Disability Law Center

Massachusetts Protection and Advocacy

A Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served

Exterior barbed wire fence and exterior sign of Bridgewater State Hospital.

A Report to the President of the Senate, Speaker of the House of Representatives, Chairs of the Joint Committee on Mental Health Substance Use and Recovery, Joint Committee on the Judiciary, Senate Ways and Means Committee, and House Ways and Means Committee, submitted pursuant to the FY 2021 Budget (Line Item #8900-0001.)

July 2021

Table of Contents

Introduction and Overview

This report covers the monitoring of Bridgewater State Hospital (BSH), including the Bridgewater Units at Old Colony Correctional Center (OCCC Units) – the Intensive Stabilization and Observation Unit (ISOU) and the Residential Unit (RU) – pursuant to expanded authority granted by Line Item #8900-0001,[1] for the period from January 2021 to June 2021. This year, more than ever, the extent of DLC's ongoing extensive monitoring would not be possible without our expanded authority granted by Line Item #8900-0001.

During this monitoring period, DLC conducted regular monitoring of BSH through remote site visits, person served (PS) video and phone meetings, staff video and phone meetings, review of daily reports from both Wellpath and DOC, and weekly internal staff meetings. DLC participated via video in BSH Governing Body meetings and Department of Mental Health (DMH) quarterly meetings. For the first time, DLC's monitoring authority incorporates assessing continuity of care for BSH PS upon their discharge or transfer from BSH to county correctional facilities and Department of Mental Health facilities. Accordingly, during this monitoring period, DLC has also created and staffed a new facet of BSH monitoring focused on identifying barriers to successful transfers for PS through examining agency coordination, admission, discharge, and transfer planning processes and seeking input from current and former PS served regarding their experiences.

DLC now has over seven (7) years of institutional knowledge of Bridgewater State Hospital. DLC is in the unique position as the Commonwealth's Protection and Advocacy agency to have a federal mandate and authority to monitor BSH,[2] and hold information confidential under such authority. There is no other organization that is conducting daily oversight at BSH, while understanding the complexity of the issues faced at BSH. Moreover, DLC conducts monitoring and investigations in facilities that serve individuals with disabilities across the Commonwealth, and is familiar with the delivery of mental

[1] "[P]rovided further, that not less than $125,000 shall be expended for the Disability Law Center, Inc. to monitor the efficacy of service delivery reforms at Bridgewater state hospital, including units at the Old Colony correctional center and the treatment center; provided further, that the Disability Law Center, Inc. may investigate the physical environment of those facilities, including infrastructure issues, and may use methods including, but not limited to, testing and sampling the physical and environmental conditions, whether or not they are utilized by patients or inmates; provided further, that the Disability Law Center, Inc. may monitor the continuity of care for Bridgewater state hospital persons served who are discharged to county correctional facilities or department of mental health facilities, including assessment of the efficacy of admission, discharge and transfer planning procedures and coordination between the department of correction, Wellpath, the department of mental health and county correctional facilities; provided further, that at least once every 6 months, the Disability Law Center, Inc. shall report on the impact of these reforms on those served at Bridgewater state hospital to the joint committee on mental health, substance use and recovery, the joint committee on the judiciary, the house and senate committees on ways and means, the president of the senate and the speaker of the house of representatives." Massachusetts FY 2021 Budget, Line Item #8900-0001

[2] *See, e.g.,* 42 U.S.C. § 10805(a)(1)(A) (PAIMI – persons with mental illness); 42 U.S.C. § 15043(a)(2)(B) (PAIDD persons with intellectual and developmental disabilities), 29 U.S.C. § 794e(f)(2) (PAIR – persons with other disabilities, including physical disabilities); 42 U.S.C. § 300d-53(k) (PATBI – persons with traumatic brain injury).

health services on locked units. DLC's broad engagement provides us an expansive perspective on the gaps in existing and planned essential services. It is clear that there is still much more work to be done to improve the quality and continuity of care for and protect the rights of all BSH PS – individuals who can fairly be deemed as having some of the most severe behavioral health conditions in Massachusetts.

Within BSH and the OCCC Units, we have observed concerning practices and stagnation with respect to important reforms, making clear the importance of ongoing monitoring to ensure that past practices and cultural norms do not slip back into daily practice and that progress continues. Furthermore, because Wellpath's contract as vendor at BSH has recently been approved for an additional two years, it remains in the best interests of BSH PS and the DOC to have DLC continue to offer expertise and advocacy on behalf of this incredibly vulnerable population.

During this reporting period, Wellpath began to ease pandemic restrictions while BSH experienced an increase in both facility population and use of restraints and seclusions. Once again trying to stabilize staff turnover, Wellpath's continual recruiting efforts are noteworthy. DLC thanks Assistant Hospital Administrator Christina Harrington for her commitment to the PS at BSH and wishes her well in her new endeavors.

For PS who transfer from Bridgewater to DOC or county correctional facilities, concerns that individuals with behavioral health needs are not being adequately treated are equally, if not more, serious. While this Administration has announced its *Roadmap for Behavioral Health Reform: Ensuring the right treatment when and where people need it*,[3] these expansive plans do not aim to improve access to mental health care for people inside DOC or county correctional facilities. At the same time, the November 17, 2020 U.S. Department of Justice (DOJ) investigative findings made clear the harsh realities of experiencing mental health crisis in Massachusetts prisons. The DOJ found that DOC's failure to provide adequate mental health care and supervision to prisoners in mental health crisis constitutes an Eighth Amendment violation; pursuant to a separate contract, Wellpath has also been the medical and mental health provider for all DOC facilities for several years. And the scale of the problem translates to widespread human suffering. Per DOJ's findings, looking only "between July 1, 2018 and August 31, 2019, there were 217 instances of cutting, 85 instances of prisoners inserting objects into their bodies, 77 attempted hanging incidents, 34 instances of ingestion of foreign bodies, and 17 attempted asphyxiations, all on mental health watch."[4] Notably, DOC personnel have informed DLC that prisoners who engage in the most serious self-harm end up in the Bridgewater Units at OCCC for evaluation and observation – individuals with whom DLC is able to remain in contact and track due to continued in-depth monitoring. Sadly, these outcomes are mirrored in many Massachusetts county correctional facilities.

