

SECTION 35 COMMISSION

*Established by Section 104 of Chapter 208
of the Acts of 2018*

July 1, 2019



On March 29, 2019, the Commonwealth was formally served with *John Doe v. Mici et al.* As a result, all executive branch employees appointed to this Commission abstained from opining or voting on specific recommendations. No executive branch employee endorsed this report either in part or in its entirety.¹

1. The legal memorandum in Appendix G was prepared by executive branch employees for the Commission's consideration.

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 - b. Evaluate and develop a proposal for a consistent statewide standard for the medical review of individuals who are involuntarily committed due to an alcohol or substance use disorder pursuant to Section 35 of Chapter 123 of the General Laws
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Commission Overview

- The Section 35 Commission was established in Section 104 of Chapter 208 of the Acts of 2018 to study the efficacy of involuntary inpatient treatment for non-court involved individuals diagnosed with a substance use disorder.
- The Commission was charged with:
 - a) Reviewing medical literature and expert opinions on the long-term relapse rates of individuals diagnosed with a substance use disorder following involuntary inpatient treatment, including:
 1. the differences in outcomes for coerced and non-coerced patients,
 2. any potential increased risk of an individual suffering a fatal overdose following a period of involuntary treatment,
 3. medical literature on length of time necessary for detoxification of opioids and recommended time following detoxification to begin medication-assisted treatment,
 4. the 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,
 5. whether the current capacity, including acute treatment services, clinical stabilization services, transitional support services and recovery homes, is sufficient to treat individuals seeking voluntary treatment for substance use disorder,
 6. the availability of other treatments for substance use disorder, including those treatments used in less restrictive settings, and
 7. the effectiveness of the existing involuntary commitment procedures pursuant to Section 35 of Chapter 123 of the General Laws at reducing long-term relapse rates; and
 - b) Evaluating and developing a proposal for a consistent statewide standard for the medical review of individuals who are involuntarily committed due to an alcohol or substance use disorder pursuant to Section 35 of Chapter 123 of the General Laws, including, but not limited to, developing:
 1. a proposed standardized form and criteria for releasing medical information for use in a commitment hearing under Section 35 that is in compliance with federal and state privacy requirements, and
 2. criteria and guidance to medical staff about filing a petition under Section 35.

Commission Overview (continued)

- The Commission was required to file recommendations, including any proposed legislation, with the Clerks of the House of Representatives and the Senate, not later than July 1, 2019.
- The Commission met seven times from October 2018 through June 2019. All meetings were subject to the open meeting law and minutes were taken and approved for each meeting. Minutes of the Commission's meetings may be found online: <https://www.mass.gov/lists/section-35-commission-meeting-minutes>.
- Appendix C outlines the meetings and input provided, including the individuals who presented. Reading materials considered by the Commission are posted on a publicly-available webpage: <https://www.mass.gov/orgs/section-35-commission> and listed in Appendix D.
- The Department of Correction was not asked to make a presentation to the Commission. Data provided by the Department of Correction can be found on Slides 15 and 16.
- An email address was created for members of the public to submit comments and questions for the Commission: EHS.Section35Commission@MassMail.State.MA.US

Recommendations Proposed by Individual Members and Voted on June 27, 2019

Recommendation	In favor	Opposed	Abstained	Absent
<p>The Commonwealth should expand development of low-threshold, treatment on demand models, including harm reduction interventions in community-based settings, immediate access to medication-assisted treatment (MAT) and expansion of bridge clinics, addiction consult services, outreach and engagement programs, post-overdose intervention programs, syringe services programs, and family intervention programs.</p>	18	0	4	7
<p>The Commonwealth should establish standards of medical care for patients who are committed under Section 35.</p>	18	0	4	7
<p>The Commonwealth should ensure continuity of care post-discharge between Section 35 facilities and community-based facilities.</p>	18	0	4	7
<p>The Commonwealth, in conjunction with the research community and other relevant stakeholders, should define and collect the necessary data to determine the effectiveness of the current Section 35 process as it relates to relapse, ongoing treatment and recovery within the next two years. EOHHS should seek appropriations, grants and other financing tools to conduct an in-depth multi-year study using best research practices. As part of the study, EOHHS should identify any successful initiatives or practices that support the recovery of people with a substance use disorder.</p>	18	0	4	7

Recommendations Proposed by Individual Members and Voted on June 27, 2019 (cont.)

Recommendation	In favor	Opposed	Abstained	Absent
The Commonwealth, in consultation with provider organizations, peer and family groups, legal advocates, other stakeholders, and academic experts in the field of evaluation of care of people with substance use disorder, should create a consistent set of required quality metrics that will be regularly, publicly reported on by every provider of care to a person civilly committed through the Section 35 process.	16	0	6	7
The Commonwealth, in consultation with provider organizations, peer and family groups, legal advocates and other stakeholders, should identify alternative pathways in addition to the current court-based process, to civilly-commit individuals for addiction treatment.	14	4	4	7
The Commonwealth should prohibit civilly-committed men from receiving treatment for addictions at any criminal justice facility, provided that the Commonwealth fund and/or procure vendor or state-operated beds in Western Massachusetts and other parts of the Commonwealth to offset on a one-to-one basis diminished bed capacity resulting from the prohibition on placing individuals in criminal justice settings.	13	1	8	7
If restraints are needed, they should be humane, and training should be provided to staff on proper usage.	12	0	10	7
The Legislature, in conjunction with EOHHS and in consultation with stakeholders, should (1) conduct an analysis of the benefits of, and any barriers to, creating a Section 35 process that models the Section 12 process found in MGL Chapter 123, and (2) develop and file legislation to implement this change.	12	5	5	7

Recommendations Proposed by Individual Members and Voted on June 27, 2019 (cont.)

Recommendation	In favor	Opposed	Abstained	Absent
The Commission should oppose a 72-hour involuntary civil commitment for substance use disorder without judicial involvement.	11	2	9	7
The use of Section 35 should be statutorily narrowed in two ways: (1) Section 35 should not be used for voluntary commitments; (2) Even for involuntary commitments Section 35 should be rewritten so that it is available only in cases in which it is clear that the subject individual is in danger of causing severe immediate harm to self or others or loss of life above and beyond the harms that are routinely attendant upon the abuse of substances, such as death by overdose.	9	1	12	7
The Section 35 process should be amended to provide adequate time for the presentation of independent medical testimony by the respondent.	8	1	13	7
The Commonwealth should “commence a process with the goal to reduce and/or eliminate the use of Section 35,” as there is insufficient evidence of its efficacy to justify deprivation of individuals’ civil liberties. Demographic data suggests significant racial and ethnic disparities in the use of Section 35.	6	3	13	7

Recommendations Proposed by Individual Members and Voted on June 27, 2019 (cont.)

Recommendation	In favor	Opposed	Abstained	Absent
Nurse practitioners should be allowed to file Section 35 petitions.	4	7	11	7
The Legislature should amend the law to allow for correctional facilities to become licensed by DPH and/or DMH to provide addiction treatment services. In the case of dual status individuals, it would make sense to be able to provide services for addiction simultaneously to the path and time of ongoing criminal cases. While the current system may need improvement a complete ban on Section 35 commitment in correctional settings is not ideal either.	2	10	10	7
The Commonwealth should create a process where the Trial Court "On Call Judge" be incorporated into the current process of civil commitment to address the expiring nature of apprehension warrants and the limited ability of law enforcement in locating individuals during the courts regular business hours. Additionally, a preliminary request for commitment could be approved that could bridge the gap until a full hearing could be conducted.	1	11	10	7
The Legislature should authorize the short-term hospitalization of patients with a substance use disorder under Chapter 123 S. 12. The legislative change would amend Chapter 123 S. 12 to include "a person who represents a likelihood of serious harm by reason of a substance use disorder."	1	15	6	7

Section 35 Commitment Criteria

Under Section 35, in order for an individual, referred to as the “respondent,” to be involuntarily committed, the courts must find that the individual meets the following two criteria:

1. The respondent has an alcohol or substance use disorder, as defined in G.L. c. 123, Section 35, and
2. There is a likelihood of serious harm, as defined in G.L. c. 123, Section 1 and through case law, as a result of the respondent’s alcoholism or substance use disorder, to the respondent, the petitioner, or any other person.

G.L. c. 123, Section 35

“Alcohol use disorder,” the chronic or habitual consumption of alcoholic beverages by a person to the extent that (1) such use substantially injures the person’s health or substantially interferes with the person’s social or economic functioning, or (2) the person has lost the power of self-control over the use of such beverages.

“Substance use disorder,” the chronic or habitual consumption or ingestion of controlled substances or intentional inhalation of toxic vapors by a person to the extent that: (i) such use substantially injures the person’s health or substantially interferes with the person’s social or economic functioning; or (ii) the person has lost the power of self-control over the use of such controlled substances or toxic vapors.

G.L. c. 123, Section 1

“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; (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.¹

¹ *Matter of G.P.*, 473 Mass. 112, 120, 40 N.E. 3d 989 (2015); *Matter of A.M.*, 94 Mass. App. Ct. 399 (2018); see also District Court Standards of Judicial Practice, Civil Commitment and Authorization of Medical Treatment for Mental Illness (revised April 2019).

Overview of Section 35 Process

Under Section 35, a spouse, immediate family member, police officer, physician, or court official who believes that an individual has an alcohol or substance use disorder and is at risk of serious harm to themselves or others as a result of their alcohol or substance use disorder may file a petition for civil commitment.

Process to file a petition for commitment¹

- Petitions for commitment under Section 35 may be filed in District, Boston Municipal, or Juvenile Courts and are heard by judges during regular business hours, Monday through Friday (See Appendix E for copies of Trial Court forms).
- In the written petition, signed under the penalties of perjury, the petitioner must provide detailed information documenting that the respondent has an alcohol or substance use disorder and is at risk of serious harm as a result of their addiction.
- A judge will review the submitted facts and decide whether to issue either a summons for the respondent to appear before the court or a warrant of apprehension if there are reasonable grounds to believe that they will not appear voluntarily or that a delay in the proceedings would present an immediate danger to the physical well-being of the respondent.
- If summonsed, the respondent will receive an order to appear in court before a judge. If a warrant is issued, police officers will attempt to locate the person, take the person into custody, and deliver the person to the court for a commitment hearing.
- Warrants of apprehension are valid for up to five consecutive days, excluding Saturdays, Sundays, and legal holidays, or until the person appears in court, whichever occurs first. After five days, the warrant “sunset” and must be renewed.
- If the judge determines that the case should be heard in another Division or Department, e.g., due to the respondent's age, location, or for other good reasons, the judge may make the warrant or summons returnable to an appropriate court in another Division or Department.

¹ See Trial Court Rule XIII: Uniform Trial Court Rules for Civil Commitment Proceedings for Alcohol and Substance Use Disorders G. L. c.123 s.35

Overview of Section 35 Process (cont.)

Commitment hearing process¹

- The respondent has the right to counsel and the right to present evidence, including independent medical testimony. If the respondent is not represented by counsel, the court may provide counsel.
- Under Rule 9 of the Uniform Trial Court Rules for Civil Commitment Proceedings for Alcohol and Substance Use Disorders G. L. c.123 s.35 the respondent may be handcuffed or shackled throughout the commitment hearing process.
- The court orders an examination by a qualified physician, psychologist, or social worker. This examination is done by a Department of Mental Health (DMH) court clinician. The clinician conducts an assessment to determine whether the individual has an alcohol or substance use disorder and whether there is a likelihood of serious harm as a result of the person's substance use disorder.
- During the hearing, the court may also hear from other interested parties such as the respondent's family.
- After hearing testimony and reviewing the clinical assessment and any evidence presented, the judge will decide whether: (1) there is clear and convincing evidence that the respondent has an alcohol or substance use disorder and (2) there is a likelihood of serious harm to themselves or others as a result of their addiction. If only one of the two criteria are met, the respondent will be released. If the judge determines that both requirements are met, the judge grants the petition and orders the commitment.
- A commitment order is then signed by the judge, committing the respondent to an approved treatment facility. (See Slide 13 for a detailed list of Section 35 treatment facilities).
- After the hearing, the respondent will be returned to a holding cell to await transportation by the local sheriff's department to the commitment facility. Transportation often does not occur until after the courts close, so the respondent may wait several hours depending on what time the hearing was held.
- The respondent is handcuffed and shackled and transported to the treatment facility by the sheriff's department. On occasion, civilly committed individuals are transported in the same vehicle as others facing criminal charges, although they may be placed in separate compartments.

¹ See Trial Court Rule XIII: Uniform Trial Court Rules for Civil Commitment Proceedings for Alcohol and Substance Use Disorders G. L. c.123 s.35

Overview of Section 35 Process (cont.)

Intake, treatment and discharge

- Intake protocols vary across facilities. Upon arrival at a treatment facility, an individual's medical and mental health needs are assessed by a medical professional, including their need for detoxification.
- The length of time necessary for detoxification varies depending on the substance(s) used, the amount of use, the time since last use, and the individual's overall health. During this time, medical staff monitor the individual's health, overseeing the physical aspects of the withdrawal process.
- Once detoxification is complete, the individual receives clinical support services in the facility and works with counselors and case managers to learn more about addiction, sobriety, and strategies for preventing relapse. Generally, alcoholics anonymous and narcotics anonymous group sessions are also available.
- Practice varies by facility, medication-assisted treatment (MAT) may be offered as a complement to addiction counseling and other supports. (See Slide 15 for additional information about treatment options available at each facility.)
- Under the statute, a review of the necessity of the commitment shall take place by the superintendent of the facility on days 30, 45, 60, and 75, as long as the commitment continues. Individuals may be released prior to the expiration of the 90-day commitment period upon a written determination by the superintendent that release of the person will not result in a likelihood of serious harm.

Section 35 Facilities and Current Capacity

Oversight	Facility Name	Location	Population	Capacity
DPH	High Point Women's Addiction Treatment Center (WATC)	New Bedford, MA	Female	102 beds (30 ATS and 72 CSS) ⁴
	High Point Treatment Center at Shattuck Hospital (HPTC)	Jamaica Plain, MA	Female	32 beds (16 ATS and 16 CSS)
	High Point Men's Addiction Treatment Center (MATC)	Brockton, MA	Male	108 beds (32 ATS and 76 CSS)
DMH	DMH Women's Recovery from Addiction Program (WRAP)	Taunton, MA	Female	45 beds (15 ATS and 30 CSS) ⁵
DOC ¹	Massachusetts Alcohol and Substance Abuse Center (MASAC)	Plymouth, MA	Male	251 beds (42 ATS and 209 CSS)
	MCI – Framingham First Step Program ³	Framingham, MA	Female	N/A; dual status must have bail (ATS and CSS)
HCSD ²	Stonybrook Stabilization and Treatment Center – Ludlow	Ludlow, MA	Male	85 beds (ATS and CSS)
	Stonybrook Stabilization and Treatment Center – Springfield	Springfield, MA	Male	32 beds (CSS)

¹ Department of Correction (DOC)

² Hampden County Sheriff's Department (HCSD)

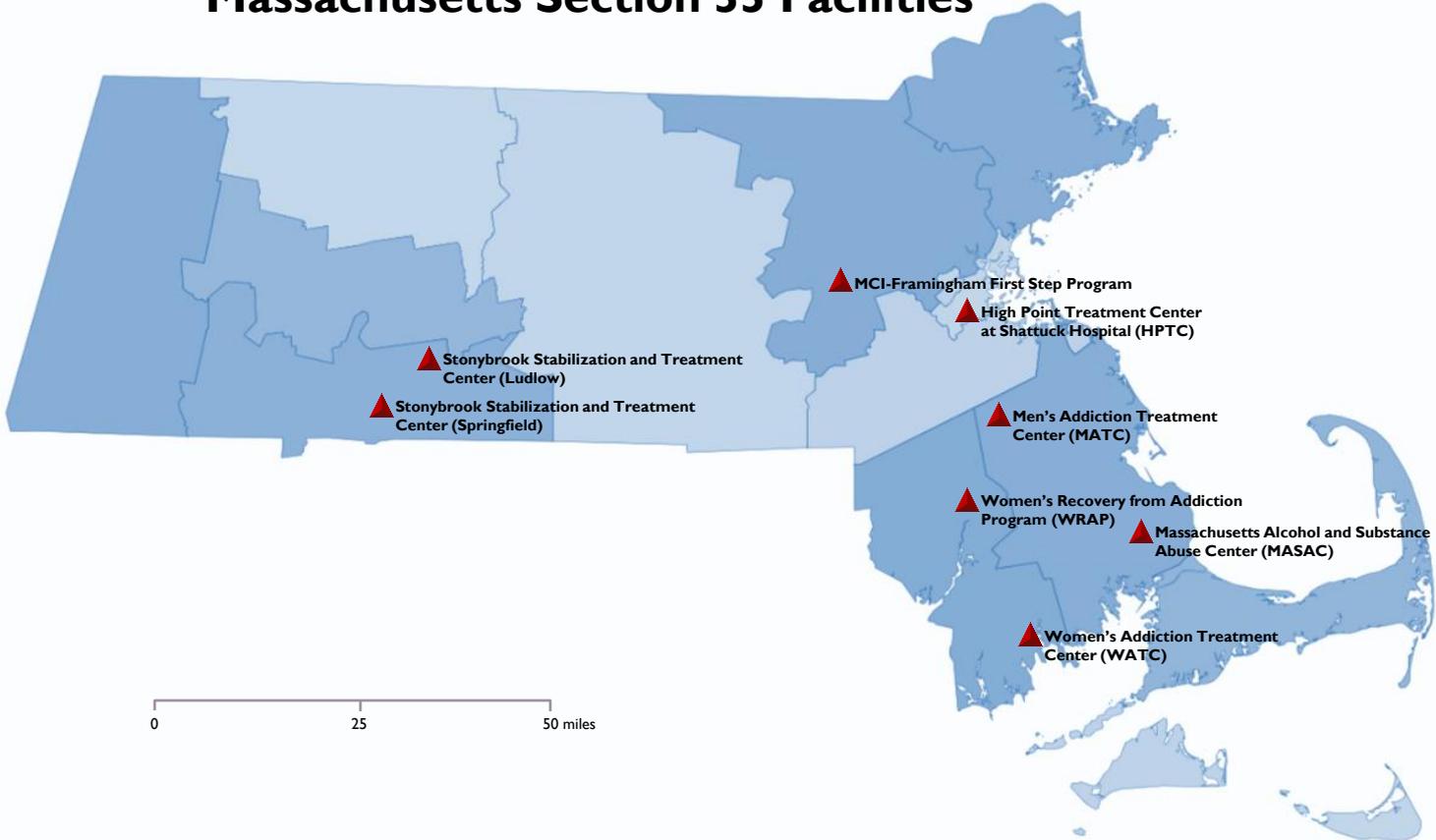
³ Female dual status commitments (civil commitment and bail set pursuant to a criminal case) are committed to the Massachusetts Correctional Institution (MCI) in Framingham, where they are housed in a separate unit from the general population and participate in a treatment program offered at the facility called "First Steps." If bail is paid, the individual is transferred to a different Section 35 facility for women.

⁴ Acute Treatment Services (ATS) and Clinical Stabilization Services (CSS) (See Appendix F for additional details)

⁵ In January 2016, Governor Baker signed Chapter 8 of the Acts of 2016 (<https://malegislature.gov/Laws/SessionLaws/Acts/2016/Chapter8>). Under this law, women who are civilly committed under Section 35 may no longer be sent to MCI-Framingham. To ensure the closure did not reduce the availability of treatment capacity for civilly committed women, EOHHS created the DMH WRAP 45 bed treatment program and a 32 bed treatment program at Shattuck Hospital. The WRAP is funded by a state appropriation to the Department of Mental Health.

Section 35 Facilities and Current Capacity (cont.)

Massachusetts Section 35 Facilities



Section 35 Facilities' Treatment Options and Length of Stay

* Information accurate as of June 19, 2019

Facility Name	Medication Options for Detoxification*	Options for Induction on MAT	Access to Counseling/ Group Therapy	Discharge Planning/ Aftercare	Avg. Length of Stay
High Point Women's Addiction Treatment Center (WATC)	<ul style="list-style-type: none"> • Methadone • Buprenorphine • Additional medications (Clonidine, Chlordiazepoxide, Oxazepam, Phenobarbital) 	<ul style="list-style-type: none"> • Methadone • Buprenorphine • Naltrexone (oral & inject.) • Baclofen 	<p><u>ATS</u></p> <ul style="list-style-type: none"> • 4 hours/day of psycho-educational group sessions • 4 hours/week of group self help sessions <p><u>CSS</u></p> <ul style="list-style-type: none"> • 3 hours/week of individualized clinical counseling • 1.5 hours/week with care coordinators • 10 hours/week of group therapy • 15/week psycho-educational group sessions • Access to AA/NA 	<ul style="list-style-type: none"> • Individualized aftercare plans developed with Aftercare Coordinator • May include medical and psychiatric appointments • Referrals to community-based case management, SUD services, and MAT providers • May include Recovery Coaches, Recovery Support Navigators, Behavioral Health Community Partners 	• 20 days (FY 2018)
High Point Treatment Center (HPTC) at Shattuck Hospital					• 19 days (FY 2018)
High Point Men's Addiction Treatment Center (MATC)					• 23 days (FY 2018)
DMH Women's Recovery from Addiction Program (WRAP)	<ul style="list-style-type: none"> • Methadone • Buprenorphine • Additional medications (Chlordiazepoxide, Clonidine, Oxazepam, Phenobarbital) 	<ul style="list-style-type: none"> • Methadone • Buprenorphine • Naltrexone (oral & inject.) • Acamprosate • Disulfiram 	<ul style="list-style-type: none"> • 11-12 hours/day of individual counseling, psycho-educational group sessions, skill development, relapse prevention, and self-help • Access to AA/NA 	<ul style="list-style-type: none"> • Individualized aftercare plans developed with Aftercare staff • Includes medical and psychiatric appointments • Referrals to community-based case management services, MAT providers, and Recovery Coaches 	• 44 days (FY 2019 partial)
Massachusetts Alcohol and Substance Abuse Center (MASAC)*	<ul style="list-style-type: none"> • Buprenorphine • Additional medications (Chlordiazepoxide, Clonidine, Depakote, Levetiracetam, Lorazepam, Ondansetron, Promethazine, Ropinirole) 	<ul style="list-style-type: none"> • Buprenorphine • Naltrexone (inject.) 	<ul style="list-style-type: none"> • 1.5 hours/week individual case management planning • 1 hour/week of group therapy • 16 hours/week of group education • Access to peer-led support groups (AA/NA) 	<ul style="list-style-type: none"> • Individualized aftercare plans developed with Substance Abuse Programming staff. • Includes medical and psychiatric appointments • Referrals to community-based case management services, MAT providers, and Recovery Pathfinders, based on client interest 	• 39 days (FY 2019 partial)
MCI – Framingham First Step Program*	<ul style="list-style-type: none"> • Methadone (for pregnant maintenance and postpartum taper) • Buprenorphine • Additional medications (Chlordiazepoxide, Clonidine, Depakote, Levetiracetam, Lorazepam, Ondansetron, Promethazine, Ropinirole) 	<ul style="list-style-type: none"> • Methadone (for pregnant maintenance and postpartum taper) • Buprenorphine • Naltrexone (oral & inject.) 	<ul style="list-style-type: none"> • 30 minutes/week individual counseling • 2.5 hours/day (Mon-Thurs) of group therapy • 2 hours/day (Fri) of group counseling and self help sessions 	<ul style="list-style-type: none"> • Aftercare plans developed with counselors during weekly meetings • Counselors may facilitate arrangements for community-based care • Due to dual status, majority of civil commitments are transferred to awaiting trial status or WATC if bail is posted. 	• 34 days (FY 2019 partial)
Stonybrook Stabilization and Treatment Center – Ludlow	<ul style="list-style-type: none"> • Buprenorphine • Chlordiazepoxide 	<ul style="list-style-type: none"> • Buprenorphine • Naltrexone (oral & inject.) 	<ul style="list-style-type: none"> • 32 hours/week of group and individual counseling • Access to AA/NA 	<ul style="list-style-type: none"> • Individualized aftercare plans developed with Aftercare staff • Includes medical and psychiatric appointments • Referrals to community-based case management services, MAT providers, and Recovery Coaches and/or Recovery Pathfinders 	• 49 days (FY 2019 partial)
Stonybrook Stabilization and Treatment Center – Springfield	• N/A		<ul style="list-style-type: none"> • 32 hours/week of group and individual counseling • Access to AA/NA • 15 hours/week of intensive outpatient services through Providence Hospital 		

Section 35 Discharge Data

Facility Name	Discharge Data	
High Point Women's Addiction Treatment Center	<p><u>FY 2018</u></p> <ul style="list-style-type: none"> • Home (alone, family, community organization): 74.6% • Residential program (CSS, TSS, sober home): 24.3% • Opioid treatment (MAT): 12.0% • Acute medical facility: 6.1% • Other: 6% • AMA: 4.9% • Shelter: 2.0% 	<p><u>Notes:</u></p> <ul style="list-style-type: none"> • Up to three referrals may be listed for each discharged individual, but majority (70%) of discharged individuals only listed a single referral.
High Point Treatment Center at Shattuck Hospital		
High Point Men's Addiction Treatment Center		
DMH Women's Recovery from Addiction Program	<p><u>FY 2018</u></p> <ul style="list-style-type: none"> • Home (alone, family, non-family): 69.1% • Residential program: 18.0% • Shelter: 6.3% • Acute medical facility: 4.1% • State operated mental health center: 1.2% • Court: 0.7% • Respite: 0.2% • AMA: 0.2% 	
Massachusetts Alcohol and Substance Abuse Center	<p><u>FY 2019 (partial)</u></p> <ul style="list-style-type: none"> • Referrals for self help (AA/NA): 44.5% • Referrals for intensive outpatient services: 24.6% • Home (alone, family, non-family): 24.0% • Referrals for mental health services: 15.6% • Shelter: 14.5% • Residential program: 12.9% • Court: 10.4% • Acute medical facility: 2.7% 	<p><u>Notes:</u></p> <ul style="list-style-type: none"> • Acute medical facility data includes commitments under Section 12 and medical releases to hospitals.
MCI – Framingham First Step Program	<p><u>FY 2018</u></p> <ul style="list-style-type: none"> • Awaiting trial: 20 • Court: 17 • Released to criminal sentence: 2 • State operated mental health facility: 1 • Home, Residential program, Shelter, Acute Medical Facility: 0 	<p><u>Notes:</u></p> <ul style="list-style-type: none"> • Total number of commitments, not percentages. • Due to dual commitment status, civil commitments are not released directly to the street from facility; all are released either through court or to their awaiting trial status.
Stonybrook Stabilization and Treatment Center – Ludlow	<p><u>FY 2019 (partial)</u></p> <ul style="list-style-type: none"> • Home (alone, family, non-family): 43.7% • Residential program, Foundation House, TSS, CSS: 20.9% • Court: 11.0% • Transferred back to MASAC: 9.3% • Shelter: 7.3% • Transferred to other HOC (various counties): 2.4% • Medical rescission: 1.2% • Other agency: 0.8% • Nursing home: 0.6% • Section 12: 0.4% 	<p><u>Notes:</u></p> <ul style="list-style-type: none"> • Out of 551 total discharges, 89% (492) were tracked with confidence. Additional discharge data for remaining 59 releases is being validated and will be incorporated. • Patients transferred back to MASAC included non-Western MA clients with open cases.
Stonybrook Stabilization and Treatment Center – Springfield		

Section 35 Commitment Data

In FY 2018:

- 10,770 petitions for civil commitment under Section 35 were filed in Massachusetts courts.¹
- 32.5% (3,503) were not heard and did not proceed as a Section 35 commitment.^{2,3}
- 67.5% (7,267) moved forward, resulting in an order for an in-court evaluation by court clinicians.
- Overall, 83.2% (6,048 of 7,267) of all petitions heard resulted in commitment to a Section 35 treatment facility.

