Court Based Civil Commitment of Alcoholics and Substance Abusers

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Problem. To study court ordered substance abuse commitment (SAC) in one jurisdiction. We investigated who was evaluated, by whom, and with what outcome. Is SAC primarily a purely civil procedure as originally intended? Are men and women being treated equally? Method: Questionnaire survey of court clinicians to determine demographic and clinical status of persons evaluated, the process of evaluation, and the disposition. Results: SAC is common and more frequent in criminal cases than in purely civil ones. SAC of women is clearly influenced by the restricted choices for disposition: either state prison or an unlocked facility. Conclusions: SAC is an important public health procedure, which courts are using in highly variable and at times unintended ways. SAC has emerged as an alternative to other dispositions in criminal cases involving substance-abusing defendants.

American society views alcoholism and substance abuse from two distinct perspectives: medical and legal. From the medical perspective alcoholism and substance abuse are diseases.[1-7] Legally, they were crimes until 1962 when the Supreme Court found it unconstitutional to prosecute a person for being an addict.[1] The Court distinguished the status of addiction from criminal conduct such as possession of narcotics. In a dictum, the majority wrote that states could require addicts to undergo compulsory treatment—thus opening the door to civil commitment statutes.[1,8]

Drug addiction and alcoholism present social problems that diabetes and hypertension do not. The idea of decriminalization—providing treatment rather than punishment for addiction—derives from the medical model, without addressing directly the antisocial consequence of addiction and alcoholism. The medical model does not anticipate the violence associated with alcoholism and the property crime associated with illegal drug use.

Civil commitment of the substance abuser often represents a hybrid of medical and legal approaches. It provides treatment, social control, and diversion from the criminal justice system.[7] Over 60 percent of states have special statutes for commitment of alcohol and/or substance-abusing persons.[8,9]

Typically, papers on SAC address either legal issues relating to involuntary

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commitment,[8–10] or they address coercive versus voluntary treatment.[11–15] No study has addressed how courts administer the statutes: who is evaluated, by whom, and with what outcome.

We found only two papers that addressed civil liberties and involuntary treatment.[7,8] This is in marked contrast to the large clinical and legal literature on civil commitment of persons with mental disorders (e.g., refs. 16–18). Given the current prosecution of pregnant substance abusers for damage to the fetus and the concern about containing the AIDS epidemic, the question of involuntary treatment takes on new urgency. In the absence of data, courts and legislatures will address these problems and create law based on their preconceptions and experience.

The purpose of our study is to provide an initial, empirical description of SAC in one jurisdiction. We report on who is being evaluated, criminal versus civil status as related to SAC, disposition, and on some apparent differences in how the Massachusetts SAC system deals with men and women.

The 1971 Massachusetts SAC law, MGL Ch. 123 s.35, originally applied only to alcoholics. The law was amended in 1987 to apply to other substance abuse as well. This is a civil procedure, not originally intended as an adjunct to criminal proceedings.

Our clinical experience suggested that, contrary to the intent of the law, the courts were using SAC as a diversion program for persons facing criminal charges. We evaluated whether this was occurring.

The state legislature authorized SAC for men at a secure civil detoxification facility. The SAC law mandated detoxification for women only at the women's state prison. This disparity in facilities for men and women persists.

The absence of a locked detoxification facility for women created a natural experiment. In a preliminary way we studied whether the absence of a secure civil detoxification facility appeared to influence the treatment of women as compared with men.

Our research represents an initial attempt to describe how SAC works in one jurisdiction. We surveyed court clinicians to obtain data on persons evaluated for possible SAC, on how clinicians made SAC assessments, on disposition, and on outcome for committed women.

Method

The Statute MGL Ch. 123 s.35 authorizes 30 days of involuntary inpatient treatment for persons who chronically or habitually use substances to the extent that their health is damaged or their social or economic functioning is significantly impaired, or who have lost the power of self-control over the use of such substances.

Any police officer, physician, spouse, blood relative, or guardian may petition a district court for a commitment order for such a person. The court then schedules a hearing and issues a summons or bench warrant, depending on the urgency of the case.

Statutory Procedure At court the person is examined by a designated mental health professional, either physician

or psychologist, who has been specially qualified for this work, and a hearing follows. The person has the right to counsel even if indigent, and the right to present independent experts and testimony. After a finding of likelihood of serious harm by reason of alcohol or substance abuse, the judge may order the person into inpatient SAC for up to 30 days. No extension is possible.

Persons with insurance are sent to locked private facilities. Men without insurance are sent to a secure state facility. There is no comparable facility for women, and they go either to state prison or to an unsecured state facility. After detoxification is complete, women may be transferred to an unsecured substance abuse facility for the remainder of the statutory 30 days.