[3] *See* Executive Office of Health and Human Services, *Roadmap for Behavioral Health Reform,* https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform.

[4] U.S. Department of Justice, *Investigation of the Massachusetts Department of Correction*, pp. 5-6 (November 17, 2020), https://www.justice.gov/opa/press-release/file/1338071/download.

The disproportionate impact on individuals of color caused by systemic inequities in mental health care available in BSH, the OCCC Units, DOC, county correctional facilities, and DMH facilities must be recognized, as must their relationship to established disparities in access to and quality of community medical and mental health care, racial bias in mental health treatment, and racial bias in the criminal justice system. Indeed, available data concerning the population of BSH makes plain the glaring overrepresentation of people of color – particularly, Black and African American men – with behavioral health issues deemed to require the strict security of BSH.

Race/Ethnicity	BSH Population (January 1, 2021)[5]	Massachusetts Population (2020 US Census)[6]
White/Caucasian	44% (88 PS)	80.6%
Black/African American	30% (60 PS)	9%
Latinx/Hispanic	11% (22 PS)	12.4%
Asian	1% (1 PS)	7.2%

In the discussion below, DLC focuses on seven (7) broad areas of concern during the period from January 2021 to June 2021:

1. Physical Plant Health and Safety Risks;
2. Pandemic Response and Reopening;
3. Chemical Restraint, Irreversible Decline Orders and Statutorily Mandated Reporting;
4. Access to Programming and Treatment for Persons Served with Intellectual and/or Developmental Disabilities;
5. Discharge Planning for Long Term Persons Served;
6. Inequality of BSH and the OCCC Units; and
7. Continuity of Care for BSH Persons Served.

Sections 1 through 6 include DLC's recommendations to improve the safety and treatment of PS. The complete list of recommendations can also be found at the Conclusion of the report. As this has been the first reporting period in which DLC has been granted expanded authority to monitor continuity of care for PS, we will provide recommendations in our next report.

[5] DOC, *January 2021 MA DOC Institutional Fact Cards*, https://www.mass.gov/doc/institutional-fact-cards-january-2021/download.
[6] U.S. Census Bureau, *QuickFacts Massachusetts: Race and Hispanic Origin*, https://www.census.gov/quickfacts/MA.

1. Physical Plant Health and Safety Risks

As discussed in DLC's last five reports between May 2018 and October 2020, each entitled *A Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital*,[7] the physical plant and infrastructure at BSH are potentially hazardous to the health of any individuals on-site and necessitate endlessly costly and marginally effective repairs. During this reporting period, DOC reported additional physical plant updates that demonstrate the inescapable inefficiency and safety concerns that come with the continued operation of BSH.

DLC has exhaustively raised concerns about physical plant deficiencies that impact PS safety, from repeated roof leaks to mold. While DOC makes a patchwork of repairs, persistent problems, such as continually failing roofs and steam pipes, directly impede the delivery of treatment with leaks and moisture buildup in areas populated by PS. It is impossible to estimate the extent of the insidious mold throughout BSH and DOC has consistently refused to conduct extensive mold sample swab testing throughout BSH (see DLC's recommendation in our reports dated February 25, 2019 and July 15, 2019). DLC toured BSH with our expert, Gordon Mycology Laboratory, Inc. on December 5, 2019 and returned on December 19, 2019 to conduct mold sample swab testing throughout the facility. Both observations and sample testing revealed extensive mold in almost every single area swabbed by our expert, including the medical building and HVAC systems/vents. For years, individuals receiving and providing treatment at BSH have reported symptoms consistent with dangerous air quality.

Since the last DLC reporting period, DOC has completed a myriad of repairs and attempted mold removal in the medical building, administrative building basements, and the Adams building mechanical room. These mold remediation efforts were not clearly completed per industry standards. In addition, DOC has done no independent review or expert testing to ensure that mold no longer poses a risk to individuals – staff and PS alike – at BSH.

Unfortunately, there is no amount of diligence, however, that can adequately address the facility's deficiencies, especially given the vulnerable population it houses. The failure to provide PS with a more suitable and therapeutic environment, while denying them their liberty, should weigh heavy on the Commonwealth.

Moreover, given that many medical conditions may masquerade as psychiatric illness, it is of the utmost importance to screen and treat PS medical conditions. As Wellpath continues to recruit medical staff, we recommend including Medical Board Certification as a prerequisite and in accordance with best medical practice across the industry. Given the failed and mold-ridden buildings, one cannot underestimate the potential medical conditions that may be influencing staff and PS at BSH. DLC notes Wellpath's new

[7] All DLC's reports concerning BSH are available at: https://www.dlc-ma.org/monitouing-investigations-reports/.

nursing initiative around tracking and communicating PS chronic diseases and believes this is a step in the right direction.

DLC once again strongly urges DOC to swiftly address mold, moisture, and other existing physical plant issues at BSH.

At the same time, the Commonwealth must commit to shuttering BSH and constructing a new facility designed with trauma-informed person-centered mental health treatment in mind.

In addition to building a new modern facility, all individuals in need of "strict security" psychiatric evaluation and/or treatment should be under the auspices of the Department of Mental Health.

2. Pandemic Response and Reopening

As pandemic fatigue has grown across the world, so too has it for individuals at BSH. BSH has not kept pace with many other settings in Massachusetts that are returning or moving quickly toward pre-pandemic functions and services. Although Wellpath has made efforts to increase remote and in-person programming for PS overall, reduce cohorts of housing units, and continually offer vaccines, individuals with the highest level of need continue to face prolonged isolating conditions for quarantine purposes upon admission. PS restraints, seclusion and grievances are all on the rise.

In fact, conditions for PS on quarantine status in BSH and the OCCC Units have been akin to or even harsher than those permitted for Massachusetts prisoners in Restrictive Housing per the Criminal Justice Reform Act of 2018, at times providing PS hospitalized for evaluation and treatment of serious mental health conditions only one (1) to two (2) hours of out of cell per day. During the reporting period, PS were subjected to quarantine at BSH and the OCCC Units without regard to verifiable vaccination status of the site from which they were transferred. For example, vaccinated prisoners transferred to the OCCC Units from the general population units at OCCC were nonetheless forced to quarantine. Disturbingly little focus has been placed on providing PS in quarantine additional programming and activities, despite the likely already precarious state of their mental state upon admission. This excessive isolation and lack of robust programming has been especially shocking in the former Intensive Treatment Unit (ITU), the site of excessive and unlawful seclusion for so many years, now repurposed as the Containment Unit (CU).

