Disability Law Center

Massachusetts Protection and Advocacy

Public Report: 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 2023 Budget (Line Item #8900-0001).

July 2023

Introduction and Overview

This report covers the Disability Law Center's (DLC) monitoring of Bridgewater State Hospital (BSH), including the Bridgewater Units at Old Colony Correctional Center (OCCC Units), known as the Intensive Stabilization and Observation Unit (ISOU) and the Residential Unit (RU), pursuant to authority granted by Line Item #8900-0001,[1] for the period from January 2023 through June 2023. DLC is the federally designated Protection and Advocacy agency for persons with disabilities in Massachusetts. DLC's intensive ongoing monitoring of BSH would not be possible without the support and expanded authority granted by Line Item #8900-0001.

During this reporting period, DLC conducted monitoring of Wellpath LLC's (Wellpath) delivery of services at BSH, incorporating assessment of continuity of care for Person Served (PS) upon discharge, through a variety of activities, including:

- Weekly onsite BSH visits;
- Onsite visits to the Intensive Stabilization and Observation Unit and the Residential Unit at Old Colony Correctional Center to meet with facility; staff and current and discharged PS;
- BSH PS video, phone, and in person meetings;
- BSH staff in-person meetings;
- BSH PS Governance Meetings;
- Participation in BSH Governing Body meetings and Department of Mental Health quarterly meetings;
- Requests for data and documentation to Wellpath and DOC;
- Review of Wellpath 24-Hour Nursing Reports;
- Review of DOC video footage of PS physical and chemical restraint, seclusion, and administration of other involuntary medication;
- Review of DOC Incident Reports;
- Review and analysis of BSH physical restraint and seclusion data;
- Review of BSH physical restraint and seclusion orders and documentation;
- Review of numerous PS medical records;
- Review and analysis of PS discharge data;
- Onsite visits to Lemuel Shattuck Hospital, Worcester Recovery Center and Hospital, Tewksbury State Hospital, and Vibra Hospital to meet with facility staff and discharged PS;

[1] FY23 Budget Line Item #8900-0001: "[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 LLC, the department of mental health and county correctional facilities; provided further, that not less than 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 senate president and the speaker of the house of representatives."

- Onsite visit to Nashua Street Jail to tour facility, meet facility staff, and meet with discharged PS;
- Phone interviews with discharged PS in Department of Mental Health hospitals, county correctional facilities, and the community;
- Regular meetings with fellow mental health advocates about BSH; and
- Meetings and correspondence with BSH friends and family group.

In addition to monitoring activities, DLC continues to seek information relative to our open investigations commenced in the last reporting period. As explained in DLC's later report, the investigations include three (3) complaints of violent attacks on PS by staff – two (2) within BSH and one (1) on an individual awaiting evaluation in the ISOU.

At the close of another reporting period, DLC again urgently calls on the Commonwealth to transfer oversight of the BSH population to the Department of Mental Health (DMH) and to construct a new hospital. Both steps are essential to protect the health, safety, and rights of people with complex mental health needs and disabilities who are involuntarily committed to BSH. Efforts aimed at improving BSH's deteriorating physical plant and tamping down violations of PS legal rights, human rights, and bodily autonomy by DOC and Wellpath – even if temporarily successful – will not lead to the significant, sustainable changes required.

In the discussion below, DLC focuses on six (6) broad areas:

1. Key Updates Since DLC's Last Report;
2. Continuing Illegal and Unreported Restraint and Seclusion;
3. Inadequate Access to Medical Care for Persons Served;
4. Treatment of Persons Served in the BSH Annex Units at Old Colony Correctional Center;
5. Persons Served Continuity of Care; and
6. Other Important Issues DLC Is Following.

DLC's comprehensive recommendations for improving the legal rights, health, safety, and treatment of PS can be found in the Conclusion of the report.

1. Key Updates Since DLC's Last Report

DLC's January 2023 report included discussion of: a number of issues related to the physical plant and management of BSH, such as expert findings of continuing widespread mold growth through BSH, sanitation and vermin infestation issues, power outages, ineffective heat mitigation efforts during the summer months; persistent systemic violations of Massachusetts law regarding chemical and physical restraint and seclusion within BSH; DLC's observations of BSH culture, de-escalation practices, and staff training; inadequate language access for individuals with Limited English Proficiency; limited treatment available for PS with substance use disorder and potentially serious irregularities in BSH Medication Assisted Treatment prescribing practices; DLC's concerns about the use of an inhaled "atypical antipsychotic" with contraindications for people with respiratory conditions and dementia; and impediments to and experiences of PS with continuity of care following discharge from BSH.[2]

In recent news, Governor Healey's Administration issued its first "Five-Year Capital Investment Plan" on June 22, 2023. The Plan states that "Human Services leadership and agencies will be engaged with their colleagues in Public Safety and Corrections around the long-term strategy for Bridgewater State Hospital." In addition, the Plan provides funding to restart and conclude the Division of Capital Asset Management and Maintenance (DCAMM) study of "the development of a new Forensic Psychiatric Hospital to be under the direction of the Department of Mental Health (DMH) – which would mean moving those services from DOC to DMH."[3]

DLC met with the President of Wellpath's Recovery Solutions Division within which BSH falls on May 9, 2023. The meeting allowed for a constructive discussion of DLC's concerns about Wellpath staff, administration, and treatment provided to PS as well as a sharing of information about Wellpath's transition to a new Hospital Administrator, a change that DLC strongly supports. Wellpath was unable to provide substantive responses to the majority of concerns DLC raised in our January 2023 report or indicate when DLC could expect a response. Beyond the change in the BSH Hospital Administrator, Wellpath experienced leadership turnover during this reporting period in the following positions: Risk Manager, Director of Performance Improvement, Human Resources Manager and Chief Nursing Officer. Some of these positions remain vacant.

On June 7, 2023, the Commissioner of the Massachusetts Department of Correction (DOC) responded to DLC's January 2023 report. The DOC response covered eleven (11) broad areas it titled as follows: "Physical Plant"; "Emergency Medication, Seclusion, and Restraint"; "De-escalation Practices Training, and Culture"; "Access to Confidential Documentation"; "Language Access for Persons Served"; "Co-occurring Substance Use Disorder Treatment"; "Use of Atypical Medications;" "Access to Medical Care"; "Continuity of Care"; "Gender Non-conformity"; and "Disability Accommodations." While DLC encourages all to read DOC's response, **attached hereto as Appendix B**,[4] in its entirety, DOC's major points and related DLC monitoring observations and comments are summarized in Subsections A through K below.

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[2] DLC, *Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served* (January 2023), https://www.dlc-ma.org/wp-content/uploads/2022/07/DLC-BSH-Report-July-2022-Final.pdf (hereinafter "DLC January 2023 Report").
[3] Commonwealth of Massachusetts, *Five-Year Capital Investment Plan – Fiscal Years 2024-2028* (June 22, 2023) at 26, https://www.mma.org/wp-content/uploads/2023/06/FY24-FY28CapitalInvestmentPlan.pdf.
[4] The document referenced as Appendix 1 in the June 7, 2023 was omitted from the original transmission and provided on June 30, 2023.

A. Physical Plant: Mold, Sanitation, and Heat Mitigation

DOC's June 7, 2023 Response:[5]

DOC acknowledged that, despite disagreements between DLC and the agency, DLC's "continuing concerns with the safety of the physical plant are genuinely held." DOC emphasized that it "continues to make substantial improvements to the condition of BSH's physical plant and to perform all necessary cleaning and testing." To address pest control issues, DOC reported working closely with Wellpath on sanitation practices and utilizing contractor Flynn Pest Control, which assesses the physical plant and any emerging issues weekly. "Exclusion work on identified areas of concern are prioritized, as is the continuous removal of trash and debris that could invite pests."

In addition, recognizing that DLC's expert and DOC's contracted vendors have different views concerning the threat of mold exposure in the facility, DOC offered to retain a mutually agreed upon vendor to "conduct a new assessment of air quality in the physical plant."

DLC Monitoring Observations and Comments:

DLC is pleased to learn of DOC's focus on sanitation and preventing recurrent pest infestation at BSH. Further, DLC appreciates DOC's offer to choose a mutually acceptable vendor to assess the air quality at BSH. However, in keeping with the opinion of DLC's expert and existing industry standards, DLC must reaffirm that air quality testing cannot adequately address the threat that persistent mold growth at BSH poses to the health and safety of PS and BSH staff. It is accepted in the mold remediation industry that visible mold growth, mold growth confirmed by surface swab sampling, and chronic moisture must be resolved. DLC's expert has confirmed the presence of all three (3) of these unacceptable conditions during three (3) separate site visits in 2019, 2021, and 2022, followed by lab testing of surface samples taken.[6] Until these obvious problems are addressed appropriately, collecting air samples would misrepresent the actual mold contamination to which people inside BSH are exposed daily. Absent an agreement to also contract with a vendor to conduct a thorough visual inspection and surface swap sampling (not tape-lift sampling) at BSH, DOC's offer will not resolve continuing concerns about environmental toxins throughout the facility.

Although discussed in DLC's January 2023 report, DOC's response is silent regarding any changes to BSH's heat mitigation plan and repeated power outages. However, DLC is aware of several heat mitigation plan improvements during this reporting period. DOC reported transitioning from heat to "conditioned air" the week of June 3, 2023, installing window air conditioning units in all classrooms in the Attucks building, and replacing a split air conditioning unit in the Bradford 1 treatment office. In June, the Superintendent of BSH and OCCC indicated that DOC and Wellpath's new Hospital Administrator are working together on heat mitigation and are keeping in mind Department of Public Health recommendations as well as humidity and heat index in their planning. One stated goal is to have consistency between BSH and the OCCC Units. Thus far, this cooperation has notably given rise to misters for PS to utilize while outside in the yards and outdoor pavilion.

DLC finds the enhanced focus on heat mitigation since our last report encouraging. Still, minor improvements and measures that do not address the heat in PS cells mean that PS are still in danger. As reported previously, BSH units have only "conditioned air," rather than air

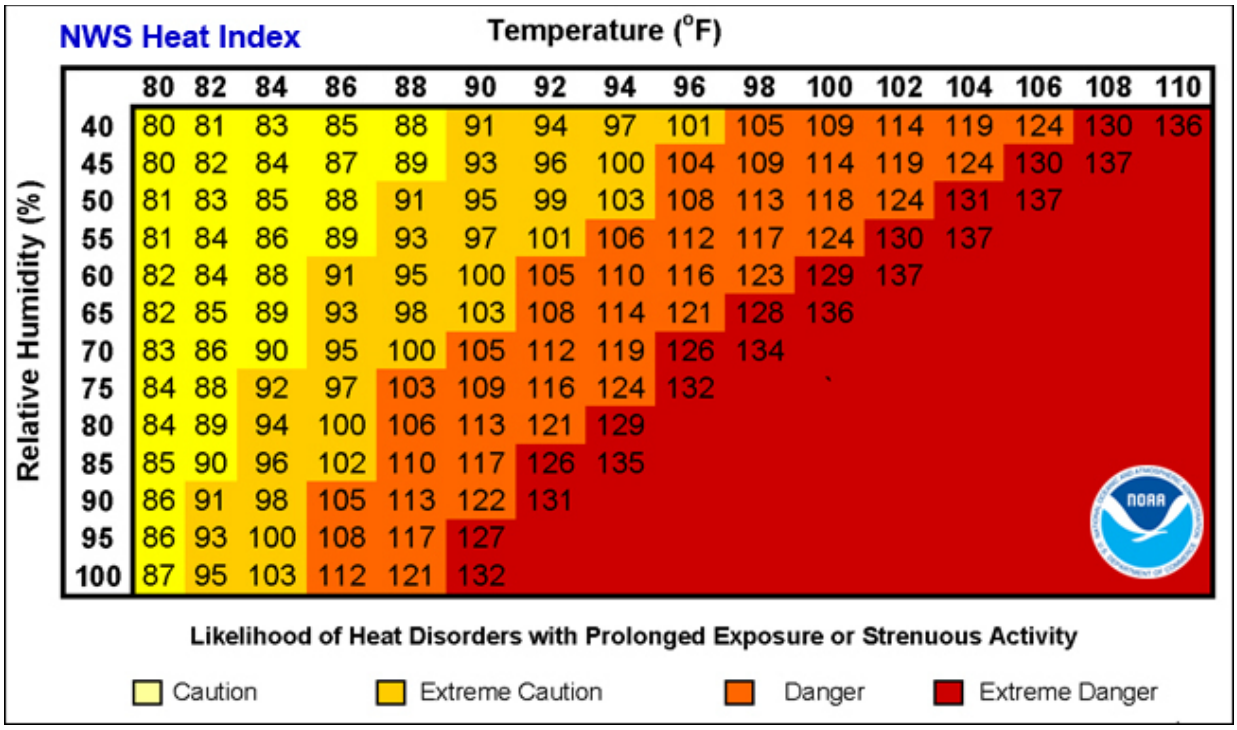
[5] App. B at 1-2.
[6] See DLC's January 2023 report at 10-12.

conditioning, with the exception of areas where DOC has installed separate air conditioning unit. PS report that the "conditioned air" vents in their cells provide limited air flow and little or no relief on hot days. Moreover, power outages during summer months, like those that happened last year, would impact BSH's existing cooling mechanisms.

The humidity and moisture throughout BSH units means that the heat index, rather than the temperature, is key to determining the risk to PS. Per the National Weather Service,

> The heat index, also known as the apparent temperature, is what the temperature feels like to the human body when relative humidity is combined with the air temperature… When the body gets too hot, it begins to perspire or sweat to cool itself off. If the perspiration is not able to evaporate, the body cannot regulate its temperature. Evaporation is a cooling process. When perspiration evaporates off the body, it effectively reduces the body's temperature. When the atmospheric moisture content (i.e., relative humidity) is high, the rate of evaporation from the body decreases. In other words, the human body feels warmer in humid conditions.[7]

The National Weather Service's chart[8] below shows the heat index, based on the air temperature and relative humidity, and identifies the likelihood of heat disorders with prolonged exposure or strenuous activity for the average person. It does not, however, account for increased sensitivity to heat based on psychotropic medications, age, or underlying medical issues.



Conditions at BSH are unacceptable for this population of persons with disabilities – a population who should be treated in air-conditioned hospitals licensed by DMH. As described in

[7] *What is the heat index?*, NATIONAL WEATHER SERVICE, https://www.weather.gov/ama/heatindex.
[8] *Id.*

DLC's last report, extreme heat may: lead PS taking psychotropic medications to suffer hyperthermia, which can be fatal; place PS who are older and/or have co-occurring medical conditions, such as heart disease, at risk; and have mental health impacts due to interference with sleep and increased irritability, symptoms of depression, and suicidality.[9] Psychiatric medications "can interfere with hypothalamic-set body temperature, impede the thermoreceptors (nerve endings that detect temperature on our skin and skeletal muscles), and reduce or accelerate sweat production."[10] The table below[11] shows several major types of psychiatric medications and their heat-related symptoms.

Types of Psychotropic Medications	Heat Intolerance	Low Blood Pressure	Fainting from Heat	Excessive Sweating	Decreased Sweating	Reduced Alertness in Heat	Lethargy, Confusion in Heat
Antipsychotics	YES	YES	YES	NO	YES	YES	YES
Benzodiazepines	YES	YES	YES	NO	NO	YES	YES
Serotonin and norepinephrine reuptake inhibitors (SNRI)	YES	YES	YES	YES	NO	YES	YES
Selective serotonin reuptake inhibitors (SSRI)	YES	YES	YES	YES	NO	YES	YES
Tricyclic Antidepressants (TCA)	YES	YES	YES	NO	YES	YES	YES

As a prison, BSH's hot conditions are not unique, although some DOC facilities do have air conditioning in prisoner cells. Sadly, heat-related deaths of incarcerated people with disabilities are not uncommon.[12] The Commonwealth must ensure that similar tragedies do not occur here.

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[9] American Psychiatric Association, *Extreme Heat Contributes to Worsening Mental Health, Especially Among Vulnerable Populations* (June 30, 2021), https://www.psychiatry.org/newsroom/news-releases/extreme-heat-contributes-to-worsening-mental-health-especially-among-vulnerable-populations.

[10] Deborah Serani Psy.D., *Heat Intolerance and Psychiatric Medications*, PSYCHOLOGY TODAY (July 21, 2021), https://www.psychologytoday.com/us/blog/two-takes-depression/202107/heat-intolerance-and-psychiatric-medications.

[11] The source of the table's content is: Deborah Serani Psy.D., *Heat Intolerance and Psychiatric Medications*, PSYCHOLOGY TODAY (July 21, 2021), https://www.psychologytoday.com/us/blog/two-takes-depression/202107/heat-intolerance-and-psychiatric-medications.