Section 35 Commitment Data, FY 2011-2018 ²								
Section 35 Data	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Number of petitions for civil commitment filed in MA courts	6,105	7,129	7,358	7,773	8,371	10,040	10,917	10,770
Number of petitions filed in MA courts that were not heard	859	1,017	1,776	2,004	2,034	2,647	3,403	3,503
Number of Section 35 evaluations by court clinicians	5,246	6,112	5,582	5,769	6,337	7,393	7,514	7,267
Number of commitments to a Section 35 treatment facility	4,103	4,984	4,790	4,890	5,363	6,337	6,338	6,048

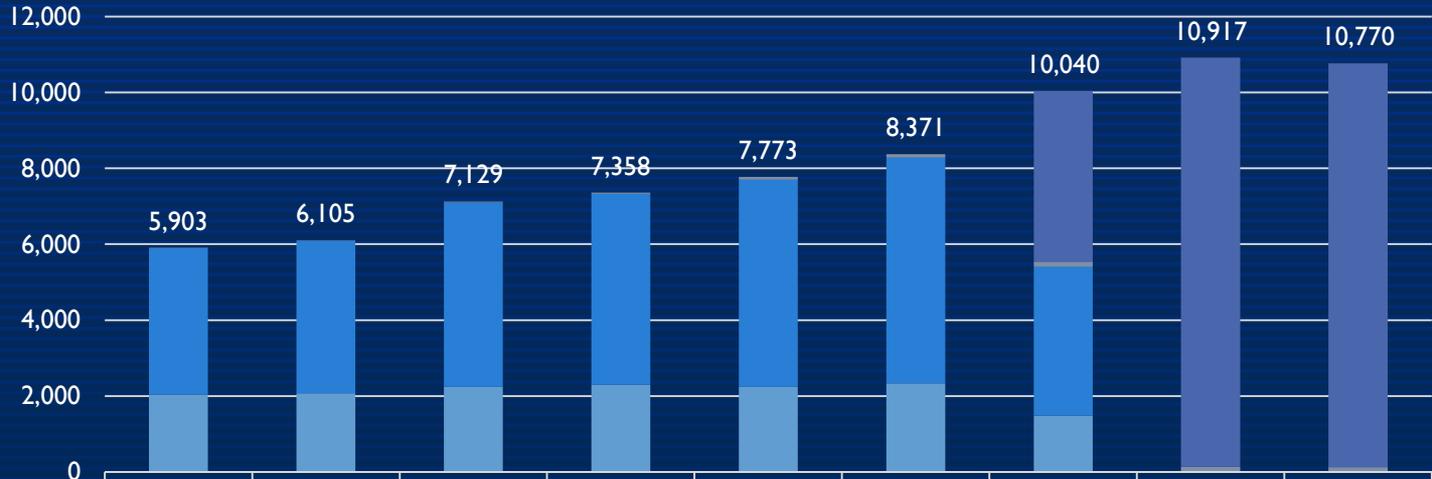
¹ Massachusetts Trial Court data

² DMH Court Clinic data

³ Examples of reasons for cases not to proceed as a Section 35 commitment include an advancement of criminal proceedings, inability of police to locate the respondent, and hospitalization or detainment elsewhere.

Section 35 Commitment Data (cont.)

**District and Boston Municipal Court Departments
Chapter 123, Section 35 Case Filings, FY2010 to FY2018**



	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
Total	5,903	6,105	7,129	7,358	7,773	8,371	10,040	10,917	10,770
■ Unspecified	0	0	0	0	0	0	4,509	10,781	10,642
■ Juveniles	3	9	25	31	70	93	125	136	128
■ Adult Drug Abuse	3,858	4,019	4,865	5,022	5,457	5,944	3,919		
■ Adult Alcohol Abuse	2,042	2,077	2,239	2,305	2,246	2,334	1,487		

Source: Massachusetts Trial Court data

Section 35 Commitment Data (cont.)

- In May 2019, the Committee for Public Council Services (CPCS) conducted an informal, online survey of 269 CPCS attorneys that handle Section 35 petitions. The informal survey suggests that a portion of Section 35 commitments are unopposed by the respondent.*
- 94% of attorneys surveyed acknowledged representing a client who was not objecting to the Section 35 petition.
- Of those, 24% indicated that over a third of their clients did not object to the Section 35 petition.
 - When representing a client who was NOT objecting to the Section 35 petition:
 - 47% of attorneys indicated that while in court, the respondent was restrained and held in the same lock up as criminal defendants.
 - 27% of attorneys indicated that the respondent was allowed to remain in court without restraint.
 - 81% of attorneys indicated that the wait for a hearing is between 1-3 hours.

* The complete survey results can be found at: <https://www.mass.gov/files/documents/2019/06/28/CPCS%20Survey%20May%202019.pdf>

Section 35 Demographic Data

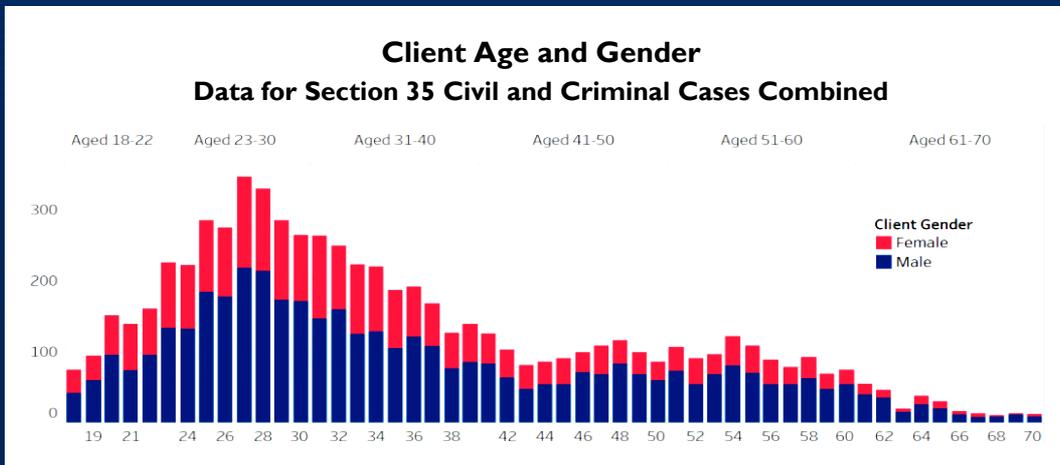
DMH Adult Court Clinic Data (FY 2018)¹

Race (N = 6,982)	
White (non-Hispanic)	84.2%
White (Hispanic)	1.7%
Black or African-American (non-Hispanic)	6.3%
Black or African-American (Hispanic)	0.1%
Asian	0.44%
American Indian or Alaska Native	0.1%
Native Hawaiian or Other Pacific Islander	0.01%
Two or More Races	1.3%
Declined	6%

Area	
Central	2,600
Southeast	1,731
Northeast	1,060
Western	946
Boston	472

Housing Status	
Homeless	22.8%

County	
Homeless ²	1,654
Middlesex	835
Bristol	705
Worcester	631
Hampden	607
Plymouth	519
Suffolk	416
Essex	391
Norfolk	383
Barnstable	268
Berkshire	138
Hampshire	99
Franklin	72
Dukes	11
Nantucket	6



¹ Totals may not reflect all client demographic data due to incomplete data reporting at time of court clinic evaluation.

² County of residence for homeless respondents not recorded.

Research on Outcomes Following Involuntary Commitment

The Commission is charged with reviewing medical literature and expert opinions on the long-term relapse rates of individuals diagnosed with a substance use disorder following involuntary inpatient treatment, including:

- 1) the differences in outcomes for coerced and non-coerced patients,*
- 2) any potential increased risk of an individual suffering a fatal overdose following a period of involuntary treatment,*
- 7) the effectiveness of the existing involuntary commitment procedures pursuant to Section 35 of Chapter 123 of the General Laws at reducing long-term relapse rates.*

- There is limited quality, peer-reviewed research on the efficacy of involuntary treatment for alcohol and substance use disorders. The limited research that exists generally relies upon observational data of previously incarcerated populations. Variations across study conditions make comparisons difficult. Moreover, findings related to observations about compulsory treatment in the criminal justice context cannot be generally extrapolated to civilly committed individuals because the coercive factors at play are different.
- A 2016 review by Werb et al.¹ of nine quantitative studies looked at whether compulsory drug treatment results in decreased drug use or a decrease in criminal recidivism. Of the nine quantitative studies, four were from Southeast Asia, four were from North America and one was from Western Europe. Across the nine studies, a range of compulsory treatment settings including drug detention facilities, short (i.e., 21-day) and long-term (i.e., 6 months) inpatient treatment, community-based treatment, group-based outpatient treatment, and prison-based treatment were evaluated.

¹ Werb et al. (2016). The effectiveness of compulsory drug treatment: A systematic review. *International Journal of Drug Policy*, 28:1-9. <https://www.ncbi.nlm.nih.gov/pubmed/26790691>

Research on Outcomes Following Involuntary Commitment (cont.)

- The analysis by Werb et al. concluded that while limited literature exists, the majority of studies evaluating compulsory treatment failed to detect any significant positive impacts on drug use or criminal recidivism over other approaches, with two studies detecting negative impacts of compulsory treatment on criminal recidivism compared with control arms.
- Werb et al. further found, only two studies observed positive impact of long-term compulsory inpatient treatment on criminal recidivism: one reported a small effect size on recidivism after two years, and one found a lower risk of drug use within one week of release from compulsory treatment.
- Werb et al. further concluded that in light of the potential for human rights violations that were reported in some of the studies (i.e. forced labor, physical and sexual abuse) within compulsory treatment settings, the results of this systematic review did not, on the whole, suggest improved outcomes in reducing drug use and criminal recidivism among drug-dependent individuals.
- Rafful et al.¹ also noted that few studies have examined the relationship between drug treatment (either voluntary or involuntary) and non-fatal overdose.

¹ Rafful et al. (2018). Increased non-fatal overdose risk associated with involuntary drug treatment in a longitudinal study with people who inject drugs. *Addiction*, 113(6): 1056-1063. <https://www.ncbi.nlm.nih.gov/pubmed/29333664>.

Research on Outcomes Following Involuntary Commitment (cont.)

- In Massachusetts, the availability of outcome data for patients following periods of involuntary commitment has been limited. The most recent analysis of outcome data related to involuntary and voluntary commitments was published by DPH in 2016, *An Assessment of Opioid-related Deaths in Massachusetts (2013–2014)*.¹
- The DPH report acknowledges that data from only two Section 35 treatment facilities (WATC, MATC) over a limited time period were utilized for the analyses. This was a crude analysis, meaning it did not account for all factors that may have contributed to opioid-related overdose deaths. In the report, DPH recommends additional analysis be conducted to better understand the underlying risk factors that impact patient outcomes following a period of involuntary treatment.
- Direct comparisons of treatment outcomes for individuals who have undergone involuntary and voluntary treatment is challenging, as characteristics of those not seeking treatment for addiction are inherently different than those who have chosen to seek help through either inpatient or outpatient treatment settings. Patients who are committed for treatment under Section 35 are among the most ill, most complex and at the greatest risk for an overdose.
- If the Commonwealth wants to examine the effectiveness of Section 35, additional datasets would need to be compiled and linked over an extended period of time. This work would be extensive. Due to the significant changes to the treatment environment over the past five years, careful thought would need to be given to study design. This first of its kind analysis would need to be conducted in a way that addresses potential biases and other limitations inherent to this kind of study.

¹ DPH Chapter 55 report (<https://www.mass.gov/files/documents/2016/09/pg/chapter-55-report.pdf>)

Detoxification Prior to Induction on Medication-assisted Treatment

The Commission is charged with reviewing medical literature and expert opinions on the length of time necessary for detoxification of opioids and recommended time following detoxification to begin medication-assisted treatment

For the Commission’s November 5, 2018 meeting, Alexander Y. Walley, MD, MSc, Colleen LaBelle, MSN, RN-BC, CARN, and Maria Sullivan, MD, PhD were invited to present on this topic; a summary of their presentations appears in the table below.

MAT Option	Abstinence Required?	Dosing Schedule	Required Training/Regulation
Methadone	No, but recommended to initiate with low dose and titrate based on patient’s response ¹	Daily clinic administered ¹	Licensed OTP clinic only ¹
Buprenorphine	12 hours ¹	Daily pharmacy prescription ¹	8 hour training for MD/DO 24 hour training for NP/PA ¹
Naltrexone (extended-release injectable) (Vivitrol)	7-10 days ²	Every 4 weeks; administered by a health care provider as an intramuscular gluteal injection ²	None ¹
Naltrexone (oral)	7-10 days ¹	Daily pharmacy prescription ¹	None ¹

¹ Dr. Walley’s presentation <https://www.mass.gov/files/documents/2018/11/16/Section%2035%20PPT%20Walley%2011.5.pdf>

² Dr. Sullivan’s presentation <https://www.mass.gov/files/documents/2018/11/16/Section%2035%20PPT%20Sullivan%2011.5.pdf>

Legal Implications of an Alternative Path for Involuntary Treatment

The Commission is charged with reviewing the 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

- A draft memorandum was prepared by the Office of DMH General Counsel and shared with a sub-group of the Commission on May 7, 2019. Limited edits were offered, all of which were incorporated. An updated version of the memorandum was shared with the entire Commission on May 17, 2019. An email from the ACLU, in response to the memorandum, is also attached to the final document. See Appendix G.
 - The memorandum concludes that there is no legal impediment; the Massachusetts Legislature may permit a qualified clinician to authorize short-term emergency hospitalizations 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. The memorandum notes that such an amendment should include similar due process protections that apply to commitments made under Section 12. A full copy of the memorandum is available in Appendix G, as well as the [Section 35 Commission's webpage](#).
- A memorandum drafted by the Committee for Public Counsel Services (CPCS) was submitted to the Commission on May 23, 2019.
 - The memorandum acknowledges that the Legislature could authorize short-term emergency hospitalizations without judicial involvement. However, the memorandum outlines constitutional, procedural and practical concerns with the current commitment process under M.G.L. c. 123, § 12. Specifically, the lack of a statutory limit on the length of time a person can be detained while waiting for admission to a mental health facility and the lack of judicial review for the short-term emergency hospitalization in the emergency department. Given these concerns, the memorandum cautions against grafting section 12 (a) and 12 (b) onto Section 35. A full copy of the memorandum is available in Appendix H, as well as the [Section 35 Commission's webpage](#).
- During the May 23 meeting, during the discussion of the two memoranda, several Commission members raised practical concerns regarding implementation of a non-court involved alternative pathway to involuntary treatment, similar to the process outlined in Section 12 of Chapter 123 of the General Laws. (See <https://www.mass.gov/lists/section-35-commission-meeting-minutes>) Two members also raised that procedural and substantive due process questions had never been litigated with respect to Section 12, and noted they had substantive due process concerns with the existing Section 12 process and the proposed addition of short-term emergency hospitalizations without judicial involvement for individuals with a substance use disorder.

Current Treatment Capacity

The Commission is charged with reviewing:

- 5) whether the current capacity, including acute treatment services, clinical stabilization services, transitional support services and recovery homes, is sufficient to treat individuals seeking voluntary treatment for substance use disorder,*
- 6) the availability of other treatments for substance use disorder, including those treatments used in less restrictive settings*

- Since 2015, treatment capacity has significantly increased. (See chart on following slide for additional details.)
- Chapter 208 of the Acts of 2018 required acute care hospitals that provide emergency services within an emergency department and satellite emergency facilities to have the capacity to initiate opioid agonist therapy to patients that present after an opioid-related overdose. The patient must also be directly connected to continuing treatment prior to discharge.
- The Massachusetts Helpline is a statewide public resource for finding licensed and approved substance use treatment and recovery services. In 2018, it launched several new enhancements, including an online chat feature, real-time wait list management system for use by all DPH-funded residential treatment programs, and a Spanish version of the Helpline website. (<https://helplinema.org>)
- Massachusetts Behavioral Health Access (MABHA), administered by the Massachusetts Behavioral Health Partnership, helps providers and members locate openings in mental health and substance use treatment services. (<https://www.mabhaccess.com>)
- Learn to Cope is a statewide family support organization. (<https://www.learn2cope.org>)

Behavioral Health Treatment Capacity

Adult Behavioral Health Inpatient Beds	Licensed Capacity as of January 1, 2015	Licensed Capacity as of May 1, 2019	Change
DPH Acute Treatment Services (ATS) (level 4.0 & 3.7)	846 beds	173 beds (4.0) 1,033 beds (3.7)	360 beds
DPH Clinical Stabilization Services (CSS)	297 beds	819 beds	522 beds
DPH Transitional Support Services (TSS)	339 beds	382 beds	43 beds
DPH Adult Residential Recovery Services (RRS)	2,300 beds	2,324 beds ¹	24 beds
DPH Co-occurring Enhanced Adult Residential Programs ²	N/A	50 beds	50 beds
DPH Second Offender Residential Program	58 beds	58 beds	0
DPH Adolescent / Transitional Youth Residential Beds	144 beds	101 beds	(43 beds)
Section 35 Men's Beds	258 beds	476 beds	218 beds
Section 35 Women's Beds	90 beds	179 beds	89 beds
Youth Behavioral Health Inpatient Beds			
DPH Youth Stabilization Beds	48 beds	48 beds	0
DPH Family Residential	110 families	112 families	2 families
Outpatient Substance Use Disorder Programs			
DPH Outpatient Treatment Program (OTP) – MAT Programs (methadone)	39 programs	43 programs	4 programs
DPH Outpatient Counseling and Outpatient Detoxification Programs	190 programs	245 outpatient counseling 1 outpatient detox	56 programs
DPH Office-Based Outpatient Treatment (OBOT) (buprenorphine) – MAT sites funded by DPH	14 programs	33 licensed 32 funded	51 programs
Sober Homes			
Sober Homes Certified by the Massachusetts Alliance for Sober Housing	0	186 homes (2,579 beds)	186 homes (2,579 beds)
Recovery Support			
Recovery Centers	10 centers	18 centers	8 centers

¹ These numbers reflect total licensed capacity. In 2017, RRS became a covered benefit under MassHealth. This significantly increased access to this level of care for MassHealth members.

² This new level of care is a covered benefit under MassHealth and DPH has contracted with 26 providers as the payer of last resort. Approximately 350 additional beds are projected to open by the end of FY 2022. More info at: <https://www.mass.gov/news/baker-polito-administration-to-fund-26-new-programs-to-help-people-with-substance-use-and>

Treatment for Individuals Committed Under Section 35 in Western Massachusetts

- The Hampden County Sheriff's Department developed a Section 35 treatment program in Western Massachusetts. The commission heard more positive comments about the program run by the Hampden County Sheriff than about MASAC.
- A procurement for Section 35 treatment beds for men has not been released since FY 2007. A procurement for Section 35 treatment beds for women has not been released since 2006.^{1,2}
- This Commission issued a request for information to identify vendors with potential interest in operating a secure treatment center for individuals committed under Section 35 in Western and Central Massachusetts.
- Seven responses were received. Six of those responses indicated an interest in providing treatment for individuals committed under Section 35 in Western and Central Massachusetts. For more details, see Appendix I.

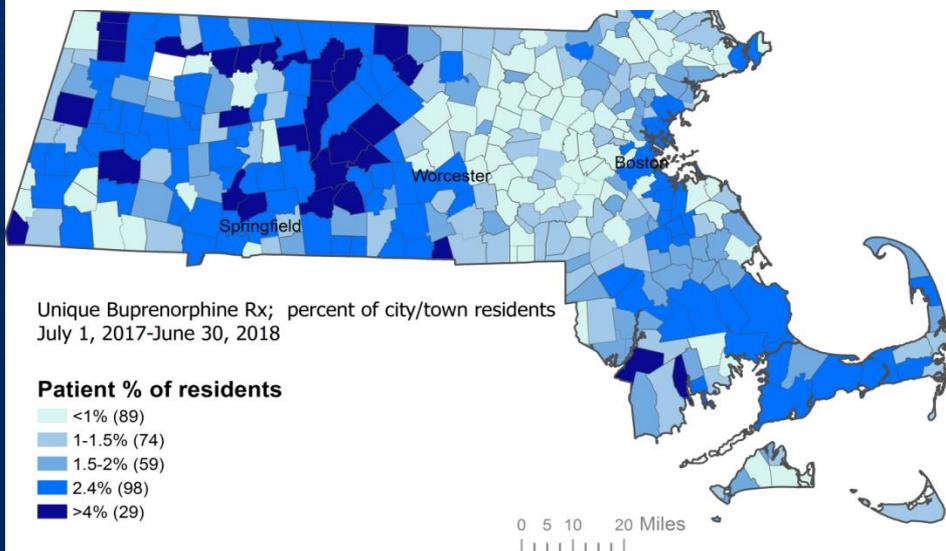
¹ See COMMBUYS: (S104135-vCurrent) Statewide Treatment Center for Civilly-Committed Women and (S107833-vCurrent) Substance Abuse Treatment for Civilly Committed Men.

² A procurement for Acute Treatment Service beds to provide treatment for individuals who are voluntarily seeking treatment was issued in December, 2016. As part of this procurement, the Department of Public Health attempted to identify providers who provide voluntary treatment in a setting that also could meet the security requirements necessary to provide involuntary treatment. The Department was attempting to identify providers that could accept Section 35 transfers from another Section 35 facility if existing Section 35 treatment beds were full. No provider indicated that they had this type of dual capacity.

