Disability Law Center

Massachusetts Protection and Advocacy

Public Report: The Commonwealth's Treatment of Individuals with Mental Health Disabilities Committed to Bridgewater State Hospital and Continuity of Care Upon Discharge

Exterior view of Bridgewater State Hospital's main entrance.

A private 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 2024 Budget (Line Item #8900-0001).

July 2024

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Overview and Recommendations

In this report, the Disability Law Center (DLC) discusses detailed findings from our monitoring of Bridgewater State Hospital (BSH), including the Bridgewater State Hospital Units at Old Colony Correctional Center (OCCC BSH Units), for the period from January 2024 through June 2024. BSH and the OCCC BSH Units are under the authority of the Department of Correction (DOC). An advance, private report was provided to legislators identified in Line Item #8900-0001[1] on July 23, 2024.

DLC is a nonprofit organization and the Commonwealth's designated Protection and Advocacy agency (P&A) for persons with disabilities, granting DLC federal authority to investigate abuse and neglect of people with disabilities, monitor settings where people with disabilities live or receive services, provide legal representation, and engage in other advocacy to advance the rights of individuals with disabilities. Because of the high demand for DLC services and our limited staffing and resources, DLC's decade of intensive ongoing monitoring of BSH would not be possible without the support and expanded authority granted by Line Item #8900-0001.

During the reporting period, DLC engaged in consistent communication with DOC and Wellpath. DLC sent almost weekly emails concerning issues DLC discovered during monitoring and had regular, informative meetings with the BSH administrators. DLC provided input to DOC via a meeting and written comments on BSH's new Use of Seclusion and Restraint and Use of Involuntary Psychotropic Medication policies. In April, DLC met with Wellpath executives to discuss DLC's February 2024 findings and current issues. On May 21, 2024, DOC formally responded to DLC's February 2024 report in a letter attached hereto as Appendix B.[2] Unfortunately, even with the lines of communication open and positives changes stemming from DLC's recommendations, improvements fall short of addressing the countertherapeutic conditions and legal violations that dominate the experiences of BSH Persons Served (PS).

Massachusetts law explicitly provides DOC control of BSH, also known as "Massachusetts Correctional Institution, Bridgewater."[3] By statute, BSH is only for males determined to require, "strict security"; all women in need of psychiatric evaluation and treatment are committed to psychiatric hospitals.[4] The law grants the DOC Commissioner the authority to appoint the medical director of BSH and requires the medical director to provide care "in accordance with rules and regulations approved by the [DOC] commissioner."[5] While the statute calls for the appointment of the BSH medical director to occur "with the approval of" the Department of Mental Health (DMH) Commissioner, whether and to what extent DMH is involved is unclear. What is clear, however, is that DMH rules and regulations do not apply at BSH.

While the daily tragedies occurring within BSH cannot solely be attributed to DOC rules and regulations, DMH rules and regulations include extensive protections for patients related to health, safety, and quality of care that BSH PS do not receive. These include the 6 fundamental rights and detailed restrictions of restraint and seclusion practices.[6] Moreover, prohibitions against regular staff violence and use of tactical gear in patient interactions need not even be written into DMH rules and regulations because such practices would be so contrary to the mission and ethos of the agency.

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[1] Complete Line Item languages is available at: https://malegislature.gov/Budget/FY2024/FinalBudget.
[2] Department of Correction Response to February 2024 Disability Law Center February 2024 Report on Bridgewater State Hospital (May 21, 2024) [hereinafter "Appendix B"].
[3] M.G.L. c. 125, § 18.
[4] *See, e.g.,* M.G.L. c. 123, §§ 7, 13, 15, 16, 18.
[5] M.G.L. c. 125, § 18.
[6] *See, e.g.,* M.G.L. c.123, § 23; 104 CMR 27.

Furthermore, the lack of clarity about the legal standard for "strict security" gives rise to inconsistent application and significant risk that "strict security" determinations are grounded in decision-maker bias based on an individual's race and ethnicity. As discussed below, Black and African American individuals are consistently disproportionately represented at BSH. The impact of racial bias in Massachusetts' mental health and criminal systems on the BSH population is as true today as it was 20 years ago when a study found that Black and Hispanic/Latinx male defendants were more likely than White male defendants to be referred for an inpatient evaluation in a strict security facility, regardless of diagnoses and the level of severity of the criminal charges.[7]

Faced with report after report of illegal restraint and seclusion practices, disproportionate and unnecessary uses of force, a culture of intimidation, and the absence of a therapeutic milieu, the Commonwealth has not taken action to protect BSH PS – a population widely recognized as including individuals with the most significant mental health disabilities in the Commonwealth – by requiring that the rules and regulations that apply to all other Massachusetts psychiatric hospitals apply at BSH. Every day the law remains unchanged, individuals involuntarily committed to BSH on the basis of their mental health condition suffer. And every day, individuals with serious mental health disabilities suffer, the Commonwealth fails to uphold its legal and moral obligations to PS and the general public.

With the knowledge from a decade of intensive onsite monitoring at BSH and regular monitoring of all DMH hospitals across the state as the Protection & Advocacy agency, DLC fully understands that the transition from DOC to DMH will not be a simple one. Providing DMH authority over BSH will not solve the issues related to the physical plant – a prison facility with cells instead of living spaces and a failing infrastructure. DMH will have to make adjustments to some of its standard operating practices and press for completion of the study and construction of a new hospital facility to serve the BSH population.

DLC RECOMMENDATIONS

With absolute clarity that only 2 actions will be sufficient to protect the rights and health of the current and future BSH population, and to stem the impact of racial bias in strict security determinations, DLC recommends:

1. **The Commonwealth must immediately place BSH operations under the authority of DMH to ensure current and future PS access to trauma-informed, person-centered mental health treatment; and**

2. **The Commonwealth must urgently construct a modern DMH hospital facility designed to provide all individuals in need of "strict security" psychiatric evaluation and/or treatment in a safe, therapeutic environment and finally close BSH.**

[7] D. Pinals, et al., *Relationship Between Race and Ethnicity and Forensic Clinical Triage Dispositions*, Psychiatric Serv., 55:8, 873, 877 (August 2022), https://psychiatryonline.org/doi/epdf/10.1176/appi.ps.55.8.873.

1. The Commonwealth's Undefined "Strict Security" Standard Permits Determinations Grounded in Bias

BSH is the designated facility for the Commonwealth to provide psychiatric evaluation and treatment services to "male patients"[8] when there has been a determination that "failure to hospitalize in strict security would create a likelihood of serious harm by reason of mental illness." As noted above, women cannot go to BSH and there is no strict security determination for women. Regardless of the severity of their symptomatic behavior, the nature of any pending criminal charges, or whether they are serving a county jail or state prison sentence, females go to DMH hospitals and cannot by law be subjected to psychiatric commitment to a prison.

The BSH population consists of people committed under a range of legal statutes pursuant to sections of Massachusetts General Laws Chapter 123. Absent a finding of "strict security," people are committed to DMH hospitals under those same sections. The OCCC Units solely hold individuals already sentenced to DOC prisons who are committed for evaluation or hospitalization under M.G.L. c. 123, §§ 18(a) or 18(a½).

Commitment Statuses of Individuals at BSH			
M.G.L. c. 123 Section	**Type of Commitment**	**Duration of Commitment Order**	**Facility**
§7 and § 8	Commitment for hospitalization initiated by petition of facility where the person is held alleging mental illness and resulting likelihood of serious harm without any pending criminal charges.	Court with jurisdiction over the facility orders an initial commitment up to 6 months and recommitment on subsequent petitions of up to 1 year.	BSH, DMH
§15(b)	Commitment for further pretrial evaluation of competency to stand trial or of criminal responsibility for pending criminal charges.	Court hearing criminal charges issues order of hospitalization for 20 days, extendable for an additional 20 days under exceptional circumstances.	BSH, DMH
§15(e)	Commitment after a guilty finding on criminal charges for an examination to aid the court in sentencing.	Court hearing criminal charges issues order of commitment up to 40 days. If facility petitions during this period, the court may order commitment up to 6 months.	BSH, DMH
§16(a)	Commitment for observation and examination after a finding of incompetence to stand trial or "not guilty by reason of mental illness or other mental defect" (NGRMI) verdict to determine need for further involuntary inpatient treatment.	Court of criminal charges issues order commitment up to 40 days, but combined hospitalizations under § 15(b) and § 16(a) cannot exceed 50 days.	BSH, DMH
§16(b) and §16(c)	Commitment for hospitalization after a person is found by court to be incompetent to stand trial or NGRMI verdict.	Court of criminal charges or court where facility located order commitment up to 6 months under §16(b); length of order on §16(c) recommitment petition up to 1 year.	BSH, DMH
§18(a)	Commitment initiated by a county correctional facility for evaluation of whether a pretrial or sentenced individual requires inpatient hospitalization by reason of mental illness.	Court of criminal charges (pretrial) or court with jurisdiction over place of detention (sentenced) orders evaluation lasting up to 30 days. Facility may then petition for commitment. Court order of an initial commitment up is to 6 months. Subsequent commitments ordered last up to 1 year.	BSH, OCCC Units, DMH

[8] While not very common, trans women may be placed in BSH for evaluation and treatment.

§ 18(a½)	Commitment initiated by petition of pretrial or sentenced individual in a correctional facility on mental health watch for at least 72 hours to access inpatient care.	Court with jurisdiction over place of detention orders transfer to psychiatric facility. The statutory provisions do not reference duration of order of transfer or commitment.	BSH, OCCC Units, DMH

While every individual committed to BSH has been deemed to need "strict security," the meaning of the phrase is undefined by statute and case law establishes no clear criteria for a strict security determination. There is no agreed upon definition utilized by courts, county correctional facilities, DOC, Wellpath, or DMH.

Judges, clinicians, DOC administrators, County Sheriff's Department administrators, and attorneys representing those facing commitment often disagree with the appropriateness of an individual's placement at BSH.[9] Indeed, clinicians who review the same records and meet with the same individual come to different conclusions as the need for strict security of BSH. Some patients pass back and forth between BSH and other facilities because of conflicting clinical diagnoses or security assessments. At times, the facility clinicians, administrators, and attorneys agree that the court's decision to commit to BSH, informed by the court clinician's often truncated evaluation, was improper, but cannot promptly correct the situation.

The lack of clarity about the strict security standard leads to inconsistent application and significant risk of decision-maker bias based on an individual's race, ethnicity, or other factors influencing both who is sent to BSH and who is forced to remain at BSH. **The BSH Medical Director noted this reporting period an increase in minor criminal charges leading to findings of strict security and BSH admissions.[10] The Medical Director further stated that, in some cases, courts order an individual to go to BSH due to the lack of available DMH hospital beds – not due to a strict security recommendation by the court clinician.**[11] Current District Court Standing Order 1-22, which permits courts to hold G.L. c. 123 proceedings remotely, leaving the patient unable to appear in-person before the judge, heightens the potential for differential outcomes and bias.[12] Wellpath reports that it is tracking and studying whether there is judicial racial bias in strict security and competency decisions,[13] choosing to focus on bias in the courts, rather than among Wellpath clinicians responsible for conducting evaluations and filing petitions for commitment.

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[9] Wellpath has repeatedly expressed contempt for judges with "dissenting opinions from the hospital opinion." Wellpath often complains that appointed counsel for PS contest "everything," with no acknowledgement of PS legal rights or due process. BSH Governing Body Meeting, Forensics Department Report (March 14, 2024).

[10] DMH/BSH Quarterly Meeting (April 11, 2024).

[11] DMH/BSH Quarterly Meeting (April 11, 2024).

[12] See, District Court Standing *Order 1-22: Scheduling G.L. c. 123 Hearings* (November 28, 2022), https://www.mass.gov/doc/district-court-standing-order-1-22-scheduling-gl-c-123-hearings/download. The Supreme Judicial Court discussed in detail the drawbacks of trial "by video" in *Vazquez Diaz v. Commonwealth*, 487 Mass. 336, 349 (2022). In the case, the SJC found that the denial of an in-person suppression hearing was an abuse of discretion, not a *per se* violation of the right to confrontation under Article 12 of the Massachusetts Declaration of Rights because the state was in the midst of the COVID-19 pandemic. Justice Kafker's concurrence included a review of the evolving empirical evidence demonstrating that virtual hearings alter evaluation of demeanor evidence, diminish the solemnity of the legal process, and impact the ability to use emotional intelligence such that it influences the factfinder's assessment and perceptions of participants. *See id.* at 357-366, 369 (Kafker, J., concurring).

[13] "Our postdoctoral fellows have continued to work on the research project (a survey of judges to see if race has an impact on decision-making regarding competency or need for hospitalization/strict security)…." BSH Governing Body Meeting, Forensics Department Report (June 13, 2024).

Individual bias and structural racism impact aspects of our society. The effect on people of color – particularly the Black community – who are involved in the mental health system is undeniable.[14] "Racist discourse on mental health among medical professionals has occurred throughout the history of the United States" and "medical racism" continues today.[15] Studies have shown disparities for Black individuals and other individuals of color compared to White cohorts, even controlling for other factors, in diagnosis and misdiagnosis of schizophrenia and other psychotic conditions, imposition of involuntary psychiatric commitments, use of physical and medication restraint, higher dosing of antipsychotics and increased likelihood of receiving first-generation medication.[16]

These include recent studies concerning Massachusetts hospitals that substantiate the need for the Commonwealth to invest in addressing how our mental health system treats Black and Brown people:

- A retrospective chart analysis of all adult Emergency Department visits over a 2-year period at Massachusetts General Hospital, showed that race had a significant effect on use of physical restraint that remained when controlling for sex, age, diagnosis, insurance, and history of violence.[17]
- A study of data of all admissions to a 24-bed inpatient adult psychiatric unit in a large general hospital in Boston over a 6-year period, with a sample size of 4,393 unique patients, concluded that "[p]atients of color, and particularly Black and other or multiracial patients, were more likely than White patients to be involuntarily admitted" and "these differences were not fully explained by clinical and demographic factors, including diagnosis and multiple social determinants of health." Further, "[c]ourt commitment petitions were more likely to be filed for Black and other or multiracial patients; however, this finding did not remain significant in multivariate analysis." [18]

In 2004, authors affiliated with the law and psychiatry program in the department of psychiatry at the University of Massachusetts Medical School conducted a study examining the association between race and ethnicity and dispositions for pretrial defendants referred for forensic mental health evaluations conducted in Massachusetts court clinics.[19] Twenty years later, the study and its results are no less instructive or troubling:

- "Before a person is referred to a forensic mental health bed, they have already been through several decision points in the criminal justice system."[20] Whenever the mental

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[14] *See, e.g.*, C. Smith, et al., *Association of Black Race with Physical and Chemical Restraint Use Among Patients Undergoing Emergency Psychiatric Evaluation*, Psychiatric Serv. 73:7, 730 (July 2022), https://psychiatryonline.org/doi/epdf/10.1176/appi.ps.202100474 ("Racial disparities in psychiatric care for Black individuals are widely documented in the United States…Decades of evidence point to a systemic or structural inequity, along with health care provider bias, contributing to observed disparities in psychiatric care.")