Study Procedure All clinicians employed by the Division of Forensic Mental Health of the Massachusetts Department of Mental Health were mandated to participate. Clinicians in one of eight regions did not participate because of organizational problems.

For all SAC evaluations during February to April 1989, the clinician filled out a questionnaire on client demographics, treatment history, criminal status, the evaluation process, and clinician recommendations including for women whether the lack of a secure detoxification facility influenced the recommendation.

In addition, we asked the 20 most active clinicians to fill out a separate 37 item questionnaire assessing the importance of specific client characteristics in evaluating commitability. Fourteen of 20 clinicians returned these questionnaires (70%).

Each item was rated on a five point scale from 1, strongly opposes commitment, to 5, strongly favors commitment. Means and standard deviations were calculated for each item as rated by all 14 clinicians. Correlations between item scores for all pairs of items were computed.

Results

The Sample We obtained SAC data from 30 different courts. Table 1 describes the sample and summarizes data on the evaluation process and disposition. Clinicians evaluated 208 men (76%) and 65 women (24%), and one person for whom data on sex was missing, total 274.

Median age was 33.4 years; 77 percent of the sample was between 20 and 39 years old. Almost two-thirds of the sample were facing criminal charges, and men were significantly more likely than women to be facing criminal charges. There were approximately equal numbers of drug and alcohol SAC evaluations, but persons evaluated for drug abuse were more likely to be facing criminal charges.

The SAC Evaluation Process The legally mandated petition process was followed in only 40.8 percent of cases. Table 1 shows the clear, highly significant relationship between mandated process and criminal charges. Persons facing charges were evaluated with no formal petition in 68 percent of cases. In these cases, the judge decided based on his or her own observation of the defendant or

Table 1
Persons Evaluated for Substance Abuse Commitment According to Current Criminal Status (N = 274)[1]

	Criminal Charges		All Clients
	Pending	None	
	n (%)	n (%)	n (%)
No. of clients	174 (63.5)	77 (36.5)	251 (100)
Client Characteristics			
Sex			
Male	133 (78.7)	47 (62.7)	180[2] (73.8)
Female	36 (21.3)	28 (37.3)	64 (26.2)
Age: median years	32.8	33.4	33.4
Substance abused			
Alcohol	68 (40.2)	46 (61.3)	114[3] (46.7)
Drug	101 (59.8)	29 (38.7)	130 (53.3)
Evaluation Procedure			
Formal petition filed			
Yes	52 (32.1)	43 (60.6)	95[4] (40.8)
No	110 (67.9)	28 (39.4)	138 (59.2)
Evaluated by MD			
Yes	97 (86.6)	52 (80.0)	149[5] (84.1)
No	15 (13.4)	13 (20.0)	28 (15.9)
Person requesting evaluation			
Court personnel	110 (91.7)	5 (17.2)	115[6] (77.1)
Family or other	10 (8.3)	24 (82.7)	34 (22.9)
Disposition			
Committed	132 (76.7)	43 (58.1)	175[7] (71.1)
Other	40 (23.3)	31 (41.9)	71 (28.9)

[1] Where totals are less than 274, data are missing or unknown.
[2] $\chi^2 = 6.90$, df = 1, $p < .01$.
[3] $\chi^2 = 9.29$, df = 1, $p < .01$.
[4] $\chi^2 = 16.56$, df = 1, $p < .001$.
[5] $\chi^2 = 1.35$, df = 1, NS.
[6] $\chi^2 = 73.46$, df = 1, $p < .0001$.
[7] $\chi^2 = 8.75$, df = 1, $p < .01$.

on representations made by the defense attorney to order SAC evaluation. In a related finding, family members were involved in SAC of defendants facing criminal charges in only 10 cases (8.3%).

In contrast to the criminal cases, over 60 percent of SAC evaluations of persons not facing charges were initiated by a formal petition as the law mandates. Family members were involved in 24 cases (82.8%) of SAC for clients who were not facing criminal charges ($\chi^2 = 42.45$, df = 1, $p < .0001$).

It was not always clear from our data how civil cases were initiated absent a petition, since unlike criminal defendants, the subject was not in court. In the cases we understood, there was typically an informal prescreening process. A community physician might telephone the court or a family member might come to court, and the clinician would then initiate an informal evaluation. In some cases a negotiated disposition for voluntary substance abuse treatment was reached. In some of these cases,

there was an overhanging threat of petition and commitment.

Not all clients were evaluated by physicians, as the law at that time required. Some smaller courts had clinics staffed by an on site social worker or psychologist with a physician on call. Often these clinicians would assist the judge to dispose of substance abuse cases informally. The proportion of clients evaluated by MDs was the same for those facing criminal charges as those who were not.