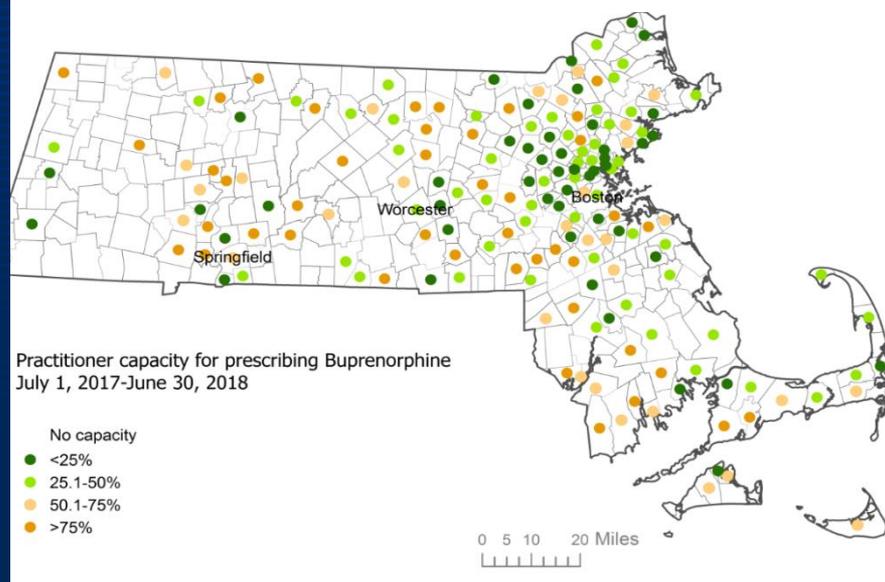
Access to Buprenorphine

- Chapter 208 of the Acts of 2018, requires acute care hospitals to have the capacity to initiate opioid agonist therapy to patients that present after an opioid-related overdose. The patient must also be directly connected to continuing treatment prior to discharge.
- The Massachusetts Health and Hospital Association (MHA) worked in collaboration with the Massachusetts College of Emergency Physicians (MACEP) to develop guidelines for administering MAT for opioid use disorder within the emergency department. The guidance primarily focuses on the prescription and administration of buprenorphine.¹

Percentage of MA City/Town Residents Receiving Buprenorphine Medications²



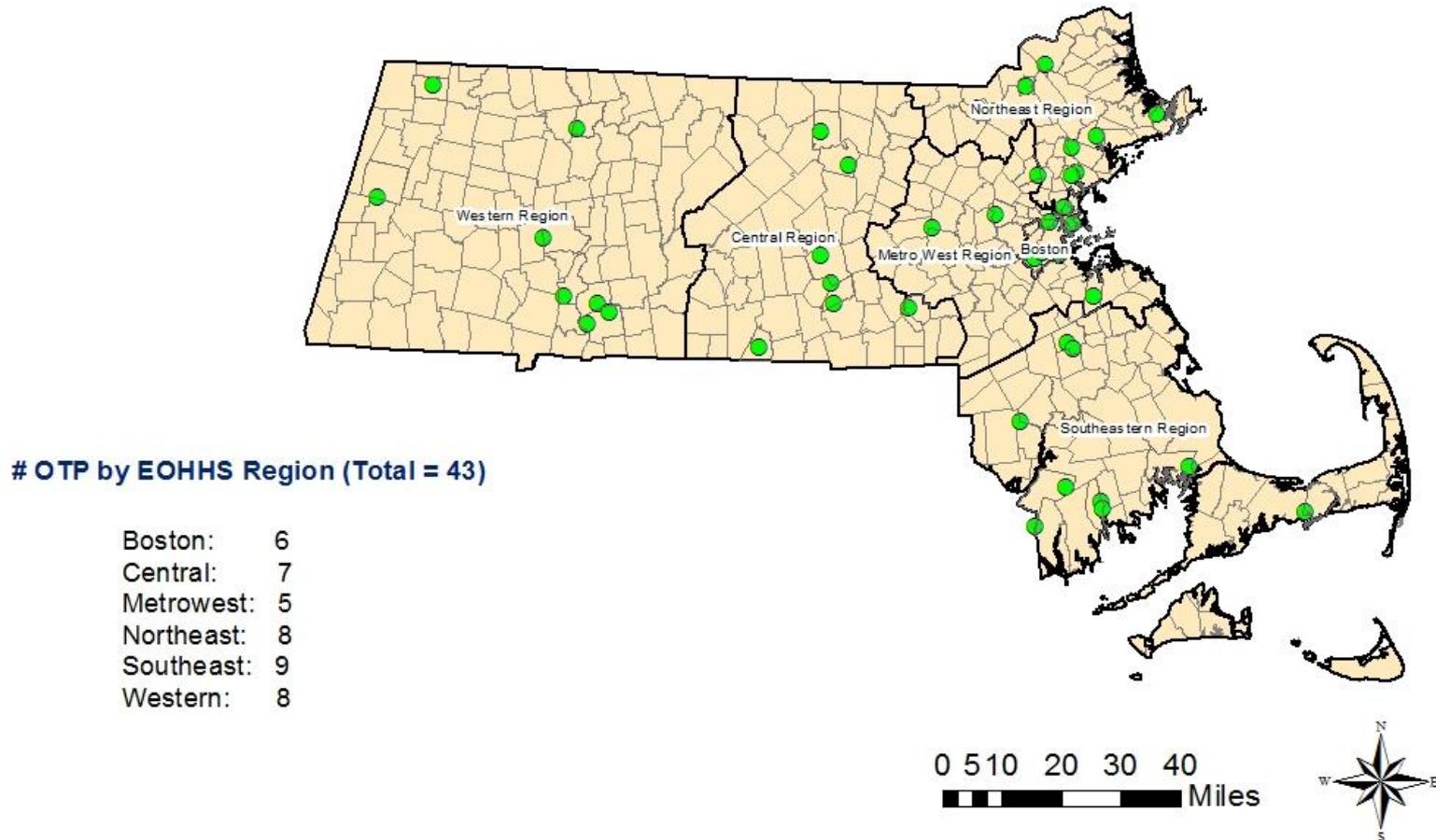
Practitioner DATA Waivers (by City/Town FY18)²



¹ Latest version available on PatientCareLink (<https://patientcarelink.org/improving-patient-care/substance-use-disorder-prevention-treatment-2/>)

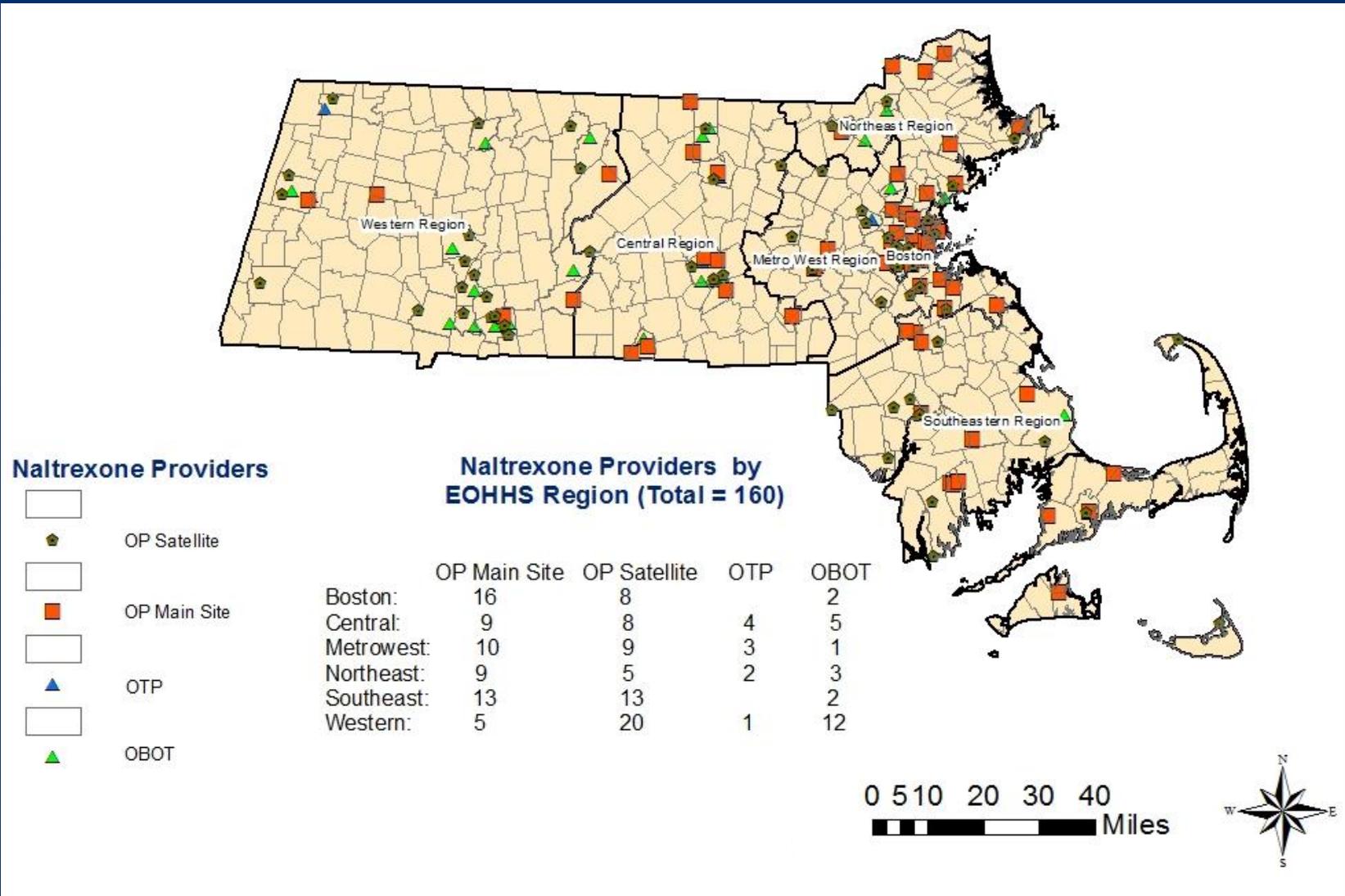
² Source: DPH 2019 (<https://www.mass.gov/files/documents/2019/06/28/BSAS%20Buprenorphine%20provider%20capacity%205-21.pdf>)

Access to Methadone – Locations of Opioid Treatment Programs



Locations as of June 1, 2019

Access to Naltrexone – Known Naltrexone Providers



Locations as of June 12, 2019

Standardization of Forms and Procedures

The Commission is charged with evaluating and developing a proposal for a consistent statewide standard for the medical review of individuals who are involuntarily committed due to an alcohol or substance use disorder pursuant to Section 35 of Chapter 123 of the General Laws, including, but not limited to, developing:

- 1) a proposed standardized form and criteria for releasing medical information for use in a commitment hearing under said Section 35 of said Chapter 123 that is in compliance with federal and state privacy requirements, and*
- 2) criteria and guidance to medical staff about filing a petition under said Section 35 of said Chapter 123*

- Massachusetts Health and Hospitals Association (MHA), working with a representative group of providers, developed a proposed set of materials to help standardize the process for submitting patients' medical information to the Courts for use during a Section 35 commitment hearing. Copies of the materials are available on the [Section 35 Commission's webpage](#) and include the following:
 - Affidavit letter issued by a physician that outlines the clinical support for the Section 35 petition. The affidavit letter would be attached to the existing Trial Court form: "Affidavit in Support of Petition for Commitment under G.L. c. 123, Section 35" (See Appendix E for copies of the Trial Court forms).
 - Checklist of supporting clinical information for use by hospitals and physicians that outlines the minimum information and supporting documentation that should be included along with the affidavit letter.
 - Privacy memorandum drafted by an outside counsel retained by MHA that outlines the federal and state legal protections that permit the disclosure of patients' medical information to the Courts for use during a Section 35 commitment hearing.
- Beginning in June 2019, MHA and DMH will coordinate to pilot the introduction of the affidavit and checklist with specific courts in the Commonwealth to ensure that the clinical information outlined in the documents is sufficient, whether additional information is needed to assist with care coordination during placement post-hearing, and to identify any potential gaps in the process.
- Following the pilot program, MHA will coordinate with the Trial Courts and DMH to host a statewide educational webinar for providers to review the materials and process and discuss best practices based on the pilot program. The session may be recorded for the benefit of new hospital staff to ensure continuous understanding of the new standardized process and materials.

Appendices

Appendix A – Legislative Mandate

CHAPTER 208, SECTION 104 OF THE ACTS OF 2018

There shall be a section 35 involuntary commitment commission to study the efficacy of involuntary inpatient treatment for non-court involved individuals diagnosed with substance use disorder. The commission shall:

- a) review medical literature and expert opinions on the long-term relapse rates of individuals diagnosed with substance use disorder following involuntary inpatient treatment including:
 - 1) the differences in outcomes for coerced and non-coerced patients
 - 2) any potential increased risk of an individual suffering a fatal overdose following a period of involuntary treatment,
 - 3) medical literature on length of time necessary for detoxification of opioids and recommended time following detoxification to begin medication-assisted treatment,
 - 4) the legal implications of holding a non-court involved individual who is diagnosed with substance use disorder but is no longer under the influence of substances,
 - 5) whether the current capacity, including acute treatment services, clinical stabilization services, transitional support services and recovery homes, is sufficient to treat individuals seeking voluntary treatment for substance use disorder
 - 6) the availability of other treatments for substance use disorder, including those treatments used in less restrictive settings, and
 - 7) the effectiveness of the existing involuntary commitment procedures pursuant to section 35 of chapter 123 of the General Laws at reducing long-term relapse rates; and
- b) evaluate and develop a proposal for a consistent statewide standard for the medical review of individuals who are involuntarily committed due to an alcohol or substance use disorder pursuant to section 35 of chapter 123 of the General Laws, including, but not limited to, developing:
 - 1) a proposed standardized form and criteria for releasing medical information for use in a commitment hearing under said section 35 of said chapter 123 that is in compliance with federal and state privacy requirements, and
 - 2) criteria and guidance to medical staff about filing a petition under said section 35 of said chapter 123.

The commission shall consist of: the secretary of health and human services or a designee, who shall serve as chair; the house and senate chairs of the joint committee on mental health, substance use and recovery or their designees; the house and senate chairs of the joint committee on judiciary or their designees; the minority leader of the house or a designee; the minority leader of the senate or a designee; 1 representative of an academic institution appointed by the speaker of the house; 1 representative of an academic institution appointed by the senate president; the chief justice of the trial court or a designee; the commissioner of the department of mental health or a designee; the commissioner of the department of public health or a designee; the director of the office of health equity in the department of public health; an addiction expert with experience in federal and state policy on substance use disorder; and 1 representative from each of the following organizations: Massachusetts Organization for Addiction Recovery, Inc.; The Boston Health Care for the Homeless Program, Inc.; Massachusetts Nurses Association; the Massachusetts Association of Advanced Practice Psychiatric Nurses; the Massachusetts chapter of the National Association of Social Workers, Inc.; American Civil Liberties Union of Massachusetts, Inc.; the committee for public counsel services; Massachusetts Health & Hospital Association, Inc.; the Massachusetts Psychological Association, Inc.; Massachusetts Medical Society; Massachusetts Psychiatric Society, Inc.; Massachusetts College of Emergency Physicians, Inc.; Massachusetts Society of Addiction Medicine, Inc.; Association for Behavioral Healthcare, Inc.; and Massachusetts Association of Behavioral Health Systems, Inc.

The commission shall file recommendations, including any proposed legislation, with the clerks of the house of representatives and the senate not later July 1, 2019.

Appendix B – Section 35 Commission Members

Name	Title / Affiliation
Marylou Sudders (Chair)	Secretary, Executive Office of Health and Human Services, Massachusetts
Ruth B. Balsler, PhD	Massachusetts State Representative
Leo Beletsky, JD, MPH	Associate Professor of Law and Health Sciences, Northeastern University
Kristin Beville, MSW, LICSW, MPH	Director, Department of Social Work, McLean Hospital
Monica Bharel, MD, MPH	Commissioner, Massachusetts Department of Public Health
William N. Brownsberger	Massachusetts State Senator
Hon. Paula M. Carey	Chief Justice, Trial Court
Alain A. Chaoui, MD	President, Massachusetts Medical Society
Nancy Connolly, PsyD	Assistant Commissioner, Massachusetts Department of Mental Health
Vicker V. DiGravio III	President/CEO, Association for Behavioral Health
Michael J. Finn	Massachusetts State Representative
Marcia Fowler	CEO, Bournewood Health Systems
Maryanne Frangules	Executive Director, Massachusetts Organization for Addiction Recovery
Richard G. Frank, PhD	Professor of Health Economics, Harvard Medical School
Cindy F. Friedman	Massachusetts State Senator

Appendix B – Section 35 Commission Members (cont.)

Name	Title / Affiliation
Mark Green, MD	Addiction Psychiatrist, Psych Garden
Neal S. Hovey	Sergeant, Topsfield Police Department
Carrie Jochelson PMHCNS-BC	Clinical Nurse Specialist, Massachusetts Association of Advanced Practice Psychiatric Nurses
Todd A. Kerensky, MD	Medical Director, Spectrum Health
Mark Larsen	Committee for Public Counsel Services
Carol Mallia, RN, MSN	Massachusetts Nurses Association
David Munson, MD	Medical Director, Respite Programs, Boston Health Care for the Homeless Program
David Podell, PhD	President, MassBay Community College
John E. Rosenthal	Police Assisted Addiction and Recovery Initiative
Jessie Rossman	American Civil Liberties Union of Massachusetts
Sabrina Selk, ScM, ScD	Director, Office of Health Equity, Department of Public Health
David G. Stewart, PhD, ABPP	Chief of Psychology, Department of Psychiatry, Cambridge Health Alliance
Scott G. Weiner, MD, MPH, FACEP, FAAEM	President, Massachusetts College of Emergency Physicians
Leigh Simons Youmans, MPH	Director, Behavioral Health and Healthcare Policy, Massachusetts Health and Hospital Association

Appendix C – Summary of Meetings and Input Provided to the Commission

Presenters	Topics Discussed	Resources and Supporting Documents
October 30, 2018		
Secretary Sudders <i>Commission Chair</i>	Discussion of the Commission’s charges, members’ expectations, and proposed schedule for each meeting	Commission presentation
November 5, 2018		
Hon. Rosemary Minehan <i>Massachusetts Trial Court</i>	Overview of the Section 35 process	Judge Minehan’s presentation
Alexander Y. Walley, MD, MSc <i>Boston Medical Center</i>	Medication-based treatment approaches for addressing opioid overdose and opioid use disorder	Dr. Walley’s presentation
Colleen LaBelle, MSN, RN-BC, CARN <i>Boston Medical Center</i>	Treating opioid use disorder with evidence-based treatments	Ms. LaBelle’s presentation
Maria Sullivan, MD, PhD <i>Alkermes</i>	Detoxification and induction on medication-assisted treatment	Dr. Sullivan’s presentation

Appendix C – Summary of Meetings and Input Provided to the Commission (cont.)

Presenters	Topics Discussed	Resources and Supporting Documents
December 6, 2018		
Lina Abdalla Denise Bohan Merredith Cunniff Joel Kergaravat Joanne Peterson Robin Wallace Zachary Wallace	Patients' and families' perspectives and firsthand experiences with the Section 35 process	
February 28, 2019		
Hermik Babakhanlou-Chase Michael Richardson Dana Bernson, MPH <i>Bureau of Substance Addiction Services</i>	DPH data from Section 35 facilities	<u>Bureau of Substance Addiction Services' presentation</u>
Steven Garceau <i>Boston EMS</i> Chief John McCarthy <i>Gloucester Police Department</i> Leslie W. Milne, MD <i>Massachusetts General Hospital</i> John Rosa <i>Boston EMS</i> Deputy Superintendent Leonard Shubitowski <i>Boston EMS</i>	First responders and their experiences with the Section 35 process	<u>Dr. Milne's presentation</u>

Appendix C – Summary of Meetings and Input Provided to the Commission (cont.)

Presenters	Topics Discussed	Resources and Supporting Documents
April 25, 2019		
<p>Sheriff Nicholas Cocchi Thomas Foye Elizabeth Hanna Sally Johnson Van Wright Anthony Scibelli <i>Hampden County Sheriff's Department</i></p>	<p>Overview of the Stonybrook Stabilization and Treatment Centers</p>	<p><u>Hampden County Sheriff's Department presentation</u> <u>Hampden County Sheriff's Department materials</u></p>
<p>Teri St. Pierre, LMHC Rasim Arikan, MD <i>Women's Recovery from Addiction Program</i></p>	<p>Overview of Women's Recovery from Addiction Program</p>	<p><u>Women's Recovery from Addictions Program presentation</u></p>
<p>Mark Larsen Jessica Gallagher Ann Grant <i>Committee for Public Counsel Services</i></p>	<p>Legal representation and the Section 35 process</p>	<p><u>Committee for Public Counsel Services presentation</u></p>

Appendix C – Summary of Meetings and Input Provided to the Commission (cont.)

Presenters	Topics Discussed	Resources and Supporting Documents
May 23, 2019		
<p>Anuj K. Goel, JD, MPH <i>Massachusetts Health and Hospital Association (MHA)</i></p> <p>Nancy Connolly, PsyD <i>Department of Mental Health</i></p>	<p>Proposed guidelines and standardized clinical forms for submission of medical information to the Courts for use during Section 35 commitment hearings</p>	<p>MHA presentation Proposed affidavit, checklist, and privacy memorandum</p>

Appendix D – Resources Reviewed by the Commission

October 30, 2018

1. [Section 35 Commission Meeting Presentation](#)
2. [Massachusetts Department of Public Health Chapter 55 Data Brief. \(2017\) “An Assessment of Opioid-Related Overdoses in Massachusetts 2011-2015 \(2017\)](#)
3. [Massachusetts Department of Public Health Chapter 55 Data Brief \(excerpt\) \(2017\)](#)
4. [Harvard Institute of Politics \(2014\) “Involuntary Commitment for Substance Abuse Treatment in Massachusetts: Problems and Proposed Solutions.”](#)
5. [National Alliance for Model State Drug Laws. \(2016\) “Involuntary Commitment for Individuals with a Substance Use Disorder or Alcoholism.”](#)
6. [Overview of New Requirements Related to Involuntary Treatment Act \(1/18/2018\)](#)
7. [Summary of Massachusetts Behavioral Health Treatment Capacity \(October 2018\)](#)
8. [Chelsea Appeals Court. \(2016\) In the Matter of A.M.](#)

November 5, 2018

9. [Section 35 Commission Meeting Presentation](#)
10. [Section 35 Commission Updated Meeting Agenda](#)
11. [Presentation from Hon. Rosemary Minehan on Section 35 Process](#)
12. [Presentation from Alexander Y. Walley, MD, MSc on Medication-based Treatment Approaches](#)
13. [Presentation from Colleen LaBelle, MSN, RN-BC, CARN on Medication-assisted Treatment for Opioid Use Disorder](#)
14. [Presentation from Maria Sullivan, MD, PhD on Detoxification and Induction on Medication-assisted Treatment](#)
15. [Bisaga, A. et al. \(2018\) Antagonists in the Medical Management of Opioid Use Disorders: Historical and Existing Treatment Strategies. *American Journal on Addictions*, 27: 177–187](#)

Appendix D – Resources Reviewed by the Commission (cont.)

December 6, 2018

16. [Section 35 Commission Meeting Presentation](#)
17. [Section 35 Commission Updated Meeting Agenda](#)
18. [Uniform Trial Court Rules for Civil Commitment Proceedings for Alcohol And Substance Abuse](#)
19. [Opioid Related Overdose Deaths Among MA Residents](#)
20. [Jain,A. et al. \(2018\) Civil Commitment for Opioid and Other Substance Use Disorder: Does It Work? *Psychiatric Services*, 69:4](#)
21. [In the Matter of G.P. Summary](#)
22. [In the Matter of G.P. Opinion](#)
23. [In the Matter of A.M.](#)

February 28, 2019

24. [Section 35 Commission Meeting Presentation](#)
25. [Section 35 Commission Updated Meeting Schedule](#)
26. [Presentation on DPH Opioid and Civil Commitment Data](#)
27. [DPH Opioid-related Overdose Deaths Among Massachusetts Residents \(Feb. 2019\)](#)
28. [Dr. Leslie W. Milne MGH Emergency Department Section 35 Data](#)
29. [Christopher, P. et al. \(2018\) Civil Commitment Experiences Among Opioid Users](#)
30. [Cover Letter and Additional Materials Provided by Dr. Maria Sullivan \(12/3/2018\)](#)

Appendix D – Resources Reviewed by the Commission (cont.)

