COMMONWEALTH OF MASSACHUSETTS
DISTRICT COURT DEPARTMENT OF THE TRIAL COURT

STANDARDS OF JUDICIAL PRACTICE

CIVIL COMMITMENT AND AUTHORIZATION OF MEDICAL TREATMENT FOR MENTAL ILLNESS

Revised April, 2019

ADMINISTRATIVE OFFICE OF THE DISTRICT COURT

DISTRICT COURT ADMINISTRATIVE REGULATION

No. 4-79

(Amended April 4, 2019)

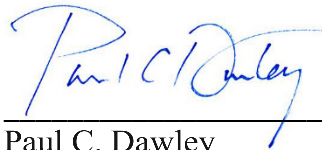
PROMULGATION OF STANDARDS OF JUDICIAL PRACTICE,

CIVIL COMMITMENT
AND AUTHORIZATION OF MEDICAL TREATMENT
FOR MENTAL ILLNESS

(Revised April, 2019)

Administrative Regulation 4-79 is hereby amended as follows:

The provisions of the Standards of Judicial Practice, *Civil Commitment and Authorization of Medical Treatment for Mental Illness,* Specifically, sec. 4:00 as revised in light of the Supreme Judicial Court's decision in *Matter of M.C.*, 481 Mass. 336 (2019), are hereby promulgated for use in the District Court Department.



Paul C. Dawley
Chief Justice of the District Court

Effective: April 4, 2019

Note:

The *Civil Commitment* Standards were first promulgated by Chief Justice Samuel E. Zoll in 1979. They were developed by the District Court Committee on Mental Health, consisting of Hon. George N. Covett (Brockton), Chair, Hon. Morris N. Gould (Worcester), Hon. Arlyne F. Hassett (Waltham), Hon. George N. Hurd (Brockton), Hon. Walter J. Moossa (Westborough), Hon. Alvertus J. Morse (Northampton), William J. O'Neil, Esq., Executive Director, Mental Health Legal AdvisorsCommittee, and Hon. Maurice H. Richardson (Dedham), with the assistance of James A. Robbins, Esq., Administrative Attorney in the Administrative Office of the District Court.

The Committee dedicated their work to Chief Justice Franklin N. Flaschner, who had died untimely before its completion, and to Committee member Hon. Morris N. Gould, who had since retired. As the Committee noted,

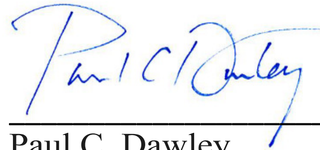
> "Judge Flaschner recognized the unique problems which these sensitive and often complex cases present for judges and other personnel in the context of a sometimes hectic community court system in which the court's time and attention are in demand by great numbers of litigants, most of whom are far more able to assert their positions than is the typical respondent in a psychiatric commitment case. The late Chief Justice was a nationally recognized leader and prolific writer in this area . . . . His leadership and his commission of the District Court Committee on Mental Health have served and continue to serve to improve the performance of the District Courts in this as in other areas of law and judicial administration.
>
> "Judge Gould was a charter member and a primary member of the Committee which produced these standards . . . . His contributions were invaluable. He administered and heard most of the civil commitment cases in central Massachusetts, and did so in a way which brought great credit to our system in the eyes of all involved, in no small measure because of the great human concern which he exhibited toward the less fortunate members of society. His decisions and opinions in this area, both as a trial judge and as a member of the Appellate Division, have provided us with a proud legacy."

In 2011, Chief Justice of the District Court Lynda M. Connolly promulgated revised Standards. At that time, she made the following acknowledgment,

> "Three decades of experience and many significant appellate decisions and statutory amendments have made a comprehensive revision of the Standards necessary, as well as their expansion to include the District Court's responsibility since 1986 for substituted judgment decisions concerning medical treatment of mental illness for incompetent civilly committed persons. I am grateful to Hon. Rosemary B. Minehan (Plymouth), Regional Administrative Judge for Region 1 and Chair of the District Court Committee on Mental Health and Substance Abuse, for undertaking this complex task. Thanks are also due Hon. Michael J. Brooks (Natick), Regional Administrative Judge for Region 4; Michael H. Cohen, Esq., Supervising Counsel at Bridgewater State Hospital; Hon. Kevan J. Cunningham (First Justice, Taunton); Hon. Paul F. LoConto (Worcester), Regional Administrative Judge for Region 5; and Debra A. Pinals, M.D., Assistant Commissioner of Forensic Mental Health Services, Massachusetts Department of Mental Health, for their thoughtful review and suggestions. A special word of thanks to Lester Blumberg, Esq., General Counsel, Massachusetts Department of Public Health; Stan Goldman, Esq., Director, Mental Health Litigation Division, Committee for Public Counsel Services; Michael T. Porter, Esq., of Connor & Hilliard, P.C.; and John M. Connors, Esq., former Deputy Court Administrator in the Administrative Office of the District Court, for their contributions of expertise, thoughtful input, and extensive drafting."

Unlike rules of court, the Standards of Judicial Practice are not mandatory in application. They represent a qualitative judgment as to best practices in each of the various aspects of the civil commitment procedure. As such, each court should strive for compliance with the Standards and should treat them as a statement of desirable practice to be departed from only with good cause. In addition, many references are made throughout the Standards to provisions of statutory and case law which, of course, must be observed.

These Standards may be amended from time to time. Comments and suggestions on how they may be improved are always welcome and should be sent to the Administrative Office of the District Court.



Paul C. Dawley
Chief Justice of the District Court
Boston, MA
April 4, 2019

CIVIL COMMITMENT AND AUTHORIZATION OF MEDICAL TREATMENT FOR MENTAL ILLNESS

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GENERAL
(Standards 1:00 through 1:02)

1:00 Introduction to District Court Mental Health and Addiction Proceedings

The District Court is responsible for conducting sixteen separate types of mental health or addiction proceedings under G.L. c. 123. They fall into five groups:

1. ***Civil commitment of mentally ill persons.*** **Civil commitment of persons alleged to be mentally ill** (G.L. c. 123, §§ 7 & 8, 12, 13)**;**

2. ***Medical treatment of civilly committed persons.*** **Authorization for medical treatment of mental illness for incompetent persons who have been civilly committed** (G.L. c. 123, § 8B)**;**

3. ***Forensic examination and commitment of criminal defendants.*** **Forensic mental health examinations and commitments of persons involved in the criminal justice system** (G.L. c. 123, §§ 15-18)**;**

4. ***Examination of witnesses or civil litigants.*** **Examination of the mental condition of witnesses or civil litigants** (G.L. c. 123, § 19)**; and**

5. ***Civil commitment of alcoholics and substance abusers.*** **Civil commitment of persons alleged to be alcoholics or substance abusers** (G.L. c. 123, § 35)**.**

These Standards address only the first two of these five types of proceedings. They have been promulgated to provide guidance in applying the law and to promote uniformity of procedure in such cases in the District Court.

The Standards describe the legal requirements and recommended practices for adjudicating petitions seeking any of the following:

1. Emergency involuntary civil commitment of a person alleged to be mentally ill to a public or private mental health facility for three days on petition of any person and after examination by a designated physician or forensic psychologist. Where necessary, these proceedings may also involve the issuance of a warrant of apprehension to bring the person before the court. (G.L. c. 123, § 12[e].) See Standard 6:00.

2. Involuntary civil commitment of a person alleged to be mentally ill to a public or private mental health facility or Bridgewater State Hospital, initially for six months and on subsequent recommitments for one year, on petition of a mental health facility director or Bridgewater State Hospital's medical director, after a "conditional voluntary" admission (G.L. c. 123, §§ 10-11), an involuntary emergency admission (§ 12[b]), or a prior court commitment under §§ 7 & 8, 12(e), 13, 15, 16 or 18. (G.L. c. 123, §§ 7 & 8). See Standards 2:00 through 5:04.

3. Authorization to administer medical treatment for mental illness (usually antipsychotic drugs) to a putatively incompetent civilly committed person, on petition of a facility director or Bridgewater State Hospital's medical director (G.L. c. 123, § 8B)**.** See Standards 7:00 through 11:04.

4. An emergency hearing on an application by an involuntarily hospitalized person to determine whether his or her admission resulted from abuse or misuse of the § 12(b) admission or commitment procedure (G.L. c. 123, § 12[b])**.** See Standard 6:01.

5. Involuntary civil commitment to Bridgewater State Hospital of a patient transferred from a mental health facility, on petition of the Commissioner of Mental Health, a facility director, or the medical director of Bridgewater State Hospital (G.L. c. 123, §§ 7[b] or 13)**. The Department of Mental Health is limited by a 1987 consent decree and by St. 1988, c. 1, § 5 to filing such petitions only for respondents with criminal charges.**

Chapter 123 and these Standards do not apply to persons with an intellectual disability but who are not mentally ill.

Commentary

For an outline of all sixteen types of mental health or addiction proceedings conducted by the District Court under G.L. c. 123, see Appendix A. For a section-by-section outline of G.L. c. 123, along with the statutory text, court forms, and links to leading cases, see R. B. Minehan, *Mental Health Proceedings under Chapter 123: A Benchbook for Trial Court Judges* (Judicial Institute, 2011 ed.). See also 53 R. B. Minehan & R. M. Kantrowitz, *Mental Health Law* (2007 & Supp. 2011).

Note that the Uniform Probate Code (G.L. c. 190B, § 5-309[f]), unlike prior G.L. c. 201, § 6(b), no longer permits the Probate and Family Court to grant a court-appointed guardian the authority to admit the ward to a mental hospital. Instead, commitment proceedings must be initiated in the District Court under G.L. c. 123, §§ 7 & 8.

CONSENT DECREE ON TRANSFERS TO BRIDGEWATER STATE HOSPITAL

In 1987, the Department of Mental Health agreed that it would henceforth seek to transfer patients already committed to a mental health facility to Bridgewater State Hospital only if they had criminal charges. In a consent decree, DMH agreed that it would no longer petition under G.L. c. 123, §§ 7(b) or 13 for court approval to transfer already-committed patients to Bridgewater State Hospital if they "neither have a pending criminal charge against them nor are serving a criminal sentence nor are awaiting sentencing, except for persons found not guilty by reason of mental illness or mental defect." *Shawn P. O'Sullivan v. Michael S. Dukakis,* C.A. No. 87-3881 (Suffolk Supr. Ct.), Interim Settlement Agreement at 8-9 (1987). The consent decree was subsequently ratified by St. 1988, c. 1, § 5, which directed DMH to implement a plan to end such transfers unless required by G.L. c. 123. Note that the consent decree and statute do not

affect the court's authority to commit or transfer respondents to Bridgewater State Hospital pursuant to G.L. c. 123, § 7(b) or § 13.

Intellectually Disabled Persons

"[A] person with an intellectual disability may be considered mentally ill; provided further, that no person with an intellectual disability shall be considered mentally ill solely by virtue of the person's intellectual disability." G.L. c. 123B, § 1. A person with an intellectual disability is "a person who, as a result of inadequately developed or impaired intelligence, as determined by clinical authorities as described in the regulations of the [Department of Developmental Services], is substantially limited in the person's ability to learn or adapt, as judged by established standards available for the evaluation of a person's ability to function in the community." *Id.* Admission procedures for facilities for persons with an intellectual disability are set out in G.L. c. 123B, §§ 5-7 and do not involve the court.

Intellectual disabilities were sometimes formerly referred to as developmental disabilities or mental retardation, but that terminology was eliminated from the General Laws by St. 2010, c. 239.

1:01 Definitions

DESIGNATED FORENSIC PSYCHIATRIST: A psychiatrist who has been designated by the Department of Mental Health to conduct examinations and make reports pursuant to G.L. c. 123, §§ 12(e), 15-19 and 35. To qualify for such designation, a psychiatrist must (1) be licensed to practice medicine in Massachusetts; (2) either be certified or eligible to be certified by the American Board of Psychiatry and Neurology or have completed at least three years of post-graduate medical training, two years of which were in an accredited psychiatric residency training program; (3) submit at least two letters attesting to his or her professional capabilities from licensed mental health professionals; (4) have completed a written examination on knowledge relevant to performing such evaluations; (5) have conducted such evaluations or completed approved training in conducting such evaluations, and have completed at least two kinds of forensic reports; (6) have completed training visits to Bridgewater State Hospital, a DMH adult inpatient facility, a court clinic, a county or state correctional facility, the Massachusetts Alcohol and Substance Abuse Center at Bridgewater, and at least one other substance abuse treatment facility that accepts § 35 admissions; and (7) be employed in a setting in which he or she will be performing such evaluations or related forensic mental health work. Such examinations and reports may also be done by psychiatrists who have been accepted by DMH as Designated Forensic Psychiatrist Candidates and are supervised by a Forensic Mental Health Supervisor, and psychiatic residents in a DMH-approved training program. 104 Code Mass. Regs. § 33.04(2)-(6).

DESIGNATED FORENSIC PSYCHOLOGIST: A psychologist who has been designated by the Department of Mental Health to conduct examinations and make reports pursuant to G.L. c. 123, §§ 12(e), 15-19 and 35. To qualify for such designation, a psychologist must (1) be licensed by the Board of Registration of Psychologists and certified as a Health Service Provider; (2) have obtained under the supervision of a licensed mental health professional, during graduate training or beyond, at least 2,000 hours of clinical experience in a setting with adult mentally ill psychiatric patients, or 1,000 hours of clinical experience in an inpatient psychiatric hospital for mentally ill adults, or other significant clinical experience working with mentally ill adults; (3) submit at least two letters attesting to his or her professional capabilities from licensed mental health professionals; (4) have completed a written examination on knowledge relevant to performing such evaluations; (5) have conducted such examinations or completed approved training in conducting such evaluations, and have completed at least two kinds of forensic reports; (6) have completed training visits to Bridgewater State Hospital, a DMH adult inpatient facility, a court clinic, a county or state correctional facility, the Massachusetts Alcohol and Substance Abuse Center at Bridgewater, and at least one other substance abuse treatment facility that accepts § 35 admissions; and (7) be employed in a setting in which he or she will be performing such evaluations or related forensic mental health work. Such examinations and reports may also be done by psychologists who have been accepted by DMH as Designated Forensic Psychologist Candidates and are supervised by a Forensic Mental Health Supervisor, or who have been approved as provisional Designated Forensic Psychologist Candidates, or who are post-doctoral psychology fellows participating in an approved forensic psychology postdoctoral training program. 104 Code Mass. Regs. § 33.04(7)-(11).

DESIGNATED PHYSICIAN: A physician who has authority to admit a person to a mental health facility for up to three days pursuant to G.L. c. 123, § 12(b). Any public or private facility which admits patients under § 12 may so designate any licensed physician on its medical staff with admitting privileges who is certified or eligible to be certified by the American Board of Psychiatry and Neurology or has had six months accredited residency training in psychiatry or is enrolled in and working at an accredited psychiatry residency training site, and who has demonstrated an understanding of the legal and clinical requirements for hospitalization under § 12(b). 104 Code Mass. Regs. § 33.03.

FACILITY: "[A] public or private facility for the care and treatment of mentally ill persons, except for the Bridgewater State Hospital." G.L. c. 123, § 1. "Facility shall mean a Department-operated hospital, community mental health center with inpatient unit, or psychiatric unit within a public health hospital; a Department-licensed psychiatric hospital; a Department-licensed psychiatric unit within a general hospital; or a secure intensive residential treatment program for adolescents that is either designated as a facility under the control of the Department or licensed by the Department." 104 Code Mass. Regs. § 25.03.

FACILITY DIRECTOR: "Facility Director or Director of a Facility shall mean the superintendent or other head of a facility who is responsible for the admission, discharge, and treatment of patients in the facility, who may petition the district or juvenile court for commitment pursuant to M.G.L. c. 123; and who may take such other action as is authorized or required of the superintendent or other head of a facility pursuant to M.G.L. c. 123." 104 Code Mass. Regs. § 25.03.

LIKELIHOOD OF SERIOUS HARM:

> "(1) a substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; or
>
> "(2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior or serious physical harm to them; or
>
> "(3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community." G.L. c. 123, § 1.

Note that the definition requires a "substantial" risk of harm when the danger is based on potential physical harm to self or others. If the danger is based on the person's alleged inability to protect himself or herself in the community, a "very substantial" risk of harm is required. In all three situations, the potential risk must involve *physical* harm or impairment.

MENTAL ILLNESS: "For the purpose of involuntary commitment, mental illness is defined as a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall not include alcoholism or substance abuse which is defined in M.G.L.

c. 123, § 35." 104 Code Mass. Regs. § 27.05(1). "The [Department of Mental Health] shall . . . adopt regulations consistent with this chapter which . . . shall define the categories of mental illness for the purpose of this chapter . . . ." G.L. c. 123, § 2.

PSYCHIATRIST: "[A] physician licensed pursuant to [G.L. c. 112, § 2] who specializes in the practice of psychiatry." G.L. c. 123, § 1.

PSYCHOTHERAPIST: For purposes of the testimonial privilege concerning confidential communications to a psychotherapist, "psychotherapists" include physicians who devote a substantial portion of their time to the practice of psychiatry (including pain management), licensed psychologists, doctoral students under the supervision of a licensed psychologist, and psychiatric nurse mental health clinical specialists. G.L. c. 233, § 20B; *Board of Registration in Medicine v. Doe,* 457 Mass. 738, 743-745 (2010).

QUALIFIED PHYSICIAN: "[A] physician who is licensed pursuant to [G.L. c. 112, § 2] who is designated by and who meets qualifications required by the regulations of the [Department of Mental Health]; provided that different qualifications may be established for different purposes of [G.L. c. 123]. A qualified physician need not be an employee of the [Department of Mental Health] or of any facility of the [Department of Mental Health]." G.L. c. 123, § 1.

QUALIFIED PSYCHIATRIC NURSE MENTAL HEALTH CLINICAL SPECIALIST: "[A] psychiatric nurse mental health clinical specialist authorized to practice as such under regulations promulgated pursuant to the provisions of [G.L. c. 112, § 80B] who is designated by and meets qualifications required by the regulations of the Department of Mental Health]; provided that different qualifications may be established for different purposes of [G.L. c. 123]. A qualified psychiatric nurse mental health clinical specialist need not be an employee of the [Department of Mental Health] or of any facility of the [Department of Mental Health]." A psychiatric nurse is "a nurse licensed pursuant to [G.L. c. 112, § 74] who specializes in mental health or psychiatric nursing." G.L. c. 123, § 1.

QUALIFIED PSYCHOLOGIST: "[A] psychologist who is licensed pursuant to [G.L. c. 112, §§ 118-129, inclusive,] who is designated by and who meets qualifications required by the regulations of the [Department of Mental Health], provided that different qualifications may be established for different purposes of [G.L. c. 123]. A qualified psychologist need not be an employee of the [Department of Mental Health] or of any facility of the [Department of Mental Health]." A psychologist is "an individual licensed pursuant to [G.L. c. 112, §§ 118-129, inclusive]." G.L. c. 123, § 1.

SOCIAL WORKER: For purposes of the testimonial privilege concerning confidential communications to a social worker, "social workers" include licensed certified social workers, licensed social workers, and government-employed social workers. G.L. c. 112, § 135B.

1:02 Privacy of Court Records

Petitions, dockets, notices, examination reports, orders and other documents, and electronic recordings of civil commitment proceedings are not available for public inspection without a court order. They remain available to the parties and their counsel, and in most instances to the prosecutor in any pending criminal cases against the respondent, except for any materials impounded by the court. G.L. c. 123, § 36A.

An expert's report of a court-ordered examination for competence or criminal responsibility is not available to the prosecutor unless a judge has determined that it has been redacted to contain nothing that falls within the scope of the privilege against self-incrimination. *Seng v. Commonwealth,* 445 Mass. 536, 539-548 (2005) (competence); *Blaisdell v. Commonwealth,* 372 Mass. 753, 768 (1977) (criminal responsibility); Mass. R. Crim. P. 14(b)(2)(B) (same).

The dockets and case files of civil commitment proceedings must be kept separate from other court records so as to ensure properly restricted access.

Commentary

Commitment proceedings involve not only restraint of the respondent's liberty, but also an inquiry into highly personal matters. General Laws c. 123, § 36A requires that records and other information related to commitment proceedings be kept separate from other court documents and, except on court order, away from public inspection.

Section 36A provides that "any person who is the subject of an examination or a commitment proceeding, or his counsel, may inspect all reports and papers filed with the court in a pending proceeding, and the prosecutor in a criminal case may inspect all reports and papers concerning commitment proceedings that are filed with the court in a pending case." However, if the respondent has pending criminal charges, the Supreme Judicial Court has held that Mass. R. Crim. P. 14(b)(2)(B) applies to any competency or criminal responsibility evaluations, and that prosecutors are not automatically entitled to view competency evaluation reports. The judge may inspect such evaluation reports *in camera* with defense counsel to determine if there are any statements that fall within the defendant's privilege against self-incrimination. *Commonwealth v. Seng,* 445 Mass. 536, 546-547 (2005).

Section 36A also states that, as a matter of discretion, the court may allow others access to such court records for good cause. Normally this should be done only after the respondent has been provided with notice of the request and an opportunity to be heard. Because such restrictions on public access are generally for the benefit of the respondent, his or her consent to such access is an important but not controlling factor in the judge's determination. With appropriate guarantees of confidentiality for individual cases, legitimate institutional concerns may also be weighed, such as the need of the Committee for Public Counsel Services or the Department of Mental Health to monitor the performance of their attorneys or clinicians, or requests for access by qualified researchers.

Clerk-magistrates must take care to protect the privacy of such documents and court records, storing them either in a locked room or file. Some courts keep such documents in the judicial lobby, but such an arrangement should be adopted only in consultation with the clerk-magistrate of the court, who remains legally responsible for the custody and security of all court records. G.L. c. 218, § 12.

CIVIL COMMITMENT FOR MENTAL ILLNESS
(Standards 2:00 through 6:01)

2:00 Requirements for Civil Commitment

A person may not be committed to a mental health facility under chapter 123 unless the evidence establishes beyond a reasonable doubt that:

(1) the person is mentally ill;

(2) failure to retain such person in a facility would create a likelihood of serious harm to that person or others by reason of mental illness; and

(3) there is no less restrictive alternative to hospitalization by which to treat the person.

A person may not be committed to Bridgewater State Hospital unless such person is a male and the evidence establishes beyond a reasonable doubt that:

(1) he is mentally ill;

(2) failure to retain him in strict custody would create a likelihood of serious harm by reason of mental illness; and

(2) he is not a proper subject for commitment to any facility of the Department of Mental Health.

Commentary

The law is clear that a person cannot be involuntarily civilly committed merely because the person is mentally ill or may benefit from treatment. The Due Process Clause permits involuntary civil commitment only if the respondent is shown to be both mentally ill and dangerous as a result. *O'Connor v. Donaldson,* 422 U.S. 563 (1975). In Massachusetts, a person may be committed to a mental health facility only if the petitioner proves each of three elements beyond a reasonable doubt: (1) that the person is mentally ill; (2) that failure to retain the person in a facility would create a likelihood of serious harm by reason of mental illness; and (3) that there is no less restrictive alternative by which to treat such person. The first two of these requirements are set forth in G.L. c. 123, § 8(a), the third in *Commonwealth v. Nassar,* 380 Mass. 908 (1980).

There is an even higher standard for commitment to Bridgewater State Hospital, which is operated by the Massachusetts Department of Correction and provides enhanced security. The respondent must be male and the petitioner must prove beyond a reasonable doubt: (1) that he is mentally ill; (2) that failure to retain the respondent in strict custody would create a likelihood of

serious harm by reason of mental illness; and (3) that no Department of Mental Health facility is suitable. G.L. c. 123, § 8(b). If the criteria for commitment to Bridgewater State Hospital are not met, but those required for commitment to a facility are proved beyond a reasonable doubt, the court is to order commitment to a facility designated by the Department of Mental Health. *Id.*

MENTAL ILLNESS

As authorized by G.L. c. 123, § 2, the Department of Mental Health has defined "mental illness" for the purpose of involuntary commitment as:

> "a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall not include alcoholism as defined in G.L. c. 123, § 35." 104 Code Mass. Regs. § 27.05(1).

In mental health proceedings, reference is often made to the diagnostic categories described in the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association, and now in its fourth edition (DSM-IV-TR [2000]). Although the court may find such clinical diagnoses, and the clinical observations which support them, of some value in the fact-finding process, the court should always require specific evidence of a "substantial [mental] disorder" which "grossly impairs" the person's functioning, as set out in the above statutorily-authorized definition of mental illness.

As noted in Standard 1:00, a person with an intellectual disability may not be committed under G.L. c. 123 unless he or she also suffers from mental illness. A respondent with such a "dual diagnosis" may be involuntarily committed under G.L. c. 123 only if the requisite likelihood of serious harm results from the respondent's mental illness. *Commonwealth v. Delverde,* 401 Mass. 447 (1988).

"SUBSTANTIAL" OR "VERY SUBSTANTIAL" LIKELIHOOD OF PHYSICAL HARM

Even if proven to be mentally ill, a person may not be committed unless the petitioner proves beyond a reasonable doubt that there is a likelihood of serious harm because of the person's mental illness. "Likelihood of serious harm" is defined as:

> "(1) a substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; or
>
> "(2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior or serious physical harm to them; or
>
> "(3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is

> unable to protect himself in the community and that reasonable provision for his protection is not available in the community." G.L. c. 123, § 1.

Note that the statute requires proof of a "substantial" risk of harm when the asserted danger is based on potential physical harm to self (G.L. c. 123, § 1[1]) or others (§ 1[2]). If the asserted danger is based on the person's alleged inability to protect himself or herself in the community, a "very substantial" risk of harm is required (§ 1[3]). In all three situations, the statute requires risk of *physical* harm.

To satisfy this element, the petitioner must present factual evidence sufficient to warrant a finding beyond a reasonable doubt that a substantial (or very substantial) risk of physical harm exists by reason of the person's mental illness. This determination will often involve a balancing of the probability, gravity and imminence of the potential harm.

Recent dangerous overt acts or omissions are relevant in showing the risk of harm. See, e.g., *Commonwealth v. Nassar,* 380 Mass. 908 (1980) (respondent's decision to stop feeding child who later died of malnutrition and neglect was "homicidal" behavior within meaning of G.L. c. 123, § 1). However, some recent manifestation of dangerous behavior is not a requisite element of proof. *Commonwealth v. Rosenberg,* 410 Mass. 347, 363 (1991) (no requirement that "likelihood of serious harm" be established by evidence of recent overt dangerous act).

The risk of harm must be immediate, since "the forecast of events tends to diminish in reliability as the events are projected ahead in time," although "in the degree that the anticipated physical harm is serious – approaches death – some lessening of a requirement of 'imminence' seems justified." *Nassar,* 380 Mass. at 917. The court may also take into account any recent restrictions on the respondent's opportunity to cause harm. See *Delverde,* 401 Mass. at 451 (prisoner found to offer substantial risk if released in light of past medical and social records, facts of crime, and violent behavior while incarcerated). Traditional evidentiary principles should guide the court's determination as to whether the evidence is sufficiently current to demonstrate present risk.

LEAST RESTRICTIVE ALTERNATIVE

As a prerequisite to any civil commitment, the petitioner must prove beyond a reasonable doubt that there is no less restrictive alternative to hospitalization. The statute expressly requires this only in the third branch of the definition of "likelihood of serious harm," but case law has determined that it is required under the other two branches as well:

> "Regardless of the constitutional place of such a doctrine, either in general or in the particular context, we think it natural and right that all concerned in the law and its administration should strive to find the least burdensome or oppressive controls over the individual that are compatible with the fulfillment of the dual purposes of our statute, namely, protection of the person and others from physical harm and rehabilitation of the person." *Nassar,* 380 Mass. at 917-918.

