STATE OF MAINE
113TH LEGISLATURE
SECOND REGULAR SESSION

REPORT OF THE COMMISSION TO STUDY THE USE OF INVOLUNTARY SERVICES FOR SUBSTANCE ABUSERS

March 15, 1988

MEMBERS:
Dr. Stanley Evans, Chairman
Sen. Zachary E. Matthews
Rep. Wesley Farnum
Lynn Duby
Betty McLaughlin
Collen Nadeau

Staff: Peter M. Siegel, State Law Librarian

Summary of Commission Recommendations

Recommendation 1. That the Legislature amend Maine's current involuntary commitment law for incapacitated alcoholics, 22 MRSA §§7119 and 7120. The key provisions of suggested amendments (Appendix A) are:

- Broadening the class of persons potentially subject to involuntary services to a new category of "chemically dependent persons" as defined by proposed sub-§4-A of 22 MRSA §7103;

- Permitting Department of Human Services staff to initiate the process of petitioning the District Court to secure involuntary services for chemically dependent persons, in proposed sub-§3-A(1) of 22 MRSA §7119;

- Limiting the scope of permissible involuntary treatment services to detoxification in the case of emergency treatment (proposed 22 MRSA §7120, sub-§2), and to extended residential care under DHS supervision in those cases where long-term care is warranted (proposed 22 MRSA §7120-A, sub-§3 and sub-§4);

- Requiring DHS to certify detoxification facilities (proposed 22 MRSA §7115, sub-§1-A) and extended residential care facilities (proposed 22 MRSA §7115, sub-§1-B) prior to their use as providers of involuntary services; and

- Providing a civil action in the District Court to secure both emergency treatment orders (proposed 22 MRSA §7120) and orders of continuing DHS supervision (proposed 22 MRSA §7120-A).

Recommendation 2. That the Department of Human Services assign responsibility for the coordination and supervision of involuntary services to a single agency, either the Office of Alcohol and Drug Abuse Prevention or the Division of Adult Services, and that additionally the Department seek funding for a minimum of two new case worker positions to manage the petitioning process and to supervise the care of persons ordered into the custody of DHS.

Recommendation 3. That the Department of Human Services, in certifying detoxification facilities authorized to receive

chemically dependent persons subject to an emergency treatment order, assess the desirability of establishing secure, locked detoxification capabilities within the State. Options to be considered might include the creation, either on a single-site or regional basis, of a Department-operated detoxification facility or the renovation of existing detoxification facilities to provide necessary locked units.

Recommendation 4. That the Department of Human Services, in certifying extended residential care facilities authorized to receive chemically dependent persons subject to an order of continuing department supervision, assess the desirability and means of expanding the availability of extended residential care facilities throughout the State.

Recommendation 5. That the Department of Human Services work closely with the District Courts and the Administrative Office of the Courts to insure that the judicial process to secure involuntary services is administered equitably, and that the law is interpreted consistently, throughout the State.

I. Introduction

The Commission to Study the Use of Involuntary Services for Substance Abusers was established by the first regular session of the 113th Legislature (Resolve 1987, c. 72). The impetus for the creation of the Commission was the widespread belief among professionals involved in the treatment and care of chemically dependent persons that the current Maine law which provides for the involuntary commitment of alcoholics, 22 MRSA §§7119 and 7120, is ineffective. As a result, persons who might benefit from involuntary services are not receiving the forceful intervention that is necessary in some cases to arrest the progressive and potentially fatal disease of chemical dependency. At the same time it was recognized that increased recourse to involuntary services would raise many subsidiary issues, ranging from the capability of Maine's substance abuse treatment system to absorb an uncertain number of involuntary commitments to protecting the civil liberties of persons subject to involuntary commitment proceedings.

The Commission, in discharging its responsibility to the Legislature, has proposed amendments to the current involuntary commitment law (Appendix A) that, if enacted, will provide an effective mechanism for initiating and securing appropriate involuntary services in those instances where such intervention is warranted and will insure procedural fairness for persons alleged to be in need of these services. It cannot be stressed too frequently, however, that it is the intent of the Commission that the amended law be invoked sparingly, and various definitional and procedural safeguards have been incorporated into the Commission's proposal to achieve this intent.

II. Deficiencies of the Current Law

Maine's current involuntary treatment law was enacted in 1973 as a provision of the Uniform Alcoholism and Intoxication Treatment Act (Laws 1973, c. 566). The act was developed as model legislation by the National Conference of Commissioners on Uniform State Laws and has been adopted and retained, with some modification, in 11 states. The act was designed to serve two major purposes, the elimination of public intoxication as a criminal offense and the establishment of a state authority responsible for developing a comprehensive treatment system for alcoholics and other substance abusers. The intent of the involuntary commitment provision was to provide a more humane and effective treatment-based response to the needs of the chronic inebriate than the "revolving door" of arrest, incarceration, and release.

A key element in the implementation of the involuntary treatment law was the availability of "approved public treatment facilities" (APTFs). One basic assumption of the model legislation was that the state alcohol authority would establish and operate these APTFs, and administrators of these public facilities were given extensive discretionary power to detain involuntarily and to treat incapacitated alcoholics. In order to develop quickly a treatment system that was flexible and responsive to local needs, however, the Department of Human Services decided to create a system based on purchased community services rather than on state-run facilities. No APTFs have been established in Maine, as a result of which extremely few commitments for alcohol abuse can be effected.

Emergency commitments under 22 MRSA §7119 are entirely precluded by these current circumstances. The non-existent APTFs are the sole statutorily designated recipients of emergency commitments, and the authority to approve emergency commitments is delegated exclusively to APTF administrators. Non-emergency commitments under 22 MRSA §7120, while possible to obtain, are also hampered by unrealized assumptions implicit in the statute. These commitments are initiated by petitioning the District Court, and the law limits persons with standing to petition to the spouse, guardian, or relative of the incapacitated alcoholic or to an APTF administrator. Apart from the non-availability of the latter group of potential petitioners, the law ignores the fact that very few chronic, late-stage alcoholics have family members available who are willing to invest the time and energy necessary to bring a petition before the court.