April 25, 2019

31. [Section 35 Commission Meeting Presentation](#)
32. [Section 35 Commission Updated Meeting Agenda](#)
33. [Presentation on Stonybrook Stabilization and Treatment Centers](#)
34. [Hampden County Sheriff's Department Section 35 Materials](#)
35. [Presentation on Women's Recovery from Addictions Program](#)
36. [Presentation on Committee for Public Counsel Services](#)

May 23, 2019

37. [Section 35 Commission Meeting Presentation](#)
38. [Massachusetts Health and Hospital Association Presentation](#)
39. [Proposed Guidelines and Standardized Clinical Forms](#)
40. [Section 35 Legal Memorandum](#)
41. [Committee for Public Counsel Services Legal Memorandum](#)
42. [DPH Opioid-related Overdose Deaths Among MA Residents \(May 2019\)](#)
43. [Prisoners' Legal Services Written Testimony](#)
44. [Bhalla, I. et al. \(2018\) The Role of Civil Commitment in the Opioid Crisis. *Journal of Law, Medicine and Ethics* \(forthcoming\)](#)
45. [Beletsky, L. \(2018\) Involuntary Treatment for Substance Use Disorder: A Misguided Response to the Opioid Crisis. Harvard Health Blog](#)

Appendix D – Resources Reviewed by the Commission (cont.)

June 27, 2019

46. [Request for Information Regarding Western and Central Massachusetts Secure Section 35 Treatment Centers](#)
47. [Charts of Licensed Addiction Treatment Capacity Submitted by Association for Behavioral Healthcare](#)
48. [Committee for Public Counsel Services Survey Results \(May 2019\)](#)
49. [Werb, D. et al. \(2016\) The effectiveness of compulsory drug treatment: A systematic review. *International Journal of Drug Policy*, Feb;28:1-9](#)
50. [Rafful, C. et al. \(2018\) Increased non-fatal overdose risk associated with involuntary drug treatment in a longitudinal study with people who inject drugs. *Addiction*, Jun;113\(6\):1056-1063](#)
51. [DPH Presentation on Opioid-related Overdose Death Data](#)
52. [BSAS Presentation on OTP and OBOT Statistics](#)
53. [BSAS Presentation on Buprenorphine Provider Capacity](#)
54. [Health Policy Commission Presentation on Availability of Behavioral Health and Substance Use Disorder Treatment](#)
55. [MassHealth Presentation on MAT Initiation Among Members with Opioid Use Disorder](#)

Appendix E – Trial Court Forms

PETITION FOR COMMITMENT FOR ALCOHOL OR SUBSTANCE USE DISORDER G.L. c. 123, § 35	DOCKET NO. DIVISION	Trial Court of Massachusetts	
IN THE MATTER OF (name of respondent)	SOCIAL SECURITY NUMBER (respondent)	DOB OR AGE (respondent)	GENDER (respondent) <input type="checkbox"/> Male <input type="checkbox"/> Female
PETITION FOR COMMITMENT FOR ALCOHOL OR SUBSTANCE USE DISORDER G.L. c. 123, § 35			
The undersigned Petitioner hereby applies to this court for an order committing the Respondent named above for inpatient care and treatment for an alcohol or substance use disorder for a period not to exceed 90 days under the provisions of G.L. c. 123, § 35.			
The Petitioner has reason to believe that the Respondent has an alcohol or substance use disorder, and petitions the court to find there is a likelihood of serious harm as a result of the Respondent's chronically or habitually consuming or ingesting alcoholic beverages and/or controlled substances or intentionally inhaling toxic vapors to the extent that such use substantially injures the respondent's health or substantially interferes with the Respondent's social or economic functioning, or that the Respondent has lost the power of self-control over the use of such beverages and/or substances.			
Reasons Respondent may not appear before the Court if summoned, and reasons Respondent is in immediate danger: _____ _____			
DATE SIGNED	PETITIONER'S SIGNATURE UNDER THE PAINS AND PENALTIES OF PERJURY		
PETITIONER'S PRINTED NAME	PETITIONER'S TITLE OR RELATIONSHIP, IF ANY, TO RESPONDENT		
PETITIONER'S CELL PHONE	PETITIONER'S HOME PHONE	PETITIONER'S WORK PHONE	
EXCERPTS FROM G.L. c. 123, §§ 1 and 35 G.L. c. 123, § 1. Definitions. "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; (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. G.L. c. 123, § 35. Commitment for alcohol or substance use disorder. "Alcohol use disorder, the chronic or habitual consumption of alcoholic beverages by a person to the extent that (1) such use substantially injures the person's health or substantially interferes with the person's social or economic functioning, or (2) the person has lost the power of self-control over the use of such beverages." "Substance use disorder, the chronic or habitual consumption or ingestion of controlled substances or intentional inhalation of toxic vapors by a person to the extent that: (i) such use substantially injures the person's health or substantially interferes with the person's social or economic functioning; or (ii) the person has lost the power of self-control over the use of such controlled substances or toxic vapors." "Any police officer, physician, spouse, blood relative, guardian or court official may petition in writing any district court . . . for an order of commitment of a person whom he has reason to believe has an alcohol or substance use disorder. . . . [T]he court shall immediately schedule a hearing on the petition and shall cause a summons and a copy of the application to be served upon the person . . . [I]f there are reasonable grounds to believe that such person will not appear and that any further delay in the proceedings would present an immediate danger to the physical well-being of the respondent, said court may issue a warrant for the apprehension and appearance of such person before it. If such person is not immediately presented before a judge of the district court, the warrant shall continue day after day for up to 5 consecutive days, excluding Saturdays, Sundays and legal holidays, or until such time as the person is presented to the court, whichever is sooner, provided, however that an arrest on such warrant shall not be made unless the person may be presented immediately before a judge of the district court. . . . The court shall order examination by a qualified physician, a qualified psychologist or a qualified social worker." "If, after a hearing which shall include expert testimony and may include other evidence, the court finds that such person is an individual with an alcohol or substance use disorder and there is a likelihood of serious harm as a result of the person's alcohol or substance use disorder, the court may order such person to be committed for a period not to exceed 90 days to a facility designated by the department of public health, followed by the availability of case management services provided by the department of public health for up to 1 year; provided, that a review of the necessity of the commitment shall take place by the superintendent on days 30, 45, 60 and 75 as long as the commitment continues. A person so committed may be released prior to the expiration of the period of commitment upon written determination by the superintendent of the facility that release of that person will not result in a likelihood of serious harm. Such commitment shall be for the purpose of inpatient care for the treatment of an alcohol or substance use disorder in a facility licensed or approved by the department of public health or the department of mental health. Subsequent to the issuance of a commitment order, the superintendent of a facility may authorize the transfer of a patient to a different facility for continuing treatment. . . ." "If the department of public health informs the court that there are no suitable facilities available for treatment licensed or approved by the department of public health or the department of mental health, or if the court makes a specific finding that the only appropriate setting for treatment for the person is a secure facility, then the person may be committed to: (i) a secure facility for women approved by the department of public health or the department of mental health, if a female; or (ii) the Massachusetts correctional institution at Bridgewater, if a male; provided, however, that any person so committed shall be housed and treated separately from persons currently serving a criminal sentence. The person shall, upon release, be encouraged to consent to further treatment and shall be allowed voluntarily to remain in the facility for such purpose."			

(Rev. 4/16)

RESPONDENT INFORMATION FORM AS PROVIDED BY PETITIONER G.L. c. 123 § 35		DOCKET NO. (for court use only)		Trial Court of Massachusetts	
This information is requested to help police identify and locate the Respondent in order to serve the Respondent with any summons or execute any warrant of apprehension pursuant to G.L. c. 123 § 35. Please provide as much information as possible.					
RESPONDENT'S NAME			OTHER NAMES USED BY RESPONDENT, IF ANY		
RESPONDENT'S DATE OF BIRTH		RESPONDENT'S PLACE OF BIRTH		RESPONDENT'S SOCIAL SECURITY NUMBER	
MOTHER'S MAIDEN NAME (FIRST, LAST)			FATHER'S NAME (FIRST, LAST)		
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RACE	EYE COLOR	HAIR COLOR	HEIGHT	WEIGHT
PHOTO AVAILABLE (HELPFUL FOR ID) <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE ATTACH <input type="checkbox"/> YES <input type="checkbox"/> NO		OTHER PHYSICAL CHARACTERISTICS (beard, glasses, scars, tattoos, complexion, hairstyle)			
RESPONDENT'S HOME ADDRESS (NO., STREET, CITY, STATE, ZIP CODE)			APT. NO.	FLOOR NO.	NAME ON DOOR/MAILBOX
RESPONDENT'S HOME PHONE NO.	RESPONDENT'S CELL PHONE NO.	DOES THE RESPONDENT UNDERSTAND ENGLISH? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF NOT, WHAT LANGUAGES?	
RESPONDENT'S EMPLOYER/WORKPLACE			TITLE		DEPARTMENT
WORK ADDRESS (NO., STREET, CITY, STATE, ZIP CODE)			WORK TELEPHONE NO.		WORK HOURS
OTHER PLACES RESPONDENT MAY BE FOUND (friends, bars, relatives, hangouts)			BEST PLACE TO FIND RESPONDENT		BEST TIME TO FIND RESPONDENT
MOTOR VEHICLE LICENSE PLATE	YEAR	MAKE	MODEL	COLOR	
DOES THE RESPONDENT HAVE: (describe briefly)					
A history of violence toward police officers?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
A history of using/abusing drugs or alcohol? If so, what kind?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
Access to guns, a license to carry, or possess a gun? If so, what kind?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
Psychiatric/emotional problems? If so, what kind?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
Any other information which might be helpful in locating the Respondent: _____ _____					
DATE SIGNED	PETITIONER'S NAME (printed)			PETITIONER'S SIGNATURE	

(Rev. 4/16)

Appendix E – Trial Court Forms (cont.)

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AFFIDAVIT IN SUPPORT OF PETITION FOR COMMITMENT UNDER G.L. c. 123, § 35	COURT DEPARTMENT <input style="width: 100%;" type="text"/>	TRIAL COURT OF MASSACHUSETTS
PETITIONER'S NAME	PETITIONER'S NAME	PETITIONER'S ADDRESS
	PHONE NUMBER	

1. What is your relationship to the Respondent? How often do you see the person? When did you last see the person?

2. Reason for the request for the petition. Please check below if the person is abusing alcohol, substances or both. Describe the frequency of use, and, if substances are involved, what kind.

Alcohol Abuse

Substance Abuse

Both Alcohol and Substance Abuse

This person is a danger to self or others for the following reasons (for example, overdose, suicide attempt, hospitalization or criminal activity). Please provide a detailed explanation including dates of events.

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3. Does the Respondent have a history of mental health and/or substance abuse commitments or treatment? If yes, please provide a detailed explanation including when, where, and how recent.

Provide any other information you feel the Court would need to support your Petition under G.L. c. 123, § 35.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY

X	DATE
---	------

(Rev. 7/18)

Appendix F – Bureau of Substance Addiction Services Treatment and Recovery Programs

Partial List of Bureau of Substance Addiction Services Treatment and Recovery Programs

- Acute Treatment Services (ATS): 24-hour medically supervised addiction treatment for adults or adolescents provided in a medically managed or medically monitored inpatient facility equivalent to American Society for Addiction Medicine (ASAM) Level 3.7 that provides evaluation and withdrawal management and which may include biopsychosocial assessment, individual and group counseling, psychoeducational groups and discharge planning.^{1,2}
- Clinical Stabilization Services (CSS): 24-hour clinically managed post detoxification treatment for adults or adolescents equivalent to ASAM Level 3.5, usually following acute treatment services for substance abuse, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others and aftercare planning, for individuals beginning to engage in recovery from addiction.^{1,2}
- Transitional Support Services (TSS): Short-term residential support services equivalent to ASAM Level 3.1 for clients who need a safe and structured environment to support their recovery process after detoxification. Designed to help those who need services between acute treatment and residential rehabilitation, outpatient, or other aftercare. Eligibility restricted to individuals ages 18 years or older who are referred by a publicly-funded ATS program, homeless shelter, or by homeless outreach worker.³
- Residential Treatment Over 30 Days: Services for individuals who have recently stopped using alcohol and/or other substances, have been stabilized medically, and are able to participate in a structured, residential treatment program. Includes Recovery Homes, Social Model Homes, Therapeutic Communities, Specialized Residential Services for Women, Specialized Residential Services for Families, and Youth Residential Programs.
- Recovery Homes: Structured, sober environments for individuals recovering from addiction to alcohol and/or other substances. Programming emphasizes recovery and treatment within a structured, therapeutic setting. Residents are encouraged to integrate with the community and to access community resources, including self-help groups and employment. Some Recovery Homes offer residents enhanced services for pregnant and post-partum women and their infants, which include coordination of prenatal/pediatric care.

¹ M.G.L. c. 175 § 47GG: <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/ChapterI75/Section47GG>

² ASAM Levels of Care: <https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/>

³ BSAS Substance Abuse Services Descriptions: <https://www.mass.gov/service-details/substance-abuse-services-descriptions>

Appendix G – Section 35 Legal Memorandum

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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.

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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.

Appendix G – Section 35 Legal Memorandum (cont.)

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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.E., 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

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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.

Appendix G – Section 35 Legal Memorandum (cont.)

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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.

From: Jessie Rossman
Sent: Thursday, May 16, 2019 10:45 AM
To: Cohen, Gabriel R. (EHS)
Cc: Jessie Rossman
Subject: RE: Section 35 memo - 5/7 draft

Gabe,

Thank you for forwarding along the draft memo. The proposed addition of a non-judicial hold within Section 35 would raise serious constitutional questions and practical problems, including the risk of harming people by creating a disincentive to seek emergency medical care. The ACLU of Massachusetts could not support such a recommendation.

This is an important matter that needs to be brought before the entire Commission. To that end, I request that we set aside ample time for an open discussion of this issue during next week's Commission meeting.

Thanks,
Jessie

Appendix H – Committee for Public Counsel Services Legal Memorandum

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The Commonwealth of Massachusetts
Committee for Public Counsel Services
44 Bromfield St., 2nd Fl., Boston, MA 02108

TEL: 617-988-8341
FAX: 617-988-8488

ANTHONY J. BENEDETTI
CHIEF COUNSEL

MARK A. LARSEN
DIRECTOR
Mental Health Litigation Division

Memorandum

TO: Secretary Marylou Sudders and Section 35 Commission

FROM: Mark A. Larsen, Director
Mental Health Litigation Division
Committee for Public Counsel Services

RE: Memo on Commitment of Individuals with Substance Use Disorders

DATE: May 23, 2019

We have received a copy of the memo addressing the question of whether the provisions of M.G.L. c. 123, § 12 (Emergency restraint and hospitalization of persons posing risk of serious harm by reason of mental illness.) can be grafted on to the section 35 provisions for commitment of alcoholics or substance abusers. While it may be possible to do so, we do not believe it is wise or practical to do so.

Section 12 (a) and (b)

M.G.L. c. 123, § 12(a) authorizes the restraint of individuals in certain emergency situations for the purpose of admission to a psychiatric facility. This section has never been subjected to constitutional scrutiny by either the Appeals Court or the Supreme Judicial Court. However, our concerns about that section have been the subject of proposed legislation and several court cases. One concern is that section 12(a) lacks any statutory limit on the length of time a person can be detained while waiting for admission to a mental health facility. Nor is there any statutory process for mandatory judicial or other review of the basis of the detention. The result is that a person can be held in an emergency room or on a medical floor, unable to leave for days and in some cases weeks with no review beyond that conducted by those who are detaining the person. Even though there is a provision in section 12(b) for judicial review, that review is limited to determining if there has been an abuse or misuse of the section.

Neither section 12(a) nor (b) provides for an opportunity to review whether there is “reason to believe that a person presents a likelihood of serious harm by reason of mental illness.” It is an unreviewable decision of the person authorizing the restraint. The only option for a section 12(a) person to challenge their detention is file a petition for a writ of habeas corpus in the superior court. But they need to know that is an option and then find a lawyer to prosecute their claim. We have assigned lawyers in a few cases where a person has contacted us for legal assistance. In every case, where we have filed for habeas corpus, the hospital has relented and released the individual.

Section 12(b) hospitalization does not require court involvement and the due process protections it includes are very limited. The facility where the person is being held must advise the person that if they make a request, the facility will contact CPCS. In every case CPCS must assign an attorney to meet with the client. If a request is made under section 12(b) the court is limited to determining if there is an abuse or misuse of the section. The court cannot review the substance of the determination that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness. The only judicial review of that determination occurs only after the facility files a petition for long-term commitment for up to six months.

Section 12(c)

Section 12(c) has more due process protections than either sections 12(a) or (b) and is similar to section 35. It provides an alternative process for emergency hospitalization of individuals who are allegedly mentally ill and for whom failure to hospitalize would cause a likelihood of serious harm. A section 12(c) petition may be filed by any person. On the filing of a 12(c) petition the court must appoint counsel and hold a preliminary hearing. If the court finds that the condition or conduct alleged in the petition is sufficient to believe that the person is mentally ill and in need of hospitalization to avert serious harm, the court may issue a warrant of apprehension to bring the person into court. Following apprehension, the person is brought to court and evaluated. If the evaluator determines that failure to hospitalize the person would create a likelihood of serious harm by reason of mental illness, the court may, after a hearing, order the person committed to a facility for a period not to exceed three days. In contrast to 12(a) and (b), section 12(c) provides for a prompt judicial review of the detention with counsel being assigned and the ability to contest whether the person is mentally ill and whether failure to hospitalize the person would cause serious harm.

Grafting section 12(a) and (b) on to section 35

While it may be conceptually true that there is no reason why the process utilized in sections 12(a) and (b) could not, after amendment, be applied to persons petitioned under section 35, there are procedural and practical concerns. The section 12 process is fraught with problems. The first being that there is no statutory limit on the length time a person can be detained. Over the past several years, Committee for Public Counsel Services, Mental Health Litigation Division has been contacted by individuals who have been detained in emergency rooms and on medical floors of hospitals for days, weeks and even months on “rolling 12(a)” restraints. In many cases we have been, through the use of petitions for writs of habeas corpus, been able to secure the release of these individuals.

Appendix H – Committee for Public Counsel Services Legal Memorandum (cont.)

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Abuses of the 12(a) process have not gone without some judicial scrutiny. In Commonwealth v. Accime, 476 Mass. 469 (2017) the defendant was held, supposedly under section 12(a), in an emergency room. Although section 12(a) detentions are supposed to be documented by a “pink paper,” no documentation was ever produced. Mr. Accime was restrained and threatened with being involuntarily medicated, to which he objected. Although charged with several criminal offenses, he was not convicted, in part because the detention was not in compliance with section 12. The Supreme Judicial Court noted that “the involuntary hospitalization and forcible medication of an individual on account of mental illness is not permitted unless there is compliance with the specific statutory requirements of G. L. c. 123, §§ 12 and 21. It has long been the law that medical treatment of a competent patient without his consent is a battery, and is permitted only for incompetent patients where procedural protections are followed.” Commonwealth v. Accime, at 478.

In Van Buskirk v. Fitzgerald, 85 Mass.App.Ct. 1103 (2014) the plaintiff was brought to the hospital by the police and detained, without examination, based on a pre-signed section 12 “pink paper.” Mr. Van Buskirk prevailed on a claim of false imprisonment and court concluded that he was detained in a direct violation of the civil commitment statute. Although the Supreme Judicial Court declined further appellate review, CPCS supported filing an amicus brief because we see violations like this on a regular basis. Our reasoning was based, in part, on Vitek v. Jones, 445 U.S. 480 (1980), where the United States Supreme Court recognized that commitment proceedings are subject to due process requirements. Justice White writing for the court stated at 445 U.S. at 491-92:

We have recognized that for the ordinary citizen, commitment to a mental hospital produces ‘a massive curtailment of liberty.’ Humphrey v. Cady, 405 U.S. 504, 509 (1972), and in consequence ‘requires due process protection.’ Addington v. Texas, 441 U.S. 418, 425 (1979); O’Connor v. Donaldson, 422 U.S. 563, 580 (BURGER, C.J., concurring). The loss of liberty produced by an involuntary commitment is more than a loss of freedom from confinement. It is indisputable that commitment to a mental hospital ‘can engender adverse social consequences to the individual’ and that ‘whether we label this phenomena “stigma” or choose to call it something else . . . we recognize that it can occur and that it can have a very significant impact on the individual.’ Addington v. Texas, 425-426. See also Parham v. J.R., 442 U.S. 584, 600 (1979). Also ‘among the historic liberties’ protected by the Due Process Clause is the ‘right to be free from, and to obtain judicial relief for, unjustified intrusions on personal security.’ Ingraham v. Wright, 430 U.S. 651, 673 (1977).

Challenges to detentions under section 12 are, however, difficult to litigate because the Supreme Judicial Court has held that there is no provision in Chapter 123 to challenge the reasons for a section 12 detention unless and until a petition for commitment is filed. Challenges under section 12(b) “do not include a challenge to the substance of the designated physician’s actual [determination] that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness,” G.L. c. 123, § 12 (b), first par., because the Legislature has already established an appropriate time to challenge that determination, namely, at the hearing afforded

Page 4

to a person when the hospital is seeking the person’s continued commitment beyond the three-day hospitalization.” Newton-Wellesley Hosp. v. Magrini, 451 Mass. 777, 784 (2008). In addition to the legal flaws in the Massachusetts’ approach to emergency detentions for mental illness and substance abuse, there are practical questions that include who could request an emergency detention under an amended section 35; where would the person be held; how long they will be held; held, will there be competent medical care available for those in withdrawal?

Conclusion:

Under Massachusetts law, a person diagnosed with substance use disorder may only be involuntarily hospitalized through judicial proceedings. There is, however, no legal authority for short-term, emergency hospitalization, similar to the process for commitment of mentally ill persons under M.G.L. c. 123, § 12. Creating a flawed process similar that contained in section 12, should not be considered. Any effort to expand emergency detentions under Chapter 123, must also consider the cost associated with such a process. Those cost would be both direct and indirect and include the costs of counsel, the cost imposed on hospitals and physicians who might be compelled to hold individuals under an expanded emergency detention process, the cost to law enforcement, if they are required to take individuals into custody when a section 35 “pink paper” is issued, the cost to the courts in hearing cases and the personal cost when serious deprivations of liberty occur.

Appendix I – Request for Information and Responses Received by June 20, 2019

Request for Information Cover

*Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108*

Request for Information (RFI)
Regarding Western and Central Massachusetts Secure Section 35 Treatment Centers

Issued: May 31, 2019

Document Number: 19CBEHSSURESECTION35RFI

Request for Information Page I

Section 1: Overview

The Section 35 Commission was established under chapter 208 of the Acts of 2018. This commission is charged with: studying the efficacy of involuntary inpatient treatment for individuals diagnosed with substance use disorder; and evaluating and developing a proposal for a consistent statewide standard for the medical review of individuals who are involuntarily committed due to an alcohol or substance use disorder pursuant to M.G.L. c. 123, § 35 (Section 35). The Section 35 Commission is chaired by the Secretary of Health and Human Services and is comprised of a diverse panel of legislators, policymakers, public health professionals, legal scholars, clinicians, and residents. During a Section 35 Commission discussion, questions were raised about whether the provider community in Western and Central Massachusetts would be willing to provide treatment services to individuals committed for treatment under Section 35. A purpose of this RFI is to seek information responsive to those questions. EOHHS will provide responses to this RFI to the Commission and may use responses it receives to inform any future procurement EOHHS, or an EOHHS agency, decides to issue for secure Section 35 treatment centers in Western and Central Massachusetts.

Section 2. Background

The availability of treatment resources is a critical part of any effective response to the epidemic of opioid addiction in Massachusetts. Section 35 allows for the adjudication of short-term civil commitment of individuals who are clinically assessed to be at risk of serious harm as a result of a diagnosed substance use disorder. Providers of involuntary treatment services in Section 35 treatment centers, must be licensed by the Commonwealth of Massachusetts Department of Public Health, Bureau of Substance Addiction Services (DPH/BSAS) pursuant to 105 CMR 164. These providers in Section 35 treatment centers must be able to provide Acute Treatment Services (ATS) and Clinical Stabilization Services (CSS), and to provide client engagement in a fully secured environment. Such providers must also connect all clients with continuing treatment and recovery options, such as residential rehabilitation, outpatient services and other community-based services and supports that promote recovery. Further, providers in Section 35 treatment centers must provide Medication Assisted Treatment (MAT), connect clients to MAT providers in the community upon discharge, and connect clients to and track recovery support services in the community, for at least six months following release, such as recovery coaches and community support programming (CSP). Finally, providers in Section 35 treatment centers must have the capacity to bill third party payers, including public and private insurance, and to assist eligible individuals with enrolling into a health insurance plan.

