

# Prevalence of Involuntary Commitment for Alcohol Dependence

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## ABSTRACT

**Background:** Alcohol dependence is a chronic relapsing illness. While some patients respond to treatment, others continue to drink alcohol and suffer serious health effects such as delirium tremens, liver failure, heart disease, and central nervous effects. One option society has used to force treatment and abstinence is the legal mechanism of “involuntary commitment.” The goal of this study was to determine the utilization of “involuntary commitment” among the 72 counties in Wisconsin.

**Methods:** A statewide survey was conducted using a mailed survey to assess the current use of this treatment option.

**Results:** Forty-nine counties responded to the survey (68%); the mean number of commitments in the last year was 5 with a range of 0 to 30. Of the petitioners who participated in the commitment, 98% were family members, 62% were friends, 49% were physicians, and 26% were counselors. Over half of the respondents (53%) felt that the process was effective in helping people deal with their alcoholism.

**Discussion:** The overall perception among those surveyed is that involuntary commitment for the treatment of alcohol dependence can help addicted persons, but its utilization varies by county in Wisconsin. Physicians may consider exploring the use of this legal process to assist patients struggling with alcoholism.

## INTRODUCTION

The aim of this article is to provide a statewide snapshot of involuntary commitment (IC) for alcohol dependence. In 1968 congress passed the Alcoholic Rehabilitation Act of 1968 (Public Law 90-574), which was the first federal law to address the need for alcoholism to be treated as a health problem vs a criminal problem. By 1971 this legislation was expanded to The Uniform Alcoholism and Intoxication Treatment Act, which allowed states to provide the health and legal guidelines to treat alcoholism.<sup>1</sup> Following this federal act, the state of Wisconsin

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enacted legislation that addressed the issue of involuntary commitment for alcoholism. This state statute defines an involuntary alcohol commitment as “a civil, legal proceeding which allows for an alcohol or drug dependent individual who is dangerous as a result of that use, to be placed in a treatment setting against his/her will.”<sup>2</sup> Other states have enacted similar statutes.

The commitment process in Wisconsin requires 3 adults to sign sworn petitions for examination alleging concern that the individual is a danger to self or others and is a proper subject for treatment. A probable cause hearing occurs within 72 hours and the judge determines the outcome. If probable cause is found, a final hearing will occur and the treatment course deter-

mined. Prior to the final hearing, which may take a few days, the person may remain in the medical facility, a detoxification facility, a shelter, or at home. A common outcome is treatment in a residential or outpatient alcohol treatment program for a period of 30 to 90 days.

Involuntary commitment and court-ordered treatment policies are supported by The National Alliance on Mental Illness (NAMI) for persons with mental illness.<sup>3</sup> Historically, involuntary commitment is used less commonly to treat alcohol use disorder (AUD) than for mental health purposes, and usually has separate implementation criteria.

Alcohol abuse is a prominent public health concern in Wisconsin. The state leads the country in rates of current alcohol use, heavy use, and binge drinking among adults.<sup>4</sup> In addition, alcohol-related injuries and diseases account for a significant number of emergency department (ED) and primary care visits.<sup>5</sup> Previous research has estimated that problem drinkers are twice as likely to report ED use compared to non-problem drinkers, even when controlling for other factors such as gender, age, and insurance status.<sup>6</sup> Physicians often face the

**Table.** Sample Survey Questions

Does your county execute three-party involuntary alcohol commitments?  
Is there a waiting list? If yes, how long, and is there a limit of commitments per individual?  
Describe the commitment process. Who are the typical petitioners? Who oversees the process in your county? Is it the same individual for each commitment?  
Does your county track commitments? Has there been a change in numbers in the last 5 years? 10 years?  
What has affected the numbers of commitments done in your county?  
Where do individuals seek treatment for their commitments?  
Is follow-up data collected?  
How much money is spent per year on commitments?  
Do you think commitments are effective?

dilemma of how to manage patients who do not respond to other methods of treatment and may harm themselves or others as a result of their alcohol or drug use disorder.

Because state and federal regulations are different, the commitment process varies throughout the country, and from county to county in Wisconsin. This article presents the results of a statewide survey of county corporation counsel or health and human service departments in order to provide clinicians with a better understanding of the alcohol commitment process by county.

