COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss. NO. SJC-12844

IMPOUNDED

MASSACHUSETTS GENERAL HOSPITAL
Defendant-Appellant,
v.
C.R.
Plaintiff-Appellee

ON APPEAL FROM AN ORDER OF THE
BOSTON MUNICIPAL COURT'S APPELLATE DIVISION
No. 1801MH000235

BRIEF OF THE CENTER FOR PUBLIC REPRESENTATION, THE DISABILITY LAW CENTER AND THE MENTAL HEALTH LEGAL ADVISORS COMMITTEE AS AMICI CURIAE IN SUPPORT OF C.R.,

Steven J. Schwartz BBO #448440
Robert Fleischner BBO #171320
Kathryn L. Rucker BBO #644697
Anna Krieger BBO #568883
Center for Public Representation
22 Green Street
Northampton, MA 01060
413-586-6024
sschwartz@cpr-ma.org

Phillip Kassel BBO #555845
Jennifer Honig BBO #55925
Mental Health Legal Advisors Committee
24 School Street, 8th f loor
Boston, MA 02108
617-338-2345
pkassel@mhlac.org

Tatum A. Pritchard BBO #664502
Disability Law Center
11 Beacon Street, Suite 925
Boston, MA 02108
617-723-8455
tpritchard@dlc-ma.org

December 20, 2019

CORPORATE DISCLOSURE STATEMENT

Pursuant to Supreme Judicial Court Rule 1:21, amicus curiae **Mental Health Legal Advisors Committee** states that it was established by the General Court in 1973 under the jurisdiction of the Supreme Judicial Court. G.L. c. 221, § 34E. It is not a corporation and issues no stock.

Pursuant to Supreme Judicial Court Rule 1:21, amicus curiae **Center for Public Representation** states that it is a non-profit corporation exempt from taxation pursuant to Section 501(c)(3) of the Internal Revenue Code and is not a publicly held corporation that issues stock. It has no parent corporation.

Pursuant to Supreme Judicial Court Rule 1:21, amicus curiae **Disability Law Center** states that it is a non-profit corporation exempt from taxation pursuant to Section 501(c)(3) of the Internal Revenue Code and is not a publicly held corporation that issues stock. It has no parent corporation.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES, LAWS, REGULATIONS

OTHER AUTHORITIES

INTEREST OF AMICI

The **Center for Public Representation** (CPR), the **Mental Health Legal Advisors Committee** (MHLAC), and the **Disability Law Center** (DLC) have jointly or separately filed numerous *amici* briefs in many of the recent mental health decisions of this Court involving the application of G.L. c. 123, including, among others, *Pembroke v. D.L.*, 482 Mass. 346 (2019); *Matter of M.C.*, 481 Mass 336 (2019); and *Matter of N.L.*, 476 Mass. 632 (2017).

CPR is a public interest legal advocacy organization with offices in Massachusetts and the District of Columbia. For more than 40 years, using a variety of strategies, the Center has advocated for the rights of individuals with disabilities, including people with mental illness. CPR has been lead counsel or submitted *amici* briefs in many of the leading cases involving G. L. c. 123 decided by this Court, from *Superintendent of Worcester State Hospital v. Hagberg*, 374 Mass. 271 (1978), to *Commonwealth v. Nassar*, 380 Mass. 908 (1981), to *Newton-Wellesley Hospital v. Magrini*, 451 Mass. 771 (2008), to *Pembroke*, *supra*,

MHLAC has longstanding concerns regarding the procedural issue raised by the instant matter. The Agency was established by the General Court in 1973 ". . . to assist and advise indigent patients and residents in ... mental health ... facilities of the commonwealth." G.L. c. 221, § 34E. Staff of MHLAC was among the members of the special District Court Committee that was

established in response to heightened concerns about arbitrariness in the commitment of people to mental hospitals. This Committee drafted the legislation that revised the provision under review in this appeal by shortening the applicable time periods. MHLAC has a keen interest in the issue involved in this case, which addresses long-standing concerns about a failure to abide by statutory timelines in the initiation of commitments under G.L. c. 123, § 12.

DLC is a statewide private non-profit organization that is federally mandated to protect and advocate for the rights of individuals with disabilities. Pursuant to the Protection and Advocacy for the Rights of Individuals with Mental Illness Program, 42 U.S.C. § 10802, DLC represents individuals with mental disabilities whose rights in private and public facilities are being compromised or violated. Appropriate interpretation and implementation of G.L. c. 123, § 12 is of great importance to many DLC clients.

STATEMENT OF THE ISSUES

Amici adopt the Statement of the Issues as set forth in Appellee's Brief.

STATEMENT OF THE CASE

Amici adopt the Statement of the Case as set forth in Appellee's Brief.

STATEMENT OF THE FACTS

Amici adopt the Statement of the Facts as set forth in Appellee's Brief.

SUMMARY OF THE ARGUMENT

Hospital emergency departments are not clinically appropriate or cost-effective settings for persons with mental illness. Rather than providing treatment for persons experiencing a psychiatric crisis, they serve primarily as barren holding areas where individuals with mental illness are often involuntarily detained and mechanically restrained, sometimes pursuant to multiple emergency detention applications. Waiting for days in an emergency department without appropriate mental health treatment frequently exacerbates the individual's crisis, intensifies their symptoms, and complicates future treatment. (pp. 4-12)

Because involuntary detention in an emergency department pursuant to G.L. c. 123, § 12, like all involuntary commitments under the statute, involves a massive curtailment of liberty, basic due process procedures are required. This Court has consistently held that such procedures include consideration of less restrictive alternatives to confinement in a hospital. Thus, before involuntarily detaining and admitting individuals with mental illness to emergency departments, mental health and other health care professionals must consider and explore available, less restrictive treatment options. And federal law requires that the Commonwealth provide such treatment in the most integrated setting, in order to avoid unnecessary institutionalization. (pp. 13-23).

