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# Involuntary Civil Commitment for Substance Use Disorder: Legal Precedents and Ethical Considerations for Social Workers

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## ABSTRACT

Although each state in the United States legally authorizes involuntary civil commitment on the grounds of severe mental illness, a considerable number do not have comparable laws to mandate drug addiction treatment. This discrepancy is due, in part, to differing ethical positions regarding whether a substance use disorder diagnosis provides sufficient justification to suspend individual liberty rights. This article chronicles some of the legal and ethical thinking on the subject and applies them to a social work-specific context.

## KEYWORDS

Involuntary civil commitment; substance abuse; addiction; ethics; social work

Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding. (Louis D. Brandeis, *Olmstead v. U.S.*, 1928 [dissenting])

## Introduction

Individuals diagnosed with substance use disorder (SUD) enter treatment by different means, for different reasons, at different points in their lives. Treatment for such individuals is often made considerably more difficult by their refusal to voluntarily admit themselves to treatment centers (Ball, Carroll, Canning-Ball, & Rounsaville, 2006; Howard et al., 2002). It was once assumed that individuals must experience “rock bottom” before change could occur—as Alcoholics Anonymous (2001) notes, “few people will sincerely try to practice the A.A. program unless they have hit bottom” (p. 24). Although the rock bottom hypothesis is being debated in the literature (Cunningham, Wild, & Koski-Jännes, 2005; Dawson, Grant, Stinson, & Chou, 2006; Matzger, Kaskutas, & Weisner, 2005), the decision to enter treatment may require a constellation of negative consequences, family pleading, and probing introspection. Tragically for some, this constellation never occurs and their substance use leads to death. Indeed, continuing drug use despite negative life consequences is a hallmark feature of SUD (American Psychiatric Association [APA], 2013). This is often the most frightening facet of the condition for family members and other persons concerned about individuals with SUDs (Orford, Velleman, Copello, Templeton, & Ibanga, 2010; Velleman et al., 1993).

Addiction researchers have posited multiple hypotheses to explain this denial phenomenon, including cognitive dysfunction (Rinn, Desai, Rosenblatt, & Gastfriend, 2002), exposure to pervasive drug use during childhood resulting in an inability to identify disordered use (Howard et al., 2002), and psychodynamic defense mechanisms that prompt a split identity (Wurmser, 1985). Alcoholics Anonymous (2001) refers to this phenomenon as a “peculiar mental twist” (p. 33) that obscures reality and allows substance users to rationalize the negative consequences of their use. Regardless of its origin, the denial process results in feelings of frustration, anger, and fear in the concerned persons that make up the social network of an individual with alcohol addiction as they witness the

confounding picture of persons who seemingly cannot see the damage they are doing to themselves. Given their special access and proximity to individuals with SUDs, family members serve as a crucial “first line of defense” in recognizing a developing problem. In this capacity they are especially potent allies in drug addiction treatment efforts.

In an effort to prevent negative health outcomes and deaths resulting from SUD, several U. S. states have passed involuntary civil commitment (ICC) laws that allow concerned persons to petition local courts to forcibly remand individuals with SUDs to treatment (Christopher, Pinals, Stayton, Sanders, & Blumberg, 2015). These laws uphold that a severe SUD that endangers self and/or others satisfies necessary criteria to legally override an individual’s right to refuse treatment. These laws are derived from two important functions of the state: police powers and *parens patriae* (Latin for, “parent of the fatherland”). Police powers are invoked to protect citizens from being harmed by dangerous substance-related behavior such as driving under the influence or violence. *Parens patriae* is a legal doctrine that affords the state to act *in loco parentis* (“in the place of a parent”) on behalf of its citizens when they are incapable of acting on their own behalf (see Ratliff, 1999, for a more comprehensive legal discussion of *parens patriae*). In essence, to protect the health and safety of individuals and communities, the court may suspend individuals’ right to liberty and compel them into drug addiction treatment for a limited period so that they may recover to the point that they are no longer a danger to self or others.