Additional minimum requirements for Section 35 treatment centers include:

- Ability to locate in Western or Central Massachusetts;
- Compliance with building and fire codes for a fully secure treatment facility;
- Provision of exterior and grounds security to prevent elopement;
- Being a therapeutic and secure environment for individuals involuntarily committed for treatment; and
- Having insurance liability coverage

EOHHS pays providers in Section 35 treatment centers rates established by EOHHS and set forth in 101 CMR 346. As of the date of this RFI, those rates are \$340.32 for ATS and \$247.82 for CSS per client bed day, plus an add-on rate of \$36.03.

Appendix I – Request for Information and Responses Received by June 20, 2019 (cont.)

Request for Information Page 2

Please feel free to respond to only those questions on which you would like to provide input. Please submit your response, according to the instructions provided in Section 5, no later than 12:00 PM on June 20, 2019. EOHHS encourages you to respond and thanks you in advance for your participation.

Section 3: Questions for Response

Please respond to the following questions:

1. If the Executive Office of Health and Human Services (EOHHS), or one of its agencies, issued a procurement to purchase Section 35 bed capacity in Western and Central Massachusetts, for men and women, do you expect that your agency would submit a proposal?
2. What factors would be most important in influencing whether your agency would submit a proposal?
3. Where in Western and Central Massachusetts would you expect to locate your treatment center?
4. If awarded a contract, how long do you expect that it would take your agency to begin delivering treatment services?

Section 4: RFI Respondent Information

Please respond to the following questions with respect to the Respondent:

1. What is your name, agency/organization, address, email address, and URL?
2. What is your affiliation or interest?
3. In what geographic areas in Massachusetts do you currently provide services?

Section 5: RFI Response Instructions

A. Response Submission Instructions

All responses to this RFI are due no later than 12:00 PM on June 20, 2019. Responses may be submitted in one of the following ways:

- By email to: Louis.DeLena@massmail.state.ma.us, placing "RFI: Western and Central Massachusetts Secure Section 35 Treatment Centers" in the subject line; or
- In writing to:
Louis DeLena
Procurement Coordinator
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108
RE: RFI: Western and Central Massachusetts Secure Section 35 Treatment Centers

Request for Information Page 3

B. Format

All parties interested in responding to this RFI (Respondents) should prepare an electronically submitted response or a typewritten response to the questions listed in Sections 3 and 4 above. EOHHS prefers to receive electronic submissions but will also accept typewritten responses. Any typewritten response should be double-sided/single-spaced. Parties responding in hard copy should submit one original and one copy of their Response.

Interested parties are invited to respond to any or all of the RFI questions; please respond to as many as you feel are appropriate. Responses should be clearly labeled.

Section 6: Additional RFI Information

A. RFI Questions

Interested parties may submit written questions concerning this RFI until no later than June 7, 2019. Written questions must be sent to the RFI Contact at the e-mail address listed in Section 5.A.

B. COMMBUYS Market Center

COMMBUYS is the official source of information for this RFI and is publicly accessible at no charge at www.commbuys.com. Interested parties are solely responsible for obtaining all information distributed for this RFI via COMMBUYS. It is each interested party's responsibility to check COMMBUYS for any amendments, addenda, modifications to this RFI and any related document. The Commonwealth accepts no responsibility and will provide no accommodation to interested parties who submit a Response based on out-of-date information received from any source other than COMMBUYS. Interested parties may elect to obtain a free COMMBUYS Seller subscription which provides value-added features, including automated email notification associated with postings and modifications to COMMBUYS records. To learn more about the COMMBUYS system, please visit the COMMBUYS Resource Center. Questions specific to COMMBUYS should be made to the COMMBUYS Help Desk at commbuys@state.ma.us.

C. Communications

Interested parties are prohibited from communicating directly with any employee of EOHHS or any of its constituent agencies with regard to the subject matter of this RFI except as specified above, and no other individual Commonwealth employee or representative is authorized to provide any information or respond to any question or inquiry concerning this RFI. Interested parties may contact the RFI contact person in Section 5.A above in the event the interested party is having trouble obtaining any documents or attachments electronically through COMMBUYS.

D. RFI Amendments

Interested parties are solely responsible for checking COMMBUYS for any addenda or modifications that are subsequently made to this RFI. The Commonwealth and its subdivisions accept no liability and will provide no accommodation to interested parties who fail to check for amended RFIs.

Appendix I – Request for Information and Responses Received by June 20, 2019 (cont.)

Request for Information Page 4

E. Costs

By submitting a Response, Respondents agree that any cost incurred in responding to this RFI, or in support of activities associated with this RFI, shall be the sole responsibility of the Respondent. EOHHS shall not be held responsible for any costs incurred by Respondents in preparing their respective Responses to this RFI.

F. Use of RFI Information

Please note that this RFI is issued solely for the purpose of obtaining information. The RFI does not obligate EOHHS to issue a RFR nor to include any of the RFI provisions or responses in any RFR. No part of the response to this RFI can be returned. Receipt of RFI responses will not be acknowledged. Information received in response to this RFI shall serve solely to assist the Commonwealth in the development of policy. No information received in response to this RFI is binding on the Commonwealth or any of its agencies. Responding to this RFI is voluntary and will not affect consideration of any proposal submitted in response to any subsequent procurement or solicitation. Responses to this RFI become the property of the Commonwealth of Massachusetts and, except as otherwise provided in this Section 6.F, are public records under the Massachusetts Freedom of Information Law, M.G.L.c.66, section 10 and c.4, section 7, clause 26, regarding public access to such documents. Information provided in response to this RFI and identified by the Respondent as trade secrets or commercial or financial information, or which EOHHS has determined is such, shall be kept confidential to the extent permitted by law and shall be considered by EOHHS as exempt from disclosure as a public record (see Massachusetts General Laws, Chapter 4, section 7(2)(g)). This exemption may not apply to information submitted in response to any subsequent procurement solicitations.

Responses to this RFI may be reviewed and evaluated by any person(s) at the discretion of EOHHS, including independent consultants retained by EOHHS now or in the future. EOHHS retains the right to request additional information from any Respondent. EOHHS may, at its sole discretion, elect to request formal presentations from certain Respondents and/or create a RFR based, at least in part, on the Responses received from this RFI. EOHHS may request further explanation or clarification from any and all Respondents during the review process.

Arbour Hospital Page 1

1. Arbour Hospital and Arbour Counseling Services intend to submit a joint proposal
2. Our proposal would take into account RFR specific requirements for medical, clinical, and security coverage. Our expectation is that the RFR will state requirements in detail.
3. The treatment center could be located in the Worcester area, and we have begun to look at available properties that can provide the security and safety required.
4. The center could be operational in three to six months.
5. The two organizations collaborating on this proposal are:

Arbour Hospital

URL: arbourhospital.com

Arbour Counseling Services

Email: John.Fletcher@uhsinc.com

Cell: 617 959 0149

URL: arbourhealth.com

6. Our organizations currently provide services to the population which include:
 - inpatient and partial hospitalization
 - Structured Outpatient Addiction Programs at all outpatient sites,
 - DAE and multiple offender programs at the Worcester Center as well as other locations,
 - Community based services to include Recovery Coaches and Recovery Navigators. Teams are located in Worcester, Lowell, Boston, and Fall River
7. Arbour Counseling Services provides care through 9 locations which cover Eastern Massachusetts. The locations are:
 - 411 Chandler Street, Worcester
 - 10 Bridge Street, Lowell
 - 116 Summer Street, Haverhill
 - 100 George P. Hasset Drive, Medford
 - 10-I Roessler Road, Woburn
 - 14 Fordham Road, Allston
 - 38 Pond Street, Franklin
 - 1082 Davol Street, Fall River
 - 384 Washington Street, NorwellArbour Hospital has locations at:
 - Arbour Hospital, 49 Robinwood Avenue, Jamaica Plain 02130
 - Quincy Center, 460 Quincy Avenue, 02169
 - Arbour Counseling JP, 157 Green Street

Appendix I – Request for Information and Responses Received by June 20, 2019 (cont.)

Behavioral Health Network Page 1

What is your name, agency/organization, address, email address, and URL?

Rose Evans, Vice President of Behavioral Health Network, Inc., 417 Liberty Street, Springfield, MA 01104, rose.evans@bhinc.org, www.bhinc.org

What is your affiliation or interest? BHN established its first Substance Use Disorder outpatient clinic and ATS over 11 years ago. Since that time, BHN has successfully added a variety of substance abuse services throughout the Springfield/Holyoke and Greenfield areas, including

- Opioid Treatment Program-at Liberty Street Clinic in Springfield
- Medication Assisted Treatment, Transitional Addiction Treatment Program in Springfield in collaboration with Providence Behavioral Health Hospital and Baystate Health System
- Residential for men, women and families-3 programs in Springfield: My Sisters House prioritizes pregnant and post-partum women, Opportunity House and Cole's Place (Section 35 for men), all in Springfield – 98 beds
- Two-tiered Jail Diversion Program: 3-month residential recovery home in Greenfield with 9-months state-wide, community-based, non-masters level case management and peer support services
- ASAM Level 3.1 co-occurring enhanced residential recovery home, 16-beds-New program in Greenfield
- Outpatient-11 clinics in Springfield, Holyoke, Agawam, Westfield and Ware
 - One SUD primary treatment at Sloan Clinic within Carlson Recovery Center
- Intensive Outpatient Program-at Liberty Street Clinic
- Forensic Services to all Western MA Drug Court Sessions: Springfield, Pittsfield, Greenfield and Orange
- MISSION services in the Springfield Mental Health Court Session for co-occurring SUD and mental illness.
- MISSION services in Franklin County Family Drug Court. BHN delivers comprehensive, trauma-informed case management as well as integrated assessment, treatment and wrap-around services.
- 1st and 2nd Offender DUI Classes-regionally
- Federal Probation SUD Outpatient Services, ATS and Residential Recovery Homes,
- FUSE-family substance use support group
- The Living Room-peer support program in Springfield. Many persons wait for ATS beds here. This is not a residential program but people may rest overnight.

These are not SUD specific, but many persons with co-occurring mental health and SUD come here:

- Partial Hospitalization Program-at Liberty Street Clinic
- Day Treatment-at Liberty Street Clinic

Specific to this RFI, BHN currently provides 64 beds in two Acute Treatment Services programs: Carlson Recovery Center, 471 Chestnut Street in Springfield (32 beds) and Franklin Recovery Center, 298 Federal Street, Greenfield (32 beds and Section 35 for women). BHN ATS programs administer Methadone, Suboxone and Vivitrol.

Behavioral Health Network Page 2

BHN currently provides 64 beds in two Clinical Stabilization Services programs: Hope Center, 35 Heywood Street in Springfield (32 beds) and Northern Hope Center, 298 Federal Street, Greenfield (32 beds and Section 35 for women).

BHN has capacity and interest in increasing our service provision for persons entering our ATS and CSS programs via Section 35 for either men or women. We are able to add Section 35 capacity for men in addition to our current position of serving women.

ACCREDITATIONS

We have many employees throughout our continuum of services with a wealth of experience and knowledge in providing high quality services to the Substance Use Disordered population. Many of our program staff are in recovery. All of our clinical programs are accredited by CARF, licensed by the DPH, DMH, EEC, or DDS, and are well respected by our payer sources throughout the Commonwealth. BHN has contractual relationships with insurers, MCO's and Medicaid that insure most individuals living in Mass, enabling those who seek service to use insurance to pay for their care.

In what geographic areas in Massachusetts do you currently provide services?

We serve all four Western MA counties, with program locations in Agawam, Greenfield, Holyoke, Springfield, Ware, and Westfield.

Please respond to the following questions:

If the Executive Office of Health and Human Services (EOHHS), or one of its agencies, issued a procurement to purchase Section 35 bed capacity in Western and Central Massachusetts, for men and women, do you expect that your agency would submit a proposal?

Yes.

What factors would be most important in influencing whether your agency would submit a proposal?

BHN would likely propose adding capacity at all of our ATS and CSS program sites, negotiating capital funds to make security improvements and create additional bedroom and clinical space. Where in Western and Central Massachusetts would you expect to locate your treatment center?

Greenfield and Springfield. BHN would be open to further discussion of locating ATS or CSS (including Section 35) in other BHN service areas.

If awarded a contract, how long do you expect that it would take your agency to begin delivering treatment services?

BHN anticipates a 3-6 month start up period to manage infrastructure upgrades in order to address the risk of elopement.

Appendix I – Request for Information and Responses Received by June 20, 2019 (cont.)

Berkshire Medical Center
Page 1

Request for Information (RFI)

Regarding Western and central Massachusetts Secure Section 35
Treatment Centers

Document Number: 19CBEHSSECURESECTION35RFI

Questions for Response

Question 1:

Our institution would plan to respond to a procurement to add Section 35 bed capacity in Western Mass for men and women. Berkshire Medical Center currently operates a level 3.7 ATS detox unit licensed by DPH/BASAS and would welcome the opportunity to add Section 35 beds to our current service line. This would allow clients the opportunity to receive this level of care closer to home and involve their families and other support systems into their recovery process. We also operate a CSS unit adjacent to our main campus. These units are licensed by DPH/BSAS.

Question 2:

There are limited factors that would influence our submission of a proposal. This service would be added to our substance use and behavioral health service line.

Question 3:

Our treatment center is located at Berkshire Medical Center in Central Berkshire County, Pittsfield, Massachusetts. This is a central location accessible to communities throughout Berkshire County. Berkshire is one of the lower socioeconomic class counties in the state with a large influx of opioids and other substances. The location of the medical center would make it easily accessible to support services that could help ensure continued recovery after treatment is completed.

Berkshire Medical Center
Page 2

Question 4:

It would take, on average, approximately three months to begin delivering services. We already have a secure treatment environment established. We would need time to train staff and develop policies to cover the delivery of high quality services to this population.

RFI Respondent Information

Question 1:

Shannon McCarthy, LCSW, LADC, MSW

Berkshire Health Systems/Berkshire Medical Center

725 North Street

Pittsfield, Ma. 01201

Email address: SMcCarthy@bhs1.org

URL: www.berkshirehealthsystem.org

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Appendix I – Request for Information and Responses Received by June 20, 2019 (cont.)

Center for Human Development Page 1

CHD Response to RFI: Western and Central Massachusetts Secure Section 35 Treatment Centers

Section 3: Questions for Response

Please respond to the following questions:

1. If the Executive Office of Health and Human Services (EOHHS), or one of its agencies, issued a procurement to purchase Section 35 bed capacity in Western and Central Massachusetts, for men and women, do you expect that your agency would submit a proposal?

Yes, CHD is interested in further developing its continuum of care for individuals with mental health and substance use disorders, including Section 35 commitments. CHD has four residential treatment programs that serve adults and adolescents who are Section 35 committed: Two Rivers Recovery Center for Women (Greenfield), Astor House (East Longmeadow), Grace House (East Hampton) and Goodwin House (Chicopee). The specific populations served is discussed below, in Section 4, Number 3.

2. What factors would be most important in influencing whether your agency would submit a proposal?

CHD would consider many factors on submission, including but not limited to:

- EOHHS siting considerations,
- Availability of start-up cost reimbursement,
- Needed renovations to meet security requirements,
- Licensing timelines, and
- Financial viability.

3. Where in Western and Central Massachusetts would you expect to locate your treatment center?

CHD provides human service, behavioral health and substance abuse programming throughout Western Massachusetts, with primary service delivery in Hampden, Worcester, Hampshire, and Franklin Counties. We would particularly look to site the program in the Springfield, Holyoke, and Chicopee areas. These areas are in high need with increasing numbers of deaths by opioid overdoses; by locating in this area we can address the treatment need and the agency would be able to provide individuals in recovery post-treatment with access to our extensive network of outpatient clinics, community supports, and peer recovery resources.

4. If awarded a contract, how long do you expect that it would take your agency to begin delivering treatment services?

CHD has extensive successful experience implementing new programs for a variety of state funders, including DPH, BSAS, DCF, DSS, DMH, DYS, and CT-DMHAS. CHD's strong organizational and administrative resources enable efficient and timely development of safe, appropriately sized, clinically effective sites. CHD retains a realtor to assist in site location, and has relationships with numerous contractors to provide required renovations, as well as in-house capacity. In the past year, we have opened a residential treatment program for persons with

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Center for Human Development Page 2

CHD Response to RFI: Western and Central Massachusetts Secure Section 35 Treatment Centers

enhanced, co-occurring disorders in East Longmeadow, three ACCS residential houses for adults with mental health issues, and are relocating a division administrative office. All new locations met zoning and occupancy requirement, fire code, and licensing requirements per funder and internal timelines. The agency's property portfolio is extensive. We currently operate over 135 program and administrative locations throughout Western Massachusetts and Connecticut, 50 are owned. In addition to the mental health and substance use disorder program location discussed below, CHD has over 350 service locations, including: 25 group homes for adult with ID/D, 6 group homes for adolescents in the care of DCF, 7 CT-DMHAS residential programs, 3 residential programs for DYS, and numerous scattered-site supervised apartments and community support locations.

Subject to many of the conditions cited above and given our organizational capacity, we anticipate it would take six months to open and ready to deliver services, depending on site location, zoning procedures, and licensing processes.

Section 4: RFI Respondent Information

Please respond to the following questions with respect to the Respondent:

1. What is your name, agency/organization, address, email address, and URL?

James Goodwin, President and CEO
Center for Human Development
332 Birnie Avenue
Springfield MA 01107
jgoodwin@chd.org
www.chd.org

2. What is your affiliation or interest?

CHD is a not for profit, human service organization that provides integrated behavioral health/substance abuse services throughout Western Massachusetts in both residential, community-based and outpatient treatment settings licensed by the Commonwealth. A CARF certified organization, CHD is committed to the provision of high quality, evidenced-based treatment modalities for persons with mental health and substance abuse issues.

CHD's recovery philosophy is one that promotes recovery and empowerment and overall health and well-being through treatment that is person and family centered and trauma-informed through the use of evidence-based practices that are culturally and linguistically competent. CHD recovery services meet the person where they are at in the recovery process; there is no wrong door or wrong path to recovery. Recovery is a life-long process that is real and possible.

CHD instills hope and the possibility of recovery through its strength-based and person-centered assessment, treatment planning and case management processes. Staff work collaboratively with individuals and their families to identify and emphasize strengths that become evident in assessment and weave these into individual action plans, goals and objectives that support

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Appendix I – Request for Information and Responses Received by June 20, 2019 (cont.)

CHD Response to RFI: Western and Central Massachusetts Secure Section 35 Treatment Centers

recovery. Through the case management process, staff provide supports necessary for recovery, independent living, social and cultural relationships, and health wellness. Peer specialists are embedded in programs and work alongside direct care staff to share their life experiences and inspire individuals in recovery. Our integrated team fosters a real working relationship with the individual that motivates them in their recovery.

CHD employs SAMSHA-endorsed, evidence-based practices in its delivery of services. Staff use Motivational Interviewing to engage individuals in making change and working towards their recovery goals and objectives. We design interventions that are trauma-informed based upon SAMSHA's Six Key Principles of a Trauma-Informed Approach: 1) Safety, 2) Trustworthiness and Transparency, 3) Peer Support, 4) Collaboration and Mutuality, 5) Empowerment, Voice, and Choice, and 6) Cultural, Historical, and Gender Issues.

By using a person-centered approach, CHD's clinical staff enters into a collaborative relationship with persons served whereby staff support self-assessments and self-determination of goals and objectives. This treatment plans developed are changed and modified as the person transitions to various stages of recovery.

CHD believes it can offer a complete continuum of care for persons discharged from the Section 35 commitment through the range of mental health and substance use disorder treatment services and supports it can offer in the community. This continuum is outlined in Question 3.

3. In what geographic areas in Massachusetts do you currently provide services?

CHD currently provides outpatient and residential mental health and substance abuse programming throughout Western Massachusetts and can provide a continuum of care for persons in recovery or maintenance when they reenter the community. As a Section 35 provider of ATS and CSS services, our existing residential, outpatient clinics and community-based supports provide a natural continuum of care for maintenance and/or recovery. This continuum includes:

- Eight outpatient clinics in West Springfield, Worcester, Easthampton, Springfield, Holyoke (2), Greenfield and Orange.
- Community-based recovery coaches and community support services that can provide additional services for individuals who are Section 35 committed individuals as they reenter the community. These services support the persons in recovery and address social determinates of health.
- Residential treatment programs include:
 - Two Rivers Recovery Center for Women, a residential treatment program for pregnant and post-partum women in recovery and their children located in Greenfield*
 - Grace House, a residential treatment program for pregnant and post-partum women in recovery and their children located in Easthampton,*
 - Astor House, a residential treatment program for individuals with enhanced, co-occurring disorders in East Longmeadow,*
 - Goodwin House, a residential treatment program for adolescent males with substance use disorders in Chicopee,*

CHD Response to RFI: Western and Central Massachusetts Secure Section 35 Treatment Centers

*Program accepts Section 35 referrals once medically stable and cleared.

In summation CHD has the clinical ability and capacity to implement this program.

CHD:

- can site the program in Western or Central Massachusetts;
- has a history of siting with compliance with building and fire codes for a fully secure treatment facility;
- can provide exterior and grounds security to prevent elopement;
- can secure third party payments;
- can provide a therapeutic and secure environment for individuals involuntarily committed for treatment; and,
- has insurance liability coverage.

Appendix I – Request for Information and Responses Received by June 20, 2019 (cont.)

Community Healthlink
Page 1



72 Jaques Avenue
Worcester, MA 01610
Tel: (508) 860-1000
Fax: (800) 518-6055

June 20, 2019

Louis DeLena
Procurement Coordinator
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: RFI: Western and Central Massachusetts Secure Section 35 Treatment Centers

Dear Mr. DeLena,

I write from Community Healthlink, Inc., in response to your above mentioned RFI.

Section 3: Questions for Response

Please respond to the following questions:

1. If the Executive Office of Health and Human Services (EOHHS), or one of its agencies, issued a procurement to purchase Section 35 bed capacity in Western and Central Massachusetts, for men and women, do you expect that your agency would submit a proposal?

We would not submit a proposal.

2. What factors would be most important in influencing whether your agency would submit a proposal?

Treatment for substance abuse is treatment for a complex medical condition. As such we do not believe that incarceration or a punitive-like environment is either trauma informed or appropriate in getting to the heart of successful treatment for substance use. In the situation for Section 35, there is a legal element to entering treatment. The proposed treatment setting milieu would have requirements to manage access in and out of the program, report to courts and potentially a responsibility/liability around what happens with such patients. To support that type of a model and staffing pattern to ensure that level of safety would require a significant increase in staffing and therefore funding. It's not clear if the funding is connected to this proposal would be sustainable in an ongoing way.

Comprehensive Mental Health,
Addiction and Homeless Services
www.communityhealthlink.org

 An Agency of the United Way

Community Healthlink
Page 2

3. Where in Western and Central Massachusetts would you expect to locate your treatment center?

N/A

4. If awarded a contract, how long do you expect that it would take your agency to begin delivering treatment services?

N/A

Section 4: RFI Respondent Information

Please respond to the following questions with respect to the Respondent:

1. What is your name, agency/organization, address, email address, and URL?

Community Healthlink
72 Jaques Avenue
Worcester, MA 01610

Contact:

Sarah Loy, Director of Communications and Resource Development

sloy@communityhealthlink.org

www.communityhealthlink.org

2. What is your affiliation or interest?

CHL contracts with BSAS to provide an array of addiction treatment services, including multiple levels of inpatient care (Acute Treatment Services, Clinical Stabilization Services, and Transitional Support Services), several Residential Recovery Services programs, and Motivating Youth Recovery, a detoxification and stabilization program for adolescent youth. We also provide robust outpatient addiction treatment services, including medication assisted treatment (MAT). We also operate an innovative Behavioral Health and Addiction Urgent Care center, which is open 24 hours a day, 7 days a week and provides walk-in triage, assessment, and referral for anyone seeking assistance for mental health or addiction issues.

We continually look for opportunities to enhance the addiction treatment related services we are able to offer our clients.

3. In what geographic areas in Massachusetts do you currently provide services?

CHL provides services throughout central Massachusetts, particularly in the Worcester area and the north central part of Worcester County.

Appendix I – Request for Information and Responses Received by June 20, 2019 (cont.)