There are other difficulties with the current involuntary commitment law, some primarily administrative in

nature and others with more serious legal implications. Persons committed under section 7120 are placed in the custody of the Office of Alcohol and Drug Abuse Prevention (OADAP), which is charged with the responsibility to place the committed alcoholic in an appropriate treatment facility. The Department of Human Services has determined, however, that the Division of Adult Services is the agency best situated to coordinate the initial petitioning process. While OADAP and Adult Services interfaced effectively in the most recent instance where an involuntary commitment was successfully achieved, it would still seem desirable to assign oversight responsibility for the entire process to a single agency. If the current law is amended, and the number of involuntary commitment actions consequently increased, the need for single agency management and coordination will be magnified.

Leaving aside the question of non-existent APTFs and APTF administrators, the emergency commitment procedure authorized under section 7119 affords little protection to the civil liberties of allegedly incapacitated alcoholics. The commitment decision is left entirely to the discretion of the APTF administrator, and there is no provision in the law for judicial review of these administrative decisions. The person subject to emergency commitment is not informed of his right to counsel until after the commitment decision has been made. With the exception of establishing time limits for the duration of involuntary commitments, neither the emergency nor the non-emergency commitment provisions restrict the type of treatment that may be given to an involuntarily committed individual. At best, the current involuntary treatment law fails to balance adequately the legitimate interests of the State in protecting the health and welfare of its citizens with the rights of individuals to be free from unwarranted interference with their personal liberty. At worst, the emergency commitment law as currently written violates the constitutionally protected right to due process of law.

The current involuntary law was intended by its legislative sponsors to be used "only in exceptional and very clearly prescribed circumstances" (remarks of Senator Conley, Legislative Record - Senate, June 6, 1973, p. 3894). The Commission subscribes to the view that any involuntary treatment or commitment law ought to be invoked sparingly, but the Commission would further submit that there is a vast difference between an unusable law and one that is usable only under exceptional circumstances. It is obvious after nearly fifteen years of experience that the current law is inadequate to address the needs of the limited population who might benefit from some form of involuntary services. Nor does the current law further the State's legitimate interest in

promoting the health and welfare of its citizens. In the absence of a workable mechanism to intervene forcefully in the lives of chronic alcoholics and other substance abusers, a new "revolving door" situation has been created in which persons requiring long-term care shuffle repeatedly from the street, to the shelter, and to the hospital. The cost to society of caring for these individuals is already great, and it is for this reason that the Commission believes that a revision of the current law is required.

III. Persons Requiring Involuntary Services

Having decided from the outset of its deliberations that Maine's involuntary treatment law ought to be strengthened, the Commission had to make two additional threshold determinations:

- Should the applicability of an amended involuntary services law be extended to groups other than incapacitated alcoholics?
- How many persons might be subject annually to court-ordered involuntary services?

In defining the proper scope of its inquiry, the Commission immediately excluded from consideration persons convicted of OUI offenses and substance abusers convicted of criminal offenses. A mechanism already exists, either through the conditional restoration of driving privileges or through the probation and parole systems, to compel persons who fall into these categories to complete some program of treatment. The Commission also excluded from consideration juvenile substance abusers, basing this limitation on its understanding that the issue of involuntary services for this group will be addressed in the final report of the Commission on Children in Need of Supervision and Treatment. In addition, the Commission declined to examine the issue of substance abuse by pregnant women, believing that this subject would require a separate study of its own.

The Commission has concluded, however, that the availability of involuntary services must be expanded to include chronic abusers of substances other than alcohol. The use of psychoactive drugs, especially cocaine, has become widespread in Maine, and the chronic abuse of cocaine frequently results in episodes of violent, life-threatening behavior. Currently there exists no mechanism by which treatment can be compelled for cocaine abusers, unless a person is apprehended while possessing the drug or commits a crime while under the influence of the drug. The Commission submits that intervention by means of a civil commitment action is preferable to an eventual criminal prosecution and believes, further, that emergency commitment is justifiable in situations in which an immediate threat of physical harm is posed to the substance abuser or to others, provided that the treatment received under an emergency court order is restricted to detoxification. Once withdrawal from the drug has been completed, any court-ordered treatment for this category of substance abuser should be terminated. The concern has been raised to the Commission that the restriction of involuntary

services for abusers of psychoactive drugs to detoxification will simply create yet another "revolving door" situation. The Commission concedes that this is true to some extent, but would hasten to point out that court-ordered detoxification will provide opportunities that currently do not exist for counseling at least some substance abusers to enter treatment voluntarily. The Commission is committed to its belief that court-ordered treatment is appropriate only when a state of incapacitation exists.

Statistics are not currently compiled on the number of emergency room admissions for cocaine abuse in Maine hospitals; hence it is difficult to predict the result of broadening the applicability of the involuntary services law to include additional types of chemical dependency. OADAP estimates that approximately 50 emergency commitments of cocaine abusers might occur annually if the scope of the involuntary services law is redefined.

Far more information is available on the size and characteristics of the population of chronic, late-stage alcoholics, who would continue to be considered appropriate recipients of involuntary services. The following profile of an "average" late-stage alcoholic was prepared for the Commission by OADAP staff, based on data drawn from 22 cases of men recently placed in the Milestone extended care facility:

> "He is 51 years old, and started to drink when he was 15, the same year he dropped out of high school. He is divorced, a direct result of his alcoholism, and has held 7 full-time jobs, although he has not worked for the last 15 years. He lives on the street, panhandling, collecting bottles, and picking up odd jobs to support his alcoholism. His father was an alcoholic, and so is at least one of his brothers. He is estranged from his ex-spouse, his children, and his brothers and sisters. Over his lifetime he can document having been in either a detoxification or rehabilitation facility 27 times. He has coronary disease, cirrhosis, kidney disease, gastrointestinal disorders, and emphysema, in addition to withdrawal seizures and delirium tremens. He can remember and document having been arrested for minor infractions 39 times and has spent a year in prison. Without long-term rehabilitation and lifelong support he will continue his marginal street existence until his early death."

As a result of the advanced state of their disease, late-stage alcoholics utilize a greater proportion of the life maintenance

and treatment services for substance abuse currently available within the State than their numbers alone would suggest. As the composite profile indicates, the longer the disease of alcoholism goes untreated, the greater the alcoholic's dependence on publicly funded services will be. Without the drastic intervention mechanism that an effective involuntary services law would provide, these persons will become increasingly debilitated, both physically and psychologically, and they will eventually die as a result of their disease.

