



Disability Law Center

Massachusetts Protection and Advocacy

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



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

A report to the President of the Senate, Speaker of the House of Representatives, Chairs of the Joint Committee on Mental Health, Substance Use and Recovery, Joint Committee on the Judiciary, Senate Ways and Means Committee, and House Ways and Means Committee, submitted pursuant to the FY 2022 Budget (Line Item #8900-0001).

July 2022

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Introduction and Overview

This report covers Disability Law Center (DLC) monitoring of Bridgewater State Hospital (BSH), including the Bridgewater Units at Old Colony Correctional Center (OCCC Units), known as the Intensive Stabilization and Observation Unit (ISOU) and the Residential Unit (RU), pursuant to authority granted by Line Item #8900-0001,¹ for the period from January 2022 through June 2022. DLC is the federally designated Protection and Advocacy agency for persons with disabilities in Massachusetts. DLC's intensive ongoing monitoring of BSH would not be possible without the support and expanded authority granted by Line Item #8900-0001.

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

- Weekly onsite BSH visits;
- BSH PS video, phone, and in person meetings;
- BSH staff in-person meetings;
- BSH PS Governance Meetings;
- Participation in BSH Governing Body meetings and Department of Mental Health (DMH) quarterly meetings;
- Requests for policies, data, and other documentation to Wellpath and DOC;
- Review of Wellpath 24 Hour Nursing Reports;
- Review of DOC video footage of PS restraint, seclusion, and involuntary medication;
- Review of DOC Incident Reports;
- Review of BSH restraint and seclusion data received through monitoring and via public records request;
- Review of BSH restraint and seclusion orders and documentation;

¹ FY22 Budget: “[P]rovided further, that not less than \$125,000 shall be expended for the Disability Law Center, Inc. to monitor the efficacy of service delivery reforms at Bridgewater state hospital, including units at the Old Colony correctional center and the treatment center; provided further, that the Disability Law Center, Inc. may investigate the physical environment of those facilities, including infrastructure issues, and may use methods including, but not limited to, testing and sampling the physical and environmental conditions, whether or not they are utilized by patients or inmates; provided further, that the Disability Law Center, Inc. may monitor the continuity of care for Bridgewater state hospital persons served who are discharged to county correctional facilities or department of mental health facilities, including assessment of the efficacy of admission, discharge and transfer planning procedures and coordination between the department of correction, Wellpath LLC, the department of mental health and county correctional facilities; provided further, that not less than once every 6 months, the Disability Law Center, Inc. shall report on the impact of these reforms on those served at Bridgewater state hospital to the joint committee on mental health, substance use and recovery, the joint committee on the judiciary, the house and senate committees on ways and means, the senate president and the speaker of the house of representatives”.

- Review multiple PS medical records;
- Review and analysis of PS discharge data;
- Virtual and in-person meetings with administration from county Sheriff's Departments;
- In-person meetings and correspondence with administration from DMH Hospitals;
- Onsite visit to Lemuel Shattuck Hospital to meet facility staff and discharged PS;
- Onsite visit to Solomon Carter Fuller Mental Health Center to meet facility staff and discharged PS;
- Onsite visit to Worcester Recovery Center and Hospital to meet facility staff and discharged PS;
- Onsite visit to Taunton State Hospital to meet facility staff and discharged PS;
- Onsite visit to Worcester County Jail and House of Corrections to tour facility, meet facility staff, and meet with discharged PS;
- Onsite visit to Plymouth County Correctional Facility to tour facility, meet facility staff, and meeting with discharged PS;
- Onsite visit to the Intensive Stabilization and Observation Unit and the Residential Unit at Old Colony Correctional Center to meet facility staff and current and discharged PS;
- Phone interviews with discharged PS at Lemuel Shattuck Hospital, Solomon Carter Fuller Mental Health Center and in the community; and
- Monthly meetings with fellow mental health advocates concerning BSH; and
- Meetings with BSH friends and family group.

With eight (8) years of continuous daily oversight at BSH, DLC is convinced now more than ever that providing PS appropriately intensive and trauma-informed services is not possible under the authority of DOC. The promise of optimal services under Wellpath, while encouraging at first, has not been realized, with staffing, delivery of services, and the overall environment for PS deteriorating in recent years. Too many PS confined in BSH and the OCCC Units for evaluation and treatment leave BSH without receiving meaningful access to mental health programming and burdened by new traumatic experiences. It is time for the Commonwealth to commit to protecting the rights, health, and safety of PS and to supporting public safety by transferring oversight of BSH from our state correctional agency to the Department of Mental (DMH) and constructing a new hospital.²

² Under the control of DOC, BSH has only a Behavioral Health Care and Human Services accreditation from the Joint Commission. BSH's current accreditation information is available at: <https://www.qualitycheck.org/quality-report/?bsnId= 363109>. "Behavioral health care organizations, include[e] those that provide mental health, chemical dependency, child welfare, foster care, and []

In the discussion below, DLC focuses on six (6) broad areas of concern during the period from January 2022 to June 2022:

1. Physical Plant Health and Safety Risk Updates;
2. Illegal and Unreported Restraint and Seclusion;
3. Insufficient Language Access for Persons Served;
4. Limitations on Persons Served Access to Medical Care;
5. Daily Barriers to Recovery for Persons Served: Observations of Staff Contact and Access to Programs and Treatment; and
6. Persons Served Continuity of Care.