Hampden County Sheriff's Department Page 1

Section 3: Questions for Response

Please respond to the following questions:

1. If the Executive Office of Health and Human Services (EOHHS), or one of its agencies, issued a procurement to purchase Section 35 bed capacity in Western and Central Massachusetts, for men and women, do you expect that your agency would submit a proposal?
 - a. Yes. The Hampden County Sheriff's Department (HCSD) would submit a proposal to continue operating our existing Section 35 program that currently has 117 beds and serves men from the 5 western counties of Massachusetts. The Hampden County Sheriff's Department would be willing to make changes to meet EOHHS guidelines to become a licensed facility. Beginning on September 1, 2019 the HCSD will also have a licensed Opioid Treatment Program within our facilities. In the one year that the Section 35 program has been operational in Ludlow and Springfield, the HCSD has treated over 750 men with an average stay of 49 days. We have also been able to treat these men at a fraction of the cost of current DPH licensed facilities in MA due to our existing infrastructure. We foresee this will hold true should we be allowed to continue treating men and hopefully begin to treat women from the 5 western counties of MA.
2. What factors would be most important in influencing whether your agency would submit a proposal?
 - a. The Hampden County Sheriff's Department serves the people of Hampden County and Western Massachusetts. We do not believe that any factors would deter us from submitting a proposal and seeking licensure. In the year that we have been operational, we have had a tremendous amount of support from the courts, law enforcement, families and the clients themselves. There is a tremendous need for this program in Western Massachusetts and given our success in treating over 750 men, we strongly believe we are the best and most prepared agency to operate a Section 35 program for both men and women. Additionally, we know that having a secure treatment facility, particularly during the detoxification period, is critical to the success of a treatment program. In a recent DPH meeting where Section 35 statistics were discussed, it was noted that DPH facilities had 200 elopements in a year period, most occurring within the first week of treatment. With our model, there are no elopements within the first week of treatment and we are able to treat for longer periods of time. Currently we are averaging between 48 and 49 days of treatment.
3. Where in Western and Central Massachusetts would you expect to locate your treatment center?
 - a. Treatment for men would continue at the Stonybrook Stabilization and Treatment Centers located in Ludlow and Springfield. We would explore options in Hampden County, a central point for the counties of Worcester,

Hampden County Sheriff's Department Page 2

Berkshire, Franklin and Hampshire, to open a treatment center for women. With the many relationships the HCSD has with the community and our partners, we have full confidence that we can locate a facility to begin to treat women if necessary.

4. If awarded a contract, how long do you expect that it would take your agency to begin delivering treatment services?
 - a. Our Section 35 treatment centers for men are currently operational. Should the HCSD be licensed to provide treatment for women, we believe we could be operational within 1-2 months if we are allowed to operate at one of our minimum security facilities. If we are required to open up a new, standalone facility, our timeline for opening would be dependent on the build out of such facility.

Section 4: RFI Respondent Information

Please respond to the following questions with respect to the Respondent:

1. What is your name, agency/organization, address, email address, and URL?
 - a. Hampden County Sheriff's Department
 - b. 627 Randall Rd, Ludlow, MA
 - c. Katie.fitzgerald@sdh.state.ma.us
 - d. <http://hcsdma.org>
2. What is your affiliation or interest?
 - a. The only interest of the HCSD is to serve the people of Western Massachusetts.
3. In what geographic areas in Massachusetts do you currently provide services?
 - a. Our treatment centers are in Hampden County – Ludlow and Springfield, but we currently treat men and women from the 5 western counties of Massachusetts.

Appendix I – Request for Information and Responses Received by June 20, 2019 (cont.)

Steward Health Care System

Page I

Printable Version

June 19, 2019

Louis DeLena
Procurement Coordinator
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: RFI: Western and Central Massachusetts Secure Section 35 Treatment Centers

Dear Mr. DeLena:

Please consider this as a response to the above-captioned RFI on behalf of Steward Health Care System (submission in red); CC'g our VP/Business Development for the North East Division of Steward.

Section 3: Questions for Response

Please respond to the following questions:

1. If the Executive Office of Health and Human Services (EOHHS), or one of its agencies, issued a procurement to purchase Section 35 bed capacity in Western and Central Massachusetts, for men and women, do you expect that your agency would submit a proposal?
Yes, on behalf of Steward Health Care System, we could expect to submit a proposal for 3.35 beds in Central Massachusetts.
2. What factors would be most important in influencing whether your agency would submit a proposal?
Beyond the then in effect per diem rates for ATS and CCS levels of care, a capital add-on methodology to offset design and building retrofitting costs for licensure and start-up would be required for us to consider this service expansion.
3. Where in Western and Central Massachusetts would you expect to locate your treatment center?
Ayer, at Nashoba Valley Medical Center.
4. If awarded a contract, how long do you expect that it would take your agency to begin delivering treatment services?
Construction/building retrofitting and start up staffing would be our timeline to licensure and opening – estimated to be 6 months after successful award and contracting (including capital add-on).

Section 4: RFI Respondent Information

Please respond to the following questions with respect to the Respondent:

1. What is your name, agency/organization, address, email address, and URL?
**Steward Health Care System c/o, Nashoba Valley Medical Center, 200 Groton Road, Ayer, MA 01420 <https://www.nashobamed.org>
My position and contact information is below in my signature line for any follow-up.**
2. What is your affiliation or interest?
Steward Health Care System has an array of behavioral health and substance use disorder programs at our inpatient and outpatient sites, as well as in our primary care and specialty physician offices (Steward Medical Group and other doing business as local names) and clinics and also provided through our accountable care organization (Steward Health Choice) to its members.
3. In what geographic areas in Massachusetts do you currently provide services?
Hospital services areas: Southeast (Fall River); SE Mass (Taunton, Brockton, and Stoughton); Metro Boston (Dorchester and Brighton); Suburban Boston (Norwood); Central Mass. (Ayer); and Merrimack Valley (Methuen and Haverhill). In addition, we have physician practices throughout Massachusetts (Steward Medical Group) and a Medicaid ACO of some 120k lives that overlaps our hospital service areas as well as Worcester County and The Cape (through Steward Health Care Network).

Section 5: RFI Response Instructions

A. Response Submission Instructions

All responses to this RFI are due no later than **12:00 PM on June 20, 2019.**

By

Kevin R. Burchill, JD, FACHE
Senior Vice President for Behavioral Health Services
STEWART HEALTH CARE SYSTEM, LLC

Appendix J – Recommendations Considered Out-of-scope and Not Voted on by the Commission on June 27, 2019

Recommendation
A review should be conducted on use of gabapentin, Klonopin, and Adderall combined with Suboxone post treatment.
The Commonwealth should implement “Know Your Rights Campaigns” that would ideally be supported by EOHHS, AGO, and DOI with family and recovery community organizations on how to use the continuum of care and get immediate access to care.
Actions should be taken by the Commonwealth to strengthen parity laws for equal access to care.
The Commonwealth should explore whether the Hampden County model could be scaled up for general population.
The Commonwealth should address the lack of adequate insurance coverage, including inadequate networks, low and wildly disparate rates among plans, insufficient treatment duration as well as workforce that pose barriers to treatment.

Appendix K – Comments Received from Members on the Draft Report to the Legislature

Thank you for forwarding the RFI information.

In addition to including the RFI responses in an Appendix, I recommend that included in the main body of the report should be a discussion of the Western Mass experience. It should be recognized that the commission heard more positive comments about the program run by the Hampden County Sheriff than about MASAC. It should also be noted that the Sheriff developed a program in the absence of others in the area, but it is important to explicitly state, as the Secretary indicated at one of the sessions, that no RFP was ever put out. And that further, the Commission has put out an RFI and that 7 programs have responded.

Additionally, I want to add my voice to the comments from many other members that one recommendation should be that Section 35 programs not be in correctional facilities, but rather in programs overseen by the Exec Office of Health & Human Services; further, that total bed capacity should not be diminished in the transition, and that adequate capacity for both men and women should be in all parts of the state, with special mention of the requirement that they be in Western Massachusetts.

Thank you,

Ruth B. Balseer, State Representative
12th Middlesex District (Newton)
House Chair, Joint Committee on Elder Affairs
Room 167, State House
617-722-2810

The use of Section 35 should be statutorily narrowed in two ways:

1. Section 35 should not be used for voluntary commitments.
2. Even for involuntary commitments Section 35 should be rewritten so that it is available only in cases in which it is clear that the subject individual is in danger of causing severe immediate harm to self or others or loss of life above and beyond the harms that are routinely attendant upon the abuse of substances, such as death by overdose.

Senator Brownsberger and Senator Friedman

Appendix K – Comments Received from Members on the Draft Report to the Legislature (cont.)

Page 1

Dear Gabe and Secretary Sudders,

Please accept my sincere thanks to you and your staff for drafting this report, and for soliciting feedback as we proceed to the conclusion of the Commission process. It has been a privilege to serve on this Commission, and to work with you and the fellow commissioners.

MMS continues to appreciate that Section 35 serves as an important last resort for many families and patients in Massachusetts, but also feels that many of the presentations to the Commission, including those of people with lived experiences, as well as the data presented to the commission and the academic literature distributed, have raised critical questions about the future directions of Section 35.

Please find below initial comments from the Massachusetts Medical Society Regarding the 6/12 Draft of the Section 35 Draft Deliverable. I look forward to providing additional detail at the upcoming meeting.

Here are several points that I wish to raise to my fellow Commissioners:

- 1) MMS requests that the final portion of the enabling statute of this Commission, which prompts the representative to “file recommendations, including any proposed legislation, with the clerks of the house of representatives and the senate not later than July 1, 2019,” be added to the second page of the Report.
- 2) On slide 17, regarding involuntary commitment outcomes, the main bullet says that there is limited research, and then lists the Werb paper in the small footnote. I think the full conclusion of Werb should be listed in the main bullet:

“There is limited scientific literature evaluating compulsory drug treatment. Evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms. Given the potential for human rights abuses within compulsory treatment settings, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms.”
- 3) MMS proposes a vote of the Commission to add the following Recommendation to slide 20.
“The Commission recommends not pursuing the option of a 72 hour involuntary civil commitment for substance use disorder at this time.”
- 4) MMS supports a “Recommendations page” be inserted after Slide 26, which includes Recommendations of the Commission, pursuant to the authority referenced in point number 1 above.
- 5) MMS supports an amended version of recommendation #2 from Vic DiGravio, which states, “That the Commonwealth prohibit civilly-committed men from receiving treatment for addictions at any criminal

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justice facility, and encourages the Commonwealth to fund and/or procure vendor or state-operated beds in Western Massachusetts and other parts of the Commonwealth to offset on a one-to-one basis diminished bed capacity resulting from the prohibition on placing individuals in criminal justice settings.”

6) MMS supports a Recommendation that, “The Commonwealth, in consultation with provider organizations, peer and family groups, legal advocates and other stakeholders, and academic experts in the field of evaluation of care of people with substance use disorder, create a consistent set of required quality metrics that will be regularly, publicly reported on by every provider of care to a personally civilly committed through the Section 35 process.”

Please feel free to reach out if you have questions on any of these comments. You are welcome of course to share these points with the rest of the Commission. I respectfully ask that you share comments from my fellow commissioners so that we can be best prepared to respond in the final meeting.

Sincerely,

Alain Chaoui, MD

Appendix K – Comments Received from Members on the Draft Report to the Legislature (cont.)

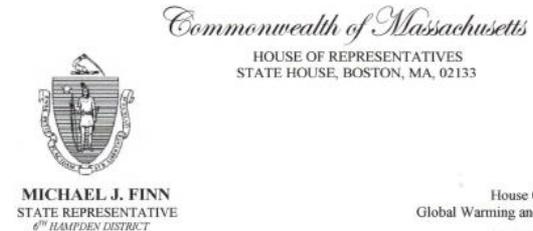
1. That the Commonwealth, in consultation with provider organizations, peer and family groups, legal advocates and other stakeholders, identify alternative pathways in addition to the current court-based process, to civilly-commit individuals for addiction treatment. Additionally, individuals that are civilly-committed through a judicial process should not be shackled in any way and shall not be held in court "holding cells" while awaiting transport to a treatment program.

RATIONALE: Testimony provided by CPCS attorneys made clear that the process of forcing an individual to be held in court holding cells with and being transported by criminal justice officers can be unnecessarily traumatizing. Alternative pathways for civil-commitment may allow individuals and their families to avoid the trauma of being treated by a criminal simply because of their disease.

2. That the Commonwealth prohibit civilly-committed men from being held in any criminal justice facility, provided that the Commonwealth fund and/or procure vendor or state-operated beds in Western Massachusetts and other parts of the Commonwealth to offset on a one-to-one basis diminished bed capacity resulting from the prohibition on placing individuals in criminal justice settings.

RATIONALE: Massachusetts law currently prohibits civilly-committed women from being "sectioned" to criminal justice settings. The same prohibition should apply to men, notwithstanding the fine work being done by Sheriff Cocci in Hampden County. Testimony provided by individuals who have been sectioned to MASAC was very distressing and made very clear why men should not be held in criminal justice settings.

Submitted by Vic DiGravio, President/CEO, Association for Behavioral Healthcare



House Chair
Global Warming and Climate Change

Room 274, STATE HOUSE
TEL: (617) 722 - 2676

June 26, 2019

I write today to offer my thoughts for inclusion in the final draft deliverable of the Section 35 Commission's report.

- 1) I recommend a process to allow for correctional facilities to become licensed by DPH and/or DMH.** Some of my fellow commissioners are recommending a "bed for bed exchange" from correctional settings to DMH/DPH Licensed facilities. The recommendations made acknowledge both the current regional inequities in the western part of the state, and more importantly acknowledge the tremendous work currently being done and the services being provided by the Hampden County Sheriff's Department. To date the Hampden County Sheriff has provided to the Commission evidence showing that their services are equal to if not exceeding the current statewide statistics regarding length of stay, medically assisted treatments for detoxification, and successful outcomes for Section 35 committed individuals. Additionally, in the case of dual status individuals, it would make sense to be able to provide services for addiction simultaneously to the path and time of ongoing criminal cases. While the current system may need improvement a complete ban on Section 35 commitment in correctional settings is not ideal either.
- 2) I recommend creating a process where the Trial Court "On Call Judge" be incorporated into the current process of civil commitment.** This could be an important tool when considering the expiring nature of apprehension warrants and the limited ability of law enforcement in locating individuals during the courts regular business hours. Additionally, a preliminary request for commitment could be approved that could bridge the gap until a full hearing could be conducted.
- 3) The Commission's report must recommend immediate steps to correct regional inequities for women's treatment under current Section 35 capacity.** Evidence supports that the current capacity for women committed under section 35 is inadequate when viewed through a regional lens. The four western counties have no beds available to them and the nearest facility is a minimum of 2 hours away. This is in my opinion unacceptable and must be remedied as soon as possible. I acknowledge the fact that women are currently prohibited by law to receive Section 35 treatment in correctional settings, however, if correctional facilities were able to become licensed DPH or DMH facilities, then I would highly recommend the Hampden County Sheriff's Department to be considered as an operator of any future Section 35 women's facility in order to address the regional inequity of zero beds available in the four most western counties.

Respectfully,

Michael J. Finn

Appendix K – Comments Received from Members on the Draft Report to the Legislature (cont.)

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Marcia Fowler / CEO Bournewood Health Systems

1. The Commonwealth should commence a process with the goal to reduce and or eliminate the use of Section 35. There is insufficient evidence that Sec. 35 is an effective treatment intervention or improves treatment outcomes to support or justify the deprivation of an individual's civil liberties. The use of Sec. 35 results not only in loss of liberty but often alienation from family, the treatment system, loss of housing and employment. Resources should be directed towards what we know to be effective.

The lack of access to appropriate ongoing outpatient treatment and the availability of MAT places individuals who have been involuntarily committed at risk for fatal overdose. This is also true for individuals receiving voluntary acute treatment. There is no evidence that Sec. 35 reduces relapse rates. The demographic data would also suggest significant racial and ethnic disparities in the use of Sec. 35. While there is data demonstrating that communities of color access the behavioral health system less frequently than whites in general, a pathway to treatment through the court system may further exacerbate this phenomenon and create a chilling effect, limiting access to treatment for immigrant and communities of color.

2. The Commonwealth should prohibit the commitment of individuals under Sec. 35 to criminal justice settings. This process should occur in such a way as to not reduce statewide treatment capacity.

3. The Commonwealth should explore alternatives to the current Sec. 35 court commitment process in order to further de-criminalize the intervention. However the existing system for civil commitment as it is currently resourced and designed does not have the capacity to manage the use of Chapter 123 Sec.12 as an alternative to Sec. 35. The negative unintended consequences starting in particular in the EDs and throughout the treatment continuum would significantly outweigh any possible gains. Significant system transformation in the realm of capacity, access, insurance coverage, and due process to name a few would be necessary for this worthwhile goal to be successful.

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4. The data presented indicates that the availability of voluntary treatment capacity by geographic region reduces the use of Sec. 35 in those areas. In many areas of the state individuals in need of SUD treatment in essence need to "fail up" into the most acute levels of care, including involuntary treatment, in order to receive treatment.

The Commonwealth has successfully expanded treatment capacity for SUD in the last four years. Despite these robust gains there remains significant unmet need both in terms of capacity and access. Capacity and access while overlapping should be examined as separate issues. Lack of adequate insurance coverage including inadequate networks, low and wildly disparate rates among plans, insufficient treatment duration as well as workforce pose barriers to treatment.

The development of low threshold, treatment on demand type models including the expansion of harm reduction interventions in community based settings should be significantly expanded in order to reduce negative health outcomes and provide a treatment connection to people when they seek it. The lack of stable housing is one of the most significant barriers to an individuals ability to engage in and remain in ongoing treatment.

Appendix K – Comments Received from Members on the Draft Report to the Legislature (cont.)

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Section 35 Recommendations

- Section 35 is being utilized is likely being used because so many are desperate and want their family member to be alive and not a statistic.
- Many say that it has helped to save lives, others say it is taking away civil liberties.
- Many do not know how to use the continuum of care and find it too overwhelming to even think about how to use their insurance.
- There appears a lack of consistent standards from the time of “apprehension” to “re-entry” - and that sounds “criminal” - when a person really needs help and support.

So What do We Need to Do

- To implement Consistent Standards of “Care” that are followed from time of apprehension (welcoming a person to care all the way through discharge with an agreed upon continuing care plan that is followed up. To make sure that Section 35 is carried out in a standard manner period following the law-
- To come up with consensus about the difference between offering safe and secure treatment for persons whose alcohol and other drug use leaves them hurtful to themselves versus the view that it is taking away a person’s civil liberties
- To implement early access to treatment that offers comfort and care with no stigma that is paid for by insurance throughout the whole continuum of care.
- To implement **Know Your Rights Campaigns** supported by EOHHS, AGO, and DOI with family and recovery community organizations on how to use the continuum of care and get immediate access to care. To support efforts to help people get immediate access.
- To ensure that 90 days of treatment is offered if the section 35 participant demonstrates that long term is necessary, and it is positive preparation for further residential treatment or whatever seems appropriate.
- To support moves to strengthen Parity laws for equal access to care
- To ascertain that private/public insurance should guarantee appropriate treatment with recovery supports -----long term with understanding that there is resistance with those who suffer from addiction
- To support workforce to work as a team with open communication to support the person at the level that the person and family can comprehend. Make sure that the work force is supported

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with education and strong supervision. The workforce should be both professional and peer and paid well. This is to ensure clinical appropriateness and peer identification.

- To ensure that all section 35 participants be treated humanely with kindness, involving family unless history demonstrates this would be harmful.
- To ensure that participant’s history is thoroughly reviewed, as if the appropriate intervention does not happen -----history will repeat itself
- To ensure equity for support to rule out geographic and cultural disparity when sectioned nobody should go through traveling in a van shackled because it is the la
- If restraints are needed – they should be humane – and training as to how to apply or avoid is important
- To agree with the recommendation for taking section 35 out of prison -----however, not until there is appropriate treatment in place. Steps need to immediately take place to take away any detrimental actions towards Section 35 participants in any setting.
- To consider making Hampden County model for general population - -----
- To make sure that western Massachusetts gets a facility for women like Taunton
- To please note that as much as MAT is a valued treatment for persons who have been sectioned and have overdosed repeatedly – we need to question why **uppers** – Adderall, **sedatives** - Klonopin, and gabapentin – **meant for seizures** are being prescribed at the same time – and often does not appear to be helping the person in need.

submitted by Marianne Frangules, **MOAR** Executive Director
with support from concerned recovery community members
and MOAR survey

Appendix K – Comments Received from Members on the Draft Report to the Legislature (cont.)

Comments on Deliverable: Richard Frank

1. Slide 15: The data should be presented in a more direct and straight forward manner. The figures on the slide seem somewhat inconsistent with the numbers on slide 13. What percentage of the 10,770 petitions were unopposed? The 94% figure seems to create an impression at odds with the data on slide 13.
2. Slide 17-18: I think we have taken an overly narrow approach to examining the literature. There is evidence from studies that apply leverage (e.g. Physicians' Health Recovery Program, Drug Courts) to SUD treatment. My reading of this literature is that leverage can help increase retention and reduce mortality under specific conditions. Leverage of course is not the same as institutional commitment. A broader review would give the two slide greater context and more weight. These slides come across as a punt.
3. Slide 19: It might be worth pointing out that oral naltrexone for use in OUD treatment is not well supported by evidence. Some nuance around induction following an overdose and use of naloxone would be useful here.
4. Slides 21-25 are very useful. One suggestion, it may be helpful on slide 21 to identify sources of referrals to buprenorphine waived providers.

OFFICE OF CINDY F. FRIEDMAN

Suggested draft recommendations for Section 35 Commission report

1. The Executive Office of Health and Human Services (EOHHS), in conjunction with the research community and other relevant stakeholders, should define and collect the necessary data to determine the effectiveness of the current Section 35 process as it relates to relapse, ongoing treatment and recovery. EOHHS should seek appropriations, grants and other financing tools to conduct an in-depth multiyear study using best research practices. As part of the study, EOHHS should identify any successful initiatives or practices that support the recovery of people with a substance use disorder.
2. The Commonwealth should require that all Section 35 commitment beds for substance use disorder (SUD), for men as well as women, be in facilities approved and licensed by the Department of Public Health (DPH) or the Department of Mental Health (DMH), and not in correctional facilities. EOHHS should develop a plan within 90 days for transferring control of, and relocating, all Section 35 beds currently housed in any DOC or HOC facility. All such beds should be transferred to DPH- or DMH-licensed and regionally- or community-accessible facilities for SUD treatment and dual-diagnosis (SUD and mental illness) treatment. No reduction in total number of available beds should result from this transfer.
3. The legislature, in conjunction with EOHHS and in consultation with stakeholders, should (1) conduct an analysis of the benefits of, and any barriers to, creating a Section 35 process that models the Section 12 process found in MGL Chapter 127, and (2) develop and file legislation to implement this change.

Appendix K – Comments Received from Members on the Draft Report to the Legislature (cont.)

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Summary of recommendations from

Mark Green, MD.
Addictions Specialist
Representing the Massachusetts Psychiatric Association.
6/25/19

Thank you for the privilege of participating in this Governor's Commission. It has been highly educational and I have felt challenged while being deeply impressed at the thoughtfulness and dedication of everyone involved.

I recognise that the Section 35 commitment order has been established by well-meaning people trying to do the right thing; and that some people have benefited from compulsory treatment. Many people, especially family members of people suffering with addictions, and law enforcement personnel on the front line feel that section 35 provides a necessary last resort for people who are refusing care. However, in my opinion, the evidence does not support the continued provision of section 35 at all and it should be revoked. The resources spent on this program should be diverted into more fruitful approaches.

I have raised my concerns under three headings.

1. Is section 35 effective? The desired outcomes would be improved survival, transition to effective treatment, or reduced recidivism.
At numerous meetings, evidence was presented that showed that people who were committed under section 35 had worse outcomes than those that were not. There were more deaths in people who were sectioned, and these were overdose deaths. There was an extremely high readmission rate. Only 0.8% of people admitted under section 35 received medication assisted treatment, the treatment of choice for opioid addiction, after discharge. The only positive outcome was presented by Leslie Milne MD, who reports a reduction in emergency room attendance following section 35 in a tiny sample of 23 homeless people. However, it is not at all clear what happened to these people and whether they merely discharged to housing, and so used the ED less. Overall, section 35 had terrible outcomes.
2. Is section 35 ethical? To be justified, the outcome should be worth it (see above); the patients should be grateful after the fact; the treatment should ascribe to general medical ethics of doing no harm; the treatment should be equitable; the treatment should not impede better alternatives; society should benefit.