[12] *See, e.g.*, The Marshall Project, *"Cooking Them to Death": The Lethal Toll of Hot Prisons* (October 11, 2017), https://www.themarshallproject.org/2017/10/11/cooking-them-to-death-the-lethal-toll-of-hot-prisons; *McCollum v. Livingston*, No. 4:14-CV-3253, 2017 WL 608665 (S.D. Tex. Feb. 3, 2017) (describing a the heatstroke death of a prisoner diagnosed with depression, diabetes, and hypertension, and acknowledging 10 health-related deaths in that facility during the same summer in 2011); Michael Schwirtz, *$2.25 Million Settlement for Family of Rikers Inmate Who Died in Hot Cell*, N.Y. TIMES (October 31, 2014), https://www.nytimes.com/2014/11/01/nyregion/settlement-for-family-of-rikers-inmate-who-died-in-overheated-cell.html ("Jerome Murdough, died on Feb. 15, when the temperature in his cell in a mental health unit at Rikers exceeded 100 degrees…He was put in a cell at Rikers, in a unit reserved for inmates

Despite continuing efforts by DOC to improve physical conditions within BSH, pervasive mold and oppressive heat during the summer months are just some of the many reasons that care and treatment of BSH PS must be transferred to DMH, and a new facility constructed.

B. *Involuntary Medication, Seclusion, and Restraint and BSH Implementation of Review of Serious Clinical Episodes*

DOC's June 7, 2023 Response:[13]

DOC has retained Dr. Debra A. Pinals as an independent expert consultant "to examine the use of Seclusion, Restraint, Emergency Treatment Orders (ETO) and Involuntary Medication Practices at BSH to ensure that practices at BSH are in line with the best interests of the [PS] and nationally recognized best practices." DOC stated its intention to enhance efforts to "minimize unnecessary delays in the adjudication of petitions for commitment because such delays prevent clinical staff from treating [PS] according to a court-authorized treatment plan."[14] DOC explained that between July 1, 2022, and January 31, 2023, 21% of the 331 ETOs were on PS with pending commitment petitions and 44% involved a PS undergoing evaluation "before Wellpath ha[d] determined whether a commitment petition was warranted." DOC touted the improvement in PS once clinicians are able to implement a *Rogers* treatment plan and stated its belief that "in a majority of instances where Wellpath issued [ETOs], there was no alternative means by which to treat a [PS] with medication involuntarily."

DOC acknowledged "DLC's concern that the use of the term "Emergency Treatment Order" is not aligned with M.G.L. c. 123, § 21 and 102 CMR 27.12, and the case *Rogers v. Comm 'r of the Dep 't of Mental Health*, 383 Mass. 489 (1983) and that DLC conceptualizes this treatment as 'chemical' or 'medication restraints.'" But DOC continued that "[i]t remains the case – I have explained in prior letters – that an ETO is not a form of restraint." Nevertheless, DOC expressed commitment to revising the Use of Involuntary Psychotropic Medications policy and Use of Seclusion and Restraint policy "to utilize the terminology [DLC] feel[s] is required by G.L. c. 123 and regulations."

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with mental illness."); *Hinojosa v. Livingston*, 994 F. Supp. 2d 840, 842 (S.D. Tex. 2014) (denying motion to dismiss of disability discrimination claims in a case concern the death from hyperthermia of the prisoner diagnosed with schizophrenia, depression, hypertension, diabetes, and obesity*); $750,000 Settlement in Alabama Prisoner's Heat Death*, PRISON LEGAL NEWS (March 15, 2010), https://www.prisonlegalnews.org/news/2010/mar/15/750000-settlement-in-alabama-prisoners-heat-death/ ("A $750,000 settlement was paid to the mother of an Alabama mentally ill prisoner who died as the result of exposure to extreme heat while on psychotropic medication… [the correctional facility] has an air conditioned mental health unit [but the prisoner] was not placed in the unit and was housed in a regular segregation cell."); Dan Moran and John Hurst, *Officials Seek Answers in Heat-Wave Deaths of 3 Prison Inmates : Medication: The men were all using mind-altering drugs known to raise body temperatures*, L.A. TIMES (July 6, 1991), https://www.latimes.com/archives/la-xpm-1991-07-06-mn-1565-story.html ("It seems significant that all three of the patients who died were on (anti-psychotic) medications…The drugs used by the prisoners cause dehydration, but the tranquilizing effect may mask thirst.").

[13] App. B at 2-3.

[14] DOC noted correctly that Wellpath cannot get a *Rogers* petition granted by a district court absent an order of civil commitment to a psychiatric facility and that *Rogers* treatment plans can be ordered by a probate and family court, regardless of commitment status, as part of guardianship proceedings. DOC commented that the latter process takes longer. App. A. at 2 n.1.

DOC also established a Serious Clinical Episode (SCE) policy, creating a procedure "where all Serious Clinical Episodes, including instances of seclusion, restraint, or emergency medical treatment, are reviewed (both the video footage of the event and the supporting documentation) by the Serious Clinical Episode Oversite Committee."

DLC Monitoring Observations and Comments:

DOC's decisions to retain Dr. Pinals and revise policies pertaining to the use of involuntary medication, seclusion, and restraint are positive updates. However, DOC's intransigent restatement of its position that ETOs do not constitute chemical restraint does not inspire confidence. DLC calls upon DOC and Wellpath to include DLC and the Massachusetts Association of Mental Health (MAMH) in drafting policy revisions and to consult with the Department of Mental Health concerning the requirements of Massachusetts law. As Section 2 below makes clear, the need for change in BSH's illegal restraint, seclusion, and involuntary medication practices is urgent.

DLC agrees with DOC that preventing unnecessary delays in commitment and *Rogers* petition hearings is very important. However, the primary importance of ensuring that hearings proceed without undue delay is that it better protects PS legal rights and interests – not that it will hasten or otherwise support Wellpath's utilization of forced medication. Underlying DOC's response is the notion that reliance on involuntary medication as a primary form of treatment should be encouraged, even before a court-ordered treatment plan is approved. This fails to recognize what the Supreme Judicial Court did in 1981 – that "few legitimate medical procedures [] are more intrusive than the forcible injection of antipsychotic medication,"[15] as well as the many legal protections in place to stop providers from using involuntary medication by default.

Finally, DLC finds the new SCE review process very encouraging and responsive to many of DLC's concerns about the lack of oversight of staff uses of force and administration of seclusion, physical restraint, and ETOs. The relevant policy broadly defines Serious Clinical Episode (SCE) as:

> Any event, or incident, within the hospital that may impact the safety of the person served, the staff, and/or the safe running of the hospital. This may include, but is not limited to, property destruction, administration of involuntary medication (i.e., irreversible decline order, emergency treatment order, court authorized treatment back up order, and medication restraint), self-directed violence, application of mechanical restraints, use of manual holds, the occurrence or threat of extreme violence, seclusion and restraint episodes, and emergency codes.[16]

According to the policy, the Safety Director, Director of Clinical Services, and Chief Nursing Officer are to conduct an initial screening of "100% of SCEs on a concurrent daily basis" using shift reports, electronic medical records, and video footage. The SCE Oversight Committee, which also includes the Medical Executive Director and Hospital, then meets weekly and reviews a "10% random sample" of SCEs for "performance improvement and training opportunities" as well as SCEs referred from the daily screening that require further review. A disposition is then issued indicating whether there is a need for staff "re-education," corrective

[15] See *Matter of Guardianship of Roe*, 383 Mass. 415, 435-438 (1981).
[16] Bridgewater State Hospital Policy and Procedure Manual – Serious Clinical Episode - Review Process, 6.1 (January 19, 2023).

action, internal investigation, or referral to the Disabled Persons Protection Commission (DPPC).[17]

DLC has started requesting aggregate data regarding disciplinary actions, terminations, and DPPC referrals and/or complaints per month. Moving forward, DLC will monitor the impact of the SCE Review Process through interviews with staff and PS and data review. Enhanced oversight of SCEs, however, will not fully address the troubling, often violent incidents that occur within BSH until DOC and Wellpath implement restraint and involuntary medication policies that comport with Massachusetts law.

C. De-escalation Practices, Training, and Culture

DOC's June 7, 2023 Response:[18]

DOC expressed agreement with DLC that seclusion and restraint "must be avoided when 'interven[tion] with de-escalation technique[s]' would be effective." DOC invited DLC to attend a Mandt training. DOC outlined Wellpath's employee handbook guidance for how employees "are encouraged to voice any concerns related to safety or performance issues among coworkers and are required to report any misconduct toward [PS]." According to DOC, employees can make complaints to Human Resources, to management, and confidentially.

DLC Monitoring Observations and Comments:

As detailed in the January 2023 report, DLC did, in fact, attend two Mandt trainings for BSH staff in the last reporting period.[19] Indeed, DLC's concerns about the content and approach of the Mandt training offered at BSH are based on firsthand observations during the trainings attended. DLC acknowledges the content of Wellpath's employee handbook, but restates that, if accepted BSH policies, practices, and trainings do not conform with Massachusetts law and/or appropriate standards for psychiatric care, many employees will not have the knowledge and tools necessary to make the reporting requirements meaningful. Moreover, according to a letter from an anonymous group of long-time BSH direct care staff sent to DLC during the last reporting period and reports to DLC while onsite, Wellpath employees who do have concerns about what is happening within the prison walls do not come forward due to fear of retaliation and an overall sense of disrespect and unresponsiveness to their concerns.[20]

D. DLC Access to Confidential Documentation

DOC's June 7, 2023 Response:[21]

DOC responded to DLC's update in the January 2023 report that DOC abruptly stopped producing documentation previously provided to DLC as part of monitoring, leading DLC to open an investigation pursuant to federal Protection and Advocacy authority. DOC stated that its position requiring DLC to formally invoke its authority was necessary. Further, because it ultimately produced the documentation after the close of the reporting period, DOC took the

[17] *Id.* at 5.1, 5.5.
[18] App. B at 3-4.
[19] DLC's January 2023 Report at 32-33 ("Having witnessed a range of interactions between PS and staff – from the respectful and de-escalatory to the instigative and abusive – DLC observed two BSH Mandt trainings in the hopes of learning more about how staff learn these methods….").
[20] *See* DLC's January 2023 Report at 8.
[21] App. B at 4.

position that it did "not decline[] to provide [DLC] with the requested information that was available."

DLC Monitoring Observations and Comments:

DOC has yet to explain the basis for its decision to suddenly require DLC to find probable cause to open an investigation, instead of continuing to produce the documentation to DLC pursuant to the authority that our organization has to monitor under federal law and Line Item #8900-0001. DOC's motivation aside, there was – and still is – ample evidence to support a finding of probable cause that BSH PS are being subjected to abuse and neglect as a result of restraint, seclusion, and involuntary medication practices and DLC can confirm that we have consistently received responsive records from DOC during this reporting period.

E. Language Access for Persons Served

DOC's June 7, 2023 Response:[22]

DOC "acknoweldge[d] the difficulty of providing diverse language coverage through specially trained forensic bilingual clinical staff and service providers in a strict security psychiatric facility." Responding to DLC's recommendations, DOC reported that Wellpath is considering making bilingual fluency a basis for a pay rate increase; BSH has identified a Language Access Monitor "responsible for monitoring and tracking language access issues"; Wellpath is using the Office of Criminal Justice Service's 'I Speak' language identification cards in the admissions area to assist the identification of a [PS]'s proficient language"; Wellpath has "improved signage in the admissions area and housing units to highlight programming in other languages; and rehabilitation coordinators are made aware of LEP PS and assign them programming accordingly. At the time of its response, DOC said, "there are 11 Limited English Proficient (LEP) [PS], including three Russian speakers, one Burmese speaker, one Vietnamese speaker, one Taishanese speaker and five Spanish speakers." Once a PS's primary language is identified, PS with LEP can participate in English language groups using the "Voyce tablet" with a live remote interpreter and access translated written materials.

DLC Monitoring Observations and Comments:

The progress in implementing DLC's recommendations to improve language access is promising. Introduction of language identification cards upon admission and greater availability of Voyce tablets, assigned to the rehabilitation department and each of the housing units, has the potential to greatly improve access to information for PS with LEP. However, DOC confirmed little change in direct access to non-English treatment and activity groups – BSH still offers groups only in English, Spanish, and Russian. DLC again calls on DOC and Wellpath to expand group programming offerings in Spanish, Haitian-Creole, and other languages as needed to suit the needs of the BSH population. DLC also learned that the Language Access Monitor responsibilities were assigned to the Person Served Advocate; DLC has concerns about further burdening the limited Wellpath positions created to advocate for PS rights and interests.

Finally, DLC must emphasize that translation alone is not sufficient to provide PS with culturally competent mental health care. BSH, in caring for and promoting recovery for people with acute mental health disabilities, must strive to provide care that accounts for the cultural and communication need of PS with diverse backgrounds and experiences related to their racial,

[22] App. B at 4.

ethnic, disability, religious, gender, and LGBTQ+, and other identities. See Section 2.G. below for a discussion of BSH's failure to gather vital race/ethnicity information from PS.

F. *Treatment for Persons Served with Co-occurring Substance Use Disorder*

DOC's June 7, 2023 Response:[23]

Recognizing that substance use disorder (SUD) is a frequent comorbidity for PS, DOC confirmed that BSH has offered assessment and treatment for substance use disorder for years and offered Medication Assisted Treatment (MAT) since 2021. "When [PS] are actively enrolled in a MAT treatment program, treatment at BSH is continued, and if such treatment is not continued, justification for cessation must be provided by the clinical provider." DOC "welcomed DLC's suggestion to audit the delivery of MAT services at BSH," "conducted a thorough record review of MAT Services," and expressed that it "will continue to share statistics and audit findings with DLC." DOC's audit appeared to consist of cataloging PS receiving MAT as of January 18, 2023, by the medication they were receiving: ten (10) PS were receiving Medications for Opioid Use Disorders (MOUD) – three (3) Methadone, five (5) Buprenorphine Naltrexone, and two (2) Buprenorphine sublingual.

DLC Monitoring Observations and Comments:

DLC looks forward to increased transparency around MAT services. Unfortunately, the information DOC provided thus far concerning its audit does not address DLC concerns and recommendations about denial of MAT upon admission and BSH providers making treatment decisions that do not comport with the standard of care and state and federal antidiscrimination law. DLC has engaged an expert to review treatment provided to identified PS with co-occurring SUD to determine whether BSH provider prescribing practices comport with the medical standard of care.

G. *Use of Atypical Medications on Persons Served*

DOC's June 7, 2023 Response:[24]

DOC conveyed that Wellpath initiated the use of Adasuve (inhaled Loxitane powder) "in response to concerns expressed in several DLC reports regarding utilization of injectable medications" and that BSH is certified to administer the medication after completing the Risk Evaluation and Mitigation Strategy (REMS) required by the Food and Drug Administration. DOC confirmed that the medication has been used on "appropriate" PS and "will certainly be responsive to concerns or objections expressed by the independent psychiatric expert in her report."

DLC Monitoring Observations and Comments:

DLC looks forward to reading Dr. Pinal's report and hopes that it will address the appropriateness of using Adasuve on BSH PS. DLC can also share information that BSH's Medical Executive Director reported in the June 2023 Governing Body meeting: "We are pleased to have passed an audit related to our use of this medication and we also note that our

[23] App. A at 4-5.
[24] App. A at 5.

Pharmacy Vendor has interacted with the manufacturer of Adasuve to ensure the adequacy of their REMS program, regarding the safe and appropriate use of this medication." The Medical Executive Director also said that he hoped "to expand the usage" of the drug.

While DLC accepts representations by DOC and Wellpath that BSH is REMS certified, we continue to have concerns about use of Adasuve on PS, given the layered vulnerabilities of BSH's population. Many factors contribute to the vulnerability of PS, including: their involuntary commitment – whether long-term or temporarily for evaluation – to a prison; symptoms or other effects of their mental health disabilities that may impact their behaviors and ability to provide accurate medical histories and informed consent; the prevalence of preexisting medical comorbidities – both known and unknown; PS' generally limited access to information and choice concerning their mental health treatment plans; for many PS, their concern that failure to exhibit unquestioning compliance with Wellpath wishes will prevent their transfer to a licensed DMH hospital; the presence of environmental toxins in the facility; and BSH's reliance on involuntary medication and coercion related thereto. Accordingly, DLC will continue to monitor utilization of Adasuve as part of our monitoring.

H. Access to Medical Care for Persons Served

DOC's June 7, 2023 Response:[25]

In response to DLC's recommendations, DOC "worked with Wellpath leadership to initiate universal sick call procedures" that includes the following:

> All requests for medical attention are now documented on a sick call request form by a person served or with the assistance of a peer support specialist, an advocate or healthcare provider. This sick call request is logged in the unit logbook to monitor "sick call" follow up, which outlines the date of the sick call request, and referral type: Emergent, Urgent or Routine. The sick call request is also scanned into the [PS]'s electronic medical record. Unit nurse managers are required to monitor the logbook daily and follow up on any outstanding issues. In addition, the Department has added a review of the unit sick call logs and sick call response to the general healthcare audits conducted twice annually.

DOC asserted that all PS, "including LEP and persons with disabilities that impact their communication abilities, are providing reliable access to medical and medical equipment," and BSH provides "the community standard of care for screenings for physical health conditions" that includes heightened care management for chronic diseases and utilization of higher levels of healthcare at appropriate hospitals when needed. "Nursing is available and present on each unit 24 hours a day/7 days a week" and "[a] medical provider is accessible on-site 24 hours a day/7 days a week."

