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November 11, 2021

The Honorable Julian Cyr
Chair, Joint Committee on Mental Health, Substance Use and Recovery
24 Beacon Street, Room 312-E
Boston, MA 02133

The Honorable Adrian Madaro
Chair, Joint Committee on Mental Health, Substance Use and Recovery
24 Beacon Street, Room 33
Boston, MA 02133

Submitted via MyLegislature

Dear Chair Cyr, Chair Madaro, and Members of the Committee:

**Re: S.1265 - An Act relative to providing lifesaving treatment**

On behalf of the Massachusetts Association for Mental Health (MAMH), thank you for strong and steadfast leadership in advancing the health of people with behavioral health conditions and their families across the Commonwealth. I am writing to respectfully submit this testimony **in opposition to S.1265** - **An Act relative to providing lifesaving treatment**. This bill unfortunately perpetuates the placement of men in need to treatment for substance use disorders in carceral settings and does nothing to expand access to voluntary, community-based services.

Formed over a century ago, MAMH is dedicated to promoting mental health and well-being, while preventing behavioral health conditions and associated disability. We are committed to advancing prevention, early intervention, effective treatment, and research for people of all ages. We seek to eliminate stigma and discrimination and advance full inclusion in all aspects of community life. This includes discrimination affecting not only people with behavioral health conditions, but also people who face unequal burdens and barriers to the protections and benefits of citizenship due to their race, ethnicity, gender identity, or disability status. MAMH has a demonstrated track record of furthering its mission by convening stakeholders across the behavioral health and public health communities; disseminating emerging knowledge; and

providing subject matter expertise to inform public policy, service delivery, and payment methodologies.

This bill would amend Section 35 of Chapter 123 to add a provision applicable to petitions filed regarding persons with a substance use disorder when the court is closed. In such situations, a justice of the court could order such a person committed to a Department of Public Health designated facility upon a finding of likelihood of serious harm as a result of such a disorder, with a hearing provided only after the fact and within 72 hours. The bill also provides that correctional facilities operated by the Suffolk County Sheriff "shall be permitted" to contract with section 35 facilities to serve as section 35 facilities.

The first provision of this legislation is unnecessary and would set a disturbing precedent. Currently, individuals are simply brought before the court when the court is in session for a section 35 hearing. This preserves the due process rights of such individuals and still allows for timely transfer to treatment facilities upon a judicial order. Should this legislation be enacted, it would create a substantial presumption in favor of commitment, as well as a deprivation of liberty without due process, were the individual already undergoing confinement, assessment, and treatment prior to a judicial hearing on whether the person meets the standard for civil commitment.

The second provision of this bill is attempting to do through legislation what has already been rejected and counseled against by public officials, policymakers, and researchers across the state: using carceral facilities as sites for section 35 treatment.

On March 29, 2019, the Commonwealth was formally served with *John Doe v. Mici et al*. concerning the practice of men being sent to prisons pursuant to section 35. In response to the lawsuit, a Massachusetts Section 35 Commission recommended in July 2019 that men with substance abuse issues not be sent to prison for treatment.[1] The Commission instead recommended: that the Commonwealth:

- expand development of low-threshold, treatment on demand including harm reduction interventions in community-based settings, immediate access to medication-assisted treatment (MAT) and expansion of bridge clinics, addiction consult services, outreach and engagement programs, post-overdose intervention programs, syringe services programs, and family intervention programs;
- identify alternative pathways in addition to the current court-based process, to civilly-commit individuals for addiction treatment.[2]

[1] https://d279m997dpfwgl.cloudfront.net/wp/2019/07/0703_section-35-commission-report.pdf
[2] https://d279m997dpfwgl.cloudfront.net/wp/2019/07/0703_section-35-commission-report.pdf

By statute, women in the state who are committed pursuant to section 35 may only be treated in DPH or DMH approved programs and cannot be confined in carceral facilities. Men, on the other hand, are treated in treatment programs licensed or approved by DPH or DMH or, if the court makes a specific finding that a secure facility is required, in the Massachusetts correctional institution at Bridgewater or other such facility as designated by the DOC Commissioner.