There is now a significant body of research and programmatic data confirming that community mental health services, including crisis intervention

services and related programs, can substantially decrease the need for inpatient hospitalization and reduce admissions to emergency departments. The Commonwealth already has developed many of these programs, but is required by federal law to expand community programs to avoid unnecessary admissions to emergency departments. (pp. 27-33).

ARGUMENT

I. Emergency Departments Are Clinically Inappropriate and Unduly Restrictive Settings for Persons with Psychiatric Disabilities, and Often Exacerbate, Rather Than Ameliorate, the Symptoms of Their Mental Illness.

It is widely accepted that emergency departments are not designed to meet the needs of individuals in psychiatric crisis, and that forcibly holding people in these settings against their will while awaiting disposition—a practice known as "psychiatric boarding,"[1] – is inappropriate and detrimental to both patients and staff. Kimberly Nordstrom et al., *Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document*, 20(5) W. J. Emergency Med. 690 (2019) (hereinafter Nordstrom, *Boarding of Mentally Ill Patients*).

[1] "Boarded Patients" are defined in The Joint Commission Accreditation manual as: "Patients being held in the emergency department or another temporary location after the decision to admit or transfer has been made." The Joint Commission, *Care of Psychiatric Patients Boarded in EDs*, Issue One, Quick Safety, 1 (April 2004), https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_One_April_20142.PDF (last visited December 12, 2019).

The highly restrictive nature of these settings, their reliance on coercive and involuntary interventions, and the lack of mental health treatment result in a deprivation of individual liberty and often a worsening of psychiatric symptoms. Data show that prolonged confinement in emergency departments and unnecessary inpatient admissions can be significantly reduced by the use of specialized emergency care and prevented by delivery of community-based mental health services, including mobile crisis intervention, crisis stabilization, and intensive clinical supports. [2]

A. Emergency Departments Are Restrictive Settings That Involuntarily Detain and Frequently Restrain or Seclude Psychiatric Patients.

Thousands of individuals with psychiatric disabilities are involuntarily transported to and then detained in Massachusetts emergency departments. Emergency departments have policies and procedures that authorize detention and prevent patients with psychiatric conditions from leaving the facility. And while most medical patients cannot be treated without their consent, and cannot be prevented from leaving the hospital, persons with psychiatric disabilities are often involuntarily treated, detained, and restrained in emergency departments. Susan

[2] Mobile crisis intervention is an evidenced-based practice that provides short-term mental health treatment in the community to address mental health emergencies. Crisis stabilization services is an evidence-based practice that provide short-term residential living arrangements and supports to allow individuals who are experiencing a mental health crisis to stay overnight and receive emergency mental health care. Intensive clinical supports are ongoing mental health services that are flexible, individualized, and responsive to the needs of individuals who otherwise would be admitted to emergency departments for mental health care. For a more detailed description of each program, *see* Section III, *infra.*

Stefan, *Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements*, 30-31 (Oxford University Press 2006).

In addition to being involuntarily detained, psychiatric patients are often subject to a regime of involuntary restraint. Mechanical and physical restraint are common in emergency departments, despite the evidence that negative health outcomes from their use can be severe, including blunt chest trauma, aspiration, respiratory depression, and asphyxiation. Christopher Cheney, *New Research Helps ER Staff Identify Patients For Restraint*, Health Leaders, Aug. 27, 2018, https://www.healthleadersmedia.com/clinical-care/new-research-helps-er-staff-identify-patients-restraint (last visited Dec. 12, 2019). Emergency departments have security guards authorized by hospital policy and procedure to restrain and use force on patients, and to prevent them from leaving. Stefan, *Emergency Department Treatment* at 34-35. Even when a physical injury does not occur, restraint and seclusion can be traumatic events. According to a survey found in the Annals of Emergency Medicine, 66% of emergency department patients reported experiencing "severe psychological distress and lasting consequences in regard to care-seeking behavior after physical restraint." *Id.* (citing this survey). In another survey, individuals in inpatient settings reported significant increased psychological distress as a result of forced medication, seclusion, or other physical force applied to them. Daryl Knox & Garland H. Holloman, *Integrating Emergency Care with Population Health Title Use and Avoidance of Seclusion and*

Restraint: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup, 13(1) UC Irvine W. J. Emergency Med. 35 (2012) (hereinafter Knox, *Integrating Emergency Care*). Similarly, the use of drugs as a form of chemical restraint has been found to have short- and long-term detrimental implications for the patient and the physician/patient relationship. *Id.*

Increasingly, mental health professionals and behavioral health leaders have recognized the need to reduce and eliminate restraint and seclusion.[3] In a summary report entitled *National Call to Action: Eliminating the use of Seclusion and Restraint*, the Substance Abuse and Mental Health Services Administration (SAMHSA) states, the ‘‘culture must change from one in which seclusion and restraint are viewed as positive and therapeutic to one in which they are regarded as violent acts that result in traumatization to patients, observers, and others.”

---

[3] For instance, the National Association of State Mental Health Program Directors has concluded that

> [e]very episode of restraint or seclusion is harmful to the individual and humiliating to staff members who understand their job responsibilities. The nature of these practices is such that every use of these interventions leaves facilities and staff with significant legal and financial exposure. Public scrutiny of restraint and seclusion is increasing and legal standards are changing, consistent with growing evidence that the use of these interventions is inherently dangerous, arbitrary, and generally avoidable. Effective risk management requires a proactive strategy focused on reducing the use of these interventions in order to avoid tragedy, media controversy, external mandates, and legal judgments.

Stephan Haimowitz et al., Nat’l Ass’n State Mental Health Program Directors, *Restraint and Seclusion - a Risk Management Guide* 31 (2006), https://www.nasmhpd.org/sites/default/files/R-S%20RISK%20MGMT%2010-06%282%29.pdf.