25 Flanders Rd, Belmont, MA 02478 • P: (857) 598-2808 • F: (857) 598-2864 • www.psychgarden.com

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The outcomes appear to be very poor, perhaps worse than doing nothing (see above). The patients are not grateful and report grave dissatisfaction with their experience, for the most part. The treatment is not desired but imposed, antithetical to medical ethics for someone with the capacity to make decisions. It is inequitable: The patients who are sectioned are actually healthier, having connected, engaged, advocating families. They have homes, less overdoses, are more employed than those not sectioned. There is a higher percentage of black alcoholic patients who are involuntarily committed. Thus it is neither equitable, nor targeting those most in need. The treatment does not appear to be overall helpful to society: it is expensive, ineffective and unwanted by the people who receive it.

The treatment violates the basic tenets of effective care for addictions: Medical research and experience is clear that people with addiction make choices to reduce use, or improve the safety of their use patterns (thus moving towards better health and positive change) when motivation to change is high; coercion is low; a range of treatment options are presented; treatment is accessible and attractive; alternatives to treatment are undesirable; there is associated healthcare; there are positive contingent rewards associated with treatment paths. For opioid addiction, early and convenient access to opioid replacement therapies is essential. Family engagement in a collaborative, supportive (non-critical, non-hostile) manner leads to improved outcomes.

- Section 35 commitment violates most of these criteria. It is involuntary, oppositional, coercive, fails to employ a motivational enhancement approach, engage people in safer use patterns or positive reward pathways. It is not surprising that outcomes are so poor.
3. What does it get in the way of? Obviously there is an impassioned, desperate group of people - mainly parents and law enforcement officers - who want adequate treatment for their loved ones. There are more effective approaches for the family, rooted in motivational interviewing, contingency management, and effective communication skills. For example, Community Reinforcement Approach - Family Therapy (CRAFT) is a strongly researched and effective family therapy which, in studies, results in successful engagement of patients in drug treatment. Another example is safe injection sites where patients receive support and engagement with peers and counselors and where many transition to addictions treatment. Another is simple befriending and peer counseling. Another is provision of low cost, easy access opioid replacement therapy. Another is the provision of housing. All of these cost money, take time, and are only partially successful. However, there point is that there are alternatives and our focus on maintaining ineffective, expensive, coercive approaches does not serve the Commonwealth's community well.

Our Commonwealth's addiction problem is severe and, of course, is a deeply passionate issue. Moreover, addiction arouses a feeling of helplessness and powerlessness in treaters, family members and anyone trying to help people with addictions who can appear to be in denial, stubbornly doing something that can lead to their death and to harm for others and society. Under such desperate conditions, it is natural to apply more forceful, even draconian, measures.

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Appendix K – Comments Received from Members on the Draft Report to the Legislature (cont.)

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However, these are not successful in treating addiction. This has been clear for decades. It is enshrined in AA's first steps and Al-anon's principles. It is established through scientific research on motivational interviewing, harm reduction, contingency management and CRAFT. When patients are correctly engaged, families corrected educated, and medication assisted therapies employed outcomes are better. In my opinion, the Commonwealth, through section 35, has engaged with families in an emotional reflex that is harmful, while ignoring this AA tradition and research database. I believe it is time to abandon section 35 and put the money, deep dedication and considerable human resources to more effective use.

Thank you again for the honor of participating.

Mark Green, MD
Board Certified in General Psychiatry and Addictions Psychiatry

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Although this is a very complex issue, it was very exciting being part of this Commission to dissect the current system and propose changes to better serve the citizens of the Commonwealth that suffer from this serious disease.

As this is my first time sitting on a Commission, I am not sure how you the commentary. If you require my comments in a different format or that you require me to be more specific with citations, please let me know. It was an absolute honor to sit on this Commission and to be nominated by Senator Tarr.

My comments are primarily focused on the Section 35 process and the treatment facilities.

It is my opinion that there needs to be extensive legislature changes to the current law. The section 35 process should not involve the court system. Statically, the courts would be hearing approximately twenty nine (29) Section 35 petitions per day across the state involving nearly 7500 patients suffering from drug or alcohol diseases. These patients need to be evaluated and treated by health care professionals monitoring their signs and symptoms and providing aggressive treatment to these patients. Referring them to the courts during business hours and placing them in holding cells presents a grave risk of increasing in custody deaths which can be and must be prevented. Statements were made during the Commission meeting's that the Commonwealth has already experienced in-custody deaths during the process and transportation of these patients.

In reviewing the legal letters and literature provided, it appears that legislature changes would be required in an effort to mirror the short term hospitalization of patients classified under the Chapter 123 S. 12 which allows for the involuntary commitment of a person who presents a likelihood of serious harm by reason mental illness. The legislative change would amend Chapter 123 S 12 to include " a person who represents a likelihood of serious harm by reason of a substance use disorder". Under Chapter 123 S 12(b) the patient can initially be held for 3 days (72 hours) after being evaluated by a physician with admitting privileges. Chapter 123 S 12 also has a provision that allows for a hospital to file a petition for an extended commitment for up to six months. Amending Chapter 123 S 12 still allows for the patient to still have due process.

The current system does not make logical sense in that a person is suffering from a disease in which they cannot control their temptation of consuming drugs and/or alcohol. The person and family members cannot care for this person any longer. The police are called. The person refuses care but we are faced with a grave situation in which not transporting the person to the hospital may end up with the person dying. We execute an option of writing a Section 12 and have the person transported to the hospital involuntarily. The police try to convince the hospital to keep the patient over night so that we can petition the courts in the morning to have the person committed under a Section 35. The petition is heard and a warrant is issued for the patient. The police then return to the hospital and serve the warrant to the person and then transport the person to court where they are placed in a holding cell still withdrawing from their disease. The court hears the evidence and determines the the need to grant the Section 35. The person is then return to a holding cell. A prisoner transport van is called through the local county sheriffs department. The person is then transported to a facility that maybe two plus hours away in which the person is unsupervised during the transport.

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Another concerning matter is that when the courts issued a Section 35, the length of the Section 35 is for up to 90 days. The literature presented shows that the average length of stay for people in the Section 35 programs average 37 days for males and 30 days for females. Literature also indicates that overdose survivors who receive medications have a better survival rate.

Another concern is the inconsistent reports of available beds for Section 35 patients. The document on page 9 of the draft outlines the Section 35 Facilities and Current Capacity. The male population has a bed capacity of 476 beds including DOC facilities. If the DOC facilities were eliminated as options the male bed capacity would be 108 beds. The female bed capacity is 179. The question is raised that if we have nearly 7500 petitions per year and 82% of the petitions resulted in a commitment what is the actual number of patients that we can provide adequate treatment too?

My last comments strictly have to do with the facilities in which care is being provided to these Section 35 patients. After hearing heart wrenching testimony by recipients and their families to the inhumane conditions and treatment offered by the Plymouth County treatment facility, it is without hesitation that I recommend that the legislature's and/or Governor enact legislation similar to the 2016 legislation ending the incarceration of female patients with substance use disorders that are not subjects of the criminal justice system. This same legislation needs to be enacted by the Governor for male patients with substance use disorders. It is evident that any facility that offers care to the Section 35 patient must have the abilities to provide medication assisted treatment. From my perspective the evidence based literature and testimony is overwhelming supportive of

Below is a commentary from a nurse at Brockton Hospital and a Deputy Chief of Police from the Lynn Police Department

Families report after placing their loved one on a Section 35 they are receiving calls from the receiving facility within 24 hours asking them to start putting a plan in place for aftercare. Families are often

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taking their first deep breath in months knowing their loved one is in a "safe" place to only find out they most likely will not be spending two weeks on the Section.

1. Families report due to the amount of angst and stress they went through to place their loved one on a Section 35 – they will never do it again due to their loved ones being released too early.
2. We placed a client on a Section 35 on November 5, 2018. On November 16, 2018 he was in the ER being treated for a Fentanyl overdose. He required CPR and 10 mg of Narcan. This is a 29 year old man who has lost 40 pounds within the past three months; has a history of hypertension; coronary artery disease; Hepatitis C and endocarditis. We placed him on a section hoping they would hold him for a minimum of 30 days to assist in breaking his cycle of addiction. To find out he was held for 11 days was extremely disappointing and sad. This is a young man who is dying.
3. Worked with DMH and the courts to place a 40 year old male with a long history of crack cocaine and marijuana abuse on a Section 35. He is a paranoid schizophrenic. He has lost nearly 50 pounds in the past year due to his excessive use of cocaine; he is homeless and refuses to sleep in the shelter; he sleeps on the street and commits crimes to support his habit. When the court accepted the petition he was sent to the Plymouth House of Correction (MASAC). MASAC contacted DMH to make a discharge plan for the male – they wanted to discharge him within the first 14 days. DMH was informed by MASAC they wished to discharge the male due to him "being difficult to manage."
4. We have sectioned numerous homeless individuals in Brockton with the police department in an effort to help break their cycle of addiction. This could be individuals with polysubstance abuse; alcohol abuse; opiate abuse; crack abuse and so on. Often, many of these individuals are released within a week. When the facilities have been contacted to ask why the early release, the reply is "they don't want to participate in the programs...why keep them?"

Correct me if I am wrong – but wasn't the Section 35 process put together to assist families and communities with obtaining assistance for the person with an addiction that refused treatment? It often takes a week to two weeks for the person with addiction issues to start to think clearly when they are not using. Typically, they want out – getting clean and sober is hard. If the process is not followed – what is the point???

DC Lynn Police

Starting in 2012 as our overdose numbers started to spike we made it a formal practice to give family members of non-fatal overdose victims the Lynn District Court Court Clinician's Section

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35 packet. It clearly explains the process and how to go about it. It also set out the possible options as to where the subject may be sent if the petition is successful.

As our numbers really took off in 2013 it was clear that a lot of the overdose victims, due to their current lifestyle, no longer had a connection with family members who could petition for them. We then began to petition on a more regular basis for not only overdose victims but also a number of the serial inebriates who frequent the downtown area. In fact I would say our number as far as Sec. 35's is probably split between the two. (From 04 30 14 to 09 30 18 the LPD was the petitioner on 50+ successful Sec. 35's.)

We still will try to find a family member who will petition when we encounter someone who is in danger of dying due to their substance abuse. I believe the judge is much more likely to issue the Sec. 35 when a family member is involved. I do sometimes get the feeling that some judges look at a police led petition with a more critical eye and may see it as an attempt to simply get someone "out of our hair" for awhile.

I think a big part of using the Sec. 35 process to find help for those who no longer have others to help them is getting the officers to buy in. Primarily of course as a way to help people. But, also as a way to address what has become an ongoing problem on their route. Leading by example and doing some petitions may have played a role. But I think most of any "success" in getting officers to petition is having mental health/substance abuse workers, our Behavioral Health Unit, working in our station. Officers can talk to the clinicians and recovery coaches whenever they wish and get advice and / or assistance in going forward with a petition. Also, the Behavioral Health personnel have been key in getting a clinician, social worker, or other professional to also be available to testify at the hearing if the initial petition is successful. I have found that a judge is much more likely to issue the Sec. 35 if there is a mental health/substance abuse professional also providing

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testimony.

Additionally, having a good connection with community providers is very helpful. Being able to speak with nurses, outreach workers, clinicians, etc. means we are able to bring more than just the LPD's perspective into a possible Sec. 35 situation. When there are regular meetings among the agencies that are all dealing with the same person all the options can be discussed. Or, other providers may have someone who can support the officer's testimony. Also, there is more likely to be some follow up when the subject of the 35 is released. (Huge Problem #1.)

Finally, as far as positives, having a good relationship with a great court clinician is key. We are very lucky to have that in the LDC Court Clinician. Tudy Bartlett is always available to us and ready to "hold our hands" as we try go through the Sec. 35 process. She will let us know if it might be a useless gesture to petition on a given day as there are no beds available. (Huge problem #2.)

Huge Problem #1 is the great difficulty in getting the facility where the subject of the Sec. 35 is sent to coordinate with community providers before he/she is released back to the community. We have seen Sec. 35 after Sec. 35 come right back to their previous situation with the only notice being that we see them back on the street. I have been told by numerous providers that coordinating with any of the facilities where a Sec. 35 subject is sent is frustrating. If the facilities could be more open with community providers it would be a big step in possibly making the Sec. 35 "stick."

Huge Problem #2. Not enough beds in the treatment facilities. There are many times

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we have made the decision to attempt to Sec. 35 a party and been told it was not a good day to do so as there were no beds that day. I would say that is the biggest need to start. We can encourage family members and officers to petition. We can have strong working relationships with other providers. But, if there are no beds there are no beds and it means another day of use that might result in death.

Other Commentary:

In the presentation with Chief McCarthy and Boston EMS the panel discussed the availability of Narcan to EMS. It was stated that Narcan was plentiful. I would strongly disagree with this statement as there is limited funding through grants to subsidize the cost for the purchase and replacement of opiate antidote Naloxone. It generally cost \$40.00 for a dual pack of the 4mg nasal spray Narcan through the State Pharmacy. Today it generally takes 6 - 8 mg of Narcan to reverse the effects of the Opiate. To be able for a police department to carry Narcan, the police department must find a physician that is willing to be the medical advisor for their Narcan program, complete a Controlled substance registration, have the medical advisor sign the application and submit their medical credentials. Once the application is approved, a Controlled Substance license is issued to the agency. Once approved, the agency must train each member of their department in an approved 1.5 hour training program. Again the cost of the training and supplies is cost prohibited for some departments which prevents them from carrying the lifesaving drug.

Another factor is the replacements costs for the Narcan as there is no mechanism to exchange the medication with hospitals and or ambulances. EMS may incur initial expenses but the replacement costs are off set with insurance claims.

Respectfully submitted,

Neal S. Hovey

Hi Gabe,

During our last commission meeting it was brought up that only physicians can petition for a section 35.

This new law below was brought to my attention and think it could apply to Section 35.

Please let me know whether Dr.Sudders is aware of this.

Thank you so much for all you do.

Carrie Jochelson PMHCNS-BC

Section 80I: Required signature, certification, etc. by physician relating to physical or mental health; fulfillment by nurse practitioner

Section 80I. When a law or rule requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, when relating to physical or mental health, that requirement may be fulfilled by a nurse practitioner practicing under section 80B. Nothing in this section shall be construed to expand the scope of practice of nurse practitioners. This section shall not be construed to preclude the development of mutually agreed upon guidelines between the nurse practitioner and supervising physician under section 80E.

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Comments on June 12 Draft of Section 35 Commission Report – June 17, 2019

Page 5 – Section 35 Commitment Criteria

To give a complete picture of the criteria, it is essential that the report include reference to at least two cases. [Matter of G.P., 473 Mass. 112, 120, 40 N.E.3d 989 \(2015\)](#) was the first case setting out the meaning of “likelihood of serious harm.” The Appeals Court subsequently addressed similar issues in in the [Matter of A.M.](#), 94 Mass. App. Ct. 399 (2018). There have also been over 20 Appellate Division cases that help define the limits of section 35.

There should also be reference to the District Court Standards of Judicial Practice, Civil Commitment and Authorization of Medical Treatment for Mental Illness (Revised April 2019). Those standards contain a detailed discussion of the important definitions that apply to commitments under Chapter 123 at pages 17-19.

Page 6 – Overview of Section 35 Process

This section should reference the Uniform Trial Court Rules for Civil Commitment Proceedings for Alcohol and Substance Abuse, which were promulgated after the decision in [G.P.](#) They are part of the Commission’s material.

Contrary to the statement that the warrants of apprehension are valid for five consecutive days the Judge has discretion, under Trial Court Rule 3(c) to issue the warrant for up to five days.

Since there is a reference to shackling on page 7, the use of which we strongly oppose, there should probably be a statement, either on page 6 or 7 that respondents may be placed in handcuffs and shackles when they are apprehended, based on a writ, or voluntarily appear before the court. To my knowledge, Section 35 respondents are the only civil litigants who are routinely handcuffed, shackled and placed in holding cells with defendants in criminal cases. In addition, they appear before the court, not as other civil litigants, but in the dock with defendants in criminal cases. As we have noted in the civil commitment process under M.G.L. c.

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123, sec. 7, this disparate treatment of a class of allegedly disabled litigants is likely a violation of the American’s with Disabilities act. This issue was left unresolved in [Matter of M.C.](#), 481 Mass. 336, 343 (2019).

This section fails to address the problems with the existing process. They were laid out in the presentation by Attorneys Grant and Gallagher. In particular, while the statute and rules provide for the presentation of independent medical testimony by the respondent, it is impossible to do so. The cases are often heard on the day they are filed. The attorney is assigned hours before the trial. “The fundamental requisite of due process is an opportunity to be heard at a meaningful time and in a meaningful manner. [Goldberg v. Kelly](#), 397 U.S. 254, 267 (1970).” [Matter of Kenney](#), 399 Mass. 431, 435 (1987). The Section 35 process does not meet this standard.

In addition, the appellate process, which is not addressed in the report, is lacking. While the Rules provide for expedited appellate review, it is the rare case where the appeal is heard before the person has completed the commitment. In the meantime their lives have been disrupted with the potential for loss of employment, housing and reputation. When considering the efficacy of involuntary commitment, there should be a balancing of the risks and benefits to the individual. There is no place in the existing process for such a balancing. With little time to prepare, the defense attorney has no opportunity to investigate either the client or options other than commitment or release.

Page 7 – Overview of Section 35 Process (cont’d)

The appointment of counsel should come earlier in the description of the process. Pursuant to paragraph 5 of Section 35, the appointment of counsel for indigents is mandatory and occurs before the in-court evaluation. Pursuant to Trial Court Rule 4 “Unless the respondent is represented by counsel, the court shall appoint counsel pursuant to Supreme Judicial Court Rule 3:10(1)(f)(iii) before or upon the respondent’s appearance before the court.” Under SJC Rule 3:10, section 6, counsel is appointed “immediately upon the filing of a petition.” The status of appointed counsel for individuals who are able to pay can be addressed later in the Section 35 process.

While that DMH court clinician is the person who conducts the evaluation, the statute refers specifically to “a qualified physician, a qualified psychologist, or a qualified social worker.” This should be the language in our report. As noted earlier, the SJC in [G.P.](#) clarified the standards and guidelines for commitment, some of which are constitutionally mandated. These were outlined in the CPCS presentation and should be included in the report.

While the statement at the end of the fourth bullet point that “the judge grants the petition and orders commitment” may be factually correct, it ignores a factor not discussed in this report. That factor, which is required under the definition of likelihood of serious harm, is “that reasonable provision for [the respondent’s] protection is not available in the community.”

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M.G.L., c. 123, sec 1. The presentation on December 6, 2018, included just such a situation. One of the panelist was a young man who had gone to an ER seeking treatment for his addiction, but instead was arrested on a writ of apprehension, brought to the Boston Municipal Court and committed to MASAC, where, in his view he received no meaningful treatment. This a stark example where there was a reasonable and desired program in the community. The attorney in that case should have raised the issue with the court. The issue of least restrictive alternative to commitment is discussed in [Commonwealth v. Nassar, 380 Mass. 908, 917, 406 N.E.2d 1286 \(1980\)](#), quoting [Lessard v. Schmidt, 349 F.Supp. 1078, 1093 \(E.D. Wis. 1972\)](#), vacated and remanded on other grounds, [414 U.S. 473, 94 S.Ct. 713, 38 L.Ed.2d 661 \(1974\)](#); and [Gallup v. Alden, 57 Mass. App. Div. 41 \(1975\)](#). The constitutional and statutory requirement that the petitioner must establish that there is no less restrictive alternatives to involuntary commitment should be included in the report.

Finally, the last bullet point implies that respondents are not handcuffed and shackled until the court grants the petition. This is not accurate as many, if not most respondents, whether they are voluntarily before the court or brought in as a result of a writ of apprehension, are handcuffed on apprehension or on their voluntary appearance in court.

Page 9 – Section 35 Facilities and Current Capacities

Just a note that there are several bills pending in the legislature to eliminate the option of any section 35 programs in correctional facilities.

Page 13 – Section 35 Commitment Data

The FY 2018 statistic in bullet point 5 should probably reflect the percentage of those committed based those evaluated by the court clinicians. By my calculation, the percentage of those committed (6,048) out of those evaluated and presumably found to meet the criteria (7,267) is 83.2%.

The unanswered question from these numbers is what happens to the thousands of petitions that are filed but never heard. In FY 2018 that number accounts for roughly 35% of all the petitions filed.

Page 17 – Review of the medical literature

I need to review some of the research, but I do not agree with the conclusions on this page that we cannot consider research that is based on compulsory treatment in the criminal justice context without examining them. In addition, it appears, there is newly published research on the effectiveness of coerced treatment and civil commitment. This was to be one of the main issues we were to address. I am not sure we have completed the task. In addition, it is my understanding the Dr. Christopher Paul from Brown is in the midst of a relevant research project on this issue with DPH/BSAS programs.

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It is hard to determine the efficacy of the DOC programs. MASAC has not provided the Commission with any data and the Hampden County Sheriff's program is too new to provide any meaningful data.

Page 18 – Review of the medical literature (Cont.)

We are reviewing the research that has been provided to the Commission as well as some recent articles that appear to address our primary focus: the efficacy of involuntary commitment for substance abuse. However, the existing research is equivocal on the usefulness of involuntary, coerced treatment. The data available for the Massachusetts, section 35 is very limited and does not exist for the single largest programs, the Department of Correction.

I doubt that we have data to support the assertion that the “patients who are committed for treatment under Section 35 are among the sickest, most complex and at the greatest risk for an overdose.” The apparent source of this is the DPH Chapter 55 Report from September 2016. While that report presents a picture of a complex problem, the only comparisons I can find is on page 49. They compare the prior history of the population and their risk of overdose after treatment:

Based on admissions during the study period, 67% of clients with a history of involuntary treatment had at least one opioid-related admission, 83% reported prior mental health treatment, and 44% reported a prior overdose. For clients with only a voluntary treatment history, 46% had at least one opioid-related admission, 58% reported prior mental health treatment, and 18% reported a prior overdose. Clients who received involuntary treatment were 2.2 times as likely to die of opioid-related overdoses and 1.9 times as likely to die of any cause compared to those with a history of voluntary treatment only.

It is hard to conceive that the Department of Correction has been running a section 35 program for many years and has no idea who is being sent to their programs and whether they work. The testimony from those who have been through the program and available public reports indicates that what happens and has happened at MASAC is neither productive nor therapeutic. The result, in addition to the pending lawsuit, is that several bills have been introduced to end the practice of committing section 35 respondents to any DOC program. H. 1700 (Rep. Balsler) has seventeen co-sponsors. Lacking any data that indicates that the largest section 35 program in the Commonwealth has any benefit, it should be closed.

I must also note that there is an ongoing study through Brown University that is looking at the data from DPH/BSAS programs. It is conceded that these programs have a better reputation than the DOC programs. This ongoing research should provide useful information on the very

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basic task of this commission. It might show that the assertion that section 35 committees are sicker, more complex and a greater risk for overdose, but for now that is hypothesis, not a fact.

Page 20 – Legal Implications

The summary of our memo should include the fact that we believe and others on the Commission agree, that there are constitutional problems with the existing section 12 process. This is more than procedural. In addition, this page should reflect the concerns of many of the healthcare professionals on the Commissions with the practical problems with any attempt to create a process for involuntary, emergency detentions for substance abuse.

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Memorandum

To: Marylou Sudders, Secretary EOHHS
Gabriel Cohen, EOHHS
Section 35 Commission

From: Mark A. Larsen, Director
Mental Health Litigation Division
Committee for Public Counsel Services

Date: June 30, 2019

Re: Restraint of Respondents and Committees in Civil Commitment Proceedings for Alcohol and Substance Use Disorders

The Commission Report on page 11 states that under Rule 9 of the Uniform Rules for Civil Commitment Proceedings for Alcohol and Substance Use Disorders "the respondent may be handcuffed or shackled throughout the commitment process." Committee for Public Counsel Services strongly disagrees with this statement as a matter of law and principle.

Rule 9 provides:

The court shall take such action and issue such orders as maybe necessary to secure the presence of the respondent after the respondent's arrival at the court, prior to or during the hearing, and while awaiting transport following the issuance of a commitment order, as the circumstances may require.

Commentary

Rule 9 is intended to address those situations in which a respondent may present a risk of flight or harm, given the fact that the respondent may be before the court unwillingly and may be suffering from the effects of alcohol or drugs resulting in unpredictable, aggressive, or violent behavior.