Nassar indicates that the petitioner must consider "all possible alternatives to continued hospitalization" (citing G.L. c. 123, § 4) and this is also the standard that the court must apply. *Id.* See also *Gallup v. Alden,* 57 Mass. App. Dec. 41 (1975). The petitioner is not required to develop as part of its case the factual basis for any expert opinions it proffers about alternatives to hospitalization; that may be explored on cross-examination. *Siddell v. Marshall,* 1987 Mass. App. Div. 3 (psychiatrist's unchallenged opinion that hospitalization was only appropriate alternative sufficient to support court's conclusion that no less restrictive alternative was available).

As a practical matter, this inquiry will often turn on whether hospitalization is the only available setting in which the respondent may be safely and appropriately treated. If the petitioner can initially establish beyond a reasonable doubt that this is the case, the inquiry will normally be at an end.

STRICT CUSTODY

As noted above, a male respondent may be committed to Bridgewater State Hospital upon a finding beyond a reasonable doubt that he is mentally ill, that failure to hospitalize him in strict custody would create a likelihood of serious harm by reason of mental illness, and that he is "not a proper subject" for commitment to any Department of Mental Health facility. G.L. c. 123, § 8(b).

3:00 Filing the Petition

A petition for involuntary commitment of a current patient at a public or private mental health facility may be filed by the superintendent or other head of that facility. G.L. c. 123, § 7(a).

A petition for involuntary commitment to Bridgewater State Hospital of a current male patient may be filed by the Medical Director of Bridgewater State Hospital, by the Commissioner of Mental Health, or (with the approval of the Commissioner) by the superintendent of a public or private mental health facility. G.L. c. 123, § 7(b).

The petition must be filed in the District Court division with jurisdiction over the facility (or Bridgewater State Hospital) where the patient is located. G.L. c. 123, § 7(a) & (b).

The petition must allege that the person meets each of the criteria for commitment to a facility or to Bridgewater State Hospital. Since the filing of a petition authorizes the facility to retain the patient during the pendency of the petition (G.L. c. 123, § 6[a])**, any petition must be based on a good faith belief that there is credible evidence that will satisfy these criteria. A petition may not be filed merely for administrative convenience or delay.**

The traditional petition form used by most district courts additionally requests the petitioner to specify the respondent's mental illness and risk of harm. If there is objection at the hearing that the evidence does not conform to these specifications and a resulting motion to amend the petition is offered, the court must consider whether the respondent has been prejudiced in preparing for the hearing and determine the most appropriate remedy.

The petition should include brief but specific factual assertions that demonstrate that each of the criteria for commitment is met.

If known at the time of filing, the petitioner should inform court staff if the respondent will require a translator or other language or hearing assistance in order to participate meaningfully in the hearing. Non-English speaking respondents are legally entitled to the assistance of trained interpreters. G.L. c. 123, § 23A (psychiatric hospitals must offer "competent interpreter services" by trained interpreters); G.L. c. 221C, § 2 (courts must use Federally- or Trial Court- "certified" interpreters).

If the respondent is presently a conditional voluntary patient, a petition may be filed only if the respondent (1) has given a three-day notice of intent to leave, or (2) has refused an authorized transfer to another facility, or (3) is no longer competent to remain as a conditional voluntary patient.

Commentary

The "superintendent or other head of a facility who is responsible for the admission, discharge, and treatment of patients in the facility" (104 Code Mass. Regs. § 25.03, "Facility Director") is the only person authorized to file a petition for commitment to a facility. The term includes the head of a psychiatric unit within a general hospital or other subsidiary psychiatric unit within a larger institution. *Bayridge Hosp. v. Jackson,* 2010 Mass. App. Div. 12 (N. Dist.). The Bridgewater State Hospital's Medical Director is a physician appointed by the Commissioner of Correction, with the approval of the Commissioner of Mental Health, to have overall responsibility for the clinical care of Bridgewater patients. G.L. c. 125, § 18.

After a petition is filed, some respondents may waive a hearing pursuant to G.L. c. 123, § 6(b). The court may then allow the commitment if the petition shows on its face that each of the criteria for commitment is met. G.L. c. 123, § 8(e) (commitment to a facility) or (f) (commitment to Bridgewater State Hospital). For that reason, a petitioner should include in the petition, in the space provided on the form or in appended pages, brief but specific factual assertions in support of the petition, demonstrating that each commitment criterion is met.

This should normally include a summary description of the symptoms or behaviors exhibited by the respondent which support the allegation that the respondent is mentally ill (under the definition in 104 Code Mass. Regs. § 27.05), and of the behavior supporting a conclusion that the person is likely to seriously harm himself or herself or others if not committed. The petitioner should also briefly explain why no less restrictive alternative is appropriate (or available) for the respondent.

A petition may not be filed concerning a conditional voluntary patient (i.e., one accepted by the superintendent on a voluntary basis under G.L. c. 123, §§ 10 & 11), unless the respondent has given a three-day notice of intent to leave (*Acting Superintendent of Bournewood Hosp. v. Baker,* 431 Mass. 101, 103-106 [2000]), or has refused an authorized transfer to another facility (G.L. c. 123, § 3; 104 Code Mass. Regs. § 27.08[4] & [5]), or has been determined on periodic review to lack the competence to remain as a conditional voluntary patient (104 Code Mass. Regs. § 27.11(4)(a)).

3:01 Time Limits for Filing Petition

Any petition for the involuntary civil commitment of a person (G.L. c. 123, §§ 7 & 8) **must be filed prior to the expiration of any three-day emergency admission** (§ 12[d])**, three-day emergency court-ordered commitment** (§ 12[e])**, three-day notice of intent to leave under a conditional voluntary admission** (§§ 10-11)**, or other commitment order under G.L. c. 123 for evaluation or care and treatment.**

Upon the timely filing of a petition, the respondent may be retained at the facility until a timely court hearing. If the petition is not timely filed, the respondent must be discharged at the end of the three-day period or the expiration of any other commitment order. G.L. c. 123, §§ 6, 11 & 12(d).

The clerk-magistrate's office must time-stamp and docket all petitions upon receipt.

Commentary

The time limits established by G.L. c. 123 for filing a petition are mandatory. *Hashimi v. Kalil*, 388 Mass. 607, 609 (1983). See also *Newton-Wellesley Hosp. v. Magrini,* 451 Mass. 777 (2008) (time limit for § 12[b] emergency hearing). The court must allow a respondent's motion to dismiss any commitment petition that was not timely filed.

3:02 Right to a Hearing

A person who is the subject of a petition for involuntary civil commitment must have a timely hearing on the petition unless he or she waives the hearing in writing after consultation with counsel.

If the hearing is waived, the court may adjudicate the petition if it shows on its face that each of the criteria for commitment is met. G.L. c. 123, § 8(e) (commitment to a facility) or (f) (commitment to Bridgewater State Hospital).

Commentary

General Laws c. 123, § 6 requires a hearing unless the respondent waives that right in writing after consultation with counsel. G.L. c. 123, § 5 mandates that at all hearings required under chapter 123 the respondent must be afforded the opportunity to present independent testimony. See also Standards 3:04 (Time Limits for Hearing) and 3:06 (Continuances).

A respondent who decides to waive the hearing “may request a hearing for good cause shown at any time during the period of commitment.” G.L. c. 123, § 6(b).

3:03 Right to Counsel

A person who is the subject of a petition for involuntary civil commitment or a § 8B petition to authorize medical treatment has a constitutional and statutory right to be represented by counsel to defend against that petition.

The clerk-magistrate's office should always notify the Committee for Public Counsel Services immediately upon the filing of the petition so that counsel may be assigned to represent the respondent, unless the court subsequently finds that the respondent is not indigent, is represented by private counsel, or has voluntarily and intelligently waived the right to counsel.

The clerk-magistrate's office should determine if there are criminal charges pending against the respondent, and if so, also should notify criminal defense counsel, who should be afforded the opportunity to be heard at any hearing on the petition.

If the respondent refuses counsel, he or she should appear before the court so that the court may determine if the refusal constitutes a waiver of counsel that is voluntarily and intelligently made. If the respondent who refuses counsel also declines or is unable to appear, counsel or temporary counsel should report to the court on whether the court should visit the respondent or continue the case until the respondent can attend. Counsel or temporary counsel should also report on the respondent's capacity to refuse counsel voluntarily and intelligently. Generally, if counsel is refused, the court should appoint standby counsel to be available to assist the respondent, if necessary, in the preparation and presentation of his or her case. Standby counsel should attend the hearing whether or not the respondent chooses to attend.

Commentary

General Laws, c. 123, § 5 provides a statutory right to counsel whenever a hearing is required pursuant to G.L. c. 123, and directs the court to appoint counsel for respondents found to be indigent. The court does this by "assign[ing] the Committee for Public Counsel Services to provide representation for the party." Supreme Judicial Court Rule 3:10, § 5. See also G.L. c. 211D, § 5. The Committee for Public Counsel Services (CPCS) is, in turn, responsible to "establish, supervise and maintain a system for the appointment or assignment of counsel" in particular cases, "which shall include . . . a mental health unit" (G.L. c. 211D, § 6).

Unless the respondent is represented by retained counsel, immediately upon the filing of a commitment petition, the court should notify, by facsimile, the CPCS Mental Health Litigation Division in order that appropriate counsel may be identified and assigned.

INDIGENCY

Pursuant to Supreme Judicial Court Rule 3:10, § 1(f)(iii), persons who are the subject of commitment proceedings or proceedings seeking a substituted judgment determination concerning treatment are presumed to be indigent and entitled to appointed counsel.

The rule qualifies this presumption of indigency with a proviso that "where the judge has reason to believe that the party is not indigent, a determination of indigency shall be made in accordance with" the rule, but "for purposes of such determination 'available funds' shall not include the liquid assets or disposable net monthly income of any member of the party's family."

SUBSEQUENT REVOCATION OF INDIGENCY FINDING

If, subsequent to the assignment of counsel by CPCS, the court determines that the respondent is not indigent, the court should proceed as follows:

> "If [that determination is made] prior to the commencement of [the] hearing . . . , assigned counsel may be dismissed, and, if so, the [respondent] shall be advised to retain private counsel without delay; provided, however, that if the interests of justice so require in such proceedings, the judge shall authorize the continued services of appointed counsel at public expense. The interests of justice may require such appointment if, for example, the party is incompetent to obtain counsel, incapable of obtaining access to funds, or incapable of locating or contracting with a lawyer. If, subsequent to the commencement of [the] hearing . . . , the judge determines that the [respondent] is not indigent, assigned counsel shall continue to represent the [respondent] and the [respondent] may be ordered to reimburse the Commonwealth therefor." Supreme Judicial Court Rule 3:10, § 5.

WAIVER OF COUNSEL & APPOINTMENT OF STANDBY COUNSEL

As in any judicial proceeding, the respondent may elect to waive his or her right to the assistance of counsel. Prior to allowing such a waiver, however, the judge:

> "shall specifically determine whether the [respondent] is competent to waive counsel. Notwithstanding such waiver, if the judge determines that the [respondent] is not competent to waive counsel or is otherwise unable effectively to exercise [his or her] rights at a hearing, the judge shall appoint standby counsel pursuant to [Supreme Judicial Court Rule 3:10,] Section 6." Supreme Judicial Court Rule 3:10, § 3.

Competence to waive counsel requires not only competence to understand the proceedings but also a subjective understanding of the decision to waive counsel and its consequences, including "the seriousness of the [petition], the magnitude of his undertaking, the availability of advisory counsel, and the disadvantages of self-representation." *Commonwealth v. Barnes,* 399 Mass. 385, 391 (1987) (internal quotes omitted). See *Indiana v. Edwards,* 554

U.S. 164 (2008) (criminal defendant may be required to accept representation by counsel if mentally incompetent to conduct own defense).

Standby counsel should also be appointed if the respondent refuses to attend the hearing. See Standard 4:04.

Withdrawal by Counsel

CPCS-assigned counsel may move to withdraw his or her appearance if he or she is unable or unwilling to represent the respondent. If the court allows counsel's motion to withdraw, CPCS should be immediately notified in order that it may assign successor counsel. Supreme Judicial Court Rule 3:10, § 10(b).

Appointed counsel may not withdraw from representation except with the court's permission. If the respondent wishes to discharge his or her court-appointed attorney, the attorney should bring the respondent's statement to the court's attention, together with any reason the attorney can ascertain, taking care to avoid disclosure of secrets or confidences of the client or prejudice to his or her case. Massachusetts Bar Ass'n Comm. on Prof. Ethics, Opinion No. 80-4 (May 21, 1980).

CPCS-assigned counsel should be permitted to withdraw from the case if the respondent has retained private counsel and that attorney understands the nature of the chapter 123 proceedings and will competently represent the respondent's interests.

Pending Criminal Charges

Persons who are the subject of a civil commitment or medical treatment petition may also have criminal charges pending against them. In such cases, the person will usually have appointed or private defense counsel in the criminal proceeding. Since the effectiveness of respondent's criminal defense strategy may be affected by the civil proceedings, the clerk-magistrate's office should immediately notify the person's criminal defense counsel of the filing of any such petitions, and the court should afford him or her the opportunity to be heard at any subsequent hearing. See also Standard 3:05 (Notice of Hearing). While coordination of representation strategies is the responsibility of counsel, the court should be alert to any apparent lack of coordination between mental health counsel and criminal defense counsel.

Attorney Performance Standards

Representing a person with impaired mental capacity poses many professional challenges for an attorney. Many of these are discussed in Rule 1.14 (Client with Diminished Capacity) of the Massachusetts Rules of Professional Conduct, Supreme Judicial Court Rule 3:07 (available at www.massreports.com/courtrules).

The general rule in this situation is that:

> "Even if a client with diminished capacity has not made an adequately considered decision, counsel must advocate the client's position if it does not put the client in jeopardy. The mere fact that the lawyer believes the client is wrong is not a sufficient reason for not following the client's directions; clients are allowed to make bad decisions.
>
> "Where [an incompetent] client's expressed preferences do put the client at risk of substantial harm, the lawyer's task is more complicated. As a first step, if practicable and in the manner least intrusive to the client, the lawyer should determine whether it would help to consult family members or other appropriate persons or entities as allowed by Rule 1.14(b) and Comment 5. But if that tactic is not feasible or does not suffice to protect the client, [Comment 7] gives the lawyer four choices."

Bar Counsel Constance V. Vecchione, *Representing Clients with Diminished Capacity* (July, 2009) (available at www.mass.gov/obcbbo/diminished.htm). The four options, and the circumstances under which each is available, are further discussed in Bar Counsel's article.

Assigned counsel must comply with performance standards promulgated by the Committee for Public Counsel Services for representing respondents in civil commitment proceedings (see Appendix C) and in medical treatment authorization proceedings (see Appendix D). Judges should be generally familiar with the CPCS standards and should inform CPCS' Mental Health Litigation Division when there is significant noncompliance. These standards are also available on the CPCS internet website (www.publiccounsel.net).

3:04 Time Limits for Hearing

For an *initial commitment* petition under G.L. c. 123, §§ 7 & 8, the hearing must be commenced within five days after the date of filing, unless a continuance is granted at the request of the respondent or respondent's counsel. G.L. c. 123, § 7(c).

For a *subsequent recommitment* petition under G.L. c. 123, §§ 7 & 8, the hearing must be commenced within 14 days after the date of filing, unless a continuance is granted at the request of the respondent or respondent's counsel. *Id.*

For purposes of these time limits, a hearing is not "commenced" when the court and parties gather and the case is called, but only when a witness is sworn or some evidence taken. The statute does not require that the hearing be concluded within the specified five or 14 days.

In scheduling the hearing, the clerk-magistrate's office must allow the respondent and his or her counsel at least two days after the appearance or assignment of counsel to prepare for the hearing. G.L. c. 123, § 5.

Commentary

Persons involuntarily held in psychiatric facilities pending a hearing suffer a significant loss of liberty. For that reason, the time requirements set out in G.L. c. 123, § 7(c) are mandatory, and a petition for commitment must be dismissed if the hearing is not commenced within the 5-day or 14-day period. See *Hashimi v. Kalil*, 388 Mass. 607, 609 (1983); *Matter of Molina,* 2007 Mass. App. Div. 21, 22 (N. Dist.); *Myers v. Saccone,* 1999 Mass. App. Div. 305 (Boston Mun. Ct.). The mere calling of a case in court does not constitute "commencement" for purposes of this time limit, but only when a witness is sworn or some evidence taken. *Melrose-Wakefield Hosp. v. H.S.,* 2010 Mass. App. Div. 247, 250 (N. Dist.)

For criminal defendants and sentenced prisoners, hearings on both initial or subsequent forensic commitment petitions filed under G.L. c. 123, §§ 15(e), 16 or 18 must be commenced within 14 days after the date of filing, unless a continuance is granted at the request of the respondent or respondent's counsel. G.L. c. 123, § 7(c).

Although the Massachusetts Rules of Civil Procedure are not generally applicable to civil commitment proceedings (see Mass. R. Civ. P. 81), G.L. c. 123, § 7(c) provides that the period of time within which the hearing on a petition for commitment must be commenced shall be computed in accordance with Mass. R. Civ. P. 6. This means that the day on which the petition is filed is excluded from the computation, and (for time periods of less than seven days) intermediate Saturdays, Sundays and legal holidays as well, but the day of hearing is included. If the deadline falls on a Saturday, Sunday or legal holiday, the hearing must be held on the next court business day.

The Administrative Office of the District Court has provided courts with the charts below to determine how to schedule initial §§ 7 & 8 hearings, which are subject to the 5-day limit:

TIME LIMITS FOR 3-DAY PETITIONS AND 5-DAY CIVIL COMMITMENT HEARINGS			
Involuntarily hospitalized on	*Petition must be filed no later than*	***Earliest*** *date when hearing can be scheduled (if filed on date in column 2)*	***Latest*** *date when hearing can be scheduled (if filed on date in column 2)*
Monday (Week 1)	Thursday (Week 1)	Tuesday (Week 2)	Thursday (Week 2)
Tuesday (Week 1)	Friday (Week 1)	Wednesday (Week 2)	Friday (Week 2)
Wednesday (Week 1)	Monday (Week 2)	Thursday (Week 2)	Monday (Week 3)
Thursday (Week 1)	Tuesday (Week 2)	Friday (Week 2)	Tuesday (Week 3)
Friday (Week 1)	Wednesday (Week 2)	Monday (Week 2)	Wednesday (Week 3)
Saturday (Week 1)	Wednesday (Week 2)	Monday (Week 2)	Wednesday (Week 3)
Sunday (Week 1)	Wednesday (Week 2)	Monday (Week 2)	Wednesday (Week 3)

Courts may observe both the 2-day minimum period and the 5-day maximum period by scheduling commitment hearings on the same two days of each week. Any of the following five combinations of days will satisfy both statutory requirements:

POTENTIAL COURT SCHEDULES FOR 5-DAY CIVIL COMMITMENT HEARINGS	
Hearings held on	*Petitions to be heard*
Monday & Wednesday	• on Mondays, court may hear petitions filed on Monday, Tuesday or Wednesday of prior week • on Wednesdays, court may hear petitions filed on Wednesday, Thursday or Friday of prior week
Monday & Thursday	• on Mondays, court may hear petitions filed on Monday, Tuesday or Wednesday of prior week • on Thursdays, court may hear petitions filed on Thursday or Friday of prior week, or Monday of this week
Tuesday & Friday	• on Tuesdays, court may hear petitions filed on Tuesday, Wednesday or Thursday of prior week • on Fridays, court may hear petitions filed on Friday of prior week, or Monday or Tuesday of this week
Tuesday & Thursday	• on Tuesdays, court may hear petitions filed on Tuesday, Wednesday or Thursday of last week • on Thursdays, court may hear petitions filed on Thursday or Friday of prior week, or Monday of this week
Wednesday & Friday	• on Wednesdays, court may hear petitions filed on Wednesday, Thursday or Friday of prior week • on Fridays, court may hear petitions filed on Friday of prior week, or Monday or Tuesday of this week

See Appendix B, Excerpt from District Court Transmittal No. 945, *Scheduling Civil Commitment Hearings (G.L. c. 123, §§ 7-8) and Emergency Hearings (§ 12[b])* (February 23, 2007).

HEARINGS BEYOND THE STATUTORY TIME LIMIT

No appellate decision has held that the court has any inherent authority to conduct the hearing beyond the 5-day or 14-day limit, over objection, even if delay is unavoidable due to a significant weather, medical or similar emergency. In two decisions, the District Court Appellate Division recognized that possibility but found that no such emergency had been shown. In the first, the hearing was scheduled for one day before the end of the maximum five-day period; when respondent's counsel became ill, it was rescheduled for two days later. The Appellate Division observed:

> "Clearly, the judge could have granted a continuance for one day . . . to afford Petitioner's counsel an opportunity to recover from his illness or to seek substitute counsel from his law firm or elsewhere. However appropriately sympathetic the judge was to counsel's request for a continuance based on illness, the court was not authorized to continue the commitment hearing past the deadline prescribed by G.L. c. 123, § 7(c). The plain language of the statute limited the judge's discretion . . . . [D]ismissal is the appropriate remedy for any violation of the . . . deadline, absent extraordinary circumstances that would justify a very brief delay.[1]
>
> "[1] A state of emergency at the federal or state level resulting in court closings or preventing the holding of a court session would, for example, constitute such extraordinary circumstances. The illness of counsel would not."
>
> *Matter of Molina,* 2007 Mass. App. Div. 21, 22 & n.1 (N. Dist.).

In its second decision, the Appellate Division commented:

> "Nor need we address in this case whether the rescheduling of a hearing because of some extraordinary circumstances, which may provide an exception to the statutory requirement that would comport with the statute and constitutional due process, was permissible. The petitioner herein claimed that [respondent] was unable to attend the hearing because the 'hospital d[id] not feel that it [was] safe to bring her as the doctor isn't [present].' Yet no evidence was taken on the issue of whether the hospital's unilateral action was justified. At a statutory and constitutional minimum, the court should have conducted a hearing in which the petitioner had the burden of proving, subject to cross-examination, that [respondent] was incapable of attending the hearing. And the court should have stated its reasons for determining that the petitioner's unilateral action was justifiable.[8]
>
> "[8] Hypothetically, a hospital's position as to the mental or physical stability of a patient could, in some extraordinary circumstance, warrant a finding that a delay in the hearing is justifiable. But we think that it would be extremely rare that circumstances involving only the ability of the hospital itself to comply with the statutory requirement, e.g., staffing or transportation, would justify the continuation of a hearing beyond the five days required under the statute."
>
> *Melrose-Wakefield Hosp. v. H.S.,* 2010 Mass. App. Div. 247, 250 & n.8 (N. Dist.).

See also *Commonwealth v. Parra,* 445 Mass. 262, 267 n.6 (2005) ("[t]here may be extraordinary circumstances that would excuse brief violations" of statutory filing deadline for seeking sexually dangerous person commitment).

If the court concludes that it may invoke its inherent powers in a true emergency beyond the control of the court and the parties, the statutory goal should be respected by postponing the hearing no longer than absolutely necessary.

3:05 Notice of Hearing

Immediately upon the filing of a petition for commitment or an § 8B petition for authorization for medical treatment, the clerk-magistrate's office must send notice of the petition and of the time and place of the hearing to the respondent, to respondent's nearest relative or guardian, to the Committee for Public Counsel Services' Mental Health Litigation Division, to respondent's counsel (if known), to the petitioner, and to petitioner's counsel.

Because of the short lead time for such hearings, notice to CPCS' Mental Health Litigation Division, and to other recipients as appropriate, should be given by facsimile transmission.

If there is a criminal complaint or indictment pending against the respondent, the clerk-magistrate's office should also notify criminal defense counsel.

Commentary

The standard court *Notice of Hearing* form should be used to provide notice to "the [Department of Mental Health], the person, his counsel, and his nearest relative or guardian," as required by G.L. c. 123, § 5. Notice should also be given (and a copy of the petition sent) to any current criminal defense counsel.

If a hearing is scheduled or rescheduled in open court with the parties present, written notice to those present is not required. However, such oral notice should be given on the record and entered on the docket, and the parties should be informed orally that no written notice will be issued.

3:06 Continuances

The court may not allow a continuance that prevents the hearing from commencing within the required 5-day or 14-day period unless the request is made by or agreed to by the respondent or respondent's counsel. G.L. c. 123, § 7(c). See Standard 3:04 (Time Limits for Hearing).

Requests for continuances and notice to the opposing party should be made as soon as possible after the need for a continuance becomes known. Because many hearings are held in mental health facilities, requests for continuances should be made in advance of the hearing date if at all possible.

Even when respondent or respondent's counsel consents, the court should carefully examine all continuance requests to determine that they are based on good cause. When the court grants a continuance, it should be for the minimum amount of time necessary, and the court should make every effort to reschedule the hearing for the earliest possible date.

Any court authorization of funds for an independent clinical evaluation should include a definite time limit to avoid unnecessary delay.

Commentary

Aside from emergencies beyond the parties' control, some discretionary continuances may be in the respondent's best interests – for example, if time is needed to gather additional information or investigate a less restrictive placement, or if a respondent's rapidly improving condition suggests that a short continuance might result in withdrawal of the petition.

However, given the important liberty interests involved, the court should grant a continuance only when there is good cause, even if requested or agreed to by the respondent or respondent's counsel.

3:07 Independent Clinical Examination

The court may provide an indigent respondent in a mental health commitment or treatment authorization proceeding with expert clinical assistance at the Commonwealth's expense. Authorization for an independent clinical examiner, expert witness, or other litigation-related services and items may be sought by a motion for funds under the Indigent Court Costs Act (G.L. c. 261, §§ 27A-27G) **along with the official Affidavit of Indigency form.**

The court may allow a request without a hearing, but may not deny a request without first holding a hearing within five days of the request. G.L. c. 261, § 27C.

In reviewing such requests, the court must first determine whether the respondent is indigent and, if so, whether the requested service should be authorized at the Commonwealth's expense. The statutory standards of indigency are outlined on the official form. The decision whether to authorize public payment depends on whether the service "is reasonably necessary to assure the applicant as effective a . . . defense . . . as he would have if he were financially able to pay." G.L. c. 261, § 27C. **If the court rules in the respondent's favor on both issues, it must allow the motion and authorize the necessary funds on the official determination form.**

When approving a request for an independent clinical examiner or expert witness, the judge should set a definite time limit for completion of the examination and report, since even essential continuances should be carefully limited and monitored. See Standard 3:06.

In reviewing any proposed hourly compensation rate, the court should consider the statutorily-authorized CPCS guidelines for such compensation. It is preferable that a judge allowing the necessary funds do so "in an amount not to exceed" a stated monetary amount.

If the court denies a request for funds, the respondent must simultaneously be notified that within seven days he or she may file with the clerk-magistrate a notice of appeal to the District Court Appellate Division. If an appeal is taken, the court must set forth its reasons for the denial in writing within three days, and may stay the proceedings or otherwise preserve the parties' rights pending appeal. G.L. c. 261, § 27D.

An independent clinical examiner's or expert's report, if any, should not be filed with the court. Any information gathered and opinions developed during an independent clinical examination are for the benefit of the respondent, and may not be considered by the court or disclosed to the petitioner without the respondent's consent unless they are offered in evidence or the independent clinical examiner or expert testifies.

