The Commonwealth of Massachusetts
Executive Office of Public Safety & Security

Department of Correction
50 Maple Street, Suite 3
Milford, MA 01757
Tel: (508) 422-3300
www.mass.gov/doc

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

TERRENCE M. REIDY
Secretary

CAROL A. MICI
Commissioner

SHAWN P. JENKINS
Chief of Staff

KELLEY J. CORREIRA
PATRICK T. DEPALO, JR.
ROBERT P. HIGGINS
MITZI S. PETERSON
THOMAS J. PRESTON
Deputy Commissioners

March 23, 2022

Tatum Pritchard
Interim Director
Disability Law Center
11 Beacon Street, Suite 925
Boston, MA 02108

RE: Department of Correction Response to the January 2022 Disability Law Center Report on Bridgewater State Hospital

Dear Interim Director Pritchard:

I write in response to the Disability Law Center's (DLC) January 2022 report (the report) concerning the physical condition of Bridgewater State Hospital (BSH) and the care and treatment that the Department of Correction's (DOC) medical service provider, Wellpath, provides to Persons Served. The DOC carefully reviewed the report and disagrees with DLC's allegations that the condition of the physical plant is unsafe, that DOC's mold remediation work has been deficient, and that care of Persons Served is contrary to state law.

To establish the proper context for consideration of DLC's allegations, I begin by highlighting a point that goes unmentioned in the recent DLC report: in July 2021, the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) conducted an extensive review of BSH, including 4 days on-site, and renewed BSH's Joint Commission accreditation as a behavioral health hospital. The Joint Commission is the nation's premiere standard setting and accreditation body in health care, and prior to accreditation the Joint Commission considers issues related to the physical plant, the institution's written policies and adherence to Joint Commission standards, as well as the hospital's actual practices pursuant to the written policies.

The DOC is committed to maintaining BSH's physical plant and has taken significant actions to address the safety challenges that can arise in an older facility such as BSH. Because of these efforts, and in spite of its age, BSH remains a safe and healthy environment for employees, visitors, and Persons Served. Since

DLC's 2019 report, and in fact beginning as early as 2018, BSH has made substantial renovations to the physical plant and has undertaken a broad program of mold remediation measures. Following DLC's July 2021 report requesting that DOC take further steps to address mold, moisture, and other existing physical plant issues, BSH made additional investments in building improvements and mold remediation. This work is set forth in greater detail below.

DOC, together with its health care provider, Wellpath, is also dedicated to delivering effective and compassionate care for Persons Served at BSH. Wellpath is staffed by a team of dedicated professionals who provide person-centered and trauma-informed treatment for Persons Served. Their commitment extends to BSH policies governing the use of seclusion and restraint and the accompanying reporting requirements. Contrary to DLC's assertions, Wellpath's policy and practice with regard to the use of medication are consistent with state law and with the Joint Commission standards for administering seclusion and restraint in a mental health treatment facility like BSH.

DOC has properly addressed the safety of the physical plant and mold remediation.

The recent DLC report alleges that there is "overwhelming evidence of persistent health and safety risks" in the BSH physical plant and that BSH has failed to address concerns with mold raised in DLC's 2019 report. But the allegations overlook that there is no evidence of mold-related illnesses among Persons Served and ignore the $1.7 million in improvements that BSH has undertaken in recent years to remediate mold in the facility and to respond to issues identified in earlier DLC reports.

Since the onset of the COVID-19 pandemic, Wellpath has regularly monitored respiratory wellness to ensure the safety of Persons Served. This monitoring has identified no trends indicating illnesses related to mold. Wellpath has also received no complaints from Persons Served about illnesses consistent with exposure to mold or poor air quality since June of 2019. While the report from DLC alleges that Persons Served have complained about poor air quality, the report provides no information about the source of those complaints or the dates, leaving DOC unable to further investigate or respond.

In any case, the DLC account disregards DOC's continuing work in this area. Since receiving DLC's November 2019 report, which highlighted signs of mold in the facility and recommended repairs to the physical plant, BSH has undertaken extensive repairs and remediation work. Contrary to the report's repeated assertion that conditions remain "unchanged" since 2019, BSH's repair and remediation work in this area actually began in 2018. For instance, in the fall of 2018, following air sampling and assessment work, BSH began extensive mold remediation, and in 2019, BSH arranged for an electrical and HVAC assessment and an engineering study to identify work necessary to provide centralized air conditioning in the facility. The engineering study also provided BSH with interim measures that BSH implemented while undertaking capital planning for this project, which has included the installation of seasonal air conditioning units in all housing units. BSH also conducted asbestos abatement work in the mechanical rooms and dorms, and addressed problems related to mold and asbestos in the basement of the medical and administration buildings.

