g., up to 72 h) when substance use poses an imminent risk.	20.0 (6)	10.0 (3)	70.0 (21)
Civil commitment hearings provide an efficient means of intervening to address the safety risks associated with substance use.	16.7 (5)	16.7 (5)	66.7 (20)
Civil commitment for substance use does more harm than good.	73.3 (22)	20.0 (6)	6.7 (2)
I feel confident in my ability to determine when there is "a likelihood of serious harm" in the context of civil commitment evaluations for substance use.	3.3 (1)	3.3 (1)	93.3 (28)
I would like more training on what criteria are needed to justify civil commitment for substance use.	26.7 (8)	20.0 (6)	53.3 (16)

Data are presented as percentage (*n*). *n* = 30 respondents.
[a] Not answered by 3 respondents.

SD of having performed 3.5 ± 2.35 evaluations in the past week and 11.6 ± 7.81 evaluations in the past month. The substances reported as most commonly used by individuals subject to commitment evaluations were cannabis (69.7%), heroin (61.2%), and alcohol (59.9%). While cannabis was the most commonly used substance, in practice very few, if any, individuals are subject to a commitment evaluation because of cannabis use alone. Instead, cannabis is concurrently used with other substances that serve as the primary grounds for an evaluation.

Risk Behaviors

Respondents identified the presence of the following risk behaviors as most strongly supportive of civil commitment (mean ± SD): a recent suicide attempt (6.60 ± 0.89), a recent drug overdose (6.37 ± 1.03), intentional physical harm to another (6.27 ± 1.08), use of dangerous weapon in a fight (6.17 ± 1.23), and driving or using heavy machinery while drunk or high (6.17 ± 1.12). Risk behaviors with the lowest support for commitment included having a loved one express worry about one's safety (2.90 ± 1.79), neglecting personal hygiene (2.70 ± 1.71), and having trouble keeping one's home clean (2.27 ± 1.48).

A significant difference was found in support for commitment by group of risk behaviors ($\lambda = 0.025$, $F(3,22) = 28.44$, $P < .001$): Danger to self (5.73 ± 0.84), Danger to others (5.26 ± 0.70), Inability to care for/protect self (4.34 ± 0.84), and Miscellaneous (4.21 ± 1.02). Pairwise comparisons showed significantly higher support for Danger to self compared with Danger to others ($P = .047$) and for Danger to others compared with Inability to care for/protect self ($P < .001$). There was significantly higher support for all three other categories compared with Miscellaneous ($P < .001$).

Commitment Recommendations

Respondents reported a high rate (mean ± SD) of concordance (89.66 ± 7.48) between judicial decisions regarding civil commitment and their own recommendation. At the same time, more than half of respondents ($n = 19$, 57.6%) reported having recommended civil commitment at least once in the absence of meeting statutory criteria; 10 respondents (30.3%) indicated they had not, and four (12.1%) skipped this item. Among the 19 who recommended commitment in the absence of sufficient criteria, eight provided numerical estimates of the number of cases they had done so (range, 2–50), and eight provided qualitative estimates (e.g., "I don't know," a "handful," "frequent," "5%," "more than I care to say," and "many times over the years"). Thirteen respondents provided possible circumstances under which they would make such recommendations: seven had done so for individuals who had a general pattern of worsening use or myriad risks that were not necessarily imminent, six indicated doing so when the individual subject to the petition was in agreement with being committed, three stated that they had in the face of intense pressure from family members, and two reported doing so when the judge was initiating or pressing for the commitment.

Opinions About Civil Commitment

Most respondents agreed that civil commitment was the appropriate intervention for substance use and associated risks (76.7%, $n = 23$) and that commitment hearings provide an efficient means of intervening to address the safety risks associated with substance use (66.7%, $n = 20$; see Table 4). Respondents disagreed that civil commitments caused more harm than good (73.3%, $n = 22$). Overwhelmingly, respondents reported that they felt confident in their abilities to determine when there is a risk of serious harm (93.3%, $n = 28$), yet many still would like additional training on the criteria (53.3%, $n = 16$). Almost two thirds (70.0%, $n = 21$) supported legislation that would allow health care workers to involuntary hospitalize patients for brief periods when there is an imminent risk from substance use.

Discussion

This study is the first to examine court clinicians' experiences and views on performing evaluations for civil commitment for substance use disorders. Evaluations performed by clinicians in this study most commonly involve individuals who use heroin and other opioids, alcohol, and cannabis, with less frequent use of benzodiazepines, cocaine, and other substances. Substance-related behaviors that respondents found most supportive of a finding of imminent risk were a recent suicide attempt or drug overdose, intentional physical harm to another, use of a dangerous weapon, and driving while intoxicated. Overall, the strongest support for civil commitment was expressed for the category of behaviors that pose

a danger to oneself, followed closely by behaviors that pose a danger to others. Notably, behaviors classified in the inability to care for self and in the miscellaneous categories were perceived as significantly less likely to meet criteria for commitment.