Given that ICC laws are administered in the absence of a criminal conviction, there are divergent views on whether such a revocation of citizens’ liberty should ever be warranted. Some contend that ICC laws are an ethical use of state power and potentially life-saving intervention for individuals with SUD; others view them as an unethical breach of liberty rights. To better understand these different positions and their implications for social work practice, this article aims to (a) describe the primary components of ICC laws in U.S. states, (b) briefly outline how ICC laws were adopted in the United States, (c) discuss ethical arguments for and against ICC laws, and (d) evaluate whether and how social workers might reconcile ICC laws with the National Association of Social Workers’ (NASW; 2008) *Code of Ethics*.

## **What is involuntary civil commitment, and how does it work?**

### ***Civil versus criminal commitment for substance use disorder: Does this distinction matter?***

An individual may be court mandated to drug addiction treatment in two different ways. First, among the total court-mandated population, the majority of individuals with SUDs are committed to treatment through the criminal court system as a component of a drug court intervention (Wilson, Mitchell, & MacKenzie, 2006). In these cases, commitment to drug addiction treatment occurs through the criminal court system after an individual is found guilty of a criminal charge.

In ICC cases, concerned persons (e.g., family members, physicians, police officers) petition the court to enforce a mandate that an individual enter substance use treatment without needing to rely on the criminal court system. In these hearings, the petition activates the court’s power to issue a ruling rather than a criminal charge, and if the judge grants the petition, the ICC process proceeds and the individual is mandated to drug addiction treatment. This route offers benefits not present in criminal hearings. Foremost, it allows for intervention before circumstances have become so severe that criminal charges have been filed. This may allow individuals to avoid the challenges associated with carrying a criminal record, which include limited employment opportunities (Saxonhouse, 2004), access to credit (Henderson, 2005), and property rental (Clark, 2007). In sum, earlier intervention, facilitated by ICC laws, is intended to reduce harms and respond more quickly to improve future well-being for individuals with SUDs.

### ***Civil commitment for mental illness versus civil commitment for substance abuse***

In the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013)*, SUD is categorized as a mental illness alongside other mental health conditions such as schizophrenia, bipolar

disorder, and major depressive disorder. However, it is often addressed separately in civil commitment laws (see Testa & West, 2010). For this reason, the United States has extensive experience with civil commitment for severe mental illness but relatively little for SUDs (Williams, Cohen, & Ford, 2014). Although specific details differ among U.S. states, all have laws allowing ICC when individuals' mental health condition poses an imminent risk of harm to themselves or others (Treatment Advocacy Center, 2016; Williams et al., 2014). In some states, existing ICC laws for mental illness simply include SUD in their eligibility criteria (e.g., Maine) though the more common strategy has been for states to develop separate ICC laws specifically for individuals with SUDs (e.g., Kentucky). For this reason, many ICC laws that are SUD specific are newer and evidence suggests that they are not used at the same rate as those that are unique to severe mental illness (Christopher et al., 2015).

### ***Features of civil commitment cases***

For states with laws permitting individuals to petition the court to enforce involuntary commitment to drug addiction treatment, there are many similarities in how cases proceed. In legal terms, the concerned persons who file the petitions to mandate their loved ones to treatment are referred to as "petitioners" and their case is plead by prosecutors. Conversely, individuals whose substance use is in question is referred to as the defendants and their case is plead by defense attorneys. Because cases are adjudicated in the civil court system and no criminal charge has been brought against a defendant, the process necessarily begins with concerned persons completing a prescribed petition process on behalf of the individual using substances (for an example, see Kentucky Administrative Office of the Courts, 2004). This petition typically involves a paper form that requests the petitioner provide supporting information to justify why the defendant's substance use is sufficiently severe such that emergent treatment is required to address imminent risk of harm to self or others. Examples of evidence that may be presented include substance use that has resulted in driving under the influence, deteriorating health, or job loss. Once the court receives the petition, it is common for the petitioner to be questioned about the contents of the petition under oath. The court then uses this information to determine whether probable cause exists to proceed with the ICC process.

If sufficient evidence exists that the judge deems it appropriate to continue with the case, it is typical for defendants to be notified that the petition has been filed with the court and that they are required to appear for two evaluations; in many cases, state laws require that one or both of the evaluators be physicians specializing in the diagnosis and treatment of SUD. If these evaluations state that defendants do have a SUD and that their substance use poses an imminent risk of harm, the case proceeds to a hearing in front of a judge.