DLC Monitoring Observations and Comments:

DLC will continue to monitor medical care at BSH, particularly in light of the enhanced documentation of PS needs through the universal sick call slip process. During this reporting period, DLC continued to receive very concerning reports from PS with untreated or undertreated medical conditions, some of which are discussed below in Section 3.

[25] App. A at 5-6.

I. Continuity of Care for Discharged Persons Served

DOC's June 7, 2023 Response:[26]

DOC emphasized the importance of timely court orders for step downs to DMH facilities. With respect to improving continuity upon discharge, DOC stated that its "Reentry Services Division will collaborate with Wellpath to improve BSH practices to refine the protocol to ensure all [PS] can obtain needed MassHealth coverage once discharged from an inpatient facility" and [DOC] will examine how the Commonwealth's application for a federal waiver of certain Medicaid requirements could assist in continuity of healthcare coverage for [PS] for BSH."

Concerning the ISOU, DOC asserted that ISOU PS receive a high level of care, which includes offerings of four (4) to five (5) structured groups per day, peer support services, SUD treatment, music therapy, and occupational therapy; daily contact with nursing; and at least weekly contact with "Social Services Professionals and Psychiatric Providers." DOC noted the "remarkably low" incidents of *self-directed* violence in the ISOU during DLC's last reporting period, "given the acuity and dysregulation of many of the [PS] in the ISOU."

DLC Monitoring Observations and Comments:

DLC is pleased that the DOC will work to improve upon BSH practices and gather information to prevent gaps in MassHealth coverage and interruptions in continuity of care for discharged PS. Additionally, DLC agrees that daily items appear on the ISOU schedule and various Wellpath staff cycle regularly through the unit. Nonetheless, ISOU PS consistently report experiencing a lack of engagement and access to treatment providers while they are in the unit, despite the fact that ISOU placement is often precipitated by severe mental health decompensation on a Mental Health Watch and/or serious instances of self-harm. For further discussion of the BSH Annex Units at OCCC and issues related to PS continuity of care, see Section 4 and Section 5 of this report below, respectively.

J. Treatment of Transgender Persons Served

DOC's June 7, 2023 Response:[27]

Though DLC included the issue of treatment of transgender PS and compliance with the requirements of M.G.L. c. 123, § 32A, only in the list of important issues DLC is following, DOC proactively asserted that DOC and Wellpath have "clear policies regarding the identification, management, and treatment of gender non-conforming persons in our care" and transgender PS at BSH in the past have been treated appropriately. DOC encouraged DLC to raise concerns in real time.

DLC Monitoring Observations and Comments:

DLC will continue to monitor this issue, included in the January 2023 report based on reports regarding past PS, and be sure to raise concerns as they arise to protect the rights, health, and safety of PS.

[26] App. A at 6.
[27] App. A at 6-7.

K. Disability-Based Accommodations for Persons Served

DOC's June 7, 2023 Response:[28]

Similarly, based on DLC's brief reference to PS access to disability-based accommodations and deficiencies with the BSH reasonable accommodation policy, DOC welcomed DLC's input on suggested changes. Remarkably, in its response provided to DLC over four (4) months after our January 2023 report issued publicly and as the current reporting period was coming to an end, DOC also took time in its response to state that "DLC's continuing practice of waiting six months before raising its concerns in the bi-annual reports is disappointing and undermines any attempt to work together to improve the care provided to [PS]."[29]

DLC Monitoring Observations and Comments:

To increase transparency with DOC, DLC shifted during the second reporting period of 2022 to consolidating our extensive requests for documentation and data and directing them to DOC's Legal Department. DOC's Legal Department now handles all requests for PS records and video footage. Thus, any suggestion that DLC is operating or investigating issues covertly – while reviewing records DOC has provided and engaging in onsite monitoring activities in view of BSH staff – is misleading and ignores the many issues we raise directly with BSH administrators from DOC and Wellpath. Nevertheless, DLC invites greater collaboration with DOC and would be pleased to engage in monthly meetings with DOC and Wellpath representatives to improve communications.

L. Implementation of Evidence-Based Treatment Modalities

DLC has been informed through ongoing monitoring efforts that Wellpath implemented several evidence-based treatments, in keeping with recommendations in previous DLC reports, that have been effective.

In the June 2023 BSH Governing Body meeting and report, Wellpath noted that a PS who was in the top three (3) most restrained individuals during the reporting period significantly reduced the number of restraints after "receiving mentorship from a peer who has helped him greatly in both participating with him in activities along with helping him to reduce his violent behavior." DLC encourages Wellpath to keep expanding opportunities for peer support and devise a program for PS to be trained and certified as peer specialists. In another overdue measure, Wellpath expanded therapy options to include consideration of the numerous PS who are not committed to BSH during their admission. Wellpath changed the "referral and tracking system to increase access to short-term individual therapy for non-committed patients, most of whom live in the Bradford 1 and Bradford 2 units.

Additionally, Wellpath is reviewing and revising the risk assessment template used to evaluate suicidality, improving practices around suicide risk assessment, and has drafted a standardized suicide risk assessment report template with the goal of increasing consistency and quality based on current evidence and best practices. Finally, the psychology department is in the beginning stages of creating a protocol to screen BSH's "aging population for cognitive and/or adaptive declines."

[28] App. A at 7.
[29] App. B at 7.

M. Productive Advocacy to Improve Persons Served Phone Access

During this reporting period, DLC advocated with DOC to resolve issues related to PS phone access. As DLC discussed in our July 2022 report,[30] telephone access has been a frequent source of concern among BSH PS, which can cause conflict among PS vying for essential phone time to maintain contact with their attorneys and loved ones while confined to the DOC facility.

In May 2023, in a welcome step toward addressing phone availability issues, DOC installed additional telephones on most BSH units: five (5) units received a second phone, and two (2) Maximum Security units each received a third phone. Unfortunately, delays in Wellpath and DOC process approval of new PS telephone contact lists remain a barrier for new arrivals at BSH, as PS cannot access their unit phones until their personal PIN is set up with approved numbers. Sixteen (16) PS directly reported to DLC waiting anywhere from three (3) days to two (2) weeks between submitting the telephone contact form and having their list approved, with the average being around one (1) week. Multiple staff reported to DLC that this is a common complaint from PS, in particular PS who live in Bradford 1, BSH's intake unit. This can be a source of great stress and frustration for PS in the first days and weeks after their admission, when PS are often in mental health crisis, afraid, confused, and needing to connect with their attorneys and other supports. According to one PS DLC interviewed, the issues with telephone access were "nothing but pain and suffering."

In response to DLC's advocacy, DOC has outlined plans to expedite the approval process by roughly 24 hours. Implementation involves requiring treatment team members to provide PS forms directly to the representative from DOC's telecommunications contractor, Securus, by 2:00pm – rather than close of business – and returning to the PS no later than the following morning or Monday morning in the case of a weekend. DLC believes this plan could lead to significant improvements for PS and will continue to monitor its implementation.

2. Continuing Illegal and Unreported Restraint and Seclusion

DOC and Wellpath continued to employ policies and practices that subjected PS to forms of restraint and seclusion in unsanctioned circumstances and sans required documentation throughout this reporting period. DLC confirmed systemic legal violations through review of daily nursing reports, the restraint and seclusion order forms, clinical records, and video footage of as well as firsthand observations, discussions with PS, and conversations with staff.

To recap previous reports, DOC and Wellpath subject PS to restraint and seclusion absent requisite emergency circumstances. BSH's policy governing application of involuntary medication explicitly sanctions chemical restraint in the form of an "Emergency Treatment Order" when a PS presents with behaviors that pose only a "*potential* harm to self or others" as determined by "a risk assessment by the psychiatrist or other provider that contextualizes the current behavioral presentation with the PS' historical and current risk factors for serious violence leading to significant personal injury or self-harm, or harm to others."[31] An ETO can be

[30] DLC's January 2023 Report at 59.
[31] Bridgewater State Hospital Policy and Procedure Manual – Use of Involuntary Psychotropic Medication, 5.2.1, 5.2.4 (July 12, 2022) (emphasis added) (hereinafter "BSH Use of Involuntary Psychotropic

administered absent a finding that it is the least restrictive option or documentation of the forced medication as a restraint.[32] Since DLC's January 2022 report, the Executive Office of Public Safety and Security and DOC have argued that ETOs are involuntary medication "for treatment," rather than chemical restraint.[33]

As described above, DOC committed in its June 7, 2023 response to "revising BSH policies to utilize the terminology [DLC] feels is required by M.G.L. c. 123 and regulations."[34] DLC awaits the revised policies with apprehension and emphasizes, once-again, that assertions by DOC and Wellpath that an ETO is treatment does not make it so.

State law clearly limits the use of restraint in the Commonwealth. Per M.G.L. c. 123, §21, restraint and seclusion of a person with mental illness in DMH facilities and BSH "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 explicit requirements regarding examinations and who may provide written authorizations for the restraint. All uses of restraint and seclusion must be tracked in individual medical records and recorded in restraint forms that are submitted to the DOC Commissioner to review and sign within thirty (30) days.[35] A legitimate order for chemical restraint requires a finding by the ordering provider "that such chemical restraint is the least restrictive, most appropriate alternative available."[36]

Massachusetts law allows for administration of involuntary medication in three limited circumstances:

1. **Per a court-ordered *Rogers* guardianship**: After a court has made a substituted judgement decision that the individual would accept the medication if competent and approved a treatment plan;[37]
2. **As a chemical restraint:** Under the state's police power to prevent an *imminent threat of harm* to oneself or others when there is a clinical determination that there is *no less intrusive alternative to forced antipsychotic drugs available*[38] and "*the statutory and regulatory conditions for the use of chemical restraints must be followed*"[39]; and
3. **To prevent irreversible deterioration of serious mental illness:** Exercising the state's *parens patriae* power 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.'"[40]

The Supreme Judicial Court has recognized that "doctors who are attempting to treat as well as maintain order in the hospital have interests in conflict with those of their patients who may wish

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Medication Policy"). "Behaviors that may necessitate an ETO include, but are not limited to, , [sic] unremitting self-harm that is causing physical injury to the PS; serious physical harm to a team member or other PS; *escalating aggression that cannot be verbally de-escalated; and mental health emergencies such as catatonia or delirium." Id.* (emphasis added).

[32] *Id.* at 5.2.8, 5.2.9.

[33] App. B at 4.

[34] DOC Response to DLC Report (June 7, 2023) at 3.

[35] M.G.L. c. 123, § 23.

[36] *Id*.; *see Matter of Guardianship of Roe*, 383 Mass. 415, 435-438 (1981).

[37] *Rogers v. Comm'r of the Dep't of Mental Health*, 390 Mass. 489, 512-513 (1983).

[38] *Id.* at 490-491, 509-511; M.G.L. c. 123, § 21 (emphasis added).

[39] *Id.* at 509.

[40] *Id.* at 511-512. If doctors determine that the involuntary medication should continue in order to prevent irreversible deterioration, "the doctors must seek an adjudication of incompetence." *Id.* at 512.

to avoid medication,"[41] but has held that "[n]either doctors nor courts have the power to expand the circumstances in which a patient may be restrained."[42] "Any other result also would negate the Legislature's decision to regulate strictly the use of mind altering drugs as restraints."[43]

That DOC and Wellpath have incentives to maintain control within BSH is obvious. DOC is, after all, running an aging prison facility. Just like prisoners in other DOC facilities, PS live in stark cells and are required to comply with rigid institutional routines, rules, and expectations. For instance, PS are locked in their cells for count (when staff do a count of all of the prisoners in the facility) several hours per day; if patients were locked in their rooms in a psychiatric hospital in this manner, it would likely be recorded as seclusion. PS are regularly subjected to seclusion and various forms of restraint when their behavior disturbs the "climate" within the prison. Yet, in DMH-run and -licensed facilities, applicable DMH regulations prohibit seclusion for behavior management.[44] For its part, Wellpath is accountable to DOC as its contractor – a relationship initiated to put an end to the staggering overuse of seclusion, physical restraint, and mechanical restraint within BSH exposed by litigation and DLC investigations. Any admission by Wellpath that it reduces use of seclusion and physical/mechanical restraint by using chemical restraint would not be good for business. With significant limitations on movement of PS within the facility – especially for new admission and PS placed in the maximum security units – and limited access to individual therapy and therapeutic programming, perhaps it is no surprise that the agency and its contractor rely on medication to control PS. Fortunately, none of that changes the dictates of the law of the Commonwealth.

DLC is also concerned that Wellpath's use of Irreversible Decline Orders (IDOs) – intended, by policy, to fit within the third category of permissible involuntary medication – appeared to be rising in the last six (6) months.[45] Specifically, records indicate that Wellpath is issuing long-term IDOs and IDOs in circumstances that may not meet the narrow circumstances permitted by law – the "rare circumstances" of immediate, substantial, and irreversible deterioration of an individual's serious mental illness.[46] Absent a legitimate justification of preventing irreversible deterioration, an IDO constitutes a chemical restraint.

A. Overuse and Unnecessary Use of Restraint and Other Force

During this reporting period, DLC viewed approximately twenty-five (25) video recordings of uses of restraint. Notably, DOC produced handheld video camera footage this reporting period, giving DLC access to audio of recorded events for the first time. The use of handheld video cameras is the result of a change to Wellpath documentation of "planned events" implemented following DLC's January 2023 recommendations regarding improved documentation. To create this footage, Wellpath staff at BSH must retrieve a handheld video camera in advance of responding to an event – just as DOC regulations require correctional officers do when conducting a planned use of force in other DOC facilities. The quality of the footage depends on the skill of the operator. All other footage DLC receives is captured by static wall-mounted

[41] *Rogers*, 390 Mass. at 503.
[42] *O'Sullivan v. Sec'y of Hum. Servs.*, 402 Mass. 190, 194 (1988), citing *Rogers*, 390 Mass. at 510.
[43] *Rogers*, 390 Mass. at 511.
[44] 104 CMR 27.10(6)(b); 104 CMR 27.12.
[45] DLC raised concerns about BSH utilization of IDOs previously in 2021. See DLC, *A Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served*, (July 2021), https://www.dlc-ma.org/wp-content/uploads/2021/07/BSH-Report-7.27.2021.pdf.
[46] *See Rogers*, 390 Mass. 512; 104 CMR 27.10(1)(e).

security cameras in PS cells and strategically placed throughout the facility that do not record sound.

In an attempt to illustrate the regular use of physical intimidation and force by staff on PS in different types of scenarios, DLC describes several incidents below, incorporating information from available recordings, documents, and interviews.

PS "Perez"[47]

DLC interviewed PS Perez while he was housed on one of the Maximum Units at BSH. He described being assaulted by TSTs in the Bradford 1 unit shortly after his admission. Specifically, he described Wellpath staff putting him in a choke hold and repeatedly pounding his head into the floor. PS Perez, who identifies as Latinx, said he believed he sustained a concussion and had multiple cuts on his body from the incident, but that he never received a medical exam or any responses to the grievances he submitted seeking medical care. About a month after this experience in Bradford 1, PS Perez endured the following events that DLC describes based upon security camera footage DLC reviewed onsite:[48]

> *At 2:15pm, PS Perez sits at a six-seat picnic table along the side of the dayroom writing, with his back to the wall. No one else appears to be in the room. Through the windows looking out into the unit hallway, a crowd of Wellpath staff is visible.*
>
> *PS Perez walks out into the hallway, standing close to the doorway of the dayroom, and appears to read from a piece of paper. TSTs direct him back to the dayroom. He returns and closes the door. He walks over to the windows looking out into the unit hallway and begins banging on the windows. He presses his pad against the window, apparently, to show something to the TSTs in the hall. He then goes to exit the dayroom again, but the TSTs close the door on him. He sits with his back against the window and returns to writing, then moves to the picnic table again.*
>
> *Over the next few minutes, TSTs open the door to the dayroom while PS Perez is sitting and writing at the table. Multiple TSTs enter the room and, without any apparent discussion, quickly approach the seated PS Perez. Abruptly, one of the TST jumps onto the picnic table with his boots, standing over PS Perez, then dismounts on the other side where PS Perez is sitting. PZ Perez stands up and other TSTs forcefully move the picnic table away from the wall. The group of TSTs grab PS Perez with their hands, struggling against the wall to bring him into a controlled manual hold. The TSTs then walk PS Perez in the manual hold to his cell as he struggled under their grip. When they get to his cell and open the door, they forcefully push PS Perez inside and lock the door.*
>
> *PS Perez was in seclusion in his cell for four (4) hours beginning at 2:28pm.*

[47] DLC uses pseudonyms to protect the identities of PS.
[48] A copy of this video and copies of a number of videos requested in the last two reporting periods have not been timely produced by DOC to DLC. DOC attributes the delays in product to its stated need to redact the faces of those PS who have not signed a records release, despite DLC's redisclosure limitations and shared responsibility for protecting the rights and interests of PS.

A review of PS Perez's records revealed a number of similar descriptions of this event. One progress note stated:

> During a code green for someone else, [PS Perez] was in the day room. He began aggressively yelling and making verbal threats to kill staff multiple time, unable to verbally redirect person served continued with agitative behavior yelling kicking door banging window in day room, refusing to cooperate, person served an imminent risk of harm to others and causing a climate issue.