[15] S. Faber, et al., *The weaponization of medicine: Early psychosis in the Black community and the need for racially informed mental healthcare*, Frontiers in Psychiatry, at 4-5 (February 9, 2023)., https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9947477/ (citations omitted).

[16] *See, e.g.,* Faber, supra note 19, at 5-6, 8-9; Smith, supra note 18, at 734; K. Schnitzer, et al., *Disparities in Care: The Role of Race on the Utilization of Physical Restraints in the Emergency Setting*, Acad. Emerg. Med., 27:10, 945-947, 949 (Oct. 2020), https://onlinelibrary.wiley.com/doi/epdf/10.1111/acem.14092; T. Shea, et al., *Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment*, Psychiatric Serv., 73:12, 1323, 1325-1328 (December 2022), https://psychiatryonline.org/doi/epdf/10.1176/appi.ps.202100342.

[17] Schnitzer, *supra* note 20, at 943-950.

[18] Shea, *supra* note 20, at 1323-1329.

[19] D. Pinals, *supra* note 7 at 873.

[20] *Id.* at 874 (citations omitted).

state of someone facing charges is at issue, parties may raise questions about their competence and/or criminal responsibility, and the individual is referred to a court clinic for a screening evaluation conducted by designated forensic psychologists and psychiatrist.[21] "Dispositional recommendations are offered on the basis of clinical variables, the nature of charges, and the defendant's history."[22]

- Court clinic "screening evaluations produce four possible dispositional outcomes: no further evaluation; further evaluation on an outpatient basis; further inpatient evaluation in a DMH hospital; or further inpatient evaluation for males in a strict security setting – BSH.[23] "Although the ultimate decision rests with the judge, the courts most often concur with court clinicians' dispositional recommendations."[24]
- **Without any clear definition, "[b]oth clinicians and judges have substantial latitude in the decision process about strict security."** [25]
- The study found that: Black defendants were significantly more likely than White defendants to be referred for an inpatient evaluation after an outpatient forensic screening evaluation; and **Black and Hispanic/Latinx male defendants were more likely than White male defendants to be referred for an inpatient evaluation in a strict security facility, regardless of diagnoses and the level of severity of the criminal charges.[26]**

Countless sources and daily occurrences confirm that Black and Brown people suffer disparate treatment at all stages of the criminal system, from police stop, search, arrest, and use of force practices to gross overrepresentation in pretrial detention and incarceration. In 2020, the Criminal Justice Policy Program of Harvard Law School issued a landmark report submitted to Supreme Judicial Court Chief Justice Ralph D. Gants, entitled "Racial Disparities in the Massachusetts Criminal Justice System."[27] The report emphasized that "one factor – racial and ethnic differences in the type and severity of initial charge – accounts for over 70 percent of the disparities in sentence length."[28] Moreover, Massachusetts' comprehensive criminal justice reform efforts have resulted in declining incarceration rates for all groups; however, the decline was sharpest for White residents, widening the racial disparities in incarceration of Black and Latinx residents and leaving Black residents consistently incarcerated at the highest rate of all groups.[29] Similarly, "[a]rrests among the White population declined by 37 percent from 2017 to 2022, while they dropped by just 20 percent and 14 percent for Black and Latino residents of Massachusetts, respectively."[30] Still, the starkest are the disparities among the pretrial detainee population – the White pretrial population fell by 41 percent since 2017, but "is down just 3 percent and the Latino population is up by 37 percent."[31]

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[21] *Id.* at 875.
[22] *Id*.
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.* at 873, 877.
[27] Harvard Law School Criminal Justice Policy Program, *Racial Disparities in the Massachusetts Criminal System*, (September 2020), https://hls.harvard.edu/wp-content/uploads/2022/08/Massachusetts-Racial-Disparity-Report-FINAL.pdf.
[28] *Id.* at 2.
[29] B. Forman, et al., *Criminal Justice Reform in Massachusetts: A Five-Year Progress Assessment*, 16 (January 2024), https://www.documentcloud.org/documents/24372071-criminaljusticereform_report_2024-01.
[30] *Id.* at 15.
[31] *Id.* at 19.

These disparities are relevant considerations in how Black and Brown men are treated in determinations of strict security. The severity of the initial charges, even if ultimately reduced, and pretrial detention status also foreseeably impacts decisions of strict security by clinicians and judges. Moreover, "[a] long history of psychological research has found that, compared to Whites, Black people are subject to automatic negative stereotypes and prejudice."[32] "In ambiguous contexts, Black men are more likely than White men to be seen as threatening or aggressive."[33] The compiled results of 7 studies showed that people have a bias to perceive young Black men as more physically threatening than White peers, even when controlled for actual size differences.[34]

It has long been the case that individuals who identify as Black and/or African American are overrepresented in the BSH population.[35] This should come as no surprise as a convergence point for our mental health and criminal justice systems.

Table 1. BSH Population and MA Population by Race/Ethnicity		
Race/Ethnicity	BSH Population[36]	Massachusetts Population[37]
White	44% (111)	70%
Black or African American	34% (85)	10%
Unknown	8% (20)	N/A
Hispanic/Latinx	11% (27)	13%
Asian or Pacific Islander	3% (7)	8%
Other (American Indian and Alaska Native, two or more races)	N/A	3%

In keeping with its commitment to advancing health equity,[38] it is time for the Commonwealth to acknowledge the undeniable link between systemic racism in our judicial and mental health systems, the overrepresentation of Black and African American men in the BSH populations, and the persistent subpar conditions and treatment to which BSH PS continued to be subjected. The intersectional marginalization of BSH PS is a reason to take notice, not avert our collective eyes to their suffering.

Equitable forensic mental health treatment requires that DMH be charged with caring for the entirety of the population and, urgently following that transition, the Commonwealth must invest in a new hospital.

[32] J. Wilson, et al., *Racial Bias in Judgements of Physical Size and Formidability: From Size to Threat*, J. Pers. Soc. Psychol., 113:1, 60 (July 2017), https://www.apa.org/pubs/journals/releases/psp-pspi0000092.pdf (citations omitted).
[33] *Id.*
[34] *Id.* at 59, 66, 74-75.
[35] DOC Institutional Fact Cards present demographic information of the population of all DOC facilities, including BSH. DOC, *January 2024 MA DOC Institutional Fact Cards*, https://www.mass.gov/doc/institutional-fact-cards-january-2024/download. Please note that percentage calculations in the Institutional Fact Card for BSH are inaccurate based on the facility count for BSH.
[36] *Id.*
[37] U.S. Census Bureau, *QuickFacts: Massachusetts* (July 1, 2023), https://www.census.gov/quickfacts/fact /table/MA/PST045223.
[38] Executive Office of Health and Human Services, *Advancing Health Equity in MA*, https://www.mass.gov/advancing-health-equity-in-ma; Massachusetts Health Policy Commission, *Health Equity*, https://www.mass.gov/info-details/health-equity.

2. Troubling Restraint and Seclusion Practices Remain Despite Updates to Policy Language

Since May 2018, DLC has been raising concerns in public reports about the use of restraint, seclusion, and involuntary psychotropic medication on BSH and OCCC BSH Unit PS absent a court order.[39] The discussions of the ubiquitous use of seclusion, physical restraint through manual holds, and medication restraint at BSH may even seem routine to some at this point. Make no mistake, however, all forms of seclusion and restraint are serious and intended to be used as an intervention of last resort.[40]

In line with other authorities such as the American Psychiatric Association and American Psychiatric Nurses Association, and countless studies, the United States Substance Abuse and Mental Health Services Administration (SAMSHA) recognizes the extreme risks associated with restraint and seclusion:

> Studies have shown that the use of seclusion and restraint can result in psychological harm, physical injuries, and death to both the people subjected to and the staff applying these techniques. Injury rates to staff in mental health settings that use seclusion and restraint have been found to be higher than injuries sustained by workers in high-risk industries. Restraints can be harmful and often re-traumatizing for people, especially those who have trauma histories. Beyond the physical risks of injury and death, it has been found that people who experience seclusion and restraint remain in care longer and are more likely to be readmitted for care.[41]

Since DLC's last report, DLC provided feedback to DOC concerning the draft language of the updated BSH policies entitled Use of Seclusion and Restraint and Use of Involuntary Psychotropic Medication. We commend DOC for accepting the vast majority of DLC's comments to bring these BSH policies closer to compliance with M.G.L. 123, §21 and DMH regulations. After years of DLC advocacy and strident denial by DOC and EOPSS, amended policies strike Emergency Treatment Orders and include updated definitions consistent with the three categories of involuntary medication permitted by Massachusetts law – medication administered per a court-ordered *Rogers* treatment plan; medication restraint in cases of emergency when there is no less intrusive alternative; and medication "in rare circumstances" to prevent "immediate, substantial, and irreversible deterioration of a serious mental illness."[42] DOC's May 21, 2024, response to DLC's February 2024 report also states, "the Department agrees that Seclusion and Restraint, as well as the Involuntary Use of Psychotropic Medication,

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[39] All of DLC's public reports are available here: https://www.dlc-ma.org/monitoring-investigations-reports/.
[40] American Psychiatric Association, *APA Resource Document: Seclusion or Restraint* (February 2022), https://www.psychiatry.org/getattachment/e9b21b26-c933-4794-a3c4-01ad427eed91/Resource-Document-Seclusion-Restraint.pdf; American Psychiatric Nurses Association; *APNA Position: The Use of Seclusion and Restraint* (Revised 2022), https://www.apna.org/apna-position-the-use-of-seclusion-and-restraint/; SAMHSA, *Trauma and Violence,* https://www.samhsa.gov/trauma-violence#:~:text=Seclusion%20and%20restraint%20were%20once,safety%20is%20at%20severe%20risk
[41] SAMHSA, *Trauma and Violence,* https://www.samhsa.gov/trauma-violence#:~:text=Seclusion%20and%20restraint%20were%20once,safety%20is%20at%20severe%20risk; *see* American Psychiatric Association, *APA Resource Document: Seclusion or Restraint* (February 2022), https://www.psychiatry.org/getattachment/e9b21b26-c933-4794-a3c4-01ad427eed91/Resource-Document-Seclusion-Restraint.pdf; American Psychiatric Nurses Association; *APNA Position: The Use of Seclusion and Restraint* (Revised 2022), https://www.apna.org/apna-position-the-use-of-seclusion-and-restraint/.
[42] *See* M.G.L. c. 123, §21; *Rogers v. Comm'r of the Dep't of Mental Health*, 390 Mass. 489 (1983); *Matter of Guardianship of Roe*, 383 Mass. 415 (1981).

shall only be used in an emergency as defined in M.G.L. c. 123, sec. 21.[43] Wellpath reported that the policies are now officially in effect.[44]

Along with momentous changes, the Use of Seclusion and Restraint policy sets problematic language that remains unchanged because BSH is under the authority of DOC. The definition of seclusion in BSH policy explicitly states that seclusion *does not* include the time PS spend locked in their cells for the night, during institutional counts, during a facility or unit emergency unrelated to the PS's behavior. These three exclusions are not justifiable under M.G.L. c. 123, §21 and also not documented as seclusion by BSH. And these exclusions do not appear in DMH regulations governing exclusion in state hospitals.[45] As discussed further below, DLC conservatively estimates that this policy language permits well over 900,000 hours of seclusion of PS per year.

The issues with the BSH Medication Restraint Form discussed at length in our February 2024 report have not been resolved.[46] Unlike DMH's singular form for all seclusion and restraint orders,[47] the BSH form is not reflective of applicable legal standards or indicative of individualized and trauma informed care. With this form guiding and documented medication restraint determinations, DLC believes that BSH PS remain subject to medication restraint in nonemergency circumstances in contravention of M.G.L. c. 123, §21, without meaningful consideration of less restrict alternatives, and without consideration of individual trauma histories or risk factors related to physical medical conditions and disabilities.[48] In addition, the BSH form does not include fields for identifying and tracking the race/ethnicity and primary language of PS who get medication restraint, missing another opportunity to track any disparities in the administration of medication restraint and other quality of care issues for PS of color.

During this reporting period, Wellpath indicated that it was providing monthly in-service training to front line nursing department staff that includes restraint and seclusion policy, procedures and processes with a highlight on de-escalation.[49] As discussed further below, Wellpath also brought in Dr. Kevin Huckshorn to provide trauma-informed care training for RTAs and TSTs.[50] The BSH Psychiatry Department reported on partnering with Clinical Services and Nursing with the hopes of developing an "educational series on patient engagement and de-escalation in an effort to continue" to reduce seclusions, restraints and manual holds.[51] DLC encourages additional training, but improvements in adherence to legal standards for all forms of restraint and seclusion remain urgent at BSH.

Ultimately, DLC believes, based on a decade at BSH, that the effectiveness of staff oversight and training will always be limited by the undeniable status of the facility as prison operating under DOC authority and regulations and the acceptance of coercive, correction practices by members of BSH staff and leadership. The strongest leaders at BSH since the transition to Wellpath have been those not indoctrinated into the culture of DOC, who have experience with

[43] Appendix B at 2.
[44] BSH Governing Body Meeting, Psychiatry, Medicine and Dental Report Discussion (June 13, 2024).
[45] 104 CMR 27.
[46] *See* DLC February 2024 Report at 9-14.
[47] DMH's Emergency Restraint or Seclusion (R/S) Forms are available at: https://www.mass.gov/lists/emergency-restraint-or-seclusion-rs-forms.
[48] *See* DLC February 2024 Report at 9-14.
[49] Nursing Services Report, BSH Governing Body (September 2023).
[50] BSH Governing Body Meeting, Seclusion, Restraint, Manual Hold and Medication Restraints Report (June 13, 2024).
[51] BSH Governing Body Meeting, Psychiatry, Medicine and Dental Report (December 2023).

DMH and who can bring effective acute psychiatric care to the forefront. Keeping this in mind, DLC has no doubt that transition to DMH would transform care for BSH PS.

A. BSH Restraint and Seclusion Data – Incomplete, Misleading, and Indicative of Disproportionate Use on Black and African American PS

As of the date of completion of this report, DLC did not receive the seclusion and restraint documentation for the complete reporting period; in keeping with DOC's regular productions, we expect to receive it in the near future. Accordingly, the below data is based on Wellpath's documented uses of restraint and seclusion from December 15, 2023, through May 25, 2024, omitted 21 days – or 11.5% – of the 6-month reporting period.

In addition, in light of issues with the data discussed below concerning failure to track Hispanic/Latinx ethnicity, DLC calls on DOC, Wellpath, and DMH to more carefully track and report on race and ethnicity data, as well as primary language, for individuals subjected to all forms of restraint and seclusion. DLC recommends using United States Census Bureau race and ethnicity categories[52] to allow for more complete reporting and assessment of the intersectionality of race, ethnicity, and primary language.

i. Documented Medication Restraint

With a smaller data set than last reporting period preventing a comparison of totals, DLC calculated the average rate of medication restraint per day during each period. **During this reporting period, BSH administered 1.37 medication restraints per day, versus 1.26 per day from June 15, 2023, to December 15, 2023.** Based on these rates, BSH's overall rate of medication restraint increased by 9% during this reporting period and DLC projects 25 additional medication restraint administrations during the last 21 days of the period, for a projected total of 246 medication restraint administrations by Wellpath.

