Date

Hospital Name
Hospital Address
City, State, Zip

Court Department _____ *(Please indicate the name of the court - District, Boston Municipal, or Juvenile Court)*:

Re: Hospital/Physician Affidavit Letter Supporting Section 35 Petition

My name is _____, and I am a licensed physician in the Commonwealth of Massachusetts and Board Certified in _____.

I most recently evaluated _____ on _____ in the __*(Hospital)*_____ *(please indicate the ED or Inpatient Unit).* In my clinical evaluation of _____, I also obtained information regarding the patient from _____(*please indicate appropriate sources of information – including but not limited to: clinical staff members within the hospital or other locations, reviewing care management notes from other facilities through shared ENS/EMR platform, family members, EMS, patient's medical record, other).*

_____ arrived *(provide the applicable **Presentation** information from the checklist, including both the method of arrival and the reason for the current visit including the existing medical conditions from the clinical evaluation).*

_____ has been previously treated for *(provide any past evaluation/treatment information from the checklist)*

_____ has a serious health condition(s) that is/are directly affected by his/her *(alcohol and/or substance use disorder).* Based on my review and in my opinion, _____'s inability to refrain from *(alcohol and/or substance use disorder)* use puts him/her at significant risk of disability and/or death. In addition to the general risks of regular intoxication, his/her existing medical conditions put him/her at imminent risk of significant medical harm. Ongoing lack of treatment for each of these carries potentially fatal consequences, made more likely by regular *(alcohol and/or substance use disorder).*

Attached to this letter is a detailed list of laboratory test results, the clinical notes outlining the current course of treatment in the hospital, and the proposed discharge plan.

In my opinion, _____ requires commitment to a facility for treatment of *(alcohol and/or substance use disorder).* Without treatment, it is my opinion that _____ is at imminent and serious risk of disability and/or death.

_____ has been medically cleared *(please indicate medical and/or psychiatric)* and is available for transport to court at this time.

For further information about the care and treatment provided at the hospital, please contact *(Please indicate the name, phone or pager number of the treating clinician or of another physician who can answer patient related questions and clarify the reason for the petition if the treating clinician is not available post-shift)*

Signed under the pains and penalties of perjury,

(Treating Physician (MD/DO))

**Section 35 Petition Affidavit – Supporting Clinical Information Checklist/Guidance**

*The following list provides information that should be included in the hospital/physician affidavit letter or attached as outlined below*

1) **Trial Court Affidavit**
    a. On the "Affidavit in Support of Petition for Commitment under G.L. c. 123, § 35", we are requesting that the clinician or appropriate staff to simply write in Section 1: "See Attached Hospital/Physician Affidavit Letter Supporting Section 35 Petition".
    b. The provider should also sign that affidavit although all other fields should be left blank as the appropriate information will be included in the Affidavit Letter.

2) **Presentation – information that must be included in the affidavit letter**
    a. Method of arrival into the ED *(e.g., walked in, versus found in the community and brought by ambulance)*
    b. Please indicate information about the current visit as related to the following:
        i. For opioid use disorder, please include information on any of the following: the reason for the ED visit include opioid overdose, withdrawal, infections related to injecting drugs such as abscess, sepsis, endocarditis, pregnancy related complications due to opioid use, and falls, accidents, burn. Please also include information on patient receiving naloxone prior to ED visit (provided in the field by bystanders, EMTs, others) to treat overdose.
        ii. For Alcohol Use Disorder, please include information on any of the following: reasons for the ED visit include alcohol intoxication, withdrawal, seizures, DTs, Blackouts, falls, accidents resulting in injuries, burn, acute hepatitis, acute hepatic failure, acute pancreatitis and encephalopathy. In addition patients may present or brought to ED for acute safety risks such as suicidal or homicidal ideation or threats and violent acts or threats in the context of intoxication
        iii. For polysubstance use: please include information on any of the following: reasons for the ED visit was that patient presents with poly substance use (e.g., patient was mixing opioids with benzodiazepines, alcohol or cocaine) and there was a risk of life threatening complications and/or death.
    c. Provide information on any other conditions that are being evaluated for possible treatment (e.g., physical trauma, DTs, Seizures, etc…)