Each section includes DLC's recommendations to improve the health, safety, and treatment of PS and respect for PS rights. The complete recommendations are compiled at the Conclusion of the report.

developmental disabilities services for clients of various ages in various organized service settings." *Glossary*, Quality Check, https://www.qualitycheck.org/glossary/#Behavioral_Health_Care. In contrast, DMH facilities and units that serve similar – and often the exact same – individuals, including those who are forensically involved, meet the more stringent requirements of Hospital accreditation by the Joint Commission.² For instance, each of the following are accredited by the Joint Commission as hospitals: Worcester Recovery Center and Hospital (<https://www.qualitycheck.org/quality-report/?bsnid=52368>), Taunton State Hospital (<https://www.qualitycheck.org/quality-report/?keyword=taunton%20state%20hospital&bsnid=2034>), Lemuel Shattuck Hospital (<https://www.qualitycheck.org/quality-report/?keyword=lemuel%20shattuck%20hospital&bsnid=5561>), Tewksbury State Hospital (<https://www.qualitycheck.org/quality-report/?keyword=state%20of%20massachusetts%20tewksbury&bsnid=5620>), and Vibra Hospital of Western Massachusetts, LLC (<https://www.qualitycheck.org/quality-report/?keyword=state%20of%20massachusetts&bsnid=2052>).

1. Physical Plant Health and Safety Risk Updates

Every report DLC has issued since May 2018³ has made clear that the state of the physical plant and infrastructure at BSH warrant the facility's closure. In our January 2022 report, we detailed that economic inefficiency and continuing risks to health and safety remain constants in the operation of BSH based on an expert assessment, lab testing, and results analysis conducted by Gordon Mycology.⁴

During this reporting period, DOC publicly issued a March 23, 2022 response to DLC's January 2022 report, attached hereto as Appendix B. In pertinent part, DOC reported "reviewing the specific areas of concern highlighted in DLC's recent report" and the following actions:

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 response to a request for any additional information and updates regarding mold and asbestos contamination, DOC provided the following update to DLC on June 15, 2022:

From Q1:

DOC's ongoing monitoring & assessment for the need for additional remediation includes upcoming testing and remediation work as needed

- DOC Fiscal approved the removal and repair of damage asbestos-containing materials (ACMs) and the remediation of mold impacted materials and areas within the following locations: Administration Building Basement Mechanical Room, Lighthouse Building Basement Mechanical Room, Adams Building Lower-Level Mechanical Room, Bradford Building Lower-Level Mechanical Room, and the Carter Building Lower-Level Mechanical Room. Remediation will be performed by Select Demo Services LLC and oversight and testing services will be performed by Arcadis. Air sampling to begin on 3/7/22. This project is complete.

³ All DLC's past public reports concerning investigation and monitoring activities at BSH are available at: <https://www.dlc-ma.org/monitouing-investigations-reports/>.

⁴ *Public Report: Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served* (January 2022), <https://www.dlc-ma.org/wp-content/uploads/2022/02/DLC-BSH-January-2022-Public-Report-2.9.2022.pdf> (hereinafter "DLC January 2022 Report").

From Q2:

- Lighthouse Environmental placed air monitoring systems in various locations at BSH. No report received thus far. Awaiting recommendations if any.
- PO Approved for asbestos testing of gym stage ceiling and adjacent ceiling.

These overviews, while indicating that DOC has conducted some remediation efforts, do not disclose specifics about the remediation work completed or the results of any testing for the continuing presence of mold and/or asbestos. Without the details of DOC's remediation and assessment efforts, it is impossible to determine whether the work undertaken in this reporting period comports with the recommendations of Gordon Mycology and industry standards. In addition, reliance on air sampling alone cannot accurately gauge whether the mold confirmed on surfaces throughout the facility has been remediated. All of this is cause for concern, given the history of ineffective mold remediation at BSH. As discussed in DLC's last report, Gordon Mycology's December 2021 inspection and sampling confirmed that the repairs and mold removal efforts DOC completed following DLC's March 2020 report were not effective: "the continuing presence of mold growth in BSH building and HVAC systems on the same sources identified in 2019 '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.'"⁵

Moreover, DOC's March 23, 2022 response to DLC's January 2022 public report does not inspire confidence in DOC's past remediation methods, the Commonwealth's continuing reliance on DOC to manage the facility, or the choice to keep it open. Faced with Gordon Mycology's findings establishing overwhelming evidence of continuing health and safety risks to PS and staff alike posed by mold and deteriorating asbestos materials, DOC decried DLC "ignor[ing] the \$1.7 million in improvements that BSH has undertaken in recent years for mold remediation and asbestos abatement in the facility and to respond to issues identified in earlier DLC reports" such as repairing roofs, steam and water leaks, and heating controls, maintenance on air handlers and exhaust fans, and purchasing air conditioning units.⁶ The notion that any of the listed work was conducted in response to DLC's concerns begs the question – why isn't DOC identifying and addressing significant facilities issues proactively before DLC has to intervene?

