Involuntary Civil Commitment (ICC) ASAM Discussion

June 5th, 2020

Attendees: Dr. David Mee-Lee, Susan McKeown, Shanna Large, Sue Latham, Stephen Noyes, Emily Robbins, Monica Edgar, Stephanie Savard, Michele Merritt, Eliza Zarka, Alex Casale, Seddon Savage, Jamie Powers, Peter Burke, Paul Kiernan, and Caitlin Duffy.

1. Paul Kiernan shared background on why this meeting with Dr. Mee-Lee was requested.
    - The Governor's Commission asked members of the Treatment Task Force to look into involuntary civil commitment and what other states are doing.
    - The Task Force created a literature review, which can be found on the Center for Excellence website.
    - The Task Force invited speakers from Colorado and Washington state to share 2 comprehensive presentations on ICC in their states.
    - It was found that an addiction medicine perspective, including a medical model, was lacking from the discussion. Before making a recommendation to the Governor's Commission, the Task Force wanted to hear from an addiction medicine expert.
2. Dr. David Mee-Lee is a board-certified psychiatrist, the former editor in chief of the ASAM criteria, a physician, and an addiction specialist. He shared the addiction medicine perspective on ICC.
    - In the context of the opioid crisis and addiction in general, families and other concerned persons have a natural impulse to want to quickly intervene when a loved one is heading toward the "cliff of addiction demise".
    - States and families want to get people into recovery and will ask themselves how they can force someone to see the need for it. Dr. Mee-Lee pointed out that there is the same thought when it comes to severe mental illness, but this is not something that is done when treating severe physical health complications. Oftentimes, medical professionals will treat the symptoms but won't engage the patient in lifestyle change and the overall self-change process. According to the Centers for Disease Control and Prevention (CDC), chronic disease accounts for ~75% of the total U.S. health care costs.
    - In general health, there is more patient- and person-centered care, including collaborating treatment planning. This is rooted in the Institute of Medicine's principles of a new health care system.
    - For people to change, they need to be a part of the process. This can be achieved through the therapeutic alliance, which includes an agreement on goals and agreement on methods within the context of a safe and respectful relationship. This is not just true in psychotherapy but also across the behavior change spectrum, which includes addiction.
    - ICC has a piece to play in terms of engaging people in their treatment. However, we have to be careful with ICC that we don't think if we just commit someone to treatment, put them in residential, break through denial, and get them to recovery, that that's the way we get sustained ongoing change. There are anecdotes of people where this worked for, but many more stories of it not working for people.

- In addiction treatment, we need to follow the model of what is done for those with severe mental illness, particularly if someone is a danger to themselves or others. Beyond that, we want to make sure we engage patients in a collaborative process to ensure sustained change, for which a requirement could work performance.
- Overall, we need to be compassionate and meet patients where they're at in order to involve them in a lasting process.
- Dr. Mee-Lee is supportive of ICC, but not with the idea that we will commit patients, put them in residential for 30 days, and then think that we've achieved change. Instead, he recommends we have commitments for people who are in imminent danger, and also look at commitments for outpatient treatment. It must always be person-centered and assessment-based, so we can assess level of function and the necessary intensity of care and level of services.

3. Question and Answer session:
    - Susan McKeown: You raise interesting points about different types of morbidity and chronic illness that we don't have commitments for. I agree with your point that we don't have that built into addiction treatment at all, the follow-up care. I don't think we're there yet. How do we build in more realistic long-term treatment?
        - Dr. Mee-Lee: In mental health treatment, we don't want people to commit suicide or have psychotic delusions and hurt others. For addiction, we should do the same thing and assess imminent danger as we do for other illnesses. Imminent danger as defined in ASAM is the high likelihood people will continue their addiction, bad things happen when this person uses, and this will happen in hours or days not weeks or months. We want to keep patients engaged for months or years to prevent dropout. Even treatment providers think in terms of programs, completions, and fixed length. There is no fixed length of stay in any other illness, but there is in addiction treatment. We need to make sure we have the same flexible, continuous treatment for addiction as we do for physical and mental health. Similarly, there is a need for community resources and supportive living and employment.
    - Stephanie Savard: I'm intrigued by the concept of commitment to assessment and outpatient. Are you aware of any other states that have done this as opposed to ICC to residential?
        - Dr. Mee-Lee: I'm not familiar with this for addiction, but I see a parallel with mental health treatment which I know we do this for. It should be person-centered and meet the person where they're at.
        - Paul Kiernan: All the research I've done hasn't indicated something like this. In NH, people can be released from a hospital on conditional release.
    - Alex Casale: I'm curious if there are outcome studies. The 2 or 3 states we've interviewed didn't have an answer for if they are looking at whether people are more or less likely to relapse, overdose, or have a fatal overdose after ICC. Seemingly, these states only track their numbers, what type of people they are seeing, how long they are there, and what type of treatment/therapy they get. Why aren't these follow-up studies occurring, is it a lack of funding?