These pilot data should be interpreted in the context of the following limitations. While the credibility of these findings is supported by respondents' high frequency and number of years of experience conducting commitment evaluations, the generalizability of these data are limited by a small sample size and somewhat low response rate in a single state. It may be that individuals with less experience performing civil commitment evaluations were less likely to complete the survey. Strong opinions about civil commitment for substance use may have motivated others to participate or respond in particular ways. Additionally, the organization of risk behaviors into four categories was conducted by the authors and based on literature and conceptual review. Future research with larger samples would allow for identification of statistics-driven risk groups. Our sample also consisted of psychologists and social workers, the clinicians who are most commonly employed in Massachusetts court clinics; the absence of psychiatrists in this sample further limits study generalizability. Nevertheless, because psychiatrists frequently serve in comparable evaluator roles in other states, the findings of this study may be valuable in informing their work. With these limitations in mind, this study has several potentially important findings.

The court clinicians in our study bring years of experience to their work and spend the majority of their professional time performing commitment evaluations, with high numbers of cases performed weekly and monthly. This expertise, coupled with the fact that judges almost always agree with the recommendations made by court clinicians regarding the need for civil commitment for substance use, underscores the essential role they play in this process.

Respondents seem to consider a broad range of risk behaviors as satisfying the statutory criteria that substance use needs to create an imminent risk of harm to justify civil commitment. On the one hand, the most strongly endorsed behaviors were those posing an obvious risk of harm to oneself or to others. Respondents showed considerable variability, however, in how much concern they afford behaviors that do not appear to create a clear and serious danger. For example, experiencing a major loss, engaging in minor nonviolent criminal behavior, and witnessing someone overdose on drugs each had a mean response of around 3 (consistent with mild disagreement) but a standard deviation of greater than 1.5. Thus, while court clinicians generally prioritize the most dangerous behaviors when assessing for civil commitment need, some entertain a much broader range of factors before arriving at commitment decisions. This is not altogether surprising given the lack of statutory specificity in defining imminent risk and the recognized potential influence of individual clinician bias on unstructured risk assessment across various forensic contexts.[14] Nevertheless, because judges so often agree with court clinician recommendations, this fact underscores the need for greater consensus among clinicians on what behaviors should warrant commitment. To help contextualize these findings, future work should examine the percentage of cases in which evaluators do (and do not) recommend commitment.

Perhaps more concerning is the fact that more than half of respondents have formally recommended civil commitment at least once in the absence of circumstances that satisfy statutory requirements that the person meet criteria for both a substance use disorder and an associated imminent risk. Given the sensitivity of such recommendations, this finding may underestimate how often court clinicians opine to the court in support of commitment without clear legal justification. A number of factors may contribute to these instances. One cited explanation was that the individual who would be subject to compelled treatment does not oppose commitment; presumably, these individuals agree to commitment out of recognition of treatment need and inability to get it through other channels or because it seems more palatable than the consequences of refusing care (e.g., social or family reprisals). A few clinicians reported feeling pressured by the judge or by family members who petitioned the court for commitment. Most commonly, they reported that the individual exhibited a pattern of escalating engagement in risk behaviors that did not meet imminent criteria. Under such instances, a court clinician might elect to recommend commitment because they recognize a pattern of problematic behaviors and impediments to accessing voluntary community care and want to support what they view as a clinically appropriate treatment. Further work is needed to determine the extent to which court clinicians may experience difficulty maintaining impartiality when applying legal statutes to real-world situations.

When queried about their opinions regarding civil commitment, most agreed that this is an appropriate intervention for managing substance use and its associated risks. They also generally disagreed that civil commitment does more harm than good. Nevertheless, there were detractors, with some respondents either disagreeing or responding as "neutral" to whether civil commitment was an efficient means of intervening to address addiction-related safety risks. These findings suggest that, on balance, respondents view civil commitment as an imperfect but overall beneficial public health intervention for addressing immediate dangers that attend substance use.

About two thirds of the sample expressed support for the introduction of a law that would give health care workers the authority to hospitalize involuntarily patients who present with similar risks due to substance use, as has been proposed in other states.[15] This study was conducted while such a bill was being considered by the Massachusetts state legislature; the bill was ultimately rejected. It will be important to consider how clinicians' perspectives on this topic may affect policy and whether other clinicians, who do not conduct these evaluations, hold similar beliefs.

Conclusions

Our results indicate that court clinicians who perform court-ordered evaluations for civil commitment for substance use disorders most frequently assess individuals who use heroin and other opioids, alcohol, or cannabis. These clinicians identify behaviors such as a recent suicide attempt or drug overdose, intentional physical harm to another, use of a dangerous weapon, and driving while intoxicated as evidence of imminent risk. Although clinicians overall tend to agree on the most concerning behaviors that support commitment, many consider a broader range of behaviors as constituting imminent risk, and most have endorsed commitment in the absence of statutory criteria. These findings highlight a need for better guidelines and additional research on performing court evaluations for civil commitment for substance use disorders. Future studies should ideally examine multi-state or nationwide samples of clinicians who conduct civil commitment for substance use to refine and standardize categories of serious risk to self and others, which can then be used to establish best practice standards and ways of addressing clinician training needs.

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