There are eleven (11) units at BSH and typically over 220 PS. While some units have consistent turn-over, such as the Bradley admission units and the Containment Quarantine Unit, other units see very little turn-over. Prior to the pandemic, it was common for PS to forge friendships and support from PS on other units. Since March 2020, except in rare circumstances, units are not commingling. Many PS have reported to DLC that the silos have deepened the social isolation, which is worse than ever across the BSH

population, with psychological impacts far outweighing the risk of illness from COVID-19. PS at both BSH and the OCCC Units have expressed that they would prefer to risk COVID-19 than remain as isolated as they have been. This is an especially important point because the pandemic response seems to have increased distrust of Wellpath among PS and this distrust appears to fuel some vaccine refusals.

On May 3, 2021, BSH transitioned to Phase I of reopening with some programming off unit and continued programming on units. Units were offered access to the gymnasium and library. PS who are vaccinated may work together, but PS who have declined vaccination may only work in a modified capacity, primarily in on-unit job roles. DLC notes that PS work is limited based on vaccination status but Wellpath staff work is not.

DLC acknowledges Wellpath's strides to maintain remote visits at BSH and the OCCC Units during the pandemic, and DOC efforts to upgrade infrastructure to support these visits and Zoom for Court at BSH. DLC supports remote visits as an option for PS, but does not believe they should be the default. DLC believes that remote Court appearances, for the majority of PS, may foreseeably prevent and impair meaningful access to the proceedings.

Limited programming at OCCC is up and running for both the RU and ISOU. Occupational Therapy, Music Therapy and Peer Support returned to in person groups and individual services in April 2021. While the RU has had access to the garden, main yard and OCCC main library, the ISOU has not largely due to quarantine schedules. As discussed above, the traumatic impact of these periods of isolation should not be minimized.

Both the OCCC Companions – specially trained DOC prisoners – and BSH Peer Support Specialists have had additional training during this reporting period. There are currently six (6) Companions with a goal of 10 at OCCC. Both the Companion program and Peer Support Specialists serve a vital role in the treatment and quality of life for PS. DLC encourages both DOC and Wellpath to further expand these roles in keeping with best practices across psychiatric facilities and mental health care in the Commonwealth.

DLC calls upon DOC and Wellpath to ensure that PS are not subject to damaging, prolonged isolation. No matter the requirements of applicable guidance from the Centers for Disease Control and Prevention and the Department of Public Health, DOC and Wellpath are responsible for ensuring that all BSH units accommodate the serious mental health needs of PS. PS confined to their cells for 18 hours or more per day must be provided daily in-cell programming and meaningful access to Residential Treatment Assistants (RTAs) and clinical staff.

3. Chemical Restraint, Irreversible Decline Orders and Statutorily Mandated Reporting

For well over seven years, DLC has raised concerns around the use of forced psychotropic medication at BSH and OCCC Units.[8] During this reporting period, DLC monitored the administration of involuntary medication, including chemical restraint, and the reporting thereof. We now renew our previously raised concerns and press DOC and Wellpath to take corrective action to ensure compliance with G.L. c. 123, § 21.

Since the operation of BSH transferred from DOC to a private vendor, the use of seclusion and physical restraints have been significantly lower. However, the use of involuntary administration of psychotropic medication on PS without a court order remains a significant cause for concern.

Under Massachusetts law, the general rule is that mental health medication should be administered involuntary only pursuant to a court order based on (a) a specific finding that the person is incapable of making informed decisions about medical treatment; (b) applying the substituted judgment standard, a specific finding that the patient would accept such treatment if competent; and (c) approval and authorization of a specific written substituted judgment medication treatment plan.[9] These orders establish what is known as a *Rogers* guardianship. There are two distinct exceptions to this general rule. The first is under the state's police power, allowing chemical restraint to prevent an imminent threat of harm to oneself or others, where there is no less intrusive alternative to antipsychotic drugs available.[10] The second circumstance is through the exercise of the state's *parens patriae* powers, which permits the state to administer medication involuntarily "in rare circumstances" to prevent "immediate, substantial, and irreversible deterioration of a serious mental illness…in cases in which 'even the smallest of avoidable delays would be intolerable.'"[11] Repeated use of this exception, requiring that, when someone is medicated in order to avoid said deterioration "and the doctors determine that the antipsychotic medication should continue and the patient objects, the doctors *must seek an adjudication of incompetence.*"[12]

General Laws Chapter 123, § 21 sets forth the requirements regarding the use of physical and chemical/medication restraint, and seclusion in DMH facilities as well as BSH. Per the statute, "[r]estraint of a mentally ill patient may only be used in cases of emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide" with strict requirements regarding examinations and who

[8] DLC detailed these concerns in our public reports to the legislature dated May 18, 2018 at 3-5, February 25, 2019 at 10, July 15, 2020 at 6-7, March 2020 at 4-5, and October 2020 at 8.
[9] *See* G.L. c. 123, § 8B; *Rogers v. Comm'r of the Dep't of Mental Health*, 390 Mass. 489, 504-511 (1983).
[10] *Rogers,* 390 Mass. at 510-511. Per the Supreme Judicial Court, '[n]o other State interest is sufficiently compelling to warrant the extremely intrusive measures necessary for forcible medication with antipsychotic drugs." *Id.* at 511,
[11] *Id.* at 511-512,
[12] *Id.* at 512.

may provide written authorization for the restraint.[13] Use of chemical restraint, in particular, requires a determination upon examination "that such chemical restraint is the least restrictive, most appropriate alternative available; provided, however, that the medication so ordered has been previously authorized as part of the individual's current treatment plan."[14] Chemical restraint, like other forms of restraint, must be tracked in individual medical records, and "[c]opies of all restraint forms and attachments shall be sent to the commissioner of mental health, or with respect to Bridgewater state hospital to the commissioner of correction, who shall review and sign them within thirty days, and statistical records shall be kept thereof for each facility including Bridgewater state hospital, and each designated physician."[15]

