COMMONWEALTH OF MASSACHUSETTS
APPELLATE DIVISION OF THE
BOSTON MUNICIPAL COURT

SUFFOLK, ss

Docket No.: 1801MH0235

IN THE MATTER OF C.R.

C.R.
Appellant/Respondent

v.

MASSACHUSETTS GENERAL HOSPITAL
Appellee

MEMORANDUM OF DECISION

Joun, J. This matter comes before us on appeal from decisions denying the Appellant's request for an emergency hearing after involuntary admission to a mental health facility under G.L. c. 123, § 12 (b), denying her motion to dismiss the commitment petition, and subsequently involuntarily committing her to Massachusetts General Hospital pursuant to G. L. c. 123, §§ 7 and 8.

STANDARD OF REVIEW

For civil commitment proceedings we "review the hearing judge's findings of fact for clear error," but we review "without deference the propriety of the legal criteria employed by the trial judge and the manner in which those criteria were applied to the facts." Matter of D.K., 95 Mass. App. Ct. 95, 100 (2019), citing Matter of G.P., 473 Mass. 112, 129-30 (2015). As this is solely a matter of statutory interpretation, we review *de novo*. See Pembroke Hosp. v. D.L., 482 Mass. 346, 351 (2019).

BACKGROUND

On August 10, 2018, C.R. arrived at the emergency department of the Massachusetts General Hospital ("MGH") pursuant to G. L. c. 123, §12 (a). On August 15, 2018, pursuant to G.L. c. 123, §12 (b), a designated physician determined that C.R. met the criteria for an involuntary three day admission to the hospital's psychiatric department. The next day, on August 16, 2018, MGH filed a Petition for Commitment pursuant to G.L. c. 123, §§ 7 and 8. On the same day, C.R. filed a *pro se* Request for Emergency Hearing. Her counsel, having been appointed to represent C.R., filed on August 17, 2018, a second Request for Emergency Hearing. An emergency hearing was held on August 20, 2018. The court denied C.R.'s request for immediate release and scheduled a hearing on MGH's commitment petition for August 23, 2018. Prior to the commencement of that civil commitment hearing, C.R. filed a Motion to Dismiss MGH's Petition for Commitment under G.L. c. 123, §§ 7 and 8, on the ground that the court lacked jurisdiction to hear the matter due to MGH's failure to timely file the petition. The court denied C.R.'s motion to dismiss and proceeded with a hearing on the commitment petition. After the hearing, the court allowed the petition.

DISCUSSION

The issues presented in this appeal are as follows:

I. Does G.L. c. 123, § 12 (a), which permits certain qualified individuals "who believe[] that failure to hospitalize a person would create a likelihood of serious harm by reason of mental illness" to restrain such person for the purpose of applying for a three-day involuntary admission to an inpatient psychiatric facility, allow for that person to be taken to an emergency department of a hospital and restrained there, until a bed in a psychiatric unit becomes available?

II. If so, does the statutory three day limit start from the time the person is admitted to an emergency department of a hospital pursuant to G.L. c. 123, § 12 (a)?

III. Did the trial court err in ruling that MGH had proved beyond a reasonable doubt that failure to hospitalize C.R. would create a likelihood of serious harm and that there was no less restrictive alternative?

We answer the first two questions in the affirmative and decline to address the third. [1]

I. § 12(a) ALLOWS FOR DETENTION IN AN EMERGENCY DEPARTMENT UNTIL A BED IN A PSYCHIATRIC FACILITY IS AVAILABLE

This issue turns on whether language in G.L. c. 123, § 12 (a), that allows certain qualified individuals to "restrain or authorize the restraint of [a patient] and apply for the hospitalization of [the patient] for a 3-day period at a public facility or at a private facility," allows for a hospital to detain a psychiatric patient in an emergency department pending an available bed in a psychiatric facility. This language gives rise to two conflicting, but equally reasonable, interpretations. First, that § 12 (a) allows qualified individuals to restrain psychiatric patients for three days but only if the restraint occurs at a psychiatric facility. Second, that § 12 (a) allows qualified individuals to restrain psychiatric patients for up to three days in order to determine if it is necessary, or if the institution is able, to apply for an extended involuntary commitment to a psychiatric facility, pursuant to G.L. c. 123, §§ 7 and 8. In our view, in light of the language, purposes, and procedural protections of the civil commitment process, the second interpretation reflects the Legislature's intent and is more reasonable.

