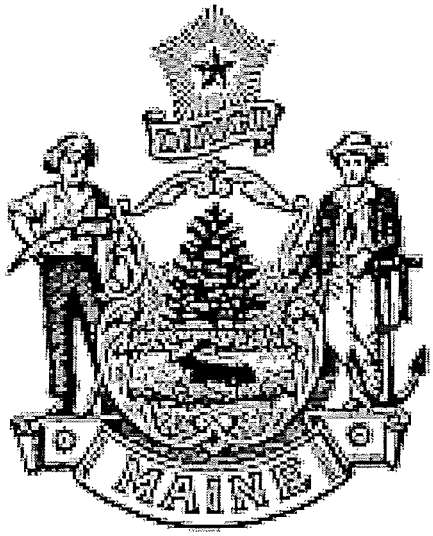
REPORT TO THE JOINT STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES REGARDING LD 611, "AN ACT TO OBTAIN SUBSTANCE ABUSE SERVICES FOR MINORS"

January 12, 2004



Submitted by: The Office of Substance Abuse, Department of Behavioral and Developmental Services

Report to the Joint Standing Committee on Health and Human Services

Re: LD 611, An Act to Obtain Substance Abuse Services for Minors

Submitted by the Office of Substance Abuse, Department of Behavioral and Developmental Services, January 12, 2004

REVIEW OF THE CHARGE

LD 611, An Act to Obtain Substance Abuse Services for Minors, introduced by Senator Rotundo of Androscoggin, sought to ensure the provision of substance abuse services to minors, either upon their own request or the request of their parents. The Joint Standing Committee on Health and Human Services, 121st Legislature carried the bill over to the second session, charging the Office of Substance abuse to study the implications of the bill, seeking input from providers, parents and other stakeholders, and making recommendations.

This report is submitted in fulfillment of that charge.

PROCESS

A work committee was identified, consisting of David Faulkner, Executive Director, Day One, Portland; Paul McDonnell, Executive Director, Milestone Foundation; Lynn Duby, Executive Director, Youth and Family Services, Skowhegan; and Kim Johnson, Director, Office of Substance Abuse. Mr. Faulkner acted as liaison to Mainely Parents, a parent group. A request was made for comment from the Legislative Youth Advisory Council. Literature reviews and review of statutes and systems of all the other states were conducted.

COMPARISONS WITH OTHER STATES

A review of statutes of the other 49 states regarding involuntary commitment for treatment was conducted. There was wide variation among the states, and no clear pattern emerged to identify a system that worked well. Many states did not distinguish between commitment for involuntary medical treatment, treatment for mental illness and treatment for substance abuse. Many states did not distinguish between commitment procedures for adults and those used for minors. Several states' statutes were internally contradictory and confusing, particularly those with separate systems for minors and adults and for mental health treatment and substance abuse treatment. It is likely that other sections of the states' codes have bearings on this subject, such as rules of procedure and probate codes, as well as regulations applying the statutes. A comprehensive review of all statutory and regulatory material was not conducted, nor was there a review of case law done. A chart summarizing the statutes is included at Appendix A.

Several issues emerged as critical decision making points in constructing an involuntary system.

- **The behavior or circumstances necessary to meet the standard for involuntary commitment.** The Maine standard for mental health commitment requires the illness to pose a likelihood of serious harm[1]. Some states used the term "gravely disabled," a subjective term without apparent clarity of definition. Of note, some states specified

[1] 34B MRSA §3864(5)(E)

substance abuse was a specific reason for commitment while others specifically excluded substance abuse.

- **The ages at which a minor may consent voluntarily to treatment and at which the involuntary commitment procedures may be utilized.** Maine law permits minors to consent to treatment for substance abuse disorders.[2] Most states specified or implied that the age of majority (age 18) was the cut-off age for commitment under juvenile procedures, after which adult commitment procedures were required. Two states set the maximum age at 17.[3] There was some additional variation regarding emancipation. Maine statute specifies the age of majority as 18.[4] The youngest specified age at which a child could be involuntarily committed for treatment in other states was 13.[5] Additionally, some states required that youths committed under the juvenile procedures either be released upon attaining majority or be subject to re-commitment under the adult procedures.[6]

- **The persons authorized to seek commitment.** There was wide variation in this area. Of particular note was an absence of consensus regarding the obligations of law enforcement officers to seek commitment. In most state statutes the issue was not addressed, but among those states describing the role of police, some granted police discretion to escort persons incapacitated by substance use to their homes or to hold them in protective custody or to seek commitment.

- **The processes of commitment, including burden and standards of proof, assistance of counsel, public v. closed hearings, formality of hearings, rules of procedure, courts of jurisdiction.**
  - All of the states that addressed burden of proof placed the responsibility on the party seeking the commitment.
  - States that addressed standard of proof in commitment proceedings ranged from findings of a neutral fact finder[7] to criminal standards (beyond a reasonable doubt).[8]
  - Those states addressing issues of counsel ranged from notice that services of public defenders were available to affirmative responsibilities to provide effective counsel to the person subject to commitment. Two states require the provision of counsel to the parties seeking the commitment of another.[9]
  - States that clearly distinguished between minors and adults in commitment proceedings specified closed hearings.
  - Application of rules of procedure ranged from informal hearing requirements to formal application of the rules of civil procedure.
  - There was no consensus regarding courts of jurisdiction.