It should be emphasized, however, that late-stage alcoholics represent a relatively small fraction of the total population of alcoholics within the State. While the prognosis for successful treatment of this population is doubtful, the Commission believes that it is appropriate for the State to intervene, by requiring detoxification and offering supervised residential care, in those cases where the effects of chronic alcohol abuse have become genuinely life-threatening. OADAP estimates that approximately 25 commitments of late-stage alcoholics might take place annually if the involuntary services law is amended. OADAP has suggested an additional, subsidiary benefit of an amended involuntary services law: the threat of court-ordered treatment might provide the necessary motivation for many alcoholics to seek treatment voluntarily.

As can be seen from the estimates provided by OADAP, it is the expectation of the Commission that very few persons -- in all likelihood no more than 100 per year -- will be affected by an amended law mandating involuntary services for substance abusers. The question properly comes to mind, why draft a law that is so limited in its application? It should be reiterated that involuntary services have always been regarded as a small, but nonetheless important component of the total network of intervention strategies available to providers of substance abuse treatment in Maine. The Commission believes that two factors justify the retention and strengthening of an involuntary services option in Maine law. The first of these is cost. To illustrate, the OADAP profile of 22 late-stage alcoholics indicates that each of these individuals will spend an average of 54 days per year in some sort of emergency shelter and 25.5 days per year in a detoxification facility. The annual cost of supporting one of these individuals is $5,557.47 (based on a daily cost of $45.05 for shelter care and of $122.54 for detoxification); thus, commitment of at least some of these individuals to an extended residential care facility would represent a more effective allocation of resources within Maine's substance abuse treatment system. The second, and more compelling factor is humanitarian in nature. To put it bluntly, without effective court-ordered intervention many of these individuals will die.

IV. Potential Abuses of Involuntary Services

In redesigning the civil action to secure appropriate involuntary services for chemically dependent persons, the Commission has attempted to safeguard its proposed system from several potential sources of abuse. From the very beginning of its deliberations the Commission discussed the likelihood that family members of substance abusers might view the expanded availability of court-ordered treatment as an easy solution to complex personal problems. The prospect was raised, too, of local law enforcement officials trying to utilize the threat of court-ordered treatment as a means of eliminating undesirable persons from their communities, in effect reinstituting the status offense of public intoxication. The Commission has incorporated within its legislative proposal a variety of measures that are designed to minimize abuse from these sources.

First, in the case of petitions not initiated by DHS staff, the Commission would require three petitioners. The Commission would also impose the additional restrictions that one of the petitioners must be a licensed physician, psychologist, or substance abuse counselor, and that no more than one of the petitioners may be a law enforcement officer, or the guardian or family member of the person alleged to be chemically dependent. These limitations will prevent collusive actions from being initiated by two family members, or by two law enforcement officials, working in conjunction with a sympathetic physician. The Commission would also provide that a defendant in a civil action for involuntary services has the right to obtain independent medical evaluation of his condition and to present evidence of these findings at the hearing to refute the allegation of chemical dependency. The judicial procedure by which involuntary services are to be provided, as outlined in the Commission's legislative proposal, contains additional protections against improper recourse to the courts: defendants must receive adequate notice of the petitioner's intent to seek court-ordered treatment; defendants are entitled to legal counsel both in actions to obtain emergency treatment orders and in actions to obtain orders of continuing DHS supervision; proof of all allegations must be made according to the relatively stringent standard of clear and convincing evidence. Finally, the Commission's legislative proposal would limit the types of treatment that may be provided to persons adjudicated as chemically dependent to detoxification and extended residential care, a restriction that would tend to reduce even further the attractiveness of court-ordered treatment as a quick-fix solution to either personal or societal problems.

Throughout the course of its meetings, the Commission was acutely aware that the very concept of involuntary services represents to many persons an impermissible abuse of individual rights. The Commission acknowledges that an individual's liberty interest in the outcome of a civil commitment proceeding is of such gravity, compared with the State's legitimate interests in providing care to its citizens and in protecting the community from the dangerous tendencies of some chemically dependent persons, that strict adherence to the requirements of due process is required. The Commission concedes that chemically dependent persons ordered into treatment would have a constitutionally protected right to refuse medication or other types of therapy, and that the exercise of this right might very well jeopardize the effectiveness of any court-ordered treatment program. The Commission is confident, nonetheless, that involuntary services are justifiable under the State's parens patriae and police powers, and that the judicial procedure mandated by its proposed legislation passes constitutional scrutiny. Involuntary services should properly be viewed as a philosophical issue as opposed to a strictly legal one, a question of how much control the State may exert over the private behavior of its citizens. In this context, the Commission concludes that the State may impose the civil sanction of involuntary services when it is necessary to protect the lives and safety of its citizens and when appropriate treatment to advance this goal is available.

V. Appropriate Forms of Treatment for Persons Subject to Involuntary Services

As was suggested in previous sections of this report, the Commission believes that the form of treatment that the State can compel for chemical dependency must be carefully circumscribed and that persons subject to court-ordered treatment retain the right to refuse medication and most other types of therapy. For persons who voluntarily undergo treatment for substance abuse, the usual regimen consists of an initial period of detoxification, followed by participation in some form of rehabilitation program. While persons who enter the treatment system involuntarily should be encouraged to obtain followup counseling and rehabilitation, the Commission feels strongly that in most instances the State ought not to require long-term treatment. The goals of involuntary services should be twofold -- the elimination of life-threatening behavior that necessitates court-ordered emergency treatment and the restoration to the chemically dependent person of the capacity to make rational decisions with respect to further treatment. In the case of abusers of psychoactive drugs, therefore, the supervisory role of the State should terminate with detoxification.

The treatment requirements of chronic, late-stage alcoholics are somewhat different. Given the extreme physical and psychological debility that accompanies long-term alcohol abuse, the Commission doubts that even a fifteen-day detoxification period can restore to these individuals the capacity to make rational treatment choices. The Commission concludes, therefore, that for most persons in this category placement in an extended residential care facility under State supervision would be an appropriate extension of an involuntary services program. Extended care will provide shelter, food, and medical attention to persons who are unable otherwise to care for themselves. Recreational and vocational therapy can be obtained on a non-cocercive, voluntary basis, and involuntary clients can, if they so choose, receive assistance in developing the life skills that they will need to maintain sobriety once they leave extended care. While the involuntary commitment of these persons to extended care raises troublesome issues of social policy, the Commission endorses the view that a lengthy recovery period is necessary to mitigate the deleterious consequences of long-term alcohol abuse. Extended residential care affords the least restrictive environment for providing court-ordered services and is the only treatment modality which the Commission believes to offer a favorable prognosis for late-stage alcoholics.

