Supreme Judicial Court for the Commonwealth Full Court: SJC-13455 Filed: 10/30/2023 10:44 PM

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Norfolk, ss. NO. SJC-13455

COMMONWEALTH,
Appellee,

V.

A.Z.,
Appellant

ON DIRECT APPELLATE REVIEW FROM A DECISION AND ORDER OF THE APPELLATE DIVISION OF THE DISTRICT COURT (SOUTHERN DISTRICT)

BRIEF OF AMICI CURIAE DISABILITY LAW CENTER, INC., MENTAL HEALTH LEGAL ADVISORS COMMITTEE, CENTER FOR PUBLIC REPRESENTATION, AND MASSACHUSETTS ASSOCIATION FOR MENTAL HEALTH IN SUPPORT OF A.Z.

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Dated: October 30, 2023

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Brangan v. Commonwealth, 477 Mass. 691 (2017) 21, 29

Carr v. State, 303 Ga. 853 (2018) 39

Commonwealth v. Nassar, 380 Mass. 908 (1980) 22, 25, 28

Commonwealth v. Madden, 458 Mass. 607 (2010) 29

Foss v. Commonwealth, 437 Mass. 584 (2002) 31

Garcia v. Commonwealth, 487 Mass. 97 (2021) 21, 36, 38

In re Newchurch, 807 F.2d 404 (5th Cir.1986) 29, 30

Massachusetts Gen. Hosp. v. C.R., 484 Mass. 472 (2020) 17

Matter of F.C., 479 Mass. 1029 (2018) 22

Matter of Minor, 484 Mass. 295 (2020) 28, 38

Newton-Wellesley Hosp. v. Magrini, 451 Mass. 777 (2008) 21

Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999) 26, 27

Pembroke Hospital v. D.L., 482 Mass. 346 (2019) 28

Pennsylvania Dep't of Corr. v. Yeskey, 524 U.S. 206 (1998) 27

Scione v. Commonwealth, 481 Mass. 225 (2019) 37

Seng v. Commonwealth, 445 Mass. 536 (2005) 36

United States v. Deters, 143 F.3d 577 (10th Cir.1998) 29

United States v. Neal, 679 F.3d 737 (8th Cir. 2012) 29, 30, 38

United States v. Song, 530 F. App'x 255 (4th Cir. 2013) 29

Vitek v. Jones, 445 U.S. 480 (1980) 22

Walsh v. Commonwealth, 485 Mass. 567 (2020) 21

STATUTES, LAWS, REGULATIONS

29 U.S.C. § 794(a) 25

18 U.S.C. § 4247(b) 30

42 U.S.C. § 12101(a)(2)-(3), (7) 26

42 U.S.C. § 12132 26

Mental Health Study Act of 1955, Pub. L. No. 85-182 24

Community Health Act of 1963, Pub. L. No. 88-164 24

G. L. c. 19 ....24, 26, 30

G. L. c. 123 ....25, 28, 30, 31

G. L c. 123, § 4 25

G. L. c. 123, § 15 ....30, 36, 37

G. L c. 123, § 15(a) 30, 31, 36

G. L c. 123, § 15(b) 22, 30, 36, 37, 38, 39

G. L. c. 123, § 35 28

G. L c. 276, § 58A 29

Mental Health Reform Act of 1970 ....25, 26, 31

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28 C.F.R. § 41.51(b)(3) 27

28 C.F.R. § 41.51(d) 25, 27

45 C.F.R. § 84.4(b)(2), (4) 27

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OTHER AUTHORITIES

ABA, *Criminal Justice Standards on Mental Health* 7-4.5 (2016),
https://www.americanbar.org/content/dam/aba/publications/
criminal_justice_standards/mental_health_standards_2016.authcheckdam.pdf 35

Appelbaum & Fisher, *Judges' Assumptions About the Appropriateness of Civil and Forensic Commitment*, 48 Psychiatric Services 710 (1997) 38

Bartlett, *Staffing Shortages Keep One-Fifth of Psychiatric Beds Out of Commission*, The Boston Globe (Sep. 28, 2022),
https://www.bostonglobe.com/2022/09/28/metro/
staffing-shortages-keep-one-fifth-psychiatric-beds-out-commission/ 17

Beltrani & Zapf, *Competence to Stand Trial and Criminalization: An Overview of the Research*, 25 CNS Spectrums 161 (2020) 16, 33

Callahan & Pinals, *Challenges to Reforming the Competence to Stand Trial and Competence Restoration System*,
71 Psychiatric Services 691 (2020) 16, 38, 39

Department of Mental Health, *Overview of the Department of Mental Health*,
https://www.mass.gov/info-details/
overview-of-the-department-of-mental-health 26

Department of Mental Health, *Reports Pursuant to Section 114 of Chapter 24 of Acts of 2021*, https://www.mass.gov/info-details/section-114-reports 17, 18, 20, 26

Department of Mental Health Forensic Service, *Designated Forensic Professional Procedures Manual* (2018), https://www.mass.gov/doc/mgl-guidelinespdf/download 36

Department of Mental Health Forensic Service, *M.G.L. c. 123, s.15 (a) Report Writing Guidelines* (2008), https://www.mass.gov/doc/designated-forensic-professional-procedures-manual/download 36

Fader-Towe & Kelly, *Just and Well: Rethinking How States Approach Competency to Stand Trial*, The Council of State Governments Justice Center (2020) 35

Fader-Towe & Pinals, *Data on Evaluations as a Foundation for States Rethinking Competency to Stand Trial*, 49 J. Am. Acad. Psychiatry & L. 540 (2021) 16

Fitch & Warren, *Community-Based Forensic Evaluations*, Inter. 11 J. L. & Psychiatry 359 (1988) 34

Flaschner, *Forward to A Manual for Commitments Under the New Mental Health Code* (1971) 31

Hogarty, *Downsizing the Massachusetts Mental Health System: The Politics of Evasion*, 12 N.E. J. Pub. Pol'y, 9 (Fall/Winter, 1996) 24, 26

Joint Commission on Mental Illness and Health, *Action for Mental Health: Final Report* (1961) 24

Joost & McGarry, *Massachusetts Mental Health Code: Promise and Performance*, 60 A.B.A. J. 95 (1974) 31, 32

Kavanaugh & Alulema, *Staffing Shortages Leave Much-Needed Mental Health Beds Empty,* Boston 25 News (Apr. 14, 2022), https://www.boston25news.com/news/local/25-investigates-staffing-shortages-leave-much-needed-mental-health-beds-empty/OCFA3LGSHZENJPAKFYQDATA75Q/ 18