- **The role of parents and persons standing *in loco parentis*.** Illinois provided for commitment over the objection of parents, something not addressed in any other statute. Missouri described the role of parents or others standing *in loco parentis,* "whether serving formally or not." Utah permitted termination of commitment upon the request of the parents. The roles of parents and parent surrogates in other statutes were mostly unspecified.

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[2] 22 MRSA §1502
[3] GA, WY
[4] 18A MRSA §1-201(24)
[5] WA
[6] NC, UT
[7] UT
[8] WY
[9] IA, LA

- **Distinctions between custody to ensure safety, custody for purposes of examination, and formal commitment, and the periods of time permitted for each.** There was probably more variation among the states on these points than any other, and it was often not possible to determine if the statute was making a distinction between minors and adults or substance abuse and mental health treatment. There was the usual variation regarding calendar, business or "judicial"[10] days.
    - Most states did not address specifically custody to ensure safety or custody for purposes of examination, though several implied that a person could be compelled to undergo examination. Of those that did specify custody for these purposes, the holding period was often unspecified; when specified it ranged from 24 hours to 15 days. Maine permits protective custody for a person who is apparently mentally ill and presents as a danger of imminent and substantial physical harm.[11]
    - Sixteen states set upward limits for periods of commitment. Most of these permitted re-commitment, but some set limits on the number of recommitments. California specified 14 days for short term substance abuse treatment and 180 days for long term treatment; the distinction between long and short term treatment was not specified. The commitment periods ranged from 72 hours to one year.

- **Inpatient versus outpatient commitment.** Most statutes did not specifically address outpatient commitment.

    - Pennsylvania, South Carolina, and Connecticut statutes clearly distinguished between and provided for both inpatient and outpatient commitment.
    - Massachusetts permitted forced participation in outpatient treatment as a condition of probation for juveniles.
    - Unless treatment was a condition of parole or probation, no state had a mechanism to enforce compliance with outpatient treatment.

STUDIES OF OUTPATIENT COMMITMENT

Two contemporary studies have been conducted to evaluate the role of involuntary outpatient commitment in mental health settings. No similar studies have been published regarding involuntary outpatient commitment for substance abuse treatment.

The Bellevue Hospital Center Outpatient Commitment Pilot Program, conducted in the mid 1990s, was designed to be a comprehensive 2 year evaluation of outpatient commitment in New York City. This program was designed to address adherence to treatment programs among the seriously and persistently mentally ill who were at risk for or had a history of involuntary rehospitalization or decompensation in the community, but who currently did not meet the requirements for commitment on an inpatient basis.

Clients perceived that Bellevue had the ability to force a readmission if the clients were not compliant with the outpatient commitment order; in point of fact, readmission to Bellevue could only be accomplished if the client met the standards of dangerousness to self or others. About 20% of clients who were committed expressed opposition to initial orders and a lesser number to renewal orders. Providers reported that the outpatient commitment orders were useful to "help clients abide by the rules of the residence."

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[10] CA

[11] 34B MRSA §3862

In the report of the pilot program, it was noted that about half of the 789 persons referred to the program were also substance abusers. Outpatient commitment orders were considered helpful to enforce compliance with medication regimens, but were not considered to be helpful with compliance with sobriety.

The study concluded that both patients who were subject to outpatient commitment and those in the control group demonstrated a statistically significant improvement in outcomes. Because there was a significant mobilization of services associated with this pilot, to which both committed subjects and the controls had access, the report speculated that the improved access to services had at least as much impact on outcomes as did commitments.[12]

A study conducted through Duke University and evaluated by the Bazelon Center, found that long term commitment and access to intensive services reduced hospitalization, but that short term outpatient commitment increased rather than decreased hospitalization. The population studied was people recruited upon discharge from a hospital and may not be applicable to people who did not require inpatient services. Access to intensive services delivered on a routine basis appears to be more indicative of improved outcome that did commitments.[13]

The Bazelon Center reviewed the works of Fernandez and Nygard[14] Zanni and deVeau,[15] Munetz et al.,[16] Rohland,[17] Hiday and Scheid-Cook[18] and Van Putten et al,[19] and found the studies to be flawed and the conclusions unsupportable, mainly due to very small sample sizes, lack of longitudinal evaluation and the absence of control groups or serious differences between the control group and the research subjects.

CURRENT SERVICES IN MAINE

The juvenile treatment network operated by Day One under contract to OSA provides assessment, referral and reimbursement for treatment services statewide. The assessment process provides us with a snapshot of the need for different types of treatment statewide. For 2003, 25% of teens assessed needed an out-patient level of care, 54% required intensive out-patient treatment, and 21% required residential treatment. Less than 1% needed detoxification services.