Commentary

The Indigent Court Costs Act (G.L. c. 261, §§ 27A-27G) sets out a comprehensive procedure for an indigent party to obtain "waiver, substitution or payment by the Commonwealth of fees and costs" of litigation. Accordingly, a respondent in a civil commitment proceeding may request that the court determine him or her to be indigent, and then order that the Commonwealth pay for any service or item reasonably needed to oppose the petition.

The most common request in civil commitment cases is for an independent examination by a psychiatrist or psychologist. However, the statutory procedures are also applicable to requests for any other litigation-related services and items.

A motion must be accompanied by the official forms promulgated by the Supreme Judicial Court, the *Affidavit of Indigency and Request for Waiver or State Assumption of Fees and Costs* and, if applicable, the *Supplement to Affidavit of Indigency*. The court must record its decision on the official *Court's Determination Regarding Fees and Costs* form. The forms and instructions for their use can be found at www.mass.gov/courts/formsandguidelines.

INDIGENCY

Indigency for purposes of the Indigent Court Costs Act is defined in G.L. c. 261, §27A and differs somewhat from the definition of indigency in Supreme Judicial Court Rule 3:10 for purposes of appointing counsel. Section 27A has three categories of indigency, and the Affidavit form has a check box for each of those categories. If the respondent checks the third box (claiming indigency based on inability to pay "without depriving himself or his dependents of the necessities of life"), the respondent must additionally submit the *Supplement to Affidavit of Indigency,* with detailed information on income and assets.

NEED FOR INDEPENDENT EXAMINATION

The statutory standard for state payment of an "extra cost" (such as the fee of an independent expert) turns on "whether [a party] who was able to pay would consider the particular item or service sufficiently important that he would choose to obtain it in preparation for trial." *Commonwealth v. Lockley* 381 Mass. 156, 160 (1980). As the Supreme Judicial Court elaborated,

> "The test is not whether a particular item or service would be acquired by a [party] who had unlimited resources, nor is it whether the item might conceivably contribute some assistance to the defense or prosecution of the indigent person. On the other hand, it need not be shown that the addition of the particular item to the defense or prosecution would necessarily change the final outcome of the case. The test is whether the item is reasonably necessary to prevent the party from being subjected to a disadvantage in preparing or presenting his case adequately, in

comparison with one who could afford to pay for the preparation which the case reasonably requires.

"In making this determination under the statute, the judge may look at such factors as the cost of the item requested, the uses to which it may be put at trial, and the potential value of the item to the litigant." *Id.,* 381 Mass. at 160-61.

If the respondent's motion and Affidavit are sufficient to meet this test, the court may allow the request without a hearing. Where a hearing must be held, on request the court should permit it to be conducted *ex parte* so that the respondent need not disclose aspects of his or her defense to the petitioner. See *Commonwealth v. Dotson*, 402 Mass 185 (1988) (prosecution has no role to play in defendant's motion for funds for expert witness); *Blazo v. Superior Court,* 366 Mass. 141, 145 n.8 (1974) (indigent should be able to obtain witness subpoenas without informing opponent).

In appropriate circumstances, the court may order the respondent to pay a portion of the cost of the requested service (*e.g.*, where the facility holds a respondent's funds in a patient funds account). In determining whether partial payment is appropriate, the court should take into account both the anticipated cost of the requested service and the impact such payment will have upon the respondent. See *Underwood v. Massachusetts Appeals Court*, 427 Mass. 1012 (1998) (court should exercise reasonable discretion, considering totality of applicant's economic circumstances, before ordering payment of partial fee).

AMOUNT AUTHORIZED

The Committee for Public Counsel Services has a statutory responsibility to:

"establish standards for . . . qualifications for vendors for [expert witness] services . . . and a range of rates payable for said services, taking into consideration the rates, qualifications and history of performance; provided, however, that such ranges may be exceeded with approval of the court. Payment of such costs and fees shall be in accordance with the provisions of [the Indigent Court Costs Act]." G.L. c. 211D, § 9.

CPCS has established qualifications and a range of hourly rates for 19 categories of experts, including psychiatrists, psychologists, physicians and investigators, in its *Qualifications and Rates for Investigators, Social Service Providers and Expert Witnesses* (June 2002, as revised). The guidelines provide that:

"no vendor may be compensated for a rate greater than the rates listed for the vendor's area of expertise, unless (1) the higher rate is previously approved by the appropriate Deputy Chief Counsel or Director of the Mental Health Litigation Unit of CPCS, and (2) the higher rate is then approved by the Court in an allowed Motion for Funds."

These guidelines are available on the CPCS internet website (www.publiccounsel.net).

The forms and instructions to judges promulgated by the Supreme Judicial Court to implement the Indigent Court Costs Act anticipate that a judge, when authorizing payment by the Commonwealth, will set in advance a specific monetary limit.

> "Applicants are asked to give their best estimates of the costs of the services whose waiver or state payment they are requesting . . . . Most applicants will not know the actual costs of many of these services. Therefore, courts should approve otherwise appropriate applications for waiver or state payment and insert in the approval the actual or estimated amount of the fee or service, as it is known to the court." *Instructions to Courts on the Administration of the Indigent Court Costs Law* (March 25, 2003).

The Standard suggests that, in the case of an independent clinical examiner or expert witness, the best practice is for the judge to approve an expenditure "not to exceed" a specific maximum amount.

Despite some older statutes suggesting that the court system is responsible for processing payments under the Indigent Court Costs Law (see G.L. c. 123, § 33 and c. 261, § 27G), such vendor invoices (with "the dates each [service] was rendered . . . and the charge for each," G.L. c. 261, § 27G) are now processed and paid through the Committee for Public Counsel Services after CPCS receives written certification from respondent's counsel that the services have been rendered. In doing so, CPCS will observe any maximum amount that was set by the judge who approved the expenditure. It is no longer necessary for vendor invoices routinely to be submitted for court review prior to payment, although in particular cases a judge may order that to be done. See *Commonwealth v. Matranga,* 455 Mass. 45 (2009) (after allowing motion for payment of funds, "the judge has no authority over the manner in which the Committee for Public Counsel Services disburses those funds since G.L. c. 211D, §§ 3, 9, and 13 commit to CPCS rather than to the judge oversight and discretion with respect to their expenditure").

CHOICE OF EXAMINER

The court should require that the examiner have the requisite training and experience; this will depend on the issue under consideration. While a respondent does not have a right to select an independent clinician of his or her choosing, the court in most instances should permit him or her to do so with the advice of counsel. See *Commonwealth v. DeWolfe*, 389 Mass. 120, 126 (1983) (criminal defendant "ordinarily should be allowed to select his own doctor to examine him, although we do not consider such a choice to be a matter of right"). The Committee for Public Counsel's Mental Health Litigation Unit maintains (at www.publiccounsel.net) a listing of psychiatrists and psychologists willing to serve as independent clinical examiners.

When the selection of an independent clinical examiner or other vendor is made by the respondent or respondent's counsel, it is not a court-made appointment and therefore should not be entered on the docket of fee-generating court appointments required by Supreme Judicial Court Rule 1:07.

RESULTS OF INDEPENDENT CLINICAL EXAMINATION

The information gathered and the opinions formed by respondent's independent clinician are not discoverable by the petitioner and not to be shared with the court unless the clinician will be called by respondent to testify or the clinician's report, if any, will be offered in evidence at the hearing. *Thompson, supra* (facts known and opinions held by independent physician treated as if physician were hired privately). See also *Commonwealth v. Sliech-Brodeur,* 457 Mass. 300, 325 n.34 (2010) (criminal defendant who intends to offer expert testimony in support of defense based on mental disease or defect or psychological impairment must disclose expert's report to prosecution when court-appointed expert's report is released to defense).

The court must not, of course, draw any adverse inferences if the respondent decides not to use the report as evidence in his or her case.

3:08 Discovery

In its discretion, the court may issue an order for discovery on motion by a party, with notice, made as early as practicable and prior to hearing, when the requested information appears to be relevant. This may include depositions, written interrogatories, production of documents, or requests for admissions. Orders for discovery should clearly state compliance deadlines and terms.

The availability and scope of discovery is discretionary with the court. Such discretion should be exercised liberally, since respondent and respondent's counsel may be at a marked disadvantage prior to the hearing with respect to relevant information compared to that available to the petitioning facility. Bona fide discovery motions seeking relevant information not currently available to respondent should usually be allowed.

Informal discovery arrangements should be encouraged. The court may inquire as to whether these have been adequately pursued before allowing a formal motion for discovery.

Commentary

The types of discovery used in civil cases may be appropriate also for civil commitment cases, including depositions (see Mass. R. Civ. P. 27-31), interrogatories (see Rule 33), inspection of documents (see Rule 34), and requests for admissions (see Rule 36).

While the Massachusetts Rules of Civil Procedure are generally inapplicable to civil commitment proceedings, see Mass. R. Civ. P. 81(a)(2), civil proceedings not governed by those rules "shall follow the course of the common law, as near to these rules as may be," Mass. R. Civ. P. 81(a)(3). See also G.L. c. 231, §§ 61-69 (authorizing interrogatories, inspection of documents, and requests for admission in civil proceedings not governed by the civil rules).

The time periods for discovery set out in the Massachusetts Rules of Civil Procedure are inconsistent with the statutory requirement to commence civil commitment proceedings within five or 14 days. Because time is of the essence in these proceedings, the court should set short discovery time limits and may hear motions ex parte as appropriate. The hearing may be continued upon agreement of the parties in order to allow for discovery. See Standard 3:06 (Continuances).

4:00 Location of Hearings

General laws c. 123, § 5, authorizes a judge to conduct civil commitment hearings at the courthouse, the petitioning mental health facility or, if applicable, Bridgewater State Hospital. The language of G.L. c. 123, § 5, does not express a preference for any particular location, but, rather, a judge presiding over a civil commitment hearing retains discretion to determine the location of the hearing on a case-by-case basis.

Wherever conducted, all court hearings should be held in rooms of adequate size and appropriate condition for a dignified and impartial judicial hearing. The physical setting must be sufficient to provide for appropriate security, permit public access, and elicit the customary respect accorded court proceedings and parties before the court.

Hearings must be electronically recorded.

If held at the petitioning facility or Bridgewater State Hospital, the judge should be accompanied by a court officer who should open and conclude the hearing as they would in any courtroom setting. In addition, the facility may provide security personnel. An assistant clerk or sessions clerk should be present to maintain custody of court records and exhibits, including the audio recording of the proceedings, to swear witnesses, to docket the proceedings, and to prepare any court forms or written orders necessary.

Commentary

Commitment hearings under G.L. c. 123 may be conducted away from the courthouse and at the petitioning facility or, if applicable, Bridgewater State Hospital. G.L. c. 123, § 5. *See Matter of M.C.*, 481 Mass. 336, 344 (2019). Wherever the hearing is held, the respondent's potential loss of liberty is a significant matter, and the court, the respondent, counsel, and facility staff are entitled to a formal and dignified hearing.

The strict hearing deadlines set forth in G.L. c. 123 require that, upon receipt of a petition for commitment, the court must promptly "provide notice of the time and place of [the] hearing . . . to the department, the person, his counsel, and his nearest relative or guardian." *M.C.*, 481 Mass. at 350, citing G.L. c. 123, § 5. Irrespective of where a hearing is initially scheduled, "a judge presiding over a civil commitment hearing retains discretion to determine the location of the hearing on a case-by-case basis." *Id*.

When the hearing is held at the facility or Bridgewater State Hospital, the hearing room must reflect and be conducive to the dignity of the court and the formality and impartiality of judicial proceedings. The physical setting must not convey, especially to the respondent, any suggestion that the hearing is merely an administrative proceeding in which the court is somehow subordinate to the facility's authority rather than a neutral and independent guardian of constitutional rights. Whenever possible, the court should use the same hearing room, with an appropriate private robing area and toilet facilities, each time proceedings are held at a facility. The facility should provide adequate parking for the judge and attorneys. At minimum, the hearing room must be of adequate size, clean and properly maintained, with adequate lighting and ventilation. There should be a separate seating space for the judge, with a suitable chair, and a separate chair nearby to serve as a

witness stand. The litigants and counsel should be seated separately, facing the judge. This seating arrangement should be followed even if, as is the case in some facilities, the hearing is held at a conference table. The hearing room must allow for public access, but should be in a quiet area of the facility. No other function or foot traffic, and no food or drink, is permissible in the hearing room during proceedings.

Proceedings, wherever conducted, must be electronically recorded. District Court Special Rule 211. See Standard 4:02 (Electronic Recording). If conducted away from the courthouse, the facility must provide the recording device and microphones, if necessary.

The flag of the United States and the flag of the commonwealth shall be displayed in every court of justice of the commonwealth while court is in session. G.L. c. 220, § 1. The judge must wear a robe, District Court Administrative Regulation No. 7-74 (October 1, 1974), and attorneys and witnesses should be in attire appropriate for a formal court proceeding. The judge should direct that electronic devices be silenced during court proceedings.

The purpose of such formality is not to inhibit the participants, but to remind them that a formal hearing is being conducted. Informal settings in mental health proceedings may easily foster other procedural informalities which are unacceptable in court proceedings. The court should not permit participants to dispense with proper courtroom practice because they are outside the traditional physical setting of a courtroom.

Sufficient security is essential at commitment hearings. The court must not, of course, draw any adverse inferences from extensive protective measures or perceived staff concerns, but must base its commitment decision solely on the evidence presented at the hearing.

When hearings are scheduled to be conducted at the facility, the court should give careful consideration to any reasons advanced by a party who files a motion requesting that the hearing be held at the courthouse, particularly if a legitimate concern about deficiencies in the hospital setting has been identified.

4:01 Public Access to Hearings

Civil commitment proceedings are presumptively open to the public.

They may be closed only if:

1. **the party seeking to close the proceedings shows an overriding interest that is likely to be prejudiced absent closure;**

2. **the closure is no broader than necessary to protect that interest;**

3. **the court considers reasonable alternatives to closure; and**

4. **the court makes particularized findings supported by the record that are adequate to justify the closure.**

Commentary

It is well established that criminal proceedings are presumptively open to the public, even when conducted outside the usual courtroom setting. See, e.g., *Richmond Newspapers, Inc. v. Virginia,* 448 U.S. 555, 580 n.17 (1980) ("[H]istorically both civil and criminal trials have been presumptively open"); *Boston Herald, Inc. v. Superior Ct. Dept.,* 421 Mass. 502 (1995) (criminal arraignment held in hospital intensive care unit presumptively open).

However, most courts had a longstanding tradition of denying public access to civil commitment proceedings, except for good cause shown, out of privacy concerns arising from the highly personal nature of the subject matter and evidence at such hearings. While there is no express statutory authority for this, it was often assumed to be implicit in the requirements of G.L. c. 123, § 36A that the records of such proceedings be kept confidential and separate from other court documents.

However, *Kirk v. Commonwealth,* 459 Mass. 67, 75 (2011), found that § 36A: "does

> not, by its terms, provide for the closure of the court room in commitment proceedings. It applies only to the privacy of reports, papers, and dockets. The absence of such a closure provision is particularly notable given that the Legislature has elsewhere provided for closure explicitly. Where the Legislature has intended to express a preference for closure, it has thus done so explicitly" (citations omitted).

Kirk held that the "long-standing presumption in Massachusetts common law that, as a general matter, the public has a right to attend civil trials" applies also to civil recommitment hearings under G.L. c. 123, § 16(c) for persons acquitted by reason of mental illness and that such hearings are presumptively open to the public.

> "Early cases in the Commonwealth illustrate that civil commitment proceedings were not formerly afforded the publicity that has, as a general matter, been characteristic of civil trials in Massachusetts. It is equally clear, however, that lawmakers and courts have moved decisively away from this prior informality and now provide in commitment cases procedural protections characteristic of criminal trials and other civil trials . . . .
>
> "The trajectory of the law as it relates to civil commitment demonstrates that commitment hearings have been increasingly clothed with the procedural protections and formality typical of other civil (and criminal) trials. As such trials are generally open to the public, this supports a conclusion that proceedings pursuant to G. L. c. 123, § 16(c), are also, as a general proposition, open to the public.
>
> "Public access to the commitment proceedings underscores the seriousness of a potential deprivation of liberty and combats tendencies toward informality that may threaten an individual's due process rights. Commitment hearings are a matter of public interest. Likewise, closure encourages skepticism and distrust among the public – and, indeed, among those whose commitment is sought – regarding posttrial proceedings after persons have been acquitted by reason of mental illness. We conclude that both the legal evolution of civil commitment proceedings and the likely beneficial effects of public access to such proceedings support a conclusion that civil recommitment hearings held pursuant to G. L. c. 123, § 16(c), are presumptively open to the public . . . ." *Id.* at 71-73 (citations omitted).

The *Kirk* decision is expressly limited to § 16(c) recommitment hearings, *Id.* at 73 n.9, and it does not discuss the privacy interests of respondents in purely civil commitments under §§ 7 & 8. However, its holding is based on the general presumption of public access to civil trials, and the opinion nowhere implies that any special considerations apply to § 16(c) petitions because such respondents have related criminal charges. While *Kirk* does not directly address other civil commitment hearings, the Standard suggests that the *Kirk* rule should be applied in all civil commitment proceedings for mentally ill persons.

Kirk offered the following guidance on how courts should determine whether the presumption of openness has been overcome in individual situations:

> "Given the presumption that G. L. c. 123, § 16(c), proceedings are open to the public in Massachusetts, as they are in criminal trials, we conclude that the *Waller* [v. *Georgia,* 467 U.S. 39, 48 (1984),] standard should likewise be applied in such proceedings.
>
> "Thus, closure may occur where four requirements are met: '[1] the party seeking to close the hearing must advance an overriding interest that is likely to be prejudiced, [2] the closure must be no broader than necessary to protect that interest, [3] the trial court must consider reasonable alternatives to closing the proceeding, and [4] it must make findings adequate to support the closure.' The essence of the *Waller* standard is thus that a moving party's position must be sufficiently

compelling to overcome a presumption of openness. The findings required for closure must be 'particularized and supported by the record . . . .'

"In adopting the *Waller* standard, we recognize that the public disclosure of medical information has the potential to prejudice the therapeutic treatment of a patient. Accordingly, in determining whether the moving party has shown an overriding interest likely to be prejudiced, the judge should take account of any alleged prejudice to a patient's therapeutic treatment that could come about by virtue of a public proceeding. The [moving party] has the burden of demonstrating that prejudice is likely to occur. We emphasize also that it is within the judge's discretion to close a limited portion of a proceeding if the *Waller* standard is satisfied as to that portion . . . .

"[Kirk] also asserts that, to succeed in the recommitment proceeding, she 'will have to provide detailed evidence describing her progress in treatment.' That argument, expressed as it is in general terms, would likely be true of most recommitment hearings. If sufficient, it would allow closure almost as a matter of course, and thus cannot succeed. [Her] argument that the dissemination of personal information disclosed in treatment 'may have a devastating effect on her treatment,' while a legitimate and serious concern, is not supported by expert opinion or any other evidence. The judge was warranted in finding these assertions insufficient to warrant closure of the proceeding.

"The final question is whether the judge was required to make findings in denying the plaintiff's motion. Explicit in the *Waller* standard is a requirement that the judge make findings if he or she concludes that closure is warranted. Where a judge denies a motion for closure, findings are also necessary. The reviewing court must be able to determine the basis for the denial." *Id.* at 73-76 (citations omitted).

4:02 Electronic Recording

The commitment hearing must be electronically recorded on an appropriate sound recording device under court control, or alternately on a recording device under the control of a party and made available to opposing counsel. District Court Special Rule 211. **Recordings must be preserved in accordance with Special Rule 211, usually for at least one year.**

If a recording device is not available at the mental health facility and counsel objects, the court should conduct the hearing at a courthouse where a proper recording may be made in accordance with the rule.

Commentary

Like other court records related to civil commitment petitions, court-controlled electronic recordings of proceedings are not available for public inspection without a court order. G.L. c. 123, § 36A. They are available to the parties and their counsel. See Standard 1:02 (Privacy of Court Records).

4:03 Adversarial Nature of Hearings

Hearings conducted pursuant to chapter 123 are adversarial proceedings.

Counsel for both parties should be present, prepared and permitted to inquire fully into the facts of the case, cross-examine witnesses, and vigorously advocate for their clients' positions. Respondent's counsel must be afforded the opportunity to present independent testimony.

All witnesses must testify under oath or affirmation.

The respondent should normally be present. See Standard 4:04.

It is recommended that the judge resolve any issues of privileged communications or other preliminary matters at the commencement of the hearing, including whether there are any issues concerning any *Lamb* warning and waiver. See Standard 5:04.

Commentary

It is a benchmark of our jurisprudence that facts are best determined by a judge based on zealous advocacy by both attorneys. Chapter 123 ensures this adversarial approach by guaranteeing traditional safeguards such as the rights to counsel, notice and a fact-finding hearing process, to present independent testimony, and to appeal. G.L. c. 123, § 5.

Assigned attorneys are required to comply with performance standards promulgated by the Committee for Public Counsel Services to ensure competent and vigorous representation. See Standard 3:03 (Right to Counsel) and Appendices C and D.

Due process requires that all testimony be taken under oath. This includes medical professionals and other staff members as well, who should not answer questions informally without being placed under oath. This can create an atmosphere of informality which is counterproductive to sound judicial practice and respect for court proceedings.

In forensic proceedings under G.L. c. 123, § 16, the district attorney's office that prosecuted the respondent's criminal case, while not a party, has the right to "be notified of . . . and . . . to be heard" at the commitment hearing. G.L. c. 123, § 16(d). This apparently includes an independent right to offer evidence under usual evidentiary rules. See *Adoption of Sherry,* 435 Mass. 331, 338 (2001) (discussing foster parent's statutory right "to attend . . . and to be heard" in child custody proceedings).

4:04 Respondent's Presence

The respondent has a right to attend the hearing and normally should be present. The court should inquire carefully of the facility staff and respondent's counsel about the circumstances if the respondent absents himself or herself voluntarily, and even more carefully if it is represented to the court that the respondent is unable to attend.

The respondent's attendance at the hearing should be strongly encouraged. If the respondent is firmly unwilling to attend, or seriously disruptive, the hearing may continue in his or her absence, although the court should do so only as a last resort. If the court proceeds without the respondent, the court should note the reason for his or her absence on the record and should have standby counsel present.

Commentary

Although the statute does not address waiver of the respondent's presence at the hearing, if the respondent is adamantly unwilling to attend, the hearing may continue in his or her absence. This should be determined by a formal inquiry and with a finding on the record, based upon representations by respondent's counsel, and, if possible, a colloquy with the respondent, that the respondent is knowingly and voluntarily choosing not to attend.

If the respondent is reported as *involuntarily* absent, the court should hear from respondent's and petitioner's counsel as to the situation and then take any reasonable steps to secure his or her attendance and participation. If there are medical concerns, all or part of the hearing may be moved to a suitable location so that the respondent may attend, or a continuance may be granted.

Where security is a concern, protective measures may be undertaken. However, the respondent's right to be present may not be curtailed merely because the petitioner asserts that the respondent's attendance would be unsafe.

> "At a statutory and constitutional minimum, the court should [conduct] a hearing in which the petitioner [has] the burden of proving, subject to cross-examination, that [respondent] was incapable of attending the hearing. . . . [I]t would be extremely rare that circumstances involving only the ability of the hospital itself to comply with the statutory requirement, e.g., staffing or transportation, would justify the continuation of a hearing beyond the five days required under the statute." *Melrose-Wakefield Hosp. v. H.S.,* 2010 Mass. App. Div. 247, 250 & n.8 (N. Dist.)

In extreme cases, a respondent may be so disruptive that he or she thereby forfeits the right to attend and may be excluded from the hearing. As with criminal defendants, this should be done only after explicit advance warnings. Before the respondent is removed, the court should inform the respondent that he or she may return upon giving assurances of good behavior. Periodically during the hearing, the respondent should again be brought into the hearing room and offered the opportunity to conduct himself or herself appropriately. If possible, the

respondent should be able to view or hear the proceedings remotely while excluded from the hearing room.

If the hearing proceeds without the respondent, the court must not, of course, draw any adverse inferences from the respondent's absence.

4:05 Decision and Order

The court must render its decision on a petition for commitment within ten days of the completion of the hearing. The ten-day period may be extended only by the Chief Justice of the District Court "for reasons stated in writing by the court." G.L. c. 123, § 8(c).

An order of commitment must be effective no later than the date of the court's decision.

The petitioner, the respondent and respondent's counsel should be notified of the court's decision immediately after it is rendered.

Commentary

An extension of the statutory ten-day deadline may be granted only by the Chief Justice of the District Court. A judge should submit such a request and the reasons therefor in writing only where the complexity of the legal or factual issues involved requires extended consideration.

Any order of commitment must be effective no later than the date of the court's decision. The independent authority provided by G.L. c. 123, § 6(a) for a respondent to "be retained at a facility or at the Bridgewater state hospital . . . during the pendency of a petition for commitment" ceases when the petition is no longer pending, and thereafter the respondent may be held only "under a court order."

4:06 Judicial Reviews

There are no statutory provisions authorizing judicial reviews during a term of civil commitment. A routine practice of scheduling periodic judicial reviews is inconsistent with the statutory scheme and should be avoided.

Apart from any treatment plan monitoring required by § 8B (see Standard 11:04)**, the court does not have any continuing supervisory role during the term of civil commitment. Instead, treatment responsibilities and the authority to release or transfer a committed person prior to the expiration of the six-month or one-year order of commitment rests with the superintendent of the facility, or in the case of Bridgewater State Hospital, its Medical Director.** G.L. c. 123, §§ 3, 4 & 6(a).

There may sometimes be good reason to schedule a post-adjudication judicial review in a particular case, e.g., if any issues were identified at the hearing that require further clarification or ongoing consideration.

4:07 Appeal

Legal issues arising in civil commitment hearings and medical treatment authorization hearings may be reviewed in the Appellate Division of the District Court "in the same manner as civil cases generally." G.L. c. 123, § 9(a). **Such appeals are governed by the District/Municipal Courts Rules for Appellate Division Appeal, which require the filing of a claim of appeal with the clerk-magistrate of the applicable district court within ten days after the entry of the commitment order.** Dist./Mun. Cts. R. A. D. A. 4(a)**.**

During the period of commitment, any person may also make written application to a Superior Court judge alleging that a committed person "should no longer be so retained" or "is the subject of a medical treatment order . . . and should not be so treated." G.L. c. 123, § 9(b).

Commentary

General Laws c. 123, § 9 offers two avenues for appeal from a civil commitment or medical treatment authorization. The first is an appeal on a matter of law to the Appellate Division under the District/Municipal Court Rules for Appellate Division Appeal pursuant to G.L. c. 123, § 9(a).

"Any person" may also challenge the propriety of a respondent's continued commitment or medical treatment through a civil action in the Superior Court pursuant to G.L. c. 123, § 9(b). Such hearings are not de novo reviews of commitment or treatment orders. Instead, the applicant has the burden of demonstrating by a preponderance of the evidence that his or her situation has "significantly changed" since the last commitment hearing so as to justify discharge or transfer. *Andrews, petitioner,* 449 Mass. 587 (2007); *Thompson v. Commonwealth,* 386 Mass. 811 (1982). See also Standard 11:04 (Monitoring § 8B Treatment Plan).

5:00 Standard of Proof

Each of the requirements for civil commitment must be proved by the petitioner beyond a reasonable doubt.

