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Dear Legislator:

On behalf of the Pennsylvania College of Emergency Physicians (PACEP), a professional organization representing nearly 1,700 emergency medicine physicians in emergency departments across Pennsylvania, I am writing to acknowledge that PACEP shares your concern about the scope of our state's opioid epidemic and the need for everyone, including physicians, to do their part to help those in need.

However, I must also share that emergency physicians also have concerns about proposed House Bill 713, which features amendments to the Mental Health Procedures Act that would allow involuntarily commitment of individuals for treatment of drug and alcohol abuse. From an emergency medicine standpoint, this legislation would likely have far-reaching implications that would hinder rather than augment our shared goals of enhancing substance use disorder treatment and decreasing overdose deaths in the Commonwealth of Pennsylvania.

As emergency physicians, we are frequently faced with the heartbreaking responsibility of informing a family in the Emergency Department (ED) that their loved one, about whom they are deeply concerned, is indeed *not* currently intoxicated, demonstrates capacity to make informed decisions, and has the right to refuse treatment and/or referral to treatment, despite suffering from a substance use disorder.

We understand and empathize with the desire to do more to help those individuals. However, the involuntary commitment of individuals who demonstrate appropriate capacity will result in unintended detrimental consequences to the patient. Medical evidence does not support the utility or effectiveness of forced treatment for substance use disorder. A central tenet in addiction medicine is that the individual being treated needs to recognize the presence of the disease and express a desire for treatment. Otherwise, chances of success are low.

Currently, one of our greatest challenges in caring for this population is a dearth of treatment programs, as well as obstacles to connecting our patients to those resources. Before we consider involuntary commitment, we need to ensure that those who are willing to voluntarily commit to treating their addiction are in fact able to do so. A predictable consequence of these obstacles are prolonged stays in the ED, thus putting a strain on limited ED resources and leading to contentious and dangerous interactions when patients attempt to leave. ED boarding is detrimental to the health of the patient involved as well as the health of all the other patients in the ED. (over)

If adopted, House Bill 713 will put emergency physicians in the precarious position of determining the need for involuntary commitment on the large numbers of patients with substance use disorder. Because we, as emergency physicians, are on the front lines of the opioid crisis, we are acutely aware of the public health epidemic of overdoses. But an emergency physician's real and legitimate concern about their legal liability if a patient is treated for overdose but not committed could lead to overuse of the involuntary commitment, further crowding of an already-overwhelmed system, and inappropriate denial of individual rights. Additionally, the potential for involuntary confinement may paradoxically serve to reduce voluntary engagement of patients with the healthcare system; patients with substance use disorder may be fearful of presenting to the ED out of concern that they will be involuntarily committed. Furthermore, a barrier may be created between patients and the family members who commit them, fragmenting relationships between patients and their critical support network.

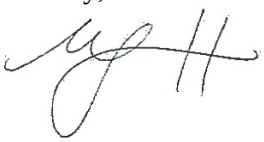
We appreciate both the concern and support of legislators who desire to address this epidemic with meaningful and substantive legislation. While there are no simple solutions, we propose several recommendations which, based upon our collective experience treating thousands of patients suffering from this disease every year, could provide substantial support to patients, family members, and medical professionals caring for this population.

PACEP's recommendations include:

1. A comprehensive, real-time statewide tracking system of available psychiatric and drug and alcohol treatment facility beds, allowing enhanced and timely placement of appropriate patients from the ED.
2. Substance abuse privacy laws commensurate with federal regulations. Currently, PA is one of only several states with stricter privacy requirements than are federally mandated. Loosening of privacy restrictions could allow improved coordination with community-based treatment programs and Single County Authorities.
3. Guaranteed coverage from insurers and Medicaid for substance abuse treatment, and a mechanism to address costs for those patients without insurance.
4. Increased funding for community-based support agencies and outpatient treatment resources. Barriers to treatment often involve more than bed availability; improved management of logistical and social impediments to accessing treatment and community outreach will allow greater access for patients who are less likely to seek treatment in traditional medical facilities while, at the same time, reducing unnecessary healthcare utilization.
5. Greater utilization of "warm handoffs," wherein patients voluntarily seeking treatment can be evaluated by a substance abuse counselor and referred to treatment directly from the ED.

Thank you for your leadership in addressing this public health crisis. The PA College of Emergency Physicians stands ready to serve as a resource and assist the General Assembly in developing legislation that reduces mental health and substance use stigma, halts and reverses the tide of overdose deaths, and protects the dignity and rights of Pennsylvanians suffering from substance use disorder, as well as their families. Please do not hesitate to contact us if you have any questions or require additional information.

Sincerely,



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