Today, men are in fact held not only at a DPH facility in Brockton, but also at MASAC in Plymouth, a DOC facility, and at the Stonybrook Stabilization and Treatment Center in the Hampden County Jail in Ludlow and at the stepdown Stonybrook Stabilization and Treatment Center in Springfield, both overseen by the Hampden sheriff, who opened these facilities for Section 35 commitments in 2018.[3] According to Prisoner Legal Services, three out of 4 section 35 beds are in correctional facilities because of a lack of DPH, non-carceral treatment slots.[4] The Commonwealth should heed the recommendations of the Section 35 Commission and increase DPH beds, not correctional ones.

On September 25 2021, Sheriff Thompkins proposed to convert an empty detention center into temporary housing for people living in tents by Mass and Cass.[5] The following day, the Globe reported that he was proposing housing people committed pursuant to section 35.[6] Advocates have soundly rejected this proposal, including by noting four prisoner deaths since July 2021 in Suffolk County facilities.[7] In the days following this proposal, advocates and clinicians have repeatedly called for a public health, not punitive response, to the Mass and Cass situation, specifically rejecting incarcerating people who need substance use treatment or detox.[8]

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[3] https://www.mass.gov/info-details/facilities-and-resources-for-section-35-treatment; https://www.wbur.org/news/2019/07/01/section-35-substance-addiction-treatment-commitments; https://www.wbur.org/news/2018/12/14/civil-commitments-reform

[4] https://plsma.org/find-help/civil-commitment/

[5] https://plsma.org/suffolk-sheriff-tompkins-proposes-to-convert-empty-detention-center-into-temporary-housing-for-people-living-in-tents-by-mass-and-cass/

[6] https://plsma.org/sheriff-proposes-committing-people-living-at-mass-and-cass-to-a-re-purposed-detention-center/

[7] https://plsma.org/sheriff-proposes-committing-people-living-at-mass-and-cass-to-a-re-purposed-detention-center/; https://plsma.org/some-advocates-and-experts-push-back-against-sheriffs-mass-and-cass-proposal/

[8] https://plsma.org/media-advisory-medical-public-health-and-addiction-experts-to-urge-officials-to-take-a-health-focused-approach-at-mass-and-cass/; https://plsma.org/press-release-public-health-mass-and-cass/

The bill's proposal to house individuals committed under section 35 in Suffolk County facilities contradicts a growing body of knowledge about how best to treat substance use disorders. Moreover, it perpetuates a serious case of gender discrimination, where men are most often committed to correctional settings for treatment of their serious substance use conditions. MAMH cited this research in its testimony, repeated below, which we recently submitted to this committee in support of S.1285/H.2066:

> ***MAMH Testimony on S.1285/H.2066:***
> *First, treating people in secure, DPH or DMH licensed facilities is less coercive than serving them in jails or prisons and substance use recovery is more likely with voluntary treatment. In general, voluntary treatment yields better results than coerced therapy.*[9] *While court-ordered substance use treatment involves some level of coercion, the lower the overall perceived coercion, the more likely the treatment is to promote recovery.*[10]
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> *Second, treating people in DPH or DMH facilities is less traumatizing than serving them in correctional settings. People with substance use disorders are often found to have a history of trauma.*[11] *As one researcher explained, the "repetitious aspects of drug dependence are intimately linked to the effects of early-life trauma on subsequent affect and personality development."*[12] *To treat such individuals in carceral settings only augments the level of trauma they already experience as evidence clearly indicates the*

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[9] K.K. Parhar et al., Offender Coercion in Treatment: A Meta-Analysis of Effectiveness. Crim Justice Behav. (2008), http://dx.doi.org/10.1177/0093854808320169; D. Werb et al. The effectiveness of compulsory drug treatment: A systematic review. Int J Drug Policy (2016) http://dx.doi.org/10.1016/j.drugpo.2015.12.005

[10] See A. Opsal et al., Perceived coercion to enter treatment among involuntarily and voluntarily admitted patients with substance use disorders, BMC Health Services Research (2016) https://link.springer.com/article/10.1186/s12913-016-1906-4#Sec11(even when an admission is coercive, increased collaboration with the patient can facilitate a better experience and a better process towards recovery); B. Habermeyer et al., Coercion in substance use disorders: clinical course of compulsory admissions in a Swiss psychiatric hospital, Swiss Medical Weekly (2018) https://smw.ch/article/doi/smw.2018.14644/ (patients involuntarily admitted for SU treatment showed lower health and social functioning compared with those with voluntary status; length of stay was significantly shorter and the proportion of patients who left treatment against recommendation was twice as high as in voluntarily admitted patients; if treatment was initiated on a compulsory basis, a subsequent switch to voluntary treatment status appeared to be very uncommon); A. Theodoridou et al., Therapeutic relationship in the context of perceived coercion in a psychiatric population. Psychiatry Res. (2012), http://dx.doi.org/10.1016/j.psychres.2012.04.012 (it is a widely accepted fact that coercion has a negative effect on the therapeutic relationship).