During 2021, and in part in response to DLC's expressions of concern, DOC repaired roofs, steam and water leaks, heating controls, and steam valves, and replaced sections of cast iron pipes, backflow preventers, and groundwater piping in 10 buildings. DOC performed preventative maintenance on air handlers and exhaust fans throughout the facility, which included replacing filters and belts and greasing moving parts. BSH also purchased new air conditioning units for installation on the minimum and maximum unit modular buildings and in the administration building.

Finally, to ensure that conditions at BSH remain safe and healthy, DOC has begun reviewing the specific areas of concern highlighted in DLC's recent report. DOC and its environmental consultant, Arcadis U.S. Inc., have inspected the areas in the mechanical rooms identified in the report and determined that, in several small areas, there were asbestos fittings that required replacement and that the mechanical areas required an industrial quality cleaning. That work started on March 7, 2022. DOC has already approved purchase orders totaling over $88,000 for additional air quality testing and asbestos and mold remediation. That testing will produce more reliable and direct evidence of the air quality and safety at BSH than the surface inspection and testing which formed the basis of DLC's consultant's report. Finally, DOC has installed air purification systems in three housing buildings as well as in the inpatient area of the medical building observation area.

In sum, BSH has taken many measures since DLC's 2019 report first raised questions about air quality at BSH, measures that went unmentioned in the report. DOC is aware of the challenges of maintaining the BSH physical plant and will continue to pursue measures to ensure that the BSH facility remains a safe environment for Persons Served, employees, and visitors.

Wellpath's reporting and use of seclusion and restraint is lawful and consistent with best practices for a psychiatric hospital treating the population of Persons Served by BSH.

The reforms that DOC instituted at BSH in 2017 to change service delivery have resulted in a dramatic reduction in the use of seclusion as well as a reduction in the use of restraints. These reforms have re-made BSH into a treatment center focused on providing proper therapeutic services for Persons Served.

That reduction is evident by comparing seclusion and restraint data from 2015, prior to the implementation of reforms and the commencement of the Wellpath contract, with data from 2021. In 2015, there were 1,669 events of seclusion, totaling 39,919 hours of seclusion. By comparison, in 2021, there were 749 total events of seclusion, totaling 1,220 hours of seclusion, representing a drastic drop in both the frequency and duration of seclusion.

Restraint data reflects similar progress. In 2015, there were 706 hours of restraint across a total of 260 events of restraint, while in 2021 there were 363 hours of restraint across a total of 257 events. Two critical points emerge from this comparison. First, there has been a 51% reduction in the amount of time spent in restraint over a nearly identical number of restraint events. Second, the number of restraint events is essentially the same in 2015 as it was in 2021, even though the current definition of "restraint event" is broader and covers more actions than in 2015. In short, restraint is used less frequently, and when restraint does occur it lasts for significantly less time.

Notwithstanding these fundamental and beneficial changes at BSH, DLC alleges that Wellpath's policies governing the use of Emergency Treatment Orders (ETOs) are unlawful and, more broadly, that BSH is subjecting Persons Served to impermissible forms of restraint and seclusion, particularly through the use of manual holds, seclusion, and practices that DLC labels as "chemical restraint." DLC also alleges that these improper practices are going unreviewed by DOC because Wellpath is substantially under-reporting its use of restraint and seclusion in the regular reports it is required to make with the DOC Commissioner.

Simply put and as described in greater detail below, DOC and Wellpath policies governing the use of both ETOs restraint and seclusion at BSH are consistent with state law and properly reported to the DOC Commissioner and the Bridgewater Medical Executive Director, as required by BSH policies and the law. Furthermore, as DLC is aware, in any case where there may be a reason to question the propriety of an

ETO, BSH procedures permit DLC or the Person Served to obtain and review the complete medical file, including the relevant entries documenting the clinician's determination of the basis for the emergency.

Emergency Treatment Orders authorize treating patients in emergency situations to address specific behaviors with appropriate medication and these are reported accordingly.

The report's criticism of BSH's restraint and seclusion policies rests in large part on DLC's mischaracterization of the use of Emergency Treatment Orders (ETOs) at BSH. An ETO is not, as DLC repeatedly states, a form of restraint. Under Wellpath policy and practice, an ETO is an order issued by a patient's treatment provider to involuntarily administer a medication that is a treatment for that particular patient's diagnosed psychiatric condition, in order to treat that condition and not for the purpose of restraining the patient.