The starting point for any statutory interpretation is the language of the statute itself, as this is the best indication of the Legislature's intent. City Elec. Supply Co. v. Arch Ins. Co., 481 Mass. 784, 788 (2019). However, "[w]hen a statute is 'capable of being understood by reasonably well-informed persons in two or more different senses,' it is ambiguous." Town of Falmouth v. Civil Serv. Comm'n, 447 Mass. 814, 818 (2006). When statutory language is

[1] Nothing in this decision applies to a situation where a patient is admitted to an emergency department for medical treatment, and it is later determined that she should be restrained under § 12 (a).

unclear, "well-established principles of statutory construction guide our interpretation" of the legislative intent. Bellalta v. Zoning Bd. of Appeals of Brookline, 481 Mass. 372, 378 (2019). We consider "the preexisting common law, earlier versions of the same act, related enactments and case law, and the Constitution." Id. In addition, "we look to the language of the entire statute, not just a single sentence, and attempt to interpret all of its terms harmoniously to effectuate the intent of the Legislature," Cuticchia v. Town of Andover, 95 Mass. App. Ct. 121, 125 (2019) (internal quotations omitted), and when the statute is part of a broader legislative scheme, "[c]ourts must look to the statutory scheme as a whole." Ret. Bd. of Stoneham v. Contributory Ret. Appeal Bd., 476 Mass. 130, 135 (2016). In all instances, a court must avoid any interpretation that defies legislative intent or otherwise leads to an absurd result. Bellalta, 481 Mass. at 378.

The Legislature enacted the civil commitment process for psychiatric patients with two distinct and equally important purposes. First, to protect psychiatric patients from the risk of serious harm and to allow for their rehabilitation. See Williams v. Steward Health Care Sys., LLC, 480 Mass. 286, 293 (2018), citing Commonwealth v. Nassar, 380 Mass. 908, 917-918 (1980). Second, to protect psychiatric patients' "fundamental right to liberty" upon which involuntary commitment inevitably treads. See Pembroke, 482 Mass. at 352. We keep the need to balance these principles in mind as we begin our analysis. See In re Adoption of Diane, 400 Mass. 196, 198 (1987) (balancing "the goal of protecting confidential relationships with the need to protect the well-being of children" in adoption proceedings); Perez v. Amherst-Pelham Reg'l Sch. Comm., 410 Mass. 396, 398 (1991) (balancing a plaintiff's right to sue the government for negligence with the need for government stability and effectiveness).

C.R. argues that § 12 (a) does not allow a hospital to restrain a psychiatric patient in an emergency department even when the hospital anticipates that a bed will open in its psychiatric facility during the three day detention period. While this may be the ideal practice, § 12 (a) recognizes the intricacies of the civil commitment process, and that complexities may arise that may make it impossible to follow ideal practices. Section 12 (a) states that "[w]henever practicable, prior to transporting [a patient], the applicant shall telephone or otherwise communicate with a facility to describe the circumstances and known clinical history and to determine whether the facility is the proper facility to receive such person." G.L. c. 123, § 12 (a). Likely, a determination about whether a facility is proper should encompass the availability of beds, but the language "whenever practicable" certainly means that the practice is not mandatory. See Commonwealth v. Brown, 481 Mass. 77, 81 (2018) (courts interpret statutory language "in light of 'ordinary and approved usage' and 'sound reason and common sense'"). Looking to other sections of Chapter 123, it is clear that the Legislature would have used other language if it had intended to make such hospital shopping mandatory.