Knox, *Integrating Emergency Care*, at 37. While strategies to reduce restraint have worked well in inpatient hospital environments, it has been difficult to achieve similar results in emergency departments, given their staffing, volume of admissions, level of acuity, and length of stay. Knox, *Integrating Emergency Care*, at 35-36 (citing survey data on the use of restraint and seclusion in emergency departments). As a result, individuals in emergency departments continue to be subject to these dangerous and harmful practices at rates "significantly higher" than in other inpatient settings. Leslie S. Zun, *A Prospective Study of Complication Rate of Use of Patient Restraint in the Emergency Department*, 24(2) J. Emergency Med. 119 (2003).

B. Emergency Departments Are Not Therapeutic Clinical Settings and Typically Do Not Provide Psychiatric Treatment Other Than Medication.

It is common to view emergency departments as the place where critical, even life-saving, care is delivered. However, for persons in psychiatric crisis, most emergency rooms offer little in the way of treatment. Emergency departments typically lack the "therapeutic milieu" that is often critical to good mental health care, do not provide counseling or other psychosocial programming, and often have few if any psychiatric providers available. Nordstrom, *Boarding of Mentally Ill Patients*, at 691.[4] Instead, what is available is primarily medication, combined

[4] In a 2008 survey of emergency department directors by the American College of Emergency Physicians, 79% of the 328 respondents reported psychiatric boarding in their emergency departments, and 62% reported no psychiatric services involved

with coercive, involuntary and restrictive measures like those discussed above. It is no surprise, therefore, that boarding in emergency departments "increases psychological stress on patients who may already be in depressed or in psychotic states." The Joint Commission, *Alleviating ED Boarding of Psychiatric Patients*, 19 Quick Safety, 1 (Dec. 2015) (hereinafter The Joint Commission, *Alleviating ED Boarding*).[5]

Waiting in the chaotic, crowded, and confined spaces of an emergency room can be anxiety-provoking and distressing for individuals already in crisis, and may exacerbate psychiatric symptoms. Nordstrom, *Boarding of Mentally Ill Patients*, at 693. The presence of security guards, continuous observation, and even being forced to disrobe and wear only a hospital gown can be traumatizing and lead patients to feel a loss of control that may result in an escalation of symptoms. *Id.*[6] This potential exacerbation of individuals' presenting problems is compounded by indefinite boarding, which further delays access to needed mental health treatment and less restrictive options in the community.

---

with these patient's care prior to their admission and transfer. Nordstrom, *Boarding of Mentally Ill Patients* at 691.

[5] For this reason, some pilot programs are working to deliver specialized emergency psychiatric care, including diversion from typical, medical emergency facilities. Scott Zeller et al., *Effect of A Dedicated Regional Psychiatric Emergency Service on Boarding and Hospitalization of Psychiatric Patients in Area Emergency Departments*, 15(1) West J. Emerg. Med., 2-3 2014).

[6] Prolonged boarding of individuals with mental health needs also consumes scarce emergency department resources, worsens overcrowding, and has a significant financial impact on facilities' reimbursement rates. The Joint Commission, *Alleviating ED Boarding*, at 1.

The Joint Commission[7] has described the boarding of psychiatric patients in emergency departments as "a Band-Aid solution to a complex problem . . . ." The Joint Commission, *Alleviating ED Boarding*, at 2. To help alleviate this problem, it recommends the identification and expansion of community-based treatment (including outpatient psychiatric care, crisis counseling, mobile crisis teams, and crisis stabilization units) to "facilitate assessment, referral, and discharge processes that reduce wait times." *Id.* at 3. As discussed in more detail below, these less restrictive, community-based interventions can help to stabilize acute symptoms, prevent unnecessary emergency department and inpatient admissions, and allow for diversion to less restrictive, and less costly, mental health services. *Id.*

C. Emergency Departments Vary Greatly in Length of Stay and Likelihood of Confinement for Behavioral Health Patients.

Numerous studies have examined the amount of time individuals in psychiatric crisis spend in the emergency departments and the factors that may influence how long they stay.[8] The results reveal considerable variations in length of stay. Published data on boarding times have ranged from averages of 6.8 hours

---

[7] According to its website, "The Joint Commission accredits and certifies over 22,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards." https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx.

[8] *See, e.g.*, Stephen R. Pitts et al., *A Cross-Sectional Study of Emergency Department Boarding Practices in the United States*, 21(5) Acad. Emergency Med. 497, 497 (2014) (reporting national median boarding time of 79 minutes based on study of National Hospital Ambulatory Medical Care Survey files from 2007-2010).

to 34 hours. Nordstrom, *Boarding of Mentally Ill Patients*, at 691. A recent study of 871 individuals at 10 Massachusetts hospitals showed a median length of stay of 10.92 hours for psychiatric patients, with discharged patients experiencing shorter lengths of stay compared to patients who were subsequently admitted or transferred to another hospital. *See* Mark D. Pearlmutter et al., *Analysis of Emergency Department Length of Stay for Mental Health Patients at Ten Massachusetts Emergency Departments*, 70(2) Annals of Emergency Medicine 193, 197 (2017) (hereinafter Pearlmutter, *Analysis of Emergency Department Length of Stay*).

The amount of time individuals spend boarding in emergency departments, and resulting inpatient admission rates, also vary considerably based on the nature and quality of the emergency services available. For instance, both boarding time and inpatient admissions have been reduced where hospitals have access to assessment, observation units, and crisis stabilization services. *See* Nordstrom, *Boarding of Mentally Ill Patients*, at 692 (observation units and active treatment for psychiatric illness and substance use mitigate the need for prolonged stays in emergency departments).