DLC remains deeply concerned that individuals onsite at BSH continue to be at risk of illness from exposure to dangerous environmental toxins. Wellpath's averred monitoring of respiratory wellness during the COVID-19 pandemic⁷ is no substitute for the recommended targeted medical evaluations of PS to determine whether they are suffering health effects related to mold exposure and potential exposure to asbestos. The limited information DOC produced during this reporting period are not an adequate counter to the findings of Gordon Mycology and years of reports of symptoms consistent

⁵ DLC January 2022 Report at p.7.

⁶ App. B at 2.

⁷ *Id.*

with exposure to poor air quality.⁸ DLC cannot yield in its efforts to protect and advocate for health and safety of PS absent clear evidence that DOC has conducted mold remediation and asbestos abatement in all areas identified by Gordon Mycology per industry standards *AND* that air quality testing and surface sampling confirms that DOC has been successful. There is no legitimate explanation for DOC's lack of transparency.

Recommendations:

DOC must, in short order, complete mold remediation and asbestos abatement throughout BSH in accordance with expert recommendations and industry standards.

DOC must provide to DLC or, alternatively, release publicly detailed information evidencing that: DOC has conducted mold remediation and asbestos abatement in all areas identified by Gordon Mycology and any DOC contracted experts per industry standards; and DOC has conducted air quality testing and lab testing of surface swab indicating that remediation and abatement efforts were successful.

Until DOC provides information evidencing that the health and safety risks have been resolved, DOC and Wellpath BSH must provide regular health screenings for symptoms of mold and environmental toxin exposure to all PS and staff, provided by a contracted health professional with expertise in the area.

The Commonwealth must protect the health of individuals confined to, working in, and visiting BSH by committing to shutter BSH and construct a modern DMH facility designed to provide all individuals in need of "strict security" psychiatric evaluation and/or treatment in a safe, therapeutic environment.

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

⁸ In its March 23, 2022 letter, DOC states, "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." App. C at 2. As the Massachusetts Protection and Advocacy agency, DLC is subject to federal regulations that require us to maintain information concerning DLC clients and individuals who have provided reports and information in confidence, with narrow exceptions. See 42 CFR § 51.45(a)(1), (b). DOC is familiar with DLC's redisclosure restrictions.

2. Illegal and Unreported Restraint and Seclusion

In 2014, faced with the findings of DLC’s investigation and pending litigation, DOC agreed to implement changes to policies and practices to reduce incidence and duration of restraint and seclusion of PS. As raised repeatedly in prior DLC reports, this progress, however, did not extend to the use of forced psychotropic medication at BSH and the OCCC Units.⁹ BSH policy and practice concerning involuntary medication plainly violate applicable Massachusetts law.

Since the 1980s, the Supreme Judicial Court has recognized that “few legitimate medical procedures [] are more intrusive than the forcible injection of antipsychotic medication”¹⁰ and that “doctors who are attempting to treat as well as maintain order in the hospital have interests in conflict with those of their patients who may wish to avoid medication.”¹¹ In recognition of these truths, the law of the Commonwealth permits the administration of involuntary antipsychotic medication in three limited circumstances:

- (1) After a court has made a substituted judgement decision that the individual would accept the medication if competent and approved a treatment plan, establishing what is known as a *Rogers* guardianship;¹²
- (2) Under the state’s police power to prevent an *imminent threat of harm* to oneself or others when there is a clinical determination that there is *no less intrusive alternative to forced antipsychotic drugs available*¹³ and “*the statutory and regulatory conditions for the use of chemical restraints must be followed*”¹⁴; and
- (3) Exercising the state’s *parens patriae* power to administer medication involuntarily “in rare circumstances” to prevent “immediate, substantial, and irreversible deterioration of a serious mental illness...in cases in which ‘even the smallest of avoidable delays would be intolerable.’”¹⁵

In keeping with the state’s police power, M.G.L. c. 123, § 21 states that “[r]estraint of a mentally ill patient may only be used in cases of emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide” with a determination upon examination “that such chemical restraint is the least restrictive, most appropriate alternative available.” Chemical restraint, like all forms of restraint,

⁹ DLC discussed these concerns in our reports to the Legislature issued in May 2018, February 2019, July 2020, March 2020, October 2020, July 2021, and January 2022.

¹⁰ *Matter of Guardianship of Roe*, 383 Mass. 415, 435-438 (1981).

¹¹ *Rogers v. Comm’r of the Dep’t of Mental Health*, 390 Mass. 489, 503 (1983).