Although DLC cannot discern from the security camera footage whether PS Perez made any verbal threats, he did remain alone in the dayroom after being directed not to come out, and was seated and writing when TSTs entered. Isolated in the dayroom without any way to act on his purported threats, the TST's physical restraint was not justified by an "occurrence, or serious threat of, extreme violence."[49] In addition to "threat of harm to others," the restraint order for this incident[50] also inexplicably cites "threat of harm to self" as a rationale for the manual hold, without any description of any behavior or that threatened self-harm. Based on DLC's observations, the TSTs' unnecessary actions to restrain and seclude PS Perez may have been motivated by annoyance with his attempts to demand their attention during another crisis.

This footage also depicts a lost opportunity for meaningful and effective de-escalation. While PS Perez stayed in the dayroom, intermittently writing and trying to get the TSTs' attention, staff had multiple opportunities to address the situation without force. Employing Wellpath clinical staff or attempting to engage with PS Perez for a longer period could have convinced him to remain in the dayroom quietly or walk to his room. Instead, brief interactions with security staff – including a TST gratuitously jumping atop a table – led to a violent confrontation indicative of the culture of intimidation that DLC has referenced repeatedly in past reports.

PS "Anderson"

PS Anderson introduced himself to DLC in the Bradford 1 unit and shared his traumatic experience with forced medication within one (1) week of his admission. He described coming to BSH shortly after, as a young Black man, he experienced excessive force at the hands of police, sustaining a concussion. PS Anderson believed he was being transported to a regular hospital to treat his injuries when he ended up at BSH. At the time of the conversation with DLC, he had visible bruising around his eye socket and reported that he had received little medical care since his arrival at BSH.

PS Anderson was subjected to a violent restraint and administration of an ETO on his fourth day at BSH. In addition to PS Anderson's account, DLC reviewed footage from a handheld video camera onsite at BSH and reviewed records to inform our understanding of what happened. Security camera footage was not available, as PS Anderson had covered the security camera in his cell and Wellpath staff failed to undercover the camera during their planned intervention. The video begins after, according to Wellpath records, PS Anderson twice covered his cell's security camera and door. The first time, he removed the coverings after staff came to speak with him. About an hour later, he did it again and "refused to obey" when prompted to remove the coverings. PS Anderson then stated, *"*I have to fight and save everybody in this jail from your

[49] M.G.L. c. 123, § 21.
[50] Note that this manual hold order – physical restraint order – was reviewed by the DOC Commissioner in keeping with M.G.L. c. 123, § 21.

maltreatment." Wellpath cites his refusal to remove the coverings, "which makes it impossible to do checks for his safety," as the reason for the ensuing ETO and physical restraint.

> *At approximately 8:50pm, four (4) TSTs in riot gear are standing in a tight group outside PS Anderson's room, lining up to enter. They open the door and quickly begin filing in as one TST grabs the mattress in front of the door and throws it out of the room. TSTs' shoes audibly squeak on the floor as they enter. PS Anderson is laying on his bare, hard plastic bed with his head and body covered with a blanket.*
>
> *The TSTs put their hands on PS Anderson and try to remove the blanket. One TST tells him, "As soon as you relax it'll be done." As they struggle, PS Anderson's breathing is audible, and he begins to verbalize his distress. PS Anderson yells "Let go of my arm!" Then, "Alright, now I can't breathe! Now I can't breathe!" The TST Supervisor directs one (1) of the four (4) TSTs to adjust slightly. As the TSTs continue trying to force him into position for an injection, PS Anderson yells "My fuckin' ankle! You don't gotta do all that…" and then "Whoever's on my right fuckin' leg can you let off a bit? Damn!"*
>
> *By 8:52pm, the team of TSTs are holding down PS Anderson, still wrapped in his blanket, on the bed. The TSTs move the blanket to expose his buttocks. The nurse enters and administers the IM ETO. At 8:54pm, the TSTs rush out of the room one by one.*

The video recording depicts the all too familiar image of a Black man violently confronted by a group of uniformed personnel. The potential for traumatization and re-traumatization for BSH PS, particularly those who have a history of abuse, is profound. PS Anderson, in his interview with DLC, described having repeated nightmares after this experience.

Crucially, PS Anderson described himself as compliant throughout the ordeal, but said that staff was rough with him. DLC questions whether appropriate manual holds and techniques employed by TSTs would have caused PS Anderson to have difficulty breathing and significant pain. Additionally, TST's minimal attempts at communication during the hold, not only failed to focus on de-escalation, but were inappropriate. It is difficult to imagine more menacing words of assurance than *"as soon as you relax it'll be done,"* particularly given the context.

It is unclear whether PS Anderson was offered any alternative method of ETO administration prior to the use of force by TSTs and ETO by intramuscular injection – an issue discussed further below in Section 2.C. Based on a review of his records, PS Anderson refused an offer of oral PRN medication approximately twenty (20) minutes before the TSTs assembled at his cell door. Given that PRNs are intended to be voluntary "as needed" medication, refusal of a PRN is not equivalent to a PS's knowing refusal to take an ETO by mouth to avoid a team of TSTs entering their cell and forcefully holding them down in a prone position while a nurse administers intramuscular injections to their buttocks. PS Anderson informed DLC that, if he had known he would receive an intramuscular injection, he would have accepted the oral medication to avoid the shots. Based on the video footage and his own account, he would have avoided considerable trauma as well.

PS "Moreno"

In a meeting on his unit, PS Moreno described an instance in which he was in his room and the TST team opened the door, came in, and shoved his head down into the bed while he received an injection. PS Moreno described his body shaking in response to the medication and then experiencing difficulty moving for a time after. BSH's petition for a court-ordered *Rogers* treatment plan was granted three (3) days after this incident. DLC's observations from the security camera footage DOC provided is as follows:

> *From 7:50am to 8:45am, PS Moreno changes positions between lying in bed, lying under his mattress, talking to staff, and sitting on his desk looking out the window. At 8:46am, a BSH staff member begins knocking on his cell door. PS Moreno looks up and rises slowly. Once at the door, they talk for a moment, he pulls down his pants leaving his boxers on, pulls them up after about eight (8) seconds, and walks away. He sits on his bed and waves to the staff person, who appears to keep talking, and he lies back down. The staff member leaves the doorway at 8:47am. At 8:48am, PS Moreno gets up and begins kicking the door. A staff member appears at the door ten (10) second later. At 8:49 PS Morena dances near the window, then sits on the desk in his room looking out at the yard, walks around slowly, and sits back on the bed at 8:51am.*
>
> *At 8:53am, TSTs in riot gear gather outside PS Moreno's door and talk to him through the window of his cell door. After two minutes of talking, PS Moreno assumes a crouching position in front of the door with his hands on the ground. He then lifts his torso up slightly and rests his hands on his knees.*
>
> *At 8:55am the team of four (4) TSTs open the door and rush inside the cell. The TST holding the shield hits the shield forcefully into PS Moreno as he stands up straight and pushes him across the cell until he is on his bed. The TST hits PS Moreno with the shield again once he is on his bed and uses the shield to push him towards the wall. The TST Supervisor stands silently in the doorway throughout the operation. The TST throws the shield off to the head of the bed and grabs PS Moreno's head with his right hand to force it downward toward the bed while also pushing on PS Moreno's head with his left hand; the TST is bent over and appears to be putting the force of his weight onto PS Moreno. Then, the same TST uses his left hand on the left side of PS Moreno's head to pull it toward the head of the bed. As the other three (3) TSTs start gaining control of PS Moreno's limbs, the first TST throws his shield to the far end of the bed and begins pushing PS Moreno's head down with right hand over his PS Moreno's ear and his left hand on PS Moreno's neck. PS Moreno tries to grab the shield TST's right forearm to try to remove his hand pushing on his ear – and the TST loses his footing, falling forward toward the bed and rotating so he lands seated between the wall and PS Moreno's head. The shield TST can be seen raising his right arm and bringing it down on PS Moreno's head or neck while seated and then lifting himself up slightly with his legs before using both hands to push down on PS Moreno's head with the force of his body weight. The shield TST stands up and, with knees bent, resumes pushing on PS Moreno's head with both hands. Seconds later, the TST falls forward landing his forearm squarely on PS Moreno's head. The shield TST leans into this position and puts the weight of his upper body on PS Moreno's head.*

At 8:56am, PS Moreno is laying on his stomach. His head and torso are not visible due to the shield TST position, covering them completely. The nurse administers the intramuscular injection to his exposed buttocks, as the four (4) TSTs hold him down. Thirty (30) seconds later, the first TST holding one of PS Moreno's legs abruptly leaves the cell, followed by the others, and the door is closed. PS Moreno stands, looking dazed, and goes to the door to talk to staff for under a minute. After walking around his room, PS Moreno lies back down on his bed at 8:58am.

Staff provide PS Moreno breakfast at 9:06am. He carries a Styrofoam tray with two (2) milks and a coffee to his desk, sits, gestures a cross on his chest, clasps his hands, kisses them, and eats.

Striking in this footage is the intense altercation with the team of TSTs. PS Moreno is rammed repeatedly with the shield until he is on his bed against the wall; the TSTs pulling and pushing on PS Moreno's head, neck, and limbs to force him to lie face down; and the shield TST pushing on and elbowing PS Moreno's head and neck with the weight of his body. The brutality was alarming and appeared driven by anger, rather than any intention to treat or protect him from mental health decline. Wellpath staff have said that this video was flagged in the new Serious Clinical Episode review process and that there was an undisclosed "disciplinary outcome" for the offending shield TST. Still, the reality is that this this type of violence is not uncommon at BSH. The TST Supervisor and other staff there did not even see fit to intervene.

PS Moreno's IDO, like others that DLC has observed this reporting period, was structured like a *Rogers* treatment plan, not a limited order to address a risk of immediate, substantial, and irreversible decline.[51] The IDO called for PS Moreno to take oral medication or, upon refusal, to receive an intramuscular injection of medication as "backup." Thus, the IDO appeared to be administered automatically without any clear assessment of PS Moreno's need for the medication to prevent irreversible decline – *i.e.,* without the necessary legal justification. The time between PS Moreno's refusal and the TST team entering his cell to force him to take an intramuscular injection was also brief, roughly ten (10) minutes, and staff devoted little time or effort to avoiding the forced injection even though PS Moreno was relaxing in his room. Wellpath records indicate that PS Moreno "refused his PO (oral) Haldol and therefore required IM backup," and when a clinician went to speak with him, he said "I want my breakfast first. You work for me." Had staff given PS Moreno breakfast and explored alternatives before forcing a confrontation, the violence and trauma may have never been inflicted on PS Moreno.

At the same time, there are concerning inconsistencies between the video footage and written documentation. Records alleges that he threw a "cup of water at the nurse" when she tried to give him medication, but DLC was unable to find that in the video footage covering that period. Wellpath records also repeatedly say that the TST team entered PS Moreno's room while he was in a "fighting stance," although video clearly shows him hunched over with his hands on his bent knees. Previously, his hands were on the floor, but he never appeared with his hands up or in fists. These inconsistencies are particularly concerning when used to justify staff use of force.

[51] Wellpath staff referred to PS Almonte's IDO as an "irreversible decline court order" in the 24-hour nursing report the day before this incident.

Each of these incidents indicate a lack of effective training and oversight at BSH and makes plain the need for DMH to assume care for PS, if the Commonwealth expects PS to receive hospital-level inpatient psychiatric treatment.

B. *Inconsistencies Between Wellpath Policy and Staff Training on Involuntary Medication Practices and Chemical Restraint*

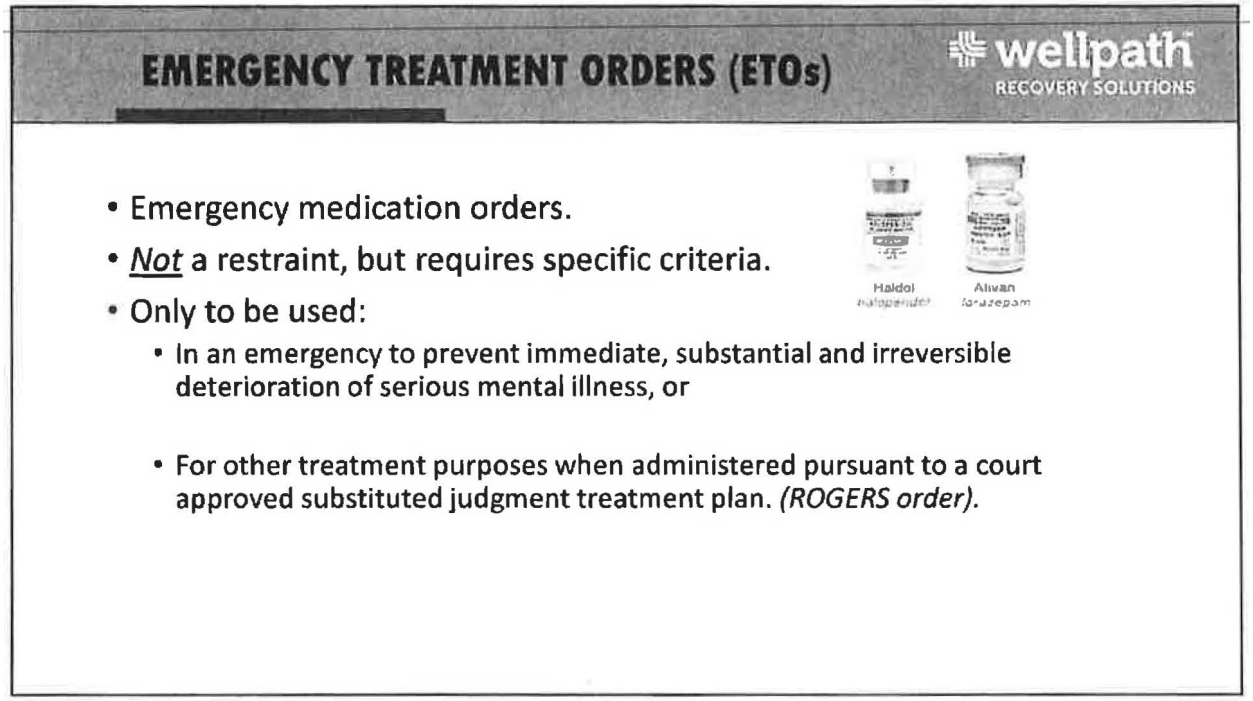
As detailed in previous reports, BSH's Use of Involuntary Psychotropic Medication policy outlines four (4) distinct circumstances for the use of forced medication:

1. Pursuant to a *Rogers* Order: "There is a valid Court Authorized Treatment Plan approved by either a District or Probate Court;"[52]
2. Emergency Treatment Order (ETO): "A PS is presenting in a psychiatric emergency such that medication is required to prevent imminent harm to self or others, or treat intolerable distress";[53]
3. Medication Restraint: A PS is engaging in serious volitional harm [not related to mental illness] to self or others, or at imminent risk of doing so, and requires medication to restrict his ability to engage in these behaviors";[54]
4. Irreversible Deterioration Order (IDO): "Psychotropic medication is needed to prevent an immediate, substantial and irreversible deterioration of the PS mental illness."[55]

Based on conversations with BSH staff and records review, DLC has significant concerns that Wellpath fails to provide BSH staff clear training on facility policies about involuntary medication and unequivocally fails to provide staff training about the legal limitations on involuntary medication and chemical restraint. **Indeed, Wellpath training about types of restraint does not even acknowledge chemical/medication restraint as a category of restraint.** Slides from staff training provided to DLC cite "manual hold," "mechanical restraint," and, occasionally, "seclusion" as forms of restraint.

The following slide from a restraint training presented to BSH employees contradicts both Wellpath policy and Massachusetts law, making improper documentation and illicit use of involuntary medication unsurprising.

[52] BSH Use of Involuntary Psychotropic Medication Policy at 3.1.1, 5.1.1-5.1.4.
[53] *Id*. at 3.1.2., 5.2.1-5.2.8
[54] *Id*. at 3.1.3., 5.3.1-5.3.5
[55] *Id.* at 3.1.4, 5.4.1-5.4.1.8.



Commonwealth agencies should not be contracting with entities, like Wellpath, that do not staff to comply with state law on chemical restraint and involuntary medication administration.

C. Failure to Give Persons Served the Option of How Involuntary Medication Administered – Oral Medication Versus Intramuscular Injection

Numerous interviews and BSH records have revealed a practice of PS being subjected to involuntary medication via intramuscular injection without first being given the opportunity accept it as oral medication (*i.e.,* take by mouth in pill or liquid form). Oral medication offers prevent the trauma of being held down by a team Wellpath staff in a prone position with your buttocks exposed and injected with substances against your will; prevents injuries to PS and Wellpath staff that happen during the physical force that generally precede ETOs and IDOs; and provide the opportunity for a modicum of PS autonomy even within the context of involuntary medication. Although documentation often indicates that PS are offered their voluntary "as needed" medication, generally called PRN (*pro re nata*) medication, before Wellpath issues an ETO and IDO – as in two of the incidents described above in Section 2.A. – a refusal of a voluntary PRN cannot justify failing to offer oral ETO medication before using physical force.