The duration and quality of emergency services directly impact the extent to which individuals experience harms commonly associated with prolonged confinement in emergency departments, as well as their potential to be successfully discharged to less restrictive service options. Leading mental health agencies and

many professional studies have recognized that the problem of emergency department boarding has its origins in insufficient community-based behavioral health services, and especially inadequate mobile crisis services, crisis stabilization services and intensive clinical supports. *See, e.g.*, Pearlmutter, *Analysis of Emergency Department Length of Stay*, at 200; Nordstrom, *Boarding of Mentally Ill Patients*, at 691; The Joint Commission, *Alleviating ED Boarding*, at 3. As discussed below, this insufficiency undermines the state law command to rely on less restrictive alternatives and the federal law obligation to provide mental health treatment in the most integrated setting.

II. The Doctrine of the Least Restrictive Alternative Applies Equally to Emergency Detention Under G.L. c. 123, §§ 12(a) and (b), As It Does to Civil Commitment Under G.L. c. 123, §§ 7 and 8.

This Court has made clear that civil commitment is a "massive curtailment of liberty." *Commonwealth v. Nassar*, 380 Mass. 908, 917 (1981) quoting *Humphrey v. Cady*, 405 U.S. 504 (1972); *Matter of N.L.*, 476 Mass. 632, 637 (2017); *Williams v. Steward Health Care System*, 480 Mass. 286, 292 (2018). The Court has also concluded that emergency detention and restraint pursuant to G.L. c. 123, §§ 12(a) and (b) implicates the same deprivation of freedom, and requires the same due process protections as civil commitment. *Newton-Wellesley Hospital v. Magrini*, 451 Mass. 771, 78-85 (2008) (temporary involuntary commitment involves "significant liberty interests" and is a "massive curtailment of liberty"). Thus, this Court's insistence that such deprivation of liberty is only permissible if

it is effectuated with the least drastic means possible and imposes the least restrictive form of treatment has become an essential finding in all involuntary detention proceedings. *Williams*, 480 Mass. at 289 (committing court must determine if there is no less restrictive alternative to hospitalization).

A. G.L. c. 123, Its Administrative Implementation, and Longstanding Judicial Interpretation Requires Consideration of Less Restrictive Alternatives Before Detaining or Committing an Individual with Mental Illness.

If the Commonwealth authorizes the involuntary detention and transportation of an individual with a mental illness, it must ensure that its agents use the least restrictive means for accomplishing that detention, and then confine the individual in the least restrictive setting and provide the least restrictive form of treatment. These principles, which are incorporated by the Legislature in the civil commitment statute, G.L. c. 123, and adopted by the Department of Mental Health (DMH) in its rules and policies, have been consistently affirmed by this Court.

1. The Civil Commitment Statute -- G.L. c. 123

In enacting and periodically amending the Commonwealth's civil commitment laws, the Legislature evidenced an enhanced respect for the civil and constitutional rights of persons with mental illness. *Nassar*, 380 Mass. at 917-918; *Matter of N.L.*, 476 Mass. at 636; *Williams*, 460 Mass. at 292-93. It not only provided for considerable procedural protections, but it also elevated the substantive standard for *both* emergency detention under Sec. 12 and civil commitment under Secs. 7 & 8 to: "likelihood of serious harm by reason of mental

illness." *Foss v. Commonwealth,* 437 Mass. 584, 589 (2002) (reviewing 1970 legislative reform of the civil commitment statute). The Legislature defined such likelihood to include a substantial risk of physical harm to self or others, or "a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that … reasonable provision for his protection is not available in the community." G.L. c. 123, § 1. Thus, the basis for emergency detention under § 12 must include a consideration of less restrictive alternatives and community options that might obviate the need for involuntary hospitalization. In considering this issue in *Nassar,* the Court cited to the provisions in G.L. c. 123, § 4, which require, for each person in the care of the Department, "a consideration of all possible alternatives to continued hospitalization or residential care including, but not necessarily limited to, a determination of the person's relationship to the community and to his family, or his employment possibilities, and of available community resources, foster care and convalescent facilities…" This consideration, the Court said, "should enter also into … judicial reviews." *Nassar*, 380 Mass. at 918.

2. DMH Regulations and Policies

The Department's regulations reflect a similar requirement that less restrictive alternatives, in the form of community treatment, are favored and must be exhausted before resort to more restrictive treatment, like hospitalization and involuntary detention. *See, e.g.,* 104 CMR §§ 29.06(3)(d) (community service

plan), 29.07 (3)(a) (Individual Service Plan) and 29.09(1)(c) (annual service plan review). Significantly, the Department's forms that clinicians must use to authorize emergency detention, restraint, and transportation under G.L. c. 123, § 12(a), or emergency hospitalization under G.L. c. 123, § 12(b), require the clinician to consider all appropriate less restrictive alternatives and community options for providing needed treatment, and to certify that none is available before authorizing the restraint or detention. *See* Department of Mental Health, Application for an Authorization of Temporary Involuntary Hospitalization, Application Pursuant to 12(a) (subsection 2(B)(3)) and Application Pursuant to Section 12(b) (subsection F) (The form states that, "In my opinion, at the present time there is no less restrictive placement that is appropriate for this person to which he or she is willing to go"), attached as Addendum 1-2.

3. Judicial Decisions

The doctrine that the statutory objectives of G.L. c. 123 must be accomplished in the least restrictive manner possible has existed in Massachusetts case law for almost forty years. *Nassar*, 380 Mass. at 917-18. *Nassar* and later cases make clear that the doctrine of the least restrictive alternative applies to all proceedings under G.L. c. 123, including orders pursuant to § 12 of the statute. As the Court stated:

> Regardless of the constitutional place of such a doctrine [least restrictive alternative], either in general or in the particular context, we think it natural and right that all concerned in the law and its administration should strive to find the least burdensome or oppressive controls over the individual that are

> compatible with the fulfilment of the dual purposes of **our statute**, namely, protection of the person and others from physical harm and rehabilitation of the person. **The statute** lends itself to this quest.