VI. Explanation of Proposed Legislation

The legislation developed pursuant to the Commission's findings is derived, at least in its procedural aspects, from a bill that was prepared in 1986 by a Department of Human Services task force on involuntary commitment, which consisted of representatives of the Division of Adult Services and OADAP. The original bill was drafted by an assistant attorney general assigned to DHS. Commission staff, in consultation with attorneys in the Legislature's Office of Policy and Legal Analysis, redrafted the bill to incorporate the Commission's views that involuntary services should be targeted at a broader category of "chemically dependent persons" than had been suggested in the DHS draft and that the type of treatment provided to persons subject to a court order should be clearly defined. What follows is an explanation of the major features of the Commission's legislative proposal.

Sections 1 through 3 of the proposed amendments introduce three new concepts to the law -- "approved detoxification facility," "approved extended residential care facility," and "chemically dependent person." The first two of these definitions are intended by the Commission to place restrictions on the type of treatment that may be provided involuntarily to persons subject to court proceedings under this law. "Chemically dependent person" replaces "incapacitated alcoholic" as the standard for determining whether involuntary services are warranted. The definition is based on language contained in the Minnesota and South Carolina involuntary commitment laws and requires that, for a person to be adjudicated as chemically dependent, there must be evidence both of incapacitation and a threat of harm to self or others. The concept of chemical dependency would bring abusers of psychoactive drugs within the purview of the involuntary services law.

Sections 10 and 11 of the proposed amendments require DHS to establish standards for the certification of detoxification facilities and extended residential care facilities authorized to receive persons ordered into treatment under this law. The certification process permits DHS to consider the extent to which "reasonable restraint" may be required in approved detoxification facilities, thus providing the department with the opportunity to assess the need for secure units. The certification process is essential to the implementation of the involuntary services law, since the issuance of a court order for either emergency treatment or continuing department supervision is predicated on the availability of appropriate facilities.

Sections 13 through 17 of the proposed amendments outline the judicial procedure through which involuntary services are to be obtained. The Commission's proposal eliminates the non-judicial summary proceeding for emergency commitments contained in the current law, providing in its place a civil action before the District Court to secure both emergency treatment orders and orders of continuing department supervision. DHS staff are authorized to initiate the petitioning process, which will allow the department to seek appropriate residential care for chemically dependent persons who lack a guardian or family members. At the same time, the court procedure protects the rights of defendants by strict adherence to the requirements of due process -- adequate notice, the right to counsel and to independent medical evaluation, proof according to the stringent standard of clear and convincing evidence, and the availability of habeas corpus as a mechanism to seek early discharge from treatment.

VII. Impact of Proposed Legislation on the Department of Human Services and on the Maine Judicial System

While the Commission is unanimous in its view that Maine's current involuntary treatment law ought to be amended, the Commission also recognizes that its legislative proposal, if enacted, may have a substantial impact on those agencies of state government which are charged with administering the new law. One of the major factors in the inability of the current law to provide effective involuntary services for its target population has been the failure, for whatever reasons, to construct or to certify approved public treatment facilities. No less than the current law, the amendments recommended by the Commission carry an implicit assumption that specific types of treatment, namely detoxification and extended residential care, will be available in sufficient quantity to meet the needs of chemically dependent persons potentially subject to a court order under a revised law. If the appropriate facilities are not in place, it makes little sense to tinker with the procedure by which court-ordered treatment is to be obtained.

Beyond this crucial issue of facilities, an effective involuntary services program will impose certain administrative and staffing requirements on the Department of Human Services. Moreover, depending upon the number of civil actions to secure involuntary services which are ultimately brought before the District Courts, the Commission's proposal will have an unpredictable impact on the Maine judicial system in terms of both additional caseloads for judges and the cost of providing legal counsel and medical examinations for indigent defendants. This final section of the report addresses the immediate implications for DHS and the judiciary of the Commission's legislative proposal, and outlines the decisions that will have to be made prior to the expansion of an involuntary services program.

As discussed briefly in Section II of this report, incapacitated alcoholics committed to treatment under the current law are remanded to the custody of OADAP, which is charged with placing these persons in an appropriate facility. DHS, however, has given responsibility for initiating and coordinating the petitioning process with the Division of Adult Services. While this splitting of responsibility is workable in an environment in which commitments are rarely sought, the need for single agency mangement of the commitment process will intensify when the number of actions brought under an amended law increases. The Commission recommends, therefore, that DHS assess from the outset whether OADAP, Adult Services, or some other agency within the department is best situated to

supervise the entire involuntary services process, from the initial identification of potentially commitable persons to the discharge of clients from extended residential care.

The Commission's legislative proposal assigns a high level of responsibility to DHS staff, both as potential initiators and coordinators of the petitioning process and as case managers for chemically dependent persons ordered into extended residential care. The commitment process mandated by the proposed legislation is potentially complex and time-consuming. While it is difficult to predict the impact of these additional case management responsibilities on DHS's existing staff resources, the Commission believes it would be unrealistic to assume that the department could effectively oversee the involuntary services program without creating new staff positions. The Commission is also aware that chemically dependent persons who are to be supervised by DHS represent a different group of clients from those customarily served by the Division of Adult Services. Case workers assigned to the involuntary services program would have to possess specialized skills and training in order to work most effectively with the new law. The Commission recommends, therefore, that DHS seek funding for a minimum of two new case worker positions to manage the petitioning process and to supervise the extended care of persons ordered into the department's custody.

In terms of the availability of the types of treatment facilities required by the proposed legislation, there is no question that sufficient detoxification capacity exists within the State to accommodate the additionl burden that will be imposed by involuntary commitments. The Commission, however, has identified one potential problem area with respect to detoxification that must be resolved by DHS in the course of certifying facilities to receive emergency commitments under the new law. Several presentations to the Commission emphasized the need to develop within the State some sort of secure, locked detoxification facility, as a means of preventing involuntarily committed persons from leaving treatment prior to discharge, of protecting voluntary patients from potential physical harm caused by involuntary patients, and thereby of shielding detoxification centers from a potential source of civil liability. At the same time, treatment providers expressed reluctance to introduce locked units to existing detoxification facilities, based on the belief that the presence of such restraints would impair the treatment of voluntary patients. The options for DHS would appear to be twofold. Funding could be sought for the establishment, staffing, and maintenance of a state-operated detoxification facility, either as a free-standing unit or as part of an existing facility such as AMHI or BMHI. As an alternative, DHS could offer some form of incentives to

existing detoxification centers to modify their physical plant to provide necessary locked units. Renovation of existing facilities is clearly the least costly option.