The law provides the court, as a matter of its inherent power, with broad discretion regarding security in the courtroom, including controlling the

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behavior of those before the court, when necessary. The Supreme Judicial Court has stated:

Of necessity, a judge's inherent powers must encompass the authority to exercise "physical control over his courtroom." Chief Admin. Justice of the Trial Court v. Labor Relations Comm'n, 404 Mass. 53, 57 (1989). As we noted in Chief Admin. Justice of the Trial Court v. Labor Relations Comm'n, "[t]he power of the judiciary to control its own proceedings, the conduct of participants, the actions of officers of the court and the environment of the court is a power absolutely necessary for a court to function effectively and do its job of administering justice." *Id.* at 57, quoting State v. LaFrance, 124 N.H. 171, 179-180 (1983).

Commonwealth v. O'Neil, 418 Mass. 760, 764 (1994).

CPCS Response to the Rule and Commentary

The cases cited in the commentary to the rule do not relate to any situation or proceeding similar to a section 35 commitment, which many trial courts treat more like a criminal than a civil proceeding. In Chief Admin. Justice of the Trial Court the Supreme Judicial Court faced "the question whether the Labor Relations Commission (commission) may conduct a hearing and render a decision on a probation officer's prohibited practice complaint against the defendant Chief Administrative Justice of the Trial Court. . . ." Chief Admin. Justice of the Trial Court at 54. Similarly, State v. LaFrance addressed the question of whether the trial court had the authority to prohibit law enforcement officers from wearing firearms in the courtroom. The language from LaFrance that is quoted in the commentary to Rule 9 is responsive that question and no other. The commentary provides no case or statute that relates to civil commitment or any similar proceeding.

While a court has certain inherent powers with regard to the physical control of the courtroom, the indiscriminate, standardless shackling of civil litigants in Section 35 commitment proceedings, especially those who appear voluntarily and are not contesting the commitment, violates basic concepts of decency and fair play. No other civil litigants are regularly subjected to being restrained in the courtroom, barring some overt act of violent or threatening behavior. In contrast criminal defendants, under court rules and case law, are entitled to appear at their trials without restraints.

A trial judge's authority and responsibility to control the "proceedings, the conduct of participants, the actions of officers of the court and the environment of the court," which is "absolutely necessary for a court to function effectively and do its job of administering justice;" (Commonwealth v. O'Neil, 418 Mass. 760, 764 (1994), quoting from Chief Administrative Justice of the Trial Court v. Labor Relations Comm'n, 404 Mass. 53, 57 (1989)) is not without limitation. "In exercising these powers, the judge may consider her own observations, reports from other judges, and recommendations of court officers and others who may have responsibility for the custody of prisoners and general court security. When it is necessary to employ "unusual security measures . . . the judge must balance the need for special restraints with considerations of maintenance of impartiality and proper decorum" and make appropriate findings. Commonwealth v. Hogan, 12 Mass App.Ct. 646, 656 (1981), quoting from Commonwealth v. DeVasto, 7 Mass App.Ct. 363, 366 (1979). (Emphasis added.) See Com. v. Scionti, 81 Mass. App. Ct. 266, 276 (2012). This rule provides no guidance as to when and how individual

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litigants can be restrained, which is in sharp contrast to the cited cases and proceedings in criminal cases.

For a criminal defendant to be restrained during trial, the court must enter into the record the reasons for the restraint. "Gagging or shackling may be employed if the trial judge has found such restraint reasonably necessary to maintain order. If the trial judge orders such restraint, he shall enter into the record of the case the reasons therefor." Mass. R. Crim. P. 45. No less a requirement should apply for a civil litigant, especially if that person is not contesting the commitment. The stigma associated with civil commitment under chapter 123 should not be exacerbated by treating individuals suffering from substance abuse in a fashion comparable to or worse than criminals.

In contrast to the provisions of Rule 9, those against who petitions are filed for mental illness have the benefit of substantial protection during transport and while in the facility. Section 21 of Chapter 123 provides ". . . Any person who transports a mentally ill person to or from a facility for any purpose authorized under this chapter shall not use any restraint which is unnecessary for the safety of the person being transported or other persons likely to come in contact with him." That section and the regulations promulgated by the Department of Mental Health provide that "Restraint of a mentally ill patient may only be used in cases of emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide." Similar standards should apply those facing civil commitment for substance abuse, which is a medical condition.

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June 17, 2019

Comments on Section 35 Draft Deliverable

Dear Secretary,

Thank you for the opportunity to provide feedback on the draft deliverable that was circulated last week. While this document clearly addresses the charges of the commission as laid out by the legislature, I believe that our Commission could take this opportunity to make other statements regarding the Section 35 process.

I would first suggest that we recommend closing DOC related section 35 programs for men. Throughout our meetings, there has been a clear pattern of testimony that has reflected how these programs provide substandard care that is not grounded in evidence on how to best treat substance use disorders. The testimony from those who were committed to Bridgewater was horrifying and I feel strongly that the Commission should not end without our group recommending its closure. The issues in Western Mass are more complicated and while the Hamden County Sheriff is clearly mission driven, his program's alarming lack of MAT prescriptions show that they are not engaged in evidenced-based practice. I believe we should recommend the closure of all DOC related 35 programs and folding these beds under the supervision of DMH or DPH.

In addition, I believe that our group needs to make recommendations on establishing standards of medical care for patients who are committed under a Section 35. This would include but should not be limited to: adequate treatment of withdrawal – especially during the hearing and transportation process, access to all forms of MAT during the commitment, ensuring that committed patients interested in remaining on MAT are connected to outpatient providers in their communities, overdose prevention training and safe injection teaching for those interested before discharge. The development of a clinical standard for section 35 would hopefully eliminate some of the disparity that appears to exist between different facilities in the Commonwealth and hopefully lead to improved outcomes and decreased relapse after discharge.

I look forward to our meeting later this month during which we can discuss the deliverable.

David Munson, MD

Gabe,

I spotted two minor errors on the power point.

On page 7, bullet three, we say "...a qualified physician, a qualified psychologist or a social worker." I think we should either insert "qualified" before "social worker," or just use qualified once, before physician.

On page 20, the sub-bullet of the first bullet, "The memorandum concludes that there is no legal impediment, the Massachusetts Legislature may permit a qualified clinician to authorize short-term emergency hospitalizations without judicial involvement for individuals with a substance use disorder." The comma is incorrect. It should be a colon. Alternatively, these could be separate sentences but it makes more sense to have a colon there.

Also, I was surprised at the inclusion of the last four recommendations in the body of the text, which had 11 yesses but a greater number of no's and abstentions. I had thought that you had to have more yesses than no's and abstentions combined, i.e., that, to go forward, the "yesses" must be the majority of those present. Do I have that wrong?

I hope these are helpful.

Thanks for handling everything so well. You made participating much easier.

Best,

David Podell, Ph.D.

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Gabe,

Sorry for the very late response and great work. I have the following suggestions:

Strengthen the recommendation around medically supervised withdrawal at all locations and phases of the process, not just during hearings and transportation. Some might say that it already exists at the various other locations but the standard of care is not well established and the SAMHSA guidelines around medically supervised detox should be strictly adhered to for humanitarian purposes. The current language is pasted below. I think our Commonwealth is capable of far more than "adequate" treatment of withdrawal and should mandate medically managed withdrawal to patients at all phases following a section.

Also I feel strongly that Naloxone should be available to the patient and their families at every step in the process. If not for Naloxone, the 2,000 annual overdose deaths a year in MA would be closer to 20,000 dead.

I hope this helps and see you at the meeting this afternoon.

Regards,

John Rosenthal



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June 17, 2019

Via Email

Secretary Marylou Sudders
Mr. Gabriel Cohen
Executive Office of Health and Human Services
1 Ashburton Place
Boston, MA 02108
gabriel.r.cohen@massmail.state.ma.us

Re: Initial Response to Draft Section 35 Commission Report

Dear Secretary Sudders and Mr. Cohen:

Thank you for circulating your first draft of the Section 35 Commission's report on June 12. I understand that you have requested that comments on this draft be delivered by the close of business today. Given the length of the draft and the complexity of the issues, it was not possible for me to conduct a complete analysis in this short time span. But I wanted to share some initial thoughts below, which I ask you to circulate to the entire Commission. I look forward to reviewing an updated draft, and to further discussing and refining it, at our meeting on June 27.

- Page 2: The disclaimer currently states that no executive branch employees appointed to the commission opined or voted on any specific recommendations, and that no executive branch employee endorsed the report in part or in its entirety. For the sake of accuracy, unless the drafting process changes significantly between now and when the report is released, the report should also state that executive branch employees drafted the report and prepared legal memoranda referenced in the report.
- Page 4: The draft should be modified to include the final provision of the Commission's charge, which states "[t]he Commission shall file recommendations, including any proposed legislation, with the clerks of the house of representatives and the senate not later July 1, 2019." MGL Ch. 208 Sec. 104(b).

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- Page 4: As drafted, the report does not include any recommendations. Consistent with the Commission's charge, it should be modified to include recommendations, including:
 - Prohibiting the use of any criminal justice facility, including state and local jails and prisons, to house individuals civilly-committed under Section 35;
 - Ensuring a warm hand-off for treatment between Section 35 facilities and community-based facilities, so that people committed under Section 35 have continued access to medication for addiction treatment and other substance use disorder treatment when their period of civil commitment ends;
 - Prescribing a set of data, to be determined at the meeting on June 27, that the Department of Public Health must collect to analyze the efficacy of Section 35; and
 - Setting a time to re-evaluate the efficacy of Section 35 within one year, at which time the Department of Public Health's data and the data from Dr. Paul Christopher's study of Section 35 outcomes will be available.
- Page 9: During our meetings, the Commission discussed the ways in which the Women's Recovery from Addiction Program (WRAP) came online to provide additional beds for women as the legislature prohibited the use of MCI Framingham to house women civilly committed under Section 35. This history, including funding information, should be added to the report in order to demonstrate how the Commonwealth has successfully adjusted Section 35 capacity from a criminal to non-criminal setting.
- Page 17: The draft's summary of the research regarding involuntary commitment outcomes is unduly cursory and under-inclusive. In a footnote, the draft quotes Dr. Werb's statement that "there is limited scientific literature evaluating compulsory drug treatment." But the draft fails to mention that Dr. Werb conducted a systemic review of studies assessing the outcomes of compulsory treatment, and that the nine eligible quantitative studies he found revealed "there is little evidence that compulsory drug treatment is effective in promoting abstinence from drug use or in reducing criminal recidivism." The full conclusion from Dr. Werb's study should be added to the main text, specifically: "There is limited scientific literature evaluating

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- compulsory drug treatment. Evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms. Given the potential for human rights abuses within compulsory treatment settings, non-compulsory treatment modalities should be prioritized by policy-makers seeking to reduce drug-related harms." In addition, the report should reference Dr. Paul Christopher's current study of Section 35 outcomes, which should provide preliminary findings within a year.
- Page 18: The draft's summary description of the Department of Public Health's review fails to mention the actual results of its analysis. While the report can of course describe the limits of the analysis, it should also describe what the DPH found, including that: (1) only .8% of individuals discharged from WATC and MATC in FY 2017 transitioned to medication for addiction treatment post-discharge, and (2) 1.4% of those with a history of involuntary treatment during the study period died of an overdose as compared to .63% of those with no history of involuntary treatment during the study period who died of an overdose. As mentioned above, we also ask that the report specifically describe the new datasets that DPH should collect, and propose a set time for re-evaluation of Section 35's efficacy. Finally, the Commissioners have asked for Section 35 data from the Department of Correction since the first meeting of the Commission. To date, the Department of Correction has not done so. This has significantly hampered our ability to evaluate the efficacy of Section 35. The report should therefore reflect both the Commission's repeated attempts to obtain relevant information from the DOC and the DOC's failure to provide it.
- Page 20: The draft currently states the General Counsel of the Department of Mental Health circulated a draft memo regarding short-term emergency hospitalizations without judicial involvement for individuals suffering from substance use disorder to a sub-group of the Commission. It suggests that all edits were incorporated into the updated version of the legal memo, and it asserts that the legal memo concludes that there is no legal impediment to such a process. These characterizations are inaccurate and incomplete. I provided written comments in response to the draft legal memo on May 16. I explained, "the proposed addition of a non-judicial hold within Section 35 would raise serious constitutional questions and practical problems, including the risk of harming people by creating a disincentive to seek emergency medical care," and emphasized, "the ACLU of Massachusetts could not support such a recommendation." These comments were not incorporated into the updated version of the legal

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memo. I also raised these and other concerns during our May 23 meeting, where I emphasized that there were not only substantive due process, but also procedural due process, questions. Numerous Commissioners, including several doctors, raised serious practical concerns regarding the implementation of this proposal during the meeting as well. The report should reflect these concerns, and any conclusions or recommendations should be modified to be consistent with these concerns.

- Finally, on December 6, the Commissioners heard from family members and individuals with lived experience with the Section 35 process. Their testimony detailed their experiences as Section 35 commitments to the Department of Corrections. For example, Mr. Zachary Wallace described his experience at MASAC as “punishment based,” and explained that the Corrections Officers who guard the patients “would call you junkies, losers, whatever.” Mr. Joel Kergarvat described a Corrections Officer responding to an overdose at MASAC by stating “that’s one less junkie the state has to worry about,” and emphasized that he has remained in active recovery since his commitment “in spite of MASAC, not because of it.” The report should incorporate the voices of these lived experiences.

Again, thank you for circulating the draft. I look forward to continuing to discuss and revise the report over the next two weeks.

Sincerely,



Jessie J. Rossman

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ACLU
Massachusetts

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June 26, 2019

Via Email

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Re: Response to Second Draft of Section 35 Commission Report

Dear Secretary Sudders and Mr. Cohen:

Thank you for circulating your second draft of the Section 35 Commission's report on June 20. I have reviewed the updates and appreciate that you incorporated some of my earlier comments. Yet I noticed that other comments were either partially, or sometimes entirely, unaddressed. Because I believe it is important that the report reflect these amendments, I wanted to bring these matters to your attention in advance of our meeting.

- Page 2: It is helpful that the disclaimer now includes a footnote disclosing that executive branch employees prepared a legal memorandum for the Commission's consideration. For the sake of accuracy, however, this disclaimer should also explain that executive branch employees drafted the report itself.
- Page 9: The addition of footnote 5, which explains that the Women's Recovery from Addiction Program (WRAP) came online to provide additional beds for women as the legislature prohibited the use of MCI Framingham to house women civilly committed under Section 35, usefully illustrates how the Commonwealth has successfully adjusted Section 35 capacity from a criminal to a non-criminal setting. I recall that we also discussed funding streams for WRAP at during the Commission meetings; this information should be added to the report as well.

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- Page 17: In response to the first draft of this report, at least three commissioners separately noted that Dr. Werb's findings -- including his article's direct quote that "evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms" -- should be added to the main text of this slide. While the second draft cites this article in more detail, it omits this quote and relegates the information to a small-print footnote while leaving the language in the main text untouched. To ensure that this slide is not misleading, the report should add Dr. Werb's article & its direct quote to the main text. It should also reference Dr. Paul Christopher's current study of Section 35 outcomes, which should provide preliminary findings within a year.
- Page 18: The updated report ignores my previous comment on this slide, which I repeat here in full. The draft's summary description of the Department of Public Health's review fails to mention the actual results of its analysis. While the report can of course describe the limits of the analysis, it should also describe what the DPH found, including that: (1) only .8% of individuals discharged from WATC and MATC in FY 2017 transitioned to medication for addiction treatment post-discharge, and (2) 1.4% of those with a history of involuntary treatment during the study period died of an overdose as compared to .63% of those with no history of involuntary treatment during the study period who died of an overdose. As mentioned above, we also ask that the report specifically describe the new datasets that DPH should collect, and propose a set time for re-evaluation of Section 35's efficacy. Finally, the Commissioners have asked for Section 35 data from the Department of Correction since the first meeting of the Commission. To date, the Department of Correction has not done so. This has significantly hampered our ability to evaluate the efficacy of Section 35. The report should therefore reflect both the Commission's repeated attempts to obtain relevant information from the DOC and the DOC's failure to provide it.
- Page 20: Both I and several other commissioners have noted that the Commonwealth should not pursue short-term emergency hospitalizations without judicial involvement, both in comments on the previous draft and during the May 23 meeting. The second draft continues to improperly minimize these practical and legal concerns. After the draft legal memo was circulated, I provided written comments that "the proposed addition of a non-judicial hold within Section 35 would raise serious constitutional questions and practical problems, including the risk of harming people by creating a

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- disincentive to seek emergency medical care." Contrary to the second draft's statement, this edit was not incorporated into the updated version of the legal memo. During the May 23 meeting, both I and Mark Larsen emphasized not just that procedural and substantive due process questions had never been litigated with respect to Section 12, but also that we believe there are procedural and substantive due process problems with the existing Section 12 process and the proposed addition of a non-judicial hold within Section 35. Finally, numerous Commissioners from the medical field raised specific practical concerns that are not detailed in the second draft. The report avoids mentioning the number of individuals who raised concerns by using the passive voice to state "practical concerns were raised." The report should accurately reflect the weight and detail of these legal and practical concerns.
- I appreciate the addition of the recommendations document, which should be incorporated into the text of the report itself. Commissioners should have an opportunity to vote on these recommendations at the meeting, and to have those votes reflected in the final report. With respect to the text of the recommendations document, I have two comments. First, several commissioners suggested a recommendation that prohibited the use of any criminal justice facility for Section 35, which was not dependent on the Commonwealth's decision to first fund and/or procure vendor or state operated beds to offset diminished capacity. The report should reflect this language. Second, in addition to Dr. Chaoui's proposal that the Commission should recommend not pursuing the option of a 72-hour non-judicial hold, (1) I noted that ACLU could not support a recommendation for the addition of a non-judicial hold within Section 35, and (2) Dr. Scott Weiner proposed adding language that "the Commission did not provide a recommendation that involuntary treatment of non-court involved individuals should occur." The report should reflect this language.
- Finally, the updated report ignores my previous request to add the voices of those with lived experiences into the main text of the document, which I repeat here in full. On December 6, the Commissioners heard from family members and individuals with lived experience with the Section 35 process. Their testimony detailed their experiences as Section 35 commitments to the Department of Corrections. For example, Mr. Zachary Wallace described his experience at MASAC as "punishment based," and explained that the Corrections Officers who guard the patients "would call you junkies, losers, whatever." Mr. Joel Kergarvat described a Corrections Officer

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responding to an overdose at MASAC by stating “that’s one less junkie the state has to worry about,” and emphasized that he has remained in active recovery since his commitment “in spite of MASAC, not because of it.” These individuals were brave and generous to share their time and experiences with us in a public forum, and this report should incorporate their voices.

Again, thank you for circulating the second draft. I look forward to continuing to discuss and revise the report.

Sincerely,

/s/ Jessie J. Rossman
Jessie J. Rossman

Page 1



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June 30, 2019

Via Email

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Re: Response to Third Draft of Section 35 Commission Report

Dear Secretary Sudders and Mr. Cohen:

Thank you for circulating the third draft of the Section 35 Commission’s report on June 28. There was a lot of material coming out of the June 27 meeting, and I appreciate the quick turnaround. I have three brief comments.

First, I appreciate the presentation of our recommendations, and the division between the recommendations approved by the members in attendance and those opposed by the members in attendance. To make this distinction clear from the outset, the header on pages 6-8 should be changed to state “Recommendations Voted on *and Approved by* Members in Attendance at the Commission’s Final Meeting.” (the addition is in italics), to mirror the header on page 63 (“Recommendations Voted on and Opposed by Members in Attendance at the Commission’s Final Meeting”).

Second, during our meeting on June 27, I agreed to provide proposed language for the slide entitled “Legal Implications of an Alternative Path for Involuntary Treatment.” (which is page 25 in the updated draft). To that end, I propose replacing the third bullet point with the following language to reflect the weight and details of the legal and practical concerns surrounding short-term emergency hospitalizations:

“During the May 23 meeting, during the discussion of the two memoranda, several Commissioners raised practical concerns regarding implementation of a non-court involved alternative pathway to involuntary treatment, similar to the process outlined in Section 12 of Chapter 123 of the General Laws. (See <https://www.mas.gov/lists/section>

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35commission-meeting-minutes). Two members also raised that procedural and substantive due process questions had never been litigated with respect to Section 12, and noted there were procedural and substantive due process concerns with the existing Section 12 process and the proposed addition of a non-judicial hold within Section 35.”

Finally, as per the discussion during the final meeting, I reviewed the meeting minutes and found several instances where Commissioners had either asked to review Section 35 data from the Department of Corrections, or noted that Section 35 data from the Department of Corrections was not available or had not been presented to the Commission. Specifically:

- During the October 30, 2018 meeting, “Judge Minehan noted that the DPH and Bureau of Substance Abuse Services (BSAS) data tends to be of good quality. She noted that MASAC data is currently not available[.]” 10/30/18 Minutes, p. 3. During that same meeting, “Commissioner Bharel noted that Department of Correction (DOC) data is not linked [.]” *Id.* Secretary Sudders “noted that her staff will reach out to DMH, DPH, and the Executive Office of Public Safety and Security for additional data.” *Id.*
- During the February 28, 2019 meeting, “Mr. DiGravio requested that data from DOC facilities be shared with the Commission.” 2/18/19 Minutes, p. 3.
- During the May 23, 2019 meeting, “Mr. Larsen stated that while Department of Public Health (DPH) data related to involuntary commitment was presented to the Commission, similar data from Department of Corrections (DOC) managed programs has not been presented.” 5/23/19 Minutes, p. 3. During that same meeting, “Professor Beletsky noted that there was a lack of information presented to the Commission related to the DOC managed Section 35 programs, particularly content and data regarding patients’ treatment and discharge plans.” *Id.* at p. 4.

The report should indicate that data from the DOC was neither presented to, nor reviewed by, the Commission. I propose adding the following language to the end of page 23: “Commissioners were not presented with, and did not review any, Section 35 data from the Department of Corrections.”

Thank you once again,

/s/ Jessie J. Rossman
Jessie J. Rossman

Hi Gabe,

Two suggestions for the overall excellent report:

1) On slide 17, regarding involuntary commitment outcomes, the main bullet says that there is limited research, and then lists the Werb paper in the small footnote. I think the full conclusion of Werb should be listed in the main bullet:

“There is limited scientific literature evaluating compulsory drug treatment. Evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms. Given the potential for human rights abuses within compulsory treatment settings, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms.”

2) On slide 20, we address involuntary treatment of a non-court involved individual. I would like a footnote that states something to the effect of “Despite the lack of legal impediment, the Commission did not provide a recommendation that involuntary treatment of non-court involved individuals should occur.”

Thank you,

Scott Weiner, MD, MPH

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Hi Gabe,

Thanks so much for the opportunity to provide feedback. This is a very robust and compelling slide set. I do have a few suggested recommendations for consideration:

- Involuntary treatment should be the last resort, which would require a system where it is easy to get into voluntary treatment.
- As such, there should be additional support/expansion of other pathways into treatment so that there is broad, enhanced, and lower threshold addiction and harm reduction services, including immediate access to MAT and expansion of: bridge clinics, addiction consult services, outreach and engagement programs, post-overdose intervention programs, syringe services programs, and family intervention programs.
- If a person is seeking voluntary commitment, commitment proceedings should be dropped and the court should work to find an appropriate treatment program.
- Treatment facilities should offer the same range of evidence-based services so there is a consistent standard of care.
- On the pieces of the report regarding outcomes following involuntary commitment, very much appreciate the limited existing research that exists and that what research does exist is not generalizable. The caveats to the available data on slide 18 are appropriate, but it would be great if the final report could also include the salient points from DPH's 2016 Chapter 55 report. The data that DPH presented to the Commission on 2/28 on post discharge transitions and voluntary versus involuntary commitment as well as the information DMH presented on 4/25 that detailed the WRAP program's data on patients initiated and discharged on MAT, aftercare enrollment, and readmissions would also be helpful context, especially if presented in a way indicating that the data only represented the specific populations that participated in these programs. With the caveats about the limitations of the data, it may also be appropriate to suggest that a study be commissioned to look at the overall effectiveness of involuntary commitment.
- On the slide concerning the legal implications of an alternative path for involuntary treatment, I suggest that any recommendation for a legislative change be delayed until we both see the outcomes of emergency department initiation rates and that we first pursue all other pathways to motivate people to seek treatment.
- I saw that you cited our MAT in ED guidelines (thanks!) on slide 23. We are updating that document sometime in the next month or two, so in the interest of not having a broken link, it might be best to link to the page where the current document lives and where the new document will be posted: <https://patientcarelink.org/improving-patient-care/substance-use-disorder-prevention-treatment-2/>

Thanks again for allowing us to provide this input,

Leigh Simons Youmans, MPH