3) **Past History – information to be included in the affidavit letter**
    a. Number of ED visits in the last month *(or another time frame if there is a consistent presentation over a long period (e.g., 45 or 60 days))*

b. Reasons for prior ED visits that are similar to the current presentation outlined above

c. If the prior ED visit was related to one of the presentations outlined above, please include the following:

    i. Please describe history of SUD and related complications in the last month or some other timeframe, including history of established diagnosis of SUD. For the prior ED visits please indicate if lab results are similar to those identified in the current ED visit. For prior history of SUD, please indicate for how long, frequency of use, amount, loss of control, compulsive use despite consequences. If known, please also include information on admissions for each prior ED visit (e.g., inpatient medical, surgical, psychiatric, detox placement) that may be due to complications of SUD for the reasons cited above in the **Presentation** section). Please also describe history of known medical conditions that may be worsened by substance use, including liver disease, Hep C, endocarditis, anoxic brain due to OD, worsened mental health conditions such as depression, suicidality, aggression, and violence

    ii. Please describe history of alcohol use disorder, including information on blood alcohol levels during prior treatments (upon admission or discharge from jail to hospital), specific risk factors of immediate medical harm related to ongoing alcohol use, impact that the alcohol use has on existing medical conditions, prior medical tests that were required as a result of medical injuries due to alcohol use

d. For any of the past history for a known disorder, please include information on involuntary admissions, inability to engage in voluntary treatment (inpatient or outpatient) programs, history of leaving against medical advice (AMA), and the ineffectiveness of previous treatment attempts.

**4) Lab Testing for either Alcohol or Substance Use Disorders – Results should be attached to the affidavit letter**

a. BALs on admission if applicable

b. Urine or oral tox screen results if applicable. Presence of opioids, fentanyl and evidence of other substance use such as benzodiazepines or cocaine

c. Increased LFTs, brain imaging to support presence of anoxia, brain injury etc

d. Provide a list of any other lab tests requested by the treating clinician to help clarify other medical conditions present at time of admission

**5) Course of Treatment in the ED or Inpatient Unit - include applicable clinical notes outlining the course of treatment within the hospital for the current treatment**

a. Describe the treatment provided in the ED

    i. Benzodiazepines for Alcohol withdrawal,

    ii. Narcan for treatment of Opioid overdose,

iii. Methadone or Buprenorphine-naloxone to treat signs and symptoms of opioid withdrawal,

iv. Psychiatric medications for agitation,

v. Medications for liver cirrhosis,

vi. antihypertensives etc.

vii. Clinician should also include a list of all medications and services provided in the ED or the inpatient unit to treat the SUD and any other condition

6) **Discharge Planning – attach to the affidavit letter the information on the following if known. Please note that this information could be included in the letter if applicable.**

   **a.** Include a copy of the proposed discharge summary from the ED (provided that it is available and assuming that the discharge summary is not already included in the information listed above)

   b. If known, the treating clinician should also indicate why community based treatment is not indicate (e.g., detox was offered and rejected, person indicated he/she does not need further treatment)

7) **Providers should be aware in their evaluations that the following medical conditions make the patient ineligible for a Section 35 Petition, so alternative placement options will need to be considered prior to seeking a Section 35 petition**

   a. Inability to ambulate independently

   b. Acute medical condition(s) requiring hospitalization

   c. Acute psychiatric condition(s) requiring psychiatric hospitalization

   d. Need for skilled nursing facility placement

   e. The need for a physician on site during alcohol and/or drug treatment

   f. Inability to perform their ADL's without assistance

   g. Intravenous injectable or oxygen is required

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May 17, 2019

Anuj K. Goel. Esq.
Vice President, Legal and Regulatory Affairs
Massachusetts Health and Hospital Association
500 District Avenue
Burlington, MA 01803

Re: Section 35 of Chapter 123

Dear Anuj:

You have asked me for my advice concerning the privacy law aspects raised by the participation of a hospital and its physicians in commitment proceedings commenced under Section 35 of Chapter 123. In particular, you have asked whether a physician who has learned of a patient's alcohol or substance abuse disorder as a result of an encounter in a hospital emergency room or an inpatient unit, and who has determined that the patient is likely to suffer serious harm as a result of such condition, may disclose protected health information concerning the patient's disorder to a court in connection with a commitment proceeding brought under Section 35.