There is insufficient extended residential care currently available in the State to deal effectively with the number of chemically dependent persons who might be subject under a revised law to an order of continuing dependent supervision. Since the length of stay in extended care is open-ended for voluntary clients, and may last in exceptional cases for up to two years, client turnover is low. Lengthy waiting periods to enter extended care are customary. Even assuming that many persons involuntarily committed to a detoxification facility will, upon completing detoxification, choose voluntarily to enter some other form of treatment, it is doubtful that the present extended care centers could accept even a limited number of involuntary referrals. As was stated earlier, it makes little sense to provide a judicial mechanism for ordering chemically dependent persons into treatment if the appropriate treatment facilities are unavailable. The Commission recommends, therefore, that the Department of Human Services examine the means by which the availability of extended residential care might be expanded throughout the State.

There is no question that the legislation proposed by the Commission, if enacted, will impose an additional burden on the Maine judicial system. While it is impossible to predict at this time the impact, in terms of caseload and court costs, of an amended involuntary treatment law, the Commission is confident that there are sufficient internal checks within the proposed law, as well as external constraints in the Maine substance abuse treatment system, to prevent the law from becoming unmanageable for the judiciary. The requirements that either three petitioners or a trained DHS representative must initiate the commitment process, and that an independent medical evaluation must be provided, will serve to limit the number of unmeritorious cases brought before the courts, and the present scarcity of extended residential care facilities will act as a further brake on the rapid implementation of an involuntary services program. The Commission is sensitive to the concern expressed by a representative of the Administrative Office of the Courts over increasing recourse to the judicial system to solve a variety of social problems. Since judges by and large are not trained to deal with complex issues of social policy, a genuine danger exists that any new law will be subject to inconsistent interpretation at the trial level. Nonetheless, the Commission believes that it is proper, under carefully restricted circumstances, to seek the involuntary treatment of chemically dependent persons and that the judicial system is the appropriate institution to perform the required task of weighing individual rights against societal interests.

The Commission recommends, therefore, that the Department of Human Services work closely with the District Courts and the Administrative Office of the Courts to insure that the judicial process to secure involuntary services is administered equitably, and that the law is interpreted consistently, throughout the State.

Appendix A

STATE OF MAINE

"AN ACT to Amend the Statutes Pertaining to the Emergency Treatment and Continuing Supervision of Chemically Dependent Persons"

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §7103, as enacted by P.L. 1973, c. 566, §1, is amended by adding a new sub-§3-A:

3-A. Approved detoxification facility. "Approved detoxification facility" means an approved treatment facility which meets the standards promulgated pursuant to section 7115, subsections 1 and 1-A, and which has been certified by the department to serve chemically dependent persons subject to an emergency treatment order. Procedures to decertify any facility or to refuse certification to any facility shall be governed by the Maine Administrative Procedures Act.

Sec. 2. 22 MRSA §7103, as enacted by P.L. 1973, c. 566, §1, is amended by adding a new sub-§3-B:

3-B. Approved extended residential care facility. "Approved extended residential care facility" means an approved treatment facility which meets standards promulgated pursuant to section 7115, subsections 1 and 1-B, and which has been certified by the department to serve chemically dependent persons subject to continuing department supervision. Procedures to decertify any facility or to refuse certification to any facility shall be governed by the Maine Administrative Procedures Act.

Sec. 3. 22 MRSA §7103, as enacted by P.L. 1973, c. 566, §1, is amended by adding a new sub-§4-A:

4-A. Chemically dependent person. "Chemically dependent person" means an adult, who by reason of the habitual and excessive use of alcohol and/or drugs:

A. Is incapable of self-management or management of personal affairs; and

B. Poses a substantial risk of serious physical harm to self or others, as demonstrated by

(1) A recent attempt or threat to harm self or others physically;

(2) Evidence of recent life-threatening physical problems; or

(3) Evidence of repeated failure to obtain necessary food, clothing, shelter, or medical care.

Sec. 4. 22 MRSA §7103, sub-§14, as enacted by P.L. 1973, c. 566, §1, is repealed.

Sec. 5. 22 MRSA §7103, sub-§15, as enacted by P.L. 1973, c. 566, §1, is repealed.

Sec. 6. 22 MRSA §7103, sub-§20, as enacted by P.L. 1973, c. 566, §1, is amended to read:

20. Treatment. "Treatment" means the broad range of emergency, out-patient, intermediate and in-patient services and care including career counseling, detoxification, diagnostic evaluation, employment, extended residential care, health, medical, psychiatric, psychological, recreational, rehabilitative, social service care, treatment and vocational services, which may be extended to an alcoholic, intoxicated person, drug abuser, drug addict, drug dependent person, chemically dependent person or to a person in need of assistance due to use of a dependency related drug.

Sec. 7. 22 MRSA §7106, sub-§9, third sentence, as enacted by P.L. 1973, c. 566, §1, is amended to read:

9. Agreements. Such agreements may include provisions to pay for such prevention and treatment rendered or furnished to an alcoholic, intoxicated person, drug abuser, drug addict, drug dependent person, chemically dependent person or person in need of assistance due to use of a dependency related drug.

Sec. 8. 22 MRSA §7106, sub-§11, first sentence, as enacted by P.L. 1973, c. 566, §1, is amended to read:

11. Operating and treatment standards. Establish operating and treatment standards, inspect and issue a certificate of approval for any alcohol or drug abuse treatment facility or program, including residential treatment centers, which meet the standards promulgated under section 7115, subsections 1, 1-A, 1-B, and licensed pursuant to section 7801 and other applicable provisions of law.

Sec. 9. 22 MRSA §7114, sub-§3, as enacted by P.L. 1973, c. 566, §1, is repealed and the following enacted in its place:

3. Alcoholics, intoxicated persons, and chemically dependent persons. The department shall provide adequate and appropriate treatment and extended residential care for alcoholics, intoxicated persons, and chemically dependent persons admitted under sections 7117 to 7120-A. Treatment may not be provided at a correctional institution, except for inmates.