Language in BSH's Use of Involuntary Psychotropic Medication policy differs regarding the necessity of offering oral medication before an intramuscular injection based on the type of involuntary medication order. Oral medication *must be* offered prior to intramuscular injections of medications from a PS' court-authorized *Rogers* treatment plan.[56] For IDOs, "oral medications *are preferable*…; however, intramuscular medications may be ordered as backup medication or as initial treatment when either safety or reliability of medication administration

[56] Bridgewater State Hospital Policy and Procedure Manual – Use of Involuntary Psychotropic Medication, 5.1.2 (July 12, 2022) (hereinafter "BSH Use of Involuntary Psychotropic Medication Policy").

warrants this route of administration."[57] Policy language on ETOs, however, does express any preference for oral medication, stating only the following:

> Emergency medication includes any psychotropic medication given against the will of the PS and without PS consent. This includes intramuscular medication and oral medication (in situations where the PS accepts the oral medication with the knowledge he will receive an intramuscular medication if he refuses the oral medication).[58]

PS describe being needlessly subjected to injected medication through violent physical confrontations while they are experiencing mental health crisis and/or in fear. One PS who is afraid of needles was offered oral medication by a staff member but was not notified that refusal would mean IM administration. He reported that he wasn't told how long he would have to respond to the offer and was then suddenly "manhandled" by a group of TSTs in his room. He recalled trying to tell TSTs he wanted the oral medication, but they refused, and he was given multiple injections on his bed. Another PS told DLC that staff are inconsistent in giving oral medication offers, but when they do offer them, he always takes them. This PS said that staff are more likely to go straight to an intramuscular injection without attempting to offer oral medication first when he is upset or may be seen as "out of control. He describes this process as being about "power" and "control" for staff. It also sounds a lot like using intramuscular injections for behavior management and punishment, in contravention of state law.

Interviews with nursing staff substantiated that staff employ inconsistent practices when it comes to offering oral medication and the amount of information provided to PS about the consequences of a refusal. Various nurses said: oral medications were always offered before a PS was given an intramuscular injection and staff might take up to 10 minutes to discuss the situation with PS before escalating to intramuscular medication; oral ETOs were "usually" offered, depending on the situation; and after refusal of an initial offer, they bring oral medication alongside injections, giving PS a final chance to avoid forcible injection and physical confrontation. When asked about staff transparency concerning the inevitability of forced medication, nurses said: they had to let PS know that oral medication refusal would result in intramuscular administration and were sure to educate and inform them of the risks of both options; and they do not offer oral ETOs with a warning about refusal because staff don't yet know if the doctor will order an injection after the initial refusal. Moreover, while most nurses said that they try to honor the wishes of PS as to the route of administration, their understanding of policies and best practices around how and when they must do so were largely unclear.

D. ETOs Prescribed as a "Standing Order"

This reporting period is the first in which DLC discovered documentation acknowledging a "standing order ETO." Though only one example, it is indicative of a disturbing instance of Wellpath providers expanding the usage and definition of already illegal ETOs. Below are two (2) entries concerning the same PS in a 24-hour nursing report:

[57] *Id.* at *5.4.1.6.*
[58] *Id.* at 5.2.5.

Time	Details of the event – Restraint type, duration, medications (PO vs. IM), ETO, ROGERS Order.
ETO IM0 [10:00am]	PS has a standing ETO for refusal of Ativan PO. He refused all AM meds including Ativan by mouth therefore an ETO/PRN/IM. He accepted it without manual hold and tolerated it well.
ETO IM [2:00pm]	PS has a standing ETO for refusal of Ativan PO. He refused all AM meds including Ativan by mouth therefore an ETO/PRN/IM. He accepted it without manual hold and tolerated it well.

Both notes describe no behavioral emergency whatsoever and state that the PS has a "standing ETO" and received an "ETO/PRN/IM." This particular PS did not have court-ordered medications.

The PS' Psychiatry Progress Notes indicate that Wellpath prescribed this PS oral medication to treat catatonia. Because PS have a legal right to refuse medication that is not court-ordered, if the PS refused, staff should have assessed his immediate clinical need for forced medication. That did not happen. Wellpath instead prescribed a four-day "standing ETO," referred to in the record as an Emergency Treatment Order PRN. Staff then applied the "ETO/PRN/IM" as an intramuscular ETO administered whenever it is "needed" – t**he result was that BSH staff subjected the PS to five (5) ETOs in four (4) days**. The standing order illegitimately combines as needed PRN medication to treat PS with an ETO, an emergency involuntary medication order that DOC and Wellpath assert is administered "to prevent imminent harm to self or others or treat intolerable distress." Notably, the BSH policy concerning prescribing and dispensing medications expressly states, "[s]tanding orders are not allowed."[59]

A Psychiatry Progress Note from two (2) days prior to the "standing order" indicates that providers believed "[w]ithout proper adherence with his oral medications catatonia is inevitable and going to return at a worsened state." It is unclear why, despite recording the standard rationale for an IDO, Wellpath chose to condone a "standing ETO." One possibility is that Wellpath providers prefer to take advantage of the extralegal status of ETOs; under Massachusetts law, if providers administer an IDO and expect to keep treating with involuntary antipsychotic medication, BSH must file a *Rogers* petition for a court-ordered treatment plan.[60] A letter from Wellpath to the DOC Commissioner makes plain the lack of accountability and safeguards for PS inherent in issuing such orders – the letter explains that "[b]ecause of the in-place order, there were no additional ETO Provider Progress notes for those dates." Indeed, the Progress Notes provided to DLC only document the first two (2) ETOs. The other three (3) ETOs, as Wellpath admits, and DOC allows, do not exist.

[59] Bridgewater State Hospital Policy and Procedure Manual – Prescribing and Dispending (July 9, 2021).
[60] *Rogers*, 390 Mass. at 491 ("If a patient is medicated in order to avoid 'immediate, substantial, and irreversible deterioration of a serious mental illness,' and the doctors expect to continue to treat the patient with antipsychotic medication over the patient's objection, the doctors4 must seek adjudication of incompetency, and, if the patient is adjudicated incompetent, the court must formulate a substituted judgment treatment plan.").

E. Persistent Deficiencies in Documentation of Restraint and Seclusion

DLC's January 2023 report highlighted deficiencies in documentation of restraint and seclusion events at BSH, with a focus on records lacking appropriate detail as to the justification for the use of restraint and seclusion. These problems persist. Wellpath continues to produce inadequate and incomplete documentation and the DOC Commissioner reviews and endorses the restraint and seclusion forms, despite glaring defects. It is not always clear, absent review of additional evidence, whether the documentation reflects poor documentation practices at BSH, violations of Massachusetts restraint law, or both. Whatever the reason, BSH restraint and seclusion documentation continues to pose a threat to PS health, safety, and rights as well as a challenge for DLC's monitoring efforts.

Below is an excerpt from a recently produced restraint and seclusion order form approved by the DOC Commissioner concerning a physical restraint and ETO:

> **Manual Hold Reason:** *Threat of Harm to Others, Escort to Another Location*
> **ETO Administered:** *Yes*
> **Describe the observed changes in the observed behavior(s) and/or elements of the Person Served's presentation and mental/status and explain how they signify, for this individual, that he currently presents a behavioral emergency such as THE OCCURRENCE or SERIOUS THREAT OF EXTREME VIOLENCE, PERSONAL INJURY, or ATTEMPTED SUICIDE:**
> "Per LPN report: PS was to be moved to another room. He has a history of assaultive behavior when being moved and for the safety of all, provider ordered IM Thorazine. Manual Hold to prevent PS from assaulting team members during the ETO administration based on prior assaultive behavior – medication administered at 10:21"

In keeping with examples discussed in DLC's last report, the content of the order is not responsive to the fields in the form and does not meet the substantive legal requirements of M.G.L. c. 123, § 21. Like far too many others, this order form fails to provide the requested description of observed behavior, PS' current presentation, or a present "behavioral emergency" to justify a restraint. Wellpath's intention to move the PS to a different cell and his "history of assaultive behavior" are the only bases provided for the use of physical and chemical restraint.

Throughout reporting period, DLC reviewed documentation that Wellpath maintains concerning physical restraint, seclusion, and involuntary medication administration, including physical restraint and seclusion order forms that the DOC Commissioner has reviewed and endorsed per M.G.L. c. 123, § 21, 24-hour nursing reports, medication orders, and Psychiatry Progress Notes reports. DLC focused on identifying any deficiencies in documentation of involuntary medication, such as mislabeling or inconsistent recording of the different types of involuntary medication defined in BSH policy. Often, DLC found that each record says something different.

Some Wellpath records manage to conflate three (3) different types of involuntary medication in a single entry. The below entry from a 24-hour nursing report mentions an ETO, court-ordered medication, and irreversible deterioration:

Time	Details of the event – Restraint type, duration, medications (PO vs. IM), ETO, ROGERS Order.
Manual Hold for ETO 11:03-11:05	P/S creating climate issues, disorganized, psychosis issues, refusing court ordered medication. IM was ordered – "irreversible deterioriation". TST'S entered the room no shield was used - manual hold during administration of medication.

After a review of this PS's records, DLC confirmed that the initial offer of medication he was "refusing" was not court-ordered medication. In reality, the PS refused oral IDO medication, then received it medication as an intramuscular injection. It is important to note that "creating climate issues, disorganized, psychosis issues" do not meet the legal or Wellpath policy standard for an IDO or ETO.

The discrepancies DLC found raise serious concerns about the treatment of PS; incomplete and inaccurate medication information provided to PS; and direct care staff's lack of understanding of Wellpath policy, Massachusetts law, and the severity of the interventions on which Wellpath relies. Varying standards of involuntary medication administration and regular mislabeling of names of medication administration makes accurately tracking instances of chemical restraint and other forced medication at BSH more difficult. As such, the prevalence of errors ensures that any methods of oversight and auditing of involuntary medication usage and record-keeping protocols employed by Wellpath and DOC administrator are flawed.

i. Conflating Administration of Court-Ordered Rogers Treatment with ETOs

During this reporting period, DLC observed frequent examples of staff conflating court-ordered medication administration with ETOs. Such confusion blurs the legal standards being applied and/or staff ability to determine when a medication order is not necessary. For example, if a PS refuses court-ordered medication, the medication may be administered involuntarily per court order. As such, there would be no need for a doctor to prescribe a backup ETO.

Below, in the same sentence, the medication is referenced as court ordered and an intramuscular ETO as backup. In contrast, the restraint and seclusion order form for the same incident indicates "ETO not administered."

> P/S refused his court-ordered medication, Psych Dr. ordered ETO/IM as a backup, in which staff utilized safety gear with no shield to make entry into the room no shield. Upon entry, staff placed PS into a manual hold from 12:21-12:23p while the unit nurse administered medication @ 12:22pm.

ii. Conflating Voluntary PRN Medication Orders with ETOs

DLC found that confusion in records between voluntary "as needed" PRN medications and ETOs is not uncommon. DLC found instances where medication offered was described as a PRN, yet a refusal appears to lead directly to an intramuscular ETO. These instances did not include an independent assessment for an ETO or an intervening offer of an oral ETO. Without access to every existing record of the incident, it is challenging to monitor and determine whether the medication administration is mistaken documentation of an oral ETO as a PRN, or the mistaken documentation of a PRN as an oral ETO. This distinction, as described in Section 2.C. has real consequences for PS rights and bodily autonomy.

iii. Conflating Irreversible Deterioration Orders with ETOs and Court Ordered Rogers Treatment

Similarly, BSH records conflate IDOs with ETOs, though the circumstances justifying each are distinctly different under Wellpath policy and the latter is not sanctioned by Massachusetts law. DLC learned from PS that these errors are not confined to documentation, as Wellpath staff have told PS that IDO medication was court-ordered when, in fact, it was not. The following restraint and seclusion order form makes this error:

> **Manual Hold Reason:** *Threat of Harm to Others, Escort to Another Location*
> **ETO Administered:** *Yes*
> **Describe the observed changes in the observed behavior(s) and/or elements of the Person Served's presentation and mental/status and explain how they signify, for this individual, that he currently presents a behavioral emergency such as THE OCCURRENCE or SERIOUS THREAT OF EXTREME VIOLENCE, PERSONAL INJURY, or ATTEMPTED SUICIDE:**
> PS disrobing, unable to follow commend [sic], ongoing of [sic] medication refusals, MH from 11:03-11:05 was necessary for irreversible deterioration backup order IM medication as PS was agitated.

The form states that an ETO was administered, but only makes mention of an IDO in the limited explanation that follows. The 24-hour nursing report for the same incident also refers to "court ordered medication."

F. Analysis of Available Data Concerning ETO Applications

DLC compiled the following table based on the content of 24-hour nursing reports and restraint and seclusion order forms – the same documents that the DOC Commissioner reviews and signs pursuant to M.G.L. c. 123, § 21. It provides a look at the frequency of ETOs over the reporting period that were documented as part of a physical restraint and/or seclusion. This data does not include ETOs that were administered without physical restraint and/or seclusion because, again, Wellpath and DOC assert that ETOs are not chemical restraints.

Table 1. ETOs by Month (December 15, 2022 – June 15, 2023)

Month	Number of Days	Number of ETOs
December (16-31)	15	7
January (1-31)	31	57
February (1-28)	28	47
March (1-31)	31	35
April (1-30)	30	27
May (1-31)	31	33
June (1-15)	15	33
Total (Dec 16-June 15)	181	239

These 239 ETOs were administered on 106 unique PS – nearly half the total census of BSH at a given time. While these numbers decreased from the previous reporting period, Wellpath's reliance on this extreme and traumatic intervention is no less alarming, especially

given the extensive reach within BSH's PS population. These ETO numbers also suggest continued and pervasive failures of treatment and unreported chemical restraint.

G. Analysis of Available Data Related to System Inequity in Application of Physical Restraint, Seclusion, and ETOs

As previously reported, individuals who identify as Black and/or African American are greatly overrepresented in the BSH population. Unfortunately, DOC reported in its January 2023 institutional demographics that the 33% of the BSH population has "unknown" race/ethnicity.[61] This data, set forth below, confounds DLC's tracking efforts.

Table 2. BSH Population and MA Population by Race/Ethnicity

Race/Ethnicity	BSH Population	Massachusetts Population
White	34% (77)	68%
Black or African American	22% (50)	9%
Unknown	33% (73)	N/A
Hispanic (Latinx)	9% (20)	13%
Asian or Pacific Islander	2% (4)	7%
Other (American Indian and Alaska Native, two or more races)	N/A	3%

The seventy-three (73) BSH PS with "unknown" race/ethnicity at the time of this census accounted for over half of all individuals with "unknown" race/ethnicity within all fourteen (14) DOC facilities. This signals that BSH is an outlier in terms of demographics reporting within DOC and fails to identify essential information about the PS population.

Reporting around race/ethnicity of PS became opaquer leading up to the January 2023 figures. In January 2020 and January 2021, the BSH population included 14% "other" race/ethnicity;[62] in January 2022, it was 12% "other."[63] In July 2022, the "other" category disappeared and 24% of the BSH population was reported as "unknown" race/ethnicity.[64] The significant growth of this unaccounted for "unknown" population at BSH, culminating in the most recent January 2023 figure of 33%, is highly concerning for a slew of reasons, including:

- If BSH does not know the racial/ethnic makeup of its nearly 250-person census, it cannot feasibly provide culturally competent mental health care or medical care to its PS population;

[61] DOC, *January 2023 MA DOC Institutional Fact Cards*, https://www.mass.gov/doc/institutional-fact-cards-january-2023/download.
[62] DOC, *January 2020 MA DOC Institutional Fact Cards*, https://www.mass.gov/doc/institutional-fact-cards-january-2020/download; DOC, *January 2021 MA DOC Institutional Fact Cards*, https://www.mass.gov/doc/institutional-fact-cards-january-2021/download.
[63] DOC, *January 2022 MA DOC Institutional Fact Cards*, https://www.mass.gov/doc/institutional-fact-cards-january-2022/download.
[64] DOC, *July 2022 MA DOC Institutional Fact Cards*, https://www.mass.gov/doc/institutional-fact-cards-july-2022/download.

- Failure to gather race/ethnicity information could mean similar failure in gathering other complete or accurate information about PS, including their primary languages and medical histories;
- Considering the paperwork and various records BSH receives upon PS admission and thereafter – in addition to the numerous opportunities staff have to revisit conversations about self-identification with PS – it is inexcusable that BSH would be unable to provide identification for one-third of its population; and
- Glaring deficiencies in gathering and/or reporting prevents accurate analysis of systemic inequities around race/ethnicity and Wellpath's use physical restraint, seclusion and ETOs;

Using the flawed data, DLC analyzed physical restraint, seclusion, and ETO data DOC provided covering January 11, 2023 to May 10, 2023 to create the charts below, comparing the total ETOs, Manual Holds, Mechanical Restraints and Seclusions administered by race/ethnicity. However, the sizable "unknown" group in the total BSH population hampered any ability to assess inequity in the distribution of various interventions. DOC and Wellpath must begin producing complete and accurate data on race/ethnicity moving forward.