Wellpath has erroneously compared BSH medication restraint data to medication restraint data for DMH's Worcester Recovery Center and Hospital (WRCH), while correctly noting that BSH and WRCH have similar patient populations.[53] This comparison in misleading, given that DMH employs a robust, all-inclusive documentation and tracking system for restraint and seclusion. BSH's medication restraint data does not tell the complete story because PS are locked in their cells for nearly half of every day, limiting contact between staff and PS. DMH hospitals, on the other hand, do not lock people in their rooms unless seclusion has been authorized – meaning that DMH staff must have meaningful interactions and incidents may arise at any time of day. WRCH also consistently operates with a higher census than BSH; for instance, as of June 30, 2024, Worcester's census was 310[54] and the BSH census was 254.

DLC fully supports DMH collaboration with BSH on these issues, but not under the guise that DMH should view BSH medication restraint data as something to emulate. DLC strongly encourages DMH to study the differences in delivery of care between DMH and DOC, including daily restrictions of PS at BSH, before considering adoption of any BSH approaches. DLC notes

[52] U.S. Census Bureau, *Measuring Racial and Ethnic Diversity for the 2020 Census* (August 4, 2021), https://www.census.gov/newsroom/blogs/random-samplings/2021/08/measuring-racial-ethnic-diversity-2020-census.html.
[53] BSH Governing Body Meeting, Seclusion, Restraint, Manual Hold and Medication Restraints Report (June 13, 2024).
[54] DMH, Section 114 Report - June 2024, https://www.mass.gov/doc/section-114-report-june-2024/download.

that BSH and DMH have not updated their Memorandum of Understanding in well over a decade.[55]

Table 2. Medication Restraints Per Month (Dec. 16, 2023 – May 25, 2024)		
Month	Number of Days	Number of Administrations
December (16-31)	15	18
January (1-31)	31	50
February (1-29)	29	55
March (1-31)	31	25
April (1-30)	30	50
May (1-25)	25	23
Total (Dec. 16-May 25)	**161**	**221**
Unique PS Receiving Medication Restraints		**108**
Medication Restraints Per Day		**1.37**

According to data received by DLC, presented in Table 3, Black and African American PS are overrepresented in medication restraint administration at BSH. Black and African American PS receive 41% of all administrations and made up 42% of the unique PS receiving medication restraint during this reporting period. In addition, medication restraints on 2 PS who identify as Asian constituted 7% all administrations.

We must emphasize, however, that BSH data does not allow for PS to identify as a person with Hispanic or Latinx heritage and by their primary race. The result is that the data indicates that Hispanic/Latinx PS were not subjected to medication restraint even once during this reporting period. This is plainly inaccurate based on DLC's review of documents, video footage, and PS interviews. While DLC cannot pinpoint the total number of Hispanic/Latinx PS who received medication restraint with the available data, controlling for primary language, there were 14 medication restraints administered to PS whose primary language is Spanish – 6% of all administrations – on 11 unique PS – 10% of PS who received medication restraint during this reporting period. Of these PS who identified Spanish as their primary language, 5 have a race categorization of White and 6 of Black/African American in the data provided to DLC.

Table 3. Medication Restraints by Race (Dec. 16, 2023 – May 25, 2024)			
Self-Identified Race	BSH Population	Number of Administrations	Unique PS Receiving Medication Restraint
White	111 (44%)	114 (52%)	60 (55%)
Black or African American	85 (34%)	91 (41%)	45 (42%)
Unknown	20 (8%)	1 (0%)	1 (1%)
Hispanic (Latinx)	27 (11%)	0 (0%)	0 (0%)
Asian or Pacific Islander	7 (3%)	15 (7%)	2 (2%)
Other (American Indian and Alaska Native, 2 or more races)	N/A	N/A	N/A
Total	**250**	**221**	**108**

[55] DMH/BSH Quarterly Meeting (April 11, 2024).

ii. Documented Physical Restraint – Manual Holds and Mechanical Restraints

Manual holds, commonly referred to as manual restraint, are a form of restraint in which BSH staff physically intervene to hold immobile or control a PS' bodily movement using body contact. As the documentation below indicates, manual holds are the most common form of restraint at BSH. They are used in isolation, to move people to seclusion, and to effect medication and mechanical restraint orders. All forms of physical restraint, including manual holds and mechanical restraints, must comply with the requirements of M.G.L. c. 123, § 21. DLC's monitoring activities indicate that BSH commonly apply these restraints without sufficient legal justification.

Table 4. Manual Holds by Month (Dec. 16, 2023 – May 25, 2024)

Month	Number of Days	Number of Manual Holds	Total Time PS in Manual Holds (Minutes)	Max. Length of Manual Hold (Minutes)	Avg. Length of Manual Hold (Minutes)
December (16-31)	15	60	88	5	1
January (1-31)	31	133	212	11	2
February (1-29)	29	155	223	5	1
March (1-31)	31	111	181	11	2
April (1-30)	30	152	238	12	2
May (1-25)	25	93	157	12	2
Total (Dec. 16-May 25)	161	704	1,099		
Unique PS in Manual Holds: 186					

Per Table 5, Black and African American PS are overrepresented in manual hold t applications at BSH. Even more concerning, PS who identify as Black and African American account for 46% of PS who received this form of physical restraint this reporting period. Again, the lack of representation of Hispanic/Latinx PS is grossly inaccurate.

Table 5. Manual Holds by Race (Dec. 16, 2023 – May 25, 2024)

Race/Ethnicity	BSH Population	Number of Manual Holds	Unique PS Receiving Manual Hold Restraints
White	44% (111)	55% (385)	52% (97)
Black or African American	34% (85)	38% (268)	46% (86)
Unknown	8% (20)	0% (0)	0 (0%)
Hispanic	11% (27)	0% (0)	0 (0%)
Asian or Pacific Islander	3% (7)	7% (50)	2% (3%)
Other (American Indian and Alaska Native, two or more races)	N/A	0% (1)	0% (1)
Total	100%	704	186

Table 6. Manual Holds by Primary Language (Dec. 16, 2023 – May 25, 2024)

Language	Number of Manual Hold	Unique PS Receiving Manual Hold
English	85% (596)	70% (61)
Spanish	11% (76)	18% (16)
Arabic	1% (7)	2% (2)
Portuguese	1% (6)	3% (3)
Jamaican	0% (2)	1% (1)

Cape Verdean	0% (2)	1% (1)
French	2% (15)	3% (3)
Total	704	87

Mechanical restraint is the use of a device or object that the PS cannot remove to restrict their movement. In psychiatric hospitals, such devices include 4-point restraints – where a PS is placed on a bed with restraints that hold down each arm and leg – and, in some cases, restraint chairs. At BSH, mechanical restraints also include common correctional equipment like handcuffs, shackles, and waist chains, which DMH unit staff are not permitted to utilize.

Table 7. Mechanical Restraints by Month (Dec. 16, 2023 – May 25, 2024)

Month	Number of Days	Number of Mechanical Restraints	Total PS Time in Mechanical Restraints (Minutes)	Max. Length of Mechanical Restraints (Minutes)	Avg. Length of Mechanical Restraints (Minutes)
December (16-31)	15	7	257	61	37
January (1-31)	31	9	359	91	40
February (1-29)	29	23	961	210	42
March (1-31)	31	20	818	135	41
April (1-30)	30	14	463	114	33
May (1-25)	25	11	595	115	54
Total (Dec. 16-May 25)	**161**	**84**	**3,453**		
Unique PS Receiving Mechanical Restraints: 44					

With respect to mechanical restraints, Black and African American PS are only slightly overrepresented in the number of mechanical restraint applications, but account for 52% of individual PS subjected to mechanical restraints. The inaccurate lack of representation of Hispanic/Latinx PS is a constant.

Table 8. Mechanical Restraints by Race (Dec. 16, 2023 – May 25, 2024)

Race/Ethnicity	BSH Population	Number of Mechanical Restraints	Unique PS in Mechanical Restraints
White	44% (111)	56% (47)	48% (21)
Black or African American	34% (85)	37% (44)	52% (23)
Unknown	8% (20)	0% (0%)	0% (0)
Hispanic (Latinx)	11% (27)	0% (0%)	0% (0)
Asian or Pacific Islander	3% (7)	0% (0%)	0% (0)
Other (American Indian and Alaska Native, two or more races)	N/A	N/A	N/A
Total	100%	84	44

Table 9. Mechanical Restraints by Primary Language (Dec. 16, 2023 – May 25, 2024)

Language	Number of Mechanical Restraints	Unique PS in Mechanical Restraints
English	86% (72)	84% (37)
Spanish	7% (6)	9% (4)
Arabic	0% (0)	0% (0)
Portuguese	2% (2)	2% (1)

Jamaican	0% (0)	0% (0)
Cape Verdean	0% (0)	0% (0)
French	5% (4)	5% (2)
Total	84	44

iii. Documented Seclusion

Of all extreme psychiatric interventions, BSH relies on seclusion most heavily. This includes documented seclusion, in which a PS is locked in their cell, or a seclusion room cell based on a clinical order, as well as the extensive undocumented seclusion discussed at length below.

Table 10. Documented Seclusion by Month (Dec. 16, 2023 – May 25, 2024)					
Month	Number of Days	Number of Seclusions	Total Time PS in Seclusion (Minutes)	Max. Length of Seclusion (Minutes)	Avg. Length of Seclusion (Minutes)
December (16-31)	15	32	2,930	268	92
January (1-31)	31	82	6,876	412	84
February (1-29)	29	96	10,904	885	114
March (1-31)	31	57	5,490	304	96
April (1-30)	30	117	12,441	615	192
May (1-25)	25	81	8,036	521	99
Total (Dec. 16-May 25)	161	465	46,677		
Unique PS Placed in Documented Seclusion: 164					

Once again, DOC data shows that Black and African American PS are disproportionately subjected to documented seclusion and an inaccurate lack of representation of seclusion imposed upon PS of Hispanic or Lantinx ethnicity.

Table 11. Documented Seclusion by Race (Dec. 16, 2023 – May 25, 2024)			
Race/Ethnicity	BSH Population	Number of Seclusions	Unique PS Secluded
White	44% (111)	58% (268)	55% (90)
Black or African American	34% (85)	41% (189)	43% (70)
Unknown	8% (20)	0 (0%)	0% (0)
Hispanic	11% (27)	0 (0%)	0% (0)
Asian or Pacific Islander	3% (7)	1 (7%)	2% (3)
Other (American Indian and Alaska Native, two or more races)	N/A	1 (0%)	1 (0%)
Total	100%	465	164

Table 12. Documented Seclusion by Primary Language (Dec. 16, 2023 – May 25, 2024)		
Language	Number of Seclusions	Unique PS Secluded
English	88% (410)	87% (142)
Spanish	8% (39)	9% (15)
Arabic	0% (1)	0% (1)
Portuguese	0% (2)	0% (1)
Jamaican	% (1)	0% (1)

Cape Verdean	0% (2)	0% (1)
French	2% (10)	2% (3)
Total	465	164

B. *Undocumented and Unauthorized Seclusion*

As highlighted in DLC's February 2024 report, every BSH PS spends extended periods of time locked in their cells each day because it is a DOC facility. **DLC's conservative estimate of the amount of daily time PS spend locked in their cell is 11 hours – 10 hours at night and 20 minutes[56] three times per day for inmate counts, amounting to in upwards of 900,000 hours of seclusion at BSH per year.**

None of these seclusion hours, however, are documented or ordered pursuant to the requisite finding of emergency circumstances under M.G.L. 123, § 21. Accordingly, this seclusion time is not included among the total seclusion hours that DOC and Wellpath report out of BSH. In practice, PS living in the Bradford units that house new admissions and those in the maximum-security units, Hadley and Lenox, experience even more undocumented seclusion that is unauthorized by BSH policy.

During this reporting period, DLC has repeatedly observed first-hand PS in each of these units being held in their cells for up to 1.5 hours past count clearing. DLC interviews with Wellpath staff provided a range of reasons for PS being locked in their cells after 12pm: "codes" being called on other units that require TST staff to leave their assigned units understaffed while they provide support; TST staff being on break, leaving the unit understaffed; and, in one instance, a PS deemed by staff to be particularly "high risk" taking a shower, requiring all other PS to remain locked in their cells. While these instances indicate understaffing, inadequate shift staggering, and insufficient administrative oversight by Wellpath, they also confirm the gross inequities between the care and treatment of BSH PS and DMH patients as well as continuing noncompliance with Massachusetts restraint law.

DLC interviewed over 20 current and former PS about out-of-cell time primarily on Bradford 1. As with the last report period, prolonged seclusion beyond the alarming standard 11 hours per day was widespread. Roughly half reported regularly receiving no more than three hours of out-of-cell time per day while on Bradford 1. Three of those individuals reported not being allowed out of their cell at all for weeks, including for meals. PS occasionally report being given a reason for being locked in for hours without being officially secluded – such as being told they must wait for hours for a nurse to perform a behavioral assessment to approve their release. The majority, however, report being kept in their cell for hours, days or weeks without being informed of any rationale and with few chances to take a shower or make a phone call. PS describe unit staff as playing favorites with whom they let out of their cells, only releasing those PS as they "see fit," revealing a concerning degree of control and discretion with regard to unauthorized seclusion on the part of RTAs and TSTs. One PS told DLC that, when he asked a staff member why he couldn't come out of his cell, he was told "that's how it is down here."

Once locked-in, PS describe how challenging it is to get staff's attention, as they are forced to knock loudly on the inside of their doors or, worse, scream. All of these actions place them at the risk of being perceived as agitated or violent and thus subject to forced medication. DLC observes while monitoring – particularly on Hadley, Lenox, and Bradford 1– PS banging on their doors to get staff's attention.

[56] Wellpath has stated that "[n]umber of hours PS are locked in their room for count should be about 20 minutes at scheduled count times." Administration Group Meeting Minutes (April 25, 2024).

Multiple PS also described the experience of being locked in and ignored for long periods as anxiety-provoking and traumatizing. For those PS who have experienced prolonged solitary confinement, it can even be retraumatizing. For one former PS, who began to experience distressing voices during his months on segregation at a county correctional facility, Bradford 1 retriggered and exacerbated those voices. Furthermore, PS frequently describe Bradford 1 as akin to solitary confinement. Indeed, according to PS reports, the number of hours spent in seclusion are often not far off from the 22.5 hour maximum dictated by DOC. On top of lack of the programming and off-unit time provided, the amount of unauthorized seclusion, as administered by floor staff, can be, as one PS described it, "mind-numbing."