Capacity to treat adolescent substance abuse has expanded dramatically over the past few years, particularly at the out-patient level because of the creation of the adolescent treatment

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[12] Telson, H., R. Glickstein and M. Trujillo, Report of the Bellevue Hospital Center Outpatient Commitment Pilot Program. Department of Psychiatry, Bellevue Hospital, New York NY. February 19, 1999.

[13] The Bazelon Center, http://www.bazelon.org/

[14] Fernandez, GA, and S. Nygard, Impact of Involuntary Outpatient Commitment on Revolving Door Syndrome in North Carolina (1990). *Hospital and Community Psychiatry* 41:1001-1004 (1990).

[15] Zanni, G., and L. deVeau. Inpatient Stays Before and After Outpatient Commitment. *Hospital and Community Psychiatry* 37:941-942 (1986).

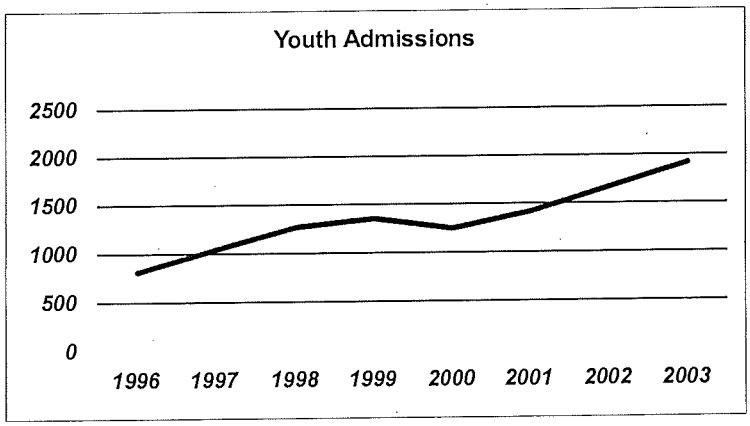
[16] Munetz, MR, T. Grande, J. Keist and GA Peterson. The Effectiveness of Outpatient Civil Commitment. *Psychiatric Services*, 47:1251-1253 (1996).

[17] Rohland, B. The Role of Outpatient Commitment in the Mangement of Persons with Schizophrenia. Iowa Consortium for Mental health Serivces, Training and research. May 1998.

[18] Hiday, VA, and TL Scheid-Cook. The North Carolina Experience with Outpatient Commitment: A Critical Appraisal. *International Journal of Law and Psychiatry*. 10:215-232 (1987).

[19] Van Putten, DA, JP Santiago and MR Bergen. Involuntary Commitment in Arizona: A Retrospective Study. *Hospital and Community Psychiatry*. 39: 2005-5002 (1988).

network. Over the course of the past five years, the number of adolescents entering substance abuse treatment has grown by 71% (from 1354 in 1999 to 1908 in 2003), primarily because of expanded access to out-patient treatment in rural areas. The increase in admissions comes as a result of both voluntary admissions and an increase in admissions of juveniles sentenced to treatment as the result of the commission of a crime. Parents interested in a civil involuntary commitment law have mentioned that the only way their child got treatment was by committing a crime and being sentenced to treatment.



Until this year, there has been a shortage of residential treatment beds particularly for younger adolescents. Given the opening of Phoenix House last year, and the opening up of some beds originally designated for DHS purposes only, there should be enough beds to meet the current demand.

Unfortunately, because there are so few adolescents that need to receive detoxification services, it is extraordinarily difficult to find those services when teenagers do need them. Intensive Out-patient services are also hard to find despite the fact that over half of the adolescent population assessed through the network needed this level of care. Most youth that need an intensive out-patient service are currently receiving out-patient therapy in a group or individual setting.

The network project has expanded recently to provide services to schools; 37 school systems are participating in outreach, assessment and referral, with 55 more waiting to be included. We anticipate that another increase in participation will occur related to this expansion, with a need for further development of services particularly, intensive out-patient, after school programs, and detoxification.

OTHER CONSIDERATIONS

Legal Findings

- A November 2003 US District Court ruling from the District of Maine (*US v. Miller,* Criminal Docket No. 02-106-P-C) found that the forced administration of medication, in the absence of an "important governmental interest," is in violation of constitutional protections, citing *Riggins v. Nevada*, 504 US 127 (1992) and *Sell v US,* 123 SCt 2174 (2003). The implications for forced imposition of treatment other than medication must be

considered in any decision regarding involuntary inpatient or outpatient commitment for substance abuse.

- In *Parham v JR*, 442 US 584 (1979), the Supreme Court established minimum standards for due process that must be accorded to minors who are committed against their will to institutions for mental health treatment. The application of these standards to commitment procedures for substance abuse treatment are unclear but must be evaluated.
- The Pennsylvania statute regarding involuntary commitment of minors for mental health and substance abuse treatment permits parents to commit a minor for treatment over the minor's objection if a physician recommends the treatment. The statute was appealed to Federal court on 14th Amendment equal protection grounds; the court declined to rule, leaving the question undecided. Ellen Mancuso, director of the children's program at the Pennsylvania protection and advocacy agency, reports that disagreement between parties revolves around the parents' "rights" to impose treatment on an unwilling child; the age at which consent for treatment is required is 14 in Pennsylvania.[20] Further details can be found in an interpretive bulletin.[21]
- *Robinson v California,* 371 US 905 (1962). This landmark decision affirmed that states could establish a program of compulsory treatment for those addicted to narcotics, which could require periods of involuntary confinement. It also held that the status of being addicted to narcotics could not be deemed a crime, and to do so was in violation of the Eighth and Fourteenth Amendments to the Federal constitution.