The documentation showed that, over the four-month period between January 11, 2023 and May 10, 2023, Wellpath imposed the following on PS:

- **171 ETOs on 67 unique PS**;
- **401 manual holds on 126 unique PS**;
- **89 uses of mechanical restraint on 33 unique PS**; and
- **273 uses of seclusion on 103 unique PS**.

The manual hold data alone translates to Wellpath staff exerting physical force over half of the BSH population.

Table 3. ETOs by Race/Ethnicity (January 11, 2023 - May 10, 2023)

Race/Ethnicity	BSH Population	Unique PS Receiving ETOs
White	34% (77)	48% (32 PS)
Black or African American	22% (50)	25% (17 PS)
Unknown	33% (73)	9% (6 PS)
Hispanic (Latinx)	9% (20)	15% (10 PS)
Asian or Pacific Islander	2% (4)	0% (0 PS)
Other	N/A	3% (2 PS)
		100% (67 PS)

Table 4. Seclusion by Race/Ethnicity (January 11, 2023 - May 10, 2023)		
Race/Ethnicity	**BSH Population**	**Unique PS Secluded**
White	34% (77)	47% (48 PS)
Black or African American	22% (50)	30% (31 PS)
Unknown	33% (73)	4% (4 PS)
Hispanic	9% (20)	16% (17 PS)
Asian or Pacific Islander	2% (4)	0% (0 PS)
Other	N/A	3% (3 PS)
		100% (103 PS)

Table 5. Mechanical Restraints by Race/Ethnicity (Jan. 11, 2023 - May 10, 2023)		
Race/Ethnicity	**BSH Population**	**Unique PS in Mechanical Restraints**
White	34% (77)	45% (15 PS)
Black or African American	22% (50)	21% (7 PS)
Unknown	33% (73)	15% (5 PS)
Hispanic	9% (20)	12% (4 PS)
Asian or Pacific Islander	2% (4)	3% (1 PS)
Other	N/A	3% (1 PS)
		100% (33 PS)

Table 6. Manual Holds by Race/Ethnicity (January 11, 2023 - May 10, 2023)		
Race/Ethnicity	**BSH Population**	**Unique PS Receiving Manual Hold**
White	34% (77)	42% (53 PS)
Black or African American	22% (50)	30% (38 PS)
Unknown	33% (73)	7% (9 PS)
Hispanic	9% (20)	17% (22 PS)
Asian or Pacific Islander	2% (4)	1% (1 PS)
Other	N/A	2% (3 PS)
		100% (126 PS)

If, for instance, the unknown 33% (73 PS) were redistributed evenly among the White, Latinx, and Black or African American groups (24 PS each), the BSH population would rise to 45% White and 20% Latinx. This redistribution would effectively erase any significant overrepresentation of White PS among PS receiving ETOs (comparing 48% to their now 45% of the total population), while shifting Latinx overrepresentation to underrepresentation, comparing 15% to their now 20% of the total population. This scenario shows the transformative effects on the data of just one potential breakdown of the BSH “unknown” population.

3. Inadequate Access to Medical Care for Persons Served

As discussed above in Section 1.H., DLC commends DOC's intention to implement "universal sick call procedures," in keeping with our recommendations in past reports and is hopeful that this will improve BSH's responsiveness to PS medical concerns moving forward. During this reporting period, however, PS access to medical care remained an issue demanding significant attention. PS have given troubling accounts of delays in receiving and denial of medical attention. Concerns about medical care at BSH go beyond the impact on the PS' physical condition – inadequate medical treatment can exacerbate and, in some cases, give rise to PS mental health symptoms. Moreover, poor health outcomes and unequal access to health care for people with mental health disabilities is a well-established systemic problem, one that is compounded by institutional racism in U.S. health care delivery systems and pervasive health disparities for communities of color, women, people who identify as LGBTQIA+, people with LEP, people with low income, and people with other disabilities.[65]

One former BSH PS, contrasted his experience in his new DMH facility with his experience at BSH – while the DMH hospital urgently transferred him to community hospital for a serious infection, he said, "BSH would wait until you're almost dead." Additionally, in stark contrast to DOC's assertion that nurses are available 24/7, this PS described the very low nurse to patient ratio at BSH and improved access to care in the DMH hospital where there are multiple nurses per unit at all times.

A. Denial of Appropriate Medical Care

DLC interviewed a former PS who had been recently transferred to a DMH hospital after years at BSH. He reported that, after arriving at the DMH facility, doctors put him on an appropriate diabetic diet and gave him the correct medication for his Type 1 diabetes, which BSH had refused to provide due to cost. The DMH hospital also used a DexCom blood glucose monitor, which allowed nursing staff to consistently remain aware of his levels.

Another person, who had spent over six (6) months at BSH, reported that BSH did not provide him with Hepatitis C treatment despite knowledge of his diagnosis. Once he stepped down to a DMH hospital, his providers gave him the treatment.

B. Delays in Access to and Lack of Responsiveness to Request for Medical Care

PS continue to consistently report considerable delays in receiving medical attention for a range of ailments, both pre-existing and new conditions that developed during their involuntary commitment.

For example, a PS reported that BSH refused to prescribe him the daily maintenance dose of an antiviral therapy he had been taking for over ten (10) years to keep a viral skin infection that causes painful blisters at bay. Although his medical records make clear that he notified BSH of his antiviral prescript on the day of his admission, the PS did not receive the medication for a week until, once he had an outbreak, BSH providers prescribed a higher dose of the antiviral for

[65] Further discussion of disparities in health care access and outcomes for people with mental health disabilities can be found in DLC's recent investigation report entitled *Death Inside Lemuel Shattuck Hospital: A Case Study on Medical Treatment for Persons with Mental Health Disabilities* (May 8, 2023) at 5-7, https://www.dlc-ma.org/wp-content/uploads/2023/05/5.8.2023-DLC-LSH-Death-Investigation-Report.pdf&hl=en.

a period of five (5) days. Thereafter, he submitted a medical referral request through staff notifying Wellpath that he needed the maintenance dose but did not receive a prescription. Three (3) weeks later, he predictably had another outbreak, and was again put on a higher antiviral dose for five (5) days. He reported that, at the conclusion of that prescription, he went three (3) days without receiving any antiviral medication before being finally started on the maintenance dose.

The following is a sampling of other PS experiences:

- A PS who reported having been put in a choke hold and having his head pounded into the floor multiple times by staff during a physical restraint said he had cuts on his body and a concussion. He did not receive immediate medical attention and, after submitting two grievances seeking a medical appointment, he had received no response from a medical provider two (2) months after the incident.
- A PS described having had multiple seizures at BSH. Despite making multiple requests, he reported still not having been sent to a neurologist months later.
- A PS reported having sciatica and vascular disease in his legs and making multiple unsuccessful requests to see the doctor since he came to BSH roughly two (2) weeks earlier. While he waited to see the doctor, he was receiving only Tylenol.
- A PS who had been experiencing homelessness prior to his arrival at BSH, arrived with badly swollen feet. It took over two (2) weeks for him to see a doctor about this issue.

C. *Failure to Maintain Minimally Hygienic Conditions*

One PS, who lives with a chronic open wound and experiences serious self-harm, reported egregious unsanitary conditions and restricted access to infection prevention measures for months. BSH did not maintain appropriate medical supplies on his unit to clean his wound. The PS was not permitted to have soap in his cell and was not allowed to have a toothbrush for weeks; he was instead told to use his finger. During the reporting period, as food and other trash piled up for over a week, staff did not clean his room. DLC observed PS' unhealthy environment, including a used bandage lying on the floor teeming with ants, showed them to BSH staff, and requested that his room be cleaned. Following DLC's request, the PS requested a cleaning multiple times and offered to clean it himself, but was denied rubber gloves. Finally, over a week after DLC's request, staff addressed these unsanitary conditions.

While some items may have been withheld from this PS due to safety considerations, his room was routinely searched by staff and he was consistently on 1:1 observation, raising serious questions about the balance of clinical restrictions aimed at limiting self-harm against necessary measures to prevent infection, infestation, and unreasonable conditions of confinement.

4. Treatment of Persons Served in the BSH Annex Units at Old Colony Correctional Center

DLC did not observe any marked progress by DOC and Wellpath in addressing issues and PS complaints about the OCCC Units. The two (2) units – the ISOU, where PS are held during the evaluation period, and the RU, for PS who have been committed to BSH – were designed to serve as an annex to BSH for PS who are sentenced state prisoners living in DOC facilities designated for men. Both units are controlled by DOC correctional officers.

A. Heat in Cells

PS continue to complain about the extreme heat in ISOU cells. The vents in cells that provide "conditioned air" often appear painted over and function as exhaust. PS explain that the vent rarely offers a breeze. The fan in the ISOU dayroom provides PS no relief either pointing toward the area where correctional officers sit. See the discussion in Section 1.A. regarding the dangers of heat exposure for PS.

B. Lack of Access to Treatment

PS in both the ISOU and RU describe a lack of access to treatment. It is DLC's understanding that there are currently two (2) clinicians who cover both units, one of whom is the director of the units. PS describe having minimal access to clinicians and scarce one-on-one time with them. DLC spoke with multiple PS about the level of mental health support they receive in the ISOU. Most PS in the ISOU are actively, or were very recently, experiencing acute mental health crises involving self-harm or a suicide attempt. Each PS reported having no meaningful clinical treatment. One PS described having had no conversations with a clinician for at least three (3) days after he was admitted to the ISOU following a suicide attempt.

PS in the ISOU reported insufficient therapeutic programming offerings. In contrast, RU PS described having multiple groups per day, but difficulty accessing movements in order to take part in programming. Recently introduced restrictions require correctional officers to pat down RU PS on their way out of the unit, making it hard for PS to get out of the unit before staff close the door when movement is not announced with sufficient lead time.

C. A Reliance on Intimidation and Force

PS who have spent time in the ISOU almost universally describe the correctional officers there as exacerbating the strain that they are already experiencing by antagonizing them. Multiple PS recounted being called a "skinner" (pedophile) by officers – to their face or to other PS on the unit to create conflict – or being taunted by the officers in other ways. PS expressed concern about the officers' qualifications to work on an intensive mental health unit, given their work history and regular negative interactions with PS. According to PS, OCCC Companions (incarcerated individuals with their own lived experience with mental health disabilities trained to offer peer support) do not visit the ISOU with as much frequency as they used to due to negative interactions with officers.

Many PS in the ISOU and the RU also recounted multiple incidents of inappropriate use of force by officers. One PS recounted witnessing officers bring a PS to the floor and beat him up, busting his lip and leaving him with blood on his shirt. **DLC noted a total of three (3) incidents in which correctional officers pepper sprayed PS in the BSH Annex Units**. DLC spoke with one of the ISOU PS who was pepper sprayed; he said that officers made no attempt to resolve a minor issue concerning property before spraying him while he held his hands up, taking him down to the ground, and placing him in restraints.

5. Persons Served Continuity of Care

DLC monitors continuity of care and any barriers thereto through onsite visits to BSH, OCCC Units, DMH facilities, and county correctional facilities, PS interviews, and document review. During this reporting period, DLC conducted site visits at the Suffolk County Jail at Nashua Street and four (4) DMH facilities – Worcester Recovery Center and Hospital, Lemuel Shattuck Hospital, Tewksbury State Hospital, and Vibra Hospital. As discussed below, some impediments to successful continuity of care for former PS remain unchanged since DLC's last report and others have improved.

Consistent with interviews during previous reporting periods, most former PS reported to DLC that they were notified several days prior to their discharge from BSH, regardless of whether they were headed to a DMH hospital or a county correctional facility. The vast majority of former PS continue to report that they were not invited to any meetings to discuss discharge, ask questions, or learn about what to expect.[66] Many felt that being included in discharge planning would have helped facilitate a successful transition. DLC concurs.

A. Continuity of Care: DMH Hospitals

i. Challenges with Facilitating BSH Transfers

Recurring Issues: "Second Shift" Arrivals, Clinical Coordination and Documentation, Transfer of Persons Served Funds, and Benefits

DMH hospital administrators shared positive reports that the occurrence of BSH step-downs to DMH facilities arriving late during the hospital's second shift has decreased overall. While there are still late arrivals, individuals now typically arrive in the morning, allowing treatment teams an opportunity to conduct the initial assessments of new patients rather than delegating to second shift staff and on-call doctors. Some hospital administrators credit this improvement to the Office of Inpatient Management (OIM) for its close work with BSH, as well as OIM's monitoring of late arrivals at DMH hospitals.

According to DMH hospital administrators, the timely receipt of psychiatric and forensic records has improved. The documentation had been arriving at DMH hospitals along with incoming BSH PS. It now tends to arrive the day before, giving treatment teams an opportunity to prepare for PS arrival.

DMH hospital administrators reported that there are still delays in getting complete PS medical records upon discharge. While doctors at DMH hospitals continue to utilize direct conversations with doctors at BSH ahead of PS transfer, most medical diagnoses and physical health concerns are still not formally or regularly shared ahead of time. This delay in access to medical information translates to "reactive" rather than "proactive" care, as one DMH hospital administrator described it, in some cases resulting in BSH PS arriving with specialized health needs about which the DMH hospital had no warning. Some hospital administrators recently cited being in more regular communication with BSH medical providers; others expressed

[66] This Wellpath practice does not comport with DMH policies and practice of affording individuals "the opportunity to participate in and contribute to their treatment planning to the maximum extent possible." See M.G.L. c.123 § 4; 104 CMR 27.10, 11, 13; DMH Policy # 03-01, s. V.C.3.

concern about not having the correct names and contact information for BSH personnel to try to address these issues.

The timely transfer of patient funds from BSH to DMH hospitals remains an area for improvement. Across DMH hospitals, administrators varied in their assessments of how long PS had to wait for their funds to follow from BSH, ranging from weeks to months. PS consistently reported significant delays in receiving their funds from BSH.

DMH hospital administrators still report that the majority of BSH step-downs arrive at their facilities with deactivated MassHealth coverage or no MassHealth coverage at all. They explain that this is caused in part by the fact that BSH typically transfers PS without a discharge summary or other proof of release from incarceration. MassHealth thus considers them to be ineligible for full benefits and their status to be a "continuation of incarceration." This can require DMH hospitals to obtain a release from transferred BSH PS to request discharge summaries from BSH to MassHealth as proof of release from incarceration. These extra steps lead to delays in medical and dental coverage for BSH PS upon arrival at DMH hospitals. As noted above in Section 1.I., DOC intends to improve BSH practices to prevent these gaps in coverage.

High Census in BSH and DMH Facilities Hinders Access to Treatment and Less Restrictive Environments

High census continues to be a challenge for the DMH system statewide. Within the past year, Worcester Recovery Center and Hospital added additional beds by converting an adolescent mental health unit to an adult psychiatric unit and Tewksbury State Hospital is in the process of converting a medical unit to an adult psychiatric unit. In an interview with DLC, a DMH hospital administrator reported that they were housing one (1) to two (2) extra patients on each unit due to being above capacity – these individuals were living in comfort rooms or meeting rooms without private bathrooms.

In addition to potentially impact quality of care and conditions on DMH units, overcrowding can lead to DMH requesting more stays of BSH transfers in court proceedings. When DMH requests a stay for a discharge ready BSH PS due to lack of space at DMH hospitals, PS are forced to stay in "strict security" despite a finding that they are ready for a less restrictive environment. In addition, with DMH thirty (30) beds over census for extended periods of time during this reporting period, judges were more likely to send someone to BSH for an evaluation than to wait for an available DMH bed.

The high census in DMH in conjunction with BSH's higher census this reporting period also impacts county correctional facilities and people with mental health disabilities incarcerated in them. County administrators reported to DLC that people have been returning from Section 18(a) evaluations[67] more quickly and seem to be receiving less treatment at BSH than they have at times when mental health facilities are less crowded.

[67] M.G.L. c. 123, § 18(a) sets forth a process by which a correctional facility may seek the commitment of a "person confined therein" on they basis that they are "in need of hospitalization by reason of mental illness" at a DMH facility or at BSH (only if male) and, following a district court order, the person may be sent to a DMH facility or BSH "for examination and observation for a period not to exceed thirty days." A psychologist or physician at the receiving facility must then send a written report of the "evaluation, supported by clinical findings, of whether the prisoner is in need of further treatment and care at a facility or, if a male, the Bridgewater state hospital by reason of mental illness." Id.

B. Continuity of Care: County Correctional Facilities

i. Mental Health Watch Across Counties

As a following to the discussion of varying access to behavioral health treatment across county facilities in our last report, DLC provides a look at Mental Health Watch (MHW) in various counties based on onsite monitoring observations and information produced by county sheriffs' departments. MHW is an essential component of PS continuity of care, as it is typically the last status of incarcerated persons before leaving county correctional facilities for an evaluation at BSH and may be where they go upon their return. Experiences of individuals on MHW vary widely from county to county and can have lasting psychological impact.

As previously reported, the U.S. Department of Justice entered into a settlement agreement with DOC in December 2022 following damning November 2020 findings that DOC's failure to provide adequate mental health care and supervision to prisoners in mental health crisis constituted an Eighth Amendment violation.[68] Unfortunately, conditions in certain county correctional facilities present similar concerns that warrant the Commonwealth's attention and enhanced oversight by DMH. DLC intends to continue gathering and sharing information concerning MHW spaces and practices in counties across the state as part of our monitoring to improve PS continuity of care.