The short answer to your question is that such disclosure is permitted by federal and state law.

**Discussion**

Section 35 of Chapter 123, as amended by the Section 4 of Chapter 8 the Acts of 2016, permits a physician (among others) to petition any district court or the juvenile court for an order of commitment of a person whom he has reason to believe has an alcohol or substance abuse disorder. If after a hearing, which shall include expert testimony and related medical records, the court determines that the individual suffers from an alcohol or substance abuse disorder and there is a likelihood of serious harm as a result of such disorder, the court may order the commitment of such individual.

A commitment hearing under Section 35 will necessarily involve the disclosure of protected health information about the individual, and that information will necessarily include topics that are generally considered highly sensitive due to the stigma associated with a diagnosis of alcoholism or substance abuse. Accordingly, your members and their associated physicians have asked for some assurance that they can provide such information to the court in accordance with applicable privacy laws.

**Federal HIPAA Standards**

In this regard, I have reviewed the HIPAA privacy regulation, case law involving the privacy obligations of physicians, and, since social workers often practice in hospital emergency departments, the regulations governing the practice of licensed clinical social work.

The HIPAA privacy regulation, 45 C.F.R. 164.512(j) states, in relevant part:

> (j) *Standard: Uses and disclosures to avert a serious threat to health or safety* (1) *Permitted disclosures.* A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure: (i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and (B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat . . .
>
> (4) *Presumption of good faith belief.* A covered entity that uses or discloses protected health information pursuant to paragraph (j)(1) of this section is presumed to have acted in good faith with regard to a belief described in paragraph (j)(1)(I) or (ii) of this section, if the belief is based upon the covered entity's actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority.

The disclosure of protected health information to a court in order to prevent "serious harm" is permitted by the privacy regulation.

The federal Office of Civil Rights ("OCR") has provided guidance on this point, as follows:

> Q: What constitutes a "serious and imminent" threat that would permit a health care provider to disclose PHI to prevent harm to the patient, another person, or the public without the patient's authorization or permission?
>
> A: HIPAA expressly defers to the professional judgment of health professionals in making determinations about the nature and severity of the threat to health or safety posed by a patient. OCR would not second guess a health professional's good faith belief that a patient poses a serious and imminent threat to the health or safety of the patient or others and that the situation requires the disclosure of patient information to prevent or lessen the threat. Health care providers may disclose the necessary protected health information to anyone who is in a position to prevent or lessen the threatened harm, including family, friends, caregivers, and law enforcement, without a patient's permission.

HIPAA should not be a barrier to a hospital's or physician's participation in the Section 35 process so long as they act in good faith.

As we have discussed, information gathered in the emergency department or medical surgical unit of a general services hospital is not subject to the federal regulations governing the privacy of substance abuse treatment records, 42 C.F.R. Part 2. Accordingly, I have not considered the application of these regulations to Section 35 proceedings. If the information to be submitted

has been received by the hospital from a substance abuse disorders treatment facility or a unit of the hospital that specializes in substance abuse treatment, then the Part 2 rules must be observed.

**Massachusetts Privacy Laws**

All persons in Massachusetts have a right against the unreasonable, substantial or serious interference with their privacy. M.G.L. Ch. 214 § 1B. In my view, where a treating physician discloses information to prevent serious harm to the individual, a court would find that the disclosure was not unreasonable, and would find that such disclosure would not violate the privacy statute.