Judicial Implications

Enforcement mechanisms for commitment would require a civil proceeding. Mental health commitment procedures are conducted in District Court and persons subject to commitment are provided counsel. It would not be surprising if many parents, desperate to regain control over their children or to keep them safe, turned to commitment provisions in an attempt to get their children into treatment. Maine repealed the commitment statutes for substance abuse treatment in 1981.

Fiscal Implications

- The Bellevue study noted that the costs for outreach increased when the outpatient commitment law took effect.
- Locations for inpatient commitment are not currently available in Maine. Considerations must be made to erect or remodel an appropriate building or buildings, or arrange for locked treatment space in existing treatment sites. Further consideration must be made for the costs of staffing a program to be prepared to accept patients and provide treatment on short notice.
- Costs of commitment must be considered, with the need for additional time in the District Courts, costs of counsel, staff time to conduct the evaluations and to prepare the commitment materials.

[20] Private correspondence, 10/28/03

[21] http://www.dpw.state.pa.us/omhsas/OmhsasBulletin/Omhsas_AgeofConsentJun2001.asp.

RECOMMENDATIONS

Based on its research and discussions, the committee has concluded that there are several approaches to consider in order to ensure greater adolescent access to and attendance in substance abuse treatment. There is no clear guidance from a review of other state's activities or from the literature; our intent, therefore, is to lay out three key policy options we conclude will be appropriate and workable for the Maine system, and to outline the major benefits and concerns associated with each option. We will, of course, work with the Health and Human Services Committee to move forward in the chosen direction.

Option 1 – Strengthen Capacity of Substance Abuse Treatment Providers

OSA could work with the existing treatment programs to increase capacity of substance abuse providers to serve youth, by incorporating evidence based practices such as motivational interviewing and family therapies that are effective even with reluctant adolescent clients. We could provide incentives to agencies to work with teens who do not present as interested in or "ready" for treatment. We could support treatment providers to work with parents of recalcitrant children, with or without the child's involvement, in order to better facilitate family management. Increasing the skills of providers in using new techniques that have been demonstrated to be effective with an "involuntary" population would address current demand and improve the retention rate of children and families in treatment.

Increased training in therapies that are effective for youth would meet some of the need by having programs that are better at recruitment and retention of substance abusing youth, and would lead to better outcomes as teenagers would be more likely to stay in treatment long enough for it to be effective. The current retention rate for adolescents is half that of adults. This would be the least costly method of addressing the concern.

OSA created a successful campaign to educate parents on the risks of teen drinking and to help parents identify strategies to enforce rules in their home. We could modify the materials somewhat and do outreach through different avenues to help parents who have children who are already abusing alcohol and drugs find resources such as treatment, self help and skill development or support groups for themselves and their children. This campaign could reach parents through school guidance offices, pediatricians, treatment providers and others.

Summary

- Increased provider training in motivational interviewing and family therapy
- Provider contract incentives to increase recruitment and retention of adolescent clients
- Outreach/ parent education

However, it important to note that this policy option would not have helped the parents who testified at the public hearing for LD 611. Parents who cannot get their child to a treatment provider in the first place would not have their expressed needs met by this option. They may be able to receive services themselves but if a child refused to attend treatment it would not provide a way for the state to enforce a parent's wishes against the child's will.

Option 2 – Strengthen Youth in Need of Services Law

There are a small number of out of control children who have run away and are using drugs and alcohol as part of a culture of street life. Maine passed legislation in 1999 (PL 00 Ch 778) to help parents of run away and out of control children gain access to necessary services. The Youth In Need of Services legislation did provide greater outreach and access to substance abuse services for homeless and runaway youth, indicated by data from one of the Homeless Youth Projects created by the legislation.

This legislation states specifically that "In a proceeding brought under this subsection, if the court orders a service provider to offer appropriate services to a youth or the youth's family or legal guardian, the court may not order secure residential placement or inpatient treatment or order the youth to participate in services or enter an order of enforcement or contempt." (Title 22, §4099-C).

The YINS legislation obviously created an incentive for providing outreach to runaway youth, and the outreach increased access to services, which in turn improved outcomes much like those in the Bellvue study cited earlier. However, the improved outcomes assume that youth access the services that they are assessed to need. There is no way for caseworkers to force runaway youth to accept services they do not wish to attend. In fact the law explicitly prohibits it. The provider can be ordered to provide treatment, but the youth or family cannot be ordered to participate.

One potential way to empower parents to obtain services for children who do not want them, is to strengthen the YINS laws by removing the clause that prohibits court ordered treatment. The downsides of allowing for court ordered treatment when there are no criminal charges are many and apply to both option 2 and option 3. If a young person is court ordered to treatment against his/her will there are only two ways to enforce the order. The youth must be committed to a locked facility or face incarceration by violating the order, which places criminal penalties on a person with no criminal charges. This essentially poses the same problems detailed in Option 3.