DLC has engaged with Wellpath around documenting unauthorized seclusion hours moving forward. Following an April 2024 meeting with DLC, Wellpath reportedly assembled a Performance Improvement Team "to develop a protocol/changes in our work process to better be able to prevent unauthorized seclusion episodes, catch any occurrence of unauthorized seclusion and then track it" and planned to meet again on July 11. DLC hopes that Wellpath will establish a plan to ensure compliance with documentation requirements of M.G.L. c. 123, 21.

At the June 13 BSH Governing Body Meeting, Wellpath reported that it is "developing a Psychiatric Emergency Response Team in order to provide a dedicated team to manage psychiatric emergencies both to supplement the de-escalation efforts already provided on unit and to provide emergency medication in a timely manner." [57] Wellpath believes "[t]his initiative will also allow for each unit to maintain full staffing numbers of TSTs so that they are not pulled from the units during emergencies thus rendering their home units with reduced staffing to manage emergencies." [58] While this may seem like a sound initiative in a vacuum, familiarity with how other DOC facilities operate tells DLC that this is not an innovation, but another way in which BSH leans into correctional models of responding to emergencies. It is customary for a team of correctional officers to be designated on every shift in DOC facilities to respond to incidents and conduct forced moves, as needed; instead of de-escalating, the flood of additional officers into a unit often causes fear and additional tension.

DLC calls on BSH to instead explore corrective actions that emphasize enhanced staff oversight to prevent the more common cause of unit staff failure to adhere to unit schedules – choice – and rather than creating a roving team of additional security staff, explore alternatives that utilize and increase access to RTAs and clinical staff.

C. Violence During the Administration of Involuntary Medication

DLC viewed video footage of involuntary medication administration, physical restraints, and other incidents of potential concern. During this reporting period, DLC reviewed footage of 15 incidents in total and interviewed dozens of PS about their experiences. The videos again confirm, in keeping with findings from prior reporting periods,[59] that restraint and seclusion interventions at BSH are violent and traumatic interactions for PS and staff alike.

With BSH under the authority, policies, and regulations of DOC, involuntary medication practices are blurred with prison practices, resulting in accepted use of violence and intimidation that would not be tolerated in a DMH hospital. Standard practice for administering medication restraint can involve a team of Therapeutic Safety Technicians (TST) entering PS cells dressed in tactical gear, forcing them to the bed with a plexiglass shield, and holding them face-down to

[57] BSH Governing Body Meeting, Seclusion, Restraint, Manual Hold and Medication Restraints Report (June 13, 2024).
[58] *Id.*
[59] DLC July 2022 Report at 11-14; DLC January 2023 Report at 20-25; DLC July 2023 Report at 20-26.

expose their buttocks for a nurse to administer intramuscular injections. TSTs carry out this violent response in PS cells, often well after and away from the original incident, leaving PS with no ability to physically retreat or escape traumatic memories afterwards.

In response to DLC's recommendations concerning the use of tactical gear and unnecessary and/or disproportionate force on PS, Wellpath administrators reported working with consultants to help develop a process for reducing reliance on tactical gear and moving to a more evidence-based approach to the use of protective gear and the plexiglass shield. In a problem statement shared with DLC informing this project, Wellpath acknowledged that "[u]se of protective gear has grown since [the] beginning of [Wellpath's] contract. Currently, the gear utilized is seen as custodial." DOC acknowledged Wellpath's efforts in its response to DLC February 2024 report, stating that it "believes that Wellpath has enacted a proper practice of assessing when protective gear is required for interactions with at risk persons served," approaching "the use of protective gear with multi-disciplinary decision-making and trauma informed principles."[60] DOC further stated that, if efforts to resolve emergency situations without physical intervention "are ineffective at resolving the emergency situation, the final determination to utilize protective gear is made by the multi-disciplinary team of clinical, nursing and security staff."[61] Wellpath reported that approval for use of the shield in particular is now elevated to BSH's Medical Executive Director.

DLC has not had the opportunity to review the new Use of Protective Gear Policy describing these practices, as the draft is pending DOC's authorization. Certainly, the notion of taking a more thoughtful approach to the use of tactical gear is a step in the right direction. However, monitoring activities and PS reports indicate that the use of gear remains significant – in its frequency, foreseeable psychological impact of PS, and divergence from accepted psychiatric hospital practices. Wellpath reported to DLC in late June that, since it began tracking tactical gear and shield use in March 2024, "there have been 194 planned events (instances of preemptive entry into a PS cell), in which 95 (49%) protective gear was utilized, and 14 (7%) the shield was utilized."

Use of tactical gear and planned use of force procedures by Wellpath staff mirroring DOC cell extractions must be eliminated.

D. *Unjustified Medication Restraint in the Absence of Emergency Circumstances*

Video footage DLC reviewed again confirmed that unjustified medication restraint – due to the absence of requisite existing emergency circumstances – continues at BSH. If the "emergency" justifying the restraint has passed and it is no longer the "least restrictive" option available, medication restraint is not sanctioned by M.G.L. c. 123.

DLC has observed emergencies pass when PS become calm in their cells during the time between an incident that gives rise to the medication restraint order and Wellpath staff's later forceful implementation thereof. In this situation, although it is clear that seclusion is the least restrictive and effective option, Wellpath fails to adjust and terminate the medication order. In other scenarios, the initial order was never justified – an incident occurs, and the emergency subsides immediately. In yet another variation, which DLC watched on video this reporting period, Wellpath combines mechanical restraint – 4-point restraints that immobilize the PS on a

[60] App. B at 2.
[61] *Id.*

bed – and medication restraint in a punishing and unacceptable piling on of the most extreme psychiatric interventions. Below are 2 troubling examples from this reporting period:

- A slight, older PS, “Gill,” rises from his bed and paces in his cell for approximately 50 minutes. He briefly talks with a Wellpath staff member at his door, then returns to walking back and forth in cell. 5 minutes later, 3 TSTs enter his cell, speak with him briefly, and exit. Gill sits calmly on his bed. Shortly thereafter, the 3 TSTs enter again, this time with a nurse. The TSTs grab Gill, lift him up from his seated position by both arms and one of his legs, and push him down into the bed. The TSTs hold him while the nurse administers the medication restraint injections in his buttocks. The nurse and TSTs leave one by one and shut his door as Gill gets up slowly.
- PS “Ben” is seen standing on the seat in his cell, looking out the window toward the yard and talking to himself, at times getting down to walk around his cell. After approximately 50 minutes, a Wellpath staff member comes to his door and the PS sits at the foot of his bed while they talk. A few minutes after the staff member leaves, Ben has a brief interaction with the lead TST while still seated on his bed. *DLC notes that documentation describing the incident states: "Person served was initially agreeable to comply with body search and room search. Upon the arrival of safety team [PS] became agitated and resistive."* Next, 5 TSTs in tactical gear appear at the PS cell door, enter quickly, roughly lift Ben up from under his arms, push him against the front wall of cell, and apply handcuffs. On video, Ben did not appear agitated or to engage in any physical resistance. TSTs bring Ben to the seclusion room, where he is forcefully pushed against the wall to remove his handcuffs. TSTs then place Ben in 4-point mechanical restraints and a nurse administers 2 intramuscular medication restraint injections. Ben remains in mechanical restraints for 55 minutes. While this occurs, 2 other TSTs perform a search on his cell. According to Ben’s medical records, there had been a staff report that he had a shank in his room. Reportedly, the search found 2 plastic forks tied together in his cell.

In these instances, PS are put through unnecessary traumatic interventions. There were no emergency circumstances present when Wellpath subjected a calm, seated Gill to medication restraint. With respect to Ben, while there may have been a legitimate reason to relocate him from his cell to a secure space to facilitate a cell search, Wellpath’s actions were unreasonable. First, nursing notes indicate that Ben was initially willing to comply with a body and room search, but he became understandably upset when confronted with a team of 5 men in tactical gear, illustrating the dangerous folly of Wellpath’s correctional practices sanctioned by DOC. Second, TST aggressively apply handcuffs – a form of mechanical restraint not utilized in DMH – to move him to the seclusion room consistent with DOC cell extraction practices, rather than giving him the opportunity to walk independently or employing a manual hold during the escort. After forcefully removing the hand cuffs, they place Ben in 4-point restraints, when there is no indication that seclusion during the cell search would not be sufficient. Finally, Wellpath administers medication restraint to Ben while he is in 4-point restraints without even taking time to observe whether his immobilization on the restraint bed ceased the emergency circumstances.

While the updated language of Seclusion and Restraint and Involuntary Psychotropic Medication policies reinforces the illegality of these practices and may result in some improvement, DLC believes that permissive and unnecessary use of medication restraint will continue until BSH’s medical leadership is held to higher standards by DMH.

E. Staff Escalation and Reliance on the Most Restrictive Interventions in Contravention of Established Law and Professional Standards

Failure of Wellpath staff to engage in de-escalation and offer less restrictive alternatives to seclusion and physical and medication restraint remain features of everyday life for individuals committed to BSH. In addition to signifying insufficient staff training and inappropriate care, this conduct often violates the law. The permissive application of these interventions by BSH providers creates an environment of intimidation rather than a treatment milieu.

The normalization of the use of restraint and seclusion, coupled with the lack of sufficient staff training on trauma informed care, the appropriate continuum of interventions in a psychiatric facility, and the requirements of M.G.L. c. 123, § 21 put PS at risk. PS reports, documentation, and video footage indicate that staff regularly escalate situations, leading to restraint, seclusion, and even injuries.[62]

- **Unnecessary physical confrontation, injury, and medication restraint:** In one incident DLC viewed on video that ended in PS injury, PS "Joel" sticks his arms through the slot of his locked cell door, grabbed on the small metal door of the slot, and refused to let go. Instead of letting Joel grow tired of the uncomfortable position while secured in his cell, unit staff forcefully tried for nearly 2 minutes straight to pry his hands off the small metal door and force his arms into the cell. Joel reported that the staff had painfully twisted and contorted his fingers to get him to comply. The video then shows Joel leaving his arms in the slot for another 20 minutes, pulling them back in when staff stop monitoring him. After reorganizing his cell and occasionally talking with staff for approximately 45 minutes, a team of 4 TSTs in tactical gear appears at his door. Joel strips down to his boxers and socks and lies face down on his bed in compliance. The TSTs hover their hands over his body as the nurse injects him in both buttocks. He retracts in pain when the needles enter, and his hands, held above his head, are visibly shaking. Joel was later found to have a fractured finger that required surgery.
- **Staff conduct heightens uneasiness and provokes physical escalation:** One PS described, "when you're stressed," TSTs tend to stand close to you, violating your personal space, heightening anxiety, and making the situation more prone to physical escalation. DLC has witnessed this behavior by TSTs leading to physical altercations with PS in video footage.
- **Staff fail to consider or acknowledge the effectiveness of less restrictive alternatives before resorting to physical and medication restraint:** One PS reported receiving intramuscular medication multiple times despite, on each occasion, asking to be secluded, left alone, and allowed to deescalate in his cell. Others report, consistent with the common practice covered in multiple DLC reports, that TSTs arrived to administer medication restraint long after placing him in seclusion to deescalate. As one PS succinctly stated, "I just calmed down over this one hour ago and now you're coming in with a riot suit on and roughly inject me?" This reporting period alone, confirming the continuation of another concerning BSH trend, DLC interviewed 8 PS who had received medication restraint via intramuscular injection without first being offered oral medication – all but one PS said they would have taken the oral medication had it been offered, obviating the need for the painful injection and the concomitant use of force by TSTs.

[62] Best practice de-escalation includes "communication, self-regulation, assessment, actions, and safety maintenance in order to reduce the risk of harm to patients and caregivers as well as the use of restraints and seclusion." The Joint Commission, *Quick Safety Issue 47 De-escalation in health* care (January 2019) 1, https://www.jointcommission.org/-/media/tjc/documents/resources/workplace-violence/qs_deescalation_1_28_18_final.pdf?db=web&hash=DD556FD4E3E4FA13B64E9A4BF4B5458A.

3. Difficult Daily Interactions Between Person Served and BSH Staff

The most frequent topic of PS grievances month after month is staff complaints (Governing Body 3/13/24 and 6/14/24). Although unit staff at BSH are PS' connection to resources, medical and mental health services, and information, many PS feel ignored by staff or choose to limit their interactions with staff to avoid negative interactions and consequences. Negative relationships hinder engagement with treatment and are one of many sources of stress for PS. Of course, unkind, insulting, and threatening verbal contacts with staff can also lead to unnecessary building of tension in BSH units and escalate, rather than deescalate, incidents.

Over 2 days in June 2024, Wellpath brought Dr. Kevin Huckshorn to provide trauma-informed care training for direct care staff. Dr. Huckshorn held 3 sessions of the training each day to allow as many RTAs and TSTs to attend as possible.[63] Based upon a review of the training materials, the presentation's approach appeared thoughtful, naming effects of the power imbalance and loss of rights experienced by patients in behavioral health settings. In light of the interactions highlighted below, DLC also appreciates the training's advice for staff on preventing "re-traumatization" in service settings by avoiding confrontational and paternalistic approaches, employing "empathic engagement," and a using a focus on "customer service" basics such as meeting the needs of guests before escalation occurs.

A. Unhelpful and Abusive Verbal Interactions

PS describe staff as being variably aggressive, cruel, demeaning, uncaring, prone to yelling and short-tempered. PS have consistently reported verbal abuse by Wellpath RTAs and TSTs, as in previous reporting periods. These include repeated complaints about specific staff members who appear to target at-risk PS. Indeed, 4 staff members – 3 TSTs and 1 RTA – were the subject of 22 of the serious staff complaints DLC received this reporting period;1 TST alone gave rise to 8 complaints from 3 different PS. Multiple PS reported TSTs threatening them with physical violence, calling them lewd names, and mocking them about past instances in which they engaged in self-harm, were assaulted, or sustained injuries. For example, a PS reported that a TST who had been harassing him on his unit declared, "I'm gonna get you when you're out of here, I've done my investigation. I know where you live. I have my people." Another PS reported 2 different staff members mocking him for having black eyes. Still others reported incidents of staff unwillingness to provide for PS' basic needs. One PS on Lenox reported complaining to a staff member in the winter about not having bedsheets, cold air flowing from the vents, and cold water in the shower. He recalled staff simply stating, "You do know this is the Max, right?" indicating that the PS should not expect comfort in a BSH maximum security unit.

DLC reports allegations of verbal abuse to BSH administration. Administrators have been responsive to individual complaints and recently brought trauma-informed training to BSH (more). Still, countertherapeutic staff-patient relationships and use of cruel and abusive language point to the larger problem of oversight by DOC, which fosters an environment of staff control over recovery.

[63] BSH Governing Body Meeting, Seclusion, Restraint, Manual Hold and Medication Restraints Report (June 13, 2024).

B. Staff Limitation on PS Movement Within Units

A PS approached DLC during a monitoring visit to describe his frustration about restrictions on his ability to walk around his unit, Bradford 1. A long-time TST confirmed to DLC that PS were only permitted to walk around their room or the dayroom and walking or standing in the hallway was off limits for safety reasons. However, in a meeting with BSH administrators, Wellpath informed DLC that there is no prohibition on PS using the hallway, whether to stand, walk, or get exercise and were surprised to find out about the restrictions imposed by staff on the units.