The leading case in Massachusetts on a physician's obligation to preserve the confidentiality of medical information is *Alberts v. Devine,* 395 Mass. 59 (1985). The Court in *Alberts* held:

> In Massachusetts, the Legislature has demonstrated its recognition of a policy favoring confidentiality of medical facts by enacting G.L. c. 111, §§ 70 and 70E, to limit the availability of hospital records. Furthermore, G.L. c. 233, § 20B, creates an evidentiary privilege as to confidential communications between a psychotherapist and a patient. The fact that no such statutory privilege obtains with respect to physicians generally and their patients . . . does not dissuade us from declaring that in this Commonwealth all physicians owe their patients a duty, for violation of which the law provides a remedy, not to disclose without the patient's consent medical information about the patient, *except to meet a serious danger to the patient or to others.* [Citations omitted].

Given this exception, the Massachusetts common law rule set forth in *Alberts* should not prevent a physician from providing testimony as part of a proceeding under Section 35.

As noted by the Court in *Alberts*, Massachusetts has established a privilege for communications between a psychotherapist and a patient. This privilege has an exception for commitment proceedings, as follows:

> (*a*) 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. M.G.L. c. 233 § 20B (a)

I note that an emergency room physician, for example, would not typically be a psychotherapist, but the existence of this exception underscores the ability of a physician to disclose confidential information to protect a patient from harm.

The regulations of the Board of Registration in Social Work are also instructive. These regulations expressly permit a licensed clinical social worker to disclose information as

necessary to prevent the client from harming himself. 258 CMR 22.04(2). The regulation states:

> (2) Disclosure Necessary to Prevent Harm to Client. (a) A social worker may disclose client communications, information or records without the prior written consent of the client, to the extent authorized by 258 CMR 22.04(2)(b) and (c), if: 1. The client's behavior creates a clear and present danger of harm to the client himself or herself; 2. The client has explicitly refused to voluntarily accept further appropriate treatment or services; 3. Disclosure of the communications, information or records is reasonably necessary to protect the safety of the client; and 4. The disclosure of client communications, information or records is limited to that authorized by 258 CMR 22.04(2)(b) and (c).
>
> (b) In any situation where disclosure of client communications, information or records without the written consent of the client is authorized by 258 CMR 22.04(2)(a), if the social worker has a reasonable basis to believe that the client can be committed involuntarily to a hospital or other health care facility for appropriate treatment or services pursuant to M.G.L. c. 135, § 12, that social worker shall take all appropriate actions which are within the lawful scope of practice for his or her licensure level, as set forth in 258 CMR 12.00: Scope of Practice, to initiate proceedings for involuntary hospitalization of that client. In so doing, the social worker may disclose any and all client communications, information or records reasonably necessary to carry out his or her obligations under 258 CMR 22.04(2)(b).
>
> (c) In any situation where disclosure of client communications, information or records without the written consent of the client is authorized by 258 CMR 22.04(2)(a), and whether or not the social worker has a reasonable basis to believe that the client can be committed involuntarily to a hospital or other health care facility for appropriate treatment or services pursuant to M.G.L. c. 135, § 12, the social worker may disclose client communications, information or records to members of the client's family or other individuals if, in the reasonable exercise of his or her professional judgment, the social worker believes that disclosure of the particular communications, information or records in question would assist in protecting the safety of the client.

It is clear that under state law, either a physician or a social worker may disclose otherwise privileged information pursuant to a proceeding under Section 35 to prevent a client from suffering serious harm.

**Maintaining Confidentiality of Court Records**

The Association has been discussing the administration of this Section 35 commitment process with the judiciary. In this regard, I note that M.G.L., Chapter 123, Section 36A states, in relevant part:

> All petitions for commitment, notices, orders of commitment and other commitment papers used in proceedings under sections one to eighteen and section thirty-five shall be private except in the discretion of the court. Each court shall keep a private docket of

> the cases of persons coming before it believed to be mentally ill, including proceedings under section thirty-five;

Based on the legislative language and the guidance provided to MHA by the Department of Mental Health ("DMH") General Counsel, it seems clear that the information provided to the DMH court forensic clinicians is used to by the court to determine the appropriateness of a Section 35 petition. Medical information that is provided to the forensic court clinicians should fall under the protection of Section 36A, which in turn should prevent that information from being exposed to the public, unless the presiding judge determines otherwise.

I trust this is helpful.

Sincerely yours,

David S. Szabo