Nassar, 380 Mass. at 917-18 (emphasis added).

The Court has consistently reaffirmed the principle that an individual subject to constraints on his or her fundamental right to liberty under G.L. c. 123 has the "right to receive the least restrictive or least burdensome control necessary to pursue rehabilitation." *Commonwealth v. Rosenberg*, 410 Mass. 347, 360 (1991); *see also Williams*, 480 Mass. at 293, quoting *Nassar*, 380 Mass. at 917; *Matter of E.C.*, 479 Mass. 113, 121 (2018).[9]

The right to least restrictive treatment or least burdensome control applies across G.L. c. 123, including proceedings under § 12, because the right derives from both this Court's application of the statute as well as the underlying constitutional principle that any "law in derogation of liberty" must be:

> narrowly tailored to further a compelling and legitimate government interest, and must be strictly construed, in order to comply with the requirements of substantive due process. [citation omitted] The right of an individual to be free from physical restraint is a paradigmatic fundamental right.

Matter of E.C. 479 Mass at 119.

Since the right to make decisions about one's treatment is a fundamental right, under both the federal and state constitutions, judicial orders limiting that

[9] The Appeals Court has adopted and expanded the application of the doctrine in various disability cases involving the deprivation of fundamental rights. *Miller v. Commissioner of Correction*, 36 Mass. App. Ct. 114, 119 (1994)(citing *Rosenberg* in support of the right to least restrictive or least burdensome control).

right under G.L. c. 123 §§ 12(a) or (b) must be the least restrictive and burdensome that meet the State's objectives of protection and rehabilitation. Thus, Massachusetts General Hospital (MGH), mental health clinicians, and health care professionals throughout the Commonwealth have an obligation under G.L. 123, § 12(a) and (b), under the Department's regulations and policies, and under controlling judicial decisions concerning less restrictive alternatives, to consider alternatives to hospitalization—specifically, community-based mental health treatment—before seeking or ordering involuntary hospitalization.

B. The Americans with Disabilities Act Also Requires the Commonwealth to Provide Mental Health Services in the Least Restrictive Appropriate Setting, and to Prevent Unnecessary Detention in Emergency Rooms or Psychiatric Hospitals.

MGH argues that prolonged detention in emergency departments is necessary due to the lack of inpatient psychiatric beds. But this argument disregards the critical role that community treatment programs play in preventing admission to hospital emergency departments in the first place. And the fact that community treatment alternatives may be limited or not immediately available does not relieve clinicians from their duty to at least consider appropriate, less restrictive alternatives prior to seeking involuntary admission under G. L. c. 123, § 12. Since such limitations are the result of the Commonwealth's and the Department's planning, administration, funding, and operation of its mental health service system, these limitations may well contravene the pre-eminent federal civil rights law for persons with disabilities—the Americans with Disabilities Act

(ADA), 42 U.S.C. § 12101 *et seq.* Therefore, to the extent that MGH or others may point to the lack of appropriate psychiatric treatment or available inpatient beds as the justification for detaining persons with mental illness in emergency departments, the ADA mandates that the Commonwealth develop and make available necessary mental health treatment in integrated community settings, using less restrictive alternatives to involuntary hospitalization.

In enacting the ADA, Congress recognized that "historically, society has tended to isolate and segregate individuals with disabilities and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem"; that "discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization"; and that "the Nation's proper goals regarding individuals with disabilities are to assure . . . full participation[] [and] independent living." 42 U.S.C. § 12101(a)(2)-(3), (7); *see also* House Report (Part III) at 49-50 ("The purpose of [T]itle II is to continue to break down barriers to the integrated participation of people with disabilities in all aspects of community life."). Congress further found that "individuals with disabilities continually encounter various forms of discrimination, including . . . segregation." 42 U.S.C. § 12101(a)(5). Thus, the ADA specifies that discrimination against people with disabilities includes "segregation" and "institutionalization." 42 U.S.C. § 12101(a)(3), (5).

Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Title II "incorporates the 'non-discrimination principles' of [S]ection 504 of the Rehabilitation Act and extends them to state and local governments," whether or not they receive federal funding. *See also* 42 U.S.C. § 12131.

The Attorney General is required to issue regulations implementing Title II of the ADA. 42 U.S.C. § 12134(a). The Attorney General's integration regulation implementing Title II of the ADA provides, *inter alia*, that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) ("the integration mandate"). An integrated setting is "a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, App. B. at 693 (2016).

Accordingly, the ADA and its integration regulation reflect a preference for community placement. "In short, where appropriate for the patient, both the ADA and [Section 504 of the Rehabilitation Act] favor integrated, community-based treatment over institutionalization." *Pa. Prot. & Advocacy, Inc. v. Pa. Dep't of Pub. Welfare*, 402 F.3d 374, 379 (3rd Cir. 2005) (citation omitted); *see also* 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d).

One form of disability discrimination under Title II is a violation of the "integration mandate." This mandate—arising out of the statute itself, the regulations of the Attorney General implementing Title II, and the Supreme Court's decision in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999)—requires that when a state provides services to people with disabilities, it must do so "in the most integrated setting appropriate to [their] needs." 28 C.F.R. § 35.130(d); *Olmstead*, 527 U.S. at 592, 607; 42 U.S.C. § 12132.

The Supreme Court in *Olmstead* explicitly held that "[u]njustified isolation . . . is properly regarded as discrimination based on disability." *Olmstead*, 527 U.S. at 597. The Court noted that "in findings applicable to the entire statute, Congress explicitly identified unjustified 'segregation' of persons with disabilities as a 'for[m] of discrimination.'" *Id.* at 600. The Court held that unnecessary institutionalization violates the ADA because it "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life," and "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id.* at 600-01.