Lutterman, *Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2018*, National Association of State Mental Health Program Directors (2022), https://www.nasmhpd.org/sites/default/files/2023-01/Trends-in-Psychiatric-Inpatient-Capacity_United-States%20_1970-2018_NASMHPD-2.pdf 16

Massachusetts Health & Hospital Association, *The Effect of Behavioral Workforce Shortages on the Availability of Inpatient Psychiatric Services* (Sep. 26, 2022), https://www.mhalink.org/reportsresources/bhstaffingshortages2022/ 18

Massachusetts Health & Hospital Association, *Psychiatric Patient Access to Continuing Care Services* (Jan. 16, 2023), https://www.mhalink.org/reportsresources/bh-continuingcare-report/ 19, 20

McGarry, *Demonstration and Research in Competency for Trial and Mental Illness: Review and Preview*, 49 B.U. L. Rev. 46 (1969) 31

Miller, *Hospitalization of Criminal Defendants for Evaluation of Competence to Stand Trial or for Restoration of Competence: Clinical and Legal Issues*, 21 Behav. Sci. & L. 369 (2003) 33

Morris & Kleinman, *Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization*, 74 Psychiatric Services 431 (2023) 22

Murrie et al., *Competency to Stand Trial Evaluations: A Statewide Review of Court-ordered Reports*, 38 Behav. Sci. & L. 32 (2020) 34

Murrie et al., *Evaluations of Competence to Stand Trial Are Evolving Amid a National "Competency Crisis"*, 41 Behav. Sci. & L. 1 (2023) 15, 16, 32

Melton et al., *Community Mental Health Centers and the Courts: An Evaluation of Community-Based Forensic Services*, University of Nebraska Press (1985) 34

Nicholson & Kugler, *Competent and Incompetent Criminal Defendants: A Quantitative Review of Comparative Research*, 109 Psychol. Bull. 355, 363, 368 (1991) 33

Perlin, *"For the Misdemeanor Outlaw": The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 Ala. L. Rev. 193 (2000) 28

Roesch, *Determining Competency to Stand Trial: An Examination of Evaluation Procedures in an Institutional Setting*, 43 J. Consult. & Clinical Psychol. 542 (1979) 32

Schlanger et al., *Ending the Discriminatory Pretrial Incarceration of People with Disabilities: Liability under the Americans with Disabilities Act and the Rehabilitation Act*, 17 Harvard L. & Pol'y Rev. 231 (2022) 28

Schreiber et al., *An Evaluation of Procedures for Assessing Competency to Stand Trial*, 15 Bull. Am. Acad. Psychiatry & L. 187 (1987) 32, 33

Walker, *Mental Health Law Reform in Massachusetts*, 53 B.U. L. Rev. 986 (1973) 25

Warren et al., *Opinion Formation in Evaluating the Adjudicative Competence and Restorability of Criminal Defendants*, 24 Behav. Sci. & L. 113 (2006) 33

Wik, *Forensic Patients in State Psychiatric Hospitals: 1999-2016*, National Association of State Mental Health Program Directors (2017), https://www.nasmhpd.org/sites/default/files/TACPaper.10.Forensic-Patients-in-State-Hospitals_508C_v2.pdf 16

STATEMENT OF INTEREST OF THE AMICI CURIAE

The Disability Law Center (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, § 15(b) is of great importance to many DLC clients. DLC has participated in many important SJC cases that affect our clients, including, in recent years: *Massachusetts Gen. Hosp. v. C.R.*, 484 Mass. 472 (2020); *Matter of J.P.*, 486 Mass. 117 (2020); *Pembroke v. D.L.*, 482 Mass. 346 (2019); and *Matter of M.C.*, 481 Mass. 336 (2019).

The Mental Health Legal Advisors Committee (MHLAC) was established as an agency of the judiciary by the General Court by virtue of the enactment of G. L. c. 221, § 34E in 1973. MHLAC provides advice and assistance to individuals with mental illness, to their families, and to other attorneys. MHLAC monitors legal issues before the courts affecting the interests of individuals with mental health disabilities. It has persistently advocated for rigorous procedural protections and substantive standards that are protective of civil liberties. MHLAC has a long history of weighing in on questions regarding the interpretation of the state mental

health law statute. It served as *amici* in numerous cases involving the procedural rights of persons with mental health related disabilities.[1]

The Center for Public Representation (CPR) is a national and state disability public interest law firm that provides training and technical assistance to public and private attorneys who represent individuals with disabilities. It authored the original commitment handbook for appointed counsel in commitment matters, the Trial Manual for Civil Commitment, which was initially published by MHLAC in 1975. Since then, it has authored or joined most of the major appeal briefs before this Court involving the interpretation and application of G. L. c. 123.

Founded in 1913, the Massachusetts Association for Mental Health (MAMH) advances mental health and well-being by promoting prevention, early intervention, effective treatment, and research to address social, emotional, and mental health challenges. MAMH also strives to eliminate stigma and discrimination and to ensure the full social, economic, and political inclusion in community life for those of us who experience mental health issues. To advance treatment access for persons in Massachusetts, MAMH advocates for a robust continuum of care from facility-based to community-based services, and for resources and policies to ensure that people move as needed through that

[1] These include: *Walden Behavioral Care v. K.I.,* 471 Mass. 150 (2015); *Guardianship of Erma*, 459 Mass. 801 (2011); *Kenniston v. DYS*, 453 Mass. 179 (2009); *Newton-Wellesley Hosp. v. Magrini*, 451 Mass. 777 (2008); and *Andrews v. Bridgewater State Hosp.,* 449 Mass. 587 (2007).

continuum. MAMH recognizes the detrimental effects of arrest, prosecution, adjudication, incarceration, probation, and/or parole on people with mental health needs, including trauma, stress, the removal from supports and services, and a decline in mental well-being. Accordingly, MAMH advocates for policies that minimize the number of individuals with mental health conditions in the criminal justice system and for alternatives to incarceration.

DECLARATION OF AMICI

Pursuant to Mass. R. App. P. 17 (c)(5), Amici Curiae DLC, MHLAC, CPR, and MAMH declare that no party or a party's counsel authored this brief in whole or in part; no party or a party's counsel contributed money intended to fund preparing or submitting this brief; and no person or entity – other than Amici – contributed money intended to fund preparing or submitting this brief.

CORPORATE DISCLOSURE STATEMENT PURSUANT TO SUPREME JUDICIAL COURT RULE 1:21

Pursuant to Supreme Judicial Court Rule 1:21, amicus curiae DLC 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 MHLAC 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 CPR 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 MAMH 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.