Suffolk County Jail at Nashua Street and South Bay House of Correction

The Suffolk County Sheriff's Department reported that an average of thirty-six (36) people per month at the Nashua Street Jail were on MHW between December 2022 and May 2023, with an average length of stay of two (2) days. During the same period at the South Bay House of Correction, there was an average of thirty-two (32) people per month, with an average length of stay of 2.25 days.

At the Nashua Street Jail, MHW cells are located in the Medical Division and in part of the Special Management Unit. In the Medical Division, cells are 120.5 square feet (16 feet 3 inches x 7 feet 7 inches) and four (4) out of seven (7) cells have in-cell cameras; the remaining three (3) are currently undergoing camera installation. The single cells contain a sink and toilet, bed, and a window facing the Charles River. There is a small dayroom outside the cells. The Sheriff's Department reported that stays of seven (7) days or more are rare.

The Special Management Unit (SMU) at the Nashua Street Jail contains one side with eight (8) cells used to house prisoners with disciplinary offenses who have diagnoses of "Serious Mental Illness." As needed, such cells are used for MWH. The area of those cells is typically 88.2 square feet (12 feet 2.5 inches x 7 feet 3 inches) and four (4) out of eight (8) cells have in-cell cameras. Per the Sheriff's Department, people in these specially designated cells have mental health rounds three times per week (versus one time per week in the Special Management Unit), have more out of cell time, and receive closer staff monitoring.

[68] DOJ, *Justice Department Secures Agreement with Massachusetts Department of Correction Investigation Involving Individuals in Mental Health Crisis* (December 20, 2022), https://www.justice.gov/opa/pr/justice-department-secures-agreement-massachusetts-department-correction-investigation; U.S. Department of Justice, *Investigation of the Massachusetts Department of Correction* (November 17, 2020), https://www.justice.gov/opa/press-release/file/1338071/download.

At South Bay House of correction, five (5) of the nineteen (19) cells in the Medical Unit are designated as MHW cells; all nineteen (19) have in-cell cameras. These single cells typically measure 110 square feet (11 feet x 10 feet).

Based on the Suffolk County Sheriff's Department Policy No. S624: Suicide Prevention, DLC understands that individuals on MHW start under continuous observation, requiring the assigned correctional officer to document their observations every fifteen (15) minutes. A medical or mental health provider determines what clothing and other property is permitted in the cell. The individual will remain on MHW status until a licensed mental health clinician determines after an assessment that less frequent observations would be appropriate. When a provider determines that housing in the Medical Division is no longer necessary, staff will arrange for transfer to another housing unit.

Middlesex Jail & House of Correction

The Middlesex Sheriff's Office reported averaging approximately 43 prisoners per month on MHW from December 2022 through June 2023.

In this facility, MHW cells are located on the Middlesex Evaluation and Stabilization Unit (MESU), the Regional Mental Health Stabilization Unit operated by the Middlesex Sheriff's office used for intensive short term mental health evaluation and treatment. In total, twenty-five (21) beds are available for MHW – eight (8) single cells, a ward with nine (9) beds, and a ward with four (4) beds. The area of single cells used for MHW on the MESU are 105 square feet (10 feet x 10 feet 6 inches). All cells on the MESU have in-cell cameras. During DLC's site visit, cells were clean and contained narrow windows to the outside. MHOC also operates four (4) additional MESU overflow cells on the E-Pod, a mental health unit, that are also designated for use as MHW cells.

Per a review of Middlesex Sheriff's Office Policy and Procedure 613: Mental Health Services and Policy and Procedure 651: Regional Evaluation and Stabilization Unit, DLC understands that individuals deemed to require MHW are placed on Constant Observation by staff or on Close Observation, consisting of checks by staff every fifteen (15) minutes. People on Constant Observation must wear a "suicide resistant garment," may have a "suicide resistant blanket" if approved by a mental health clinician, and may shower while supervised as clinically indicated. On Close Observation, the degree of clothing available depends on the level of assessed suicide risk. Middlesex Sheriff's Office policy also states that all persons on MHW may engage in "routine activities" unless otherwise indicated by a mental health professional.

Worcester County Jail & House of Correction

The Worcester County Sheriff's Office reported that, in total, there were 265 prisoners on MHW from December 2022 through mid-June 2023. This means that an average of around 40 people were on MHW per month. The Sheriff's Office noted that this number also accounts for the recurring placement of the same individuals.

MHW takes place in a dedicated unit, consisting of two tiers with a dayroom at one end. There are sixteen (16) MHW cells. All cells are 83.75 square feet and have in-cell cameras. When DLC conducted onsite monitoring, the bottom tier was unoccupied, but the top tier was in use. This top tier has noticeably low ceilings, narrow hallways, and cramped cells. It was extremely hot in the unit when DLC spoke with people in MHW, though staff expressed that they could request for their windows to be opened.

Worcester County Sheriff's Office Policy 932.13: Mental Health Services and Suicide Prevention, indicate that there are four (4) levels of MHW status: Constant Observation, Intermediate Mental Health Watch, Intensive Mental Health Watch, and Pending Mental Health Assessment. Any staff member can place an inmate on Pending Mental Health Assessment status, but only a qualified mental health professional can remove them from pending status or place them on mental health watch. With the exception of Constant Observation, people on MHW are observed every fifteen (15) minutes. When brought to MHW, individuals are strip searched, their property is searched for contraband and stored, and they are put through a body scanner. People on Constant Observation, Intensive Mental Health Watch, and Pending Mental Health Assessment are issued a suicide smock, a security mattress and reading material unless a mental health professional determines otherwise. Individuals on Intermediate Mental Health Watch are issued a jumpsuit instead of a suicide smock, as well as other property allowed in general population (except razors). Policy provides for one on one, out of cell meetings every day with a mental health professional for counseling. Mental health staff may reduce the level of observation and increase the level of privileges as people become more stable. Individuals MHW for more than five (5) days may receive one (1) hour of recreation time, subject to mental health and correctional staff discretion.

Plymouth County Correctional Facility

The Plymouth County Sheriff's Department reported that, from December 2022 through May 2023, Plymouth County Correctional Facility averaged forty-one (41) individuals per month on MHW.

The facility has eight (8) cells approved for mental health watch, each of which are equipped with a camera. The Sheriff's department did not provide cell size or dimensions. DLC observed onsite MHW cells located off in a remote-feeling area in the larger booking area. According to staff available during our monitoring, windowless booking/holding cells double as MHW cells people often start their stay on MHW without a mattress. At least one (1) of the MHW cells is a room with rubberized walls and floor that is bare except for a drain in the middle of the floor. Based on DLC's observations, attorney access on MHW entails a correctional officer holding a phone up to the door of watch cell.

BSH PS have mentioned their experiences on MHW at the Plymouth County Correctional Facility to DLC frequently, citing inadequate nutrition, lack of mental health treatment, and flashbacks and residual trauma after their release. One described it as "hell on earth."[69]

Plymouth County Sheriff's Office Policy 655: "At Risk" Management Program, indicates that individuals put on "at-risk" or suicide watch status are moved to an "observation cell," strip-searched, placed in a "padded safety smock" with a security mattress and padded safety blanket, and given food served on "appropriate harmless material." This policy contains a note stating, "If self-injurious behavior is apparent, restrict food to neutral loaf or finger foods without

[69] DLC's January 2023 report described the account from a PS about his experience on Mental Health Watch at the Plymouth County Correctional Center: "He was placed in a Mental Health Watch cell – a cell with rubberized walls and floor that is bare but for a drain in the middle of the floor – for thirteen (13) days in the fall of 2022. During that time, he reported having access only to an anti-suicide smock for clothing and the drain in the floor as his toilet while his mental health declined further due to the conditions and dehydration resulting from his limited food and water intake. As of the date of the interview, which took place at a DMH hospital, the PS was still having flashbacks to his traumatic Mental Health Watch experience." DLC January 2023 Report at 47.

utensils."[70] Correctional officers conducting constant observation record observations every fifteen (15) minutes. Notably, though observation cells at the Plymouth County Correctional Facility must have adequate lighting and ventilation, policy states that toilet, sink, and shower need not be in MHW cells, but "in an immediately accessible or adjacent area." Policy 655 defines a "soft cell" as a "[s]pecially constructed room(s) located in Booking & Release where behaviorally dysfunctional and violent inmates can be temporarily confined and observed without risk of causing injury to themselves or others, or damage to property." Further, only approval from a Shift Commander is necessary to place someone in a "soft cell"; after placement, the Booking and Release Supervisor must notify medical staff. Plymouth County Sheriff's Office Policy 656: Suicide Prevention Plan states that "a soft cell should be utilized only as long as necessary, but ideally no longer than eight (8) continuous hours, unless continued confinement is ordered by Medical staff, or other qualified medical or mental health professional."

6. Other Important Issues DLC Is Following

In the course of monitoring, DLC identifies many issues that warrant our attention and, often, further investigation. Some of the issues on our current list are:

1. The prevalence of and BSH screening for head injuries in the PS population.
2. Implementation of M.G.L. c. 123, § 18(a1/2).
3. Treatment of Transgender PS and Compliance with the Requirements of M.G.L. c. 127, s. 32A.
4. PS Access to Disability-Based Accommodations.
5. Applicability of and BSH Providers' Compliance with Requirements Related to Safety Review Via Institutional Review Board of Human Research Studies Using PS as Subjects.

[70] DLC believes that "neutral loaf" may be referring to nutraloaf, "a concoction of mashed-together ingredients that are baked into a brick-like loaf designed to meet basic nutritional guidelines… simply leftovers from the day's meals dumped into a blender and then cooked." PRISON LEGAL NEWS, *Use of Nutraloaf on the Decline in US Prisons* (March 31, 2016), https://www.prisonlegalnews.org/news/2016/mar/31/use-nutraloaf-decline-us-prisons/#:~:text=The%20prison%20systems%20in%20California,nutraloaf%20as%20a%20disciplinary%20tool. Nutraloaf's use is widely considered a form of punishment and multiple sources indicate that many states, including Massachusetts, have banned its use as punishment. *See, e.g., id.*

Conclusion and Recommendations

Based on the discussion above, DLC calls upon DOC, Wellpath, DMH, and the Commonwealth of Massachusetts to follow the recommendations set forth below to protect the rights, health, and safety, of current and former PS.

1. **To protect the health of individuals confined to, working in, and visiting BSH, the Commonwealth must commit to shuttering BSH and constructing a modern facility designed to provide all individuals in need of "strict security" psychiatric evaluation and/or treatment in a safe, therapeutic environment.**

2. **The Commonwealth must immediately place BSH operations as well as the planning, construction, and oversight of a new hospital facility under the authority of DMH to ensure current and future PS access to trauma-informed, person-centered mental health treatment.**

3. DOC must commit to fully remediating mold in accordance with expert recommendations and industry standards. DLC recommends that DOC contract with a qualified vendor to conduct a thorough visual inspection and surface swab sampling at BSH in order to adequately identify and resolve environmental toxins throughout the facility. Air sampling is not an adequate substitute.

4. DOC must devise more effective heat mitigation protocols to ensure that PS are comfortable in their cells and do not suffer serious health complications or death in high temperatures as a result of their disabilities and medications.

5. DOC and Wellpath must immediately cease imposition of chemical restraint, including ETOs, physical restraint, and seclusion in circumstances that do not meet the narrowly tailored dictates of M.G.L. c. 123, § 21.

6. DOC and Wellpath must accurately document and report all uses of chemical restraint, physical restraint, and seclusion, including ETOs, in keeping with applicable law.

7. DLC recommends that DOC and Wellpath to include DLC and the Massachusetts Association of Mental Health (MAMH) in drafting policy revisions, and to consult with DMH, to ensure that all BSH policies and practices concerning the use of involuntary medication, restraint, and seclusion on PS conforms with the law of the Commonwealth, including DMH regulations and policies.

8. DOC and Wellpath must not tolerate the use of unnecessary and/or disproportionate force on PS – in BSH or the OCCC Units – by staff. In addition to improving review of incidents after they occur, DOC and Wellpath must improve supervisory oversight during incidents involving planned uses of force and take disciplinary action against staff who engage in misconduct.

9. DLC recommends that Wellpath revise staff trainings to accurately reflect the requirements of Massachusetts law concerning restraint, seclusion, and involuntary medication.

10. DOC must gather and provide DLC access to accurate information concerning PS race/ethnicity, primary language, and identification as LEP. Without this important

information about PS, BSH cannot provide culturally competent care and DLC cannot effectively monitor compliance with DOC's legal requirements to provide language access to PS and any disparities in the application of restraint, seclusion, and involuntary medication on PS.

11. DOC must ensure that MAT access and treatment for BSH PS complies with medical standard of care, state and federal antidiscrimination law, and DOC's program for accommodating people with opioid use disorder, as memorialized in the November 4, 2021 letter from the U.S. Attorney's Office.

12. With more mechanisms in place for PS to seek access to medical treatment, DOC and Wellpath must improve responsiveness to PS' medical needs.

13. DLC recommends that DOC require Wellpath to cease use of ADASUVE on PS due to the increased risks of bronchospasm and contraindications for people with underlying respiratory conditions and aging individuals with dementia.

14. DOC and Wellpath must improve access to mental health clinicians and therapeutic programming in the ISOU to break the cycle of self-harm, ISOU evaluation, discharge, and repeat for prisoners with serious behavioral health needs deemed to not meet the commitment standard.

15. DLC recommends that the staffing model in the ISOU and RU be changed to maximize PS access to clinicians and program staff and minimize correctional officer interactions.

16. DLC recommends that DOC and Wellpath take the necessary steps to ensure that, upon discharge, MassHealth is promptly notified of any change in incarceration status and PS funds are transferred in a timely manner to receiving facilities.

17. DLC recommends that DMH resources be committed to further DMH engagement with all county correctional facilities to enhance access to mental health care for all county prisoners, including recently discharged BSH PS. Such engagement should include reviewing current care available and Mental Health Watch practices, enforcing minimum standards, promoting best practices, and creating working groups to ensure a collaborative approach to care and responsiveness to the needs of this population.

Appendix A: Glossary of Acronyms Used in the Report

BSH	Bridgewater State Hospital
DLC	Disability Law Center
DMH	Department of Mental Health
DOC	Department of Correction
DOJ	U.S. Department of Justice
ETO	Emergency Treatment Order
IM	Intramuscular
ISOU	Intensive Stabilization and Observation Unit in the Bridgewater Annex located at Old Colony Correctional Center
ISU	Intensive Stabilization Unit
LEP	Limited English Proficiency
MAT	Medication Assisted Treatment
MESU	Middlesex Emergency Stabilization Unit
MHOC	Middlesex County House of Correction
NEO	New Employee Orientation
OCCC	Old Colony Correctional Center
PS	Person(s) Served
RH	Restrictive Housing
RU	Residential Unit in the Bridgewater Annex located at Old Colony Correctional Center
SMI	Serious Mental Illness
SUD	Substance Use Disorder
TST	Therapeutic Safety Technician

Appendix B: Department of Correction Response to January 2023 Disability Law Center Report on Bridgewater State Hospital (June 7, 2023)

The Commonwealth of Massachusetts
Executive Office of Public Safety & Security
Department of Correction
50 Maple Street, Suite 3
Milford, MA 01757
Tel: (508) 422-3300
www.mass.gov/doc

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

TERRENCE M. REIDY
Secretary

CAROL A. MICI
Commissioner

SHAWN P. JENKINS
Chief of Staff

KELLEY J. CORREIRA
ROBERT P. HIGGINS
MITZI S. PETERSON
THOMAS J. PRESTON
Deputy Commissioners

June 7, 2023

Barbara L'Italien
Executive Director
Disability Law Center
11 Beacon Street, Suite 925
Boston, MA 02108

Re: Disability Law Center January 2023 Report on Bridgewater State Hospital

Dear Director L'Italien:

I write in response to the Disability Law Center's (DLC) January 2023 report on Bridgewater State Hospital (BSH), the Commonwealth's mental health facility providing care to persons served determined by the court to require strict security, inpatient psychiatric evaluation and hospitalization. I am disappointed that DLC has not perceived an improved environment for the persons served at BSH since the report of July 2022. It is the goal of the Department of Correction (Department), in collaboration with our contracted healthcare vendor, Wellpath, to provide a healthy and recovery-based environment for all in our care.

Physical Plant

My prior letters have, as your report recognizes, outlined the many actions we have taken to remediate mold, asbestos, and air quality issues at BSH, and I disagree with DLC's characterization of the Department's efforts in these regards as not "meaningful." Contrary to that characterization, the Department continues to make substantial improvements to the condition of BSH's physical plant and to perform all necessary cleaning and testing. With respect to pest control in particular, the Department and Wellpath have worked closely to ensure that sanitation practices at BSH are of the highest quality. In order to monitor and address any invasive pest issues, Flynn Pest Control – the company used for all state facilities – assesses the physical plant and any emerging concerns on a weekly basis. Exclusion work on identified areas of concern are prioritized, as is the continuous removal of trash and debris that could invite pests.

