Senate Democratic Policy Committee Hearing

Treatment for Individuals with Substance Use Disorder

Friday, December 8, 2017

Testimony Provided by:

Michael Lynch, MD
Medical Director, Pittsburgh Poison Center
Assistant Professor
Division of Medical Toxicology, Department of Emergency Medicine
Divisions of Adolescent and Pediatric Emergency Medicine, Department of Pediatrics
University of Pittsburgh School of Medicine

I. Introduction

Leader Costa, Madam Chair, and esteemed committee members, thank you very much for offering the opportunity to discuss the critically important topic of identifying mechanisms to improve the resources and treatment available to individuals suffering from substance use disorders(SUDs) as well the family members and loved ones who are experiencing this terrible ordeal alongside of them. It is only through this type of multidisciplinary and coordinated discourse that we will hope to improve our medical, social, legal, and other support systems in response to this crisis. My name is Dr. Michael Lynch. I am a practicing emergency physician and toxicologist at UPMC Presbyterian, Mercy, Magee, Shadyside, and Children's Hospital of Pittsburgh of UPMC. I am also the Medical Director of the Pittsburgh Poison Center and sit on the Government Affairs committees of the PA College of Emergency Physicians and the American Association of Poison Control Centers. In those roles, I have been actively involved in the direct care of patients with addiction and following overdose events as well as in the development and implementation of hospital, system, and statewide initiatives. I am a member of the statewide Overdose Task Force chaired by Secretary Smith and Dr. Levine. I collaborate with law enforcement at the local, state, and federal levels including the Drug Enforcement Agency, Federal Bureau of Investigation, the U.S. Attorney's office, PA State Police, Office of the Attorney General of PA, the Allegheny County of the Medical Examiner in addition to local EMS agencies and the PA Bureau of Emergency Medical Services. In those capacities, I have witnessed firsthand the tragedy of addiction and overdose, the hopelessness and helplessness experienced by families, contributed published data regarding first responder safety and opioid prescribing, and participated in the evaluation of methods to improve the continuity of care available to patients with substance use disorders.

With that as background, I applaud this committee's leadership and dedication to identifying mechanisms to support both individuals with substance use disorders as well as their families and loved ones. The motivation for the legislation, SB 391, is clear, sincere, and shared. However, I do have concerns regarding the potential unintended outcomes of this and related legislation that I feel I have a duty and responsibility to share. While I wholeheartedly support your efforts to identify and enact improvements in the treatment of individuals with substance use disorders while offering tools and support to family members and loved ones, I fear that pursuing involuntary inpatient commitment for the treatment of SUDs may not only be ineffective, but potentially counterproductive and dangerous. I greatly appreciate the care and thoughtful nature in which this committee and Senator Costa have

sought and incorporated input from experts in a variety of fields. It is my hope that with such collaboration legislation that satisfies the needs of patients, families, and providers may be submitted. Please allow me to offer concerns as well as suggestions from my point of view and following discussion with colleagues in Emergency Medicine, Psychiatry, Addiction Medicine, and other healthcare leadership.

II. Involuntary Commitment to Substance Use Disorder Treatment

The most important and relevant concern is that there is not scientific support to suggest that forced treatment of substance use disorders is effective. While mandated therapy for patients already in the criminal justice system has yielded improved outcomes, application of that approach to people who are not otherwise criminally detained or supervised has not been shown to improve ongoing treatment engagement, substance use, or survival. In fact, existing studies have suggested harm without benefit. In 2016, the International Centre for Science in Drug Policy performed a review of existing literature assessing the outcomes of compulsory drug treatment and concluded, "The available scientific evidence does not suggest significantly improved outcomes of compulsory compared with non-compulsory approaches, with some studies suggesting potential harms".[1]