Commentary

In *Superintendent of Worcester State Hosp. v. Hagberg,* 374 Mass. 271, 276 (1978), the Supreme Judicial Court held that proof "beyond a reasonable doubt" is the appropriate standard of proof in a civil commitment proceeding. The traditional "preponderance of the evidence" civil standard of proof is constitutionally inadequate where such a significant deprivation of liberty is at stake. See also *Commonwealth v. Nassar,* 380 Mass. 908 (1980) (rejecting adequacy of "clear and convincing" standard permissible under *Addington v. Texas,* 441 U.S. 418 [1979]).

5:01 Rules of Evidence

Formal rules of evidence should be applied in commitment and medical treatment authorization hearings.

Commentary

Chapter 123 proceedings are formal judicial determinations in which a substantial deprivation of liberty is at stake and there are no statutory provisions or case decisions suspending the rules of evidence.

The next three Standards concern some of the more common evidentiary issues encountered in commitment hearings: hearsay (Standard 5:02), expert opinion testimony (Standard 5:03), and privileged communications (Standard 5:04).

5:02 Hearsay

The hearsay rule and its exceptions should be applied in civil commitment and medical treatment authorization hearings. Absent a recognized evidentiary exception, an out-of-court statement offered to prove the truth of the matter asserted is inadmissible hearsay.

Commentary

Two of the most common exceptions to the hearsay rule encountered in civil commitment proceedings are:

STATEMENTS BY A PARTY-OPPONENT

An out-of-court statement made by the respondent, when offered as evidence by the petitioner, is not inadmissible as hearsay.

> "*(d) Statements Which Are Not Hearsay.* The following statements are not hearsay and are admissible for the truth of the matter asserted: . . . .
>
> "*(2) Admission by Party-Opponent.* The following statements offered against a party are not excluded by the hearsay rule:
>
> "(A) The party's own statement.
>
> "(B) A statement of which the party has manifested an adoption or belief in its truth . . . ." *Massachusetts Guide to Evidence* § 801(d)(2) (2011 ed.).

HOSPITAL RECORDS

An entry in a hospital record relating to a patient's treatment and medical history is admissible in evidence as an exception to the hearsay rule, if it is otherwise admissible. However, information that is otherwise inadmissible is not made admissible merely by inclusion in a hospital record.

The hospital records statute (G.L. c. 233, § 79) applies to the patient records of all "[h]ospitals or clinics subject to licensure by the department of public health or supported in whole or in part by the commonwealth." G.L. c. 111, § 70. A "hospital" is an institution that offers "diagnosis, medical, surgical or restorative treatment"; a "clinic" is an entity that offers "ambulatory medical, surgical, dental, physical rehabilitation, or mental health services." G.L. c. 111, § 52.

The hospital records statute "in effect provides an exception to the hearsay rule, allowing hospital records to be admitted to prove the truth of the facts contained therein, in so far as those facts pertain to treatment and medical history." *Commonwealth v. Copeland,* 375 Mass. 438, 442 (1978). This dispenses with the need for the author of that entry to appear and testify. The exception is justified by "the presumption of reliability which attaches to statements relating to treatment and medical history in these records [arising] primarily from the fact that entries in these records are routinely made by those charged with the responsibility of making accurate entries and are relied on in the course of treating patients." *Bouchie v. Murray*, 376 Mass. 524, 528 (1978).

This does not automatically make everything in the record admissible. An entry in a patient's hospital record is admissible only if the entry pertains to the patient's treatment or medical history and the author, if called as a witness, would be permitted to testify to the contents of that entry.

The Supreme Judicial Court has suggested that judges use the following approach:

> "[W]e recommend that the following analysis be employed at trial to determine the admissibility of material contained in a hospital record. First, the document must be the type of record contemplated by G. L. c. 233, § 79. Second, the information must be germane to the patient's treatment or medical history. Third, the information must be recorded from the personal knowledge of the entrant or from a compilation of the personal knowledge of those who are under a medical obligation to transmit such information. Fourth, voluntary statements of third persons appearing in the record are not admissible unless they are offered for reasons other than to prove the truth of the matter contained therein or, if offered for their truth, come within another exception to the hearsay rule or the general principles discussed *supra*." *Bouchie v. Murray*, 376 Mass. at 531.

The *Massachusetts Guide to Evidence* § 803 (2011 ed.) summarizes the hospital records rule as follows:

> "The following are not excluded by the hearsay rule, even though the declarant is available as a witness: . . . .
>
> "(6) *Business and Hospital Records* . . . .
>
> "(B) *Hospital Records.* Records kept by hospitals pursuant to G. L. c. 111, § 70, shall be admissible as evidence so far as such records relate to the treatment and medical history of such cases, but nothing contained therein shall be admissible as evidence which has reference to the question of liability. Records required to be kept by hospitals under the law of any other United States jurisdiction may be admissible.
>
> "(C) *Medical and Hospital Services* . . . .
> "(ii) *Admissibility of . . . Records, and Reports.* In any civil or criminal proceeding, . . . records, and reports of an examination of or for services rendered to an injured person are admissible as evidence of . . . the necessity of such services or

treatments, the diagnosis, prognosis, opinion as to the proximate cause of the condition so diagnosed, or the opinion as to disability or incapacity, if any, proximately resulting from the condition so diagnosed, provided that

"(a) the party offering the evidence gives the opposing party written notice of the intention to offer the evidence, along with a copy of the evidence, by mailing it by certified mail, return receipt requested, not less than ten days before the introduction of the evidence;

"(b) the party offering the evidence files an affidavit of such notice and the return receipt is filed with the clerk of the court after said receipt has been returned; and

"(c) the itemized bill, record, or report is subscribed and sworn to under the penalties of perjury by the physician, dentist, authorized agent of a hospital or health maintenance organization rendering such services . . . ."

5:03 Expert Opinion Testimony

A witness may offer an expert opinion only if the court finds:

1. **that specialized knowledge will assist the court to understand the evidence or to determine a fact in issue;**

2. **that by knowledge, skill, experience, training, or education, the witness is qualified as an expert on the issue in question;**

3. **that the testimony is based upon sufficient facts or data;**

4. **that the testimony is the product of reliable principles and methods;**

5. **that the witness has applied those principles and methods reliably to the facts of the case; and**

6. **that the facts or data upon which the witness bases an opinion either:**

   (a) are in the witness's direct personal knowledge, or

   (b) are evidence in the case, or

   (c) are hypothetically assumed to be true upon the party's representation that they will be offered in evidence; or

   (d) are not in evidence but are independently admissible in evidence and are, or constitute, a permissible basis for an expert to consider in formulating an opinion.

Commentary

The Standard is based on the *Massachusetts Guide to Evidence* §§ 702 (Testimony by Experts) and 703 (Bases of Opinion Testimony by Experts) (2011 ed.).

Qualification as an Expert

A witness may be qualified as an expert, and therefore proffer an opinion, if the court finds that he or she possesses sufficient skill, knowledge and experience in the professional discipline within whose purview the specific issue in question lies. *Commonwealth v. Boyd*, 367 Mass. 169 (1975). The fact that a witness practices within a particular discipline (e.g., psychiatry or psychology) does not in itself establish his or her expertise regarding the specific issue in question. Rather, a putative expert's professional qualifications must be examined, both as to his or her standing in general within the discipline, and as to his or her particular expertise

regarding each issue for which his or her opinion is proffered. He or she may be permitted to offer an opinion only within the scope of his or her expertise.

Opinion on Ultimate Issue

In the course of a proper expert opinion, an expert witness may offer an opinion as to an ultimate factual issue (e.g., whether the patient is mentally ill). *Massachusetts Guide to Evidence* §§ 704 (2011 ed.). See, e.g., *Commonwealth v. Gomes*, 355 Mass. 479, 482–483 (1969) (opinion that defendant was sexually dangerous person).

Validity of Expert's Methodology

Where proffered opinion testimony is challenged, the judge must determine "whether the reasoning or methodology underlying the testimony is scientifically valid and . . . whether that reasoning or methodology properly can be applied to the facts in issue." *Commonwealth v. Lanigan*, 419 Mass. 15, 26 (1994), quoting *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 459 U.S. 579, 593 (1993). The methodologies used by experts in professional disciplines that rely on personal observations and clinical experience are also subject to such *Lanigan/Daubert* challenges. Once challenged, the proponent of the opinion testimony has the burden of establishing its methodological validity. *Canavan's Case*, 432 Mass. 304, 313 (2000) (physician).

Foundation of Opinion

An opinion is admissible only if based upon information that has been admitted into evidence or would be admitted into evidence if proffered, and that is of a type typically relied on by an expert in the witness's professional discipline. *Department of Youth Servs. v. A Juvenile*, 398 Mass. 516 (1986). In formulating his or her opinion, an expert may rely on information that has not been admitted into evidence but would be admissible if proffered, but the information itself may not be admitted substantively through the direct testimony of the expert. See, e.g., *Commonwealth v. Boyer*, 58 Mass. App. Ct. 662 (2003).

Massachusetts has not fully adopted Proposed Mass. R. Evid. 703, which would permit opinions based on *inadmissible* evidence if it is of a type reasonably relied upon by experts in the relevant field. *Massachusetts Guide to Evidence* §§ 703, Note (2011 ed.)

5:04 Privileged Communications to Clinicians

The respondent has the right to refuse to disclose, and to prevent any other witness from disclosing, the respondent's communications to a psychotherapist or social worker concerning diagnosis or treatment of the respondent's mental or emotional condition that were made under circumstances in which the respondent had a reasonable expectation of privacy, unless a statutory exception applies or the respondent has made a knowing, intelligent and voluntary waiver. G.L. c. 233, § 20B (communications to psychotherapists); G.L. c. 112, § 135B (communications to social workers).

The privilege includes communications in a hospital record. The privilege belongs to the respondent. It is not self-executing and must be timely claimed by the respondent or respondent's counsel or it is waived.

The privilege does not extend to the clinician's observations or diagnosis or the facts, dates or purpose of hospitalization or treatment if they do not implicate communications between the respondent and the clinician.

The exception to the psychotherapist privilege set out in G.L. c. 233, § 20B(b) is available in proceedings under G.L. c. 123, §§ 7 & 8 and 8B. That exception provides that the privilege does not apply to communications made by the respondent about his or her mental or emotional condition during a court-ordered psychiatric exam after an appropriate *Lamb* warning was given (i.e., the respondent was informed that such communications would not be confidential) and the respondent made a voluntary and knowing waiver. G.L. c. 233, § 20B(b). **The court is required to inquire *sua sponte* and make appropriate findings if it appears that the respondent may not have understood the *Lamb* warning or that his or her waiver of rights may not have been knowing and voluntary.**

As yet there is no dispositive appellate decision whether the additional exception to the psychotherapist privilege found in § 20B(a) is available in proceedings under G.L. c. 123, §§ 7 & 8 and 8B, but it appears from the case law that it does not.

It is recommended that the judge resolve any issues concerning privileged communications at the commencement of the hearing, including any concerning any *Lamb* warning and waiver.

Commentary

See *Commonwealth v. Clancy,* 402 Mass. 664, 667 (1988) ("communications" included in psychotherapist privilege include "conversations, correspondence, actions, occurrences, memoranda, or notes relating to diagnosis or treatment," but not "the fact of a hospital admission, the dates of hospitalization or even the purpose of the admission, if such purpose does not implicate communications between the witnesses and the psychotherapist"); *Commonwealth v. Kobrin,* 395 Mass. 284, 294 (1985) (psychotherapist privilege extends to

portions of records that "reflect patients' thoughts, feelings, and impressions, or contain the substance of the psychotherapeutic dialogue"); *Three Juveniles v. Commonwealth,* 390 Mass. 357, 361 (1983) (psychotherapist privilege applies to communications made under circumstances where patient had a reasonable expectation of privacy); *Usen v. Usen,* 359 Mass. 453, 456 (1971) (hospital records hearsay exception [G.L. c. 233, § 79] does not abrogate psychotherapist privilege for communications made part of hospital record); *Adoption of Abigail,* 23 Mass. App. Ct. 191, 198 (1986) (psychotherapist privilege does not extend to conclusions based on objective indicia rather than on communications from patient).

The privilege is not self-executing or a disqualification; it must be claimed by the patient and is waived absent timely objection. *Commonwealth v. Oliveira,* 438 Mass. 325, 331 (2002) (communications to psychotherapists); G.L. c. 112, § 135B (communications to social workers).

"Psychotherapists" include physicians who devote a substantial portion of time to the practice of psychiatry, licensed psychologists, doctoral students under the supervision of a licensed psychologist, and psychiatric nurse mental health clinical specialists. G.L. c. 233, § 20B. A physician with a practice in pain management is a psychotherapist, since pain management is a subspecialty of psychiatry as well as neurology and internal medicine. *Board of Registration in Medicine v. Doe,* 457 Mass. 738, 743-745 (2010)

"Social workers" include licensed certified social workers and licensed social workers (G.L. c. 112, § 132) as well as government-employed social workers. G.L. c. 112, § 135B.

"Communications" include conversations, correspondence, actions and occurrences relating to diagnosis or treatment before, during or after institutionalization, regardless of the patient's awareness of such conversations, correspondence, actions and occurrences, and any records, memoranda or notes of the foregoing. G.L. c. 233, § 20B; G.L. c. 112, § 135.

General Laws c. 123, § 8B(h), G.L. c. 233, § 20B and G.L. c. 112, §§ 129A and 135B list a number of exceptions when the privilege does not apply, but the two discussed below are particularly pertinent in civil commitment and medical treatment authorization proceedings.

General Laws c. 233, § 20B reads as follows (G.L. c. 112, § 135B is identical for social workers):

> "The privilege granted hereunder shall not apply to any of the following communications:–
>
> "(a) **[To place or retain a patient in a mental health facility.]** If a psychotherapist, in the course of his diagnosis or treatment of the patient, determines that the patient is in need of treatment in a hospital for mental or emotional illness or that there is a threat of imminently dangerous activity by the patient against himself or another person, and on the basis of such determination discloses such communication either for the purpose of placing or retaining the patient in such hospital, provided however that the provisions of this section shall continue in effect after the patient is in said hospital, or placing the patient under arrest or under the supervision of law enforcement authorities.

"(b) **[To conduct a court-ordered psychiatric exam after *Lamb* warning.]** If a judge finds that the patient, after having been informed that the communications would not be privileged, has made communications to a psychotherapist in the course of a psychiatric examination ordered by the court, provided that such communications shall be admissible only on issues involving the patient's mental or emotional condition but not as a confession or admission of guilt . . . ."

General Laws c. 123, § 8B(h) also sets out for medical treatment authorization proceedings a separate statement of the § 20B(b) exception to the psychotherapist privilege:

"Any privilege established [for communications to social workers] by [G.L. 112, § 135] or [for communications to psychotherapists] by [G.L. c. 233, § 20B], relating to confidential communications, shall not prohibit the filing of reports or affidavits, or the giving of testimony, pursuant to this section, for the purpose of obtaining treatment of a patient, provided that such patient has been informed prior to making such communications that they may be used for such purpose and has waived the privilege."

THE § 20B(a) EXCEPTION FOR PLACING OR RETAINING A PERSON IN A MENTAL HEALTH FACILITY

There are no appellate decisions interpreting the application of the G.L. c. 233, § 20B(a) exception to the psychotherapist privilege in civil commitment proceedings under G.L. c. 123, §§ 7 & 8 or 8B. However, case law in other types of proceedings has apparently limited this exception to situations where the patient is (or is about to be) at large and is not before the court or in State custody, and therefore the § 20B(a) exception is probably not available in civil commitment and §8B proceedings.

"[E]xception (a) . . . is intended to apply to a situation in which the patient is not institutionalized or is about to be discharged from an institution. It is not, we think, applicable to the case where the patient is already in the custody of State officials and where there has commenced a deliberate, orderly, judicially-supervised proceeding for determining whether he shall be committed. Exception (a) . . . also [applies when disclosure] is made for the purpose of placing the patient under arrest or under the supervision of law enforcement authorities. These three permitted purposes show the Legislature's intention to dispense with the privilege when there is an imminent threat that a person who should be in custody will instead be at large. For any other purpose the privilege is to be maintained. The proviso indicates that after the patient is in a hospital the privilege is ordinarily to continue." *Commonwealth v. Lamb,* 365 Mass. 265, 268 (1974) (in sexually dangerous person commitment proceedings under G.L. c. 123A, exception § 20B[a] not available, and only exception § 20B[b], which requires a *Lamb* warning, is available).

The § 20B(a) exception was also held unavailable in *Department of Youth Servs. v. A Juvenile,* 398 Mass. 516, 526 (1986) (proceeding to extend juvenile commitment to Department of Youth Services past age 18 under G.L. c. 120, §§ 16-20), as well as in *Matter of Laura L.,* 54

Mass. App. Ct. 853, 860 (2002) (3-day emergency mental health commitment under G.L. c. 123, § 12[e]). The Appeals Court noted in that case:

> "We see no reason why similar safeguards should not apply here [in § 12(e) proceedings] . . . . *Lamb* puts to rest any doubts . . . and places all court-ordered examinations under the ambit of G. L. c. 233, § 20B(b) . . . . [A] valid disclosure at the ultimate commitment hearing may come only after *Lamb* warnings are given and the judge finds a knowing and voluntary waiver of the privilege. In this way, we read G. L. c. 233, § 20B, harmoniously with the involuntary commitment proceedings specified in G. L. c. 123, § 12(a) and (e), and avoid the constitutional difficulties posed when a person is examined and subsequently committed and deprived of liberty without due process based on otherwise privileged statements." *Id.* at 858-861 (citations and footnotes omitted).

See also *Board of Registration in Medicine v. Doe,* 457 Mass. at 745-746 (court lacks authority to create new exceptions to statutory privileges).

The § 20B(a) exception would additionally be unavailable in § 8B proceedings if the psychotherapist's testimony does not meet the statutory prerequisite that it be "for the purpose of placing or retaining the patient in such hospital."

THE § 20B(b) EXCEPTION FOR COURT-ORDERED EXAMINATIONS AFTER A *LAMB* WARNING AND WAIVER

The § 20B(b) exception to the psychotherapist privilege requires a patient notification and waiver that is commonly referred to as a "*Lamb* warning."

> "The policy of exception (b) is to permit a court to utilize expert psychiatric evidence by ordering an examination. In that situation, however, the statute recognizes that such court-initiated interviews entail certain risks for the person to be examined. It provides the procedural protection that notice is to be given if the privilege is not to apply in those circumstances. This protection seems particularly suitable for cases such as this where the patient runs the risk of commitment . . . depending on what he says in an interview which in the normal course of affairs would be accorded confidentiality. If we were to hold that this protection was denied patients because [court-ordered, custodial] psychiatric examinations . . . also were covered by exception (a), we would render nugatory the important policy objective of the statute evinced by the notice requirement in exception (b). Such an interpretation is to be avoided . . . .
>
> "We construe G. L. c. 233, Section 20B, as preserving a patient's rights to keep privileged any communications made to a court-appointed psychotherapist in the case of a court-ordered examination, absent a showing that he was informed that the communication would not be privileged and thus, inferentially, that it would be used at the commitment hearing. In so doing we avoid considering whether the use of such statements in the absence of such warnings infringes upon the rights of due

process guaranteed by the Fourteenth Amendment of the United States Constitution." *Commonwealth v. Lamb,* 365 Mass. at 269-270.

Giving a *Lamb* warning is effective to waive the psychotherapist privilege only if the respondent also makes a knowing and voluntary waiver of the privilege:

> "Attendant to the requirement of warnings . . . is that any waiver be knowing and voluntary. When applied to a court-ordered examination pursuant to G. L. c. 123, § 12(e), subsequent to the issuance of a warrant of apprehension, a valid disclosure at the ultimate commitment hearing may come only after *Lamb* warnings are given and the judge finds a knowing and voluntary waiver of the privilege . . . ." *Matter of Laura L.,* 54 Mass. App. Ct. at 858-861.

The court must inquire *sua sponte* and make findings if it appears that the respondent's understanding of the *Lamb* warning may have been impaired or that his or her waiver of rights may not have been knowing and voluntary. *Id.* See also *Adoption of Carla,* 416 Mass. 510, 515 n.5 (1993) (doubtful that waiver valid where examiner refused to score tests or write report unless patient agreed to waiver).

It appears that the § 20B(b) exception to the psychotherapist privilege is applicable even to examinations that are not court-ordered if a *Lamb* warning was given and a knowing and voluntary waiver obtained. See *Department of Youth Servs. v. A Juvenile,* 398 Mass. 516 (1986) (DYS psychiatrist). It should also be noted that certain mental health practitioners are separately required, either by statute or professional ethical standards, to inform a patient of any limitations upon the confidentiality accorded patient communications, such as in a subsequent judicial proceeding. See, e.g., G.L. c. 112, §§ 129A (psychologists) and 135A (social workers); American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* §§ 3.10, 4.02 and 10.01; American Psychiatric Association, *Principles of Medical Ethics Applicable to Psychiatry* § 4.

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The following excerpt from the *Massachusetts Guide to Evidence* (2011 ed.) summarizes the law in this area as follows:

> "Section 503. **Psychotherapist-Patient Privilege**
>
> " . . . . (b) *Privilege.* Except as hereinafter provided, in any court proceeding and in any proceeding preliminary thereto, and in legislative and administrative proceedings, a patient shall have the privilege of refusing to disclose, and of preventing a witness from disclosing, any communication, wherever made, between said patient and a psychotherapist relative to the diagnosis or treatment of the patient's mental or emotional condition. This privilege shall also apply to patients engaged with a psychotherapist in marital therapy, family therapy, or consultation in contemplation of such therapy. If a patient is incompetent to exercise or waive such privilege, a guardian shall be appointed to act in his or her behalf under this section. A previously appointed guardian shall be authorized to so act.

“(c) *Effect of Exercise of Privilege.* Upon the exercise of the privilege granted by this section, the judge or presiding officer shall instruct the jury that no adverse inference may be drawn therefrom.

“(d) *Exceptions.* The privilege granted hereunder shall not apply to any of the following communications:

“(1) *Disclosure to Establish Need for Hospitalization or Imminently Dangerous Activity.* A disclosure made by a psychotherapist who, in the course of diagnosis or treatment of the patient, determines that the patient is in need of treatment in a hospital for mental or emotional illness or that there is a threat of imminently dangerous activity by the patient against himself or herself or another person, and on the basis of such determination discloses such communication either for the purpose of placing or retaining the patient in such hospital, provided, however, that the provisions of this section shall continue in effect after the patient is in said hospital, or placing the patient under arrest or under the supervision of law enforcement authorities;

“(2) *Court-Ordered Psychiatric Exam.* A disclosure made to a psychotherapist in the course of a psychiatric examination ordered by the court, provided that such disclosure was made after the patient was informed that the communication would not be privileged, and provided further that such communications shall be admissible only on issues involving the patient’s mental or emotional condition but not as a confession or admission of guilt . . . .”

6:00 Emergency 3-Day Commitments

Any person may file an application requesting the District Court to commit an allegedly mentally ill person to a mental health facility for a maximum of three days, if the failure to do so would cause a likelihood of serious harm by reason of mental illness. G.L. c. 123, § 12(e).

See Standards 1:01 and 2:00 for the definitions of "mental illness" and "likelihood of serious harm." Mental illness is a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs a person's behavior, judgment, ability to recognize reality, or ability to meet the ordinary demands of life. (It does not include alcoholism or substance abuse.)

In general, "likelihood of serious harm" requires a finding that failure to hospitalize would pose a substantial risk of physical harm to the respondent or others, or a very substantial risk of physical harm to the respondent himself or herself because of his or her inability to protect himself or herself in the community.

Upon receipt of a § 12(e) application, the court must appoint counsel to represent the respondent.

If the respondent is not before the court and is unlikely to appear voluntarily, the judge may issue a warrant of apprehension to bring the respondent before the court "[a]fter hearing such evidence as [the judge] may consider sufficient . . . if in [the judge's] judgment the condition or conduct of such person makes such action necessary or proper."

When the respondent is before the court, the judge must have the person examined by a Designated Forensic Psychiatrist or Designated Forensic Psychologist. See Standard 1:01 for the definitions of those two terms.

If the Designated Forensic Psychiatrist or Designated Forensic Psychologist reports that the failure to hospitalize the respondent would create a likelihood of serious harm by reason of mental illness, the court may after hearing order the respondent committed to a mental health facility for a period not to exceed three days. The three-day period begins on the day after the order issues and does not include any intervening Saturday, Sunday or legal holiday. If the third day is a Saturday, Sunday or legal holiday, the next business day is considered the third day. G.L. c. 123, § 12(e); Mass. R. Civ. P. 6.

The superintendent of the facility may discharge the respondent at any time within the three-day period. G.L. c. 123, § 12(e).

Commentary

Apart from the emergency commitment procedure with court involvement (G.L. c. 123, § 12[e]) described in this Standard, in emergencies there are two additional admission

procedures to mental health facilities, discussed below, that do not require court involvement: conditional voluntary admission (§§ 10 & 11) and involuntary admission by a medical or mental health professional or police officer (§ 12[a]-[b]).

CONDITIONAL VOLUNTARY ADMISSION (§§ 10 & 11)

A person 16 years or older, or the parent of a minor, or certain persons or state agencies on a person's behalf, may apply to the director of a mental health facility for admission on a voluntary basis. After an opportunity for consultation with an attorney, the application may be accepted if the applicant has the capacity to understand that he or she is voluntarily entering a psychiatric facility for treatment (but may refuse any particular treatment offered), and that he or she must give three days written notice in order to leave.

A person admitted on a voluntary basis may leave at any time upon giving written notice.

However, most facilities will only admit voluntary patients on a conditional basis under G.L. c. 123, §§ 10 & 11. These are commonly referred to as "conditional voluntary admissions" or "conditional voluntaries." If the person is admitted on a conditional voluntary basis, the director may require three days written notice of intent to leave. During that three-day period, the director may petition the court to civilly commit the person involuntarily pursuant to §§ 7 & 8 and the person then may be retained at the facility until the petition is heard. G.L. c. 123, §§ 10-11. No person may be involuntarily admitted under § 12 unless he or she is first given an opportunity to apply for voluntary admission. § 12(c).

INVOLUNTARY ADMISSION BY MEDICAL OR MENTAL HEALTH PROFESSIONAL OR BY POLICE OFFICER (§ 12[a]-[b])

Any licensed physician, psychiatric nurse mental health clinical specialist, psychologist, or independent clinical social worker who examines a person and has reason to believe that failure to hospitalize that person would create a likelihood of serious harm by reason of mental illness may restrain that person (or authorize his or her restraint) and apply for his or her hospitalization for a three-day period at a public mental health facility, or at a private mental health facility authorized by the Department of Mental Health for that purpose. If it is impossible to examine the person "because of the emergency nature of the case and because of the refusal of the person to consent to such examination," the determination may be made "on the basis of the facts and circumstances." Whenever practicable, the applicant must consult with the facility before transporting the person.

In an emergency situation in which none of the medical or mental health professionals listed above is available, a police officer who believes that failure to hospitalize a person would create a likelihood of serious harm by reason of mental illness may restrain the person and apply for his or her hospitalization for up to three days. G.L. c. 123, § 12(a); 104 Code Mass. Regs. § 33.02.

If the application for admission is made by a Designated Physician (i.e., one who has been designated by a mental health facility with authority to admit to that facility) after a psychiatric examination, the person will be admitted immediately upon reception at the mental health facility. Otherwise, immediately upon reception at the facility, the person must be given a psychiatric examination by a designated physician, who may admit the person. § 12(b). See Standard 1:01 for the definition of the term "Designated Physician."