STATEMENT OF THE ISSUES

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

STATEMENT OF THE CASE

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

STATEMENT OF THE FACTS

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

SUMMARY OF ARGUMENT

The Department of Mental Health (DMH) operated and contracted psychiatric hospitals handle a high volume of commitments pursuant to court orders for evaluation to determine competency. Reducing unnecessary

commitments for inpatient competency evaluations will not only benefit defendants with mental health disabilities but will also relieve the burden these evaluations have on the criminal justice and mental health systems overall. (pp. 15-21.)

Like all other forms of mental health commitments, inpatient commitments for competency evaluation pursuant to G. L. c. 123, § 15(b) are a massive curtailment of liberty. Like incarceration and other forms of civil commitment, they can cause a range of collateral consequences, including housing loss, employment issues, and stigma. (pp. 21-23.)

Well-established legal and social doctrines, and particularly the federal and state statutory mandate to provide mental health care in the least restrictive, most integrated setting, create a strong presumption in favor of outpatient competency evaluations. During the past several decades, Massachusetts, like the rest of the United States, has dramatically reduced its reliance on large, segregated, and isolated institutions, and expanded community-based mental health care. The overarching purposes of Chapter 123 were to reduce institutionalization and restrict commitment to circumstances where no less restrictive setting existed. Nothing in the text of G. L. c. 123, § 15 suggests that the Legislature intended the process for competency evaluations to be exempt from these purposes. Legislative

intent, in addition to the broader social and legal framework, support a strong presumption in favor of outpatient competency evaluations. (pp. 23-32.)

Research shows that outpatient competency evaluations are reliable and can be performed with as much clinical rigor as evaluations conducted in hospital settings. Competency evaluations are relatively straightforward, clinical assessments that are conducted through validated and professionally accepted instruments. (pp. 32-36.)

Absent utilization of procedural safeguards, such as evidentiary hearings, G. L. c. 123, § 15(b) presents an unacceptable risk of abuse of discretion. This conclusion is bolstered by research undercutting assumptions that inpatient evaluations are clinically superior to outpatient evaluations. (pp. 36-39.)

ARGUMENT

I. Inpatient Competency Evaluations Strain Mental Health Systems and Hospitals.

A. States throughout the country have experienced dramatic increases in demand for competency evaluations while public psychiatric hospital capacity continues to decrease.

The number of competency evaluations conducted in the United States annually likely already exceeds 130,000.[2] "Courts are ordering far more defendants to undergo competence evaluations than ever before, and evaluators are opining a

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[2] Murrie et al., *Evaluations of Competence to Stand Trial Are Evolving Amid a National "Competency Crisis"*, 41 Behav. Sci. & L. 1, 3 (2023) [hereinafter Murrie (2023)].

far greater portion – and, of course, a far greater number – of those defendants as IST [incompetent to stand trial]."[3] From 1999 to 2014, the forensic population in public psychiatric hospitals increased by 76%.[4] At the same time, the overall number of beds in public psychiatric hospitals – where most inpatient competency evaluations are performed – has continued to decline.[5]

These phenomena have meant that most states are unable to meet the demand for forensic services in a timely manner.[6] "Designed to protect a specific due process right . . . for a limited number of cases, many [competency to stand trial] processes are now, somewhat ironically, becoming due process violations themselves."[7] This crisis not only affects defendants – it also leaves individuals in the "civil mental health system . . . with limited access to needed hospital beds."[8]

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[3] *Id.*

[4] Wik, *Forensic Patients in State Psychiatric Hospitals: 1999-2016*, National Association of State Mental Health Program Directors (2017) at 18, 78 https://www.nasmhpd.org/sites/default/files/TACPaper.10.Forensic-Patients-in-State-Hospitals_508C_v2.pdf.

[5] Lutterman, *Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2018*, National Association of State Mental Health Program Directors, 18, 26-27 (2022) https://www.nasmhpd.org/sites/default/files/2023-01/Trends-in-Psychiatric-Inpatient-Capacity_United-States%20_1970-2018_NASMHPD-2.pdf (finding that the number of beds in state and county psychiatric hospitals decreased by 18.5% from 2010 to 2018).

[6] Callahan & Pinals, *Challenges to Reforming the Competence to Stand Trial and Competence Restoration System*, 71 Psychiatric Services 691, 691-92 (2020); Beltrani & Zapf, *Competence to Stand Trial and Criminalization: An Overview of the Research*, 25 CNS Spectrums 161, 161 (2020).

[7] Fader-Towe & Pinals, *Data on Evaluations as a Foundation for States Rethinking Competency to Stand Trial,* 49 J. Am. Acad. Psychiatry & L. 540, 541 (2021).

[8] Callahan & Pinals, at 692.

B. Inpatient competency evaluations have contributed to an extremely overburdened public psychiatric system, with people waiting for months or years for a bed to become available at a DMH operated or DMH contracted hospital.

Massachusetts has not avoided this crisis. In any given month, forensic cases constitute a majority of admissions to DMH operated and contracted hospitals.[9] At the same time, between 2005 and 2022, the total capacity of these hospitals has contracted by close to 20%, from 829 to 685 beds.[10] Publicly available data strongly suggests that the high volume of forensic admissions to these facilities contributes to the state's overburdened psychiatric hospital system,[11] a system that this Court acknowledged in 2020 as experiencing a "crisis" involving "individuals in need of inpatient psychiatric hospitalization wait[ing] in hospital EDs for extended periods of time" for available inpatient psychiatric beds. *Massachusetts Gen. Hosp. v. C.R.*, 484 Mass. 472, 474, 483-89 (2020) (discussing the crisis of "ED Boarding" and DMH's efforts to address it through its "expedited psychiatric admission protocol"). "[A] seemingly intractable labor shortage," has exacerbated

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[9] *Amici* base this conclusion on a comparison between recent admissions data received through a public records request and data on DMH operated and contracted facilities that is publicly available at DMH, *Reports Pursuant to Section 114 of Chapter 24 of Acts of 2021* [hereinafter *Section 114 Reports*], https://www.mass.gov/info-details/section-114-reports.
[10] *Id.*
[11] *Id.*

existing bed shortages since.[12] Last year, the Massachusetts Health & Hospital Association (MHA) reported that "nearly 20%" of the state's licensed inpatient psychiatric beds were "offline, solely because there were not enough workers to staff them."[13]