In this hearing, the prosecutor's role is to present the petitioner(s)' case that treatment must be mandated in spite of the defendants' refusal to admit themselves voluntarily. In the case of many states with ICC laws, defendants have the right to counsel to contest the charges. If the judge rules in favor of the prosecution, the defendant's right to refuse treatment is over-ridden by the court and the client is forced to receive it at a center determined by the petitioners (because they are the ones paying for said treatment). Such a ruling involves decisions about where defendants will receive treatment and for how long, as well as communicating to defendants what consequences to expect should they fail to comply. If the judge rules in favor of the defendant, the charges are dropped and the defendant is free to refuse treatment.

Importantly, statutes between states vary in terms of a number of aforementioned details. Among these are who determines where defendants are sent to treatment, how long the court can commit defendants to treatment, which level of burden of proof the judge must use to issue rulings, and what punishments the court can impose on defendants that do not comply with treatment requirements (Christopher et al., 2015).

## **Legislative precedents for involuntary civil commitment laws**

There are a number of legal considerations when drafting and administering ICC laws. The foremost is the conventional understanding of individual liberty outlined in the U.S. Constitution. The inherent tension present in ICC laws evokes the classic dilemma of balancing security and liberty in American legal reasoning. A brief glimpse into American legal history can be very helpful when forming an opinion about the relative merits of ICC laws. In the following section, we review important policy positions and Supreme Court rulings that have formed the legal foundation for ICC laws for SUD.

### ***Similar instances of parens patriae***

ICC laws fall in a lineage of similar uses of legislative authority to protect the health of individuals and communities, and these laws have been shaped by several related judicial opinions. As previously noted, mental health professionals are permitted by law to recommend involuntary treatment in locked psychiatric units for individuals with severe mental illnesses (Monahan et al., 1995). Similarly, public health officials may detain and force tuberculosis patients to receive treatment (Bayer & Dupuis, 1995), and guardianship laws allow for the permanent revocation of individuals' right to liberty once they have been deemed incompetent (Teaster, Wood, Lawrence, & Schmidt, 2007). In each of those cases, lawmakers have determined that specific health conditions are sufficiently dangerous to warrant nonconsensual interventions.

State legislative bodies are understandably cautious when granting themselves authority to over-ride citizens' right to liberty. A combination of respect for civil liberties and guiding Supreme Court rulings frame a set of general provisions to ensure that such authority is not abused. These provisions include prioritizing least restrictive means, strict time limitations on involuntary commitment, and placing the burden of proof on the petitioner. The infringements resulting from ICC laws are intended to be neither punishment nor permanent, and except in the case of guardianship, liberty rights are restored once an individual is no longer a danger to self or others.

### ***Supreme Court rulings related to involuntary treatment***

As previously noted, there are a number of cases for which the U.S. Supreme Court has issued rulings that provide insight into how states should approach the ethics of ICC laws. Although these rulings were made several decades ago, their insights are still very relevant to our modern deliberation about how to best provide care to reluctant clients. In the following section, we review three notable cases related to ICC laws. Although this is by no means an exhaustive list of cases relevant to ICC, these cases each clarify legal positions that have been taken by the Court that have been highly influential in how states have drafted policy subsequent to the rulings.

#### ***Robinson v. California (1962): Criminalizing illness***

In *Robinson v. California (1962)*, Lawrence Robinson was pulled over by a police officer who subsequently noticed that Mr. Robinson had injection stigmata (i.e., track marks) on his arms, presumably from injection drug use. Mr. Robinson was subsequently convicted and sentenced to 90 days under a California state law that made it illegal to be addicted to narcotics. When the case was brought before the Supreme Court, the court struck the law down on the basis that it violated the Eighth Amendment prohibition of cruel and unusual punishment. The majority opinion also stated that it was against the due process requirements outlined in the Fourteenth Amendment to imprison individuals simply for their desire or likelihood of committing a crime (read, using illegal drugs) before they had ever done so.