The Supreme Court concluded that the ADA requires public entities to provide community services in the most integrated setting when: (a) such services are appropriate, (b) the affected persons do not oppose community-based

treatment, and (c) community services can reasonably be accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. *Olmstead*, 527 U.S at 607.

A public entity violates Title II of the ADA when it segregates people with disabilities in public or private facilities or promotes the segregation of people with disabilities in such facilities through its planning, system design, funding choices, or service implementation. *See, e.g.*, 28 C.F.R. § 35.130(b)(3), (d); 28 C.F.R. § 41.51(b)(3), (d); 45 C.F.R. § 84.4(b)(2), (4); *Steimel v. Wernert*, 823 F.3d 902, 911 (7th Cir. 2016) (explaining that a state may "violate the integration mandate if it operates programs that segregate individuals with disabilities or through its planning, service system design, funding choices, or service implementation practices, promotes or relies upon the segregation of individuals with disabilities in private facilities or programs") (internal quotation marks and alterations omitted).

The ADA, its regulations, and these principles apply with equal force to persons at risk of institutionalization. *See* Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. at 5 (2011), https://www.ada.gov/olmstead/q&a_olmstead.pdf ("[T]he ADA and the Olmstead decision extend to persons at serious risk of institutionalization or segregation and are not limited to individuals currently in institutional or other segregated settings."). Because the Department of Justice issued the ADA's integration regulation pursuant to an

express delegation from Congress, *see Olmstead*, 527 U.S. at 591-592, its interpretations of that regulation are entitled to deference.

The availability of treatment alternatives is directly related to a hospital's ability to avoid involuntary admission and detention. Federal law demands that public entities like the Commonwealth develop such alternatives and provide services in the most integrated setting. MGH and clinicians who are authorized to involuntarily transport, admit and detain individuals with mental illness pursuant to G.L. c. 123, §§ 12(a) & (b) must consider all community treatment options and may not rely upon emergency departments when other less restrictive alternatives are available. Since Massachusetts has developed many of these community treatment alternatives, this complying with duty is likely to avoid hospitalization in many cases.

III. There Are Less Restrictive Treatment Programs That Are Clinically-Effective and Prevent Admissions to Emergency Rooms for Many Persons with Psychiatric Disabilities.

A. Federal and State Practices, as well as Professional Research, Have Demonstrated that Less Restrictive Treatment Programs Like Mobile Crisis Intervention Services Are Effective in Preventing Unnecessary Hospitalization.

Federal agencies responsible for regulating, funding, and overseeing state mental health systems, as well as private hospitals, have recognized that it is possible to reduce involuntary detention and unnecessary waiting in emergency departments through the planning, development, and operation of a comprehensive community mental health system that includes crisis services and intensive clinical

supports. Mental health systems must ensure timely access to mobile crisis intervention and crisis stabilization services, which are the most effective program for preventing unnecessary hospitalization and providing necessary treatment in less restrictive settings.

The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) describes community based treatment as an effective alternative to hospitalization, stating that "[t]here is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing behavioral health crises." Substance Abuse & Mental Health Servs. Admin, Health & Human Services, *Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies*, 5 (2014), http://bit.ly/36ylVFk.

Additionally, the Centers for Medicare and Medicaid Services (CMS) has identified "crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services" as important components of any community-based mental health system. Letter from Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs. to State Medicaid Directors, 14 (Nov. 13, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

There has been substantial research into how to reduce emergency department boarding of people in mental health crisis, and studies have identified a number of replicable best practices. For example, researchers have developed a systemic action plan, based on an extensive literature review and study, for reducing emergency department boarding. Key components of this action plan include recommending that emergency departments should: partner, coordinate, and communicate with community-based services; develop a standardized process from intake to discharge for mental health issues; engage and equip patients, family members, and caregivers to support self-management; and create a trauma-informed culture among emergency department staff. Vidhya Alakeson et al., *A Plan To Reduce Emergency Room 'Boarding' Of Psychiatric Patients*, 29(9) Health Affairs 1637, 1638-41 (2010), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2009.0336 (last visited December 12, 2019).

Emergency departments often have limited information about individuals seeking mental health treatment, creating an additional barrier to treatment. Eric B. Elbogen et al., *Effectively Implementing Psychiatric Advance Directives to Promote Self-Determination of Treatment Among People With Mental Illness*, 13(4) Psychol. Pub. Pol'y & L. 273, 274 (2007). Psychiatric advanced directives could be a useful tool to address this barrier. Researchers have observed that with a psychiatric advanced directive "clinicians could gain immediate access to relevant

information about individual cases and thus improve the quality of clinical decision making." *Id.*

Other innovative approaches such as telehealth and consumer- or peer-run services offer promising ways to decrease reliance on emergency departments. A recent study showed reductions in the number of emergency department visits for a diverse group of people with a range of serious mental illnesses who used a telehealth intervention. Sarah I. Pratt et al., *Feasibility and Effectiveness of an Automated Telehealth Intervention to Improve Illness Self-Management in People With Serious Psychiatric and Medical Disorders*, 36(4) Psychiatric Rehabilitation J. 297, 298 (2013). Research also shows that participation of persons with mental illness in mental health consumer-run organizations results in a significant decrease in emergency department usage. Geoffrey Nelson, *A Longitudinal Study of Mental Health Consumer/ Survivor Initiatives: Part 2—A Quantitative Study of Impacts of Participation On New Members*, 34(3) J. of Cmty. Psychol. 261, 267 (2006). Other research has shown the effectiveness of peer-run respite – programs where individuals can stay on a short-term basis in home-like setting and receive 24-hour peer support. *See* Thomas K. Greenfield et al., *A Randomized Trial Of A Mental Health Consumer-Managed Alternative To Civil Commitment For Acute Psychiatric Crisis*, 42 Am. J. Comm. Psychol. 135, 142-43 (2008), www.ncbi.nlm.nih.gov/pmc/articles/PMC2782949/ (last visited December 12, 2019); *see also* Jeanne Dumont & Kristine Jones, *Findings From A*

Consumer/Survivor Defined Alternative To Psychiatric Hospitalization, Outlook, 2002, at 4, https://www.hsri.org/files/uploads/publications/ot-03.pdf (last visited December 12, 2019).