6:01 Emergency Hearings on Whether 3-Day Admission Resulted from Abuse or Misuse

A person who has been involuntarily admitted to a mental health facility for three days pursuant to G.L. c. 123, § 12(b):

> **"who has reason to believe that such admission is the result of an abuse or misuse of the provisions of [§ 12(b)], may request, or request through counsel an emergency hearing in the district court in whose jurisdiction the facility is located, and unless a delay is requested by the person or through counsel, the district court shall hold such hearing on the day the request is filed with the court or not later than the next business day."** G.L. c. 123, § 12(b), third par.

As long as the written request for an emergency hearing makes a minimal showing which is not patently frivolous that the person's three-day admission may have resulted from misuse or abuse of the § 12(b) process, the court must hold an immediate hearing on the request on the same or the next court day. The hearing does not necessarily have to be an evidentiary one, depending on the abuse or misuse alleged, but the person is entitled to be present and to be heard. The court need not hold a hearing on a claim that is patently frivolous because facially irrelevant or undercut by firmly established law or undisputed facts.

The scope of the "abuse or misuse" that may be raised in an emergency hearing is not limited to denial of the specific procedural rights listed in § 12(b). That broad phrase serves as "a catch-all provision to include other circumstances that have resulted in a wrongful § 12(b) admission."

It does not, however, encompass a challenge to the *substance* of the underlying clinical decision:

> **"These other circumstances do not include a challenge to the substance of the designated physician's actual 'determin[ation] that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness' . . . . because the Legislature has already established an appropriate time to challenge that determination, namely, at the hearing afforded to a person when the hospital is seeking the person's continued commitment beyond the three-day hospitalization."**

See *Newton-Wellesley Hosp. v. Magrini,* 451 Mass. 777, 784-785 & n.13 (2008).

Commentary

The *Magrini* case developed from a hospital's attempt to obtain a civil commitment under G.L. c. 123, §§ 7 & 8 for a person who had been subject to a three-day emergency admission under § 12. The District Court properly denied the petition because it was not timely

filed within the three days, and ordered the patient discharged. Without ever releasing the patient, the hospital readmitted the patient under § 12. The patient then requested an emergency hearing, asserting that the hospital had used § 12 "to effectively countermand a court order [of] discharge."

The Supreme Judicial Court agreed that the patient was entitled to a hearing and that the hospital's actions were an "abuse or misuse" of § 12 because it had "never complied with the court order." However, the opinion left open the substantive issue whether some form of immediate readmission after a discharge based on a procedural error is permissible, noting:

> "This is not to say that a hospital could never recommit a person on a temporary basis. The statutory scheme does not prohibit such action, but that issue is not before us." *Id.,* 451 Mass. at 784 n.14.

AUTHORIZATION OF MEDICAL TREATMENT FOR MENTAL ILLNESS
(Standards 7:00 through 11:04)

7:00 Overview of G.L. c. 123, § 8B Proceedings

The District Court may authorize the administration of antipsychotic medications or other medical treatment of mental illness for persons committed to mental health facilities who are incompetent to give or withhold informed consent to such treatment. G.L. c. 123, § 8B.

When both a commitment petition and a § 8B petition are filed at the same time, the court must consider them separately, and the § 8B petition may be heard only after the court has entered a commitment order. See Standards 8:02 (Right to a Hearing in § 8B Proceedings) and 8:04 (Time Limits for § 8B Hearing).

In considering a § 8B petition, the court must first determine whether the respondent is incompetent to make an informed decision about the proposed medical treatment. See Standard 7:02 (Competency to Make Informed Treatment Decisions).

Next, the court must consider whether to authorize the proposed treatment. If authorization is sought to administer antipsychotic drugs, the court must make a "substituted judgment" decision, standing in the place of the respondent. See Standard 7:03 (Substituted Judgment for Treatment with Antipsychotic Drugs). **If authorization is sought for other medical treatments for mental illness, the court must determine the applicable legal standard, which may also require a substituted judgment decision.** See Standard 7:04 (Authorizing Treatments Other Than Antipsychotic Drugs).

All required elements must be shown by a preponderance of the evidence and the court must make detailed findings. See Standards 9:04 (Findings, Decision and Order in § 8B Proceedings) and 10:00 (Standard of Proof in § 8B Hearings).

If the court authorizes the proposed treatment, it must also approve a written treatment plan and is responsible for monitoring compliance with the treatment plan, although it may delegate the actual monitoring responsibilities to a guardian or other designated person. See Standards 11:00 (Contents of § 8B Treatment Plan) and 11:04 (Monitoring § 8B Treatment Plan).

Commentary

INTRODUCTION

> "[T]he commitment proceeding itself is not intended to be a determination that the individual lacks the capacity to make his own treatment decisions . . . . [T]he commitment decision itself is an inadequate predicate to the forcible administration

> of drugs to an individual where the purported justification for that action is the state's parens patriae power . . . . [A]bsent an emergency, a judicial determination of incapacity to make treatment decisions must be made before the state may rely on its parens patriae powers to forcibly medicate a patient." *Rogers v. Okin*, 634 F.2d 650, 659-661 (1st Cir. 1980), vacated on other grounds sub nom. *Mills v. Rogers,* 457 U.S. 291 (1982).

General Laws c. 123, § 8B authorizes the District Court to adjudicate petitions seeking court authorization for administration of antipsychotic medications or other medical treatment of mental illness for persons committed to mental health facilities who are alleged to be incapable of giving or withholding informed consent to such treatment. Proceedings under this statute are often referred to as *Rogers* hearings, referring to the Supreme Judicial Court's decision in *Rogers v. Commissioner of Dept. of Mental Health,* 390 Mass. 489 (1983), decided three years before the enactment of § 8B.

The Probate and Family Court has long had jurisdiction over such medical treatment authorizations in the context of guardianship proceedings, whether or not the ward was committed to a mental health facility. Beginning in 1986, G.L. c. 123, § 8B gave the District Court such jurisdiction solely with respect to committed persons who are incompetent to make such a decision for themselves. Since the majority of commitment cases are adjudicated in the District Court, § 8B greatly expedited the resolution of medical treatment petitions for committed persons. Most petitions for authorization to medically treat committed persons for mental illness are now heard in the District Court.

Section 8B does not confer jurisdiction on the District Court to authorize *non-medical* treatment, even if related to mental illness (e.g., psychotherapy), or to authorize medical treatment for illnesses other than mental illness. The court may authorize medical treatments that are ancillary to treatments for mental illness, such as drugs that are prescribed to prevent or treat the side effects of antipsychotic drugs.

If the § 8B petition seeks authorization to treat with antipsychotic drugs (as most do), the court must make a "substituted judgment" decision on behalf of the respondent. See Standard 7:03 (Substituted Judgment for Treatment with Antipsychotic Drugs).

If the requested medical treatment for mental illness involves treatment other than with antipsychotic drugs (e.g., electroconvulsive treatment), the court must proceed "according to the applicable legal standards for such other medical treatment."

Section 8B does not authorize the District Court to override a *competent* committed person's refusal of medical treatment.

§ 8B PROCEDURES

Treatment authorization procedures under § 8B apply only to incompetent persons who have been involuntarily committed because of mental illness. The commitment may have been

ordered before the § 8B petition is filed or it may be sought at the same time the § 8B petition is filed.

When both a commitment petition and a § 8B petition are filed at the same time, the court must treat them as two separate proceedings, each involving distinct issues and evidentiary matters. The § 8B petition may be considered only after the court has entered an order committing the respondent to a mental health facility or Bridgewater State Hospital.

In considering a § 8B petition, the court has a dual inquiry. First, it must determine the committed respondent's competency – his or her capacity to make an informed decision about the proposed medical treatment for mental illness. The fact that the respondent has been committed because of mental illness is not determinative of his or her competency to make treatment decisions. If the respondent is capable of making an informed treatment decision, the court must dismiss the petition.

Second, if the respondent is determined to be incapable of making an informed treatment decision, the court must then consider whether to authorize the proposed medical treatment by applying the appropriate legal standard, depending on the nature of the treatment. Most petitions seek authorization to treat the respondent's mental illness with antipsychotic drugs, which requires the court to make a substituted judgment decision.

The elements required to authorize a requested treatment order must be proved by a preponderance of the evidence and the court must make detailed findings.

If the proposed medical treatment is authorized, it must be administered in accordance with a written treatment plan approved by the court. The treatment authorization continues in effect until modified or vacated, or until any specified expiration date, or until the commitment to which the § 8B order is linked expires, whichever occurs first. See Standards 11:01 (Scope and Duration of Authorized § 8B Treatment Plan) and 11:02 (Modifying or Vacating § 8B Treatment Authorizations). The court is responsible for monitoring compliance with the treatment plan, although it may delegate the actual monitoring responsibilities to a guardian or other designated person.

PRETRIAL CRIMINAL DEFENDANTS

A § 8B petition concerning a respondent with pending criminal charges may implicate the respondent's right to have the jury observe his or her demeanor in an unmedicated state. See *Commonwealth v. Louraine,* 390 Mass. 28, 32-38 (1983) (defendant offering insanity defense entitled to have jury observe him in unmedicated condition, but this may waive right to be tried only if competent). See also *Sell v. United States,* 539 U.S. 166 (2003) (constitutionally permissible to involuntarily administer antipsychotic medication to render defendant competent to stand trial if medically appropriate and it significantly furthers governmental interests in particular case); *Commonwealth v. Gurney,* 413 Mass. 97 (1992) (even where no insanity defense, where relevant to defendant's demeanor and mental condition during trial, defendant entitled to offer evidence about antipsychotic medication being taken at time of trial). For an analysis of how various Federal circuits have applied the *Sell* factors, see Michelle R. Cruz,

United States v. Ruiz-Gaxiola: Setting the Standard For Medicating Defendants Involuntarily in the Ninth Circuit, 41 GOLDEN GATE U. L. REV. (2011) (available at http://digitalcommons.law.ggu.edu/ggulrev/vol41/iss3/7).

MEDICAL INTERVENTION WITHOUT DISTRICT COURT AUTHORIZATION

There are several ways in which an involuntarily committed mentally ill person may receive medical intervention for mental illness without District Court authorization. A non-exhaustive list would include at least:

Voluntary treatment. Any person who is competent (i.e., capable of informed medical treatment decisions), including a person who is committed because of mental illness, can give voluntary consent to treatment.

Probate and Family Court. A guardian appointed by the Probate and Family Court does not have authority to consent to the involuntary administration of antipsychotic medication to the ward, but may request a Probate and Family Court judge to authorize such treatment in a substituted judgment proceeding. G.L. c. 190B, § 5-306A. A guardian may consent to medical treatment for the ward other than antipsychotic medication, § 5-309(a), unless such authority has been limited by the Probate and Family Court, § 5-306(c), or is displaced by a prior health care proxy, § 5-309(e).

Medication restraint. A physician may authorize the immediate administration of antipsychotic or other drugs for restraint purposes in an emergency where a committed person poses an imminent threat of physical harm to self or others and there is no less intrusive alternative. See the commentary to Standard 7:03 (Substituted Judgment for Treatment with Antipsychotic Drugs).

Emergency treatment. A physician may authorize the immediate administration of antipsychotic drugs to an incompetent committed person if necessary to prevent an immediate, substantial and irreversible deterioration of a serious mental illness. Authorization to continue treatment must be sought either through an § 8B petition in the District Court or a *Rogers* petition in the Probate and Family Court, both of which require a substituted judgment. See the commentary to Standard 7:03 (Substituted Judgment for Treatment with Antipsychotic Drugs).

7:01 Related Probate and Family Court Proceedings

Before commencing the hearing on a § 8B petition to authorize medical treatment for mental illness, the court should determine from the petitioner whether there is any prior or pending involvement by the Probate and Family Court regarding the respondent's medical treatment for mental illness.

If there was a prior Probate and Family Court determination regarding the same respondent and the same or related issues of competency and treatment, the District Court should be informed of and give careful consideration to that earlier decision.

If there is a Probate and Family Court treatment plan currently in effect, the District Court should refer the petitioner seeking to change that plan back to the Probate and Family Court that issued it, unless immediate action is necessary.

Under the Uniform Probate Code, a guardian appointed by the Probate and Family Court does not have authority to consent to the involuntary administration of antipsychotic medication to an incapacitated ward, but a guardian may request a Probate and Family Court judge to authorize such treatment in a substituted judgment proceeding. G.L. c. 190B, § 5-306A. **A guardian may consent to medical treatment for the ward other than antipsychotic medication,** § 5-309(a), **unless such authority has been limited by the court,** § 5-306(c), **or is overridden by a health care proxy,** § 5-309(e)**.**

The Probate and Family Court may not grant a guardian authority to admit the ward to a mental hospital. § 5-309(f). **Instead, commitment proceedings must be initiated in the District Court under G.L. c. 123, §§ 7 & 8.**

Commentary

In *Guardianship of Pamela,* 401 Mass. 856 (1988), the Supreme Judicial Court held that competency to make informed treatment decisions always involves *current* competency, and therefore a Probate and Family Court judge considering a *Rogers* petition to authorize medical treatment was not bound by a District Court judge's contrary § 8B decision eight months earlier, where there were changed circumstances and new evidence.

The *Pamela* decision implies that a petitioner may file a § 8B petition in the District Court notwithstanding having previously filed an unsuccessful petition to authorize medical treatment in the Probate and Family Court. For that reason, the District Court should inquire about any prior Probate and Family Court action regarding the respondent's medical treatment for mental illness. While the earlier ruling is not binding, the court should examine the petition carefully if current circumstances do not appear to support a different outcome, no new evidence is presented, and the petition seems to be an attempt to forum-shop.

Where a § 8B petition is filed solely to modify a treatment plan authorized by the Probate and Family Court that is currently in effect, jurisdiction should be declined and the petitioner

directed to the Probate and Family Court that issued that treatment plan, unless circumstances require immediate action.

The Uniform Probate Code uses the term “incapacitated” (G.L. c. 190B, §§ 1-201[22] & 5-101[9]) rather than the traditional term “incompetent” found in case law and court rules, but in this context the meaning is the same.

If the respondent has been transferred to a different facility, the court that ordered the treatment plan should continue to monitor it, and any modification should be sought from that court. When that treatment order expires, any subsequent order should be sought from the court division with jurisdiction over the facility.

7:02 Competency to Make Informed Treatment Decisions

The petitioner must prove by a preponderance of the evidence that the respondent is incompetent, i.e., he or she is incapable of making informed decisions about medical treatment for mental illness.

The court should give no weight to the commitment petition or order in its consideration of the respondent's capacity to make informed treatment decisions.

The court must make specific written findings on the respondent's competency to give or withhold consent to medical treatment for mental illness.

Commentary

The court's first task in adjudicating a § 8B petition is to determine if the respondent is competent. "[A] distinct adjudication of incapacity to make treatment decisions (incompetence) must precede any determination to override patients' rights to make their own treatment decisions." *Rogers v. Commissioner of Dept. of Mental Health,* 390 Mass. 489, 498 (1983). Only when a person is found to be incapable of giving informed consent to medical treatment may the court consider authorizing such treatment. The court must deny a petition to authorize treatment if it finds the respondent competent, i.e., capable of making informed decisions about treatment.

Like all other persons, the respondent is presumed competent. See *Fazio v. Fazio,* 375 Mass. 394, 403 (1978) (a person's capacity to "think or act for himself as to matters concerning his personal health, safety, and general welfare . . . is presumed unless specifically adjudicated otherwise"). Additionally, by statute a person may not be deemed incompetent to "manage his or her affairs" solely by reason of admission or commitment to a mental health facility for care or treatment. G.L. c. 123, § 24. "[A] mental patient has the right to make treatment decisions and does not lose that right until the patient is adjudicated incompetent by a judge through incompetence proceedings." *Rogers,* 390 Mass. at 497.

In order to overcome the presumption of competence, the court must find by a preponderance of the evidence that the respondent is incapable of making informed treatment decisions. See *Guardianship of Roe,* 383 Mass. 415 (1981). See also Standard 10:00 (Standard of Proof in § 8B Hearings).

The importance of adequate and consistent subsidiary findings was underscored in *Lane v. Fiasconaro,* 1995 Mass. App. Div. 125 (N. Dist.), in which the Appellate Division reversed a judge's finding of incompetency. The judge's ultimate finding was that the respondent "denies that she is presently ill, . . . does not understand the nature of her illness [or] the risks of nontreatment, and [her] delusions and mental illness are persistent and impair her judgment," but the judge's subsidiary findings indicated only that the respondent had an awareness of her condition and her need for medical treatment, and that the single physician witness had opined that she was improving and was competent.

Clinical research in this area suggests that the test of competency to make informed treatment decisions may involve several distinct inquiries. See Applebaum & Grisso, *Assessing Patients' Capacities to Consent to Treatment,* 319 New Eng. J. Med. 1635-1638 (1988); Beck, *Right to Refuse Antipsychotic Medication: Psychiatric Assessment and Legal Decision-Making,* 11 Mental & Phys. Disability L. Rep. 368-372 (1987).

For example, the respondent's *information-gathering ability* should be assessed, essentially asking whether the respondent is able to obtain and perceive facts about his or her condition, the need for treatment, and the possible methods and outcomes of the different treatments available. "While knowledge is evidence of competence, ignorance is not necessarily evidence of incompetence." Beck, *supra* at 369. A treating clinician shares responsibility in this area by assisting the respondent in obtaining the facts needed to arrive at an informed decision. Therefore, the court may properly inquire about the clinician's efforts to inform the respondent about his or her case.

Another important factor is the respondent's *capacity to appreciate or rationally understand information* that has been gathered. *Id.* For example, a respondent who denies his or her mental illness in the face of uncontroverted evidence may not appreciate the need for treatment, and may not be able to fairly weigh its risks and benefits. *Guardianship of Roe,* 411 Mass. 666 (1992). On the other hand, a respondent who refuses medication because of adverse side effects experienced by or known to him may be able to appreciate certain facts about treatment and arrive at an informed decision.

These factors in and of themselves are not conclusive, but they may assist the court in its deliberations. Each case requires an inquiry into the particular individual's decision-making process. *Id.* The decision itself, or its objective wisdom, is not the focus; what is important is the process by which the respondent arrived at his or her decision.

7:03 Substituted Judgment for Treatment with Antipsychotic Drugs

If an § 8B petition requests authorization for treatment with antipsychotic drugs and the respondent is found incapable of making informed treatment decisions, the court must make a substituted judgment determination. G.L. c. 123, § 8B (a)(iv).

"Substituted judgment" differs from "best interests" and does not permit the court to substitute its own judgment for that of the respondent. Instead, a substituted judgment means that the court must attempt to determine what the respondent would choose to do regarding the proposed treatment plan if he or she were competent. This should include consideration of the respondent's expressed preferences and religious convictions, how the impact on the respondent's family would affect his or her decision, the effect of the proposed treatment on the respondent's medical condition or pregnancy, the severity and probability of any adverse side effects, the respondent's prognosis with and without such treatment, the availability of alternative treatments, and any other relevant factors.

The court may authorize medical treatment with antipsychotic drugs for mental illness if it determines that the respondent, if competent, would accept the treatment.

If the court determines that the respondent, if competent, would refuse the proposed treatment, the court must deny the petition, even if that decision is unwise in the judgment of the petitioner or others, unless the court finds that there is a countervailing State interest sufficient to override the respondent's refusal.

The court must support its decision with specific and detailed findings.

The court may not allow a request for contingent authority to administer antipsychotic drugs based upon hypothetical future conditions. A substituted judgment decision is premature where a change in circumstances could reasonably occur.

Authorizing medical treatment for mental illness other than by antipsychotic drugs may require application of a standard other than substituted judgment. See Standard 7:04 (Authorizing Treatments Other than Antipsychotic Drugs).

Commentary

In making a substituted judgment decision, the court does not substitute its judgment for that of the respondent in the sense that it determines what it believes will be best for the respondent. Rather, the court must stand in place of the respondent and attempt to decide as the respondent would if competent. Thus, the court must identify as closely as possible the respondent's unique wants and needs regarding the proposed treatment plan. *Superintendent of Belchertown State School v. Saikewicz,* 373 Mass. 728 (1977). "Individual choice is determined not by the vote of the majority but by the complexities of the singular situation viewed from the unique perspective of the person called on to make the decision." *Id.* at 746-747. It is therefore primarily a subjective inquiry into at least the following six factors identified in *Guardianship of*

Roe, 383 Mass 415 (1981), and *Rogers v. Commissioner of Dept. of Mental Health,* 390 Mass. 489 (1983):

> "At least six factors must be considered by the judge in arriving at the substituted judgment decision . . . .
>
> [(1) *Patient's expressed preferences.*] "First, the judge must examine the patient's expressed preferences regarding treatment. If made while competent, such a preference is entitled to great weight unless the judge finds that the patient would have changed his opinion after reflection or in altered circumstances. Even if he lacked the capacity to make his treatment decisions at the time, his expressed preference must be treated as a critical factor in the determination of his best interests, since it is the patient's true desire that the court must ascertain.
>
> [(2) *Patient's religious convictions.*] "Second, the judge must evaluate the strength of the incompetent patient's religious convictions, to the extent that they may contribute to his refusal of treatment. The question to be addressed is whether certain tenets or practices of the incompetent's faith would cause him individually to reject the specific course of treatment proposed for him in his present circumstances . . . . While in some cases an individual's beliefs may be so absolute and unequivocal as to be conclusive in the substituted judgment determination, in other cases religious practices may be only a relatively small part of the aggregated considerations.
>
> [(3) *How impact on family would affect patient's decision.*] "Third, the impact of the decision on the ward's family must be considered . . . . [T]his factor is primarily relevant when the patient is part of a closely knit family. The consideration of impact on the family includes the cost in money and time that the family must bear, together with any desire of the patient to minimize that burden. In addition, a patient may be faced with two treatments, one of which will allow him to live at home with his family and the other of which will require the relative isolation of an institution. The judge may then consider what affection and assistance the family may offer. However, the judge must be careful to ignore the desires of institutions and persons other than the incompetent except in so far as they would affect his choice.
>
> [(4) *Probability of adverse side effects.*] "Fourth, the probability of adverse side effects must be considered. This includes an analysis of the severity of these side effects, the probability that they would occur, and the circumstances in which they would be endured.
>
> [(5) *Prognosis without treatment.*] "Fifth, the prognosis without treatment is relevant to the substituted judgment decision. It is probable that most patients would wish to avoid a steadily worsening condition. However, the judge must again reach an individualized, subjective conclusion regarding this factor, after examining it from the unique perspective of the incompetent.

[(6) *Prognosis with treatment.*] "Sixth, the prognosis with treatment must be examined. The likelihood of improvement or cure enhances the likelihood that an incompetent patient would accept treatment, but it is not conclusive.

[*Other factors.*] "Finally, the judge may review any other factors which appear relevant. After weighing the factors, the judge must reach a substituted-judgment treatment decision."

Rogers, 390 Mass. at 505-506 (citations and internal quotes omitted).

If criminal charges are pending against the respondent, the court should ensure that the respondent's criminal counsel has been notified of the § 8B proceeding. The implications that the decision would have on a pending criminal case may affect the decision that the respondent would make if competent.

The court must weigh all these considerations and determine what the respondent's judgment would be regarding the proposed treatment plan if he or she were competent.

Such a substituted judgment is constitutionally required but not always easy:

"The question presented by the [respondent's] refusal of antipsychotic drugs is only incidentally a medical question. Absent an overwhelming State interest, a competent individual has the right to refuse such treatment. To deny this right to persons who are incapable of exercising it personally is to degrade those whose disabilities make them wholly reliant on other, more fortunate, individuals. In order to accord proper respect to this basic right of all individuals, we feel that if an incompetent individual refuses antipsychotic drugs, those charged with his protection must seek a judicial determination of substituted judgment. No medical expertise is required in such an inquiry, although medical advice and opinion is to be used for the same purposes and sought to the same extent that the incompetent individual would, if he were competent. We emphasize that the determination is not what is medically in the [respondent's] best interests – a determination better left to those with extensive medical training and experience. The determination of what the incompetent individual would do if competent will probe the incompetent individual's values and preferences, and such an inquiry, in a case involving antipsychotic drugs, is best made in courts of competent jurisdiction . . . ." *Roe,* 383 Mass. at 434-435 (citations and internal quotes omitted).

"The doctrine of substituted judgment is the means by which incompetents may exercise their right to refuse or terminate treatment . . . . Lack of a prior expressed intention regarding medical treatment does not bar use of the doctrine of substituted judgment. We recognize that in situations in which there is an attempt to use substituted judgment for a never-competent person, it is a legal fiction. It is the legal mechanism by which society (at least in Massachusetts) attempts to vindicate liberty interests, albeit through a legal fiction. We are also aware that therefore the substituted judgment doctrine is difficult to apply. That difficulty, however, provides inadequate justification for denying its benefits. While it may be necessary

> to rely to a greater degree on objective criteria in the case of a never-competent person, the effort to bring the substituted judgment into step with the values and desires of the affected individual must not, and need not, be abandoned." *Guardianship of Doe,* 411 Mass. 512, 518 (1992) (citations and internal quotes omitted).

As the case law emphasizes, the court's responsibility to determine, and normally to implement, what the respondent would decide if he or she were competent goes to the heart of the fundamental constitutional right that the proceeding is designed to ensure. This may sometimes require the court, however uncomfortably, to respect the respondent's right to make a "bad" decision:

> "Where the medical evidence, unchallenged at every turn and unimpeachable in its sincerity, shows that treatment will maintain or regain competence, this is a weighty factor to be considered by the judge as it would be considered by the affected individual. It is not conclusive, however. If the judge feels that the 'best interests' of the [respondent] demand one outcome but concludes that the [respondent's] substituted judgment would require another, then, in the absence of an overriding State interest, the substituted judgment prevails. In short, if an individual would, if competent, make an unwise or foolish decision, the judge must respect that decision as long as [the judge] would accept the same decision if made by a competent individual in the same circumstances." *Roe,* 383 Mass. at 449 n.20.

The court may not grant contingent authority to administer antipsychotic drugs if certain potential events occur where those possibilities are sufficiently uncertain in the circumstances as to be hypothetical. In such cases, a substituted judgment decision is premature. "A substituted judgment determination may only be made upon direct application of a party with standing who actually seeks the administration of the medication. A premature decision will needlessly burden all involved and will make any substituted judgment determination less accurate." *Roe,* 383 Mass. at 432 & n.8.

OVERRIDING STATE INTEREST

"There are circumstances in which the fundamental right to refuse extremely intrusive treatment must be subordinated to various State interests" which are sufficient to override the respondent's refusal. *Roe,* 383 Mass at 433.

In the substituted judgment context, the Supreme Judicial Court has recognized at least four countervailing State interests: (1) the preservation of life, (2) the protection of interests of innocent third parties, (3) the prevention of suicide, and (4) the maintenance of the ethical integrity of the medical profession. The Court has "been willing to consider other State interests as well, particularly when the State interests are specifically related to the right to privacy." *Brophy v. New England Sinai Hosp.,* 398 Mass. 417, 433-434 (1986). However, the Court has specifically refused to hold that "the State ha[s] a vital interest in seeing that its residents function at the maximum level of their capacity and that this interest outweighs the rights of the individual," noting that "the State, in certain circumstances, might have a generalized parens

patriae interest in removing obstacles to individual development, [but] this general interest does not outweigh the fundamental individual rights" to refuse extremely intrusive treatment. *Roe,* 383 Mass at 449.