In his dissenting opinion, Justice Tom C. Clark offered a perspective that is instructive in the discussion of ICC. He argued there to be two fundamental stages of drug use; the first involving voluntary use and a second marked by involuntary use. Justice Clark's opinion indicated that a state could imprison individuals in the first stage to prevent them from progressing to the second stage, but state laws must transition to treating individuals as sick rather than criminal once they had entered the involuntary stage. In other words, Justice Clark opined that the state can constitutionally mobilize its police powers to protect citizens from becoming involuntary drug users (Neibel, 1963).

### **O'Connor v. Donaldson (1975): Dangerousness**

In the case of *O'Connor v. Donaldson* (1975), Kenneth Donaldson, who had a history of mental illness, was visiting his parents in Florida when he began to suspect that someone may be poisoning his food. Mr. Donaldson's parents then petitioned the courts for a sanity hearing. He was involuntarily committed for treatment of a delusional disorder to Chattahoochee State Psychiatric Hospital on January 3, 1957 and remained there until 1971. During his commitment, Mr. Donaldson completed 18 court petitions to appeal his commitment on the grounds that he was neither a danger to himself nor others. It was reviewed and rejected by the various courts until it was eventually heard by the Supreme Court.

The Supreme Court ruled in favor of Mr. Donaldson, noting that imminent threat of harm to self or others was required for a state to enforce future involuntary civil commitment laws. Additionally, the court held that the state has an ongoing responsibility to justify the commitment. In other words, once an individual is no longer at imminent risk of danger to self or others, it is unconstitutional to keep them in treatment against their will. The Court also ruled that mental health professionals may be deemed personally liable when they violate individuals' right to liberty on the basis of a failed appeal to their dangerousness.

### **Addington v. Texas (1979): Burden of proof**

In the case of *Addington v. Texas* (1979), Frank O'Neal Addington, a man diagnosed with schizophrenia, appealed a decision of a Texas court to indefinitely confine him to a psychiatric hospital after he threatened his mother. Although Mr. Addington did not contest the psychiatrists' expert witness testimonies that he did suffer from a mental illness, he argued that they had failed to sufficiently prove that he was a danger to himself or others and therefore could not be involuntarily committed. This addressed the issue of the burden of proof ICC cases must meet when arguing that individuals are a danger to themselves or others. There was disagreement between the courts whether to use the less stringent condition of "preponderance of the evidence," a stronger condition of "clear and convincing evidence," or the most stringent "beyond a reasonable doubt" condition, which is required in criminal cases (Kaplow, 2012).

Simultaneously noting the seriousness of infringing on individual liberties in ICC cases, and the improbability of meeting the level of certainty required by the beyond a reasonable doubt burden of proof, the Supreme Court ruled that the intermediate clear and convincing evidence standard be applied. This decision was intended to balance the rights of the individual against the rights of the state to protect its citizens though also acknowledging that even highly skilled, experienced mental health professionals are incapable of perfectly predicting future dangerous behavior (Ross, 1979).

Taken as a whole, these judicial opinions have supported the right of the courts to temporarily suspend citizens' right to liberty to protect themselves or others from harm. Additionally, they suggest that the court views SUD as an illness (which cannot be deemed illegal in and of itself), and that the clear and convincing burden of proof be used to issue rulings on involuntary commitment. These opinions ultimately informed the Uniform Alcoholism and Intoxication Treatment Act of 1971 (UAITA; Council of State and Territorial Alcoholism Authorities, 1976). Uniform acts are template laws drafted by legal authorities that serve as prototypes for state legislatures. The UAITA outlined relevant considerations for states drafting ICC policies, such as, what criteria must be met before an individual can be committed (e.g., danger to self), who may initiate petitions and how they



are filed, how long the court may enforce a commitment along with prescribed intervals for reevaluations, and that defendants may be granted the right to counsel to contest their commitment. It was also in agreement with *Addington v. Texas* (1979) in terms of prescribing the clear and convincing burden of proof standard (Uniform Alcoholism and Intoxication Treatment Act, 1971, p. 26).