DMH operates five psychiatric hospital sites and contracts with a private provider to operate a Western Massachusetts Unit.[14] Based on the most recent publicly available data from September 2023, the six sites had a total of 685 adult "operational beds" but a census of 706.[15] Some of the hospitals have been consistently operating above their approved census. In September, Worcester Recovery Center & Hospital (WRCH) had 290 beds and a census of 304; Solomon Carter Fuller Mental Health Center (SCF) had 60 beds and a census of 61; Lemuel Shattuck Hospital had 95 beds and a census of 95; Tewksbury State Hospital (TSH) had 165 beds and a census of 167; Taunton State Hospital had 45 beds and a census of 49; and the Western Massachusetts Unit had 30 beds with a census of

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[12] Bartlett, *Staffing Shortages Keep One-Fifth of Psychiatric Beds Out of Commission*, The Boston Globe (Sep. 28, 2022), https://www.bostonglobe.com/2022/09/28/metro/staffing-shortages-keep-one-fifth-psychiatric-beds-out-commission/; *see also* Kavanaugh & Alulema, *Staffing Shortages Leave Much-Needed Mental Health Beds Empty,* Boston 25 News (Apr. 13, 2022), https://www.boston25news.com/news/local/25-investigates-staffing-shortages-leave-much-needed-mental-health-beds-empty/OCFA3LGSHZENJPAKFYQDATA75Q/.

[13] MHA, *The Effect of Behavioral Workforce Shortages on the Availability of Inpatient Psychiatric Services* (Sep. 26, 2022), https://www.mhalink.org/reportsresources/bhstaffingshortages2022/.

[14] Until August 2023, the Western Massachusetts Unit was run by Vibra Healthcare. It is now administered by Valley Springs Behavioral Health Hospital.

[15] *Section 114 Reports.*

30.[16] The Department of Correction's Bridgewater State Hospital (BSH) houses men undergoing forensic evaluations, as well as those who the court has found meet the standard for civil commitment and require "strict security." Most, if not all, inpatient competency evaluations take place in BSH, WRCH, SCF, and TSH.

DMH also licenses private psychiatric hospitals and psychiatric units in general hospitals. *See generally* 104 CMR 27.00. Nearly all of these facilities and units are designed to provide only short-term acute care. When a person in an acute care facility needs longer term inpatient care, the person must be transferred to one of DMH's operated or contracted facilities.

The large number of individuals at these licensed acute care psychiatric facilities awaiting transfer to DMH operated or contracted hospitals for long-term care as civil patients strongly suggests that hospitals that serve persons needing inpatient care and treatment are significantly overburdened. A November 2022 survey of freestanding (non-DMH) psychiatric facilities and psychiatric units in acute care hospitals in Massachusetts conducted by MHA and the Massachusetts Association of Behavioral Health Systems indicated that 110 patients at these facilities were awaiting transfer to DMH operated or contracted hospitals for continuing care services.[17] Of those 110 patients, 24 had been waiting for more

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[16] *Id.*

[17] MHA, *Psychiatric Patient Access to Continuing Care Services* (Jan. 16, 2023), at 6-7, https://www.mhalink.org/reportsresources/bh-continuingcare-report/. The report describes DMH

than one year to transfer, 41 patients for more than 200 days, and 62 patients for more than 100 days.[18] As illustrated in Table 1, from December 2021 through September 2023, only 53 of these individuals had been transferred to DMH operated or contracted hospitals. In contrast, DMH admitted 1,923 individuals for inpatient forensic evaluation during this same period. Forensic admissions, primarily for competency evaluations, deny long term care beds to non-forensic patients, resulting in a significant disruption in Massachusetts' inpatient mental health system.

Table 1: DMH Monthly Forensic and Acute Inpatient Admissions – December 2021 Through September 2023[19]

Month	Total Adult Forensic Admissions	Admissions from Acute Inpatient Transfer Waitlist
Dec-21	85	1
Jan-22	80	2
Feb-22	94	4
Mar-22	89	6
Apr-22	82	1
May-22	79	3
Jun-22	75	11
Jul-22	82	2
Aug-22	108	1
Sep-22	95	4
Oct-22	93	6
Nov-22	80	2
Dec-22	102	1
Jan-23	91	2

continuing care as services for individuals with serious mental illness who "present serious psychiatric symptoms requiring extended hospital stays with levels of care beyond an acute care hospital." *Id.* at 2.

[18] *Id.* at 7.

[19] *Section 114 Reports.*

Feb-23	76	2
Mar-23	80	2
Apr-23	81	1
May-23	94	1
Jun-23	95	1
Jul-23	89	0
Aug-23	91	0
Sep-23	82	0
Total	1923	53
Average	87.41	2.41

II. Inpatient Competency Evaluations, Which Are Not Intended or Required to Provide Mental Health Treatment, Constitute a Massive Curtailment of Liberty.

As this Court has consistently recognized, even brief involuntary hospitalizations are "massive curtailment[s] of liberty." *Garcia v. Commonwealth*, 487 Mass. 97, 102-103 (2021). Indeed, even "a temporary [involuntary] hospitalization as short as three days . . . is a 'massive curtailment' of liberty." *Id.* at 103 (citing *Newton-Wellesley Hosp. v. Magrini*, 451 Mass. 777, 784 (2008)). While involuntarily committed, patients' choice of food, communication with the outside world, control over their daily schedule, and ability to engage in religious worship and other communal activities are all severely restricted. Like pre-trial detention,[20] involuntary hospitalization has the potential to cause a range of

[20] Both this Court and the Supreme Court of the United States have recognized the potential for significant, long-term collateral consequences for defendants held in pretrial detention. *See Barker v. Wingo*, 407 U.S. 514, 532-533 (1972) ("The time spent in jail awaiting trial has a detrimental impact on the individual. It often means loss of a job; it disrupts family life . . . . Imposing those consequences on anyone who has not yet been convicted is serious."); *Walsh v. Commonwealth*, 485 Mass. 567, 579 (2020) ("This temporary deprivation of liberty can have

collateral consequences beyond the immediate infringement on one's liberty and bodily autonomy. These consequences can include loss of employment, housing, and/or relationships, interference with family and childcare obligations, and stigma.[21]

Furthermore, an involuntary commitment under G. L. c. 123, § 15(b) is explicitly not for treatment purposes. Whereas civil commitment serves the "dual purposes of . . . protection of the person and others from physical harm and rehabilitation of the person," *Commonwealth v. Nassar*, 380 Mass. 908, 917-18 (1980), involuntary hospitalization for a competency evaluation is for the sole purpose of assessing "whether mental illness or mental defect have so affected a person that he is not competent to stand trial or not criminally responsible for the crime or crimes with which he has been charged." G. L. c. 123, § 15(b).