[11] See, e.g., A. Sisselman-Borgia, Comorbid Trauma and Substance Use Disorders (2018), https://link.springer.com/chapter/10.1007/978-3-319-72778-3_7.

[12] E. Khantzian, The Self-Medication Hypothesis of Substance Use Disorders: A Reconsideration and Recent Applications, Harv. Rev. Psychiatry (1997), https://sci-hub.se/10.3109/10673229709030550.

*inherently traumatic nature of such settings.[13] For these reasons, practitioners advise attention to the potential for the replication of traumatic conditions in correctional treatment.[14]*

*Third, this bill would help reduce the additional stigma encountered by people with substance use disorders that being placed in a correctional setting likely imposes. Researchers have documented the stigmatizing impact of correctional stays and how that stigma is "inscribed on the body" upon release.[15] Given the existing stigma of having a substance use disorder, it is simply cruel to add to that burden. This risks of enduring "intersectional stigma" in the prison context have been documented.[16]*

*Fourth, by ensuring that people who enter the section 35 process will be placed in treatment settings outside jails and prisons, this bill should make it more likely that families can comfortably consider the section 35 process if they have exhausted other avenues for helping their loved ones. Families may worry about the conditions that their loved one may face in jail or prisons. They may also justifiably worry that their loved ones will become suicidal at the prospect of incarceration.[17]*

*Fifth, this bill rectifies the current discriminatory arrangement where, pursuant to state law, women are treated for substance use disorders in treatment facilities, but men may still potentially receive section 35 services in correctional settings.[18] The bills also may*

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[13] See J.S. Levenson & G.M. Willis (Implementing Trauma-Informed Care in Correctional Treatment and Supervision, Journal of Aggression, Maltreatment & Trauma (2019), https://sci-hub.se/10.1080/10926771.2018.1531959 at 482 ("[c]orrectional mandates and court-ordered services can be disempowering and oppressive, replicating traumagenic childhood conditions"; see also discussion at 485-87).

[14] Id. at 484-85.

[15] See D. Moran, Prisoner reintegration and the stigma of prison time inscribed on the body, Punishment and Society (2012) (the vast literature on prisoner reintegration shows that overcoming the stigma attached to imprisonment is one of the key, interconnected, issues) https://sci-hub.se/https://doi.org/10.1177/1462474512464008, at 567.

[16] See J.M. Kilty, 'I just wanted them to *see* me': Intersectional stigma and the health consequences of segregating Black, HIV+ transwomen in prison in the US state of Georgia, Gender, Place & Culture (2020), https://sci-hub.se/https://www.tandfonline.com/doi/abs/10.1080/0966369X.2020.1781795. While this study addresses the intersectionality of stigma other than that caused by incarceration itself, the potential for harm from the joint stigmas of substance use and incarceration is also worthy of consideration.

[17] See D. Becker, Prison for Forced Addiction Treatment? A Parent's "Last Resort" Has Consequences (April 20, 2019), WBUR, https://www.npr.org/sections/health-shots/2019/04/20/712290717/prison-for-forced-addiction-treatment-a-parents-last-resort-has-consequences

[18] M.G.L. c. 123, s. 35.

*redress patterns of racial bias in the treatment of people with substance use disorders in correctional settings.*[19]

For all these reasons, MAMH opposes the release of S.1265 from your committee.

Thank you for your consideration.

Sincerely,

Danna Mauch, Ph.D.
President and CEO

[19] See E.M. Errison, An historical review of racial bias in prison-based substance abuse treatment design, Journal of Offender Rehabilitation (2017) ("History demonstrates that the extent to which the law seeks to medicalize or penalize substance abuse is not a colorblind phenomenon." "Prison-based [drug rehabilitation] programs have always better served the needs and social contexts of White addicts, more so than those of their counterparts of color."), https://sci-hub.se/https://doi.org/10.1080/10509674.2017.1363114 at 2, 7.