### **Ethical considerations related to involuntary civil commitment laws**

The fact that ICC is legal does not necessarily make it ethical. The United States has upheld unethical laws in its history, meaning that ongoing analyses of existing laws remains necessary. The following section expounds on this dilemma and how to think about clinical ethics in the case of ICC laws. Although current policy in the United States reflects the position that ICC laws fall within the twofold police powers and *parens patriae* roles of the state, many scholars have argued that they are unethical and run counter to the conventional understanding of the limitations on state power. In fact, arguments for and against are rooted in longstanding historical and ethical traditions detailed by Munetz, Galon, and Frese (2003). Specifically, arguments against ICC laws tend to rely on the individual rights-based thought found in the classical liberalism ideology borne of the work of John Locke and Adam Smith. Their ideas, which have come to be called “classical liberalism,” emphasize individual rights and have played a formative role in American legal and ethical thinking. Claims that each individual is master of his or her own destiny and that an individual’s freedom is only checked by whether his or her behavior violates the freedom of others are pervasive ideas in American society; especially among modern-day libertarians. On the other hand, arguments for ICC share ethical beliefs with communitarianism, a philosophical position that emphasizes the formative role of communities in individual development. Communitarian ethics understands communities and their shared values and history to be the proper source of providing one’s understanding of the good life (Kuczewski, 2009). In his essay on the topic, Kuczewski (2009) wrote:

At our best, we deliberate together about things that affect us individually as well as those that affect us collectively. We are not the content-free selves of liberal democracy nor is our nature pre-given in a way that we can simply read off the content of the good life from self-reflection or reflection on nature. We are continually engaged in processes of mutual self-discovery in and through our encounters with each other. (p. 47)

Fundamentally, positions on the ethical nature of ICC are informed by the relative weights placed on the rights of the individual versus the rights of communities and other social units. In other words, “to thine own self be true” or “one for all and all for one”?

Ethical considerations of ICC are informed by multiple factors, though two warrant special discussion. Foremost is how substance use and SUDs are defined and understood. Individuals who believe that substance use is more moral condition than disease state are likely to hold the view that it does not sufficiently impair autonomy to consider ICC laws warranted; for a comprehensive review of this position, see Hammer and colleagues (2013), Hall, Carter, and Forlini (2015), and Levy (2013). In this viewpoint, if substance use involves the conscious decision to commit a criminal act, then criminal law allows for an appropriate response. On the other hand, the scientific community currently understands SUDs to be chronic health conditions with genetic, neurologic, and behavioral components (Leshner, 1997; McLellan, Lewis, O’Brien, & Kleber, 2000). From this perspective, an affected individual’s behavior may be judged to be at least partially outside their control and therefore ICC laws may be justifiable. In other words, if SUD involves a compromised brain and the brain is understood to play the determinative role in behavior, the proper course of action involves healthcare interventions as opposed to criminal courts.

A second issue of central importance is the question of whether severe SUD degrades individual autonomy to the point that invoking *parens patriae* is justified. As *Robinson v. California* (1962) and *O’Connor v. Donaldson* (1975) illustrate, simply having an SUD is insufficient to use this power of the state. Neither can the courts suspend citizens’ right to liberty simply because they routinely

engage in an activity that places them at risk of a negative health outcome; were this the case, football players, who are at risk of acute and cumulative injury (Shankar, Fields, Collins, Dick, & Comstock, 2007) would be subject to ICC laws. Dangerousness and diminished autonomy must be present. The risks that excessive substance use poses to physical and mental health are well established, yet whether it renders persons incapable of acting in their own best interest is a matter of debate—even deciding on a proper definition of autonomy for use in these cases requires care (Levy, 2006). Is autonomy a construct that can be measured on a continuum, or is it an all-or-nothing state where a person either is or is not autonomous? Given these considerations, we turn our attention to the arguments made in favor of and in opposition to the use of ICC laws for individuals with SUD.