These issues are probably the reason that the 119th legislature avoided providing for court ordered treatment in the initial YINS legislation.

Prior to making such dramatic changes it may be worthwhile to request that the Homeless Youth Projects collect data on youth who refuse services. This data should include demographic information, assessed needs if available, and stated reason for refusal.

It may also be useful to require joint training and communication between the Homeless Youth Projects and substance abuse treatment providers regarding engagement of reluctant youth in treatment.

Summary

- Require collection of data on youth who refuse services from Homeless Youth Projects
- Consider revising law when adequate data demonstrates need
- Joint training for DHS and BDS programs

Option 3 – Provide for Involuntary Commitment of Youth

Finally, statutory language could be added to the substance abuse statute to allow for the involuntary commitment of youth under the age of 18 to substance abuse treatment. This would require court involvement with assessing the appropriateness of the commitment. It would also require defining the circumstances under which a child could be committed. The statute regarding involuntary commitment for mental illness in Maine requires that the patient be a danger to self or others. We would have to be very clear what constitutes danger to self or others as the act of ingesting illegal drugs could be perceived as creating a danger to self, and an intoxicated person is indeed a danger to both self and others given the high rate of accidents that occur to someone who is under the influence of alcohol or drugs. Because of the nature of

addiction and substance abuse, the standard is hard to define narrowly enough to prevent abuse of the process, but broadly enough to capture the appropriate clientele.

Another problem with involuntary commitment is the need to develop locked substance abuse treatment wards, which do not currently exist in Maine. The numbers that would be committed should be low enough that it would not be cost effective to create new programs. We would have to work with existing programs to discuss the feasibility of them locking children in against their will and holding open bed space in order to have capacity to provide emergency admissions. Placing a child in a locked ward may have long term psychological consequences that must be weighed against the apparent immediate safety concern.

While this option would be the most likely to achieve the intended goal of the legislation, it is the most costly and the most complicated of the three choices. It involves the need to address civil rights and due process issues. It would involve the development of new programming as the research implies that involuntary commitment must be done on an in-patient basis in order to be effective.

The Legislative Youth Advisory Committee supports recommendation number three; stating that they don't know anybody who would willingly go to treatment on their own and that committing them to treatment would be the only way to get them into services. There was not time to discuss civil liberties or fiscal implications with them, so their recommendation is not based on a broad understanding of the implications of passing such legislation.

In a statewide survey performed by Mainly Parents (neither a representative nor other scientific sampling method was used) 40 of 57 responding parents believed that the state should pass a law allowing for the mandating of treatment of adolescents. They did not differentiate between a civil commitment and a criminal commitment, however, and most of them suggested using a drug court model indicating that they may have been thinking of commitment to treatment for juveniles that had committed a crime. Most did not feel that there should be criminal sanctions for refusal to comply with treatment, but some (12 out of 57) did feel a locked facility would be necessary. Thirty-eight of the fifty-seven respondents were aware of their own child's use of alcohol or drugs.

The committee assembled to review these options recommends they be implemented in the order they are presented. By first trying to improve recruitment and retention in treatment, and by requiring the collection of data on children who refuse services under the current YINS legislation, we think we can address some of the unmet need and obtain better data on the population who may meet criteria for civil commitment to substance abuse treatment. With better data, we could craft a model that meets an identified need rather than either being too inclusive or too exclusive in our definitions. Until option 1 has been implemented and assessed and data is collected as recommended in option 2, we do not recommend the more drastic methods in option 2 and 3.

Summary

- Involuntary commitment only after other options have been implemented

Appendix A

Summary of Statutes Governing Involuntary Treatment

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth ?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
AK	AS Title 47, Ch 47.37	SA						alcoholic or drug abuser who has threatened, attempted to inflict or inflicted physical harm on self or other; unless committed is likely to inflict physical harm on another, or is incapacitated by alcohol or drugs.		30 days	no right to jury trial
AL	AS Title 22, Subtitle 2, Ch 52, Article 1	MH									
AR	AC Title 20, Subtitle 4, Ch 64, subch 8	SA		yes				homicidal, suicidal or gravely disabled		45 days	

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth ?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
AZ	36-520; 36-2024	MH, SA			up to 48 hours, 72 weekday hours in some circimstances			danger to self or others, persistently or acutely disabled, gravely disabled and unwilling to be admitted voluntarily		24 hours emergency	
CA	CC 11759; CC 5325-5337: CC 5300	MH, SA	yes	yes						Inpatient 14 days with 180 day renewal. Outpatient 90 days with 90 day renewals	jury trial permitted
CT	CS Title 17a, Ch 319j	SA		yes				alcohol or drug dependent person who is dangerous to self or others when intoxicated, or gravely disabled		30-180 days, one 30-180 day renewal. May also be required to participate in outpatient treatment for 1 year following commitment	