DMH regulations and policies comply with these statutory requirements.[16] DMH regulations state that "[m]edication restraint occurs when a patient is given a medication or combination of medications to control the patient's behavior or restrict the patient's freedom of movement and which is not the standard treatment or dosage prescribed for the patient's condition."[17] DMH regulations exclude from medication restraint only the two situations recognized by Massachusetts law: (1) when administered through a substituted judgment treatment plan; and (1) involuntary administration of medication to a patient who is believed to lack capacity to give informed consent to treatment with antipsychotic medication without court approval "to prevent an immediate, substantial, and irreversible deterioration of the patient's mental illness."[18] Crucially, DMH regulations dictate that "if treatment is to be continued over the patient's objection, and the patient continues to lack capacity, then an adjudication of incapacity and court approval of a treatment plan must be sought."[19] DMH-run and -licensed facilities are required to document each restraint, including medication restraints, and report data in the aggregate to the DMH Commissioner, as required by G.L. c. 123 s. 21.[20]

Conversely, DOC and Wellpath have devised a policy that gives rise to irregular administration of involuntary medication without a court order and without documentation as a chemical restraint. Within BSH and the OCCC Units, Wellpath applies the Bridgewater State Hospital Policy and Procedure Manual – *Use of Involuntary Psychotropic Medication* (effective 1/24/2020), which identifies four (4) "procedures" for administering involuntary medication to PS – Court-Authorized Treatment Plans, Emergency Treatment Orders, Medication Restraint, and Irreversible Deterioration Orders. Policy requirements concerning underlying behavior and determinations giving rise to each procedure and documentation are discussed below:

[13] G.L.c. 123, § 21.
[14] G.L.c. 123, § 21.
[15] G.L.c. 123, § 21.
[16] *See, e.g.,* 104 CMR 27.10(1); 104 CMR 27.12(8).
[17] 104 CMR 27.12(8)(3)(a).
[18] 104 CMR 27.10(1); 104 CMR 27.12(8) (3)(a)
[19] 104 CMR 27.10(1)(e).
[20] 104 CMR 27.12(8)(i).

(i) Court-Authorized Treatment Plans

This procedure, as the name suggests, permits the provision of involuntary medication when a PS refuses medication approved per a court-ordered substituted judgment plan.[21]

There is no indication in the policy whether and where the medication administration must be recorded, though this generally appears to be recorded, in practice, in PS medical records.

(ii) Emergency Treatment Orders (ETOs)

This option permits involuntary medication "[i]f a PS presents in a psychiatric emergency such that leaving him untreated would result in potential harm to self or others, or an intolerable level of distress."[22] The decision to give an ETO is "contingent on a risk assessment…that contextualizes the current behavioral presentation with the PS historical and current risk factors for serious violence leading to significant self-harm or personal injury." [23] "Behaviors that may necessitate an ETO include, but are not limited to, unremitting self-harm that is causing injury to the PS; serious harm to staff or other PS; escalating aggression that cannot be verbally deescalated; and mental health emergencies such as catatonia or delirium."[24]

An ETO to treat a behavioral emergency is documented in an ETO Progress Note in the PS medical record.[25] In practice, BSH staff use the term ETO interchangeably with "EMO" in medical records.

(iii) Medication Restraint

This procedure permits involuntary medication "[i]f a PS volitionally engages in dangerous behaviors (i.e.[,] not related to a mental illness) which places self or others at imminent risk of harm, and less restrictive interventions are unsuccessful at deterring these behaviors."[26]

An order must be documented as a Medication Restraint and documented in a Medication Restraint Progress Note.[27]

(iv) Irreversible Deterioration Orders (IDOs)

An IDO permits involuntary medication "[i]n instances when a PS is at risk of immediate substantial and irreversible deterioration of his mental illness due to refusal of treatment and requires sustained treatment with medication to prevent permanent harm to himself.[28] The policy further states, "[w]hen the BSH provider determines that the PS does not have the capacity to make

[21] Bridgewater State Hospital Policy and Procedure Manual – Use of Involuntary Psychotropic Medication, 5.1 (effective 1/24/2020).
[22] *Id.* at 5.2.1.
[23] *Id.* at 5.2.4.
[24] *Id.* at 5.2.4.
[25] *Id.* at 5.2.7.
[26] *Id.* at 5.3.1.
[27] *Id.* at 5.3.4.
[28] *Id*.at 5.4.1.

decisions regarding treatment with antipsychotic medications" with suffer the aforementioned irreversible deterioration, "the provider must file the necessary paper with the BSH Legal Department to file for adjudication of incompetence and court approval or a treatment plan."[29]

When the Medical Executive Director approves of the IDO, the order is documented as a progress note in the PS medical record.[30]

Strikingly, the BSH *Use of Involuntary Psychotropic Medication* policy is silent as to whether any of the authorized forms of non-court-ordered involuntary medication orders must be reported to the DOC Commissioner as chemical restraints, per G.L. c. 123, § 21. At the same time, the Bridgewater State Hospital Policy and Procedure Manual – *Use of Seclusion and Restraint* (effective 1/24/2020) explicitly includes the reporting obligations to the DOC Commissioner, but focuses on the use of physical and mechanical restraints on PS.[31] Additionally, unlike the expansive descriptions regarding situations in which ETOs are permitted, the *Use of Seclusion and Restraint* policy explicitly adheres to the language of § 21 regarding when restraint can occur – "only situations that can justify the use of seclusion and restraint are causes of emergency, such as the occurrence of, or serious threat or, extreme violence, personal injury, or attempted suicide."[32]

DLC's monitoring has allowed us to see how these policies are implemented in real time. We have reviewed medication records, incidents reports, and nursing reports in which ETOs and IDOs are referenced. We have also attended meetings where these involuntary medication orders are discussed. BSH does not report medication orders to the DOC Commissioner, its Governing Body, or DMH – unless reference to an ETO or IDO happens to be within the extensive documentation associated with seclusion, manual holds, and mechanical restraints that is provided to the DOC Commissioner. As a result, there is no oversight of the use of medication orders and no opportunity to compare BSH use to DMH use of medication orders. This is vital to understanding the current BSH model, as the lauded dramatic decrease in use of physical restraints and seclusion at BSH should not be celebrated if it is achieved through reliance on forced and/or excessive medication.