Courts varied greatly in how they used SAC. In one inner city court, 100 percent of SAC evaluations involved persons facing criminal charges. In one suburban court, only 40 percent of SAC evaluations involved persons facing criminal charges. Courts that had a higher proportion of criminal SAC evaluations also had a higher proportion of drug rather than alcohol evaluations.

One court evaluated many more women than the average: 40 percent of its SAC evaluations were women. In 29 other courts, 21 percent of SAC commitments were women.

Dispositon Seventy-one percent of SAC evaluations led to commitment. Persons facing charges were significantly more likely to be committed than those who were not.

Over 81 percent of the men in the study, n = 146, were committed to the secure state SAC facility. We obtained data from that facility on how many men were committed state-wide during the three months of the study. 437 men were committed as substance abusers. Thus, our study involved 146/437 (33%) of men committed to this facility. In the same time period, 792 men were civilly committed as mentally ill to all psychiatric facilities in Massachusetts.

Disposition varied with gender. Of the 65 women evaluated, fewer than 25 percent of women were committed to a locked facility. Alternate dispositions for women reflected the reluctance of judges to send women to the state prison, which is the only locked public facility.

Thirty-four women were sent to an unlocked facility. In 18 of those 34 cases (53%), the clinician stated that he or she would have recommended disposition to a locked civil facility if any had existed.

Follow-up We obtained some follow-up data on 45 women. The 11 women sent to locked facilities completed 30 days of treatment. Of 34 women sent to unlocked facilities, 10 (32%) left against advice, usually within a few days. This figure almost certainly underestimates the problem, since 17 other women were lost to follow-up, and some of those went to unlocked facilities.

Here are two composite case vignettes illustrating the problems arising from lack of a secure detoxification facility for women.

Case 1 Ms. A was a 43-year-old separated, homeless white woman who had a history of chronic severe alcoholism dating back at least 15 years. The local police brought her to the court one winter day after finding her lying badly bruised in the gutter. She was barely able to walk.

After evaluation, the court ordered her commitment. The police trans-

ported her to an unlocked detoxification facility, and she walked out after 48 hours. She resumed her drinking, and within several weeks was hit by a car and hospitalized.

Case 2 Ms. B was a 38-year-old white, pregnant, single mother with a long history of polydrug abuse. Ms. B's father petitioned for her commitment after Ms. B, while intoxicated, assaulted her crippled mother. After evaluation, the court committed her to an unlocked facility. She left within three days and resumed drinking. Two weeks later, she was back in court on another petition. Her sister petitioned after she saw Ms. B pick up her baby while intoxicated, stagger across the room and fall, hitting the baby's head against the radiator.

The Client Characteristic Rating Scale Sixteen of 37 items had mean scores favoring commitment of 3.5 or higher, and SD 1.0 or less. These items are shown in Table 2. We computed the matrix of intercorrelations between these 16 items. Fourteen of the items correlated above .30 with at least six other items. The two that did not are "client under restraining order," and "relatives are frightened of client when intoxicated."

Table 2
Items Rated as Important for Assessing Substance Abuse Commitment

Item	Mean	SD
Seriously harmed other when drinking	4.79	0.18
Seriously harmed self when drinking	4.71	0.22
Homicidal threats when drinking	4.71	0.37
In acute withdrawal	4.58	0.27
History of binge drinking	4.57	0.42
Several recent auto accidents	4.57	0.42
Suicidal threats when drinking	4.50	0.42
Intoxicated	4.21	0.49
History of blackouts	4.00	0.18
Smells of alcohol	4.00	0.73
History of alcohol-related convictions	3.93	0.07
History of alcohol-related loss of job or relationship	3.86	0.13
Prior inpatient substance abuse treatment	3.75	0.20
Mild medical complications of addiction	3.62	0.67
Poorly groomed	3.50	0.27
Unemployed for several months	3.50	0.27

Discussion

This is an initial, limited study. We do not know why our survey included only 33 percent of men committed to the state facility during the time of the study. The one region that did not participate includes the busy Boston Municipal Court, which has a large caseload. Small courts without clinics may have committed some men using other clinicians or no clinicians. In post-study interviews, participating clinicians said that they had provided data on substantially all the evaluations done through their clinics.

This initial study illustrates that SAC is an important public health event that occurs relatively frequently. For every three men committed for mental illness during the study period, two were committed for substance abuse.

The study illustrates that courts are typically using SAC not, as originally intended, as a purely civil procedure. The vast majority of SAC evaluations occur as a somewhat informal adjunct to criminal proceedings. In these cases, the outcome of the evaluation is almost always commitment. Thus, courts appear to be using SAC as an alternative

disposition in criminal cases rather than holding defendants on bail in overcrowded jails.