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severe and long-lasting collateral consequences."); *Brangan v. Commonwealth*, 477 Mass. 691, 709 n.23 (2017) ("Pretrial detention disrupts a defendant's employment and family relationships, with often tragic consequences.").

[21] *See Matter of F.C.*, 479 Mass. 1029, 1029-1030, 1030 n.2 (2018) (acknowledging the potential for stigma and that records of involuntary commitments are stored in the "national instant criminal background check system"); Morris & Kleinman, *Taking an Evidence-Based Approach to Involuntary Psychiatric Hospitalization*, 74 Psychiatric Services 431, 432 (2023) (noting "potential harms, such as worsening of psychiatric distress, perceptions of coercion, separation from social supports, loss of housing or employment, and financial consequences of hospital-level care"). "It is indisputable that commitment to a mental hospital can engender adverse social consequences to the individual . . . and that it can have a very significant impact on the individual." *Vitek v. Jones*, 445 U.S. 480, 492 (1980) (quotations and citations omitted) (holding that prisoners cannot be transferred to a psychiatric hospital absent adequate due process because of the potential for stigma from such hospitalization).

Involuntary admissions pursuant to Section 15(b) also may interrupt defendants' outpatient mental health treatment. Indeed, the record before the Court provides an instance in which A.Z.'s inpatient evaluation interrupted an ongoing outpatient therapy schedule. (RA:35).

III. A Presumption in Favor of Outpatient Competency Evaluations Is Consistent with the Professional Standard of Providing Services to Persons with Mental Illness in the Community.

Before the mid-twentieth century, society and governments in the United States largely accepted that institutionalization of people with mental disabilities was appropriate, and even desirable. However, beginning in the 1950's, mental health providers, acknowledging the benefits of – and right to – community treatment, began to redesign their mental health service systems. The development and utilization of community-based care has since provided immense benefits to people with mental health disabilities. Competency evaluations and related services have been included in this redesign and now are part of the community care system in many states. Furthermore, the statutes and cases establishing the doctrine of "least restrictive alternative" apply equally to persons undergoing competency evaluations as they do to the broader population of civilly committed people who require mental health treatment. Research, practical experience, and the legal framework all support a strong presumption in favor of outpatient competency evaluations.

A. Federal and state legislation have spurred the development of robust methods of evaluating and treating mental disabilities in community-based settings.

The Mental Health Study Act of 1955, Public Law 85-182, commissioned a study "to analyze and evaluate the needs and resources of the mentally ill in the United States and make recommendations for a national mental health program."[22] The final report stated that "the objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner."[23] The report identified "sav[ing] the patient from the debilitating effects of institutionalization as much as possible" as a "necessary" component of achieving this objective.[24] This report formed the basis for President Kennedy's Community Health Act of 1963, Public Law 88-164, which sought to establish a national program of community-based mental health care.[25]

Changes to Massachusetts law followed shortly thereafter. First, in 1966, the Commonwealth adopted Chapter 19 in order to expand community-based mental health treatment as an alternative to institutionalization.[26] Then, in 1970, the

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[22] Joint Commission on Mental Illness and Health, *Action for Mental Health: Final Report* (1961), at vii.
[23] *Id.* at xvii.
[24] *Id.*
[25] Hogarty, *Downsizing the Massachusetts Mental Health System: The Politics of Evasion*, 12 N.E. J. Pub. Pol'y 9, 32 (1996).
[26] *Id.* at 33.

Legislature passed the Mental Health Reform Act, a comprehensive overhaul of Chapter 123 that is still, for the most part, in effect today.

This new version of Chapter 123 directly addressed the problem of excessive and unnecessary civil commitment. It "clearly made it impossible to commit mentally ill people who are not dangerous merely because they need treatment."[27] The revised statute also incorporated a requirement that mental health services be administered in the least restrictive setting available, *see Nassar*, 380 Mass. at 918, provided for periodic reviews of patients' statuses, and mandated that "any patient who is no longer in need of care as an inpatient shall be discharged or placed on interim community leave." G. L. c. 123, § 4.

A few years later, through passage the Rehabilitation Act of 1973, the federal government took further steps to establish that people with disabilities have a right to receive services in the most integrated – or least restrictive – setting appropriate to their needs. Section 504 of the Act, through regulations promulgated by the Department of Justice, established an "integration mandate" requiring recipients of federal funds to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 29 U.S.C. § 794(a); 28 C.F.R. § 41.51(d). Passage of Title II of the American with Disabilities Act (ADA) in 1990 fortified this integration mandate.

[27] Walker, *Mental Health Law Reform in Massachusetts*, 53 B.U. L. Rev. 986, 992 (1973).

42 U.S.C. § 12132; 28 C.F.R. § 35.130(d); *see also Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597-602 (1999). In the Findings section of the ADA, Congress acknowledged that "discrimination against individuals 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).

Since the Legislature's passage of Chapter 19 in 1966 and of the Mental Health Reform Act of 1970, the Commonwealth has closed most of its large state hospitals and, over time, created what is now a robust system of community-based mental health services. The extent of this transformation of mental health treatment can be measured in part by the decline in the number of individuals in public psychiatric hospitals. In Massachusetts, the census in these hospitals dropped from over 23,000 in 1955 to about 2,000 by 1991.[28] Currently, as described above, there are fewer than 700 long term care beds on DMH operated and contracted units.[29] As of October 10, 2018, there were also 2,720 beds licensed by DMH in private facilities for the purpose of providing "acute short-term" care.[30]

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[28] Hogarty, at 11, 14.
[29] *Section 114 Reports.*
[30] DMH, *Overview of the Department of Mental Health*, https://www.mass.gov/info-details/overview-of-the-department-of-mental-health.

B. Decisions of the Supreme Court of the United States, the Supreme Judicial Court, and other courts reflect the requirement for providing mental health services in the least restrictive setting possible.

The legislation described above established an affirmative obligation that the government provide services in the least restrictive setting available. The Supreme Court's decision in *Olmstead v. L.C.*, significantly strengthened the federal statutory basis for the least restrictive alternative doctrine, holding that "[u]njustified isolation . . . is properly regarded as discrimination based on disability." 527 U.S. at 597. Thus, a public entity discriminates when it unnecessarily segregates people with disabilities in public or private facilities, or promotes such segregation, 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).