¹² *Id.* at 512-513.

¹³ *Id.* at 490-491, 509-511; M.G.L. c. 123, § 21 (emphasis added). “No other State interest is sufficiently compelling to warrant the extremely intrusive measures necessary for forcible medication with the antipsychotic drugs. Any other result also would negate the Legislature’s decision to regulate strictly the use of mind altering drugs as restraints.” *Id.* at 511.

¹⁴ *Id.* at 509.

¹⁵ *Id.* at 511-512. If doctors determine that the involuntary medication should continue in order to prevent irreversible deterioration, “the doctors must seek an adjudication of incompetence.” *Id.* at 512.

must be tracked in PS medical records *and* reported to the DOC Commissioner as restraints per M.G.L. c. 123, § 21.¹⁶

BSH policy governing application of involuntary medication permits improper chemical restraint and fails to require tracking and reporting of each use of restraint. Since DLC's January 2022 report, DOC has brazenly argued that Emergency Treatment Orders (ETOs) are involuntary administration of medication "for treatment," not restraint, in an apparent attempt to create a fourth permissible circumstance for subjecting PS at BSH and the OCCC Units to involuntary medication.¹⁷ Doubling down, DOC and Wellpath recently issued a new version of the Use of Involuntary Psychotropic Medication Policy effective July 14, 2022 that continues to exclude ETOs from restraint and allows greater flexibility than the law as to when involuntary medication can be imposed:

5.2.1. If a PS presents in a psychiatric emergency such that leaving him untreated would result in *potential* harm to self or others, , [sic] then the PS may be involuntarily medicated...

5.2.4. The decision to provide an ETO is contingent upon a risk assessment by the psychiatrist or other provider that contextualizes the current behavioral presentation with the PS' historical and current risk factors for serious violence leading to significant personal injury or self-harm, or harm to others. Behaviors that may necessitate an ETO include, but are not limited to, , [sic] unremitting self-harm that is causing physical injury to the PS; serious physical harm to a team member or other PS; *escalating aggression that cannot be verbally de-escalated*; and *mental health emergencies such as catatonia or delirium*.¹⁸

In addition, the policy does not require any determination that the forced antipsychotic medication is the least restrictive option and only requires documentation of the ETO in an "ETO Progress Note in the PS medical record and daily notification of ETOs to the Medical Executive Director."¹⁹

With the exception of removing extreme distress as one basis for finding a psychiatric emergency, the policy maintains the permissive criteria of the prior policy which

¹⁶ Hospitals run and licensed by DMH report all restraints to the DMH Commissioner. M.G.L. c. 123, §21.

¹⁷ Appendix B at 4.

¹⁸ Bridgewater State Hospital Policy and Procedure Manual – Use of Involuntary Psychotropic Medication, 5.2.4 (7/12/2022) (emphasis added) (hereinafter "BSH Use of Involuntary Psychotropic Medication Policy"). DLC notes that, in response to DLC's critique of policy language in the January 2022 report, DOC and Wellpath did remove from the list of behaviors necessitating an ETO "or an intolerable level of distress" and "or in significant distress" from the language describing the nature of "psychiatric emergency" warranting an ETO. *Id.* at 5.2.1; 5.2.4.

¹⁹ *Id.* at 5.2.8, 5.2.9. Remarkably, DOC policy concern Mental Health Services, 103 DOC 650, that applies to *prisoners* across DOC in non-BSH units only permits "involuntary administration of psychotropic medication" if "[a]n inmate poses a *clear and immediate threat to harm him/herself or others*; or to present the immediate, substantial and irreversible deterioration of a serious mental illness of an inmate who is currently incapable of making informed medical decisions" and "[a]ll less restrictive or intrusive measures have been employed or judged by the treating psychiatrist, on-call psychiatrist, or physician to be inadequate 103 DOC 650.08(D) (emphasis added). This language makes DOC's endorsement of the BSH policy and Wellpath's practices as treatment for PS all the more puzzling.

governed the ETO practices DLC reviewed during the last and current reporting periods.²⁰ Given the permissive language, which is in stark contrast to DMH regulations,²¹ it is not surprising that ETOs are administered often in the absence of any present emergency, as discussed further below. What is shocking, however, is the unnecessary level of force BSH Therapeutic Safety Technicians (TST) regularly use to administer ETOs. With all of this in mind, the fact that DOC and Wellpath continue to endorse ETOs as a key component of treatment at BSH warrants a reevaluation of oversight of BSH.

A. Use of Force to Administer Involuntary Medication

During this reporting period, DLC continued to gather information about involuntary medication practices through review of daily nursing notes, restraint and seclusion orders, clinical records, and conversations with PS. DLC also invoked our P&A Authority to gain access to another form of records: video footage from BSH's video surveillance system.