## METHODS

Representatives from either the health and human services department or county corporation counsel's office in each of Wisconsin's 72 counties were contacted to participate in the study during August and September 2010. Each representative was identified as the primary contact regarding involuntary alcohol commitments in their county via a telephone conversation with their county health and human services agency. Approval for this project was obtained through the University of Wisconsin-Madison Health Sciences Institutional Review Board. The analysis was completed by research staff at the University of Wisconsin.

A survey instrument was designed to gain understanding of the alcohol commitment process and trends in Wisconsin counties. The estimated time to complete the survey was 10 minutes. This survey was mailed to the identified representative of each county. If no response was received within 2 to 3 weeks of the initial mailing, a follow-up telephone call was placed prompting them to return the survey. Completed surveys were used as the data source. The survey questions included both preselected options and open-ended questions. (See Table) The survey questions provided factual information regarding whether or not a county executed involuntary alcohol commitments, data collection, and number trends. The survey also provided an opportunity for the county representative to expound on their clinical impressions regarding the effective-

ness of such commitments and what may have affected the number of commitments done. The survey was returned by 49 of the 72 counties (68%). Descriptive analysis was completed using SPSS. The data did not lend itself to statistical testing or differences by county.

## RESULTS

Of the 49 county representatives who returned the survey, 44 representatives reported that their county currently utilized 3-party involuntary alcohol com-

mitments to help county residents deal with their alcoholism. The number of commitments ranged from 0 to 30 in a typical year, with 12 (25%) counties reporting no IC in 2010. The remaining 37 (75%) counties reported an average of 5 commitments per year. When asked if there was a waiting list and how long a person would have to wait to be committed, 75% (n = 37) reported a waiting time of up to 3 months.

According to the survey, a majority of the petitioners for alcohol commitments are family members (97.73%), followed by friends (66%), physicians (50%), and social workers or counselors (25%). A majority of these commitments are overseen at the county level by the county human and social services agencies (72.72%), followed by corporation counsel (48.8%), and a mix of other agencies such as alcohol and other drug abuse (AODA) treatment centers, case management agencies, mental health coordinators, or unified community services. A majority of the treatment for commitment is sought either at inpatient or outpatient facilities (90.90%), followed by in-county facilities (79.55%) and out-of-county facilities (77.27%).

The survey also inquired about changes in number of commitments and some of the possible reasons that could have affected alcohol commitments. Of the total number of counties who answered the survey, 23 (48%) reported that the number of commitments remained the same over the last 5 years, and approximately one-third reported a decrease in the number of commitments.

Some of the possible factors reported by respondents to have affected the number of commitments were budget cuts (11.36%), decreasing number of referrals (11.36%), physicians unwilling to testify to successfully complete a commitment (11.36%), lack of alcohol and drug treatment facilities (9.09%), lack of resources (9.09%), a belief that commitments are ineffective (6.8%), and lack of family and community understanding about referrals (6.8%).

Finally, when questioned on budgets and the effectiveness of commitments, 68.18% of respondents reported that they did not have a separate budget for involuntary commitments.

Slightly more than half of the county representatives believed that commitments are effective (52.27%).

## DISCUSSION

This paper presents new information on the utilization of involuntary commitment for alcohol dependence in Wisconsin. The report suggests that the use of this mechanism varies by county. Family members are the primary petitioners. These families try to work with local courts to obtain treatment for loved ones suffering from alcoholism. There is the overall perception that this legal option can help addicted persons, their family members, and friends to deal with alcoholism.

Why would a physician choose this option to help their patients? First, some patients are so resistant to any kind of help that forced sobriety over a 3-month period may provide sufficient healing of brain pathways to initiate long-term recovery. Second, while there is no primary outcome research on efficacy, anecdotal experience by the authors suggests involuntary commitment may prolong life and reduce the frequency of detoxification admissions, repeat admissions for acute pancreatitis and other medical sequelae of alcoholism. Third, it can provide resources for treatment that are otherwise not available. County funding for 90 days of treatment often is available to people with alcohol dependence who have limited resources to pay for alcohol treatment.

Physicians struggle with patients who have chronic relapsing alcoholism. There are no easy answers. However, unlike most brain diseases, the effects of alcoholism on the brain are at least partially reversible. Long-term recovery is possible, with many recovering alcoholics leading productive and accomplished lives.

While many physicians are not comfortable with some of the methods used to get people into treatment, involuntary commitment is another recovery tool available to physicians and families. Physicians who are not familiar with procedures in their county may want to contact the local county board, the county judge, or county mental health center for more information.

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