DLC has witnessed similar issues in previous reporting periods of unit staff gratuitously choosing to control PS movement – sometimes with commands and other times with physical restraint. In one such incident that DLC has investigated, a TST approached a PS leaning against a wall and told him to vacate an otherwise empty hallway; the TST aggressively got into the PS face and instigated a confrontation that was then used to justify a physical restraint, seclusion, and medication restraint. In a DMH facility, patients, including forensic patients, are free to move around their units.

C. Staff Refusal to Self-Identify

PS report a widespread refusal among staff to wear Wellpath-supplied ID badges while working. When PS ask staff for their names, many refuse to identify themselves. This includes Wellpath medical doctors, according to PS. In the course of monitoring, DLC has rarely observed a TST wearing an ID badge. Some PS report that this refusal makes them feel disempowered and unsafe, leading them to decline engagement in medical and mental health services. This also impedes PS ability to report and grieve problematic staff conduct.

Overall, DLC is pleased that the BSH administration has reportedly issued staff directives regarding PS movement within units and staff identification and conducted investigations into verbal abuse. Nevertheless, we find it concerning that that directives and accountability measures were implemented as a result of DLC's onsite monitoring.

More intensive Wellpath oversight of unit staff conduct, in combination with continuing reinforcement of trauma-informed principles through training, is needed at BSH.

4. Ongoing Physical Plant Conditions Pose Health and Safety Risks to Persons Served and Staff

BSH's poor infrastructure, environmental contamination, and the summer heat – both separately and together – pose unreasonable risks to the health and safety of PS and staff continue. DLC repeats, as we have in each semi-annual report since May 2018, that the state of BSH's physical plant as well as the economic inefficiency of the Commonwealth sinking money into its aged, failing infrastructure warrant the facility's closure.[64]

While awaiting construction of an appropriate hospital facility, transfer to DMH and wholesale application of DMH regulations and policies – that, for example, do not allow PS to be locked in nearly half of every day without individual clinical orders justifying seclusion – will have a significant impact in making conditions more humane. DMH standards and therapeutic focus would likewise inform maintenance and necessary remediation efforts. DLC hopes that a transition would entail engagement with new vendors, as mold remediation and prevention and industrial cleaning efforts by DOC vendors to date have not been effective, per DLC's mold expert.

A. Dangerously Hot and Humid Conditions Exacerbated by Extended Periods Locked in Prison Cells

High summer temperatures and high humidity in BSH units remain a grave concern for PS health and safety. The "conditioned air" in BSH units offers little to provide relief to BSH PS and staff and BSH heat mitigation efforts fail to meaningfully address the suffering of PS during the many hours they spend locked in their cells. Infrastructural deficiencies, restrictive practices, along with the increasing frequency, duration, and intensity of heat waves,[65] demonstrate why BSH, operating under the DOC, is a danger to the individuals with mental health and other disabilities forced to live there.

As of the issuance of this report, PS have had to suffer through two generator outages during this summer's heat waves that specifically impacted the "conditioned air" systems. On July 8, both generators went offline at approximately 10:00am, were determined by DOC to require replacements, were replaced with new generators, and went back online at 4:00pm. During the 6-hour period on this day – with a high outside temperature of 96.8 degrees[66]– Wellpath passed out "freeze pops" during the 12:00pm and 5:00pm counts, as well as frozen water cups at 9:30pm night lock-in, moving all units into cooling areas during the afternoon. One of the replacement generators was then determined to need replacement, which occurred on July 9. On July 11, one of the new generators failed at around 8:50pm. It was operational again after 12:00am on July 12. On July 12, DOC installed a backup generator and transfer switch to each primary generator to prevent the same issues from occurring in future outages.

Because conditioned air does not utilize refrigerant to absorb heat and moisture, a discussion of conditions within BSH must focus on heat index - what the temperature feels like to the human body when relative humidity is combined with the air temperature. [67] The National Weather

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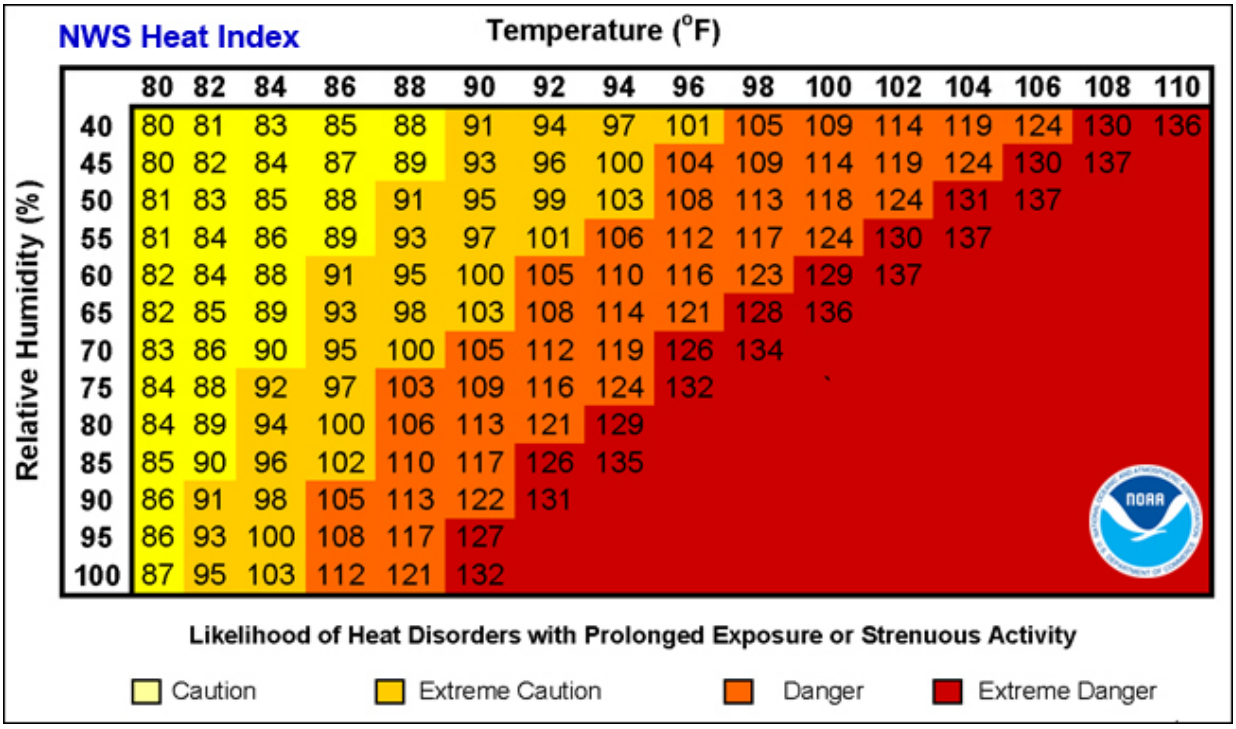
[64] All DLC's past public reports concerning investigation and monitoring activities at BSH are available at: https://www.dlc-ma.org/monitoring-investigations-reports/.
[65] U.S. Environmental Protection Agency, *Climate Change Indicators: Heat Waves* (Updated June 2024), https://www.epa.gov/climate-indicators/climate-change-indicators-heat-waves.
[66] Bridgewater MA Past Weather (2008-2024). Local Conditions, https://www.localconditions.com/weather-bridgewater-massachusetts/02324/past.php
[67] *Id.*

Service's charts[68] below shows the heat index and identifies the likelihood of heat disorders with prolonged exposure or strenuous activity for the average person. These charts do not, however, account for increased sensitivity to heat based on psychotropic medications, age, or underlying medical issues.



Classification	Heat Index	Effect on the body
Caution	80°F - 90°F	Fatigue possible with prolonged exposure and/or physical activity
Extreme Caution	90°F - 103°F	Heat stroke, heat cramps, or heat exhaustion possible with prolonged exposure and/or physical activity
Danger	103°F - 124°F	Heat cramps or heat exhaustion likely, and heat stroke possible with prolonged exposure and/or physical activity
Extreme Danger	125°F or higher	Heat stroke highly likely

As discussed in both of DLC's 2023 reports,[69] the impact of 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.[70] Psychiatric medications "can interfere with hypothalamic-set body temperature, impede the thermoreceptors (nerve endings that detect temperature on our skin and skeletal

[68] *Id.*
[69] *See* DLC January 2023 Report at 14-15; DLC July 2023 Report at 7-10.
[70] 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.

muscles), and reduce or accelerate sweat production."[71] The table below[72] shows several major types of psychotropic medications and their heat-related symptoms.

Table 13. Heath-Related Symptoms Select Categories of Psychotropic Medications							
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

Unfortunately, DLC does not currently have access to information regarding the number of visits to BSH's in-facility medical clinic per day or the reasons therefore. PS report a significant increase in these visits due to the impact of the heat. Documentation that DLC does have, which provides information about daily codes and restraint and seclusion incidents, highlights negative health effects of daily like on BSH units. A review of Wellpath nursing reports from May through early July, DLC identified numerous instances of PS reporting that they felt dizzy or faint– all on days with high temperatures of 76 or above. In addition, DLC noted one day with temperatures in the 90s during which two PS were transferred to an outside hospital due to hyponatremia – low blood sodium levels.[73]

i. DLC's Onsite Observations

During a site visit on June 20, 2024, with temperatures in the 90s, DLC took temperature and humidity readings of all 9 BSH units in cells and common spaces, observed available heat mitigation options, and interviewed PS on each unit. DLC first took readings at BSH between 1:15pm and 2:10pm and then moved onto so it is likely the internal temperatures rose further later that afternoon.[74] Higher internal temperatures and humidity levels were found across all

[71] D. Serani., *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.
[72] The source of the table's content is: Serani, *supra* note 71.
[73] A. Altuntas, *Hyponatremia: Is it related to the seasons?*, J. Med. Biochem. 40(4):407-413 (September 3, 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8451223/#:~:text=The%20highest%20hyponatremia%20incidence%20was,to%20the%20development%20of%20hyponatremia (concluding that "[t]he highest hyponatremia incidence was observed in summer in a four-year period. Loss of sodium by perspiration, along with increased temperature and/or excessive hypotonic fluid intake, might contribute to the development of hyponatremia").
[74] "The hottest part of the day during the summer is usually between 3 p.m. and 4:30 p.m., depending on cloud cover and wind speed." G. Elliot, *What Is the Hottest Time of Day?*, SCIENCING (Updated October 6, 2017), https://sciencing.com/what-is-the-hottest-time-of-the-day-12572821.html.

units, including Lighthouse, the only housing unit with air conditioning. The failure of conditioned air handlers in BSH and the OCCC BSH Units to address heat and humidity and provide safe, comfortable living were obvious. Indoor heat indices in BSH ranged from 83.3 degrees to 96.4 degrees; in the 2 OCCC BSH Units, they ranged from 94.1 degrees to 99.3 degrees.

Table 14. BSH Internal Temperature, Humidity, and Heat Index (June 20, 2024, 1:15pm-3:00pm)

Unit/Area	Temp.	Humidity	Heat Index	Unit/Area	Temp.	Humidity	Heat Index
Adams 1				**Hadley**			
Cell	82.9º	72.8%	88.9º	Cell	82.7º	62.4%	86º
Day Room	86º	66%	93.4º	Day Room	86.5º	67.8%	95.3º
Adams 2				**Lenox**			
Cell	83.4º	73.3%	90.2º	Cell	85.6º	75.4%	96.4º
Day Room	83.8º	73.3%	91.1º	Day Room	85.6º	67.8%	93.2º
Bradford 1				**Lighthouse (Medical)**			
Cell	80.4º	67.8%	83.3º	Cell	82º	69%	86.2º
Day Room	85.6º	60.4%	90.5º	Day Room	82º	72.9%	87.1º
Bradford 2				**OCCC BSH Unit – ISOU**			
Cell	79.3º	68.8%	81.8º	Cell	85.6º	71%	94.5º
Day Room	79.8º	71.7%	82.8º	Day Room	85.6º	69.9%	94.1º
Carter 1				**OCCC BSH Unit – RU**			
Cell	81.3º	63.2%	84º	Cell	87.9º	68.9%	99.3º
Day Room	84.2º	63%	88.7º	Day Room	86.3º	68.9%	95.3º
Carter 2				**Outside**	91.4º	52.6%	98.7º
Cell	79.3º	68.4%	81.7º				
Day Room	79.7º	67.4%	82.2º				

DOC's June 2024 "Bridgewater State Hospital: High Emergency/High Heat Index Preventative Measures," attached hereto as Appendix C, sets out several heat mitigation options to be used during high heat days, including access to air-conditioned rooms in the Attucks Building and Recovery Place, access to misting stations in multiple outdoor areas, and increased staff monitoring of heat-related illness in PS. In addition to these provisions, DOC's protocol also requires the following select on-unit heat mitigation measures:

- "Water shall be accessible in all patient areas (Units, Recovery Place, Attucks, gym, etc.)."
- "Ice shall be provided to the population during 9:30pm[75] count times. Ice may be considered any of the following: frozen water, frozen juice, popsicles, freeze pops, etc."
- "Large Fans shall be utilized on each housing unit and in off unit program areas."

[75] DLC notes that DOC's May 2023 Bridgewater State Hospital: High Emergency/High Heat Index Preventative Measures protocol required ice to be offered "during the 12pm and 5pm count times."

The following are observations from DLC's June 20 site visit with respect to DOC's on-unit heat mitigation requirements outlined above:

- DLC observed cold water coolers available to PS on every unit.
- All but one PS interviewed by DLC reported that that the day of the site visit was the first day that popsicles or frozen juice ("ice" per the June 2024 DOC policy) had been offered to them. This was the third day of a heat wave with daily temperatures in the 90s and above.
- 4 out of 9 units had no fan, 2 had small fans, and 2 had medium fans (roughly the size of a home box fan). Only 1 had a large fan, as required by the June 2024 DOC policy.
- The ISOU at OCCC had a single small wall mounted fan in the dayroom pointed at the area where the COs sit, with two additional mounted fans that were not working. The RU had two small wall mounted fans with one pointing towards the COs.

ii. PS Experiences of High Temperatures at BSH

DLC received complaints from PS regarding living conditions at BSH during high heat days. PS describe constantly sweating and having difficulty sleeping. On a day with temperatures in the 90s a PS reported it was so hot that it was difficult to breathe and described most PS as walking around with their shirts off, sticky, listless, and dizzy, and select others as agitated and arguing because the discomfort was so. PS have reported that their only water source while locked in their cells – the sinks attached to the toilet commode – is warm and that the new push-button showers, which removed PS temperature controls – are always hot.

Some PS DLC interviewed have not heard of the cooling centers in air-conditioned areas of BSH or the misting stations. Others had not been allowed to take advantage of them because they were designated as on "unit restriction."

