MEMORANDUM

TO: Secretary Sudders, Chair of the Section 35 Commission

FROM: Lester D. Blumberg, Department of Mental Health General Counsel
Jeffrey Mackenzie, Department of Mental Health Deputy General Counsel

RE: Legal implications of holding a non-court involved individual who is diagnosed with a substance use disorder but is no longer under the influence of substances

DATE: May 17, 2019

Introduction

Chapter 208 of the Acts of 2018 created a commission to study and report on the efficacy of involuntary inpatient treatment for non-court involved individuals diagnosed with substance use disorder. This memo reviews the current statutory and case law provisions regarding the holding of a non-court involved individual who is diagnosed with substance use disorder but is no longer under the influence of substances. For purposes of this analysis, we assume that the holding of non-court involved individuals refers to a process that would allow a clinician to authorize short-term emergency hospitalization of an individual with a substance use disorder, similar to the process for involuntary commitment of mentally ill persons under M.G.L. c. 123, § 12.

Summary of M.G.L. c. 123, § 12

M.G.L. c. 123, § 12(a), authorizes the holding of a non-court involved individual who is diagnosed with a mental illness in certain conditions. Specifically, section 12 (a) authorizes certain health care professionals (or a police officer if no clinician is available), who have reason to believe that a person presents a likelihood of serious harm by reason of mental illness to restrain the person and apply for short-term emergency hospitalization. Section 12(b) provides that unless the applicant is a designated physician, i.e., a physician with admitting privileges, the person must be examined by a designated physician upon reception at the facility and prior to admission. The designated physician may admit the person for a period of three business days upon a determination that failure to hospitalize would present a likelihood of serious harm by reason of mental illness.[1] A person hospitalized under § 12(b) must be discharged at the end of the three-day period unless the hospital files a petition for extended commitment (up to six months) under the provisions of M.G.L c. 123, §§ 7&8 or the person has agreed to remain on a voluntary status.

Although the § 12(b) hospitalization does not involve the court, this process is not without due process protections. Upon admission, the person must be afforded the opportunity to apply for conditional voluntary treatment. The hospital is also required to notify the Committee for Public

[1] For purposes of commitment, a likelihood of serious harm is: "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; (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 and 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." M.G.L. c. 123, Section 1.

Counsel Services when a person is admitted to arrange for counsel to meet with the person. In addition, the person may request an emergency hearing in the district court based on an allegation that there has been an abuse of the commitment process. The statute provides that the court must hold a hearing, no later than one business day from the date the request was made.

Summary of M.G.L. c. 123, § 35

As currently drafted, chapter 123 does not have a similar provision for short-term commitment of persons diagnosed with substance use disorder. These commitments are governed by § 35 which authorizes commitment for a period of up to ninety days through judicial proceedings. These proceedings may be initiated by a petition filed in the district court. If the respondent is not present when the petition is filed, the court may issue a writ of apprehension or summons for the person to appear in court. Prior to hearing, the statute provides that the judge must order an examination of the person by a qualified clinician to assess whether the respondent has an alcohol or substance use disorder and whether the person presents a likelihood of serious harm as a result of their addiction. The court may also hear from other interested parties such as the respondent's family. The respondent has the right to counsel and the right to present evidence, including independent medical testimony.

For purposes of commitment, the assessment of dangerousness requires some evidence of prior conduct that demonstrates the potential for harm. In the Matter of G.P., 473 Mass 112, 126 (2015). In addition, with respect to the anticipated risk of harm, there must be some showing of imminence. Commonwealth v. Nassar, 380 Mass. 908, 912-917 (1980). This means that the harm will occur "in days or weeks rather than months." In the Matter of G.P., 473 Mass. at 128. At the conclusion of the hearing, the judge may authorize the commitment upon clear and convincing evidence that 1) the person has a substance use disorder and there is a likelihood of serious harm as a result of the person's substance use disorder.

A statutory change would be necessary to authorize the short-term hold of a non-court involved individual in a clinical setting who presents a likelihood of serious harm by reason of a substance use disorder. A non-judicial process similar to the one for involuntary commitment of mentally ill persons under M.G.L. c. 123, § 12 would also require due process protections, such as access to legal counsel, a notice of rights, including the right to contact an attorney, an opportunity for voluntary treatment, and an expedited judicial review in cases where the person alleges an unlawful restraint.

The question whether the restraint of a person who is not under the influence of substances, but who has been determined by a clinician to have a substance use disorder and to be at risk of serious harm as a result of their substance use disorder, violates substantive due process has not been litigated in Massachusetts.

Analysis:

1. A clinician's ability to determine whether a person requires hospitalization under §12 would logically extend to a process for short-term commitment of persons diagnosed with substance use disorder.

The § 12(b) commitment process relies solely on a qualified clinician's exercise of professional judgment in determining whether an individual is in need of hospitalization. See, Reida v. Cape Cod Hospital, 36 Mass. App. Ct. 553, 556 (1994) ("Whether something beyond observation is required to convince the applying physician that the patient may need psychiatric hospitalization is a matter of professional judgment."). Indeed, Section 12(b) demonstrates a legislative recognition that treatment for mental illness, even involuntary treatment, begins with a clinical determination and an opportunity for the individual to engage voluntarily in treatment before resorting to court proceedings. There is no reason why this approach could not be applied to persons who present a likelihood of serious harm by reason of a substance use disorder.