To date the Supreme Judicial Court has recognized at least two situations where State interests are sufficient to override a committed person's refusal to consent to antipsychotic drugs. Neither of them, however, have involved a judicial substituted judgment determination:

Medication restraint. A physician may authorize the immediate administration of antipsychotic drugs for restraint purposes in an emergency where the patient poses an imminent threat of physical harm to himself or others and there is no less intrusive alternative. Such emergency cases do not require prior court approval through a § 8B petition in the District Court or a *Rogers* petition in the Probate and Family Court. See *Rogers,* 390 Mass. at 507-511. Such restraint is limited to "occurrence or serious threat of extreme violence, personal injury, or attempted suicide." 104 Code Mass. Regs. § 3.12(2), adopted pursuant to G.L. c. 123, § 21.

Emergency treatment. A physician may authorize the immediate administration of antipsychotic drugs to an incompetent patient if necessary to prevent an "immediate, substantial and irreversible deteriorization of a serious mental illness." *Rogers,* 390 Mass. at 511-512. In such cases, if the physician believes that the drug should be continued and the patient objects, and is believed to be incompetent to make a treatment decision, then court approval must be sought through an § 8B or *Rogers* petition under the substituted judgment test. If the court concludes that the person, if competent, would refuse medication, it appears that the State's *parens patriae* concerns would not be a sufficient State interest to override the respondent's right to refuse treatment. "Obviously, if a patient is found to be competent, the doctors may not forcibly medicate that patient over his objection, despite the fact that the patient's condition may deteriorate." *Rogers,* 390 Mass. at 512 n.30.

Commissioner of Correction v. Myers, 379 Mass. 255 (1970), recognized a State interest sufficient to override a competent prisoner's refusal of intrusive medical treatment where a mentally competent prisoner refused dialysis treatment to protest his placement in a medium, as opposed to a minimum, security prison. The Court held that the State's interest in orderly prison administration "tip[ped] the balance in favor of authorizing treatment without consent." *Id.* at 263. The prison setting in which the *Myers* case arose is unique, and it may not offer any guidance for § 8B proceedings.

For general information about the properties of commonly prescribed psychoactive medications, see Department of Mental Health, *Medication Information Manual* (2010) (available at http://www.mass.gov/eohhs/docs/dmh/publications/medication-manual-2010.doc).

7:04 Authorizing Treatments Other than Antipsychotic Drugs

If a § 8B petition requests authorization for medical treatment for mental illness other than by antipsychotic drugs, and the court finds the respondent incompetent, the court should then decide whether it must apply a substituted judgment standard. This should be determined based on the following factors:

1. **the intrusiveness of the proposed treatment,**
2. **the possibility of adverse side effects,**
3. **the presence or absence of an emergency precluding a judicial determination,**
4. **the nature and extent of prior judicial involvement, and**
5. **the likelihood of conflicting interests.**

Applying this test, it appears that a § 8B petition requesting authorization for electroconvulsive therapy (ECT) for an incompetent respondent would require a substituted judgment decision as well as a showing that there is no less intrusive alternative. See *Lane v. Fiasconaro,* 1995 Mass. App. Div. 125 (N. Dist.) (since § 8B provides that treatments other than antipsychotic medications must be "necessary," petitioner must also show that there is no less intrusive effective alternative than ECT).

The District Court has no authority to authorize medical treatment for an incompetent committed person unless that treatment is for mental illness. The court may authorize medical treatments that are ancillary to treatments for mental illness, such as drugs that are prescribed to prevent or treat side effects of antipsychotic drugs.

Commentary

Rogers v. Commissioner of Dept. of Mental Health, 390 Mass. 489, 490 (1983), which required the court to make a substituted judgment decision in deciding whether to authorize medical treatment for mental illness for an incompetent committed person, was expressly limited to treating mental illness with antipsychotic drugs.

However, in granting the District Court jurisdiction over petitions for medical treatment for mental illness, the Legislature did not limit § 8B to treatment by antipsychotic drugs. Like *Rogers,* it requires the court to use the substituted judgment standard in authorizing antipsychotic drug treatment. G.L. c. 123, § 8B(a)(ii). However, it also permits the court to authorize "such other medical treatment as may be necessary for the treatment of mental illness," using "the applicable legal standards." § 8B(a)(iii).

Rogers did not offer guidance regarding any specific medical treatments for mental illness other than antipsychotic drugs, but reaffirmed that the five factors set out above, derived

from *Guardianship of Roe,* 383 Mass. 415 , 435-436 (1981), are the appropriate considerations in determining whether a judicial substituted-judgment decision is required. *Rogers,* 390 Mass. at 503. A court adjudicating a § 8B petition to authorize medical treatment for mental illness other than antipsychotic drugs should apply those five factors in determining whether a substituted judgment standard must be employed. If a substituted judgment determination is not required, it would appear that the traditional "best interests" test should be applied.

The Standard suggests that application of the five-point test should result in a finding that a substituted judgment determination is required to authorize electroconvulsive therapy (ECT). The Appellate Division apparently reached that conclusion in dicta in *Lane v. Fiasconaro,* 1995 Mass. App. Div. 125, 128 n.2 (N. Dist.), and also suggested that "[i]n view of the requirement in Section 8B that treatment other than with antipsychotic medications be 'necessary' and the concern . . . with the existence of an 'emergency,' it would appear that before ECT may be authorized, the petitioner would be obligated to establish that the patient could not be adequately treated with medications or other alternatives, and that the patient specifically required the more intrusive intervention of ECT." See also G.L. c. 123, § 23 ("[A] mentally ill person in the care of the [Department of Mental Health] shall have the following legal and civil rights: . . . to refuse shock treatment . . . ; provided, however, that any of these rights may be denied for good cause by the superintendent or his designee and a statement of the reasons for any such denial entered in the treatment record of such person").

The Standard does not attempt to determine which medical treatments for mental illness (other than antipsychotic medication and electroconvulsive therapy) require court authorization before they may be administered to an incompetent committed person. The common law requires guardians to obtain prior judicial authorization only before consenting to *extraordinary* medical treatment. See *Matter of Moe,* 385 Mass. 555 , 559 (1982). Cf. G.L. c. 190B, § 5-306A(a) (requiring court authorization for guardian "to consent to treatment for which substituted judgment determination may be required" but not specifying which). Section 8B is not on its face limited to "extraordinary" medical treatment. It permits the court to "authorize according to the applicable legal standards such other medical treatment as may be necessary for the treatment of mental illness." However, it is unlikely that this wording was intended to require court authorization even for *ordinary* medical treatments for mental illness, which would represent a significant change in the law.

The District Court has no jurisdiction under § 8B (or otherwise) to authorize medical treatment for an incompetent committed person unless that treatment is for mental illness. Thus, an § 8B petition cannot be used to obtain a "Do Not Resuscitate" order or to authorize treatments for a patient's medical conditions other than mental illness. However, medical treatments that are ancillary or adjunctive to treatments for mental illness (such as drugs prescribed to prevent or treat the side effects of antipsychotic drugs) appear to be within the court's § 8B jurisdiction. Any such associated measures should be taken into account in the court's substituted judgment determination regarding the antipsychotic drug.

7:05 Incompetent Patients Who Agree to Proposed Treatment

Since incompetent persons cannot give informed consent to medical treatment, a court determination is required not only for respondents who refuse proposed treatment, but also for those who agree to proposed treatment but who are not capable of giving informed consent (so-called "passive acceptors").

Commentary

"Because incompetent persons cannot meaningfully consent to medical treatment, a substituted judgment by a judge should be undertaken for the incompetent patient even if the patient accepts the medical treatment." *Rogers v. Commissioner of Dept. of Mental Health,* 390 Mass. 489, 500 n.14 (1983). See also *Guardianship of Linda,* 401 Mass. 783 (1988) (within judge's discretion to condition authorization of antipsychotic medication for incompetent respondent who was then voluntarily accepting such medication on his continued consent and to require a new substituted judgment determination if he began to refuse).

8:00 Filing a § 8B Petition

A § 8B petition for medical treatment for mental illness of an incompetent patient may be filed only by the superintendent of a mental health facility or the medical director of Bridgewater State Hospital. G.L. c. 123, § 8B(a).

The petition must be filed in the court division in whose territorial jurisdiction the facility (or Bridgewater State Hospital) is located. *Id.*

The petition should be made on the appropriate District Court form and should allege:

1. **that the respondent has been committed, or is the subject of a petition for commitment, under G.L. c. 123, §§ 7 & 8, 15(e), 16 or 18;**

2. **why the proposed treatment is necessary or appropriate;**

3. **that the respondent is incapable of making an informed decision about the proposed treatment; and**

4. **that the respondent, if competent, would accept the proposed treatment.**

The petition must be accompanied by a proposed treatment plan sufficiently detailed to provide adequate notice to the respondent of the proposed medical treatment, and to enable the court to monitor the treatment if the petition is allowed.

The petition should explain the reasons for the proposed treatment and should list, briefly but specifically, the facts that support a finding that the respondent is incompetent to make an informed decision about the proposed treatment, as well as the factors that support a substituted judgment that the respondent, if competent, would agree to the proposed treatment.

Alternately, the petition may allege that the respondent, if competent, would refuse the proposed treatment, but there are State interests sufficient to override that refusal. Before the court may accept such a claim, normally an extensive hearing and careful development of both the factual record and legal precedent is essential.

If known at the time of filing, the petitioner should inform court staff if the respondent will require a translator or other language or hearing assistance in order to participate meaningfully in the hearing. Non-English speaking respondents are legally entitled to the assistance of trained interpreters. G.L. c. 123, § 23A (psychiatric hospitals must offer "competent interpreter services" by trained interpreters); G.L. c. 221C, § 2 (courts must use Federally- or Trial Court- "certified" interpreters).

Commentary

As with petitions for civil commitment, the statutory term "superintendent of a facility" (§ 8B) refers to the "superintendent or other head of a facility who is responsible for the admission, discharge, and treatment of patients in the facility" (104 Code Mass. Regs. § 25.03, "Facility Director"), including the head of a psychiatric unit within a general hospital or other subsidiary psychiatric unit within a larger institution. See *Bayridge Hosp. v. Jackson,* 2010 Mass. App. Div. 12 (N. Dist.). The Medical Director of Bridgewater State Hospital is a physician appointed by the Commissioner of Correction, with the approval of the Commissioner of Mental Health, to have overall responsibility for the clinical care of Bridgewater patients. G.L. c. 125, § 18.

After a petition is filed, some respondents may waive a hearing and the court may then "base its findings exclusively upon affidavits and other documentary evidence if it (i) determines, after careful inquiry and upon representations of counsel, that there are not contested issues of fact and (ii) includes in its findings the reasons that oral testimony was not required." § 8B(d). For that reason, the petitioner should include in or with the petition sufficient specific factual evidence and information to support the petition if the hearing is waived.

Any petition must be based on a good faith belief that there is credible evidence that will satisfy all the criteria for allowing the petition. A petition may not be filed merely for administrative convenience. Although amendments to petitions may be allowed as a matter of judicial discretion, considerations of fairness and resources require that petitioners file only petitions that they believe to be factually sufficient. Where a deficient petition prevents the respondent from receiving adequate notice and the opportunity to prepare for the hearing, the court should dismiss the petition and require the petitioner to refile.

8:01 Time Limits for Filing § 8B Petitions

A § 8B petition to authorize medical treatment for mental illness may be filed at the same time as a petition for commitment, or separately at any time during the respondent's term of commitment.

If filed concurrently with a petition for commitment, the § 8B petition "shall be separate from any pending petition for commitment and shall not be heard or otherwise considered by the court unless the court has first issued an order of commitment" under G.L. c. 123, §§ 7 & 8, 15(e), 16 or 18. G.L. c. 123, § 8B(b).

The clerk-magistrate's office must time-stamp and docket all petitions upon receipt.

8:02 Right to a Hearing in § 8B Proceedings

The court must hold a hearing to consider a § 8B petition to authorize medical treatment for mental illness unless the respondent waives the hearing. The hearing may not commence until the court has issued an order of commitment.

With the respondent's consent, G.L. c. 123, § 8B(d) permits the court to "base its findings exclusively upon affidavits and other documentary evidence if it (i) determines, after careful inquiry and upon representations of counsel, that there are not contested issues of fact and (ii) includes in its findings the reasons that oral testimony was not required." Although, with appropriate safeguards, hearings on affidavits are statutorily authorized, in most cases the court should take advantage of the additional benefits from having the parties and witnesses present before the court.

Commentary

An § 8B petition "shall not be heard or otherwise considered by the court unless the court has first issued an order of commitment." G.L. c. 123, § 8B(b).

The court should presume that the hearing will include live testimonial evidence, unless respondent's counsel requests that the evidence be presented by affidavit. While § 8B appears to indicate that it is in the court's discretion whether to resolve the petition without hearing and "exclusively upon affidavits and other documentary evidence" if there are no contested issues of fact, the court's discretion is limited by G.L. c. 123, § 5, which guarantees the respondent an opportunity to present independent testimony in all cases.

In *Guardianship of Erma,* 459 Mass. 801, 805 n.7 (2011), the Supreme Judicial Court declined on mootness grounds to consider whether the Probate Court's identical statutory authority to make substituted judgments "exclusively upon affidavits and other documentary evidence" (G.L. c. 190B, § 5-306A [d]) violates due process.

A hearing by affidavit requires the court preliminarily to determine that no factual issues are contested, after consultation with counsel. § 8B(d). The court should make careful inquiry about this, so that a hearing by affidavit does not diminish the adversarial nature of the proceeding. If the court decides to resolve the petition exclusively on affidavits, it must include in its findings the reasons that oral testimony was dispensed with. *Id.*

A hearing by affidavit requires the same quantum and reliability of evidence as a determination on live testimony, and is subject to the same rules of evidence. See Standards 10:02 (Hearsay in § 8B Hearings), 10:03 (Lay and Expert Witnesses in § 8B Hearings) and 10:04 (Privileged Communications to Clinicians in § 8B Hearings). A hearing by affidavit must also conform to the statutory requirements governing notice (Standard 8:05), timely commencement of hearing (Standard 8:04), and other procedural matters.

While permissible, hearings on affidavits should generally be discouraged. They do not permit the court to ask questions and observe witnesses during examination and cross-examination, or readily allow follow-up questions or clarification. Some § 8B petitions, particularly those to which the respondent does not object after consultation with counsel, may be relatively straightforward and appropriate for determination on affidavits. For contested, doubtful or complex issues, however, the court should carefully consider whether devoting the additional time required for a hearing with live testimony is appropriate, given the importance of the matters at issue.

8:03 Right to Counsel in § 8B Proceedings

The legal requirements and District Court standards that apply to civil commitment proceedings in this area also apply to G.L. c. 123, § 8B proceedings. See Standard 3:03.

8:04 Time Limits for § 8B Hearings

The hearing on a § 8B petition that is *filed concurrently with a petition for commitment* must be commenced on the same day that the hearing on the commitment petition concludes, unless a continuance is granted at the request of the respondent or respondent's counsel. G.L. c. 123, § 8B(c).

The hearing on a § 8B petition *concerning an already committed respondent* must be commenced within 14 days after the date of filing, unless a continuance is granted at the request of the respondent or respondent's counsel. *Id.* In scheduling such a hearing, the clerk-magistrate's office must allow the respondent and his or her counsel at least two days after the appearance or assignment of counsel to prepare for the hearing. G.L. c. 123, § 5. **The 14-day deadline should be calculated in accordance with Mass. R. Civ. P. 6.**

A hearing is not "commenced" when the court and the parties gather, but only when a witness is sworn or some evidence taken.

Commentary

"We are certain that every judge recognizes that in any case where there is a possibility of immediate, substantial, and irreversible deterioration of a serious mental illness, even the smallest of avoidable delays would be intolerable." *Guardianship of Roe,* 383 Mass. 415 , 441 (1981).

All parties benefit from swift resolution of the treatment issues presented in a § 8B proceeding. Observance of these time requirements not only furthers that interest but is required by statute.

"The hearing shall be commenced within fourteen days of the filing of the petition unless a delay is requested by the person or his counsel, provided that the commencement of such hearing shall not be delayed beyond the date of the hearing on the commitment petition if the petition was filed concurrently with a petition for commitment." G.L. c. 123, § 8B(c). The mere "calling" of a case does not constitute "commencement" for purposes of compliance with the statutory deadline. Rather, a hearing is "commenced" only when a witness is sworn or some evidence taken. *Melrose-Wakefield Hosp. v. H.S.,* 2010 Mass. App. Div. 247, 250 (N. Dist.)

Although the Massachusetts Rules of Civil Procedure are not generally applicable to civil commitment proceedings, see Mass. R. Civ. P. 81, the provisions of G.L. c. 123, § 7(c) require that the 5-day or 14-day time limits for hearing a petition for civil commitment "under the provisions of [§ 7] shall be computed pursuant to Rule 6 of the Massachusetts Rules of Civil Procedure." This means that the day on which the petition is filed is excluded from the computation, and (for time periods of less than seven days) intermediate Saturdays, Sundays and legal holidays as well, but the day of hearing is included. If the deadline falls on a Saturday, Sunday or legal holiday, the hearing must be held on the next court business day. There is no comparable reference to Rule 6 in § 8B, but it is unlikely that a different rule was intended for

calculating the 14-day deadline for a § 8B petition concerning an already committed respondent. See also G.L. c. 4, § 9 (when statutory deadline falls on Sunday or legal holiday, act may be done on next succeeding business day).

Since the time requirements set out in G.L. c. 123 are mandatory, a § 8B petition must be dismissed if the hearing is not commenced within the statutorily mandated deadlines for commencing the hearing. Cf. *Hashimi v. Kalil,* 388 Mass. 607 (1983) (§ 7[c] deadlines for commitment hearings).

Note that the urgency reflected in the statutory time limit for commencing the hearing can be subverted if the completion of a timely-begun hearing is delayed by unwarranted continuances. See Standards 3:06 (Continuances) and 8:06 (Continuances of § 8B Hearings).

8:05 Notice of § 8B Hearings

The legal requirements and District Court standards applicable to civil commitment proceedings in this area also apply to G.L. c. 123, § 8B proceedings. See Standard 3:05.

8:06 Continuances of § 8B Hearings

The court may not allow a continuance that prevents the hearing from commencing within the required time period unless the request is made by or agreed to by the respondent or respondent's counsel. See Standard 8:04 (Time Limits for § 8B Hearing).

Requests for continuances and notice to the opposing party should be made as soon as possible after the need for a continuance becomes known. Because many hearings are held in mental health facilities, requests for continuances should be made in advance of the hearing date if at all possible.

Even when respondent or respondent's counsel consents, the court should carefully examine all continuance requests to determine that they are based on good cause. When the court grants a continuance, it should be for the minimum amount of time necessary, and the court should make every effort to reschedule the hearing for the earliest possible date.

Commentary

"We are certain that every judge recognizes that in any case where there is a possibility of immediate, substantial, and irreversible deterioration of a serious mental illness, even the smallest of avoidable delays would be intolerable." *Guardianship of Roe,* 383 Mass. 415 , 441 (1981).

Because competing interests of personal liberty and treatment for mental illness are at stake, the court must conduct its § 8B inquiry with the utmost care and expedition. Any delay in hearing or determining a § 8B petition may prevent the resolution of important treatment decisions. For that reason, the court should generally decide a § 8B petition on the same day as the hearing. If a lengthier trial is anticipated, the parties should inform the court prior to the hearing so that additional court time can be made available.

Given the important liberty interests involved, the court should grant a continuance only when there is good cause, even if requested or agreed to by the respondent. Apart from obvious emergencies beyond the parties' control, some discretionary continuances may be in the respondent's best interests – e.g., for additional discovery about side effects or alternatives to the proposed treatment, or if a respondent's rapidly improving condition suggests that a short continuance might obviate the need for the proposed medication.

8:07 Independent Clinical Examination in § 8B Proceedings

The legal requirements and District Court standards applicable to civil commitment proceedings in this area also apply to G.L. c. 123, § 8B proceedings. See Standard 3:07.

8:08 Discovery in § 8B Proceedings

The legal requirements and District Court standards applicable to civil commitment proceedings in this area also apply to G.L. c. 123, § 8B proceedings. See Standard 3:08.

9:00 Location of § 8B Hearings

The legal requirements and District Court standards that apply civil commitment proceedings in this area also apply to G.L. c. 123, § 8B proceedings. See Standard 4:00.

9:01 Public Access to § 8B Hearings

The legal requirements and District Court standards applicable to civil commitment proceedings in this area also apply to G.L. c. 123, § 8B proceedings. See Standard 4:01.

9:02 Electronic Recording of § 8B Hearings

The legal requirements and District Court standards that apply to civil commitment proceedings in this area also apply to G.L. c. 123, § 8B proceedings. See Standard 4:02.

9:03 Adversarial Nature of § 8B Hearings

The legal requirements and District Court standards that apply to civil commitment proceedings in this area also apply to G.L. c. 123, § 8B proceedings. See Standard 4:03.

9:04 Findings, Decision and Order in § 8B Proceedings

The court should render its decision on the § 8B petition immediately upon the completion of the hearing, if possible, and no later than ten days after the completion of the hearing.

"[T]he court shall not authorize medical treatment [with antipsychotic medication] unless it (i) specifically finds that the person is incapable of making informed decisions concerning the proposed medical treatment, (ii) upon application of the legal substituted judgment standard, specifically finds that the patient would accept such treatment if competent, and (iii) specifically approves and authorizes a written substituted judgment treatment plan." G.L. c. 123, § 8B(d).

The court's decision must include specific, written findings of fact and conclusions of law.

The petitioner, the respondent and respondent's counsel should be notified of the court's decision immediately after it is rendered.

While routine periodic judicial reviews of commitment decisions are disfavored (see Standard 4:06)**, judicial reviews in support of the court's obligation to monitor the treatment plan** (see Standard 11:04) **are entirely appropriate.**

Commentary

Since time is usually of the essence in § 8B proceedings, whenever possible the court should render an immediate decision regarding the authorization of treatment at the conclusion of the hearing, with specific, written findings to follow immediately afterward. In no event should the decision be rendered more than ten days after completion of the hearing, so that the treatment plan may be implemented forthwith in order to achieve the desired benefit.

The statutory requirement in § 8B(d) of specific findings echoes the Supreme Judicial Court's direction that the court enter "specific and detailed findings demonstrating that close attention has been given the evidence." *Guardianship of Roe,* 383 Mass. 415 , 421 (1981). The court may rely on counsel to assist in this regard by requesting the preparation of proposed findings of fact and rulings of law.

Findings must include a summary of the evidence necessary to support the court's determinations of the four key issues:

1. the respondent's competency or lack thereof to make informed treatment decisions;

2. if the respondent is found incompetent, a substituted judgment determination on whether the respondent, if competent, would consent to the proposed medical treatment, including specific findings on the *Rogers* criteria (see Standard 7:03);

3. if there is a substituted judgment determination that the respondent, if competent, would not consent to the proposed treatment, a further determination as to whether there is a countervailing State interest; and

4. the authorization of a treatment plan, if applicable.

If the court authorizes treatment for the respondent, it may, on its own motion or at the request of either party, set the case down for judicial review at any appropriate point during the period of authorization. At such a review hearing the court may consider the current status of the respondent, take further evidence, and modify or vacate its original authorization as it determines to be appropriate.

9:05 Appeal of § 8B Orders

The legal requirements and District Court standards applicable to civil commitment proceedings in this area also apply to G.L. c. 123, § 8B proceedings. See Standard 4:07.

10:00 Standard of Proof in § 8B Hearings

The petitioner must prove all elements of the petition by a preponderance of the evidence. The court must give close attention to the evidence and enter specific and detailed findings on each of the issues. *Guardianship of Doe,* 411 Mass. 512, 523-524 (1992).

Those issues are:

1. **Whether the respondent is competent to make an informed decision concerning the proposed medical treatment;**

2. **If the respondent is incompetent, whether, applying the substituted judgment standard, the respondent would accept such treatment if competent;**

3. **If the respondent is incompetent and, applying the substituted judgment standard, would refuse the proposed medical treatment if competent, whether there is any State interest sufficient to override such refusal; and**

4. **If the proposed medical treatment is to be authorized, whether it is adequately and specifically described and limited in the written treatment plan.**

Commentary

> "[F]act-finding is enhanced by requiring that it be done in writing and in meticulous detail. This rationale clearly applies to substituted judgment determinations. We are confident that judges, mindful of the serious consequences following entry of substituted judgment orders, will enter such orders only after carefully considering the evidence and entering specific findings on each factor and then balancing the various interests. What we require is careful work and reflection on the part of the judge before entering a substituted judgment order." *Doe,* 411 Mass. at 524 (citations and internal quotes omitted).

Thus, after careful inquiry and specific evidentiary findings by the court, the treatment should be authorized only if the petitioner has shown by a preponderance of evidence (1) that the respondent is incapable of making informed treatment decisions; (2) if respondent is found incapable, that the respondent's judgment would be to accept treatment, *or* (3) if the respondent's judgment would be to refuse treatment, that there is a State interest sufficient to override the respondent's refusal; and (4) if the proposed medical treatment is to be authorized, that it is properly set out in the proposed treatment plan.

If the respondent is *competent* to make an informed decision and refuses the proposed medical treatment, § 8B does not give the District Court authority to consider whether there is any State interest sufficient to override that refusal. Such a determination would have to be sought by a *Rogers* petition in the Probate and Family Court.

10:01 Rules of Evidence in § 8B Hearings

The legal requirements and District Court standards that apply to civil commitment proceedings in this area also apply to G.L. c. 123, § 8B proceedings. See Standard 5:01.

10:02 Hearsay in § 8B Hearings

The legal requirements and District Court standards that apply to civil commitment proceedings in this area also apply to G.L. c. 123, § 8B proceedings. See Standard 5:02.

10:03 Lay and Expert Witnesses in § 8B Hearings

Both lay witnesses and expert witnesses, if properly qualified, may testify in § 8B proceedings.

Lay witnesses may testify as to relevant facts personally known or observed by them.

For the prerequisites for expert opinions, see Standard 5:03 (Expert Opinion Testimony).

Commentary

LAY WITNESSES

Lay witnesses may be of particular assistance to the court in § 8B proceedings in making a substituted judgment on behalf of the respondent. Determining what the respondent's judgment would be, if he or she were competent, does not require testimony by a mental health professional. "No medical expertise is required in such an inquiry, although medical advice and opinion is to be used for the same purposes and sought to the same extent that the incompetent individual would, if he were competent." *Guardianship of Roe,* 383 Mass. 415, 435 (1981). Anyone with a significant relationship with, or sufficient knowledge about, the respondent to know "the values and desires of the affected individual," *Guardianship of Doe,* 411 Mass. 512, 518 (1992), that are relevant to the medical treatment in question may be qualified to testify on this issue.

In weighing the witness's testimony, the court must of course consider whether any potential conflict of interest may exist between the witness and the respondent regarding the treatment decision.

See Standards 7:03 (Substituted Judgment for Treatment with Antipsychotic Drugs) and 7:04 (Authorizing Treatments Other than Antipsychotic Drugs).

EXPERT WITNESSES

Some factors in a § 8B hearing require expert testimony. Medical diagnosis or medical treatment issues normally warrant a physician's testimony.

The issue of capacity to make informed treatment decisions generally requires the testimony of an expert witness, but not necessarily that of a physician, because capacity to make informed decisions is a legal rather than a medical determination. A psychologist, social worker, or other witness with sufficient skill and knowledge about how people make medical treatment decisions may be qualified to testify. See Standard 7:02 (Competency to Make Informed Treatment Decisions).

10:04 Privileged Communications to Clinicians in § 8B Hearings

The same legal requirements and District Court standards that apply to civil commitment proceedings in this area also apply to § 8B proceedings. See Standard 5:04.