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iii. Family Members of PS Report on Conditions and Plea for Change

Starting in June, BSH family advocates began sending daily emails containing education and calls to action related to Wellpath's failed heat mitigation efforts to a mailing list of more than 25 recipients that included BSH administrators, Wellpath executives, state senators, and state representatives. Through these impassioned communications, family advocates have called attention to the conditions reported to them by their loved ones: ice water frequently running out and not being replaced in a timely manner; limited access or no access at all to cooling areas; and hot, stagnant air in locked cells in which it is "hard to breathe." Emails recount family members seeing PS after PS arrive at the air-conditioned visitor room soaked with sweat and hearing heartbreaking accounts about how unbearable the heat was on his unit. One family member reported that, in the parking lot, he asked a Wellpath employee ending his shift about heat conditions inside the hospital. The employee, replied that it was bad, and "I don't understand how this is allowed." Day after day, advocates amplify their loved ones' calls for help in these mass emails.

B. DOC's Response to December 2023 Mold Expert Site Inspection Findings

Gordon Mycology's thorough conclusions from the December 19, 2023, inspection and lab results were as follows:

> Many of the sources of mold growth identified during the 2019, 2021, and 2022 inspections of the Bridgewater State Hospital buildings and HVAC systems were confirmed to still be present (visually and with laboratory data) during the current 2023 inspection. This indicates that the necessary mold remediation, cleaning, and maintenance actions have not been performed (or kept up with as regularly as they need to be). HVAC systems observed during the inspection continued to be in deplorable condition, some with air handlers in wet and flooded basements with rampant mold growth and asbestos. The black dust/debris inside HVAC system air handlers and supply diffusers remained, seemingly untouched, along with unacceptable levels of mold growth; the air coming through these systems is what persons served and building staff members must breathe on a daily basis. Even sections of HVAC systems that had been professionally cleaned were confirmed to be filthy and riddled with active mold growth after the cleaning.
>
> Significant and long-term basement water problems have been and were still occurring at the time of this inspection. The leaks have gone, for the most part, unnoticed and/or were ignored [(] based on the amount of rust, water damage, corroded pipes, and widespread mold growth). HVAC system air handlers in wet basements and systems with major problems (absence of filters, unfiltered and unconditioned outdoor air coming directly into the systems, absence of regular maintenance and specialized cleaning, etc.) have resulted in significant mold growth within the systems that provide air to people living and working in the buildings. There has been neglect of critical building systems. Mold remediation performed by an unqualified company who did not follow industry standards and procedures was proven to be inadequate, unsuccessful, deficient. There also are remaining questions regarding the completeness of the asbestos abatement; there appeared to be potentially asbestos-containing materials in the basements that should be investigated by an independent (not Arcadis) asbestos inspector.
>
> Overall, this inspection suggests that inappropriate and harmful actions pertaining to the control and remediation of mold growth in the buildings of Bridgewater State Hospital continue and many of the 2019, 2021, and 2022 recommendations were largely ignored. These inactions have caused the mold problems to become worse in certain areas observed and potentially more harmful to those who work and live in the facility. Based on 4 years of Bridgewater State Hospital inspections by [Gordon Mycology], 27 years of professional mold/indoor air quality inspection history and experience, and industry accepted guidelines for indoor spaces contaminated with mold, [Gordon Mycology] is concluding that the facility should not be occupied until these problems have been fully resolved and the buildings retested to verify that the moisture and mold sources have been removed and resolved, respectively.[76]

[76]DLC February 2024 Report, App. C at 17-18 (emphasis added).

Laboratory testing of Gordon Mycology's December 2023 samples identified the following mold types growing on the tested BSH surfaces: *Aspergillus*[77] *niger*, *Aspergillus ochraceus*, *Aspergillus sydowii*, *Aspergillus ustus*, *Aspergillus versicolor*, *Aureobasidium*, *Chaetomium*, *Cladosporium*, *Epicoccum*, *Memnoniella*, *Penicillium*, *Pithomyces*, *Stachybotrys*,[78] and *Trichoderma*. It is well understood that persistent mold exposure is unhealthy and that people with underlying health conditions and weaker immune systems are most affected by chronic mold exposure.[79] Of course, many PS have co-occurring chronic and/or serious medical conditions, including diseases that impact their immune systems (e.g., lupus, hepatitis C). Moreover, studies indicate that exposure to mycotoxins may also be associated with "fatigue, musculoskeletal pain, headaches, anxiety, mood, cognitive impairments, and depression."[80] Many of these symptoms may readily be treated and medicated as mental health symptoms if they are not properly screened and addressed. DLC notes that DOC and Wellpath have not followed DLC's past recommendations to provide regular health screenings for symptoms of mold and environmental toxin exposure.[81]

Confronted with these findings, DOC provides a limited response in which it asserted that it "will contract with an environmental consulting firm to inspect BSH for mold and will following their recommendations for remediation."[82] In addition, DOC described its continuing efforts:

> The DOC will continue in its efforts to provide the best environment for our patients. Mold in trace amounts is present in BSH as it is in all buildings and outdoor spaces but based on previous testing and consultation with air quality environmental consultants, we do not believe that it poses health and safety risks to our patients. The DOC has a contracted cleaning company that cleans and disinfects BSH daily with a hospital grade sporicidal disinfectant and the hospital is inspected quarterly by a mold remediation firm. The DOC will continue to work with experts to continue to maintain the indoor air quality to all recommended standards.[83]

The discussion of harmless trace amounts of mold is clearly inconsistent with Gordon Mycology's findings based on the December 2023 inspection – and the expert's consistent findings from December 2019, December 2021, and December 2022 inspections. Informed by decades of experience, Gordon Mycology made firsthand observations of ***visible mold*** and took photographs of ***visible mold*** throughout the facility and heavily contaminated HVAC systems. Laboratory testing then confirmed the presence of mold from the surface swabs. The evidence is irrefutable, with all photographs and surface swabs taken in the presence of DOC

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[77] *Aspergillus* can cause chronic lung and sinus infections, produces mycotoxins, and is a common allergenic mold. Chronic exposure to these and the other molds confirmed in the buildings can cause a myriad of health problems, many of which may not initially be attributed to mold; colds that take longer to clear, chronic sinus infections, persistent coughing, itchy and runny eyes, sore throats, exhaustion, lethargy, mental fogginess, etc. DLC February 2024 Report, App. C at 11; *see* Centers for Disease Control and Prevention (CDC), Fungal Diseases: Aspergillosis, https://www.cdc.gov/fungal/about/types-of-fungal-diseases.html and https://www.cdc.gov/aspergillosis/index.html.

[78] Gordon Mycology noted that *Stachybotrys* – also known as black mold – found in the Lenox basement mechanical room "produces satratoxin, a powerful mycotoxin that is neurotoxic and inflammatory" and *Aspergillus*, a mold type confirmed to be present on most of the tested surfaces at BSH, including HVAC systems, can cause a host of health issues. DLC February 2024 Report, App. C at 11.

[79] DLC February 2024 Report, App. C at 11.

[80] A. Ratnaseelan, et al., *Effects of Mycotoxins on Neuropsychiatric Symptoms and Immune Processes*, Clinical Therapeutics, Vol. 40, No. 6, 912 (2018), https://www.clinicaltherapeutics.com/article/S0149-2918(18)30229-7/fulltext.

[81] DLC January 2022 Report at 14-15.

[82] App. B at 3.

[83] *Id.*

personnel. DLC once again consulted with Gordon Mycology during this reporting period for review of DOC's response. Gordon Mycology stands by its expert conclusions, stating:

> BSH should not be occupied until the facility undergoes effective remediation that removes all live and dead mold growth sources. Until this is completed, mold inside the HVAC systems is delivering contaminated air to occupied spaces throughout BSH. The same HVAC systems are carrying a load of debris, dust, fiberglass, and other particulate matter to which no one should be exposed. Though the degree of impact varies, this contaminated air does affect PS and staff. Chronically breathing in mold spores and foreign particulates is known to negatively affect and permanently damage peoples' lungs, sinuses, and immune systems. Once the immune system is compromised, other medical problems and illnesses follow.[84]

In addition, upon reviewing the temperature and humidity readings that DLC took on June 20, 2024, Gordon Mycology expressed concern that the high humidity is exacerbating existing mold growth on surfaces and inside of BSH HVAC systems and, as a result of both the heat index and mold growth, individuals who live and work at BSH face even higher risks to their health than at the time of the December inspection.

c. Attucks Gym Accessibility

In April 2024, DOC put out a bid for installation of an Incline Lift to ensure access to the Attucks gym for PS and staff who use wheelchairs. The bid has since been awarded, and the Incline Lift was delivered to BSH in June 2024. After receiving and sharing with DOC complaints from multiple PS, DLC welcomes this long-awaited development, while at the same time emphasizing the endless investments by the Commonwealth in retrofitting and remediating this facility.

[84] Gordon Mycology Statement Responding to DOC's May 21, 2024 to DLC's February 2024 Report (July 21, 2024).

5. Response to Expert Findings Concerning Problematic Treatment of PS with Opioid Use Disorder

In response to repeated concerning PS accounts about access to medications for opioid use disorder (MOUD) at BSH, DLC engaged a dual board-certified internal medicine and addiction medicine physician, Dr. Evan Gale[85] to conduct an expert analysis of 5 case studies. The expert findings were presented in DLC's February 2024 report.[86] Despite BSH administrators lauding the facility's streamlined access to these medications, PS reports suggested a rationing of MOUD care. Dr. Gale "found that BSH providers conflate mental health symptoms with withdrawal symptoms and, based on the stigma of both and lack of management of medication options, provide substandard care."[87] Through the 5 case studies, Dr. Gale identified a series of troubling common themes in the MOUD care BSH provided – or refused to provide – and identified the following concerns related to each PS' individual care, ranging from failures to follow accepted best practices to failure of BSH providers to meet the medical standard of care.

- BSH's prevailing concerns around methadone leads to a lack of management that is substandard even when taking the most conservative commonly accepted methadone management approaches.
- BSH is not comfortable managing methadone for opioid use disorder in patients who are prescribed it outpatient and avoids utilizing it for opioid use disorder despite its status as an FDA approved first-line medication for opioid use disorder that should be strongly considered if buprenorphine at maximum doses plus non-medication therapies does not control opioid cravings. There does not seem to be any provider or service at BSH that is either comfortable managing methadone as a treatment for opioid use disorder or is able to effectively seek timely consultation with addiction experts for ongoing management and adjustment of methadone.
- BSH seems more comfortable with use of buprenorphine for opioid use disorder, but again does not respond to reports of opioid withdrawals or cravings with adjustments in buprenorphine.
- BSH does not follow the general recommendation that for therapeutic effect, buprenorphine daily doses should be 16-24mg for patients for those who tolerate these doses, and so often has patients on substandard doses for opioid use disorder treatment.
- Both with methadone and buprenorphine, availability of medication is an issue. There were multiple instances where medication delays occurred due to awaiting methadone or buprenorphine from the pharmacy. This is concerning given that both of these medications are not only useful for opioid use disorder maintenance treatment, but also for acute opioid withdrawal management (especially when utilized to later transition patients on to these medications). In addition to forcing patients to endure symptoms of

[85] Dr. Gale is the Associate Medical Director for Massachusetts General Hospital's inpatient Addiction Consult Team (ACT), the Director of Clinical Education and Teaching for ACT, and the Director of Inpatient Training for the Addiction Medicine Fellowship. *See* Mass. General Hospital, *Addiction Medicine Fellowship Faculty*, https://www.massgeneral.org/education/addiction-medicine-fellowship/faculty
[86] DLC February 2024 Report at 27-31.
[87] DLC February 2024 Report at 27.

withdrawal, the immediate stoppage of such medications can lead to dangerous medical complications.[88]

DOC's May 21, 2024, response to DLC's February 2024 report contained a limited response that highlighted the experience and training among BSH clinical staff and the availability of MOUD at the facility. DOC's May 21, 2024, response:

> BSH professionals have significant experience and training in the use of medications to treat substance use disorders. All psychiatrists receive extensive training in the treatment of substance use disorders in their residency, including the challenges of providing treatment to persons served with co-morbid psychiatric disorders. All DEA registered practitioners are required to complete 8 hours of training on the treatment and management of persons served with opioid or other substance use disorders, and all medical providers as part of their medical licensing and credentialing require extensive training. The medical standards of care and guidelines for pharmacological treatment of substance use disorders, including opioid use disorder, are represented in treatment planning for all persons served. Individuals receiving MAT[89]/MOUD are continued on treatment upon intake unless there is a clear reason that continuation on treatment is contraindicated. In addition, Wellpath resumes treatment for those individuals whose treatment was interrupted by their criminal justice involvement.
>
> BSH orients all staff and providers to issues of exposure to opioid abuse during the mandatory two-week new employee orientation. Empathy, bias, and stigma surrounding a person served is extensively discussed, as is trauma informed care and the recovery model. The Department's and Wellpath's goal is to treat all persons with substance use disorders with compassion, respect, and support for recovery.
>
> Wellpath has access to all three FDA approved medications for substance use disorders. Newly prescribed or continued upon intake medication orders are ordered on a STAT basis as clinically indicated so that the medications are available promptly.[90]

DOC has not acknowledged or addressed Dr. Gale's specific findings concerning the care provided to the 5 individuals he reviewed. In addition, it is important to point out that the 8-hour training requirement for DEA-registered practitioners is a floor. Meeting this minimum requirement does not confirm expertise in addiction medicine or the use of medications for substance use disorders. Likewise, while general psychiatry residencies do involve substance use disorder training, it is not comparable to the expertise of providers who have completed fellowships in addiction psychiatry or addiction medicine specialists. Moreover, assertions concerning these minimum training requirements and consideration of standards and guidelines for pharmacological treatment of substance use disorders in treatment planning does not allay serious concerns raised by Dr. Gale's findings that BSH providers did not adhere to standards of care, as defined by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines.

Although Wellpath has not provided any direct response to Dr. Gale's findings, it has taken steps to address the root of the issues that DLC and Dr. Gale raised. Laudably, Wellpath has

[88] Evan Gale, M.D., *Findings – Disability Law Center MOUD Expert Consultation* (February 15, 2024) [hereinafter "Gale Report"].
[89] Medication assisted treatment (MAT) and MOUD are sometimes used interchangeably.
[90] Appendix B at 3.

contracted with a board-certified addiction medicine specialist, who joined BSH on June 12, 2024 and "will be providing approximately 12 hours a month to consulting on MAT services for patients admitted on MAT and/or being considered for MAT while hospitalized at BSH" and "training to staff on MAT services."[91] Additionally, Wellpath has reported that BSH substance abuse counselors having weekly contact visits with PS in the MAT program and developed a MAT group that meets once a week.[92]

DLC looks forward to monitoring the positive impacts of BSH's new addiction medicine specialist. In the meantime, DLC continues to receive reports from PS about delays in access to MOUD care during this reporting period, including:

- PS "Stan," who had been prescribed MOUD at Nahua Street Jail prior to his transfer to BSH, spent 4 days "dopesick" due to being denied his medication. His BSH records confirm that Stan filed 2 sick call slips on his first full day at BSH, but did not receive his suboxone until 4 days after he was admitted to BSH. During this time, Stan was in so much physical and mental suffering that he contemplated suicide.
- PS Gino arrived at BSH in opioid withdrawal while at BSH. During the first week of his admission, a BSH provider noted Gino had untreated "psychotic illness likely worsened by heavy illicit substance use while in the community *presently in forced sobriety while incarcerated.*" Despite his symptoms of withdrawal and medical records substantiating BSH provider's awareness of his condition, his BSH medical records did not identify him as having a substance use disorder – in this case, opioid use disorder – more than 4 months into his stay. Gino was ultimately released from BSH without ever being offered MOUD.