Despite our disagreements, I acknowledge that DLC's continuing concerns with the safety of the physical plant are genuinely held. It is apparent that the experts at the Department and the Division of Capital Asset and Management and Maintenance (DCAMM) have used to evaluate the building for air quality health are in

disagreement with the company that DLC has used, Gordon Mycology. However, the companies appear to agree on the industry standards that should be used to guide testing for mold. Contrary to the allegation in your report, the Department's expert did refer to IICRC/ANSI standards Document S520, "the most accepted and widely used document in the mold remediation industry." (See page 11 of your report.) The Arcadis final oversight report stated the following:

> "Select conducted the mold remediation activities in accordance with applicable mold guidelines and standards including but not limited to: American National Standard Institute (ANSI) IIRC S500 Standard and Reference Guide for Professional Water Damage Restoration, Environmental Protection Agency (EPA) Mold Remediation in Schools and Commercial Buildings, and Center for Disease Control and Prevention (CDC) Mold Cleanup, Removal and Remediation guidance documents."

Moreover, David Forrand, who provided oversight of Arcadis's asbestos remediation work, is a Massachusetts Department of Labor licensed asbestos remediation monitor.

Unfortunately, there are no federal or state regulations establishing air quality requirements against which our respective experts' findings could be measured; nor, significantly, are there federal or state requirements governing the methodology used to test for air quality, which is a source of disagreement between Arcadis and Gordon Mycology. Thus, I suggest that to resolve this conflict, and in the interest of transparency and collaboration, we mutually agree on a vendor for the Department to retain to conduct a new assessment of air quality in the physical plant. I have included an appendix (Appendix 1) listing state vendors that are certified to conduct environmental testing and remediation work. Please contact Deputy Commissioner Thomas Preston at 508-422-3328 at your earliest convenience to notify the Department of your preferred vendor.

Emergency Medication, Seclusion, and Restraint

Between the current DLC report (January 2023) and the penultimate report (July 2022), BSH reduced the usage of involuntary injectable medication by 13% (304 v. 263). Since the January 2022 report, there has been a 29% reduction (370 v. 263). From January 1, 2023 to May 31, 2023, there were a total of 202 involuntary injectable medications administered. Because this is only a five-month reporting period, as opposed to the previous six-month periods, DOC has extrapolated that this would result in 242 injections over a six-month period, or a reduction of approximately 8% (263 v. 242) since the last reporting period, and a reduction of 35% since the January 2022 report (370 v. 242). Nevertheless, DLC continues to find Wellpath's use of involuntary injectable medication unacceptable and therefore the Department has retained Dr. Debra A. Pinals, a forensically trained psychiatrist independent of the Department and Wellpath to examine the use of Seclusion, Restraint, Emergency Treatment Order (ETO) and Involuntary Medication practices at BSH. This review will ensure that practices at BSH are in line with the best interests of the persons served and nationally recognized best practices. Of note is that Dr. Pinals' experience includes several years with the Commonwealth's Department of Mental Health and therefore she has direct knowledge of Bridgewater State Hospital.

The Department will also be more assertive in its effort to minimize unnecessary delays in the adjudication of petitions for commitment because such delays prevent clinical staff from treating persons served according to a court authorized treatment plan. As you know, until a court has issued a judicial commitment order neither the Department nor Wellpath may obtain a court-ordered treatment plan under G.L. c.123, §8B.[1] Notably,

[1] Wellpath is permitted under state law, to administer medication involuntarily pursuant to either a District Court or a Probate Court order, without the need to rely upon the *Roger's* exceptions. Wellpath is only able to obtain such an order from the District Court if the individual has been civilly committed by the District Court to a mental health facility, or if the individual is subject to a Probate and family court order. A Probate and Family Court petition proceeds even more slowly than the civil commitment proceedings under Chapter 123.

21%, of the 331 instances of Emergency Treatment Order (ETO) administrations that occurred between July 1, 2022 to January 31, 2023 were for persons served where the petition for commitment was pending. The result of this delay is an increased likelihood that the person served is in such acute psychiatric distress that there is a risk of imminent harm to self or others or an irreversible decline in a persons served's psychiatric health. Experience has shown that once clinicians are able to implement a court ordered treatment plan, persons served demonstrate a markedly improved presentation.

Unfortunately, it is anticipated that even if the Department does become more assertive in its efforts to limit delay in the adjudication of petitions for commitment, the number of involuntary administrations may not decline as substantially as DLC would find acceptable. Of the 331 instances of ETO administration that occurred from July 1, 2022 to January 31, 2023 at BSH, 147 of these instances, 44%, involved a person served who was admitted to BSH during his Court-ordered observation period, before Wellpath has determined whether a commitment petition was warranted. In short, in a majority of instances where Wellpath issued an emergency treatment order, there was no alternative means by which to treat a person served with medication involuntarily.

In addition to the conditions under which ETOs are used, I understand that DLC continues to express concern that the use of the term "Emergency Treatment Order" is not aligned with M.G.L. c. 123, §21 and 104 CMR 27.12, and the case *Rogers v. Comm'r of the Dep't of Mental Health*, 383 Mass. 489 (1983), and that DLC conceptualizes these treatments as "chemical" or "medication restraints." It remains the case – as I have explained in prior letters – that an ETO is not a form of restraint. Nevertheless, in response to DLC's concerns, the Department and Wellpath are revising BSH policies to utilize the terminology you feel is required by G.L. c. 123 and regulations. These revisions will appear in both the Use of Involuntary Psychotropic Medications policy and the Use of Seclusion and Restraint policy, both of which are currently in the revision process and will be implemented once that process is complete.

A third new policy is the Serious Clinical Episode policy. This policy establishes a procedure where all Serious Clinical Episodes, including instances of seclusion, restraint, or emergency medical treatment, are reviewed (both the video footage of the event and the supporting documentation) by the Serious Clinical Episode Oversight Committee. If the reviewing staff notice employee conduct issues posing a risk to the safety of persons served, immediate action is taken, including but not limited to the initiation of an investigation, referral to the Disabled Persons Protection Commission (DPPC), or referral to the Department's Criminal Prosecution Unit (CPU). To further enhance oversight, all findings, actions taken, and follow-up related to Serious Clinical Episodes are presented to the Department's Health Services Division (HSD) at Executive Staff Meetings conducted on the first and third Wednesday of each month.

De-escalation Practices, Training and Culture

DLC's report observes that seclusion and restraint must be avoided when "interven[tion] with de-escalation technique[s]" would be effective. I agree. Wellpath offers six to eight Mandt System training classes per month, led by instructors required to be recertified every two years, with each BSH staff member receiving a Mandt refresher training annually. The frequency of the classes makes it untenable to rely on external trainers to lead the Mandt classes. The presence of qualified in-house instructors allows BSH to ensure that all staff consistently receive the required training. Additionally, this model ensures that instructors have insight into working with persons served at BSH and allows instructors to effectively relate the techniques taught to real-life experiences at BSH. A role-play component that pairs with Mandt training was added to the New Employee Orientation starting in October 2022 and has continued since. I invite representatives of DLC – especially those who frequently visit the hospital – to participate in the Mandt training. I hope this involvement will affirm for DLC that the Mandt trainings and trainers are integral to a recovery and trauma-informed environment.

Finally, as outlined in the employee handbook, Wellpath employees are encouraged to voice any concerns related to safety or performance issues among coworkers and are required to report any misconduct toward persons served. Any incidents of discrimination, harassment, or retaliation by any Team Member or any other person, or any conduct believed to violate this policy, must be reported immediately to any member of Human Resources or management. A Team Member is not required to bring a complaint to any member of Human Resources or management if the Team Member is uncomfortable doing so for any reason. In that case, complaints may be reported to the Chief Human Resources Officer. The complaint may be brought in person, in writing, or orally. Team Members may also contact the confidential toll-free hotline or email to report a complaint. This information is provided to all employees in their new employee handbook, and the confidential toll-free number is posted throughout the buildings. Finally, team members have access to the Department's Inmate Management System where they can make confidential reports about concerning conduct.

Access to Confidential Documentation

You are correct that, in response to one of DLC's requests for confidential records, the Department requested that DLC follow the procedures for access to confidential health records set forth in federal law. As you know, it was necessary for DLC to issue a probable cause finding under 42 U.S.C. §10805, before the Department could provide you with confidential medical information about persons served. After DLC followed those procedures by formally invoking its authority under federal law to obtain confidential information, the Department produced the otherwise privileged records and identifying information on February 1, 2023. Thus, the Department has not declined to provide you with the requested information that was available.

Language Access for Persons Served

The Department and Wellpath acknowledge the difficulty of providing diverse language coverage through specially trained forensic bilingual clinical staff and service providers in a strict security psychiatric facility. Wellpath currently considers bilingual fluency when calculating rates upon hire. Though bilingual fluency is not currently a standalone qualification that results in a predetermined rate increase, Wellpath is currently exploring options to implement a process that provides for a specific rate.

At this time, there are 11 Limited English Proficient (LEP) persons served, including three Russian speakers, one Burmese speaker, one Vietnamese speaker, one Taishanese speaker and five Spanish speakers. BSH has identified a Language Access Monitor who is responsible for monitoring and tracking language access issues. Based on DLC's recommendation, Wellpath is now using the Office of Criminal Justice Service's "I speak" language identification cards in the admissions area to assist the identification of a person served's proficient language. Once ascertained, LEP persons served can participate in English language groups utilizing the Voyce tablet, of which there are eleven at BSH, or utilize the curricula and therapeutic tools translated into Spanish and Haitian Creole. When additional materials are desired in languages other than Spanish, English, or Haitian Creole, Language Line Solutions, a company with significant experience in interpreting healthcare information, is used to interpret the materials.

Wellpath has also improved signage in the admissions area and housing units to highlight programming in other languages. Finally, rehabilitation coordinators are always made aware of LEP persons served and assign them to programming that meets their language abilities and needs. There are currently Russian, Spanish and English treatment and activity groups occurring within BSH.

Co-occurring Substance Use Disorder Treatment

BSH has offered assessment and treatment for substance use disorders (SUD) for many years, and has offered Medication Assisted Therapy (MAT) since the summer of 2021. SUDs are a frequent co-morbidity for persons

served. Since 2021, providers have been able to continue MAT for persons served who were receiving it prior to admission and resume or initiate it for persons served who are assessed to be in need of this therapy. When persons served are actively enrolled in a MAT treatment program, treatment at BSH is continued, and if such treatment is not continued, justification for cessation must be provided by the clinical provider. Delays caused by criminal justice involvement have often caused interruptions in treatment; however, treatment is resumed promptly once assessed as clinically indicated at BSH.

The Department welcomed DLC's suggestion to audit the delivery of MAT services at BSH and, accordingly, has conducted a thorough record review of MAT Services. As of January 18, 2023, there were 10 persons served receiving Medications for Opioid Use Disorders - 3 treated with Methadone, 5 treated with Buprenorphine Naltrexone and 2 treated with Buprenorphine Sublingual. The Department will continue to share statistics and audit findings with DLC.

Use of Atypical Medications

Wellpath has demonstrated the ability to treat the Commonwealth's most acutely ill persons served and is always seeking to use the safest and least invasive treatments. To that end, and in response to concerns expressed in several DLC reports regarding utilization of injectable medications, Wellpath has initiated the use of Adasuve, (inhaled Loxitane powder), which is an evidence-based and FDA approved treatment for psychiatric emergencies. During the September 21, 2022 Governing Body meeting, the Medical Executive Director presented the Psychiatry, Medicine and Dental Report and introduced BSH's initiative regarding Adasuve. As reflected in the report of that meeting: "The Hospital is now REMS certified to administer Adasuve which is an inhaled form of Loxitane designed to help alleviate the psychiatric symptoms associated with behavioral emergencies. We hope that this will reduce the need for injectable emergency medications."

Wellpath has used Adasuve with success on appropriate persons served at BSH and hopes to continue to promote its safe usage. That said, the Department and Wellpath will certainly be responsive to concerns or objections expressed by the independent psychiatric expert in her report.

Access to Medical Care

The Department appreciates DLC's suggestion that requests for evaluation and treatment of medical conditions be submitted in writing. Consequently, the Department has worked with Wellpath leadership to initiate universal sick call procedures. All requests for medical attention are now documented on a sick call request form by a person served or with the assistance of a peer support specialist, an advocate or healthcare provider. This sick call request is logged in the unit logbook to monitor "sick call" follow up, which outlines the date of the sick call request, and referral type: Emergent, Urgent or Routine. The sick call request is also scanned into the person served's electronic medical record. Unit nurse managers are required to monitor the logbook daily and follow up on any outstanding issues. In addition, the Department has added a review of the unit sick call logs and sick call response to the general healthcare audits conducted twice annually.

For clarity, all persons served, including LEP and persons served with disabilities that impact their communication abilities, are provided reliable access to medical care and medical equipment directly from designated members of the medical provider and nursing staff. Nursing is available and present on each unit 24 hours a day/7 days a week. A medical provider is accessible on-site 24 hours a day/7 days a week. The Language Line is available 24 hours a day/7 days a week for translation to all persons served via a specialized call center. Specialized communication devices are available and accessible for persons served with hearing deficits.

Finally, as has been practice in this and prior healthcare contracts at BSH, the Department of Medicine at BSH provides the community standard of care for screenings for physical health conditions. Every person served admitted to BSH is offered a comprehensive, physical examination upon admission, which includes a full review of systems, including the pulmonary system. Should a refusal of an initial physical examination occur, additional opportunities to complete the physical examination are offered. Persons served have unlimited access to nursing staff, who are permanently posted on-unit, and persons served may always request appointments with Medical Providers should they experience any physical health symptoms, including that of respiratory symptoms. In addition, persons served with chronic disease are referred to the Chronic Disease Clinic for ongoing care management. BSH has established an enhanced monitoring process for these persons served that ensures regular follow up visits or referral to the Medical Risk Committee should persons served persistently decline medical care. If clinically indicated, consideration of alternative interventions, including a Medical Guardianship, are considered to ensure that the chronic disease is appropriately managed. All higher level of care healthcare needs are promptly referred for specialty consultation at appropriate hospitals, which may include Lemuel Shattuck Hospital, Boston Medical Center, UMASS, Massachusetts General Hospital or whichever hospital is thought to best be able to consult on the condition.

Continuity of Care

As I have said in the past, issues related to the continuity of care include the importance of having a timely transfer once the court has deemed it appropriate for a person served to step down to a Department of Mental Health facility. As DLC is aware, BSH cannot transfer a person served before obtaining the proper court order. Wellpath providers work closely with the receiving site's providers to ensure that clinical discussion, progress, successful interventions, and individual needs are communicated thoroughly to provide the person served with the greatest chance of success.

Similarly, Wellpath discharge planners make great efforts to ensure MassHealth is informed of any changes in a person served's level of care. As DLC may be aware, involvement in the criminal justice system complicates one's coverage due to suspension or termination of coverage under federal law governing Medicaid eligibility. The Department's Reentry Services Division will collaborate with Wellpath to improve BSH practices to refine the protocol to ensure all persons served can obtain needed MassHealth coverage once discharged from an inpatient facility. In addition, the Department will examine how the Commonwealth's application for a federal waiver of certain Medicaid requirements could assist in continuity of healthcare coverage for persons served at BSH.

With regard to DLC's recommendation for the Intensive Stabilization and Observation Unit (ISOU), persons served in the ISOU currently receive a high level of care. Persons served are offered four to five structured groups per day, peer support services, substance use disorder treatment, Music Therapy, and Occupational Therapy. Each person served is seen daily by nursing staff. Social Service Professionals and Psychiatric Providers also see each person served in the ISOU at minimum once a week; however, several persons served are typically seen daily based on their level of need. Significantly, incidents of self-directed violence have been remarkably low in the ISOU during this most recent DLC reporting period, including three months during which there was not a single instance of self-directed violence. This is notable given the acuity and dysregulation of many of the persons served in the ISOU.

Gender Non-Conformity

Proactively, I believe it is important to address the four concerns outlined in section 10 of your most recent report. The Department and Wellpath have clear policies regarding the identification, management, and treatment of gender non-conforming persons in our care. While rare, BSH has received transgender men and women and have appropriately addressed their individual needs per policy and in accordance with M.G.L. c.

127, §32A. The Department encourages DLC to discuss with us and the Wellpath clinical team any concerns that arise in real time so that we can all ensure the wellbeing of all persons served, especially those with gender affirming needs.

Disability Accommodations

To the extent DLC perceives deficiencies in the Reasonable Accommodations Policy, I encourage DLC to discuss these issues with the Department and Wellpath when your staff is on-site or by contacting my office. We welcome DLC's input on suggested changes. It is imperative that we work together to ensure the appropriateness of accommodations and access to all services. DLC's continuing practice of waiting six months before raising its concerns in the bi-annual reports is disappointing and undermines any attempt to work together to improve the care provided to persons served.

As I have stated in the past, the Department, Wellpath and DLC all share a common goal, which is to ensure the wellbeing and safety of the persons served at BSH. It is my sincere hope that this letter will be received with that commitment to wellbeing and safety in mind.

Respectfully,

Carol A. Mici
Commissioner