One of the most important predictors of successful substance use disorder treatment and retention is the early establishment of a therapeutic alliance between a treatment provider and patient.[2] Without that, the likelihood of success is low. At the same time, several potential harms could result. First, individuals with substance use disorders may see the threat of compulsory treatment as a reason to avoid seeking medical treatment due to fear of commitment. Even if the ability to petition commitment rests solely with family members and loved ones, that distinction may not be clearly perceived by patients with SUDs or healthcare providers in some instances. More importantly, the potential for, or the act of, involuntary commitment by a caring loved one could lead to worsening of family relationships. The support of an individual with an SUD by loved ones is a critical piece of ongoing recovery. That system of support and encouragement may no longer be intact as a result these concerns. Finally, there may even be a hesitation to activate emergency medical services(EMS) in the setting of an acute overdose for fear that an individual suffering the overdose could end up committed against their will. I have cared for many patients who were not brought directly to an emergency department or for whom EMS was not activated due to concerns by their associates that engagement with the medical system could result in negative consequences for both the patient and others present. I would be concerned that such thought processes could delay or avoidance of emergency care resulting in further harm or death.

Another concern with mandatory inpatient treatment of SUDs is the associated loss of tolerance. As patients exit a prolonged inpatient treatment program or other forced incarceration, they are at very high risk of overdose due the inability to tolerate similar doses of a drug as was previously used. The best illustration of this is the high rate of overdose following imprisoning.[3] As the evidence would suggest a very high risk of early relapse without ongoing engagement, similar increases in overdose deaths following forced inpatient treatment would be anticipated.

Finally, involuntary commitment of an individual to care is a mechanism rarely employed in medicine and typically requires either a lack of capacity to make an informed decision with a demonstrated

understanding of risks and/or an imminent intention to hurt oneself or others. While individuals with substance use disorders frequently make decisions that many would not consider rational or logical regarding engagement in treatment, mandating hospitalized treatment for those patients would be a departure, and potentially a slippery slope, from current views of patient autonomy. As corollary examples, despite the potential for immediate and life-threatening harm, we do not commit to hospitalized treatment patients with diabetes who do not take their insulin, individuals with severe chronic lung disease who continue to choose to smoke, or persons with coronary artery disease that do not adhere to diet, exercise, and medication management despite the clear and proven risk of both immediate harm and an overall shortening of life. Doing so for an individual with an SUD who understands the risk of ongoing use and without intention to hurt him or herself, while seemingly well intended, would represent a new application of involuntary commitment. It is unlikely to result in long term recovery and undermines individual autonomy in an unintentionally stigmatizing way compared to the treatment of other chronic diseases.

III. Implications to the Healthcare System

The capacity of drug and alcohol inpatient treatment facilities is extremely limited. Patients who are involuntarily committed for evaluation would subsequently be remanded to a healthcare or other facility pending completion of evaluation and treatment as mandated by legal commitment. The precise impact and volume of individuals who would be committed is unclear, however it could be quite large. Based upon estimates from EMS, public health, the poison centers, and healthcare facilities, it is anticipated that a single county could need to respond to as many as 10-20 events per day. If even a fraction of that number were committed to inpatient treatment against their will, the drug and alcohol treatment facilities would be completely overwhelmed.

The focus of legislation is to provide improved care to individuals with SUDs as well as empowering family members and loved ones to respond. However, a necessary outcome of mandating inpatient treatment for unwilling patients is the absence of treatment availability for persons with SUDs who are motivated and committed to recovery. As a result, motivated individuals who qualify for and would be much more likely to benefit from treatment would be forced to await resources that are being occupied by patients who are unlikely to benefit. I fear that delays in therapy could allow for relapse or reconsideration on the part of the individual leading to a missed opportunity. In that scenario, the family of the initially motivated individual would be understandably frustrated and helpless. Moreover, the unintended consequence would be two people with SUDs more likely to continue use rather than only one.

While awaiting placement in a treatment facility, patients would not be receiving dedicated substance use treatment. In many cases, they would likely be kept in emergency departments and/or hospitals. While the person might temporarily be safe from an accidental overdose, the harms to the patient as well as other patients without SUDs would be significant as there is not inherent capacity to maintain large numbers of additional patients in EDs or hospitals.