DLC has observed regular use of ETOs throughout the monitoring period. ETOs generally involve a combination of Haldol, Ativan, Benadryl and/or Thorazine, which are typically the medications used to restrain psychiatric patients in mental health facilities, and which are considered a medication or chemical restraint. Perhaps unsurprisingly in light of the BSH policy language quoted above, ETOs appear to be imposed at times in situations that, at least as described in documents, do not fit within the narrowly tailored emergency situations delineated in G.L. c. 123, § 21. And, although ETOs constitute chemical restraints, Wellpath does not record or report them as such internally or to the DOC Commissioner. DLC has requested clarification as to reporting practices in compliance

[29] *Id.* at 5.4.2.
[30] *Id.* at 5.4.4.
[31] Bridgewater State Hospital Policy and Procedure Manual – *Use of Seclusion and Restraint*, 9.1 (effective 1/24/2020).
[32] *Id.* at 5.3.4.

with § 21 and has yet to see reported BSH restraint data that recognizes the use of ETOs at BSH as chemical restraints. As a rule, restraint data for BSH and the OCCC Units consistently includes only physical/mechanical restraints and seclusion.

Based on our observations, DLC also has serious concerns about Wellpath's use of IDOs, both as to the duration of the orders and whether each administration of medication meets the *parens patriae* legal standard. DLC has viewed records in which Wellpath issues long-term IDOs (e.g., six-month orders) authorizing staff to repeatedly force medicate PS without court order and, it appears, without DOC and Wellpath promptly seeking a court-ordered substituted judgment treatment plan in keeping with the law of the Commonwealth.[33] DLC is also aware of IDOs being applied when records do not suggest the presence of the "rare circumstances" of immediate, substantial, and irreversible deterioration of a serious mental illness.[34] For example, records indicate that Wellpath uses IDOs in some cases for behavior control and prevention. Absent a legitimate justification of preventing irreversible decline, an IDO constitutes a chemical restraint.

Thus, DOC and Wellpath appear to be evading compliance with the plain language, purpose, and spirit of Massachusetts law limiting the imposition of restraint by mental health treatment providers by hiding behind labels they have created. DLC has deep concerns that PS are being subjected to rights violations and physical abuse due to BSH policies and practices.

DLC maintains that provision of medication with informed consent must be a priority and vehemently objects to the use of forced medication on PS in violation of Massachusetts law.

Wellpath must not use ETOs in situations that do not fit within the narrowly tailored emergency situations delineated in G.L. c. 123, § 21 and must appropriately record and report use of ETOs as chemical restraint. Likewise, IDOs must be used only "in rare circumstances" to prevent "immediate, substantial, and irreversible deterioration of a serious mental illness…in cases in which 'even the smallest of avoidable delays would be intolerable'" [35] **and, should the need continue, be promptly followed by the filing of petition for a *Rogers* guardianship.**

While Wellpath maintains lower rates of restraint and seclusion than recorded in pre-transition data, DLC's observations indicating a failure to accurately record and include chemical restraint suggests that those low rates are longer an appropriate measure of success. The Commonwealth should demand that DOC and Wellpath accurately record and report data and documentation on the use of forced medication (ETO/IDOs), physical restraints, mechanical restraints and seclusion. DLC recommends that all such data be reported to DLC on a regular basis. Without this data and documentation, the care and treatment PS receive at

[33] *See Rogers, 390 Mass.* 512; *compare* 104 CMR 27.10(1)(e).
[34] *Rogers*, 390 Mass at 511-512.
[35] *Id.* at 511-512,

BSH and in the OCCC Units cannot be measured against the data and standards in DMH facilities.

DLC recommends that, to resolve medication administration issues, all individuals in need of "strict security" psychiatric evaluation and/or treatment should be placed under the DMH umbrella. Based on DLC's observations, maintaining DOC's control over BSH will foreseeably permit variation in both quality of care and compliance with legal requirements.

Finally, as Wellpath has developed telepsychiatry providers in the absence of on-site providers, DLC strongly encourages Wellpath to provide all psychiatric assessments and treatment on-site and in-person to ensure that proper standards are being observed.

4. Access to Programming and Treatment for Persons Served with Intellectual and/or Developmental Disabilities

For the first time in years, Wellpath has reconvened group programming for five (5) individuals with developmental and/or intellectual disabilities in the Developmental Services Program (DSP). The DSP is also fully staffed. However, as raised in DLC's May 18, 2018 report, there continues to be a complete lack of engagement with the Department of Developmental Services (DDS) in any treatment or discharge planning for BSH PS. Unlike other PS at BSH, the PS in the DSP are currently commingling for in-person services even though they do not all live in the same housing units.

It is important to note that, during this reporting period, an individual with autism spectrum disorder was among those ordered to be secluded most often. In March 2020, Wellpath reported that the "primary reasons for seclusion continue to be threat or occurrence of extreme violence or self-injury in the context of psychosis, mania, catatonia and an individual with co-morbid Autism Spectrum Disorder, Bipolar Disorder and Antisocial Personality Disorder." This raises concerns about the treatment available, response to self-injurious behaviors, and the therapeutic environment for individuals with autism during a reporting period with excessive isolation, limited programming, and increases in seclusion and restraint. Wellpath also noted that PS are experiencing "more catatonia as of late." Wellpath has, notably, used catatonia as a justification for the use of IDOs, an intervention on which neither DMH nor DDS relies.

Treatment modalities regularly used by both DMH and DDS include sensory stimulation and comfort rooms. Prior to the transition to Wellpath, DOC rolled out a rudimentary version of Comfort Rooms. These comfort rooms were, however, repurposed as seclusion rooms when the Intensive Treatment Unit (ITU) was closed during the transition. Now, three (3) years after the transition, Wellpath has finally opened its first Comfort Room as part of de-escalation techniques and treatment options for PS. While DLC acknowledges that much effort has gone into this initiative, outside of BSH and in any DMH environment, it is hard to imagine that it would take three years to fully

incorporate occupational therapy and de-escalation techniques into mental health treatment in an acute psychiatric setting. Comfort Rooms are currently available in only one (1) of the ten (10) BSH Units and one (1) of the two (2) OCCC Units.