Section 12 (d) requires that any person restrained under § 12 be discharged unless the superintendent of a psychiatric facility applies for a longer commitment under G.L. c. 123, §§ 7 and 8, or unless the patient chooses to remain voluntarily. Section 7 (a) provides that "[t]he superintendent of a facility may petition . . . for the *commitment to said facility and retention of any patient at said facility* whom said superintendent determines that the failure to hospitalize would create a likelihood of serious harm by reason of mental illness." G.L. c. 123, § 7 (a) (emphasis added).[2] As both parties agree, that section allows the superintendent of a facility to

[2] "Facility" is defined in the statute as "a public or private facility for the care and treatment of mentally ill persons, except for the Bridgewater State Hospital." G.L. c. 123, § 1.

apply for an extended commitment only if the patient is admitted to a psychiatric facility at the time of the application. The Legislature could have used similar language in § 12 (a) but it did not do so. For example, if § 12 (a) instead allowed qualified individuals to "restrain or authorize the restraint of such person [at a facility] and apply for the hospitalization of such person for a 3-day period at a public facility or at a private facility," the inclusion of the additional language "at a facility," mirroring the language of § 7 (a), would make it clear that the Legislature intended § 12 (a) restraints to occur solely within the walls of a psychiatric facility. The Legislature did not include such clarifying language and "[w]e do not read into the [act] a provision which the Legislature did not see fit to put there, nor add words that the Legislature had an option to, but chose not to include." Commonwealth v. Wade, 475 Mass. 54, 63 (second alteration in original). Moreover, considering that §§ 7 (a) and 12 (a) were enacted at the same time, G.L. c. 123, § 12 (added by St. 1988, c. 599 §38); G.L. c. 123, § 7 (same), the Legislature's failure to use similar language is evidence that it intended the sections to have different effects. See Commonwealth v. Wynton W., 459 Mass. 745, 752 (2011) (holding that different words in statutes enacted at the same time should have different meanings).

MGH's standard practice also supports the interpretation that the Legislature intended to allow hospitals to restrain psychiatric patients in emergency departments. MGH regularly holds psychiatric patients in the emergency department while waiting for a bed to open in the psychiatric unit. In its brief, MGH explained that this "process has long been considered the best practice for hospital intake . . . . The emergency department acts as a clearinghouse to identify patient needs, and also to assess which hospital unit would be most appropriate for said patient at a given point in time, and whether a bed in that unit is currently available." Appellee Br. at 14. This practice is also evidently followed by at least one other hospital in the Commonwealth. See

Williams 480 Mass. at 287 (reciting that a patient was held "in the [Steward Carney Hospital's] emergency room because no psychiatric beds were available."). While it is further evidence of the Legislature's intent, "[a]n industry practice, standing alone, does not necessarily dictate our construction of a statute." City Elec. Supply Co, 481 Mass. at 793 n.6 (alteration in original), quoting Tremont Tower Condominium, LLC v. George B.H. Macomber Co., 436 Mass. 677, 688 (2002).

Finally, adopting C.R.'s interpretation of § 12 (a) would require us to ignore the Legislature's intent to protect psychiatric patients and provide for their rehabilitation. A complete bar on admitting § 12 (a) patients to emergency departments would lock a psychiatric patient out of potential treatment solely because a facility had no available beds when the patient arrived at a hospital. In extreme circumstances, where all local psychiatric facilities lack beds at the moment of a patient's arrival, C.R.'s interpretation would require the release of someone whom a qualified § 12 (a) applicant believed was at risk of serious harm, thereby nullifying the protections unambiguously granted by the statute. We decline to read § 12 (a)'s language as preemptively halting the very process the statute is intended to begin because "[i]f a sensible construction is available, we shall not construe a statute to make a nullity of pertinent provisions or to produce absurd results." Commonwealth v. Figueroa, 464 Mass. 365, 368 (2013).

Allowing hospitals to admit psychiatric patients to emergency departments, pursuant to § 12 (a), when the hospital expects to have an open bed in a psychiatric facility, strikes the appropriate balance between protecting patients from a risk of substantial harm and their fundamental right to liberty. However, as we explain in the next section, this calculus only stands when the three day detention period begins to run as soon as the patient is admitted to the emergency department.

II. THE THREE-DAY DETENTION PERIOD BEGINS WHEN A PATIENT ARRIVES AT THE EMERGENCY DEPARTMENT

Section 12 (a) allows a qualified person to "apply for the hospitalization of such person for a 3-day period at a public facility or at a private facility." As we have already determined, the statute allows a hospital to admit a patient to its emergency department pending an open bed at a psychiatric facility. The next question, then, is whether calculation of the three day time limit begins upon arrival at the emergency department or at the psychiatric facility. For the following reasons, we agree with C.R. that the three day time limit begins when the patient arrives at the emergency department.