### ***Involuntary civil commitment is unethical: Qui bono?***

ICC cases involve multiple stakeholders, each with their own interests. Defendants wish to maintain their liberty—typically involving continued drug use. Courts want social order and the well-being of citizens. Petitioners want to prevent catastrophe. In such instances of opposing interests, discerning a guiding ethical perspective becomes necessary. Critics of ICC laws argue that they are unethical because they fail to satisfy necessary criteria for invoking *parens patriae*. These arguments can fall along two general themes: (a) SUD does not sufficiently impair autonomy to the point that revoking civil liberties are justified, or (b) ICC laws are unethical regardless of whether autonomy is impaired—individuals are free to govern their bodies and cannot be compelled to treatment against their will for any reason.

An example of the first theme can be found in the objection put forward by Foddy and Savulescu (2010), which argues that SUD is neither disease nor failure of willpower but “strong, regular appetitive desires” (p. 15) that are indistinguishable from other nondrug pleasure seeking. The authors assert that it is impossible to prove that individuals who use substances have lost their autonomy versus merely choosing to behave in ways that run afoul of societal norms. From this viewpoint, forcing substance users into treatment could be considered akin to forcing individuals with a high body mass index into weight loss treatment if they are caught consuming sugary foods.

Cherry (2010) provides an example of the second theme and argues that the long-standing jurisprudential convention in Anglo-American society affirm that individuals are the best judge of their own best interests, therefore courts should protect their rights to be left alone. Such respect for individual autonomy means considering the pluralistic nature of the United States and citizens’ varying understandings of appropriate moral behavior. As such, the state’s protections should extend beyond those behaviors it deems wise, prudent, or rational. In other words, though many consider substance use immoral and destructive, this alone does not create the authority for the state to disregard the rights of individuals to engage in it as long as they are not harming others.

Another common justification for ICC laws is that individuals who are involuntarily committed to treatment eventually “come to their senses” and express gratitude for the suspension of their rights. Cherry (2010) refers to this as the thank you theory and says, firstly, clients may not feel gratitude after receiving treatment and, secondly, it is an insufficient ethical justification even when clients do recover and feel that their commitment was for the best.

Further opposition to ICC laws stems from libertarian political philosophy, which treats state power with extreme skepticism and places high value on personal liberty rights. The “slippery slope” argument is commonly employed: If the government is permitted to suspend an individual’s right to autonomy of choice concerning substance use, it could perhaps be extended to other potentially addictive activities, such as Internet use. Moreover, those who hold this position may question the courts power to mandate treatment that does not reliably show consistent success. Though no healthcare intervention is effective all the time for every person, drug addiction treatment has not yet achieved the efficacy of a course of antibiotics for treatment of tuberculosis (see Burke & Gregoire, 2007; Miller, Walters, & Bennett, 2001).



To summarize, opponents of ICC argue that our current understanding of SUD is insufficient to justify such a dramatic violation of individual rights. Moreover, they argue that the assumptions that provide support for the use of ICC laws (e.g., after treatment, people will be grateful that they were held against their will, commitment to SUD will reliably achieve desired outcomes, etc.) are incorrect or at least insufficient to justify breaking the U.S. legal tradition of protecting an individual's right to be left alone by the government. With that, we now move on to a discussion of counterarguments made in favor of ICC laws.

### ***Involuntary civil commitment is ethical: An instance of justified paternalism***

Arguments in favor of laws that grant the state the power to revoke an individual's right to liberty in the absence of a criminal conviction require vigorous justification. Such laws not only present risks of harm to individual defendants, but as previously noted, their mere existence could signal a "slippery slope" of ever-encroaching state power to suspend civil rights. Proponents of civil commitment laws believe that severe SUD does sufficiently impair autonomy to the point that ICC laws and government intervention are justified—that, though it is unfortunate that such lengths are necessary to protect people, it is ethically preferable to standing idly by and allowing possible calamity.