[91] BSH Governing Body Meeting, Hospital Administrator's Report (June 13, 2024).
[92] BSH Governing Body Meeting, Programming and Rehabilitation Department Report (June 13, 2024).

6. Inadequate Access to Medical Care for Persons Served

DLC's February 2024 report covered monitoring findings concerning BSH medical staff's lack of responsiveness to PS health concerns and detailed 4 disturbing examples of PS with varied health conditions who endured serious delays and denials of medical care at BSH.[93] In its May 21 response to these accounts and DLC's recommendations to improve timely access to medical care and specialist consultations, DOC plainly recited the access to care that PS are supposed to receive, but neither acknowledged nor addressed any of the examples:

> BSH is committed to providing comprehensive care and services to all persons served. All individuals admitted to BSH receive a history and physical upon admission and annually thereafter. Persons served with chronic illness are monitored as indicated with nursing, and medical providers are on site 24 hours per day, 7 days per week. Persons served have access to medical and dental care via the sick call process 7 days per week, and requests deemed urgent or emergent are referred to medical on the same day. Specialty care is available off site, and a tracking mechanism for all appointments is in use at BSH to ensure follow up, provider review of any results, recommendations, and plan of care with the individual.[94]

DLC likewise received no targeted response from Wellpath to discuss what happened in those 4 cases and what, if any, corrective action had been taken to prevent future lapses.

Wellpath has, however, reported to the BSH Governing Body that it is working on "enhancing the admission process for non-English speaking PS and improving healthcare access for marginalized groups with chronic diseases.[95] Wellpath is also adding an experienced internist with fellowship training in Pulmonary and Critical Care Medicine to the medical staff rotation.[96] In addition, Wellpath is rolling out medical identification bracelets for PS who want to them to assist with patient safety and easy identification for PS medications and care.[97]

Wellpath's continuing implementation of the sick call slip process initiated in response to DLC recommendations is proceeding with varied success. Weekly onsite monitoring has revealed inconsistent compliance with making the forms available in hanging folders in each unit to allow PS independent access. DLC observed multiple units with no sick slips, no grievance forms, or neither form accessible. One unit had no sick slips accessible to PS for three consecutive weekly visits, despite DLC providing weekly feedback to Wellpath. DLC hopes that appropriate staff guidance can prevent such barriers for PS who wish to request medical care.

Unfortunately, improved access to sick call slips and grievance forms has not put an end to PS complaints about Wellpath's lack of responsiveness to their medical concerns. The following are 2 of the many PS complaints to DLC about delays in, denials of, and lack of transparency about medical care from this reporting period:

- In an admission interview, PS "Hugo" reported to Wellpath staff his need to continue receiving daily prescription eyedrops to treat his diagnosed pre-glaucoma. The eye drops lower the pressure in one's eye and prevent damage to the optic nerve. Despite his disclosure upon admission, a medical referral was not submitted until 20 days later. Records indicate that it took Wellpath nearly 3 weeks to begin providing him with the eye drops, risking exacerbation of his condition.

[93] DLC February 2024 Report at 32-46.
[94] Appendix B at 4.
[95] BSH Governing Body Meeting, Clinical Services Report (June 13, 2024).
[96] BSH Governing Body Meeting, Psychiatry, Medicine and Dental Report (June 13, 2024).
[97] Administration Group Meeting Minutes (April 25, 2024).

- PS “Gus” reported that he had refused the oral version of a court-ordered antipsychotic medication he knew was allergic to while at BSH. Because Gus refused, BSH staff forced him to take the medication by intramuscular injection. Gus’ hands curled up and he had difficulty talking, eating, walking, and getting out of bed. When Gus complained, he said that staff told him he was “making it up.” Gus received the injection again the next day after he objected based on his allergy. Then, Gus gave up and started taking the medication orally in order to avoid the pain of the needle, despite the persistent debilitating physical effects. It took 6 days of Gus suffering for a BSH psychiatrist to credit his complaints, agree to place this medication on his allergy list, and prescribe a different medication.

7. Disparate Treatment and Conditions for Persons Served in the BSH Units at Old Colony Correctional Center

During this past reporting period, DLC did not observe any marked progress by DOC and Wellpath in addressing the issues and PS complaints about the 2 OCCC BSH Units. The Intensive Stabilization and Observation Unit (ISOU), where PS are held during the evaluation period, and the Residential Unit (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. DOC correction officer control both units. Treatment staff as well as access to medical and mental health care provided by Wellpath fall under DOC's BSH contract with Wellpath. The transition to working in coordination with VitalCore, which now holds the DOC-wide medical and mental health services contract, to facilitate evaluations and transfers to and from the OCCC BSH Units is underway.

A. Insufficient Staffing and Access to Programming

OCCC BSH staff reported to DLC that Wellpath continues to maintain staffing levels below their contractual obligations in the OCCC BSH Units, with 3 out of 4 mental health clinician positions filled, until a resignation in February dropped that to 2. Nursing and RTA fill rates for the OCCC BSH Units remain lower rates than those at BSH.

At the same time, PS reported to DLC that there is a lack of rehabilitation staff. Wellpath confirmed that, as of June 13, 2024, there were only 3 rehabilitation staff – a fill rate of 60% – to provide programming to PS on both OCCC BSH Units.[98] According to PS, this understaffing has resulted in insufficient engagement by staff with PS during programming and a lack of diversity among groups and activities offered in the ISOU. One PS on ISOU reported believing that programming and groups were not running at all on the unit. RU residents have more opportunities for engagement.

B. Troubling Interactions with Correction Officers

As has discussed in previous DLC reports,[99] both staff and PS report tensions between the provision of clinical care and the role of correction officers in the ISOU and RU. One PS described officers as "overstepping" their bounds with Wellpath staff, echoing the complaints of multiple PS who report that RTAs and clinical staff are intimidated by officers into abandoning or changing planned clinical interactions with PS. Notably, despite the small size and capacity of the ISOU – with only 18 single bed cells – there are 5 officers assigned to the unit during the day. In the unit, a team of officers often sit imposingly behind a table looking in the day room area of the unit. Outnumbered treatment staff can feel disempowered to contradict the directives of officers or worried for their safety should an incident arise on the unit.

i. Verbal Abuse

PS continue to report that correction officers pick on and antagonize certain PS in both OCCC BSH Units. PS consistently report lewd comments from officers. Staff too lament the fact that OCCC BSH Unit officers – working with a population with high mental health needs – are not required to undergo specialized mental health training, unlike officers assigned to the OCCC Residential Treatment Unit (RTU), a specialized housing unit.

[98]BSH Governing Body Meeting, Programming and Rehabilitation Department Report (June 13, 2024).
[99] DLC January 2023 Public Report at 48; DLC July 2022 Public Report at 42.

ii. Physical Abuse in the ISOU

Many PS in the OCCC BSH Units that DLC interviews bring with them painful memories of physical abuse at the DOC facilities from which they were transferred. PS come to the ISOU for mental health treatment, yet often find themselves minimally treated and retraumatized. One PS, who reported that he had witnessed the first incident of inappropriate physical force described above told DLC: “The other day they just beat the living crap out of someone in front of my face.” Explaining that the PS was cuffed and shackled while the assault occurred, he said officers “punched his face in– I witnessed the whole entire thing.” This PS found the whole ordeal deeply upsetting, as it prompted him to have flashbacks to a time he was assaulted at a previous institution.

DLC interviewed a PS who reported having been “jumped,” hit in the face three times, and having his eyes gouged by multiple COs. He was then placed in 4-point restraints and involuntarily medicated twice, 4½ hours apart. During the interview, DLC observed a slight bend to his right pointer finger, bruises and cuts on his left eye, nose, and right eye, as well as deep scrapes from handcuffs around both wrists. He reported that staff did not offer him medical attention or clean him up after the incident, and believed this incident gave him a concussion. DLC’s review of documentation substantiates the extent of his injuries from the interaction with officers.

Another PS interviewed by DLC recalled being unexpectedly tackled by 4 COs in retaliation for an incident earlier that day. DLC observed deep handcuff indentations on his right wrist where he said COs had tried to break his wrist. He further recalled having his chest pushed to the floor while he was shackled, as the COs tried to fold his legs backwards. This PS said that a quarter of all COs on the OCCC BSH units go “overboard,” but the more pervasive problem is those who fail to report their coworkers’ misconduct.

8. Challenges in Persons Served Continuity of Care

DLC monitors continuity of care for PS and any barriers thereto through onsite visits to BSH, OCCC Units, DMH facilities, and county correctional facilities, PS interviews, facility staff interviews, and document review. During this reporting period, DLC conducted site visits at 5 DMH hospitals – Worcester Recovery Center and Hospital, Lemuel Shattuck Hospital, Tewksbury State Hospital, Taunton State Hospital, and Mountain View Unit at Valley Springs Behavioral Health Hospital.[100] DLC also conducted repeat site visits at Plymouth County Correctional Facility and Worcester County Jail and House of Corrections. Some impediments to successful continuity of care for former PS remain unchanged since DLC's last report and others have improved.

A. Continuity of Care: DMH Hospitals

Many challenges former PS in DMH hospitals raised are consistent with previous reporting periods:

- Among these former PS, the standard notice they received prior to their transfer from the prison to the DMH hospital was 2 to 3 days. Roughly half reported having a meeting with BSH staff about what to expect at the DMH hospital.

- After transferring to DMH, PS report delays in receiving their funds from BSH of one month or longer as well as delays in accessing their property.
- DMH hospital administrators reported difficulties obtaining complete PS medical records and psychosocial evaluations from BSH prior to or upon PS transfer. Records that do arrive with or ahead of the transferred PS can be out of date or missing, and DMH hospitals may be missing highlighted medical issues in advance. BSH administrators do provide missing documents upon request, but this is no substitute for complete paperwork prior to PS arrival.
- DMH administrators report that BSH transfers frequently arrive with no DMH services application completed or submitted, which can contribute to delays in discharge to the community.
- BSH PS continue to be discharged under "continuation of incarceration," thus requiring a status change to obtain full benefits. However, DMH hospital administrators report their staff have been able to rectify these issues when they arise by calling BSH.

Former BSH PS typically describe DMH staff as vastly superior to BSH staff in most every way. One former PS said that DMH staff are a "1,000% improvement," and that at DMH, "they know what they're doing." Former PS also describe improved food quality at DMH hospitals; the improved quality of therapeutic groups, and access to electronics as elements of DMH facilities that they appreciate over BSH. As DMH patients, they report being treated with more respect and attention to recovery. Like at BSH, "codes" (emergencies) happen in DMH, but because DMH staff seem well-trained, the codes are not as "emotional" or "hectic" as they are at BSH. Noting that DOC runs BSH like a prison, he highlighted the fact that while DMH hospitals don't do institutional count (as in DOC), "everyone is safe" and accounted for.

DLC continues to receive complaints about access to the outdoors and opportunities for exercise, which vary across DMH facilities based on their construction and staff capacity. Both DMH personnel and former BSH PS in Lemuel Shattuck Hospital Metro Boston Mental Health

[100]The Mountain View Unit is a contracted DMH unit for Western Massachusetts. The unit was formerly located at Vibra Hospital.

Units also express deep concern about the revocation of supervised and unsupervised privileges based on administrative application of DMH psychiatric risk assessment protocols.

DLC engages productively with DMH to improve access to community integration opportunities, increase access to the outdoors, and promote equitable and individualized application of risk assessment protocols. Nevertheless, even with room for improvement, DMH patients enjoy considerably safer and healthier conditions, more privileges, and enhanced rights than their pre-transfer counterparts at BSH.

B. Continuity of Care: County Correctional Facilities

Former and current BSH PS regularly report troubling conditions and neglect of their medical and mental health needs in county correctional facilities. PS describe long waits to physicians who can prescribe MOUD and other medications, minimal access to mental health care through momentary contacts by rounding clinicians. When individuals seek further access to mental health care and report negative thoughts, they report feeling at risk of being subjected to punitive conditions of mental health watch (MHW).

County correctional administrators generally reported good working relationships with their BSH counterparts for facilitating transitions to and from BSH. However, they had similar concerns about the timeliness of medical records transfers for individuals discharged back to county correctional facilities, which they report tend to arrive the day of discharge rather than a day or 2 ahead. Earlier access to records would allow counties to ensure the correct medications are stocked, for example.

i. Treatment of Individuals Transferred Under M.G.L. c. 123, § 18(a½)

Additionally, some county correctional administrators expressed a desire for BSH to spend more time evaluating and treating individuals transferred to BSH under M.G.L. c. 123, § 18(a½). This relatively new statute allows for individuals held on mental health watch in DOC and county correctional facilities to, after 72 hours, petition the court for transfer to a DMH hospital or BSH for care and treatment. However, those petitioning from county correctional facilities who are admitted to BSH under § 18(a½) are returned to county correctional facilities, on average, 6 days later.

DLC shares this concern. Individuals in mental health crisis at county correctional facilities who seek the assistance of the court to access more intensive mental health treatment are systemically being denied an opportunity to benefit from that treatment at BSH through truncated evaluations. However, individuals who often do not want to come to BSH from county facilities, but who are adjudged to warrant a § 18(a) evaluation after the correctional facility files a petition, are evaluated for up to 30 days. The discrepancy is, at least in part, related to the standard of review being applied to § 18(a½) commitments in the absence of clear guidance from the statute.

ii. Mental Health Watch in County Correctional Facilities

Experiences of individuals on Mental Health Watch (MHW) vary among county sheriff's department facilities and can have lasting psychological impact. MHW is often an essential component of PS continuity of care, as it is typically a PS' last status before leaving county correctional facilities for an evaluation at BSH and may be where they go upon their return. Since the July 2023 BSH report, DLC has been visiting, gathering information, and interviewing former BSH PS at select county correctional facilities with a focus on MHW. DLC looks forward to continuing this work in hopes of pushing for improvements and adoption of minimum standards of mental health care, and mental health watch conditions for all county prisoners

The below accounts are drawn from the range of DLC's monitoring activities, including interviews with former BSH PS during DLC's two county correctional facility visits, interviews with PS at BSH, and interviews with former PS at DMH hospitals. They reflect conditions at county correctional facilities across the state. 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.

DLC has previously referenced the United States Department of Justice's December 2022 settlement agreement with DOC 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, based on DLC's observations, conditions in certain county correctional facilities present similar concerns that warrant the Commonwealth's attention and enhanced oversight by DMH.