Section 12 (a) is silent on whether the three day detention period begins when a patient arrives at an emergency department, or if the period does not begin until a patient is admitted to a psychiatric facility. In order to determine when the period begins to run, we look to the relevant guideposts of legislative intent, discussed *supra*. In addition, when "a statute is simply silent on a particular issue, we interpret the provision in the context of the over-all objective the Legislature sought to accomplish." Wing v. Comm'r of Prob., 473 Mass. 368, 373 (2015) (internal quotations omitted). Applying these principles of statutory construction makes it clear that the three day period begins at the time of admission, regardless of whether a patient is admitted to a psychiatric facility or an emergency department.

Under G.L. c. 123, §§ 12 (a) and (b), a psychiatric patient may be restrained and hospitalized once a physician determines that failure to hospitalize the patient would likely create a risk of serious harm. Section 12 (d) provides that "[a] person shall be discharged at the end of the three day period unless the superintendent applies for a commitment under the provisions of sections seven and eight of this chapter or the person remains on a voluntary status." Read in harmony, these three sections require a hospital to discharge a psychiatric patient within three

business days unless the hospital complies with the provisions of G.L. c. 123, §§ 7 and 8. See Pembroke, 482 Mass. at 348. As discussed *supra*, both parties agree that § 7 (a) requires a patient to be admitted to a psychiatric facility before the facility superintendent may apply for extended commitment under §§ 7 and 8.

MGH argues that the requirement that a patient be admitted to a psychiatric facility before a hospital may apply for a commitment pursuant to §§ 7 and 8 suggests that the Legislature did not intend for the detention period to begin until a patient is admitted to such a facility. There is no language in the relevant sections of Chapter 123, however, which supports this position. In fact, a review of precedent and the legislative history of § 12 shows that the courts and Legislature have been much more concerned with curtailing periods of involuntary confinement rather than in allowing their expansion. Nearly forty years ago, the Supreme Judicial Court explained that it is "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 [Chapter 123]." Nassar, 380 Mass. at 917–18. Since then, the Legislature has amended § 12 twice to reduce the allowable detention period; first from ten days to four (St. 2000, c. 249 §§ 4 to 8), and subsequently from four days to three (St. 2004, c. 410 § 2, eff. Mar. 1, 2005). Most recently, the Supreme Judicial Court held that the meaning of the word "discharge" in § 12 requires that a patient be "set at liberty from involuntary restraint" and not simply "released from care . . . [o]therwise, the protections of the statute would be impermissibly weakened, if not rendered meaningless." Pembroke, 482 Mass. at 352. We cannot conclude, given this history, that interpreting the statute in a way that would conceivably allow indefinite detention comports with a patient's fundamental right to liberty under Chapter 123.

Nevertheless, MGH urges us to adopt its interpretation because of the treatment difficulties that would arise if a hospital were required to release a psychiatric patient within § 12 (a)'s three day detention period. We recognized *supra* that these practical concerns were evidence that a rational legislature would not have intended § 12 to bar the detention of psychiatric patients at risk of serious harm in an emergency department when it would detrimentally affect the patient's treatment. However, these same concerns do not justify overriding the Legislature's clear intent to protect patient liberty. See Commonwealth v. Diggs, 475 Mass. 79, 81-82 (2016) ("To the extent that the Legislature's intent is clear, 'the statute, if reasonably possible, must be construed to carry out that intent.'"), quoting Automobile Insurers Bureau of Mass. v. Comm'r of Ins., 425 Mass. 262, 267 (1997). Taken to its logical extreme, MGH's interpretation means that a hospital could indefinitely detain psychiatric patients in an emergency department while waiting for an open bed.[3] Indefinite restraint without *any* due process is, on its face, the most egregious infringement upon a person's "fundamental right to liberty" and cannot possibly be harmonized with § 12 (a). See Pembroke, 482 Mass. at 354, n.12 (when "a hospital is free to engage in serial involuntary admissions under § 12 by supplanting judicial determinations with medical opinion" it violates all due process protections that apply to civil commitment proceedings).