Sec. 10. 22 MRSA §7115, as enacted by P.L. 1973, c. 566, §1, is amended by adding a new sub-§1-A:

1-A. Standards concerning detoxification. The department shall establish standards for the reasonable restraint and treatment of chemically dependent persons subject to an emergency treatment order. No facility shall restrain such a person against his will unless the following criteria are met:

A. The facility has been presented with an attested copy of an emergency treatment order; and

B. The facility has been certified by the department.

Sec. 11. 22 MRSA §7115, as enacted by P.L. 1973, c. 566, §1, is amended by adding a new sub-§1-B:

1-B. Standards concerning extended residential care. The department shall establish standards for the extended residential care of persons subject to continuing department supervision. No facility shall provide service for such a person against his will unless the following criteria are met:

A. The facility has been presented with an attested copy of an order of continuing department supervision; and

B. The facility has been certified by the department.

Sec. 12. 22 MRSA §7118, as enacted by P.L. 1973, c. 566, §1, is amended to read:

§7118. Treatment and services for intoxicated persons and ~~persons/incapacitated/by/alcohol~~ chemically dependent persons

1. Intoxicated person. An intoxicated person may come voluntarily to an approved ~~public~~ treatment facility for emergency treatment. A person who appears to be intoxicated and to be in need of help, if he consents to the proffered help, may be assisted to his home, an approved ~~public~~ treatment facility, ~~an/appropriate/private/treatment/facility~~ or other health facility by the police. ~~Or/the/emergency~~ ~~service/police/officer~~

2. Chemically dependent person. A person who appears to be chemically dependent shall be taken into protective custody by the police or the emergency service and brought to an approved public detoxification treatment facility for emergency treatment. If no approved public detoxification treatment facility is readily available, he shall be taken to an emergency medical service authorized for this purpose. The police or the emergency service, in detaining the person and in taking him to an approved public detoxification treatment facility, is taking him into protective custody and shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. Taking Use of protective custody under this section is not an arrest. No entry or other record shall be made to indicate that the person has been arrested or charged with a crime.

3. Voluntary commitment. A person who comes voluntarily or is brought to an approved public treatment facility or to an approved detoxification facility shall be examined by a licensed physician forthwith. He may then be admitted as a patient or referred to another health facility. The referring approved public treatment facility shall arrange for his transportation.

4. Length of stay. A person, who by medical examination is found to be chemically dependent at the time of his admission or to have become chemically dependent at any time during his period of hospitalization, may not be detained at the facility once he is no longer chemically dependent or if he remains chemically dependent for more than 48 seventy-two (72) hours after admission as a patient, unless he is committed under section 7119. A person may consent to remain in the facility as long as the physician in charge believes appropriate.

5. Shelter. A person, who is not admitted to an approved public treatment facility, or is not committed to an approved detoxification facility under section 7119, or is not referred to another health facility and has no funds, may be taken to his home, if any. If he has no home, the approved public treatment facility shall make a reasonable attempt to assist him in obtaining shelter.

6. Notification. If a patient is admitted to an approved public treatment facility or committed to an approved detoxification facility, his guardian, family or next of kin shall be notified as promptly as possible, provided that

permission for such notification is given by the patient. ~~If an adult patient who is not incapacitated requests that there be no notification, his request shall be respected.~~

7. Official duty. A police officer who acts in good faith in carrying out duties under this section shall be immune from any civil or criminal liability for such acts. Nothing in this subsection is intended to limit or to waive any provisions of the Maine Tort Claims Act. ~~The police or members of the emergency service patrol who act in compliance with this section are acting in the course of their official duty and are not criminally or civilly liable therefor.~~

8. Further diagnosis and voluntary treatment. If the administrator in charge of the approved ~~public~~ treatment facility determines it is for the patient's benefit, the patient shall be encouraged to agree to further diagnosis and appropriate voluntary treatment.

Sec. 13. 22 MRSA §7119, as enacted by P.L. 1973, c. 566, §1, is repealed and the following enacted in its place:

§7119. Involuntary Treatment of Chemically Dependent Persons

1. Jurisdiction.

A. The District Court shall have jurisdiction over actions involving treatment orders under this subchapter.

B. The Probate Court shall have concurrent jurisdiction to hear requests for emergency treatment orders under §7120. The final hearing under §7120-A shall be heard in the District Court.

2. Venue.

A. Petitions shall be brought in the district where the person alleged to be chemically dependent legally resides or where the person is present.

B. A judge from another district may hear a treatment petition and make an emergency treatment order if no judge is available in the district where the petition is filed.

3. Petitions: Petitioners; Contents.

A. Petitions may be brought by the following:

(1) The department through an authorized agent; or

(2) Three or more persons, one of whom must be a licensed physician, licensed psychologist, or a licensed substance abuse counselor. No more than one of the petitioners may be a law enforcement officer, and no more than one of the petitioners may be the guardian or family member of the person alleged to be chemically dependent.

B. Petitions must be sworn to and contain at least the following:

(1) Name, birthdate and current residence of the person alleged to be chemically dependent;

(2) Name(s) and address(es) of that person's closest living relative(s), if known, and his legal guardian, if any;

(3) A summary statement of the facts which the petitioner believes constitute the basis for the petition;

(4) A request for a specific court order;

(5) A statement that the person for whom the treatment is sought has the right to counsel and, if he cannot afford one, the court may appoint counsel for him;

(6) A statement that the proceedings may lead to an order of continuing department supervision;

(7) If an emergency treatment order is sought, a statement of the facts which the petitioner believes substantiate the need for an emergency treatment order; and

(8) A notice of hearing.

C. Certifying Examination: Every petition shall be accompanied by a dated certificate, signed by a licensed physician, stating at least the following:

(1) That the physician has examined the person;

(2) That the examination took place within three (3) days of the date of filing the petition;

(3) A diagnosis of the person's physical and/or mental health problems;

(4) That the physician is of the opinion that the person is chemically dependent and that without treatment the person's condition will deteriorate; and

(5) If an emergency treatment order is sought, a statement that substantitates the need for an emergency treatment order.

(6) If the person has refused to be examined by a licensed physician, despite the petitioner's good faith attempt to obtain such an examination, this fact shall be stated in the petition.