Extreme Physical and Environmental Conditions

Former BSH PS from a variety of county facilities report that they have access to little or no programming and scant reading material. Multiple PS report being intermittently deprived of toilet paper and running water, with shower access 1 to 2 times per week.

For those placed in the "soft cell" at Plymouth County Correctional Facility, a bare rubber-padded room,[101] there is no toilet, no running water, and no place to sit. There individuals must ask an officer every time they need to move their bowels. If they need to urinate, they are typically left to do so in a drain in the middle of the floor which, according to those who have utilized this cell, results in splashing and pooling of urine on the floor. One former PS said you are "lucky" if Plymouth County provides people on MHW with a suicide smock– he was held in a restraint chair, naked, for 1 to 2 hours in the rubber room before being transferred to BSH.

Former PS who have been held at Worcester County Jail & House of Correction report the agony of being kept in MHW cells with lights on 24 hours a day. Multiple interviewees described this as making it impossible to sleep as well as contributing to anxiety and night terrors. One individual reported sleeping under his metal bunk while on MHW just to escape the constant light. Another called his MHW cell a "torture room."

Inadequate Mental Health Care

Over the course of this reporting period, current and former BSH PS described their experiences on MHW in the following terms: "stuck;" "trapped;" "isolating;" "claustrophobic;" treated like an "animal;" or like "less than a human being." Former PS typically characterize the mental health care on MHW in county correctional facilities as worse than that provided at BSH, and roughly equivalent to that provided in general population units. Despite increased restrictions and surveillance on MHW and lack of contact with other incarcerated individuals, PS describe daily clinician rounds as typically amounting to little more than being asked, "are you going to hurt yourself?" Access to out-of-cell sessions is often infrequent – once or twice every week.

Nearly everyone DLC interviewed said MHW was not helpful, and the majority found it harmful to their mental wellbeing. A PS who experienced MHW in the Essex County Correctional Facility said that MHW was so painful that most of his peers would rather lie to mental health staff and stay on a segregation unit than tell them the truth about how they were feeling. Another from

[101] DLC July 2023 Report at 41-44.

Essex relayed that he could not work through his suicidality in that environment. One PS who spent time on MHW in the Worcester County Jail & House of Correction reported that, when he was released from his MHW cell – where he was placed due to suicidality – he was so relieved to be out that he kissed the ground.

Appendix A: Summary of DLC Monitoring Activities During Reporting Period

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;
- BSH PS video, phone, and in-person meetings;
- BSH staff in-person meetings;
- Onsite visits to the OCCC BSH Units - ISOU and the RU;
- OCCC BSH Unit PS video, phone, and in-person meetings;
- OCCC BSH Unit staff in-person meetings;
- Meetings and correspondence with BSH administrators and Wellpath leadership;
- Meetings and correspondence with DOC administrators and DOC Legal Department;
- BSH PS Governance Meetings;
- 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 restraint and seclusion;
- Review of DOC Incident Reports;
- Review and analysis of BSH restraint and seclusion data;
- Review of BSH restraint and seclusion orders and documentation;
- Review of individual PS medical records;
- Review and analysis of PS discharge data;
- Onsite visits to DMH hospitals and units: Lemuel Shattuck Hospital, Worcester Recovery Center and Hospital, Tewksbury State Hospital, Taunton State Hospital, and Western MA Unit at Mountain View to meet with facility staff and discharged PS;
- Onsite visits to Plymouth County Correctional Facility and Worcester County Jail and House of Corrections to tour facilities, meet facility staff and discharged PS;
- Phone interviews with discharged PS in DMH 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, DLC continues to work on several investigations into PS abuse and neglect commenced in previous reporting periods.

Appendix B: Department of Correction Response to Disability Law Center February 2024 Report on Bridgewater State Hospital (May 21, 2024)

The Commonwealth of Massachusetts
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Deputy Commissioners

May 21, 2024

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

Re: Disability Law Center Public Report dated February 2024 on Bridgewater State Hospital

Dear Director L'Italien,

The Department of Correction is in receipt of DLC's February 2024 report on Bridgewater State Hospital (BSH). As is always the case, we respect the diligence that DLC maintains in its advocacy on behalf of our persons served. This response will focus on your recommendations.

Future of BSH

DLC's first two recommendations relate to the Department's statutorily assigned role, and to the recommended construction of a new facility. These matters are beyond the scope of our ability to respond. Given that the Department is and has been responsible for the care of all persons served, it is imperative to know that we share the goal of protecting the wellbeing and rights of all individuals in a challenging setting. Individuals determined by the court to need the strict security environment of an involuntary psychiatric hospitalization have varied and diverse needs, and it is the Department's goal to provide the highest quality of

care, forensic evaluation and treatment to those at BSH. Oftentimes, the persons served have been failed by every system in which they have been involved and it is our goal to assist each individual in their recovery.

Seclusion and Restraint

With respect to recommendation number three, the Department agrees that Seclusion and Restraint, as well as the Involuntary Use of Psychotropic Medication, shall only be used in an emergency as defined in M.G.L. c. 123, sec. 21. Wellpath, the Department and DLC have reviewed the policies independently and collectively to ensure that the language satisfies the law, and more importantly that practice follows. Our retained expert, Dr. Debra Pinals, assisted in the rescripting of the policies to ensure the language was clear. The Department shared the draft policies with DLC, which provided the Department with feedback in both a March 15, 2024 meeting and in March 25, 2024 written notes. The Department has incorporated this feedback into further revisions and provided the most recent drafts to Wellpath for review. We appreciate the collaboration, as well as DLC's acknowledgment that the ongoing tracking is encouraging.

With regard to documentation of these serious clinical events, Wellpath has revised the documentation used for emergency medication usage to more clearly conform to Massachusetts requirements. These changes are codified in the draft version of the documents shared with DLC for review and comment. As noted in the Department's prior responses, all serious clinical incidents and corresponding documentation are reviewed by hospital leadership to ensure appropriate use of seclusion, restraint or emergency medication, and any issue noted is addressed, providing for the retraining of all staff. In addition, the Commissioner reviews the documentation twice monthly to ensure oversight of the hospital.

Protective Gear

The Department agrees with recommendations four and five. and believes that Wellpath has enacted a proper practice of assessing when protective gear is required for interactions with at risk persons served. It is the policy of BSH to approach the use of protective gear with multi-disciplinary decision making and trauma informed principles. All wish to achieve the safest outcome for persons served and staff, and therefore de-escalation efforts, utilizing the MANDT system and seeking alternatives to a physical intervention, are primary tasks. If these efforts are ineffective at resolving the emergency situation, the final determination to utilize protective gear is made by the multi-disciplinary team of clinical, nursing and security staff.

The Department does not tolerate the use of unnecessary force on persons served in any environment. Any such allegation or event that impact a person served is reviewed, investigated and forwarded to the Disabled Persons Protection Commission as needed. Wellpath reviews all incidents and events as well to ensure adherence to hospital policy and state law.

Environmental Concerns Reported by DLC

With respect to recommendations numbers 6 and 7, the DOC will contract with an environmental consulting firm to inspect BSH for mold and will follow their recommendations for remediation.

The DOC will continue in its efforts to provide the best environment for our patients. Mold in trace amounts is present in BSH as it is in all buildings and outdoor spaces, but based on previous testing and consultation with air quality environmental consultants, we do not believe that it poses health and safety risks to our patients. The DOC has a contracted cleaning company that cleans and disinfects BSH daily with a hospital grade sporicidal disinfectant and the hospital is inspected quarterly by a mold remediation firm. The DOC will continue to work with experts to continue to maintain the indoor air quality to all recommended standards.

MAT/MOUD

With respect to recommendations numbers 9 and 10, BSH professionals have significant experience and training in the use of medications to treat substance use disorders. All psychiatrists receive extensive training in the treatment of substance use disorders in their residency, including the challenges of providing treatment to persons served with co-morbid psychiatric disorders. All DEA registered practitioners are required to complete 8 hours of training on the treatment and management of persons served with opioid or other substance use disorders, and all medical providers as part of their medical licensing and credentialing require extensive training. The medical standards of care and guidelines for pharmacological treatment of substance use disorders, including opioid use disorder, are represented in treatment planning for all persons served. Individuals receiving MAT/MOUD are continued on treatment upon intake unless there is a clear reason that continuation on treatment is contraindicated. In addition, Wellpath resumes treatment for those individuals whose treatment was interrupted by their criminal justice involvement.

BSH orients all staff and providers to issues of exposure to opioid abuse during the mandatory two-week new employee orientation. Empathy, bias and stigma surrounding a person served is extensively discussed, as is trauma informed care and the recovery model. The Department's and Wellpath's goal is to treat all persons with substance use disorders with compassion, respect and support for recovery.

Wellpath has access to all three FDA approved medications for substance use disorders. Newly prescribed or continued upon intake medication orders are ordered on a STAT basis as clinically indicated so that the medications are available promptly.

Medical Care

With respect to recommendations 11 and 12, BSH is committed to providing comprehensive care and services to all persons served. All individuals admitted to BSH receive a history and physical upon admission and annually thereafter. Persons served with chronic illness are monitored as indicated with nursing, and medical providers are on site 24 hours per day, 7 days per week. Persons served have access to medical and dental care via the sick call process 7 days per week, and requests deemed urgent or emergent are referred to medical on the same day. Specialty care is available off site, and a tracking mechanism for all appointments is in use at BSH to ensure follow up, provider review of any results, recommendations and plan of care with the individual.

Specific Units

As to the specific units identified in recommendations numbers 13 through 16, Hospital personnel are keenly aware of the impact of isolation on mental health issues and prioritize keeping persons served actively engaged in a therapeutic milieu. BSH respects individual preferences, particularly for those experiencing active symptoms who may become dysregulated in a social setting. To ensure that persons' served access to the milieu is not unduly restricted, the Director of Clinical Services and Director of Social Services are conducting ongoing, random checks. This proactive approach aims to strike a balance between promoting engagement and safeguarding wellbeing.

Persons served in the ISOU receive regular attention from their clinicians and psychiatric provider with a minimum of one weekly session and more frequent visits as required - sometimes daily based on individual needs. Nursing staff also provide documented updates for each individual on each shift. All individuals have equal access to crisis intervention services available to persons on the main campus, ensuring consistent and timely access to critical mental health supports.

A comprehensive matrix of professionals underscores the dedication to providing quality care in the ISOU and throughout the hospital. The ISOU and RU have around the clock nursing care and medical support, complemented by a team of Recovery Treatment Assistants on duty at all times. Five social services positions and five rehabilitation specialist positions, complemented by an addiction specialist, are assigned to the ISOU and RU. To enrich services, BSH has integrated nine peer support companions, educational providers, occupational therapists, music therapists and a patient advocate, ensuring a diverse range of support for the average population of 25 persons served.

Reintegration Needs

Finally, with respect to recommendations numbers 17 and 18, we note that, upon discharge, BSH submits documentation via fax to MassHealth to release the individual from Inpatient Care.

The Department provides access to funds upon a planned discharge. If persons served do not release with their funds due to an unplanned discharge, they may request that the funds be mailed to them. Funds will be issued in a check payable to the individual. Persons served may also forward a request to have the funds mailed prior to their release, if they are informed ahead of time of their release date and destination. Since February 1, 2024, there were 32 transactions of which 17 had funds sent to the individual within a week of their leaving the institution. The Department will continue to monitor the timeliness of access to funds upon discharge.

Should you have any follow-up questions, please do not hesitate to contact me. Thank you.

Respectfully,

Shawn Jenkins
Interim Commissioner

Appendix C: Bridgewater State Hospital, Heat Emergency/High Heat Index Preventative Measures (June 2024)

Bridgewater State Hospital

HEAT EMERGENCY / HIGH HEAT INDEX PREVENTATIVE MEASURES

The following preventative measures, protocols, and operational considerations shall be implemented in the event of a heat emergency or a high heat index to ensure the safety of all throughout the facility. This procedure has taken into consideration recommendations made by the Massachusetts Department of Public Health to prevent heat related illness.

Education:

- Notices shall be posted regarding heat-related precautions to raise awareness in patient accessible areas (housing units, library, dining hall, medical clinic) and on staff bulletin boards. This information aims to raise awareness for all and especially vulnerable populations within the facility who are most at risk for heat related illness based on their medications, age, chronic disease, obesity, working/living conditions, and mental health.

Hydration:

- Although there is unimpeded access to water in patient rooms, ice water dispensers shall be accessible to all patients on their housing units throughout the day.
- Water shall be accessible in all patient areas (Units, Recovery Place, Attucks, gym, etc)
- Ice shall be provided to the population during 9:30pm count times. Ice may be considered any of the following: frozen water, frozen juice, popsicles, freeze pops, etc.

Cooling:

- Patients shall have access to designated shared cooling areas to include the Chapel, Recovery Place and School classrooms.
- A misting stations are located in the Pavilion, Max Yard, AB Yard and shall be activated.

Maximizing the buildings designed ventilation:

- The Maintenance Department shall ensure proper utilization of existing mechanical or natural ventilation design/systems. This shall be accomplished by the constant monitoring of the EMCS ventilation management system.
- Large Fans shall be utilized on each housing unit and in off unit program areas.

Showers:

- Showers shall be available during times when patients are out of their rooms.

Recreation:

- Patients shall have access to fresh air/outdoor spaces (unit courtyards, pavilion and the main yard).
- Outdoor spaces shall be monitored for excessive sun exposure/heat and may be cancelled or altered between the hours of 11am and 5pm due to limited shade.
- Strenuous activities shall be limited (basketball, running, etc.) during a heat emergency/high heat index.

Monitoring:

- Patients shall be monitored by all staff to ensure adherence with appropriate clothing recommendations (shorts, loose-fitting, light-colored clothing).
- Medical staff shall provide monitoring for signs and symptoms of heat-related illness and perform daily round in all units.
- All staff shall monitor patients for signs and symptoms of heat-related illnesses such as heat exhaustion, heat stroke, heat cramps, dehydration, etc.
- Daily temperatures shall be taken on all shifts and recorded on the following form, **BSH High Heat Index Monitoring Form** (attached).

Bridgewater State Hospital

HEAT EMERGENCY / HIGH HEAT INDEX PREVENTATIVE MEASURES

Temperatures will be taken during all shifts. During 7x3 shift, the recording should be in the afternoon hours which traditionally is the hottest part of the day.

These temperatures will focus on ambient temperature in patient rooms and common areas and should avoid the ceiling, floor, and outside walls.

Date:_____ Time:_____ Staff Recording Temperatures:_____ _____

	Day Room	Room 6	Dorm 1
Adams 1			
Adams 2			
Bradford 1			
Bradford 2			
Carter 1			
Carter 2			
	Day Room	**Dorm 2**	**Dorm 6**
Lighthouse			
	Day Room	**Room 106**	**Room 122**
Hadley			
Lenox			
	Common Area		
Recovery Place			
Dining Hall			
Gym			
Library			
Chapel			
Visiting Room			

Shift Supervisor Signature: _____