While the decision to commit a person under § 35 lies with the judge, it is the qualified clinician who provides an objective and reliable assessment upon which the decision stands. See McCabe v. Lifeline Ambulance Services, Inc. 77 F.3d 540 (1st Cir. 1996) ("The role of the licensed physician under Massachusetts law is to provide a neutral, objective assessment of the 'dangerousness' and 'likelihood of serious risk' criteria upon which the involuntary commitment decision depends."). A clinician's medical determination in support of a § 35 is similar to the legal standards for a § 12 commitment. However, there would have to be a statutory amendment to use such assessments for hospitalization in a non-judicial process for commitment, provided that there are also due process protections in place.

2. A person does not have to be intoxicated or under the influence of a substance in order to be involuntarily hospitalized.

The commitment statute does not require a finding that the person is intoxicated or under the influence of a substance at the time of hearing. Rather, the commitment turns on whether the person has a disorder, an addiction to alcohol or substances, which creates a likelihood of serious harm. Conversely, even if a person were intoxicated or under the influence of substances during the clinician's assessment or hearing, this would not be dispositive in determining whether they have an alcohol or substance use disorder. M.G.L. c. 123, § 35 defines alcohol or substance use disorder in terms of "chronic or habitual consumption" that "substantially injures the person's health" or "substantially interferes with the person's social or economic functioning" and "loss of self-control".

Thus the requisite findings for commitment, i.e., that the person has an alcohol or substance use disorder that presents a likelihood of serious harm, requires evidence of the person's addictive behavior spanning some period of time. This determination does not turn on whether the person is intoxicated or under the influence of a substance at the time of hearing. See for example, In the Matter of N.F., 93 Mass. App. Ct. 1113 (2018) in which a Section 35 commitment was affirmed by the Appeals Court based on evidence that the respondent used heroin but was unable to obtain

it and, as a result, had expressed suicidal thoughts and experienced withdrawal symptoms such as vomiting. See also, In the Matter of G.P., supra, vacating a Section 35 commitment on grounds that evidence of dangerousness (alleged physical harm to the respondent's mother) was lacking. In that case, however, the trial court's finding that the respondent had a substance use disorder was supported by family reports of her substance use, recent detoxification admissions, the respondent's admission to having a heroin problem, and observation of what appeared to be fresh needle marks on her arms. In neither of these cases was the respondent under the influence of any substance at the time of hearing on the petition for commitment.

Since a person diagnosed with substance use disorder who is not currently under the influence of substances may be committed under Section 35, it follows that this would also be the case if the person were hospitalized through non-judicial proceedings, similar to the process for involuntary commitment of mentally ill persons under M.G.L. c. 123, Section 12.

3. A non-judicial process for commitment under Section 35 raises a number of due process concerns that could be addressed through an amendment to existing law.

Section 35 of Chapter 123 of the General Laws authorizes a qualified health-care professional to petition the Court for the commitment of a person with a substance use disorder who is in imminent risk of harm. This law does not currently authorize short-term emergency hospitalizations for these individuals, such as under M.G.L. c. 123, § 12. If the law were amended to allow qualified health-care professionals to invoke short-term emergency hospitalization procedures for persons committed under Section 35, it should incorporate due process protections similar to those found in M.G.L. c. 123, § 12. These include the right of appeal and an expedited hearing if the person alleges an abuse or misuse of the commitment process. In addition, there should be some provision to notify the person of the right to consult with an attorney or legal advocate. If these protections are available, the extra-judicial commitment would satisfy any due process concerns.

4. A non-judicial commitment process predicated on dangerousness by reason of a substance use disorder does not violate substantive due process.

The Supreme Court has consistently held that a finding of dangerousness alone is insufficient to justify civil commitment. It is well settled law, however, that a state may commit individuals who are dangerous by reason of mental illness. See O'Connor v. Donaldson, 442 U.S. 563, 575 (1975). This exercise of the state's parens patriae powers may also extend to persons who present a danger to themselves or others by reason of a "mental abnormality" such as violent sex offenders. See Kansas v. Hendricks, 521 U.S. 346 (1997). Commitment based upon uncontrolled and dangerous behavior due to a substance use disorder is likewise constitutional. In Robinson v. California, the Supreme Court struck down a law that made it a criminal offense to be addicted to narcotics. In dicta, however, the Court observed that a state may establish a program of compulsory treatment for addicted persons, including periods of involuntary confinement. Robinson v. California, 37 U.S. 660, 664-665 (1962). This issue has not been litigated in Massachusetts, but the reasoning is consistent with existing case law in commitments for mental illness.

Conclusion:

Under Massachusetts law, a person diagnosed with substance use disorder may only be involuntarily hospitalized through judicial proceedings. Under the current commitment standard, an individual does not have to be under the influence of alcohol or substances in order to be committed for inpatient care and treatment. Rather, commitment turns on whether the person has a chronic condition, i.e., an alcohol or substance use disorder, that presents a likelihood of serious harm. The Legislature could authorize short-term hospitalization without judicial involvement for individuals with a substance use disorder similar to the process for commitment of mentally ill persons under M.G.L. c. 123 § 12. Such amendment should include similar due process protections that apply to commitments made under Section 12.