With written consent from multiple PS, DLC was able to view video more than fifteen (15) incidents that included restraint, seclusion, and ETO administration.²² In each, intramuscular (IM) ETOs were forcibly injected by nurses with a team of TSTs equipped in riot gear – including black helmets with visors obscuring their faces, padded vests, knee pads, and one member of the team holding a large plexiglass shield – holding down the PS. Notably, DLC is not aware of TSTs utilizing riot gear prior to the COVID-19 pandemic. Owing to BSH's Use of Involuntary Psychotropic Medication Policy, Wellpath did not report any of these ETOs as chemical restraints or record any finding that the involuntary medication was the least restrictive, most appropriate alternative available.²³

The video footage of these incidents, while it does not include audio, has allowed DLC a real-time view into the deeply disturbing reality of restraint, seclusion, and involuntary medication practices at BSH, and to “read” between the lines of records of the standard terse and vague descriptions in restraint and seclusion orders. The following incident

²⁰ BSH Use of Involuntary Psychotropic Medication Policy, 5.2.4.

²¹ 104 CMR 27.12, which lawfully define medications given “to control the patient’s behavior or restrict the patient’s freedom of movement and which is not the standard treatment or dosage prescribed for the patient’s condition” as medication restraint subject to usage requirements of other restraints. Medication restraint may be used only in an emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide. Such emergencies shall only include situations where there is a substantial risk of, or the occurrence of, serious self-destructive behavior, or a substantial risk of, or the occurrence of, serious physical assault. A “substantial risk includes only the serious, imminent threat of bodily harm, where there is the present ability to effect such harm.” DMH regulations likewise make clear that “[s]eclusion and restraint, as defined in these regulations, may not be used for behavior management, but may only be used in accordance with 104 CMR 27.12.”

²² Some of the footage that DLC requested had been deleted due to regular video surveillance system operations, which records over existing footage within roughly sixty days, or destroyed due to other technical issues, such as a facility blackout. Commonplace deletion of such incidents highlights the importance of DLC consistent on-site monitoring and underscore the need for DOC transparency in reporting all uses of forced medication as restraints.

²³ Compare M.G.L. c. 123, § 21; 104 CMR. 27.12(5)(d), (i).

descriptions draw from this video footage, supplemented with information from restraint orders and comments from the PS themselves:

Example No. 1 – “Sam”

PS Sam enters the dayroom, walks up to another PS, slaps him, then tries to chase him. Two TSTs then enter the room and tackle Sam to the ground. Another TST enters and all three escort Sam down the hall in a manual hold, until they release him to walk the rest of the way to his room calmly. Back in his room, the PS talks to the Recovery Treatment Assistant (RTA) observing him outside his door; he removes his shirt and does push-ups and other exercises; then lies in bed and reads.

***After approximately 35 minutes of calm**, staff starts to gather outside Sam’s door – nine (9) individuals in total, including four (4) unknown TSTs wearing riot gear, with one holding a large plexiglass shield. Seeing this, Sam rises from his bed and grabs a cup. He stands on his bed with the cup as if in preparation for a confrontation. Staff open the door and TSTs quickly move into the room led by the TST holding the shield, as Sam throws liquid from the cup toward them. The lead TST pushes him into the wall along the length of the bed and Sam’s head visibly hits the wall with force. The other TSTs pile on top of Sam on his bed with significant force, and they maneuver him onto his stomach on the bed. Next, a TST supervisor and nurse have entered the room, and with the small room nearly full to capacity, the TSTs pull down Sam’s pants so the nurse can administer two shots per buttock. After the must administers the medication, the TSTs put handcuffs on Sam and then quickly exit the room, one by one, before he can rise from the bed where he was held down and medicated. Staff then direct Sam to put his handcuffed wrists in front of the wicket (the small opening in the room door), while the same TSTs remove the cuffs.*

Subjecting an individual committed for psychiatric treatment, like Sam, to physical force by four masked staff members and intramuscular injections of medication against his will should never be deemed successful treatment. DMH has long recognized in its Seclusion and Restraint Philosophy Statement:

Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individuals involved. In addition, using power to control an individual's behavior or to resolve arguments can lead to escalation of conflict and can ultimately result in serious injury or even death.²⁴

What is more, elements of this video footage illustrate that the use of force was gratuitous. **First**, Sam walks to his room and locks in voluntarily, a sign of compliance with staff directives. There was no seclusion order in place. **Second**, a significant amount of time (roughly 35 minutes) passes from the time Sam returns to his room to the administration of involuntary medication. **Third**, Sam occupies that time working out and lying in bed reading, activities reasonably understood as efforts to deescalate himself and manage his stress. Each of these elements calls into the question the presence of the requisite “emergency” justifying the ETO intramuscular injection ultimately carried out.

²⁴ DMH, *Seclusion and Restraint Philosophy Statement* (September 18, 2007), <https://www.mass.gov/lists/department-of-mental-health-seclusion-and-restraint-philosophy-statement#>.