As previously noted, advocates call attention to the fact that the United States has well-established procedures of revoking citizen's right to liberty for the purpose of protecting the health and safety of individuals and communities. Why, they ask, is SUD different from other conditions where society has deemed it appropriate for the courts to take extraordinary measures to intervene on behalf of vulnerable individuals? Additionally, recent research has increased our understanding of the brain's involvement in problem drug use. For example, the field of neuroscience has identified a "pleasure pathway" that has been mapped using a variety of research techniques (Esch & Stefano, 2004). The neurotransmitter dopamine plays an especially important role in this pathway. Hyman (2007) outlines the role of complex dopaminergic pathways in learning, memory, and reward, and how the pharmacologic effects of drugs on these pathways impairs cognitive control. Such impaired cognitive control weakens drug users' capacity for self-care and other rational goal-directed behavior, as well as the capacity for self-control. This suggests that the brains of individuals with SUDs are effectively hijacked as a result of their dependence on drugs, leaving them with diminished insight and sharply reduced capacity to resist urges and cravings, even in the face of negative consequences (Goldstein et al., 2009). Taken cumulatively, these findings describe a pathogenic process by which sustained drug use moves from hedonic to compulsive as the motivation to use shifts from volitional pleasure-seeking behavior to reflexive withdrawal aversion.

Perhaps the most emotionally compelling argument in favor of the establishment of ICC laws is evidenced by the nicknames given to the laws in some states. In Kentucky, for example, KRS 222.430 – 222.437, referred to as Casey's Law (2004), is named after Matthew Casey Wethington who died of a heroin overdose in 2002. His mother, Charlotte Wethington, used the tragedy of her son's death to lobby the state legislature to pass an ICC law that was specific to drug use. In a story recounting her son's addiction and his resultant death (West, 2016), Ms. Wethington described her newfound understanding of addiction and autonomy, noting:

Now that I know about the disease of addiction and that it is a brain disease, I know that most of the time when people are addicted, they are not able to make [the decision to enter treatment], because they can't make a good decision for themselves. (West, 2016, p. 1)

### **Considerations and recommendations for social work practitioners and researchers**

Because ICC laws for SUDs exist in some form in 33 states and the District of Columbia (Christopher et al., 2015), it is important to discuss possible ethical implications and responsibilities for practicing social workers. Likewise, social workers practicing in the 18 states without ICC laws

are positioned to help formulate laws that consider the ethical tensions previously outlined. Given these tensions, it is worthwhile to consider ICC laws in light of the National Association of Social Workers (2008) *Code of Ethics*.

Section 1.02 of the Code of Ethics reads:

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others. (p. 5)

This tenet is, at face value, in consonance with the dangerousness requirement found in ICC laws and establishes explicit justification for social workers to confidently participate in ICC without violating our professional code of ethics. At the very least, the *Code of Ethics* does not expressly forbid social workers from participating in ICC and acknowledges that social workers may be called to do just that.

That being said, establishing dangerousness of SUDs is a highly inexact science, and ICC laws do not mandate a specific test or evaluation to of imminent threat of harm. This skepticism about the accuracy of predictions of future behavior made by psychiatrists and other mental health professionals has been raised for many years and for many types of predictions—from risk of violence to others to likelihood of committing suicide (Ennis & Litwack, 1974; Krongard, 2002; Simon, 2006). There is great faith placed in the hands of psychiatric professionals in civil commitment cases; the court cedes enormous authority to those who perform psychiatric evaluations, and at present the field of psychiatry has limited resources at its disposal to make these kinds of predictions.

Assessments of risk are vulnerable to any manor of biases, including personal opinions on the morality of drug use or past traumatic experiences to enter the process of determining whether to involuntarily commit an individual. Consider the case of Alicia Beltran outlined in Schwartz (2015). In 2013, after disclosing a past history of opiate pain medication addiction to her obstetrician during a routine prenatal visit, her physician utilized a Wisconsin state law to have her forcefully taken to court to face a hearing about her competence to safely bring her child to term. This was in spite of never testing positive for illicit drug use nor presenting with any symptomatology of active SUD. That particular case suggests an instance of a healthcare provider's bias unduly influencing the outcome of an ICC case.

Considering the high stakes, social workers must strive toward avoiding false positives and false negatives. Until we are able to more accurately predict risk, the way to do this is to employ the timeless principles of employing critical thinking and checking personal biases when completing ICC evaluations. This begs the question, "Assuming that participation in ICC for SUD is not in and of itself unethical, how can social workers best practice within known ethical tensions?"