Particularly in criminal cases, judges are creative in the procedures they follow. The judge often orders an evaluation without any formal petition. If there is any petition, it is after the fact. The petitioner is someone whom the judge recruits for the purpose from persons present in court, a police prosecutor or police witness. Some judges interpret "police officer" in the statute to include officers of the court, and then the judge recruits a probation officer to petition.

In some of these cases, the entire process is even more informal. The defendant waives his right to a petition and is subsequently committed without any petition ever being filed. In some courts where a social worker but not a mandated clinician was present, judges ordered SAC after a report by a social worker. In a few cases, judges ordered SAC without any petition or clinical evaluation at all.

It appears that judges and mental health professionals behave similarly. When emergency psychiatrists are asked about their application of commitment law in the emergency room, many respond that they find a legal justification to fit their clinical judgment. Similarly, judges use the SAC law as a basis to commit those individuals whom they think should be committed. Procedural niceties do not stand in their way.

Only 25 percent of the clients were women. This reflects the relationship of sex to criminal charge—90 percent of criminal defendants are men—rather than the proportion of women in the general population with serious substance abuse problems. The one court that had many evaluations of women had a clinic staffed by a woman psychiatrist who took a special interest in women substance abusers.

Fewer women than men were committed. This appears to reflect the lack of secure detoxification facilities for women, according to reports of the clinicians involved.

The facilities for men and women appear to be grossly unequal. Almost a third of the women committed to unlocked facilities on whom we had follow-up data left against advice. Involuntary commitment and treatment are almost meaningless when there is no adequate facility and the individual can walk out at will. These limited data support the policy recommendation that secure facilities are an essential element if the care system is to treat the most severe substance abusers.

Finally, our data on the client characteristic rating scale suggest that clinicians can make reliable ratings of how important specific characteristics are in evaluating SAC. The fact that 14 items are seen as strongly related to commitability, have relatively little interrater variability, and intercorrelate above .30 suggests that these items form a scale that could be used in future to assess commitability.

References

1. Robinson v. California, 370 U.S. 660, 664–665 (1962)
2. Shaffer HJ: The epistemology of "addictive

disease": the Lincoln-Douglas debate. J Subst Abuse Treat 4:103–13, 1987
3. Shaffer HJ: Conceptual crises and the addictions: A philosophy of science perspective. J Subst Abuse Treat 3:285–96, 1987
4. Brown EM: "What shall we do with the inebriate?" Asylum treatment and the disease concept of alcoholism in late nineteenth century. J Hist Behavioral Sci 21:48–59, 1985
5. Fingarette H: The perils of Powell: In search of a factual foundation for the "disease concept of alcoholism." Harvard L Rev 83:793–812, 1970
6. Note, Alcohol abuse and the law. Harvard L Rev 94:1660–712 (1981)
7. Twomey DP: The chronic alcoholic: Treatment v. punishment. Suffolk U L Rev 3:406–20, 1969
8. Rosenthal MP: The constitutionality of involuntary civil commitment of opiate addicts. J Drug Issues 18:641–61, 1988
9. Brakel SJ: Historical trends, involuntary institutionalization, in The Mentally Disabled and the Law. Edited by Brakel SJ, Parry J, Weiner BA. Chicago, American Bar Foundation, 1985
10. Brown BS: Civil commitment—An international perspective. J Drug Issues 18:663–78, 1988
11. Maddux JF: Clinical experience with civil commitment. National Institute on Drug Abuse Research Monograph 86:35–57, 1988
12. Anglin MD: The efficacy of civil commitment in treating narcotic addiction. National Institute on Drug Abuse Research Monograph 86:8–34, 1988
13. Collins James J, Allison Margaret: Legal Coercion and Retention in Drug Abuse Treatment. Hosp Community Psychiatry 34:1145–9 1983
14. Salmon RW, Salmon RJ: The role of coercion in rehabilitation of drug abusers. Int'l J Addict 18:9–21, 1983
15. Webster CD: Compulsory treatment of narcotic addiction. Int'l J Law Psychiatry 8:133–59, 1986
16. Bursztajn H, Gutheil TG, Mills M, Hamm M, Brodsky A: Process analysis of judges' commitment decisions: A preliminary empirical study. Am J Psychiatry 143:170–4, 1986
17. Lipsitt PD, Lelos D: Decision makers in law and psychiatry and the involuntary civil commitment process. Community Ment Health J 17:114–22, 1981
18. Lidz CW, Mulvey EP, Appelbaum PS, Cleveland S: Commitment: The consistency of clinicians and the use of legal standards. Am J Psychiatry 146:176–81, 1989