While nursing notes indicate that Sam “refused” to take an intramuscular shot, thus requiring the manual hold, Sam informed DLC that he was never offered the option of an oral medication in lieu of a forced injection. Sam expressed being deeply upset about the incident. He reported that he was spitting blood in the toilet afterwards, his nose and head in extreme pain following the violent altercation. He felt staff had taken “advantage of (him) in (his) weak state” and that the whole incident messed up his state of mind.

Example No. 2 – “Edwin”

PS “Edwin” is released from his room and proceeds to walk down the corridor towards the dayroom. He sees another PS using the phone and pushes him into the wall. As they struggle briefly, a single TST walks toward the incident while calling on his radio. By the time the TST arrives, the two PS have already separated, pushing off of each other.

*Edwin walks back to his room with two TSTs escorting him lightly holding his arms. In seclusion, Edwin can be seen walking around his room, sitting on the edge of his bed, taking his shirt off, and sleeping under the covers. **Almost two (2) hours later**, four (4) TSTs in riot gear, along with other staff, show up outside his room door. Edwin rises from his bed and stands by the door. When the TSTs open the door, he runs toward them, seemingly attempting to exit the room, but he ends up wedged between the TSTs and the door. After a struggle, the TSTs pull Edwin back into his room by one of his legs, while one TST shoves Edwin’s head down over his leg towards the bed. Eventually, the PS ends up on his stomach atop his bed. His pants are pulled down in front of the crowd and all four TSTs keep their hands on his limbs as the nurse administers four intramuscular shots. Immediately after, the TSTs sprint out of the room. Edwin remains in bed and gets up slowly.*

Similar to Example No. 1, Edwin had a brief altercation with another PS, but the TST approaches Edwin with little urgency, calling on his radio, as the altercation ends without intervention. Edwin’s escort to and behavior inside his room indicate compliance and an attempt to self-regulate and deescalate. While Edwin’s restraint order describes him as “threatening” and “disorganized, delusional, unable to have meaningful conversation,” they omit that he was sitting or sleeping in the hours preceding the ETO.

Example No. 3 – “Milo”

PS “Milo” is in the dayroom, sitting in a chair facing the TV with a TST standing next to him and a nurse behind him. After much discussion, the TST finds medication on the floor (nursing reports indicate staff concerns that this PS was diverting medication). When Milo stands up, he appears upset and jerks toward the nurse, making no contact. The nurse and TST speak with Milo; the TST is standing in Milo’s face and putting his hand on Milo’s shoulder, aggressively trying to coax him to leave the dayroom. Eventually another TST arrives and the two (2) TSTs use a manual hold to bring Milo, who is holding paperwork of some kind, towards his room. In the hallway, Milo begins to struggle with the TSTs and falls to the floor.

Once at the entrance of his room, the TSTs throw Milo into the room with extreme force and the papers he was holding fly onto the floor. Milo holds onto one of the TSTs to keep from falling and the TST pushes him in the room onto his bed. Milo attempts to run back toward the door, but the TSTs leave and close the room door. In his room, Milo paces, sits on the edge of his bed, and eventually sits leaning against the back wall of the room drinking a cup of water.

After nearly one (1) hour in his room, four (4) TSTs in riot gear enter. They put the shield down when they see Milo in his sitting position, but one TST walks quickly towards the PS, grabs his arm, and forcefully pulls him forward onto his stomach. With the hands of all four TSTs holding Milo and the TST supervisor along the wall, the nurse enters the room, administers the intramuscular medication in his buttocks, and walks out, followed quickly by the TSTs.

This video displays a remarkable asymmetry in the physical actions taken by Milo and BSH staff. While Milo appears upset, and nursing notes state he was being “aggressive” toward staff, the footage makes clear that he makes no physical contact with staff until staff put their hands on him against his will. Throughout the video, it is staff who initiate aggression, escalating the situation and the potential for physical harm. Staff throw Milo into his room using extreme force, evidenced by flying papers and his attempt to hold on to staff, and aggressively pull him from a relaxed seated position into a prone position for ETO administration, with no discussion. Furthermore, as with Example Nos. 1 and 2, the hour that elapses – during which Milo poses no threat by virtue of his seclusion and relaxed behavior – makes it obvious that there is no emergency basis for the intervention.

The pattern and practice of substantial delays in administering ETOs flies in the face of DOC’s position that this intrusive intervention is in response to an emergency and constitutes treatment.²⁵ Clinical justification for an emergency-based forced medication order that ignores current behavior not only contravenes Massachusetts law, it is simply not sound.

At the same time, as discussed further below, the potential negative impact these practices have on PS are both severe and foreseeable. The regular use of force against an outnumbered PS in their room – the only personal, safe space in the institution – can lead to physical and mental trauma for the individual subjected to the injection and create stress for every PS in the unit. And delays in administering forced medication are anxiety-inducing for PS waiting in their rooms after complying with staff directives, wondering what may be coming for them and when.

B. Involuntary Medication Administration Absent Emergencies

Throughout this reporting period, DLC identified a significant number of ETOs administered for reasons that do not comply with the standards of the applicable laws on restraint in Massachusetts. In-depth review of daily nursing reports, available PS clinical records, restraint and seclusion orders, and interviews with PS revealed a lack of documented justification for involuntary medication.