Social workers have a laudable professional history of advocacy, and ICC laws present several opportunities to for social workers to promote social justice for individuals affected by SUDs. One such area would be ensuring that all citizens have equal access to the possible benefits of ICC laws. In many states, legislatures require that petitioners pay for the assessment and treatment of individuals with SUDs. This includes paying court and attorney fees, evaluation fees to psychiatrists and other clinical evaluators, as well as the cost of inpatient drug addiction treatment. For low-income families, these costs could be prohibitive. Potential measures to address this include applying for grants to fund the ICC process, covering evaluations and treatments under Medicaid, and finding ways to offer low-cost treatment options.

Additionally, ICC laws in many states effectively extend the power of the courts into the hands of drug addiction treatment practitioners, which requires additional restraint and conscientiousness among social workers involved in the process. By admitting involuntary clients into treatment programs, social workers are expressly participating in an element of social work that many find uncomfortable: social control. Specifically, the knowledge that a social worker can simply call the courts and have a client punished for rule violations in a treatment program introduces a level of power not present in cases of noncoerced clients. As social work scholars have been saying for many years, power differentials create opportunities for unethical behavior and should therefore be coupled with renewed attention to ethical responsibilities to clients and communities served.

Another opportunity to employ social work advocacy concerns the treatment available to those committed under ICC laws. It has long been known by the treatment field that there are too few treatment resources available in the United States, and many treatment opportunities available require significant improvement (McLellan & Meyers, 2004). If ICC laws are to be effective, there must be adequate treatments settings to refer to—and there is evidence that this is not the case. For example, in Massachusetts, rather than be admitted to a freestanding treatment venue, women committed under MGL 123, Section 35 are sent to a unit of a women's prison for drug addiction treatment (Honig, 2015).

There are several steps that could be undertaken by researchers, policy makers, and clinicians to improve the effectiveness of ICC laws for individuals and communities affected by SUD, and to reduce the moral tensions involved in using laws that suspend individual rights. Foremost, there are currently few outcome studies with individuals served through ICC. Thus, rigorous evaluation of ICC laws is an urgent research need. Given the paucity of outcome studies, the current knowledge base is insufficient to answer specific questions about how states should write, structure, and enforce ICC laws. Researchers and policy makers must determine whether the goal of ICC is to achieve a measurable clinical goal, such as 90 days of abstinence, or a more comprehensive, though nebulous, goal of recovery from SUD. Individuals may be abstinent from drugs well before they could be said to have recovered, thus the intended outcome of ICC for SUD will frame decisions about length of commitment. Moreover, though it is beyond the scope of this article, the use of ICC with minors requires additional consideration and research (see Levitt & Pinals, 2012).

Finally, studies should examine the role that psychiatric advance directives may play in ICC cases (Andreou, 2008; Bell, 2015; Davis, 2008). Psychiatric advance directives have become increasingly popular in mental health care practices as a means of respecting the rights of clients with psychotic disorders that render them incapable or resistant to voluntary treatment (Appelbaum, 2004). Advance directives for SUD specify client preferences in the event of relapse; for example, favored treatment providers, type of treatment received, and which friends or family to involve in the planning process (Substance Abuse and Mental Health Services Administration, 2016). In ICC cases, SUD advance directives may be incorporated into the judicial monitoring process by having defense attorneys to complete advance directives with clients once they are through the initial treatment phase. Given previously discussed concerns about ICC's infringement on self-determination, the addition of advanced directives offers one potentially effective way to increase client engagement and decision-making in the ICC process.

## Conclusion

ICC laws exist in more than one half of the states in the United States, and there is little sign of them being repealed. To be sure, there is a tension between valuing the rights of individual citizens to self-determination and upholding laws that appear to violate them. Although ICC laws have generated an important and justified ethical debate, they afford concerned persons the chance to step into the arena and attempt to alter the course of their loved one's life and recovery. Social workers can play an important role in the continued use of ICC laws by monitoring their ethicality and evaluating their effectiveness, as well as educating families, providing court assessments, and administering treatment services for those admitted through ICC cases. By keeping the ethical standards of respect for the dignity and worth of persons at the forefront, social workers will only trespass on rights to autonomy and self-determination when in the interest of preventing harm.

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