DOC and Wellpath must commit to providing appropriate and accessible mental health care to PS with intellectual and/or developmental disabilities. This necessarily includes reviewing best practices for treatment modalities and interventions for individuals with co-morbid mental health and intellectual and/or developmental disabilities; maintaining a robust DSP; and engaging with both DMH and DDS in treatment and discharge planning for PS.

Comfort rooms must be made available to all PS at BSH and in the OCCC Units without further delay.

5. Discharge Planning for Long Term Persons Served

DLC renews its concerns that certain PS are languishing at BSH due to DOC, Wellpath, DMH, and DDS devoting insufficient time and effort to facilitating their discharge to a less restrictive environment.

As in past reports, DLC recommends that DOC, Wellpath, DMH and DDS should have regular clinical meetings to assess readiness for discharge for PS who have resided at BSH for 1 year or more with low or significant improvement in incidence of behavioral problems. In cases where the treatment team and/or forensic evaluators are nonetheless resistant to discharge, and where there are few recent behavioral problems, Wellpath should explore using outside evaluators to assess readiness for discharge or to make other treatment recommendations.

DOC, Wellpath, DMH and DDS need to make additional and more specialized efforts to assess discharge on behalf of: (1) PS under GL c. 123 sec. 7 and 8 who have no pending criminal charges; (2) PS who have dual diagnoses such as I/DD or traumatic brain injury, or neurological disorders who may be particularly ill-suited for BSH, and may benefit from other more specialized services not available at Bridgewater; (3) PS who have complex medical needs or who are advanced in years; and (4) PS who are otherwise vulnerable and who lack the ability to advocate for themselves and/or who have few family, friends or other advocates to act on their behalf.

6. Inequality of BSH and the OCCC Units

State prisoners who are serving sentences are limited to the OCCC Units. On a typical day, there might be roughly 10 men in the ISOU and 30 men in the RU. Because the authority to send men to BSH is tied to the statutory authority under G.L. c. 123, § 8(b), fundamental to the creation of the "Bridgewater Annex" at OCCC was the underlying principle that the programs and services at OCCC would be substantially equivalent to the programs and services at BSH proper. This was the explicit representation made by the Administration when the OCCC Bridgewater Annex was established. Despite those assurances, however, the programs, services and conditions at the RU and the ISOU at OCCC are far from being substantially equivalent to those at BSH proper.[36] DLC notes that DOC and Wellpath have no formal policy on when a PS from BSH may be transferred to the OCCC Units for security purposes, although this has already occurred at least once.

Wellpath has signed up for the impossible task of trying to push DOC culture towards a recovery model of mental health treatment. Yet, this obscures the more important question – how is it acceptable that a population with some of the most serious mental and behavioral health conditions in Massachusetts are being treated in prisons under the direction of DOC rather than DMH? Forcing this Sisyphean task of providing trauma-informed care and a culture of recovery in prison facilities under DOC control is contrary to best practice per any recognized standards for forensic mental health services delivery. DLC monitors the efforts of Wellpath with this framework in mind.

As in all previous reporting periods, Wellpath continues to function with inherent DOC restrictions, especially in the OCCC Units While Wellpath has made genuine efforts to improve the OCCC Units, there remain fundamental challenges and contradictions. Given the differing staffing constructs of the BSH and OCCC units, differing regulations and protocols, and differing union constraints, the disparity between BSH and the OCCC Units may only be fully addressed if the "Bridgewater Annex" is abandoned and all individuals needing "strict security" in the Commonwealth are once again housed together.

The starkest difference between BSH and the OCCC Units goes to the very essence of Bridgewater's existence – the staff charged with maintaining strict security. At BSH, Wellpath staff are trained to handle all aspects of security within the facility. At OCCC, uniformed correctional officers serve as security in a visual and, often, literal clash with Wellpath treating staff. During this monitoring period, DLC received reports of correctional officers in the ISOU making disparaging and even threatening comments to Wellpath Residential Treatment Assistants, interfering with Wellpath-directed activities, and encouraging PS to self-harm.

The same PS behavior would give rise to drastically different security responses at BSH and OCCC. BSH utilizes an integrated approach of de-escalation techniques, medication

[36] See DLC May 2018 BSH Report.

orders, and manual holds. It is significantly more likely for a PS at OCCC to experience a Use of Force by correctional officers, which can include a response team in tactical gear, take-downs, and chemical agents, without meaningful intervention or integration of treating staff. In the BSH scenario, that manual hold or physical restraint would be tracked as such and reported to the DOC Commissioner for review. In the OCCC Units, the Use of Force would be tracked as such and would not be tracked as a restraint, unless an additional mechanical restraint was medically ordered. As such, PS at OCCC are subject to a significantly more intense culture of violence and emergency responses detached from their treatment teams.

The disparities between BSH and OCCC do not stop there. Even within OCCC, the RU and ISOU are not equal in services. Since their creation, PS in the RU have more robust treatment options than the ISOU. During this reporting period, while the RU has had access to the garden, main yard and OCCC main library, the ISOU has not, primarily due to quarantine schedules. Again, the traumatic impact of excessive isolation in quarantine for those who are most acute and awaiting evaluation cannot be underestimated.

Wellpath is wholly responsible for collecting and responding to PS grievances. DLC commends PS Advocate Paul Baker for his role in this process. While the overwhelming majority of grievances filed are unsubstantiated, resolutions such as staff training around shining flashlights in PS faces during 15-minute checks and staff discipline around response to incidents are important examples of the process working. DLC notes, however, that PS Advocate Baker is the only PS Advocate for BSH and the OCCC Units. Because his office is at BSH and there are more BSH PS, PS in the OCCC Units have more limited access to him. In addition, PS in the OCCC Units cannot call PS Advocate Baker using their unit telephones – an issue that DOC and Wellpath have inexplicably failed to resolve. As a result, PS in the OCCC Units are told that they should inform staff when they would like to speak with the PS Advocate, rather than being able to reliably access his services directly. By contrast, DMH's Worcester Recovery and Hospital has three Human Rights Officers for a comparable population.