Emergency departments are typically not effective in assuring that discharged patients receive community services designed to address issues resulting in their admission. A recent study shows that around a quarter of the patients on Medicaid who visited emergency departments for a mental health issue did not receive outpatient follow-up care within 30 days, and that follow-up rates were even lower for African-American patients. *Id.* at 569-70. Lack of follow-up care after an emergency department visit for a mental health condition can also makes a person "more likely to return to the [emergency department] and experience worsening of their conditions," Sarah Croake et al., *Follow-Up Care After Emergency Department Visits for Mental and Substance Use Disorders Among Medicaid Beneficiaries*, 68(6) Psychiatric Servs. 566 (2017).

Law enforcement is often the first point of contact for individuals in a mental health crisis, and police often transport individuals to emergency departments for evaluation. Due to the significance of police officers' role in a mental health crisis, a number of interventions have been developed to deliver police training on mental illness, increase officer awareness of less restrictive alternatives and, in so doing, avoid unnecessary reliance on emergency departments. *See, e.g.*, National Alliance on Mental Illness, Crisis Intervention

Team (CIT) Programs, https://www.nami.org/get-involved/law-enforcement-and-mental-health (last visited Dec. 12, 2019). One of the leading police-based diversion models is the Crisis Intervention Team (CIT), a community-based collaborative approach. Mass. Dep't of Mental Health, Jail/Arrest Diversion Grant Program FY2018 Mid-Year Report, 6 (2017), http://bit.ly/2PjkWDe (last visited December 12, 2019) [hereinafter, *Jail/Arrest Diversion Grant Program*]; *see also* Laura Usher et al., Crisis Intervention Team International, *Crisis Intervention Team (CIT) Programs: A Best Practice Guide For Transforming Community Responses To Mental Health Crises* (2019), http://bit.ly/2Efx81u (last visited Dec. 12, 2019). CIT programs are most effective when paired with a Co-Responder model of service in which a clinician linked to the local crisis team and community behavioral health organization serves as a partner to police officers, riding along with them and consulting to them as they encounter persons with behavioral health or disability conditions. These partnerships between police officers and clinicians often serve to deescalate and stabilize an emerging crisis, connecting individuals to care and diverting them from emergency rooms or jail. This program also can include a specialized law enforcement team that partners with key stakeholders to improve police response to mental health crisis, and includes a strategic component which involves developing formal diversion efforts. *Jail/Arrest Diversion Grant Program*, at 6. A portion of officers in the police department participate in a comprehensive 40-hour training on mental health. *Id.*

The wide range of strategies and models described above demonstrates that there are numerous evidence-based, less restrictive programs and services that can de-escalate and divert individuals in psychiatric crisis, effectively preventing emergency department admissions and detention. As the federal government recognizes and research confirms, appropriate mental health treatment, provided through less restrictive community alternatives, is the most effective long-term strategy for reducing unnecessary hospitalization in emergency departments.

B. The Commonwealth, Through Its Mental Health and Medicaid Programs, Operates a Range of Less Restrictive Treatment Programs Including Mobile Crisis Intervention Services that Are Intended to Prevent Unnecessary Hospitalization.

A number of new initiatives in Massachusetts specifically target the issue of emergency department boarding and are less restrictive means of addressing a mental health crisis compared to hospitalization. Recently, Massachusetts has invested $60 million dollars in a redesign of the community mental health system, adding additional clinical services and supports. Exec. Office of Health & Human Services, *Reforms to Strengthen And Improve Behavioral Health Care For Adults*, 3 (Jan. 2018),https://www.mass.gov/files/documents/2018/01/24/bh-system-restructuring-document_1.pdf. The redesigned system, called Adult Community Clinical Services (ACCS), provides residential, ambulatory, and other crisis services, as well as peer support to individuals who require high intensity services to live in the community. *Id.* at 4, 19. One of the expected impacts of this investment and reform is reduced reliance on emergency departments. *Id.* at 4. In

addition, through the Commonwealth's Medicaid program—MassHealth—Massachusetts is investing over $600 million over the next five years to address treatment gaps, with the goal of addressing some of these issues including reducing emergency department boarding. *Id.* at 18.

Massachusetts also has existing services that can reduce unnecessary hospitalization. The "front door" to Massachusetts' community mental health system is the 24-hour 7 day per week Emergency Service Programs (ESPs) that provide behavioral health crisis assessment, intervention and stabilization. Emergency Services Program Mobile Crisis Intervention, Massachusetts Behavioral Health Partnership, https://www.masspartnership.com/provider/ESP.aspx (last visited Dec. 12, 2019). ESPs provide services through four different programs: Mobile Crisis Intervention services for youth, adult mobile crisis services, community-based crisis facilities, and community crisis stabilization. *Id.* The twenty-one ESPs are located across the state and cover every city and town. MBHP ESP Statewide Directory, (Aug. 2019), http://bit.ly/2RNfKsM (last visited Dec. 12, 2019).

Further, Massachusetts has a range of evidence-based community mental health services targeted to individuals with severe and persistent mental health needs, including: Respite Services (short-term, community-based clinical and rehabilitative services allowing someone to remain in the community), Program of Assertive Community Treatment (multidisciplinary team approach providing acute

and long term support, community based psychiatric treatment), Clubhouses (skill development and employment services), Recovery Learning Communities (mental health consumer-operated networks of self-help/peer support), DMH Case Management, and Homelessness Services. DMH Adult Services Overview, Dep't of Mental Health, https://www.mass.gov/service-details/dmh-adult-services-overview (last visited Dec. 12, 2019).