In order to enforce a commitment, an individual would be placed under constant supervision as currently occurs with psychiatrically committed patients. Keeping patients in a hospital setting against their will is potentially dangerous for the patient, healthcare providers, and other patients receiving care at the same time. If verbal redirection was unsuccessful and/or a committed individual physically attempted to leave a healthcare setting, that facility would be required by law to forcibly detain the

individual. In addition to the physical risks of doing so, significant psychological damage could be inflicted on a person who is physically or chemically restrained. While such interventions are occasionally necessary for the protection of a patient and prevention of an immediate threat to his or her life, they are avoided at all costs and only as a last resort. In this scenario, as bed waits could be days or longer, I fear that such events would become much more common and dangerous.

The result of resource allocation of EDs and hospitals to detaining patients against their will would also be diverted from other individuals. It can easily be anticipated that the influx of patient volume could occupy medical bed capacity and lead to overcrowding of EDs. It is well established that ED overcrowding is associated with harm to patients, in general.[4] Therefore, another unintended consequence of involuntary commitment for the treatment of substance use disorders would be a decline in generally available medical care.

IV. Proposed Opportunities to Improve Resources Available to Patients and Their Families

There is clearly a need to improve our ability to facilitate treatment engagement for individuals with SUDs as well as to better support and empower their families and loved ones. Based upon existing scientific evidence, involuntary commitment seems unlikely to achieve these stated goals and improve the outcomes for patients with SUDs. However, based upon my experience, review of available literature, and discussion with colleagues from various disciplines engaged in the treatment of SUDs, I would propose suggestions for legislative consideration that may address our shared goals.

1. Increase support for community based engagement and harm reduction resources. Rather than force individuals into an inpatient treatment system that is already overwhelmed with little chance of success, meet that individual where he/she is physically and psychologically so that a therapeutic relationship based upon trust and collaboration can be established.[2]
2. Develop and expand support and educational resources for family members and loved ones of individuals with SUDs. Programs aimed at assisting family members can improve their own health, provide tools to help in their relationship with loved ones with SUDs, and actually play a role in facilitating voluntary and effective treatment engagement and retention.[5]
3. Current confidentiality rules in PA related to sharing information regarding substance use disorders (Pa. Cons. Stat. Ann. tit. 71 § 1690.108) limit the ability for treatment providers to coordinate care. Federal guidelines are less restrictive and application of those standards may improve the ability of providers to care for individuals with substance use disorders while maintaining appropriate confidentiality.[6]
4. Continue to expand access to inpatient as well as outpatient substance use disorder treatment, including medication assisted therapy (MAT). Optimize existing and developing warm handoff programs.

V. Conclusion

Thank you for offering the opportunity for professionals and the public to provide testimony regarding this critically important topic. As we consider steps to address this terrible epidemic, we should be guided by scientific evidence to develop best practices. While well-intended, involuntary commitment is unlikely to benefit those it is meant to help, patients and families, and may result in harm including more lives lost and families shattered. I look forward to ongoing collaboration as we work together to help Pennsylvanians suffering with SUDs, their families, and loved ones.

References

1. Werb D et al. The effectiveness of compulsory drug treatment: A systematic review. *International Journal of Drug Policy*. 2016; 28: 1-9
2. Allen RS et al. Predicting attrition in the treatment of substance use disorders. *Journal of Addiction Research & Therapy.* 2015 Aug; 6: 238
3. Bukten A et al. High risk of overdose death following release from prison: variations in mortality during a 15-year observation period. *Addiction*. 2017 Aug; 112(8): 1432-1439
4. Bernstein, S. L., Aronsky, D., Duseja, R., Epstein, S., Handel, D., Hwang, U., McCarthy, M., John McConnell, K., Pines, J. M., Rathlev, N., Schafermeyer, R., Zwemer, F., Schull, M., Asplin, B. R. and Society for Academic Emergency Medicine, Emergency Department Crowding Task Force. The Effect of Emergency Department Crowding on Clinically Oriented Outcomes. *Academic Emergency Medicine*. 2009, 16: 1–10
5. Landau, Judith et al. 2000. "Strength in numbers: The ARISE method for mobilizing family and network to engage substance abusers in treatment." *The American Journal of Drug and Alcohol Abuse:* Vol 26(3), 2000, 379-398.
6. Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington (DC): National Academies Press (US); 2006. Appendix B, Constraints on Sharing Mental Health and Substance-Use Treatment Information Imposed by Federal and State Medical Records Privacy Laws