Under the policy an ETO may be ordered by a treatment provider to involuntarily administer medication when the patient is undergoing a psychiatric emergency which, if left untreated, would "result in potential harm to self or others, or an intolerable level of distress." The provider considers, for instance, "unremitting self-harm that is causing injury to the [patient]; serious physical harm to staff or other [patients], escalating aggression that cannot be verbally de-escalated; and mental health emergencies such as catatonia or delirium." In such emergency circumstances, a treatment provider may issue an ETO to authorize administration of psychiatric medication that is a treatment for the patient's diagnosed psychiatric condition, without the patient's consent.[1]

Contrary to the suggestions of the DLC report, ETOs do not go unreported under the Wellpath and DOC policies and practices. Because an ETO involves a treatment decision squarely within the expertise of the knowledgeable medical professionals, under the Wellpath policy, ETOs must be reported daily to the BSH Medical Executive Director, who is charged with reviewing these treatment interventions. ETO usage is also separately recorded in a twice-monthly report for review by all BSH and Health Services Division executive staff.

While an ETO is not itself an order for restraint, it is not uncommon when a patient is experiencing a psychiatric emergency that some sort of restraint (e.g., a brief manual hold) is required to execute the ETO and administer the medication to treat the psychiatric condition. As a result, because the DOC Commissioner receives reports of <u>all</u> uses of restraint, she necessarily receives reports from Wellpath of all ETOs that involve restraint. She then reviews whether the circumstances of the restraint complied with Wellpath and DOC policies. An ETO accomplished without the use of restraint, however, is generally not reported to the Commissioner under Wellpath policy.

---

[1] An ETO is not, as the report seems to suggest, a "medication restraint order." A medication restraint order does not involve the use of psychiatric medication to treat the patient's diagnosed psychiatric condition, but rather, the use of medication to reduce the ability of the person to continue to engage in dangerous behavior unrelated to mental illness, "which places self or others at imminent risk of harm, and less restrictive interventions are unsuccessful in deterring these behaviors." Wellpath Policy, Use of Involuntary Psychotropic Medication, § 5.3.1. Under Wellpath's restraint policy, such restraints are used "only in cases of emergency, such as the occurrence or serious threat of, extreme violence, personal injury, or attempted suicide." Wellpath Policy, Use of Seclusion and Restraint, § 2.1. This is consistent with the statutory definition of restraint as "means which unreasonably limit freedom of movement." G.L. c. 123, § 1.

While DOC and Wellpath continue to view ETOs as treatment and not restraint, DOC will create a process for reporting information about ETOs that increases transparency for DLC into the ways ETOs are used at BSH.

Wellpath's policies limit the use of seclusion and restraint and ETOs to emergencies.

DLC's claim that Wellpath's policy permits the use of restraint and seclusion or ETOs absent an emergency is simply inaccurate. By its own terms, the restraint and seclusion policy limits restraint and seclusion to emergency situations and directly tracks the statutory requirements in G.L. c. 123, § 21. Furthermore, the Joint Commission would not have accredited BSH if Wellpath's policies did not limit the use of restraint and seclusion to emergencies because the requirement is clearly stated in the Joint Commission's standards. Likewise, as explained above, the policy is clear that even ETOs can only be issued in emergency circumstances, where a Person Served "is presenting in a psychiatric emergency such that medication is required to prevent imminent harm to self or others, or treat intolerable distress."

The report's isolated quotations from the records of Persons Served paint an incomplete picture of the events in each of the reported cases that justified seclusion or restraint or an ETO. The medical determination that seclusion or restraint or an ETO is required is based upon the entirety of the patient's clinical record and specific circumstances presented. The report repeatedly omits this critical context in its recounting of individual instances of seclusion or restraint or an ETO. Again, to the extent that DLC has concerns that those measures were used in non-emergency circumstances, standard Wellpath procedures provide a means in each case for DLC or the Person Served to obtain access to the Person Served's entire clinical records that would provide that context and allow a complete evaluation of the propriety of the intervention at issue. Moreover, the Health Services Division of the Department of Correction conducts four audits annually to review the treatment and associated documentation of the treatment at BSH.

To further ensure that these interventions are properly administered, the Health Services Division will also reinstitute the Seclusion and Restraint audits referenced in DLC's report. The Director of Behavioral Health and her team will conduct the audits monthly to ensure that the documentation clearly delineates the emergency as well as de-escalation attempts, alternative treatment, and similar efforts to avoid seclusion and restraint. Audit reports will be available to DLC upon request.