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth ?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
CO	CRS Title 25, Art 1, Part 11	SA	no		5 days under emergency procedures			protective custody: under the influence of or incapacitated by drugs and clearly dahgerous to the health and safety of self or others. Commitment: drug abuser and has threatened, attempted to inflict or inflicted physical harm on self or others, or incapacitated by drugs		30 days initially, two 90 day renewals	
DC	DC ST 21-541							lilely to injure self or others			
DE	73 Del Laws 358	SA		yes	10 working days			in need of treatment and incapable or unwilling to accept voluntary treatment		30 days, renewals in 6 month increments	

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
GA	37-3-90	MH, SA		MH, SA			under 17		request for release terminates commitment		
HI	HS Div 1, Title 19, Ch 334, Part IV	MH, SA	no		under temporary order, 5 days					90 days initially, one 90 day and one 180 day recommitment	
IA	IS Title IV, Subtitle 1, Ch 125, Div 5	SA	same procedure but conducted in juvenile court	out-of-institution detention permitted; outpatient commitment permitted	24 hours for protective custody, 15 days for commitment			chronic substance abuser			
ID	IS Title 16, Ch 24	MH	yes							120 days initially, unlimited 180 day periods of recommitment	only if child or parent cannot or will not consent
IL	405 ILCS 5	MH	yes	"alternative treatment"	15 weekdays	16 to facility					
IN	IC 12-26	SA					18				
KS	KSA Ch 59, Article 29b	SA						emergency: has or may have SA problem and liklely to cause harm to self or others		emergency:5pm 2nd business day following order	

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth ?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
KY	KRS Ch 222.430	MH, SA									
LA	LRS Title 28, Ch 1, Part III	MH, SA			72 hours for protective custody			mentally ill or suffering from substance abuse and in need of immediate treatment to protect person or others from physical harm for protective custody. Must be suffering from MI or SA which contributes or causes dangerousness to self or others or is gravely disabled for commitment			
MA	GL c 123, ss 35	SA						alcoholic or substnace abuser, likelihood of werious harm		30 days	

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth ?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
MD		SA	yes		72 hours			immediate danger	right to active involvement		discharge if not compliant permitted
MI	MCL	SA at the request of parent/ guardian			48 hours	any	14		may request admission over child's objection	5 days	"brief periods of intoxication" or "dependence upon or addiction to" cannot be sole reason for commitment
MN	253B.05	MH, SA			72 weekday hours			"chemically dependent" and in danger of causing injury to self or others			peace officer has discretion to take intoxicated person into custody or transport to home
MO	MRS 431.061, 631.120	MH, SA			96 hours			imminent likelihood of serious harm to self or others			
MS	MS Code Title 31	SA						has threatened, attempted or actually inflicted physical harm upon self or another		5 days emergency, 30-90 days for treatment	

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth ?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
MT	MS Title 53, Ch 24, Part 3	SA	no		5 days			habitually lacks self control and has threatened, attempted or inflicted physical harm on another or is incapacitated by alcohol		40 days, with 90 day renewals. Limited to 2 renewals	
NC	NCGS Ch 122C, Art 5, Part 3	MH, SA									commitment becomes invalid 72 hours after attaining 18th birthday
ND	NDS Title 25, Ch 25-03.1										
NE	NRS	MH						substantial risk of serious harm to self or others within the near future			

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth ?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
NM	NMS Ch 43, Article 2	SA	no					alcoholic or drug impaired and has threatened, attempted or inflicted physical harm on self or others or is incapacitated by alcohol or drugs		30 days, 90 day renewals (2 renewals permitted)	refusal to submit voluntarily to treatment insufficient to demonstrate incapacity
NV	NS Title 39, Ch 433										
OH	ORC Title 5	MH									
OK	OS Title 43A, Ch 1,	MH, SA	yes		yes, 72 weekday hours			mentally ill and requiring treatment			pre-hearing detentions also permitted
PA	PL 221, No. 63	SA	yes	yes			18		costs	45 days, unlimited 45 day periods of renewal	

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth ?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
RI	RIGL Title 23, Ch 1.10	SA	no		5 days			has threatened, attempted or inflicted physical harm to self or another; is incapacitated by the effects of alcohol or drugs; is pregnant and abusing alcohol or drugs		10 days under emergency orders. 30 days, 2 90 day renewals	
SC	SCC Title 44, Ch 52	SA		yes				chemically dependent person		90 days inpatient, 1 year outpatient	voluntary agreement to outpatient care prohibits commitment

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth ?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
SD	34-20A-72	SA	no					has threatened, attempted or inflicted physical harm to self or another, is likeley to inflict harm if not committed; poses a danger to self due to "distress," or will continue to deteriorate and is unable to make a choice to receive treatment.			facility may refuse person committed. Person may be detained 30 days waiting for appropriate location

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
TN	TC Title 33, Part 5	MH						threatened or attempted suicide or to inflict serious harm on self; threatened or attempted homicide or other violent behavior; placed others in reasonable fear of violent behavior; unable to avoid severe impairment or injury; substantial liklihood of harm unless committed			
UT	UC 62A-15-301	SA	yes		72 hours			addicted to drugs or alcohol and poses a serious risk of harm to self or others	financial responsibilities		"neutral fact finder" makes determination; commitment terminated on request of parent