In addition, since 2007, DMH has funded police-based jail diversion programs, similar to the CIT programs described above. One of the stated goals of these programs is to avoid the use of emergency rooms. *Jail/Arrest Diversion Grant Program*, at 4. Models funded include: Co-Response (mental-health based diversion model that pairs a clinician, often a clinician affiliated with the local Emergency Services Program with police to co-respond to calls with mental health elements), Crisis Intervention Teams (CIT), Innovative program models, and Crisis Intervention Team Training & Technical Assistance Centers (creates a hubs for CIT development across a region). *Id.* at 5-8.

A number of consumer peer-run services in Massachusetts provide support during a mental health crisis. For example, the Living Room is a walk-in space at the Behavioral Health Network's program in Springfield where individuals in a mental health crisis can meet with peers and obtain needed support to avoid emergency department admissions. Living Room, Behavioral Health Network https://www.bhninc.org/services-and-programs/emergency-services/living-room

(last visited Dec. 12, 2019). Another consumer-led service funded largely by the Department of Mental Health is Afiya Peer Respite, a program run by Western Mass Recovery Learning Community. Afiya supports people during a mental health crisis by providing a place to stay in a home-like, non-clinical environment and 24-hour access to peer mentors. Afiya, Western Mass Recovery Learning Community, https://www.westernmassrlc.org/afiya (last visited Dec. 12, 2019); Sera Davidow, *Peer Respite Handbook: A Guide to Understanding Building and Supporting Peer Respites*, Western Mass Recovery Learning Community, (2017), http://bit.ly/2PjfVuc (last visited December 12, 2019). One of the primary goals of Peer Respite is to avoid the need for hospitalization through peer support in a crisis.

A wide range of community mental health services and supports specifically designed to prevent unnecessary hospitalization and provide needed treatment in less restrictive settings already exist in Massachusetts. While there may be service gaps or challenges accessing these alternatives in a timely manner, it is clear that the Commonwealth is familiar with and attempting to expand effective, less restrictive interventions that have been demonstrated to reduce emergency department boarding. Thus, in order to comply with federal law, the ADA's integration regulation, and this Court's longstanding jurisprudence, the Commonwealth can and must prevent unnecessary admission to, and detention in,

emergency departments through the referral to and delivery of these community-based services.

CONCLUSION

For the reasons set forth above, the Court should affirm the Appellate Division's decision requiring emergency departments to discharge or transfer to a psychiatric facility, within three days of admission, any person admitted pursuant to G.L. c, 123, § 12(a).

Respectfully submitted,

Steven J. Schwartz BBO #448440
sschwartz@cpr-ma.org
Robert Fleischner BBO #171320
rfleischner@cpr-ma.org
Kathryn L. Rucker BBO #644697
krucker@cpr-ma.org
Anna Krieger BBO #56883
akrieger@cpr-ma.org
Center for Public Representation
22 Green Street
Northampton, MA 01060
413-586-6024
sschwartz@cpr-ma.org

Tatum A. Pritchard
BBO #664502
Disability Law Center
11 Beacon Street, Suite 925
Boston, MA 02108
617-723-8455
tpritchard@dlc-ma.org

Phillip Kassel
BBO #555845
pkassel@mhlac.org

Jennifer Honig
BBO #559251
jhonig@mhlac.org
Mental Health Legal Advisors Committee
24 School Street 8th floor
Boston, MA 02108
617-338-2345

CERTIFICATE OF SERVICE

I, Steven Schwartz, hereby certify that on December 20, 2019, I electronically filed the foregoing document with the Massachusetts Supreme Judicial Court by using the CM/ECF system. I certify that the following counsel of record are registered as ECF Filers and that they will be served by the CM/ECF system:

Emily Kanstroom Musgrave
Mintz Levin Cohen FG & P, PC
1 Financial Center
Boston, MA 02111
617-542-6000
EKMusgrave@Mintz.com

Michael T. Porter
Connor & Hillard, PC
1350 Main Street
Walpole, MA 02081
508-668-4774
mikeporter@connhill.com

Andrew N. Nathanson
Mintz Levin Cohen FG & P, PC
1 Financial Center
Boston, MA 02111
617-542-6000
ANNathanson@Mintz.com

Karen Owen Talley
Committee for Public Counsel Services
44 Bromfield Street
Boston, MA o2108
617-353-2326
ktalley@publiccounsel.net

Catherine S. Lombardo
Mintz Levin Cohen FG & P, PC
1 Financial Center
Boston, MA 02111
617-542-6000
CSLombardo@Mintz.com

Dated: December20, 2019

/s/ Steven Schwartz
(BBO #448440)
Center for Public Representation
22 Green Street
Northampton, MA 01060
413-586-6024
sschwartz@cpr-ma.org

CERTIFICATE OF COMPLIANCE

I, Steven Schwartz, hereby certify that the foregoing brief complies with the rules of court that pertain to the filing of briefs, including but not limited to: Mass. R. A. P. 16(a) (contents of briefs); Mass. R. A. P. 16(e) (references to the record); Mass. R. A. P. 16(f) (reproduction of statutes, rules, regulations); Mass. R. A. P. 16(h) (length of briefs); Mass. R. A. P. 17 (amicus briefs); and Mass. R. A. P. 20 (form of briefs, appendices, and other papers).

I also certify that the foregoing brief complies with Mass. R.A.P. 20(a)(2)(C). The brief contains 7,192 non-excluded words in Times New Roman, size 14 font, and was produced using Microsoft Word 2010.

Dated: December 20, 2019

/s/ Steven Schwartz
(BBO #448440)
Center for Public Representation
22 Green Street
Northampton, MA 01060
413-586-6024
sschwartz@cpr-ma.org

ADDENDUM

TABLE OF CONTENTS