Finally, DLC is mistaken in asserting that Wellpath and DOC do not track, report, or compile the information DLC gathered for its report raising concerns with the use of ETOs. Since 2021, Wellpath, under the direction of Health Services Division, provides bimonthly Emergency Treatment Order statistics during Executive Staff Meetings. Moreover, DOC tracks the orders for seclusion and restraint, as is evident by the data contained in this response.

In sum, DOC disagrees with DLC's allegation that Wellpath, and by extension DOC, uses seclusion and restraint in impermissible circumstances, impermissibly relies on ETOs, and fails to comply with reporting requirements. Nonetheless, to ensure the highest degree of clarity, Wellpath will review current BSH policies governing involuntary medication and restraint and seclusion to ensure that the language of these policies fully and clearly reflects practice.

DOC agrees with DLC that the mission of BSH should be to reduce the use of seclusion and restraint whenever possible. To that end, last year, DOC and Wellpath created a subcommittee of the seclusion and restraint committee, consisting of clinical providers at BSH, who are tasked with making treatment recommendations for the Persons Served that most frequently require seclusion or restraint. Wellpath has adopted all of the recommendations of the subcommittee for using specialty services, and those services are available to Persons Served when clinically appropriate.

DOC and Wellpath provide Persons Served with regular, simple access to medical care and meaningful treatment programs.

The DLC report claims that Persons Served at BSH have limited or restricted access to medical care, claims that peer supports are underutilized, and that other services are insufficient. These allegations are simply incorrect.

Wellpath has a nurse on every unit, on every shift. Persons Served are seen by the nurse daily and otherwise have regular access to the nurse to make in-person requests for medical services. Persons Served can also submit written requests to the nurse. All requests are entered into the DOCs electronic medical record system, ERMA, which then allows DOC to audit the data necessary to ensure compliance with policies and standards.

When a Person Served expresses a medical concern, he is assessed immediately. If the issue requires an additional medical referral, the nurse enters the request in ERMA, and the request is then sent to the clinic for scheduling. If the issue is emergent, emergency procedures ensure that the Person Served is treated accordingly. Finally, access to medical staff is extensive and clearly delineated in Wellpath policy and the orientation handbook for Persons Served.

DOC agrees with DLC's view that peer supports provide an important component of treatment at BSH. Indeed, Peer Support Specialists at BSH lead groups, engage in one-on-one service, consult with treatment teams, deescalate crises, and advocate for Persons Served along with the full-time Person Served Advocate.

DLC's Advocacy for transferring control of BSH and constructing an entirely new facility are long-standing DLC policy positions that do not comfortably fit in the bounds of the legislatively directed report.

In addition to raising the concerns addressed above, DLC also advocates for two long-standing DLC policy positions: (1) the transfer of responsibility for BSH from DOC to the Department of Mental Health; and (2) a complete replacement of the BSH physical plant and construction of a new facility to house and treat the BSH population. This advocacy appears to fall somewhere beyond or at least at the very outer limits of DLC's statutory responsibilities.

In any case, the report delivers DLC's policy positions on these two matters as criticisms of DOC's administration of BSH. The General Laws charge DOC with overseeing and administering BSH. This is a policy determination that DLC may continue to disagree with on philosophical grounds, but despite DLC's characterization, DOC oversight of BSH does not constitute an objectionable condition of care for Persons Served at BSH.

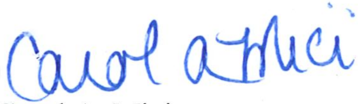
In fact, since the reforms were adopted in 2017, BSH has been operated exclusively by clinical professionals employed by Wellpath under standards applicable to a behavioral health facility. The Joint Commission again certified BSH in July 2021 after finding that BSH meets the Commission's exacting standards for accreditation as a behavioral health care hospital.

DLC can reasonably continue to advocate for the replacement of the BSH physical plant with an entirely new facility, and DOC for its part recognizes that a modernized facility would enhance the delivery of services at BSH. There may be more useful vehicles for such advocacy, however, than a semi-annual report ostensibly focused on the service delivery reforms adopted in 2017. Like other State hospitals, the age of the BSH facility presents challenges. To be clear, however, a project to build an entirely new BSH physical

plant would require the investment of several hundred million dollars and extensive planning. As such, the project would require the agreement and support of a broad range of stakeholders and, even then, would need to be evaluated as one call for capital investment alongside many that are reviewed and prioritized in determining the Commonwealth's overall, multi-year capital plan.

DOC, Wellpath, and DLC have worked together for several years to improve and protect the health, safety, and care provided to Persons Served at BSH. As a member of the BSH Governing Body, DLC can raise concerns to the many individuals and entities that comprise the Governing Body. DOC remains available to meet with DLC to address its concerns.

Sincerely,



Carol A. Mici
Commissioner