Wellpath continues to use vague terms, which often lack any reference to harm whatsoever, as “rationale for [Restraint/Seclusion]”: a lack of “compliance,” “refusal to follow staff directives,” PS causing “climate issues” (even within their room), “agitation,” “escalating,” or no justification beyond reference to earlier “incidents.” One former PS described to DLC an incident in which he went to dispense hand sanitizer for himself,

²⁵ App. B at 4-5.

but the mechanism wouldn't work. As he attempted to open the container to fix it, a TST saw him and "tackled him," and he got an IM ETO, with no PO (oral medication) option.

The below examples, derived from the descriptions available in nursing reports and restraint and seclusion orders,²⁶ illustrate how Wellpath's documented reasons for ETOs, restraint, and seclusion fail to establish emergency circumstances:

- PS was a new admission in the booking area, "presenting with bizarre/paranoid behaviors." No manual hold was for administration of IM ETO used as PS "complied with all directives."
- PS was secluded for causing "climate issues and verbally threatening staff." A manual hold was used for administration of IM ETO.
- PS refused to return to his room after a shower and became "agitated," "yelling and crying" that it is not fair for him to be at BSH. TSTs escorted him to his room with no manual hold, and PS continued "crying" and "yelling" in his room. PS refused a PRN and was given an IM ETO using a manual hold.
- PS attempted to leave the unit with his belongings, received a manual hold and was escorted back to the unit for seclusion. An IM ETO was administered with a manual hold. No other behavioral observations were noted.
- PS was described as "psychotic," "disorganized," "unable to engage in meaningful conversation with staff," and "an imminent risk for constantly refusing" to move to another unit. PS was manually held by staff in tactical gear, administered IM ETO medication, and immediately transferred to another unit while in a manual hold.
- PS was outside in front of the unit wearing boxers, shirtless, stomping on the bushes, "agitated" and swearing at staff. PS came back inside the unit and was put into seclusion. PS was ordered an ETO "for agitation." PS refused to comply with the IM ETO, therefore TSTs entered the room with tactical gear at which point PS agreed to take, and was provided with, oral medication.

²⁶ DOC took exception to DLC's reliance on restraint and seclusion orders and nursing notes as sources of examples in the January 2022 report, suggesting that DLC would have to consider the specific circumstances of a particular incident *and* the "critical context" of the PS' entire clinical record to assess the basis for the order. App. at 5. Of course, that position is unreasonable as a practical matter and underscores how Wellpath's assessment of "emergency" is flawed because it relies heavily upon past events, rather than appropriately focusing on whether immediate circumstances present a "serious, imminent threat of bodily harm where there is present ability to effect such harm." See 103 CMR 21.12(5)(b); see *also* *Rogers*, 390 Mass. at 511 n.26 ("The defendants suggest that certain patients, as a symptom of their illness, will periodically threaten violence. Predictable crises are not within the definition of emergency. Therefore, in those cases, the consent of the patient for medication with antipsychotic drugs must be obtained in advance, while the patient is competent and calm. If the patient has been declared incompetent, the periodic episodes of violence should be considered in formulating the substituted judgment treatment plan.")

- PS refused to exit the shower despite staff requests, sitting on the shower floor and “screaming” while “threatening staff to come in and take him out.” A manual hold was used to bring PS to 4-point restraints where he also received an IM ETO. In the hall on the way to receive 4-point restraints, PS “began to struggle with TST.”
- PS was “yelling and banging on his door,” “verbally threatening staff” and “creating climate issues.” PS refused to comply with ETO and TSTs utilized tactical gear to enter room. Once inside, he complied and received IM with no manual hold.
- PS was a new admission, “not complying with booking rules and regulations” and beginning to “threaten staff.” PS refused to comply with IM ETO therefore manual hold and handcuffs were used to administer the IM ETO.
- PS was “highly agitated from prior incident on unit.” PS was “noncompliant” with IM medication, taking a “fighting stance,” and TSTs in tactical gear utilized a shield to enter the room, placing the PS in a manual hold and administering an IM ETO. **Records indicate that in the “prior incident” approximately 1.5 hours earlier, the PS felt staff had dumped his food on the floor by carelessly pushing it through the wicket. He was placed in a manual hold and escorted to his room and secluded, but was noted to be calm. After the incident that followed, described above, the PS recounted his arms being twisted to the point that he required a shoulder x-ray.*
- PS was in the administration building for a zoom meeting when he began to “posture,” “yell,” and “threaten” staff. At this point he was escorted back to his unit with a manual hold and put into seclusion. Over 30 minutes later, he was administered an IM ETO with a manual hold. Seclusion was then discontinued after 10 minutes.
- PS was “loud and delusional” during the night and refused oral PRN medications. He then received an IM ETO with a manual hold.
- PS was out for recreation time, upset that he had not received canteen items he ordered. PS began to “yell” and “postured” at staff, then was escorted to his room in a manual hold while saying he was able to “use de-escalation techniques” to calm himself and did not need medication. Thirty (30) minutes later he was observed to be “relaxing, calm and quiet” but was still given a PO ETO (oral medication).
- PS stood at the entrance to the unit holding linens under his arm, posture rigid, not making eye contact or communicating verbally. PS would not move away from unit entrance or respond to offers of PRN medication. TSTs used a manual hold to lift him to seclusion room. PS can be heard saying he wants “to get the f*** out of here.” Notes indicate “Serious threat of command hallucinations.” PS received an IM ETO.