Notably, Congress did not exempt persons in the criminal justice system from the ADA's protections. A failure to conduct competency evaluations in the least restrictive setting available, therefore, may constitute discrimination under the ADA. *See, e.g.*, *Pennsylvania Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210-211

(1998) (holding that "the plain text of Title II of the ADA unambiguously extends to state prison inmates").[31]

This Court's opinions, grounded in both statutory and constitutional reasoning, similarly reflect the vital importance of the least restrictive alternative requirement. In 1980, this Court interpreted the text of Chapter 123 as requiring a finding that there is no less restrictive alternative to hospitalization in order to justify civil commitment under Section 16(b). *Nassar*, 380 Mass. at 917-918. More recently, the Court determined that a finding that civil commitment pursuant to G. L. c. 123, § 35 is the least restrictive alternative is also necessary to avoid constitutional infirmity under that section of Chapter 123. *Matter of Minor*, 484 Mass. 295, 310 (2020).[32] This Court's opinions regarding the presumption of pre-trial release in criminal matters further support the argument that the principle of least restrictive alternative is an essential aspect of constitutional due process

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[31] *See also* Schlanger et al., *Ending the Discriminatory Pretrial Incarceration of People with Disabilities: Liability under the Americans with Disabilities Act and the Rehabilitation Act*, 17 Harvard L. & Pol'y Rev. 231, 251 (2022) ("There is no question that the ADA and Rehabilitation Act protect individuals with disabilities from discrimination in . . . programs within . . . criminal systems."); Perlin, *For the Misdemeanor Outlaw: The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 Ala. L. R., 193, 229-239 (2000) ("[*Olmstead*] may force us to . . . think carefully and deliberately about the implications of the ADA and the [least restrictive alternative] doctrine for forensic populations in general.").

[32] *See also Pembroke Hospital v. D.L.*, 482 Mass. 346, 352 n. 9 (2019) ("[T]he modern version of the statute reflects a fundamental shift in our law toward destigmatization of mental illness and the elevation of the dignity of human beings, which warrants constitutional protection against involuntary restraint.") (quoting Flaschner, *The New Massachusetts Mental Health Code – A Magna Carta or a Magna Maze*, 56 Mass. L. Q. 49, 50 (1971)).

whenever the state seeks to limit bodily liberty. *See, e.g.*, *Brangan v. Commonwealth*, 477 Mass. 691, 709 (2017) ("Requiring a particularized statement as to why no less restrictive condition will suffice to assure the defendant's presence at future court proceedings is appropriate in light of the applicable standard of substantive due process."); *Commonwealth v. Madden*, 458 Mass. 607, 609-610 (2010) (describing the options available in dangerousness proceedings under G. L c. 276, § 58A, as "increasingly graduated levels of restraint . . . allow[ing] a judge to tailor an order to impose the least restrictive measures necessary" to assure the safety of another person or the community).

The least restrictive alternative doctrine also appears in the competency evaluation context in federal criminal proceedings, where multiple circuit courts of appeals have applied it on constitutional and statutory grounds. *See*, *e.g.*, *United States v. Song*, 530 F. App'x 255, 260 (4th Cir. 2013); *United States v. Neal*, 679 F.3d 737, 740–42 (8th Cir. 2012*); United States v. Deters*, 143 F.3d 577, 582–84 (10th Cir.1998); *In re Newchurch*, 807 F.2d 404, 409 (5th Cir.1986). While the relevant federal statute authorizes federal district courts to involuntarily commit criminal defendants for inpatient competency evaluations, "the statute does not grant a district court unfettered discretion to order such a commitment." *Neal*, 679

F.3d at 740.[33] Absent a "'sufficiently compelling' governmental interest" to justify commitment, the examination should be conducted on an outpatient basis. *Id.* at 741. In short, these courts concluded that "[d]ue process . . . requires the government, when it deprives an individual of liberty, to fetter his freedom in the least restrictive manner." *Newchurch*, 807 F.2d at 408.

These decisions demonstrate that, as a matter of statutory and constitutional law, a court must consider less restrictive placements before determining whether an involuntary commitment pursuant to Section 15(b) is appropriate. They support both the preference for conducting competency evaluations in the community as well as the procedural protections attendant to the commitment determination.

C. The overall purpose of Chapter 123 aligns with a strong presumption in favor of outpatient evaluations.

Considering Chapters 123 and 19 in their entirety, a clear statutory purpose is evident: to reduce inappropriate institutionalization and eliminate unnecessary involuntary hospital admissions. *See supra* Part III(A). Nothing in G. L. c. 123, § 15 suggests that the Legislature intended for the section to deviate from this larger statutory purpose. To the contrary, the language of Section 15(a), which

[33] Though the district court "*may* commit [a] person to be examined for a reasonable period . . . to the custody of the Attorney General for placement in a suitable facility" under 18 U.S.C. § 4247(b) (emphasis added), the Eighth Circuit, adopting the logic of the Fifth and Tenth circuits, concluded that the "statute's use of the word 'may' does not negate due process limitations, but merely reflects the district court's choice between an inpatient commitment and an outpatient evaluation" after applying the relevant standard. *Neal*, 679 F.3d at 741 (striking inpatient commitment for competency determination due to insufficient evidence of the necessity for it).

provides that initial assessments take place in the "courthouse" or "place of detention" whenever practicable, shows an alignment with the goal of reducing unnecessary institutionalization. *See also Foss v. Commonwealth*, 437 Mass. 584, 589 (2002) ("Among many other problems studied and addressed in the new mental health laws was the pretrial commitment of incompetent criminal defendants.").

The contemporaneous writings of Dr. A. Louis McGarry support the notion that the Legislature intended for Chapter 123 to promote deinstitutionalization.[34] Dr. McGarry and his co-author, Robert Joost, commenting on the dramatic drop in inpatient competency evaluations in the year after the enactment of the Mental Health Reform Act of 1970 (1,888 evaluations to 944), noted: "The drop in pretrial admissions is particularly gratifying since there was ample evidence these criminal

[34] *See* McGarry, *Demonstration and Research in Competency for Trial and Mental Illness: Review and Preview*, 49 B.U. L. Rev. 46 (1969) (discussing problems with Massachusetts' system for pretrial examination and proposing changes). Dr. McGarry served as the final director of the Special Commission on Mental Health, established by the Legislature to "to consider the laws relating to the methods of commitment, treatment and release of patients." *Foss v. Commonwealth*, 437 Mass. 584, 588 (2002). The concerns Dr. McGarry addressed in his 1969 article, *Demonstration and Research in Competency for Trial and Mental Illness: Review and Preview*, "undoubtedly were before the commission when addressing the proposed legislation." *Id.* at 588 n. 5. In 1971, Chief Judge Flaschner disseminated "A Manual for Commitments Under the New Mental Health Code," in which he acknowledged Dr. McGarry's contribution "for bearing the laboring oar on the new Chapter 123 through the years of drafting and submission to the General Court down to its present implementation." Flaschner, *Forward to A Manual for Commitments Under the New Mental Health Code* (1971).

case, court-ordered admissions had been excessive and that many were unnecessary."[35]

Thus, the general trend in federal and Massachusetts statutory enactments, as well as federal and Massachusetts court interpretations of those statutes, indicates a strong legislative preference for outpatient evaluations.