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth ?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
VA		MH	yes		72 hours	14		serious danger to self or others to the extent that "severe or irremdiable injury is likely to result;", experiencing serious deterioration of ability to care for self		90 days	parent must consent to commitment.If parent refuses consent, treatment must be necessary to preserve child's life and health
VT	VS Title 33, Part 1, Ch 7; VS Title 18, Part 8, Ch 181	SA, MH								protective custody 24 hours	
WA	Ch 71.34RCW, RCW 70.96A.020	MH, SA. MH system may refer to SA program	yes		yes, 72 weekday hours	13		"likelihood of serious harm or gravely disabled"	may seek review if child is not taken into custody		

STATE	CITE	Involuntary Commitment?	Specific to Children/Youth ?	Outpatient commitment permitted?	Holding for evaluation permitted?	Minimum age for commitment	Maximum age for commitment under youth provisions	Behavioral standard for commitment	Parents' role	Period of commitment permitted	Comments
WI	WS 51.45	SA						incapacitated: protective custody; threatened, attempted or inflicted physical harm on self or others: emergency; involuntary: habitually lack self-control, use to the point of substantial impairment or endangerment , dangerous to self or others.		72 weekday hours protective custody; 14 days emergency; 90 days involuntary and single six month renewal	may be held in custody if unable to participate in defense. Assessment of minor permitted with parent's consent
WY	WS, Title 14, Ch 6: 25-10-101	MH	yes		72 hours for preliminary hearing; 15 days for examination		"not reached 17th birthday"	"clear and present danger" to self, family, community	"residual parental rights and duties" protected by law. Uncooperative parents may be taken into custody to compel compliance	1 year	jury trial, "reasonable doubt" may be requested. Orders expire on the 17th birthday

Appendix B

Right now a legislative committee is studying the issue of mandatory substance abuse treatment for youth. Currently there are no laws that allow parents to require their children to go to treatment for their problem. The only time they are committed is when they break the law. As a parent, we would like to know what you think about this.

1) **What county are you from?** _____

2) **Are you a parent of a teen?** **Yes**_____ **No**_____

3) **To your knowledge, has your child ever experimented with drugs or alcohol?**
Yes_____ **No**_____

4) **Should the state legislature pass a law to mandate/require substance abuse treatment for youth?** **Yes**_____ **No**_____

5) **What should be the consequences for youth not complying with substance abuse treatment?**

A. No legal consequences ____
B. A locked treatment facility as an alternative ___
C. Drug Treatment Court: a choice of treatment or incarceration ____
D. Other (please explain):

_____

6) **What other things would be of special help for parents:**

A. Information about substance abuse prevention and/or treatment _____
B. Access to professional screening for substance abuse problems _____
C. Availability (location; cost; hours of operation; etc.) of substance abuse treatment services in your area _____
D. Other (please explain)

_____

Survey on Mandatory Substance Abuse Treatment for Youth

County	
Aroostook	9
Cumberland	9
Kennebec	3
Sagadahoc	1
Somerset	1
Waldo	18
York	3
Androscoggin	1

Child tried Alcohol or Drugs	
Yes	29
No	8
N/A	6

Should Mandate Law be Passed	
Yes	31
No	10

Comments:
Make funds available
On a continuum – start small
Make sure there are enough
Treatment centers & mandate
family treatment also is
Mandated.
But I would like to see support
Offered to teens when they are
Ready.
Under what circumstances would
Treatment be required? What would
Be the nature and duration of
Treatment? Who would pay?
If yes, based on what proof treatment
Is needed. Experimentation is a long
Way from needing treatment.
Who makes the decision which family
Member required to be involved.
You can't make them hear if they don't
Want to. My son has had counseling and
It became a game. Maybe counseling for
Parents with troubled teens would be a
Better idea.

Consequences for youth not complying with treatment.

A) No legal consequences 11
B) A locked treatment facility as an alternative 11
C) Drug Treatment Court: a choice of treatment or incarceration 21
D) Other:

- Service to community
- Social services / psychosocial treatment
- More intervention – diversion programs needed
- Possible 3 day dry out to see if child is ready but can't be successful w/ family involved alanon, AA, N/A or family outpatient treatment
- A variety of options that could be tailored to the individual needs of the child.
- I recommend 4 steps: 1. One on one counseling to gain understanding of the issue 2. Family counseling 3. Peer support groups 4. Community Service.
- Treatment should include the "whole" family. Parent's behavior affects the choices made by children.
- Put the funding back into local programs, in school confidential, friendly, mentoring type efforts.
- In-home support for family and individual counseling.
- Graduated and consistently enforced consequences prior to this level of intervention.
- Youth who cannot meet their needs due to drugs should have access to help.