11:00 Contents of § 8B Treatment Plan

A treatment plan authorized by the court in a § 8B proceeding must describe with particularity those medications which are then necessary. The plan may also include alternative medications and dosages which are reasonably foreseeable as necessary during the period of treatment authorization.

Commentary

Treatment plans must reflect the dynamic nature of mental illness, in which behavioral swings and dramatic effects from treatment are common. At the same time, the treatment plan cannot be so broad as to eliminate the hospital's responsibility to respond to changed circumstances with a revised § 8B petition and treatment plan.

For each medication listed in the plan, the petitioner must at minimum identify the name of the medication, the duration of use, and the range of dosages from zero to a maximum daily dosage. The plan may properly include a description of the medications which may be used to counteract anticipated side effects from antipsychotic medication. If medications or dosages are listed in the alternative, the plan should include a general explanation of the reasons for switching medications or dosages. Such an explanation may include, but is not limited to, the occurrence of adverse side effects, the respondent's failure to respond in anticipated ways to the medication, or other changes in the respondent's condition. In listing medications in the alternative, the use of the conjunction "and/or" should generally be avoided, unless the petitioner describes clearly the circumstances under which one treatment, the other, or both might be used.

The judge should not respond to concerns about any use of a particular drug by adjustments in dosage. Instead, if the judge determines that the respondent, if competent, would refuse a drug entirely, then that drug should not be authorized.

Testimony offered in support of the treatment plan may properly describe other treatments which were considered but rejected in favor of the proposed treatment. The court may also hear testimony about other, non-medical treatments which the respondent could receive, such as psychotherapy. This will assist the court in making the substituted judgment about what the respondent, if competent, would have chosen from the available treatment alternatives.

11:01 Scope and Duration of Authorized § 8B Treatment Plan

The court's authorization of medical treatment for mental illness pursuant to G.L. c. 123, § 8B permits the administration of that treatment only as expressly described in the court's order.

A § 8B treatment authorization expires at the same time as the commitment order that was in effect when the treatment authorization was issued. G.L. c. 123, § 8B(f). **A treatment authorization may be in effect for a lesser period of time if so limited by its express terms.**

An approved § 8B treatment plan is only authorized, not ordered, by the court, and therefore the petitioner may discontinue the use of any medications which are later found to be ineffective or otherwise contraindicated.

Commentary

Since a § 8B treatment authorization is limited to its express terms, the court's findings and order should be as specific as possible regarding the medications and dosages to be administered. Medications and other treatments requiring court authorization that are not listed in the order cannot be administered until the § 8B authorization is modified by the court or another court of competent jurisdiction.

To avoid repeated court proceedings, a proposed § 8B treatment plan should include alternative medications and dosages that may be reasonably anticipated as necessary, depending on the respondent's response to treatment. If such alternatives are included, they should be accompanied by a general explanation of the situations that would cause such a change in medications or dosages. See Standard 11:00 (Contents of § 8B Treatment Plan).

11:02 Modifying or Vacating § 8B Treatment Authorizations

The petitioner or the respondent may request the court at any time to modify or vacate a § 8B authorization of medical treatment. G.L. c. 123, § 8B(f).

Commentary

Section 8B provides that authorizations of medical treatment for mental illness are subject to modification at the request of any party. A petition for modification or termination should normally be based on a substantial change in circumstances.

Any request to modify a treatment plan should be quickly adjudicated in order to protect the respondent's rights and to ensure the respondent's well-being. The court must commence the hearing and enter its order within the required time limits. To expedite this, the court may consider hearing such petition by affidavit only, if the parties agree. See G.L. c. 123, § 8B(d). See also Standards 8:02 (Right to a Hearing in § 8B Proceedings) and 9:03 (Adversarial Nature of § 8B Hearings).

As with the original authorization, the court's order to modify or vacate the § 8B treatment authorization requires specific findings on each of the relevant issues.

11:03 Transfer of § 8B Patient to Different Facility

A § 8B treatment authorization remains in effect when the respondent is transferred to a different mental health facility, so long as the underlying commitment order remains in effect. Until that treatment authorization expires, the District Court division that issued the treatment plan should continue to monitor it, and should hear and determine any request to modify or vacate the treatment plan.

When the commitment or treatment authorization expires, any subsequent commitment order or treatment plan should be sought from the District Court division in whose territorial jurisdiction the receiving mental health facility is located, and that court should then be responsible for monitoring the new treatment plan.

Commentary

When a person is transferred between mental health facilities, or transferred between a mental health facility and Bridgewater State Hospital, issues may arise regarding the viability of any existing § 8B treatment authorization, the monitoring of the treatment plan, and modification procedures.

A § 8B treatment authorization is dependent upon the respondent's underlying commitment order. G.L. c. 123, § 8B(b) & (f).

When a person is transferred between two public or private mental health facilities (G.L. c. 123, § 3) or from Bridgewater State Hospital to a public or private mental health facility (§ 14), any unexpired order of commitment remains in effect, and any unexpired § 8B treatment authorization also remains in effect. The receiving facility may continue to implement the treatment plan for the remainder of its authorized period, or may request a modification from the court division that issued the treatment plan. That court division remains responsible for monitoring, modifying or vacating the treatment plan as long as it remains in effect. When the commitment or treatment order expires, subsequent proceedings should be in the court division with geographical jurisdiction over the receiving facility. See Standards 11:02 (Modifying or Vacating § 8B Treatment Authorizations) and 11:04 (Monitoring § 8B Treatment Plan).

11:04 Monitoring § 8B Treatment Plan

The court is required "to monitor the antipsychotic medication treatment process to ensure that an antipsychotic medication treatment plan is followed" (G.L. c. 123, § 8B)**.**

The court may delegate this responsibility to a court-appointed guardian. *Id.* Absent a guardian, the court may appoint some other appropriate third party to do so. The court should explain the responsibilities of the monitor's function, and should authorize the monitor to have access to pertinent court records and records of the facility where the respondent is located in order to determine compliance with the treatment plan.

Where no guardian or other appointee is available to the court, the court itself must monitor compliance with the treatment plan. This may be done either by requiring the facility to provide the court with detailed periodic reports documenting such compliance, or by scheduling periodic hearings for the purpose of reviewing the administration of medications to the respondent under the treatment plan, the occurrence of any side effects, and other issues deemed appropriate by the court. The purpose of such hearings is to review the implementation of the already-ordered treatment plan, not to reconsider the § 8B petition de novo.

During the monitoring process, the court does not have authority to allow the respondent funds for an independent expert under the Indigent Court Costs Law, which is limited to the "prosecution, defense or appeal" of a case (G.L. c. 261, § 27C[4]) and does not extend to postjudgment proceedings. See *Commonwealth v. Davis,* 410 Mass. 680 (1991) (inapplicable to motion for new trial).

The court should also initiate a formal review whenever a question is raised about compliance with the treatment authorization or the respondent's well-being.

When the Superior Court acts under G.L. c. 123, § 9(b) to modify a District Court's § 8B treatment authorization, the Superior Court then becomes responsible for monitoring the treatment plan it has approved.

Commentary

Apart from the statutory requirement of monitoring that the authorized treatment plan is being followed, periodic monitoring is important because the relevant factors are likely to change over time. *Guardianship of Weedon,* 409 Mass. 196, 200 (1991).

The court may delegate the monitoring responsibility to a guardian "duly appointed by a court of competent jurisdiction." § 8B(e). This is normally a guardian (G.L. c. 190B, § 5-306) appointed by the Probate and Family Court, since the District Court has no statutory authority to appoint guardians for mentally ill persons.

In the absence of a guardian, the court "shall monitor the treatment process to ensure that the treatment plan is followed" (§ 8B[e]). In order to fulfill this important duty when a guardian is not available, the court may appoint an appropriate qualified person to be paid from the appropriate Trial Court account for necessary services, or may itself periodically monitor compliance with the treatment plan. Any appointment of a compensated monitor is a fee-generating appointment subject to the selection and appointment docket requirements of Supreme Judicial Court Rule 1:07.

The court should not delegate the monitoring responsibility to respondent's counsel, or to hospital staff, petitioner's counsel or any other agent or officer of the petitioner, because of the obvious conflict of interest issues. CPCS performance guidelines do not allow respondent's counsel to assume such a role. (See Appendix D.)

If the court conducts the monitoring function itself through periodic written reports from the facility, the court should include in its written § 8B order a requirement that the facility or a specific official of the facility (identified by title) submit such reports to the court at specified intervals, with a copy to respondent's counsel. The report should include, at minimum, the medication and dosages actually administered to the respondent, any side effects experienced, and any other information required by the court or deemed material by the facility. The frequency of such reports should be determined by the court in relation to the potential side effects of the authorized medication and other factors deemed relevant by the court.

The Superior Court's jurisdiction under G.L. c. 123, § 9(b) is original rather than appellate. For that reason, if pursuant to § 9(b) the Superior Court modifies a District Court's § 8B treatment authorization, the District Court's monitoring duties are discharged, and the Superior Court then becomes responsible for monitoring its own treatment authorization and the respondent's condition while that authorization remains in effect.

Appendix A

Outline of District Court Mental Health and Addiction Proceedings under G.L. c. 123

	1. CIVIL COMMITMENT OF MENTALLY ILL PERSONS	*Court*
G.L. c. 123, §§ 7 - 8	**Civil commitment** of mentally ill person to mental health facility or Bridgewater State Hospital (initially for 6 months, followed by recommitments for 1 year) on petition of director	Court where facility located
G.L. c. 123, § 12(b)	Application by civilly committed person for **emergency hearing** on whether admission resulted from abuse or misuse of § 12(b)	Court where facility located
G.L. c. 123, § 12(e)	With or without a warrant of apprehension, **emergency civil commitment** of mentally ill person to authorized facility for 3 days on petition of any person and after examination by designated physician	Any District Court
G.L. c. 123, § 13	**Civil commitment to Bridgewater State Hospital after 5-day transfer from mental health facility** under §§ 7 & 8 on petition of director of facility or Bridgewater State Hospital	Brockton District Court unless already filed elsewhere

2. AUTHORIZING MEDICAL TREATMENT FOR COMMITTED PERSONS

G.L. c. 123, § 8B	Authorization of **medical treatment for mental illness** for incompetent civilly committed person on petition of director	Court where facility located

3. FORENSIC EXAMINATION & COMMITMENT OF CRIMINAL DEFENDANTS

G.L. c. 123, § 15(a)	Order for **outpatient examination for competence and/or criminal responsibility** of criminal defendant by qualified physician or psychologist	Court of criminal charges
G.L. c. 123, § 15(b)	**Commitment for further examination for competence and/or criminal responsibility** of criminal defendant at facility or Bridgewater State Hospital (for not more than 20 days, extendable for not more than another 20 days)	Court of criminal charges

G.L. c. 123, § 15(e)	Order for **outpatient examination, or for subsequent commitment** at facility or Bridgewater State Hospital, for not more than 40 days **to aid in sentencing** convicted criminal defendant	Court of criminal charges
G.L. c. 123, § 16(a)	**Commitment for examination of criminal defendant found incompetent to stand trial or acquitted by reason of mental illness** for not more than 40 days (but combined periods under §§ 15[b] and 16[a] may not exceed 50 days) at facility or Bridgewater State Hosp.	Court of criminal charges
G.L. c. 123, § 16(b)	**Commitment of criminal defendant found incompetent to stand trial or acquitted by reason of mental illness** to facility or Bridgewater State Hospital for 6 months on petition of director of facility or Bridgewater State Hospital or district attorney	Court of criminal charges
G.L. c. 123, § 16(c)	**Recommitment of criminal defendant found incompetent to stand trial or acquitted by reason of mental illness** to facility or BSH for 1 year	Court where facility located
G.L. c. 123, § 17(a)	**Review of prior incompetency determination** at request of director of facility or BSH	Court of criminal charges
G.L. c. 123, § 17(b)	**Hearing on defense to pending criminal charges** (other than mental illness) offered by incompetent defendant	Court of criminal charges
G.L. c. 123, § 18	**Commitment for examination of pretrial detainee or sentenced prisoner** to facility or BSH for not more than 30 days after examination by designated physician or psychologist on petition of superintendent of place of detention, who may subsequently petition for 6-month commitment; successive commitments are for one year	*For pretrial detainee:* Court of place of detention *For prisoner:* Court of criminal charges

4. EXAMINATION OF WITNESSES & CIVIL LITIGANTS

G.L. c. 123, § 19	Order for **examination of party or witness** by DMH-assigned qualified physician or psychologist to determine mental condition	Court where case pending

5. COMMITMENT OF ALCOHOLICS & OTHER SUBSTANCE ABUSERS

G.L. c. 123, § 35	With or without a warrant of apprehension, **commitment of alcoholic or substance abuser** to DPH-approved facility or MCI-Bridgewater (for male) or MCI-Framingham (for female) or for not more than 30 days (as of 7/1/12, not to exceed 90 days) after examination by qualified physician or psychologist on petition of police officer, physician, spouse, blood relative, guardian or court official	Any District Court

Appendix B

EXCERPT FROM DISTRICT COURT TRANSMITTAL NO. 945

Lynda M. Connolly
Chief Justice

Trial Court of the Commonwealth
District Court Department

Administrative Office
Two Center Plaza (Suite 200)
Boston, MA 02108-1906

TRANSMITTAL NO. 945

Last Transmittal No. to:	
First Justices	944
Other Judges	944
Clerk-Magistrates	944
CPOs/POICs	—

CLERK-MAGISTRATES: *Please distribute the additional copies (enclosed) of this memorandum to the court's designated mental health scheduling coordinator and to his or her backup coordinator.*

M E M O R A N D U M

TO:	District Court Judges and Clerk-Magistrates
FROM:	Hon. Lynda M. Connolly, Chief Justice
DATE:	February 23, 2007
SUBJECT:	**Scheduling Civil Commitment Hearings (G.L. c. 123, §§ 7-8) and Emergency Hearings (§ 12[b])**

This memorandum describes the procedures to be followed in scheduling civil commitment hearings in mental health matters pursuant to G.L. c. 123, §§ 7-8. It also describes the procedures for emergency hearings requested by patients who allege that "abuse or misuse" of the provisions of G.L. c. 123, §12(b) resulted in their involuntary admission to a facility without court involvement.

This memorandum brings together in one place information previously distributed in a series of earlier memoranda from 2000-2005. (See Trans. 752, 754, 756, 757, 766, 800 and 878.) This memorandum consolidates and replaces those earlier transmittals; it does not include any new or different information.

I. Civil commitments under G.L. c. 123, §§ 7 and 8

1. **When are these procedures applicable?** The procedures below apply only to *initial* civil commitment proceedings under §§ 7-8. These may follow a court commitment under § 12(e), often after service of a warrant of apprehension. Alternately, they may follow an

emergency admission without court involvement, either involuntarily under § 12(a) or (b), or as a "conditional voluntary" admission under §§ 10-11 or 12(c)-(d).

These procedures *do not apply* to:

- *Subsequent* ***recommitment*** *hearings* under G.L. c. 123, §§ 7-8, which may result in a one-year commitment. Such hearings are not subject to the 5-day hearing deadline. Instead they are subject to a 14-day hearing deadline, unless a delay is requested by the respondent or his or her counsel. G.L. c. 123, § 7(c).

- *Hearings that arise in the context of* ***criminal*** *cases* under G.L. c. 123, §§ 15(e) (aid in sentencing), 16(b) and (c) (defendants found incompetent or not guilty by reason of insanity), and 18(a) (mentally ill prisoners and pretrial detainees). Such hearings too are subject to a 14-day hearing deadline. G.L. c. 123, § 7(c).

- ***Alcoholism*** *and other* ***substance abuse*** *commitments* under G.L. c. 123, § 35.

The chart appended to this memorandum summarizes the hearing deadlines for each of the various types of civil commitment petitions.

2. **Each court must *designate a mental health scheduling coordinator* (and a backup) to receive mental health petitions and to coordinate hearings and notices.** When the court receives petitions for mental health commitments, it must act promptly to fulfill its statutory obligation to schedule timely hearings on those petitions. Those employees at each court who receive such commitment petitions, schedule hearings, and send notices of the hearings are key to that court's ability to meet these obligations. Failure to perform these responsibilities properly may result in the release of persons who may be mentally ill and dangerous, but whose release is required by law if the hearings to which they are entitled are not timely provided.

Each court's First Justice is responsible for designating a mental health scheduling coordinator (and a back-up) to coordinate the process. If the coordinator and back-up are employees of the Clerk's Office, the designation decision should be coordinated with the Clerk-Magistrate. A current list of these mental health scheduling coordinators is available to court personnel in the "Clerks" section of the District Court's intranet website. This list is also provided to the Department of Mental Health and to Bridgewater State Hospital, private mental health facilities, and the Committee for Public Counsel Services (CPCS) Mental Health Litigation Unit by Regional Administrative Judge Rosemary B. Minehan, Chair of the District Court Committee on Mental Health and Substance Abuse. Please notify Faith L. Shannon at the Region 1 regional office (508-295-9100) of any corrections or changes to the list of mental health scheduling coordinators.

3. **Mental health facilities must *file a petition* for commitment under G.L. c. 123, §§ 7-8 within 3 days.** A mental health facility may hold a person involuntarily for a maximum of *three* business days before filing a petition for initial commitment under G.L. c. 123, §§ 7-8. G.L. c. 123, §§ 11 (voluntary conditional admissions), 12(d) (emergency admissions), 12 (e) (court-ordered commitments).

4. **The court must *commence a hearing* on an initial commitment petition under G.L. c. 123, §§ 7-8 within 5 days.** Civil commitment hearings must be commenced within *five* business days from the date of the filing of the petition for an initial commitment under G.L. c. 123, §§ 7-8. Failure to comply with this time limit requires that the respondent be discharged, unless the delay has been requested by the respondent or his or her counsel. *Hashimi v. Kalil*, 388 Mass. 607, 446 N.E.2d 1387 (1983).

As indicated above, the 5-day hearing deadline applies only to *initial* commitment petitions under §§ 7-8. It does *not* apply to subsequent recommitment hearings under §§ 7-8, which may result in a one-year commitment. Nor does it apply to hearings that arise in the context of criminal cases under G.L. c. 123, §§ 15(e), 16(b) and (c), or 18(a). Both recommitment hearings and hearings in the context of criminal matters are subject to a *14-day hearing deadline,* unless an extension is requested by the person or his or her counsel. G.L. c. 123, § 7(c).

5. **Procedures for scheduling civil commitment hearings.** In order to comply with the 5-day time limit, each court must complete the following steps:

- ***Receive the petition, usually by fax.*** The mental health facility may file the petition by fax. The fax will be expressly directed to the mental health scheduling coordinator at the court. It is essential that an arrangement be in place to notify the scheduling coordinator of incoming faxed petitions immediately so that no time is lost while the petition remains in the fax in-basket. It is the responsibility of the scheduling coordinator (or the back-up coordinator) to receive faxed petitions and take the required actions. Receipt of the fax at the court constitutes "filing" for the purpose of beginning the 5-day time limit.

  In addition to the information required to be set forth on the form "PETITION FOR COMMITMENT PURSUANT TO G.L. c. 123, §§ 7-8," mental health facilities have been requested to include two other items of information with the petition: (1) the name of the attorney, if any, who has been appointed to represent the respondent in the civil commitment matter, and (2) the names and addresses of any of the respondent's family members. An attorney may have been appointed at the time of the § 12(e) court hearing (if such a hearing was held prior to admission) or at the time of the emergency admission under § 12(a) or (b) (if there was no prior court hearing).

- ***Determine the 5-day time limit.*** General Laws c. 123, § 7(c) provides that the 5-day time limit for commencing the hearing is determined in accordance with Mass. R. Civ. P. 6, which excludes the day on which the petition was filed and any intervening Saturday, Sunday and legal holiday. If the fifth day is a Saturday, Sunday or legal holiday, it too is excluded from the computation; the next business day is then considered the fifth day.

- ***Select a hearing date.*** The first responsibility of the scheduling coordinator receiving the faxed petition is to determine the hearing date. There is a 2-day minimum period that must be allowed between the filing of a commitment petition

and the hearing date in order to permit counsel for the respondent to prepare for the hearing. G.L. c. 123, § 5.

These time requirements are reflected in the following chart:

TIME LIMITS FOR 3-DAY PETITIONS AND 5-DAY CIVIL COMMITMENT HEARINGS			
Involuntarily hospitalized on	*Petition must be filed no later than*	***Earliest*** *date when hearing can be scheduled (if filed on date in column 2)*	***Latest*** *date when hearing can be scheduled (if filed on date in column 2)*
Monday (Week 1)	Thursday (Week 1)	Tuesday (Week 2)	Thursday (Week 2)
Tuesday (Week 1)	Friday (Week 1)	Wednesday (Week 2)	Friday (Week 2)
Wednesday (Week 1)	Monday (Week 2)	Thursday (Week 2)	Monday (Week 3)
Thursday (Week 1)	Tuesday (Week 2)	Friday (Week 2)	Tuesday (Week 3)
Friday (Week 1)	Wednesday (Week 2)	Monday (Week 2)	Wednesday (Week 3)
Saturday (Week 1)	Wednesday (Week 2)	Monday (Week 2)	Wednesday (Week 3)
Sunday (Week 1)	Wednesday (Week 2)	Monday (Week 2)	Wednesday (Week 3)

A court may fulfill both the 2-day minimum period and the 5-day maximum period by *scheduling these hearings on the same two days of each week.* Any of the following five combinations of days will satisfy both statutory requirements:

POTENTIAL COURT SCHEDULES FOR 5-DAY CIVIL COMMITMENT HEARINGS	
Hearings held on	*Petitions to be heard*
Monday & Wednesday	• on Mondays, court may hear petitions filed on Monday, Tuesday or Wednesday of prior week • on Wednesdays, court may hear petitions filed on Wednesday, Thursday or Friday of prior week
Monday & Thursday	• on Mondays, court may hear petitions filed on Monday, Tuesday or Wednesday of prior week • on Thursdays, court may hear petitions filed on Thursday or Friday of prior week, or Monday of this week
Tuesday & Friday	• on Tuesdays, court may hear petitions filed on Tuesday, Wednesday or Thursday of prior week • on Fridays, court may hear petitions filed on Friday of prior week, or Monday or Tuesday of this week
Tuesday & Thursday	• on Tuesdays, court may hear petitions filed on Tuesday, Wednesday or Thursday of last week • on Thursdays, court may hear petitions filed on Thursday or Friday of prior week, or Monday of this week
Wednesday & Friday	• on Wednesdays, court may hear petitions filed on Wednesday, Thursday or Friday of prior week • on Fridays, court may hear petitions filed on Friday of prior week, or Monday or Tuesday of this week

As indicated above, the 5-day hearing deadline applies only to *initial* §§ 7-8 commitment petitions. It does *not* apply to subsequent recommitment hearings, nor to hearings that arise in the context of a criminal case, which are subject to a 14-day hearing deadline.

The selection of a hearing date is dependent on when a judge will be available in that court for such hearings. Scheduling coordinators should consult with their court's First Justice, who should in turn determine with the Regional Administrative Judge how much judge-time will be available for these hearings on particular dates.

- ***Determine the location of the hearing.*** Hearings under §§ 7-8 are normally held at the petitioning mental health facility. With the approval of the Regional Administrative Judge, hearings may be held at the court when circumstances require. First Justices should communicate with their Regional Administrative Judge on this issue as the need may arise.

- ***Prepare the Notice of Hearing.*** After determining the date and place of the hearing, the scheduling coordinator must prepare a "NOTICE OF HEARING ON PETITION(S) FOR MENTAL HEALTH COMMITMENT AND/OR MEDICAL TREATMENT." An interactive version of this notice is available to court personnel on the District Court intranet website. The notice should indicate the docket number and case caption (using the respondent's name), the petitioner's name, the name of respondent's counsel (if one has already been appointed; this should appear on the information received from the facility), and the scheduled hearing date, time and location. The notice may be signed with a facsimile signature of the Clerk-Magistrate or an assistant clerk. G.L. c. 218, § 14; G.L. c. 221, § 17. Use *only* this Notice of Hearing form for scheduling the hearing. Do not use any other form for this notice.

  Do *not* use this Notice of Hearing form to schedule "reviews." If the court schedules a subsequent "judicial review" of an already-ordered commitment, another form of notice should be used, not the Notice of Hearing form.

- ***Issue the Notice of Hearing.*** When the Notice of Hearing form has been filled out, the scheduling coordinator must immediately send copies to:

  - the respondent;
  - counsel who has previously been appointed to represent the respondent on this petition, if any;
  - the Director of the petitioning mental health facility;
  - the Director of the CPCS Mental Health Litigation Unit (whether or not the respondent has previously-appointed counsel); and
  - the respondent's nearest relative or guardian (if such information has been received from the facility).

  The notice to CPCS and, if possible, to the petitioning facility must be sent by fax. Include a copy of the commitment petition with the copy faxed to CPCS. This is the most effective way to ensure that the respondent's counsel receives a copy of the petition as soon as possible.

If the commitment petition arises in the context of a pending criminal case (and therefore involves a 14-day limit for the hearing date), a copy of the Notice of Hearing should also be sent to the respondent's criminal defense attorney and to the District Attorney involved, if that information is known.

Complete and fax the notice as soon as possible on the same day the petition is received. Do not wait until the end of the day to fax the Notice of Hearing. Send the notice out as soon as the hearing date is assigned. Waiting until the end of the day is unfair and unworkable for CPCS personnel, because they have to make the individual attorney assignments as soon as possible, and they receive many such notices daily. If the notices are not faxed until the end of the day, CPCS staff must work into the evening to avoid losing a day in notifying counsel.

Scheduling coordinators must regard this responsibility as a priority. Back-up coordinators must also act on petitions promptly on any day that the regular scheduling coordinator is not at work. Delay in completing the notice form and sending it out can have serious legal consequences, including mandatory discharge of the respondent.

- ***CPCS will then appoint and notify counsel.*** When the CPCS Mental Health Litigation Unit receives its copy of the Notice of Hearing by fax, it will then appoint and notify counsel for the respondent, in accordance with G.L. c. 211D, § 6(b). As noted above, where counsel has previously been appointed to represent the respondent on this petition (e.g., at the time of admission or at a previous § 12[e] hearing), the previously-appointed attorney should be sent a copy of the Notice of Hearing, and an additional copy should be faxed to CPCS.

- ***When hearings are cancelled or postponed.*** The scheduling coordinator is responsible for adjusting the schedule when notified by the facility that a petition has been withdrawn or when the respondent requests a continuance of the hearing date.

- ***Transmit case files and hearing list on the hearing date.*** When hearings are held at the petitioning facility, the scheduling coordinator's final task is to ensure that the case files and hearing list are available for transportation to the facility on the day of the hearing. This will require coordination with the person responsible for bringing them to the facility on the hearing date.

  When hearings are conducted at the courthouse, the scheduling coordinator should ensure that the appropriate person in the clerk's office has the case files and hearing list in advance of that court session.

II. Emergency hearings under G.L. c. 123, § 12(b)

1. **What is an emergency hearing?** Any person who has been involuntarily admitted to a mental health facility by a physician under G.L. c. 123, § 12(b), and thus without prior court authorization, may request a prompt "emergency hearing" to determine whether his or her admission resulted from an "abuse or misuse" of the provisions of § 12(b).