D. Temporary Order for Examination: In cases where no emergency treatment order is sought and where the person has refused to be examined pursuant to section 7119(3-C), the court may grant a temporary order for examination prior to hearing on the petition, according to the following procedure:

(1) Request for temporary order for examination. In addition to complying with the requirements outlined in sections 7119(3)(A) and (3)(B), the petitioner must request a temporary order for examination and must state the reasons why such an order is sought;

(2) Findings. If the court finds by a preponderance of the evidence, that the allegations of the petition are true and that the person has refused to be examined by a physician as required in paragraph C, the court may order the person to be examined by a physician. This order may be made ex parte and shall remain in effect for seventy-two (72) hours after issuance, or as otherwise limited by the court.

(3) Protective custody. The court may order the person alleged to be chemically dependent into protective custody of a law enforcement officer for the purpose of providing transportation to the examination.

(4) Findings of examination. The results of the examination shall be provided to the court. If the examining physician does not certify the person to be chemically dependent, the petition shall be dismissed.

(5) Costs. The cost of any examination obtained pursuant to this sub-section shall be paid by the District Court.

Sec. 14. 22 MRSA §7120, as enacted by P.L. 1973, c. 566, §1, is repealed and the following enacted in its place:

§7120. Request for Emergency Treatment Order

1. Request. The petitioner may request an emergency treatment order with the petition.

2. Order. The court may order emergency treatment, consisting of detoxification and necessary medical care, of a person alleged to be chemically dependent if it finds by clear and convincing evidence presented in a sworn statement of facts or otherwise that:

A. The person has been notified by the petitioner of the petitioner's intent to request an emergency treatment order on that date;

B. The person is chemically dependent;

C. Without emergency treatment there is an immediate risk of further deterioration of the person's physical and/or mental condition; and

D. That a placement in an approved detoxification facility is available for him.

The court may order emergency treatment of the person for a period not to exceed fifteen (15) days. This order may be ex parte. The court shall set hearing on the petition filed pursuant to §7119 within the fifteen (15) day emergency treatment period.

3. Waiver of certifying examination. The court may waive a certifying examination if it finds by clear and convincing evidence the following:

A. That the requirements of section 7120(2) have been satisfied;

B. That the petitioner has made a good faith effort to secure a certifying examination; and

C. That the person alleged to be chemically dependent has refused or is incapable of consenting to such an examination.

4. Counsel. The court shall appoint counsel for the person alleged to be chemically dependent if the person is not represented and upon a showing of indigency. The court shall appoint counsel at the earliest opportunity in any proceeding under this section or section 7120-A.

5. Service of emergency treatment order and petition. Service of the emergency treatment order and the petition shall be made on the person within forty-eight (48) hours of the issuance of any emergency treatment order, or as otherwise ordered by court. Service on other parties required under §7120-A(1)(B) and (C) shall be made as soon as reasonably possible, prior to the fifteen-day hearing, or as otherwise ordered by the court.

Sec. 15. 22 MRSA §7120-A is enacted to read:

§7120-A. Hearing on Petitions; Service; Time Limits for Hearings; Findings; Order.

1. Service of Petition. The petition under §7119(3) shall be served as follows:

A. Upon the person alleged to be chemically dependent by in-hand delivery by an authorized agent of the department or a law enforcement officer;

B. Upon the person's legal guardian, if known, or upon at least one of the following: his spouse, his parent(s), his adult children, his caretaker, if one of these persons exist and can be located. The petition and notice of hearing shall be sent by certified mail, return receipt requested, at least seven (7) days before the hearing; and

C. Upon the department, where the department is not the petitioner, by certified mail, return receipt requested, at least seven (7) days before the hearing.

2. Time within which hearing shall be held.

A. Hearing after granting of emergency treatment order.

The District Court shall hold a hearing on the petition within fifteen (15) days of the granting of the order. However, on motion of any party, the hearing may be continued for cause for a period not to exceed five (5) additional days. Any emergency treatment order shall continue in effect for the specified time period unless otherwise ordered by the court.

If a hearing is not held within the time periods specified in this paragraph, the court shall terminate the treatment order. In computing the time periods set forth in this paragraph, the District Court Civil Rules shall apply.

B. Hearing if emergency treatment order not in effect.

Hearing on the petition shall be set within thirty (30) days of the filing of the petition. Should the hearing not be held within this thirty (30) day period, a new Certificate of Examination shall be filed with the court.

3. Court findings. After hearing, the court shall find the following by clear and convincing evidence before ordering continuing department supervision:

A. That the person is chemically dependent;

B. That the person's chemical dependency is the result of the habitual and excessive use of alcohol;

C. That continuing department supervision is the least restrictive method of preventing further deterioration of the person's condition and for treating the person;

D. That a placement in an approved extended residential care facility is available for the person; and

E. That the treatment plan offered by the petitioner will benefit the person.

4. Order of continuing department supervision. Upon making the findings described in subsection 3, the court may order the person into the department's supervision for a period not to exceed ninety (90) days. The ninety (90) days shall not include time spent in treatment under an emergency treatment order.

The court shall issue an order of continuing department supervision within forty-eight (48) hours of the hearing. If no order is issued within forty-eight (48) hours of the completion of the hearing, the court shall dismiss the petition.

5. Appeals. The District Court Civil Rules shall apply to the conduct of any appeals.

Sec. 16. 22 MRSA §7120-B is enacted to read:

§7120-B. Continuing department supervision.

1. Responsibilities. The department shall be responsible for the delivery of services to persons ordered into its supervision, including:

A. Preparation of a reasonable case management plan;

B. Regular contact with the approved extended residential care facility and involvement in its treatment plan;

C. Regular contact with the person in extended care;

D. Involvement in any planning for the discharge of persons placed in extended care;

E. Petitioning the court for continuing department supervision or discharge of the person from department supervision whichever is reasonably warranted under the circumstances.

Sec. 17. 22 MRSA §7120-C is enacted to read:

§7120-C. Post-supervision procedure.

1. Examination after any order of continuing department supervision. Every person admitted to an approved extended residential care facility pursuant to any order of continuing department supervision under section 7120 or section 7120-A shall be examined by a licensed physician within seventy-two (72) hours after admission.