What other things would be of special help for parents:

A. Information about substance abuse prevention and/or treatment 38
B. Access to professional screening for substance abuse problems 37
C. Availability (location, cost, hours of operation, etc.) of substance abuse treatment services in your area 37
D. Other (please explain)

- Make high school administration accountable for students falling through cracks and having students turning to drugs to cope.
- Support groups
- More treatment centers first
- More prevention services to stop before it starts
- Local law enforcement officers who actually are willing to enforce existing laws. Mandating treatment only useful if we first mandate enforcement
- Al-anon, AA N/A or step program - Family outpatient treatment - access to alternative healthy stress relieving practices
- Home Drug Kits
- Workshops on: A. How to talk with your child / not at them. B. Support groups for parents to vent and attempt to find peace with role as parent in a family with a teen that is experimenting / addicted to drugs. C. Getting kids involved in their community.
- Confidential in-home private family discussions that would make it easier – non criminalized for families to get help.
- Support groups and recreational options (including peer support) for substance abusers.
- Consequences for parents, who ignore, resist or otherwise sabotage their child's wellness to include options from #5 above for them.
- What are the costs?
- Getting help from loved ones should not be a full time job.

Appendix C

Title 22, §4099-A, Definitions

§4099-A. Definitions

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings. [2003, c. 451, Pt. P, §3 (new).]

1. Case manager. "Case manager" means an agent of the department authorized by this subchapter to perform all case management functions for a youth alleged or found to be in need of services. "Case manager" may include community-based agencies contracted by the department and persons employed by those agencies to provide case management services.

[2003, c. 451, Pt. P, §3 (new).]

2. Court. "Court" means the District Court.

[2003, c. 451, Pt. P, §3 (new).]

3. Services. "Services" means housing, education, food, medical care, mental health or substance abuse services or treatment, supervision by a parent or legal guardian and support services, including mediation services, that may assist a youth in need of services or the youth's family or legal guardian.

[2003, c. 451, Pt. P, §3 (new).]

4. Youth in need of services. "Youth in need of services" means a child under 15 years of age who:

A. Is without proper care or subsistence, education, a home or medical or other care necessary for the child's well-being;

[2003, c. 451, Pt. P, §3 (new).]

B. Is without or beyond the control of the child's parent or legal guardian; or

[2003, c. 451, Pt. P, §3 (new).]

C. Is in imminent danger of serious physical, mental or emotional injury or at risk of prosecution for a juvenile offense.

[2003, c. 451, Pt. P, §3 (new).]

[2003, c. 451, Pt. P, §3 (new).]

Title 22, §4099-B, Youth in Need of Services Program

§4099-B. Youth in Need of Services Program

1. Youth in Need of Services Program established. The Youth in Need of Services Program, referred to in this subchapter as "the program," is established within the department to provide preliminary assessments, safety plans and other services as specified in this subchapter to youth and their families and legal guardians.

[2003, c. 451, Pt. P, §3 (new).]

Title 22, §4099-C, Preliminary assessment; safety plan; other services

§4099-C. Preliminary assessment; safety plan; other services

1. Preliminary assessment. When a case manager is informed that a youth may be in need of services, the case manager shall make a preliminary assessment within 48 hours, including weekends and holidays, to determine whether the youth is a youth in need of services as defined in this subchapter and whether further action should be taken under subsection 2 or 3.

[2003, c. 451, Pt. P, §3 (new).]

2. Safety plan. When a case manager determines that a youth is in need of services, the case manager shall immediately develop a safety plan and arrange services for the youth and, if appropriate, for the youth's family or legal guardian.

[2003, c. 451, Pt. P, §3 (new).]

3. Imminent danger. If a youth is determined by a case manager to be in need of services and is in imminent danger of serious physical, mental or emotional injury or at risk of prosecution for a juvenile offense, the case manager shall attempt to contact the family or legal guardian, if appropriate, to begin services to the youth and family or legal guardian and shall promptly file a petition to commence court proceedings.

A. If the court finds that a youth is in need of services and is in imminent danger of serious physical, mental or emotional injury or at risk of prosecution for a juvenile offense, the court shall order that a service provider offer appropriate services to the youth and the youth's family or legal guardian if appropriate.

[2003, c. 451, Pt. P, §3 (new).]

B. In a proceeding brought under this subsection, if the court orders a service provider to offer appropriate services to a youth or the youth's family or legal guardian, the court may not order secure residential placement or inpatient treatment or order a youth to participate in services or enter an order of enforcement or contempt.

[2003, c. 451, Pt. P, §3 (new).]

[2003, c. 451, Pt. P, §3 (new).]

4. Treatment by spiritual means. A youth may not be considered to be in need of services under this subchapter solely because treatment is provided by spiritual means by an accredited practitioner of a recognized religious organization. When medical treatment is authorized under this subchapter, treatment by spiritual means by an accredited practitioner of a recognized religious organization may also be considered if requested by a youth or the youth's parent or legal guardian.

[2003, c. 451, Pt. P, §3 (new).]

5. Reporting. The department shall report by October 1, 2003 and annually thereafter to the joint standing committee of the Legislature having jurisdiction over health and human services matters on the number and nature of preliminary assessments, safety plans and court proceedings under this section. The report must include safety plans and court proceedings under this section. The report must include recommendations for policy initiatives, rulemaking and legislative action for youth in need of services.

[2003, c. 451, Pt. P, §3 (new).]