    - Dr. Mee-Lee: That's right, outcome studies are needed. For physical health, if you stabilize someone with an acute complication from asthma and diabetes, follow-up care is needed or a poor outcome could occur. Mandated and ongoing care have similar outcomes, but if there is no long-term continuing care, then those outcomes will be poor.
- Sue Latham: I've provided MAT for 26 years, mostly methadone. The majority of patients I've seen may have ended up in addiction treatment because they suffer from co-occurring or coexisting mental health conditions. They're being admitted for reasons beside the SUD. Although we don't have statistics on outcome studies, I do support NH moving forward with ICC. I think it has its place, and as long as we're following ASAM criteria, I think it can work.
- Stephen Noyes: I really like this idea of continuum of care and a wide array of services so that we can address risk that goes beyond active use. I am not sure we have that sort of social services infrastructure. Without that, are we going to be making people more treatment resistant implementing ICC? Is there any evidence for or against mandated care without those supports in place?
    - Dr. Mee-Lee: I worry about treatment resistance if we don't attract and engage patients into a recovery dropout prevention process. If the focus of the patient is getting out of the mandated care, instead of on a personal change process, it is not sustainable. Mandated program compliance is not the goal. Mandated treatment and engagement in personal change process is the goal. We do not want patients to wait for the next crisis before coming into treatment. Let's do the "no-treatment, treatment-plan" for people who don't want to be in treatment. Otherwise, we're using resources and money but not effecting change.
- Alex Casale: Family or friends file a petition for ICC, and it goes in front of a judge. Are there tools out there for the judge to make the right call? If a judge doesn't have an assessment tool for imminent danger, then it's the burden of the person filing the petition to provide proof.
    - Dr. Mee-Lee: We have precedence and models for this, specifically in drug and treatment courts. If there is suspicion of a drug-related problem, and that the SUD is causing a civil risk, then the judge refers it to a clinician to make an assessment. The petition should go to a clinician who assesses the right level of care needed, and then their recommendation goes to the judge. We don't want a judge making decisions about level of care or length of stay. The power should be with the clinicians to determine what we are mandating, and that would build on principles we know about for mandated treatment.
    - Stephanie Savard: Are you saying that a clinician would also be assessing the imminent level of danger?
    - Dr. Mee-Lee: Yes. The parallel would be someone with mental illness who is threatening to harm someone. When the police are called, they don't take the person to a judge, they take him to a mental health hospital.
- Susan McKeown: For states with mental health and substance use ICC, do they have equal numbers?

    - Paul Kiernan: The states we spoke to did not have hard numbers about the difference between ICC admissions for mental health and substance use. He can look into it, however. The model that Dr. Mee-Lee is describing doesn't exist as extensively anywhere, but NH could lead the charge.
- Shanna Large: From a treatment provider's perspective, the long-lasting treatment plan and engaging people in the treatment process seems hard to be billable and sustainable.
    - Dr. Mee-Lee: We can try to make it billable by framing it in a different way. We need to educate our treatment providers on its importance, and ask that they educate others.
- Susan McKeown: We've found success in dropout prevention through outpatient transitions into treatment groups. We've found that the more you surround patients and require them to participate in these groups, the more likely they are to engage.
    - Dr. Mee-Lee: Similar to mental health care, we need fewer residential beds and more supports in the community.
- Monica Edgar: How do we put a process together? I am visualizing imminent danger in particular. What's the criteria to meet those levels, and based on that, are we then going into what levels of care are required? There are patients where crises are the only thing that get them back into treatment.
    - Dr. Mee-Lee: We should use ASAM and apply it to imminent danger. We need to have providers ask if the patient knows their treatment plan, what they want, and if they & their family are engaged in a self-propelled continuing care plan.
- Michele Merritt: Are there national efforts for Medicaid to pay for this model? Or other opportunities for large fiscal notes? NH would not be able to pay, so it would have to be a touchpoint federally for the state to consider something like this.
    - Dr. Mee-Lee: NH is a part of the 1115 waiver. However, I understand that anything beyond 28 days does not fall under that waiver, and 28-day treatment is not state of the art. However, the state is paying for untreated SUD anyway, in Child Protective Services and the criminal justice system. It will save the state money in the end to pay for long-lasting care. There are models for population health and integrated behavioral health centers.
    - Stephanie Savard: It feels like we're forced by our payer systems to continue with acute care. We get pushback from our own state and funding resources to keep to the 28-day model, even though we all know chronic treatment is needed.

4. Final Comments:
    - Stephanie Savard: Dr. Mee-Lee I can't thank you enough for joining us this morning and bringing a unique lens of addiction medicine to this thoughtful discussion and decision we are poised to recommend to our Commission. Love the unique perspective that we can do it differently if our system of care can support it. Thank you much!
    - Stephen Noyes: This was very helpful, lots of food for thought regarding continuum of services that are mobile and flexible.
    - Dr. Mee-Lee: We know addiction is a chronic illness, but we are still treating it like it's an acute illness.