A. The administrator of the approved extended residential care facility shall arrange for the examination by a licensed physician for every person admitted under this subchapter;

B. The examiner may not be the certifying examiner under section 7119(3)(C); and

C. If the examination under this section is not held within seventy-two (72) hours of admission, or if the physician fails or refuses to certify that the person is chemically dependent and that treatment is necessary to prevent further deterioration of the person's condition, the order of continuing department supervision shall terminate.

2. Discharge. A person shall be discharged from an approved extended residential care facility prior to the end of the ordered supervision period, if the following conditions are met:

A. The department and the facility are satisfied that the person no longer poses a risk of serious physical harm to himself or others; or

B. The department and the facility are satisfied that a less restrictive plan is available and appropriate to meet the person's need for treatment or residential care; and

C. The person is in agreement with the plan to be discharged or to participate in a less restrictive program.

3. Notification to the court. The department shall notify the court by sworn affidavit of the reasons for discharge from continuing department supervision. A copy of the affidavit shall be mailed to all other parties named in the original proceeding. The department shall file this notification with the court within five (5) days of any discharge.

4. Habeas corpus. A person comitted under this chapter may at any time seek to be discharged from continuing department supervision by writ of habeas corpus.

5. Motion for review and further orders of treatment.

A. The petitioner or the person under order of continuing department supervision may move for the judicial review. Notice of the review shall be to all parties to the initial proceeding pursuant to District Court Civil Rule 5.

B. The court may hear evidence and make any further order, based upon clear and convincing evidence, that is authorized under section 7120-A(2) and (3). No person shall receive more than a total of three (3) consecutive ninety (90) day periods of continuing department supervision under section 7120-A(4).

Sec. 18. 22 MRSA §7124, as enacted by P.L. 1973, c. 566, §1, is amended as follows:

§7124. Payment for treatment; financial ability of patients; counsel fees.

1. Payment. If the treatment is provided by an approved ~~public~~ treatment facility and the patient has not paid the charge therefor, the treatment facility is entitled to any payment received by the patient or to which he may be entitled because of the services rendered, and from any public or private source available to the treatment facility because of the treatment provided to the patient.

2. Liability. A patient in an approved treatment facility, or the estate of the patient, or a person obligated to provide for the cost of treatment and having sufficient financial ability, is liable to the treatment facility for cost of maintenance and treatment of the patient therein in accordance with rates established.

3. Finances. The director shall adopt rules governing financial ability that take into consideration the income, savings and other personal and real property of the person required to pay, and any support being furnished by him to any person he is required by law to support.

4. Court appointed attorneys. The cost of all attorneys appointed to represent indigent defendants in any actions under section 7120 or section 7120-A shall be paid by the District Court.

Sec. 19. 22 MRSA §7126 is enacted to read:

§7126. Custody and transportation.

1. Emergency treatment orders and orders of continuing department supervision. Any person subject to an emergency treatment order pursuant to section 7120 or subject to continuing department supervision pursuant to section 7120-A shall be transported to the appropriate approved facility or other medical facility by law enforcement personnel, or as otherwise ordered by court.

2. Reasonable force. Law enforcement personnel may utilize reasonable force in transporting such person.

3. Request for assistance by department. Should the department request assistance from law enforcement to return a person to the treatment facility during the period of ordered treatment, law enforcement personnel shall provide reasonable assistance.

4. Return of persons subject to an emergency treatment order or to continuing department supervision who have left a treatment facility without permission. If any person subject to an emergency treatment order or to continuing department supervision is absent from a treatment facility without permission a law enforcement officer may, upon written order of the department and without the necessity of a warrant or court order, take the patient into protective custody and return him to the facility. No person may be returned pursuant to this section after being continuously absent from the supervision of the department for at least one year.

5. Expenses of transport. The county in which the person is found shall be responsible for any transportation expenses under this section.

Sec. 20. Effective date. In view of the fact that this Act requires the department to establish standards for the

certification of detoxification and extended residential care facilities authorized to receive chemically dependent persons, and requires further that no person shall be subject to involuntary services unless placement in an approved facility is available, this Act shall not take effect until January 1, 1989.

STATEMENT OF FACT

A judicial order to secure treatment and extended residential care of chemically dependent persons becomes necessary when less restrictive measures have failed to intervene in the progressive, fatal disease of chemical dependency. Existing law requires amendment because of the following problems:

1. Lack of due process protections for the allegedly chemically dependent person;

2. The "Approved Public Treatment Facilities" defined in present law are non-existent; and

3. The possible petitioners in the present law are limited to family members or guardians.

These and other flaws prevent the use of present law for obtaining judicial orders for the involuntary treatment of chemically dependent persons.

The proposed legislation addresses these concerns in the following ways:

1. The Department of Human Services would have the authority to bring petitions and to provide supervision of the treatment process;

2. The defendant's rights to appointment of counsel and to notice of the allegations against him and of the standards by which the court will rule on the petition are clarified and made more specific;

3. The standards and procedures for obtaining orders for examination and emergency treatment orders have been clarified;

4. No proceedings may be initiated without prior determination that placement in a detoxification facility or an extended residential care facility, which meets specific standards for providing appropriate treatment, is available; and

5. Procedures for review, after admission to a detoxification facility or an extended residential care facility, have been added to the present statute.

Appendix B

List of Presentors

November 20, 1987

Neill Miner, Director, Office of Alcohol and Drug Abuse Prevention (OADAP)

December 18, 1987

Joyce Saldivar, Director, Divison of Adult Services, Department of Human Services
Calvin F. Hall, Case Worker, Division of Adult Services
Hank Cleaveland, Substance Abuse Program Consultant, Divison of Adult Services and the State Employee Assistance Program
Mel Tremper, OADAP

January 8, 1988

Christopher Leighton, Assistant Attorney General, Department of Human Services
Debra Olken, Policy and Analysis Officer, Administrative Office of the Courts
Sally Sutton, Director, Maine Civil Liberties Union

January 22, 1988

Dr. George Dreher, Medical Director, St. Mary's General Hospital Chemical Dependency Program
Ronald Anton, Program Manager, Jackson Brook Institute Careunit
George Schools, Executive Director, Aroostook Alcohol and Drug Abuse Council, Inc.
Barbara Niznik, Executive Director, Eastern Regional Council on Alcohol and Drug Abuse, Inc.
Paul McDonnell, Executive Director, Community Alcoholism Services and Milestone Extended Care
Michael Darcy, Director, Fellowship House