IV. Consistent with this Least Restrictive Requirement, Research, Professional Standards, and Clinical Practice Support a Presumption in Favor of Outpatient Competency Evaluations.

Like other forms of mental health services, competency evaluations have increasingly been provided in community-based settings. Whereas the majority of competency evaluations once took place in hospital settings, many now take place in jail or on an outpatient basis.[36] This trend accords with the straightforward nature of competency evaluations where a "brief, one-time interview can lead to a reliable competency decision in the vast majority of cases."[37] One meta-analysis found that "the correlations between competency status and defendant

[35] Joost & McGarry, *Massachusetts Mental Health Code: Promise and Performance*, 60 A.B.A. J. 95, 95 (1974). Mr. Joost also served on the Special Commission on Mental Health that led to the 1970 overhaul of Chapter 123. *Id.*

[36] "Competence evaluations were almost always performed in state psychiatric hospitals . . . until pilot projects . . . demonstrating that trained evaluators could perform outpatient evaluations comparable to evaluations conducted on inpatient status, but more efficiently and affordably." Murrie (2023) at 5-6 (citations omitted).

[37] Schreiber et al., *An Evaluation of Procedures for Assessing Competency to Stand Trial*, 15 Bull. Am. Acad. Psychiatry & L. 187, 200 (1987); *see also* Roesch, *Determining Competency to Stand Trial: An Examination of Evaluation Procedures in an Institutional Setting*, 47 J. Consult. & Clinical Psychol. 542, 548-549 (1979).

characteristics were generally quite similar across [inpatient and outpatient evaluation] settings," with the authors concluding that, "as a practical matter," the majority of competency evaluations can take place in outpatient settings.[38] "Therefore, it is rarely necessary for a defendant to be hospitalized solely for the determination of competency to stand trial."[39]

The "development of several research-validated competence assessment scales has provided reliable instruments that can easily be used on an outpatient basis, and do not require extensive legal knowledge to administer or score."[40] Community-based competency evaluations are "no less rigorous" than inpatient evaluations with respect to interview lengths and data gathering efforts.[41] Questionable assertions that inpatient competency evaluations are more thorough or reliable than outpatient evaluations are often based on assumptions rather than evidence.[42]

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[38] Nicholson & Kugler, *Competent and Incompetent Criminal Defendants: A Quantitative Review of Comparative Research*, 109 Psychol. Bull. 355, 363, 368 (1991).
[39] Schreiber, at 200.
[40] Miller, *Hospitalization of Criminal Defendants for Evaluation of Competence to Stand Trial or for Restoration of Competence: Clinical and Legal Issues*, 21 Behav. Sci. & L. 369, 385 (2003).
[41] Warren et al., *Opinion Formation in Evaluating the Adjudicative Competence and Restorability of Criminal Defendants*, 24 Behav. Sci. & L. 113, 129-30 (2006).
[42] One source of such assumptions may be that, "[i]n the past, most evaluators were employed in state psychiatric hospitals." Beltrani & Zapf at 163. *See also* Miller at 385 ("The main (stated) rationale for inpatient evaluation has been that the necessary expertise is to be found only in specialized forensic hospitals. The same rationale was advanced with respect to civil commitment during the deinstitutionalization era."). Notably, these evaluators "received little formal training in the assessment of competence and matters of law." Beltrani & Zapf at 163.

Outpatient competency evaluations are far from a novel or experimental concept and have been prevalent for decades in some states. For example, Virginia began its community-based forensic services program in 1980, quickly shifting the majority of its forensic evaluations out of hospitals and into the community.[43] Reviews of this program have found that outpatient evaluations are of comparable quality to inpatient evaluations, if not more effective.[44] One extensive study of Virginia's program found that outpatient evaluators were as knowledgeable as inpatient evaluators and tended to write better reports.[45] The authors of this study concluded that community-based forensic evaluations are "perhaps generally more effective . . . than hospital-based services" and that "[t]here apparently is no state interest – certainly not a *compelling* one – justifying use of central, maximum-security facilities for forensic evaluations."[46]

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[43] Fitch & Warren, *Community-Based Forensic Evaluations*, 11 Inter. J. L. & Psychiatry 359, 360, 369 (1988).

[44] *See, e.g.*, Melton et al., *Community Mental Health Centers and the Courts: An Evaluation of Community-Based Forensic Services*, University of Nebraska Press (1985) at 54-55, 63 (finding that the "case for community-based forensic services is compelling" through a "comprehensive evaluation of the implementation of community-based services in Virginia"); Murrie et al., *Competency to Stand Trial Evaluations: A Statewide Review of Court-ordered Reports*, 38 Behav. Sci. & L. 32, 48 (2020) (finding that the "vast majority (93%) [of 3,644 competence evaluations] were consistent with the basic statutory requirements"); Fitch & Warren at 364-369 (concluding that community-based evaluation approach "brings the mental health expert into much closer contact with others in the case – attorney, any witnesses, members of the defendant's family, and the court – and, thus, enables a much more effective use of the expert's services").

[45] Melton, at 54-55, 63.

[46] *Id.* at 22, 125.

Professional standards and recommendations also favor outpatient competency evaluations. The American Bar Association's Standard 7-4.5 of the Criminal Justice Standards on Mental Health provides that competency evaluations should take place in outpatient settings and that a defendant should only be committed for an inpatient evaluation if "an outpatient evaluation of the defendant determines that the defendant must be admitted to the facility for a professionally adequate evaluation to be completed"; "the defendant is admitted to the facility for treatment unrelated to the evaluation"; or "the defendant will not submit to outpatient examination as a condition of pretrial release."[47] Similarly, a recent report released by the Council of State Governments Justice Center, the American Psychiatric Association, and other organizations[48] recommended that "jurisdictions should consider conducting evaluations and restoration in the community to keep people close to home and in the least restrictive environment possible."[49]

In Massachusetts, attorneys, judges, and court clinicians understand that, if more information is needed to make a determination of competency, the statute permits the outpatient evaluation period to be "extended", without resort to an

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[47] ABA, *Criminal Justice Standards on Mental Health* 7-4.5 (2016), https://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/mental_health_standards_2016.authcheckdam.pdf.
[48] Partner organizations also included the National Association of State Mental Health Program Directors and the National Center for State Courts.
[49] Fader-Towe & Kelly, *Just and Well: Rethinking How States Approach Competency to Stand Trial*, The Council of State Governments Justice Center (2020) at 20.

inpatient evaluation under Section 15(b).[50] *See also Seng v. Commonwealth*, 445 Mass. 536, 540-544 (2005) (holding that Section 15(a) permits more than one competency evaluation to occur, at the request of the Commonwealth or the defense).