It is important to highlight that, from March through May 2021, as Massachusetts continued to reopen, BSH saw transfers of state prisoners for evaluation under G.L. c. 123, § 18(a) to the OCCC Units triple (13 to 42) while county § 18(a)'s decreased by half (44 to 22). It is likely that the prolonged and extreme lockdowns in DOC facilities, as compared to reopening in the community, played a role in this trend.

In order to fully resolve disparities at both BSH and OCCC, DLC recommends that all individuals in need of "strict security" psychiatric evaluation and/or treatment should be under the authority of DMH in the same or comparable settings with equivalent access to programming, treatment, and supports.

In the interim, DOC should commit to modeling the OCCC Units on BSH by removing correctional officers from within the units and allowing Wellpath to take control of all programming and security.

DLC also strongly encourages Wellpath to expand the role of the PS Advocate and PS access to the PS Advocate to be in line with psychiatric facilities across the state.

7. Continuity of Care for BSH Persons Served

As part of DLC's expanded role in Line Item #8900-001 during this reporting period, DLC expanded its monitoring to cover continuity of care for individuals who are discharged from BSH to county correctional facilities and DMH facilities. This expansion arose out of DLC's request, driven by persistent observations as BSH monitor, that PS progress and successful stabilization efforts at BSH were too often followed, upon PS transfer, by significant difficulties with adjustment and decompensation. PS and their loved ones have likened leaving BSH and going to county correctional facilities, in particular, to being pushed off of a cliff – going from an environment without correctional officers and with significant resources devoted to individualized mental health treatment and an expansive medication formulary to, in most cases, the opposite. With few exceptions, Massachusetts county correctional facilities offer sparse contact with mental health clinicians who have high caseloads, provide limited access to mental health group programming, and have limited medication formularies that often exclude common mental health medications for reasons related to security and cost. With robust monitoring, DLC is focused on identifying systemic improvements for transfer protocols between BSH and other facilities to obtain better outcomes for PS, which will improve the lives of people with disabilities and serve the interests of public health and safety.

A. Activities During the First Reporting Period of Monitoring Continuity of Care

During this reporting period, DLC hired an Advocate devoted to monitoring continuity of care. This Advocate is a Certified Peer Specialist with extensive experience in addressing gaps in care models and designing and implementing solutions. Diving into the project, the Advocate performed extensive research to become familiar with the unique characteristics of BSH and its interactions with the criminal justice system, county correctional facilities, and psychiatric hospitals.

Existing DLC staff and the Advocate met several times with BSH/Wellpath to discuss the continuity of care and discharge planning. Wellpath reported that they are meeting regularly with DOC clinical partners to improve continuity of care for individuals within the state prison system. Wellpath also reported collaborating to develop a system for implementing cross-DOC facility behavioral support plans for PS that are repeatedly admitted to and discharged from BSH. With respect to collaboration with the county correctional facilities, while Wellpath asserts that they have quarterly meetings, it is clear that coordination and planning with Sheriff's Departments to support PS is not comparable to the efforts with DOC.

DLC conducted outreach to family members of PS to discuss the continuity of care and hear stories about each of their loved one's experiences after discharge from BSH. Many

describe how the failings of continuity of care for individuals in Massachusetts' mental health system led to their loved one to BSH. At the same time, they have seen loved ones stabilized at BSH only to be sent to county correctional facilities where their mental health again declines. Family members report daily frustration and heartache of not being able to provide much-needed support and stability to their loved ones once they leave BSH. In other treatment settings, support networks are included, and, in fact, may even be mandated per a patient request, to assist in treatment planning and aid in recovery.

From clinical meetings to family member forums, many concerns emerged as to why the cliff drop is so steep from BSH to county correctional facilities. Some of these expressed to DLC include:

- County facilities immediately discontinue medications that aided in stabilization at BSH upon admission;
- County facilities lack meaningful mental health services;
- County facilities have a different philosophy of treatment and are more punitive than BSH when responding to disability-related behaviors;
- Former PS refuse treatment post-BSH due to decompensation, lack of trust, and/or stigma in county jails;
- Most county facilities consistently refuse to incorporate family support into mental health treatment;
- County facilities and staff vary with respect to bias against individuals with mental health needs; and
- Courts lack uniformity in their determinations of "strict security."

In addition to gathering opinions and consulting clinicians' expertise, DLC set out to look at the numbers of discharges from BSH. During the reporting period, DLC requested and received extensive discharge data from DOC. DLC specifically thanks the DOC Records Department at BSH for their assistance with data compilation. The data produced accounts for all discharges from BSH and the OCCC Units from January 2020 through April 2020 and includes: date of admission, legal status upon admission to BSH, sending facility/body, discharge date, receiving facility/status, and legal status upon discharge. While data from 2020 and early 2021 were not representative of regular BSH traffic due to the effects of the COVID-19 pandemic, it is nevertheless informative.

Per the data set including all discharges from January 2020 through April 2021, BSH and the OCCC Units had 955 discharges of 827 distinct individuals. People who were discharged more than once during this period accounted for 13.3% (127) of all discharges. 11.2% (93) of the 827 individuals discharged were cycled through more than once and, of those 93 individuals, 20.4% (19) cycled through more than two times. These 954 discharges were sent to the following facilities and/or statuses from BSH and the OCCC Units:

- 304 discharges (31.8%) were directly to county correctional facilities.

- 118 discharges (12.4%) were to DOC facilities.
- 163 discharges (17.1%) were to DMH facilities.
- 221 discharges (23.1%) were to courthouses, with 36 (3.8%) to Superior Courts and 185 (19.4%) to District Courts.[37]
- 129 discharges (13.5%) were to police departments.
- 16 discharges (1.7%) were to the street.
- 4 (0.4%) individuals were discharged from BSH (2) and the OCCC Units (2) upon their deaths.