Moreover, to the extent that MGH suggests that § 12's procedural protections apply to patients in psychiatric facilities, but not to patients in emergency departments, "[w]e will not adopt an interpretation of a statute which relies upon selective enforcement of the statutory provisions." City of Worcester v. Coll. Hill Properties, LLC, 465 Mass. 134, 145 (2013). Nor can

[3] At oral argument, MGH's attorney informed the court that it is the "usual practice" for the hospital to "renew or rewrite" § 12 (a) applications for patients in the emergency department, and that patients "can sit [in the emergency department] for days to weeks."

we say that protections of patient liberty are absurd because those protections may require a hospital to release a patient who may pose a serious risk of harm to herself or others. "Seemingly contradictory provisions of a statute must be harmonized so that the enactment as a whole can effectuate the presumed intent of the Legislature." Adams v. City of Boston, 461 Mass. 602, 613 (2012), quoting Wilson v. Comm'r of Transitional Assistance, 441 Mass. 846, 853 (2004). If a hospital anticipates that it will be unable to admit a § 12 (a) patient to a psychiatric facility within three days in order to pursue an extended commitment under G.L. c. 123, §§ 7 and 8, then the hospital should inform the § 12 (a) applicant that it is not at the moment an appropriate receiving facility so that the applicant may find a more suitable facility. Or, in the case where an anticipated bed did not materialize, the hospital must either find and send the patient to another psychiatric facility that does have an open bed or must release the patient. This is the appropriate balance between the Legislature's intended goals of protecting the patient and protecting the patient's liberty interest. Therefore, we hold that § 12's three day detention period begins when a patient arrives at an emergency department or psychiatric facility.

III. C.R.'S COMMITMENT WAS INVALID AS A MATTER OF LAW

The only issue remaining is whether the trial court erred in finding that MGH had proven beyond a reasonable doubt that failure to hospitalize C.R. would create a likelihood of serious harm and that there was no less restrictive alternative. We decline to answer this question as C.R.'s commitment was invalid as a matter of law.

As discussed *supra*, a hospital may only restrain a psychiatric patient in an emergency department for a maximum of three business days. On August 10, 2018, C.R. arrived at MGH pursuant G.L. c. 123, § 12 (a). On August 15, 2018, a physician determined that C.R. met the criteria for a three day involuntary commitment pursuant to G.L. c. 123, § 12 (b). MGH filed for

commitment under G.L. c. 123, §§ 7 and 8, on August 16, 2018. This is one day beyond the three day period of temporary restraint allowed under § 12 (a). Calculation of the three day period is subject to "Rule 6 of the Massachusetts Rules of Civil Procedure." G.L. c. 123, § 12 (e). Pursuant to Mass. R. Civ. P. 6 (a), the first day the designated time period begins to run is excluded from the calculation of any designated period along with any intervening weekends and holidays. While C.R. was restrained for six total days before the §§ 7 and 8 petition was filed, August 10 was Friday, and August 11 and 12 were Saturday and Sunday. This means that C.R.'s restraint period began to run on Monday August 13, 2018, and that MGH was required to file its §§ 7 and 8 application or release her no later than August 15, 2018. Because MGH failed to file its petition within the statutorily-mandated timeframe, it was required to discharge C.R. Its failure to do so invalidated her subsequent commitment. See Pembroke, 482 Mass. at 354 (vacating §§ 7 and 8 commitment where the hospital failed to discharge a patient as required by § 12).

CONCLUSION

For the foregoing reasons, we reverse the decision of the Central Division and remand the matter for an entry of dismissal of the Petition For Commitment pursuant to G.L. c. 123, §§ 7 & 8.

SO ORDERED.

Hon. Myong J. Joun	Hon. Eleanor C. Sinnott	Hon. David B. Poole
Associate Justice	Presiding Justice	Associate Justice
Boston Municipal Court	Boston Municipal Court	Boston Municipal Court
Appellate Division	Appellate Division	Appellate Division

September 4, 2019