In summary, professional research, standards, and actual experience in many states strongly supports the presumption that outpatient competency evaluations can and should be conducted in the community, absent a compelling reason that justifies hospitalization.

V. The Lack of Sufficient Procedural Protections Prior to an Inpatient Commitment under Section 15(b) Create A Significant Risk That Defendants May Be Unnecessarily Involuntarily Committed for Inpatient Evaluations.

Insufficient procedural protections within Section 15 create a substantial potential for inappropriate hospitalization for competency evaluations under Section 15(b). Lack of procedural protections prior to a Section 15(b) commitment is particularly problematic given the limited purpose of the commitment – to evaluate the defendant's capacity to participate in a criminal proceeding – and the wholesale absence of any treatment or restoration justification for the confinement. *See Garcia*, 487 Mass. at 103 ("In the mental health context, it is unconstitutional

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[50] Guidance from DMH's Forensic Service division demonstrates approval of the practice of extended Section 15(a) evaluations. *See* DMH Forensic Service, *Designated Forensic Professional Procedures Manual* (2018), https://www.mass.gov/doc/mgl-guidelinespdf/download; DMH Forensic Service, *M.G.L. c. 123, s.15 (a) Report Writing Guidelines* (2008), https://www.mass.gov/doc/designated-forensic-professional-procedures-manual/download.

to confine a nondangerous person against his or her will merely to provide treatment.”).

Specifically, Section 15 lacks procedures “designed to further the accuracy” of the judge’s determination that an inpatient evaluation is truly necessary. *Aime v. Commonwealth*, 414 Mass. 667, 682 (1993). In *Aime*, this Court found that a lack of procedures in amendments to the State’s bail law “essentially grant[ed] the judicial officer unbridled discretion to determine whether an arrested individual is dangerous,” creating “a significant potential for abuse” in violation of due process of law. *Id*. at 667, 682-684. The Court was specific in its concern: “An official making a bail determination may decide to detain an arrestee known as a ‘trouble-maker,’ and may also factor into a bail determination personal beliefs that certain crimes are more repugnant than others.” *Id.* at 682.

Because the language of Section 15(b) similarly grants judges broad discretion to determine whether an inpatient evaluation is needed, procedural protections for ensuring a fair determination are especially necessary. *Cf. Scione v. Commonwealth*, 481 Mass. 225, 232 (2019) (“We have held other statutes that . . . provide unfettered discretion to . . . the courts to be unconstitutionally vague under due process principles where the defendant’s liberty is at stake.”). For example, Section 15 does not require an evidentiary hearing prior to ordering an inpatient evaluation. This deficiency is significant because, as this Court has explained,

"[t]he core of procedural due process is the adequacy of the hearing provided before a deprivation of liberty . . . occurs." *Aime*, 414 Mass. at 683 (citing *Mathews v. Eldridge*, 424 U.S. 319, 332–333 (1976)). *See also Neal*, 679 F.3d at 742 (vacating inpatient commitment, in part, because the district court failed to hold an evidentiary hearing).

Although there is a "compelling government interest," in determining a defendant's competency, *Garcia*, 487 Mass. at 106 n.15, an outpatient evaluation typically serves this interest just as well as an inpatient evaluation does. *See supra* Part IV. Thus, permitting an involuntary commitment to perform an inpatient competency evaluation without any required findings or procedural requirements does not satisfy due process. *See Minor*, 484 Mass. at 309.

Finally, although Section 15(b) is not a mechanism to provide inpatient mental health treatment to a defendant, it sometimes may be used with the misplaced hope of achieving that goal.[51]

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[51] In a 1997 survey of Massachusetts district court judges, 53.4 percent of respondents (thirty-three judges) "reported ordering pretrial forensic evaluations as a means of ensuring adequate treatment for persons with mental illness who appear in their courts." Twenty judges (34% of respondents) further indicated that "[t]hey have no other way to hospitalize persons who need treatment but do not meet dangerous criteria for civil commitment" as a reason for ordering inpatient evaluations. Appelbaum & Fisher, *Judges' Assumptions About the Appropriateness of Civil and Forensic Commitment*, 48 Psychiatric Services 710, 711 (1997). Callahan and Pinals described the implications of similar findings from a report by the National Association of State Mental Health Program Directors: "Some judges were transparent that they use the tools available to them to ensure that an individual found IST will receive treatment while in jail. . . . [H]aving stakeholders with different goals . . . can cause disjunction in the defendant's processing through the system . . . and further bottlenecks in forensic hospitals." Callahan & Pinals, at 693 (citations omitted).

The due process concerns are especially salient in light of the research discussed above, *supra* Part IV, suggesting that outpatient competency evaluations are clinically as reliable as inpatient evaluations. *See Carr v. State*, 303 Ga. 853, 864 (2018) ("No matter how short the duration of the detention, if the nature of the confinement is not reasonably related to the government's purpose of accurately evaluating the individual defendant's potential to attain competency, the detention is unconstitutional."). Further, as discussed *supra* Parts I and II, "raising the issue of [competence to stand trial] has profound implications for individuals and the criminal justice and mental health systems, including both forensic and civil patients."[52] Both the trial courts and defendants will benefit from a ruling that clarifies the limited purpose of G. L. c. 123, § 15(b) and holds that it currently lacks sufficient procedures to further the accuracy of judges seeking to determine when inpatient evaluations should be ordered.

CONCLUSION

For the reasons presented herein and in the brief of Appellant-Petitioner, Amici urge this Court to find in favor of Appellant-Petitioner.

Respectfully submitted,

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[52] Callahan & Pinals, at 695.

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Dated: October 30, 2023

CERTIFICATE OF COMPLIANCE

I, Justin Woolf, 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 6,446 non-excluded words in Times New Roman, size 14 font, and was produced using Microsoft Word version 16.78.

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I, Justin Woolf, hereby certify that on October 17, 2023, 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:

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