Informed by the data, DLC drafted and disseminated a continuity of care survey to seventy-eight (78) PS discharged from BSH to county correctional facilities from January 2021 through April 2021. This survey seeks to collect demographic information and feedback regarding: the discharge process from BSH; behavioral health medication at county correctional facilities; behavioral health treatment at county correctional facilities; mental health watch and segregation/restrictive housing at county correctional facilities; and access to natural supports/safety at county correctional facilities. We are now collecting and compiling responses, as well as preparing to send out surveys to individuals discharged from BSH after April 2021.

Finally, during this reporting period, DLC devised a monitoring plan for focused efforts at county correction facilities and DMH facilities that serve PS upon discharge from BSH and initiated contact with facilities. This plan is informed by all of the efforts and data described above as well as fact-gathering regarding mental health services providers employed or contracted by county Sheriff's Departments and Regional Behavioral Evaluation and Stabilization Units run by the Middlesex and Hampden Sheriffs with support from budget line items.[38]

[37] DLC understands that discharges to Superior and District Courts often result in a return to county correctional facilities, depending on bail status.
[38] Massachusetts FY 2021 Budget, Line Item #8910-1101, *Middlesex Sheriff's Mental Health Stabilization Unit*; Massachusetts FY 2021 Budget, Line Item #8910-1010, *Hampden Sheriff's Regional Mental Health Stabilization Unit*.

Conclusion

To ensure the continued improvement of safety and treatment of persons served at BSH and in the OCCC Units, DLC calls on DOC, Wellpath, and the Commonwealth to follow the recommendations discussed above in Sections 1 through 6 and restated below:

DISABILITY LAW CENTER RECOMMENDATIONS:

1. Physical Plant Health and Safety Risks

DLC once again strongly urges DOC to swiftly address mold, moisture, and other existing physical plant issues at BSH.

At the same time, the Commonwealth must commit to shuttering BSH and constructing a new facility designed with trauma-informed person-centered mental health treatment in mind.

In addition to building a new modern facility, all individuals in need of "strict security" psychiatric evaluation and/or treatment should be under the auspices of the Department of Mental Health.

2. Pandemic Response and Reopening

DLC calls upon DOC and Wellpath to ensure that PS are not subject to damaging, prolonged isolation. No matter the requirements of applicable guidance from the Centers for Disease Control and Prevention and the Department of Public Health, DOC and Wellpath are responsible for ensuring that all BSH units accommodate the serious mental health needs of PS. PS confined to their cells for 18 hours or more per day must be provided daily in-cell programming and meaningful access to Residential Treatment Assistants (RTAs) and clinical staff.

3. Chemical Restraint, Irreversible Decline Orders and Statutorily Mandated Reporting

DLC maintains that provision of medication with informed consent must be a priority and vehemently objects to the use of forced medication on PS in violation of Massachusetts law.

Wellpath must not use ETOs in situations that do not fit within the narrowly tailored emergency situations delineated in G.L. c. 123, § 21 and must appropriately record and report use of ETOs as chemical restraint. Likewise, IDOs must be used only "in rare circumstances" to prevent "immediate, substantial, and irreversible deterioration of a serious mental illness…in cases in which 'even the smallest of avoidable delays would

be intolerable'"[39] *and, should the need continue, be promptly followed by the filing of petition for a Rogers guardianship.*

While Wellpath maintains lower rates of restraint and seclusion than recorded in pre-transition data, DLC's observations indicating a failure to accurately record and include chemical restraint suggests that those low rates are longer an appropriate measure of success. The Commonwealth should demand that DOC and Wellpath accurately record and report data and documentation on the use of forced medication (ETO/IDOs), physical restraints, mechanical restraints and seclusion. DLC recommends that all such data be reported to DLC on a regular basis. Without this data and documentation, the care and treatment PS receive at BSH and in the OCCC Units cannot be measured against the data and standards in DMH facilities.

DLC recommends that, to resolve medication administration issues, all individuals in need of "strict security" psychiatric evaluation and/or treatment should be placed under the DMH umbrella. Based on DLC's observations, maintaining DOC's control over BSH will foreseeably permit variation in both quality of care and compliance with legal requirements.

Finally, as Wellpath has developed telepsychiatry providers in the absence of on-site providers, DLC strongly encourages Wellpath to provide all psychiatric assessments and treatment on-site and in-person to ensure that proper standards are being observed.

4. Individuals with Intellectual and/or Developmental Disabilities

DOC and Wellpath must commit to providing appropriate and accessible mental health care to PS with intellectual and/or developmental disabilities. This necessarily includes reviewing best practices for treatment modalities and interventions for individuals with co-morbid mental health and intellectual and/or developmental disabilities; maintaining a robust DSP; and engaging with both DMH and DDS in treatment and discharge planning for PS.

Comfort rooms must be made available to all PS at BSH and in the OCCC Units without further delay.

5. Discharge Planning for Long Term Persons Served

As in past reports, DLC recommends that DOC, Wellpath, DMH and DDS should have regular clinical meetings to assess readiness for discharge for PS who have resided at BSH for 1 year or more with low or significant improvement in incidence of behavioral problems. In cases where the treatment team and/or forensic evaluators are nonetheless resistant to discharge, and where there are few recent behavioral problems, Wellpath should explore using outside evaluators to assess readiness for discharge or to make other treatment recommendations.

[39] *Rogers*, 390 Mass. at 511-512.

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DLC also strongly encourages Wellpath to expand the role of the PS Advocate and PS access to the PS Advocate to be in line with psychiatric facilities across the state.

DLC looks forward to providing recommendations addressing issues related to continuity of care for BSH PS discussed in Section 7 at the close of the next reporting period.

Appendix A: Glossary of Acronyms Used in the Report

BSH	Bridgewater State Hospital
CU	Containment Unit
DDS	Department of Developmental Services
DLC	Disability Law Center
DMH	Department of Mental Health
DOC	Department of Correction
DSP	Developmental Services Program
ETO	Emergency Treatment Order
IDO	Irreversible Deterioration Order
ITU	Intensive Treatment Unit
ISOU	Intensive Stabilization and Observation Unit in the Bridgewater Annex located at Old Colony Correctional Center
OCCC	Old Colony Correctional Center
PS	Person(s) Served
RU	Residential Unit in the Bridgewater Annex located at Old Colony Correctional Center