In pertinent part, G.L. c. 123, § 12(b) provides:

> "Any person admitted [involuntarily] under the provisions of this subsection, who has reason to believe that such admission is the result of an *abuse or misuse* of the provisions of this subsection, may request, or request through counsel an emergency hearing in the district court in whose jurisdiction the facility is located, and unless a delay is requested by the person or through counsel, the district court shall hold such hearing on the day the request is filed with the court or not later than the next business day" (emphasis added).

2. **Nature of emergency hearings.** There are several important features of this statute:

. . .

- ***Focus on "abuse or misuse" of admission provisions.*** The focus of an emergency hearing is not on whether the admitting mental health professional made the "right" decision, but on whether the patient's admission resulted from an *"abuse or misuse"* of the provisions of §12(b). Often the hearing will turn on whether there was a breach of the statutory procedural requirements. The hearing does not involve the issue of probable cause unless the patient's claim is that the "abuse or misuse" of § 12(b) was that there was no reasonable basis for the admission decision.

- ***Initiated at patient's request.*** The burden is on the patient to request (or to have counsel, if any, request) an emergency hearing.

- ***Location of hearing.*** The emergency hearing must be held in the district court in whose jurisdiction the facility is located and it must be held on the day the hearing is requested or not later than the next business day. The hearing may also be held at the facility. G.L. c. 123, § 5.

3. **Procedures for emergency hearings.** The following procedures for emergency hearings are recommended by the District Court Committee on Mental Health and Substance Abuse, and I request that you adhere to them.

- ***Patient's request for emergency hearing.*** A request for an emergency hearing under G.L. c. 123, § 12(b) shall be made on the "REQUEST FOR EMERGENCY HEARING AFTER INVOLUNTARY ADMISSION TO MENTAL HEALTH FACILITY (G.L. c. 123, § 12[b])" form, which is available in the "Forms" area of the District Court internet website at www.mass.gov/courts/districtcourt. The completed request form should be filed by the patient or his or her attorney], if any, by fax or delivery to the District Court in whose jurisdiction the facility is located. The request shall (1) indicate the

provision(s) of G.L. c. 123, §12(b) alleged to have been abused or misused, and (2) set forth the patient's reason to believe that the admission resulted from the abuse or misuse of such provision(s).

- ***Evidence submitted by the facility.*** At the time of the filing of the request, a copy thereof shall be provided to the appropriate person at the admitting facility. The facility shall forthwith file with the court, by fax or delivery, a copy of the application for hospitalization, a copy of the admitting physician's admission notes indicating the grounds for the admission decision and the time that the psychiatric examination was conducted, and an affidavit, signed under the pains and penalties of perjury, supporting any factual response to the allegations made by the patient in the request.

. . .

- ***Time and place of hearing.*** An emergency hearing must be conducted on the day the request is filed, if possible, or on the next business day. Unless the court orders otherwise, the hearing will be conducted at the court, and the patient must be transported thereto by the facility unless he or she waives the right to be present. The hearing may be conducted at the facility if the court is able to do so.

. . .

- ***Results of the hearing.*** If the court finds that the admission resulted from abuse or misuse of one or more of the provisions of § 12(b), as alleged in the hearing request, the court should order the patient discharged forthwith. If the court does not so find, the patient will remain in the custody of the admitting facility for further proceedings, in accordance with applicable law.

  If the court sustains the patient's allegations in the emergency hearing, it appears that nothing would prevent the patient again being admitted under § 12(a) or (b), with the new admission process conducted in such a way as to cure whatever "abuse or misuse" had occurred during the earlier admission.

HEARING DEADLINES FOR CIVIL COMMITMENT PETITIONS

(G.L. c. 123, § 7[c])

This chart summarizes the hearing deadlines for each of the various types of civil commitment petitions.

Section of G.L. c. 123	*Type of Commitment*	*Hearing Deadline after filing of petition*
§§ 7-8	First (6 month) Petition for Civil Commitment	**WITHIN 5 DAYS**
	Subsequent (1 year) Petition for Civil Commitment	Within 14 days
§ 8B(c)	Petition for Authorization to Treat Patient with Antipsychotic Medication	• If coupled with commitment petition under §§ 7-8, 15, 16 or 18, same as commitment hearing • Otherwise within 14 days
§ 11	Petition for Civil Commitment under §§ 7 & 8 after "conditional voluntary" admission under § 10-11	**WITHIN 5 DAYS**
§ 12(b)	Emergency Petition by hospitalized person "who has reason to believe that such admission is the result of an abuse or misuse" of a 3-day admission under § 12(b) by a facility's designated physician	"On the day the request is filed with the court or not later than the next business day"
§ 12(d)	Petition for Civil Commitment under §§ 7 & 8 after: • 3-day admission under § 12(a)-(b), or • 3-day commitment under § 12(e)	**WITHIN 5 DAYS**
§ 12(e)	Request for Warrant of Apprehension	Heard immediately when applicant is before court
	Petition for 3-Day Civil Commitment	Heard immediately when respondent is before court and examined
§ 15(e)	Petition for Civil Commitment of Prisoner after Aid-in-Sentencing Examination	Within 14 days
§ 16(b)	First Petition for Civil Commitment of Criminal Defendant found Incompetent or Not Guilty by Reason of Insanity	Within 14 days
§ 16(c)	Subsequent Petition for Civil Commitment of Criminal Defendant found Incompetent or Not Guilty by Reason of Insanity	Within 14 days
§ 18(a)	Initial Petition for Civil Commitment of Prisoner or Pretrial Detainee	Within 14 days
	Subsequent Petition for Civil Commitment of Prisoner or Pretrial Detainee	Within 14 days
§ 35	Commitment of Alcoholic or Substance Abuser	Heard immediately when respondent is before court and examined

Appendix C

Committee for Public Counsel Services

Performance Standards Governing the Representation of Indigent Persons in Civil Commitment Cases

These standards are intended for use by the Committee for Public Counsel Services in evaluating, supervising and training counsel assigned pursuant to G.L. c. 211D. Counsel assigned pursuant to G.L. c. 211D must comply with these standards and the Massachusetts Rules of Professional Conduct. In evaluating the performance or conduct of counsel, the Committee for Public Counsel Services will apply these standards and the Massachusetts Rules of Professional Conduct, as well as all CPCS policies and procedures included in this manual and other CPCS publications.

These standards generally describe the steps which should be taken by an attorney who is assigned pursuant to G.L. c. 123, § 5, to represent a person in a civil commitment case who risks a six-month or one year civil commitment in a mental health facility. [See also CPCS Performance Standards for Authority to Treat Proceedings.]

1. The role of the attorney in a commitment case is to act as an advocate for the respondent, in opposition to the petition and to insure that the respondent is afforded all of his or her due process and other rights. At a minimum, counsel must insure that the petitioning facility is made to meet its burden of proving, beyond a reasonable doubt, that the respondent meets the criteria for commitment.

2. Immediately upon receipt of the assignment of a case the attorney shall: (a) file an appearance in court; (b) communicate with the client to inform the client of the assignment; (c) arrange to meet with the client (if the attorney's schedule does not permit him or her to meet with the client no later than the next business day and promptly begin to work on the case, the attorney shall decline the assignment); and (d) shall not agree to a continuance of the case without first consulting with the client and obtaining his or her consent.

3. The attorney shall meet with the client as soon as possible, but in no event later than the next business day following the assignment. The purpose of this initial interview is to begin to develop a lawyer-client relationship based on mutual understanding and trust, to explain the commitment law and procedures to the client, to discuss the alternatives to continued hospitalization available to the client, to determine the client's version of the facts which led to the filing of the petition, and to determine the client's wishes regarding the litigation. While not required, the attorney should seek to obtain from his or her client written authorization to examine the client's medical record or, where the client is unable or unwilling to provide such authorization, a court order authorizing such examination. Finally, the attorney shall discuss the possibility of an independent evaluation.

4. If the attorney believes an independent examination will aid the client, and the client agrees to such an evaluation, the attorney shall file a motion for funds for an independent examination by

a clinician of the client's choice and at the Commonwealth's expense. The client should be advised that such an examination will take time and may cause delay.

5. The attorney shall contact the independent clinician if a motion for funds is allowed. The attorney shall remind the doctor that his or her report is the property of the client and should be sent to the attorney, and that the report is not to be filed with the court or disclosed to the hospital attorney or staff without the permission of the patient's attorney. See *Commonwealth v. Thompson,* 386 Mass. 811 (1982). The attorney should also remind the doctor that the purpose of the examination is to evaluate: (i) the client's current mental state; (ii) the likelihood of serious harm if the client were to be discharged; (iii) the client's ability to care for himself outside of the hospital; (iv) the feasibility of any less restrictive alternatives to hospitalization; and (v), if commitment to Bridgewater State Hospital is sought, the need for "strict security."

6. The attorney shall thoroughly investigate the facts. This investigation shall include reading the complete medical records and interviewing the hospital staff, including the doctors, nurses, social workers and other staff. The attorney should also speak to other patients on the ward, friends and family members of the client, and staff of any other programs familiar with the client.

7. The attorney shall use formal discovery mechanisms if indicated and tactically advisable.

8. After reviewing the medical record and the commitment petition the attorney shall determine if any procedural defenses can be raised and, if appropriate, file appropriate motions with supporting memoranda. (Procedural defenses can be raised, for example, if the hospital failed to file the petition at the appropriate time or if the hearing has not been commenced within the four- or fourteen-day time period required by the statute, or if the petition fails to set forth facts in support of the petition. See *Hashimi v. Kalil,* 388 Mass. 607 (1983) and G.L. c. 123, § 7(c)).

9. After developing a thorough knowledge of the law and facts of the case, the attorney shall meet again with his or her client for the purpose of discussing strategy and alternatives to commitment. The attorney shall discuss with the client any available alternatives to commitment. These may include the participation in an out-patient psychotherapy and counseling program, a community support program, a day treatment program, or placement in a less restrictive environment such as a half-way house, a group residence, or an apartment program. The attorney should make it clear to the client that the ultimate decision regarding the proposal of alternatives to commitment must be made by the client. The attorney should reassure the client that the attorney will stand behind the client's decision and forcefully advocate the client's position.

10. After this client meeting, and if appropriate, the attorney shall enter into negotiations with relevant persons concerning the case (e.g., discussions with the treating physician(s) regarding alternatives to hospitalization; discussions with social workers and DMH area office officials or other providers regarding the availability of alternative placements).

11. If the attorney and the hospital can agree to a negotiated settlement the attorney shall meet with his or her client to explain the terms of the agreement and obtain the client's consent to the

settlement. Should the client decline the settlement offer, the attorney shall be prepared to try the civil commitment case.

12. Prior to the hearing the attorney shall identify potential witnesses who will testify in support of the client. Where necessary, witnesses should be subpoenaed. The attorney shall meet with the witnesses in advance of the trial in order to prepare them for direct and cross-examination. The attorney shall review the medical record and identify those parts of the record which should not be admitted into evidence. The attorney should determine the identity of the hospital's witnesses in advance of the hearing, and make an effort, if tactically indicated, to interview them on the record and prepare appropriate cross-examination. The attorney shall discuss with the client the desirability of the client testifying. If the client wishes to testify, the attorney shall thoroughly prepare the client for direct and cross-examination.

13. During the hearing the attorney shall act as a zealous advocate for the client, insuring that the proper procedures are followed and that the client's interests are well represented.

14. After the hearing, the attorney shall meet with the client to explain the court's decision. If the client is committed, the attorney shall explain the client's right to appeal pursuant to G.L. c. 123, § 9(a) and the client's right to file a petition for discharge in the superior court pursuant to G.L. c. 123, § 9(b), and shall assist the client in doing so. (Where an appeal is filed the attorney shall, without delay, notify CPCS' Mental Health Litigation Unit in order that appellate counsel may be assigned). The attorney shall review the evidence which was presented at the hearing in order to advise the client about any steps the client can take during the commitment period in order to be discharged from the hospital.

<u>Appendix D</u>

Committee for Public Counsel Services

Performance Standards Governing the Representation of Indigent Adults in Guardianship Proceedings under G.L. c. 190B (Including "Substituted Judgment" Matters) And in Authorization to Treat Proceedings under G.L. c. 123

These standards describe the steps which must, at a minimum, be taken by an attorney who has been assigned to represent an adult client in the Probate Court Department against whom has been initiated a guardianship proceeding, pursuant to G.L. c. 190B, or a client in the District Court Department against whom a petition seeking the authority to administer antipsychotic medication or other medical treatment for mental illness has been filed, pursuant to G.L. c. 123, § 8B. Counsel assigned pursuant to G.L. c. 211D must comply with these standards and the Massachusetts Rules of Professional Conduct, as well as all applicable CPCS policies and procedures.

1. The role of counsel is to diligently and zealously advocate on behalf of his or her client, within the scope of the assignment, to ensure that the client is afforded all of his or her due process and other rights. To that end, only in exceptional circumstances may counsel stipulate to the client's incapacity; provided, however, that in proceedings in which a substituted judgment determination is required, counsel must oppose the petition and present "all reasonable alternatives" to the proffered treatment for the court's consideration. *See In the Matter of Moe*, 385 Mass. 555, 567 (1982); *Superintendent of Belchertown State School. v. Saikewicz*, 373 Mass. 728, 757 (1977).

Further, under G.L. c. 190B, upon a finding of incapacity, the probate court is required to

> exercise [its] authority . . . so as to encourage the development of maximum self-reliance and independence of the incapacitated person and make appointive and other orders only to the extent necessitated by the incapacitated person's limitations or other conditions warranting the procedure.

G.L. c. 190B, § 5-306(a). Thus, full or plenary guardianship is to be the exception, rather than the rule. To that end, counsel must ensure that, in those cases in which his or her client is found to be incapacitated, the guardian's authority is strictly tailored to the specific decision-making needs of the client.

2. Immediately upon receipt of the assignment, the attorney shall (a) file an appearance with the court; (b) notify petitioner's counsel of the assignment; and, (c) obtain a copy of the petition, the medical certificate or clinical team report, and any affidavit(s), documents or other pleadings that were filed with the petition.

3. Also immediately upon assignment, the attorney shall contact the client to inform him or her of the assignment and to schedule an initial meeting. The attorney shall meet with the client as

soon as possible thereafter, but in no event later than one week prior to the return date set by the court; provided, however, that the attorney shall meet with the client no later than the next business day following the assignment whenever a petition for the appointment of a temporary guardian or for a substituted judgment determination is filed, or whenever an expedited hearing or other proceeding is sought or scheduled.[1] If the attorney is unable to meet with the client in accordance with this section and to promptly begin working on the case, or if the attorney is unable to appear in court on the assigned date, he or she shall decline the appointment.

At this initial meeting the attorney shall, at a minimum, explain to the client the purpose of and procedures involved in the impending guardianship proceeding, the client's rights and options in respect to the proceeding, and ascertain the client's wishes and perspectives as to the matters that will be at issue.[2] The attorney shall explain his or her role and those of the other participants in

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[1] As a general rule, the attorney should not agree to a continuance sought by petitioner without first consulting with the client. After such consultation, and unless the attorney determines that the client's legal or clinical interests would be adversely affected, he or she may agree to the continuance.

[2] Rule 1.14 of the Massachusetts Rules of Professional Conduct affords attorneys guidance as to their ethical responsibilities in dealing with clients "under a disability." The rule provides that, as with other clients, attorneys generally should follow the wishes of their cognitively, emotionally, or otherwise impaired clients, and provides suggestions as to steps that might be taken when an attorney has serious doubts as to his or her client's ability to competently direct litigation or other legal matters. The rule recognizes, however, that in some circumstances, mental health proceedings specifically noted among them, such a course of action may be impermissible:

> Such circumstances arise in the representation of clients who are competent to stand trial in criminal, delinquency and youthful offender, civil commitment and similar matters. Counsel should follow the client's expressed preference if it does not pose a risk of substantial harm to the client, even if the lawyer reasonably determines that the client has not made an adequately considered decision in the matter.

Mass. R. Prof. C. 1.14, cmt. 7 (taking protective action).

While the "default" position of adhering to the client's expressed (albeit inadequately considered) decisions may seem reasonable, the imposition of guardianship (i.e., the removal of a client's fundamental right to make his or her own decisions) or treatment with those modalities requiring a substituted judgment determination absent the true informed consent of the client is a substantial deprivation of liberty and, therefore, most certainly "pos[es] a risk of substantial harm to the client."

the proceeding.[3,4] While not required, the attorney should seek to obtain from the client written authorization to examine and copy the client's medical records or, where the client is unable or unwilling to provide such authorization, a court order authorizing same.

4. The attorney shall thoroughly investigate the facts. This investigation shall include at a minimum (a) a review of the medical certificate, or the clinical team report, filed with the petition, and an interview of the clinician(s) who conducted the examination(s) upon which the certificate or report is based; (b) for a client who is or has been residing in a mental health, developmental disability or nursing facility, a review of (i) facility records, including medication history, (ii) treatment review notes, including diagnoses, treatment history, and comments regarding the client's capacity, (iii) unit and nursing notes, for notations as to the client's relationship and cooperation with staff and treatment programs, and (iv) the client's Individual Service Plan or similar document;[5] (c) an interview of the petitioner, current treatment providers, staff (including doctors, nurses, and social workers) of current residential programs, if applicable, and of former providers and program staff if reasonably accessible; and (d) other persons familiar with the client, such as friends and family. The attorney shall also determine whether the client has executed, or is capable of executing, a health care proxy, durable power of attorney, or similar instrument delegating authority to a surrogate decision-maker, that would obviate the need for the appointment of a guardian.

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[3] If the client refuses legal representation, the court must determine whether his or her waiver is "competent." SJC Rule 3:10, § 3. If he or she is not competent to waive counsel or is "otherwise unable effectively to exercise [his or her] rights at a hearing," standby counsel must be appointed. SJC Rule 3:10, § 3. If the client objects to a particular attorney despite that attorney's best efforts to establish an effective professional relationship, the attorney should move the court to permit him or her to withdraw, and move that successor counsel be assigned. In doing so, of course, counsel must be careful to avoid divulging any confidential information or other information that could be harmful to the client's interests. The court should determine whether the person's objections are reasonable. If so, the motions should be allowed and successor counsel appointed. If not, the motion to withdraw should be denied and the attorney should continue as counsel or be directed to serve as "standby counsel." SJC Rule 3:10, §§ 3, 6.

[4] Where counsel has been assigned but prior to the commencement of a hearing the court determines that the client is not indigent, the court may dismiss assigned counsel and advise the client to retain private counsel. However,

> if the interests of justice so require[], the judge shall authorize the continued services of appointed counsel at public [i.e., CPCS] expense. The interests of justice may require such appointment if, for example, the party is incompetent to obtain counsel, incapable of obtaining access to funds, or incapable of locating or contracting with a lawyer.

SJC Rule 3:10, § 5. If the client is advised to retain private counsel, the attorney who had been previously assigned may be retained, provided that he or she fully explains to the client that such representation may create "the appearance of impropriety, solicitation, or overreaching." If the client nevertheless wishes to retain the attorney, the attorney must obtain a written statement signed by the client stating the client's understanding of his or her right to seek other counsel for the private case. *CPCS Assigned Counsel Manual*, Part V, § 3(A)(2).

[5] Of particular significance will be information as to treatment and services that are, or can be made, available that will assist the client in "meeting the essential requirements for physical health, safety or self-care," despite his or her alleged disabilities. See definition of "incapacity" at n. 6, below.

5. In most instances, independent psychiatric or psychological expertise will be of assistance in the preparation and defense of the proceeding, particularly in the assessment of a client's capacity.[6] In most cases in which the authority to administer antipsychotic medication is sought by means of a substituted judgment determination, the expert assistance of a psychiatrist should be sought, and such assistance must be sought whenever such medications are proposed to be administered for the first time to a particular client. After meeting with the client and investigating the facts, as described above in ¶ 4, the attorney shall determine whether expert assistance will be of value and, if so, he or she shall move for funds therefor, pursuant to the Indigent Court Costs Act. G.L. c. 261, §§ 27A-G. *See Guardianship of a Mentally Ill Person*, Mass. App. Ct., No. 85-0018 Civ. (Dreben, J.).[7]

6. Upon allowance of the motion for funds, the attorney shall contact the independent clinician and instruct him or her as to the purpose and parameters of his or her role and responsibilities. To the extent appropriate, the attorney should share with the clinician all pertinent information obtained pursuant to ¶ 4, above. The attorney shall remind the clinician that all information gleaned and opinions formed by the clinician shall remain confidential and may be shared only with the client and the attorney, and that such information and opinions may not be divulged to the court, petitioner, or petitioner's attorney without the permission of the client's attorney. After the clinician examines the client, reviews the records and speaks with staff and others, as appropriate, he or she and the attorney shall meet to discuss the clinician's findings and opinions. Of particular concern should the clinician opine that the client may indeed be incapacitated to some extent, will be the identification of those areas of decision-making in which the client is not incapacitated and those areas of decision-making in which the client, although perhaps having difficulty, is able to care for him- or herself with assistance, in order that the court may tailor its order to the specific decision-making needs of the client.

The attorney shall determine whether and to what extent the clinician's services shall be of further use. If the clinician will be called to testify at a hearing, the attorney shall fully prepare him or her for direct- and cross-examination.

The attorney also should inform the clinician as to the amount of funds that have been allowed and instruct him or her to refrain from performing any services or incurring any expenses in excess of such amount unless and until a supplemental motion for funds has been allowed.

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[6] The appointment of a guardian, or the authority to administer or withhold "extraordinary treatment," is warranted upon a finding that a client is "incapacitated." An "incapacitated person" is defined as:

> an individual who for reasons other than advanced age or minority, has a clinically diagnosed condition that results in an inability to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance.

G.L. c. 190B, § 5-101(9).

[7] Sample Motions, Affidavits and other material are available on the Mental Health Litigation Unit's website: http://www.publiccounsel.net/Practice_Areas/Mental_Health/practice_aids/practice_aids_motions.html. The decision as to whether to retain the services of a clinician is the attorney's. He or she must, of course, discuss the purpose, parameters and confidential nature of the clinician's examination with the client.

7. The attorney shall use formal discovery processes if indicated and tactically advisable. The attorney shall confer with potential witnesses, including but not limited to the petitioner, personally or through counsel, treating psychiatrists and psychologists, nursing and any other staff familiar with the client's care and treatment, the prospective guardian, if one has been nominated, and other possible witnesses suggested by the client. The attorney should also confer with other involved parties, for example, family members. Where necessary, witnesses should be subpoenaed. The attorney should meet with the witnesses in advance of the trial in order to prepare them for direct- and cross-examination. The attorney shall review the medical record to identify those parts of the record that may be inadmissible and, therefore, whose admission should be objected to if proffered at trial. The attorney should identify the petitioner's witnesses and make an effort, if tactically indicated, to interview them on the record and prepare cross-examination.

8. The attorney should meet again, and as often as necessary, with the client to discuss the upcoming hearing, and should keep him or her informed of the progress of case preparation. The attorney should inform the client of the witnesses expected to be called and any other evidence he or she intends to present. The attorney also should discuss with the client the desirability of the client testifying. If the client wishes to testify, the attorney should thoroughly prepare the client for direct- and cross-examination.

9. The attorney should establish a record of: (a) the nature, type, and extent of the client's specific cognitive and functional abilities and limitations; (b) evaluations of the client's mental and physical condition and, if appropriate, his or her educational potential, adaptive behavior, and social skills; (c) the prognosis for improvement and any available recommendations as to appropriate treatment or habilitation plans;[8] (d) the client's experience, if any, with the specific treatment proposed, including side effects; (e) the client's history of participation in inpatient and outpatient treatment; (f) the relative success of previous treatment plans; (g) the current treatment plan, if any; (h) the client's criminal history, if any; (i) his or her employment record; (j) his or her home and familial situation, and (i) the client's religious beliefs, if they would be pertinent.

10. After reviewing the petition and the pleadings, the attorney shall determine if any procedural defenses can be raised, and file appropriate motions with supporting memoranda.

If it appears likely that the client will be found to be incapacitated, the attorney shall negotiate with petitioner's counsel as to the scope of the guardian's authority. If the parties are able to agree on a proposed guardianship order that is appropriately tailored to the specific decision-making needs of the client, the attorney may stipulate thereto at the hearing.

11. Prior to the hearing, the attorney shall (a) prepare any pretrial motions, memoranda, and requests for rulings; (b) prepare consistent direct- and cross-examination questions; and (c) prepare an opening argument. If required or requested by the court, or as otherwise deemed appropriate by the attorney, he or she shall prepare requests for findings of fact and law to be presented at the close of evidence.

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[8] See n. 5, above.

12. During the hearing the attorney shall act as a zealous advocate for the client, insuring that proper procedures are followed and that the client's interests are well represented. To that end, the attorney shall: (a) file any and all appropriate motions and legal memoranda, including but not limited to motions regarding the assertion of privileges and confidential relationships, and the admission, exclusion or limitation of evidence; (b) present and cross-examine witnesses, and provide evidence in support of the client's position; (c) make any and all appropriate evidentiary objections and offers of proof, so as to preserve the record on appeal; and (d) take any and all other necessary and appropriate actions to advocate for the client's interests.

13. If the court finds the client to be incapacitated, the attorney shall ensure that (i) the court tailors the guardian's authority to the specific decision-making needs of the client,[9] (ii) the guardianship order clearly delineates such limited authority, and (iii) the guardian's obligation to periodically report to the court is noted. If a temporary guardianship order issues, the attorney shall ensure that (i) the temporary guardian's authority is limited to decision-making pertinent to the exigent circumstances that warranted the appointment and (ii) the expiration date of the appointment is specified. Where treatment pursuant to a substituted judgment determination is authorized, the attorney shall ensure that (i) periodic reviews and an expiration date are incorporated into the court's decree, (ii) a treatment plan is approved by the court, and (iii) a monitor is appointed to oversee the implementation of the treatment plan.

14. After the hearing the attorney shall meet with the client to explain the court's decision and, if a guardianship or substituted judgment order has issued, the client's appellate rights. If the client wishes to exercise such appellate rights, the attorney shall file a timely notice of appeal with the trial court. Where an appeal is filed, the attorney shall, without delay, notify CPCS's Mental Health Litigation Unit in order that appellate counsel may be assigned.

15. As directed by the Administrative Office of the Probate and Family Court, in guardianship proceedings that do not involve a substituted judgment determination, the attorney's representation shall terminate upon the issuance of the court's decree, unless otherwise ordered by the court. In proceedings in which a substituted judgment determination has been made to authorize treatment, the attorney will continue to represent the client for purposes of periodic reviews and extensions of the substituted judgment order and treatment plan.

16. Whenever counsel's representation continues beyond the issuance of the initial guardianship or substituted judgment order, as described in ¶ 15, counsel is not to assume oversight responsibility for his or her client's ongoing treatment or living arrangements (*e.g.*, the attorney is not expected to attend his or her client's treatment team meetings). That is a monitor's responsibility as to substituted judgment matters and is a guardian's responsibility as to other issues. Rather, the attorney's role is to advocate on behalf of his or her client in respect to judicial proceedings.

Such proceedings will come about in either of two ways: (i) regularly scheduled periodic reviews and/or extensions of substituted judgment orders, or (ii) petitions or motions for

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[9] "The court shall exercise [its] authority . . . so as to encourage the development of maximum self-reliance and independence of the incapacitated person and make appointive and other orders only to the extent necessitated by the incapacitated person's limitations or other conditions warranting the procedure." G.L. c. 190B, § 5-306(a).

termination or modification of guardianship orders, both of which will require counsel to meet with his or her client, review monitor or guardian reports, review records, review pleadings, etc., as necessary, and in accordance with these standards, to prepare for the impending hearing.

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