As demonstrated in the descriptions above and those of video footage in Section 1.A., the time between the PS being confined to his room and the ETO administration can commonly be within the range of 30 minutes to two (2) hours. When PS are isolated in their rooms and their behavior prior to the arrival of the TSTs consists of self-regulating behaviors and even sleeping, as in the video footage DLC viewed, any emergency justifying the ETO has lapsed and both the ETO and the restraint to accomplish it are illegal. Perhaps worse, Wellpath and DOC know that administering an unwarranted ETO and concomitant restraint is dangerous. Per the BSH Use of Seclusion and Restraint policy,

Violent behavior may lead to seclusion and restraint, however, initiation of seclusion or restraint can also provoke or exacerbate violent behavior in some situations. Statistically, seclusion and restraint are associated with an increased risk or injury to both PS and team members. Avoiding the use of seclusion and restraint will reduce the risk of injury to both PS and team members.²⁷

Put simply, the frequent use of force on PS at both BSH and the OCCC Units indicates systemic problems in the way that DOC and Wellpath administer care.²⁸ The pattern and practice of violent staff interventions would not be accepted in a DMH-licensed psychiatric hospital.

C. Insufficient Documentation of Use of Force/Physical Restraint on Person Served

Wellpath uses force daily on PS at BSH in the form of manual holds and other physical restraints, without documenting how and by whom such force is used. Detailed documentation is key to ensuring proper oversight and accountability of staff charged with implementing restraint, seclusion, and ETO orders. This is especially true when the helmets that TSTs wear obscure their faces from both PS and the surveillance cameras. Nevertheless, TSTs are not required to write incident reports regarding their role in the use of restraint and are not identified by name in clinical records. While Wellpath does have a Serious Incident Reporting policy, it only encourages staff to report “injuries, process failure, near misses and/or hazards affecting and/or involving persons served, team members, or visitors.”²⁹

For review and oversight of uses of force in the context of restraint, BSH policy requires “a debriefing for seclusion and restraint events [that] will be conducted following every seclusion or restraint incident” and a debriefing form the Unit Nurse is responsible for completing.³⁰ The multidisciplinary Seclusion and Restraint Oversight Committee

²⁷ Bridgewater State Hospital Policy and Procedure Manual – Use of Seclusion and Restraint, at 3.2.5 (7/12/2022).

²⁸ One use of force on a PS conducted by correctional officers in the ISOU at OCCC during this reporting resulted in severe injuries and necessitated transfer to an outside hospital emergency department. DLC plans to investigate this incident further and will report out findings at a later date.

²⁹ Bridgewater State Hospital Policy and Procedure Manual – Serious Incident Reporting, at 5.1 (8/13/2021).

³⁰ *Id.* at 5.10.1.

reviews the use, trends, and rate of seclusion, restraint, and manual holds to support “the use of best practices for the safe use, and efforts at reduction, of seclusion and restraint at BSH.”³¹ BSH administrators indicated in this reporting period that the Committee meets every Friday to discuss events of concern, high utilizers (i.e., people restrained and secluded frequently), trends, and alternatives to restraint and seclusion. Wellpath Security also performs a periodic review of a random sampling of video footage, and staff coaching and resolution of issues are purportedly handled one on one with direct managers.

Based on DLC observations and PS input, these oversight measures do not appear to prevent improper or disproportionate use of force in staff responses and interventions. DLC believes that the absence of robust reporting requirements for all staff involved in each and every incident when staff lay their hands on PS fails to ensure that TSTs are being held accountable for their actions. This leaves BSH PS vulnerable to abuse and injury and is in stark contrast to what happens in other DOC (and DMH) facilities.

Conversely, DOC regulations concerning Use of Force on prisoners include extensive reporting and review requirements. Each correctional officer who takes part in a planned use of force on any DOC prisoner – utilizing the same riot gear as TSTs – as well as any medical staff and other witnesses present, are required by regulation to submit a report that must include:

- (a) An accounting of the events leading up to the use of force;
- (b) A precise description of the incident and the reasons for employing force;
- (c) A description of the type of force used, and how it was used;
- (d) A description of the injuries suffered, if any, and the treatment given, if known, along with attached photographs, if any, and;
- (e) A list of all participants and witnesses to the incident who are known by the reporting officer.³²

After staff members have written their reports, “as part of debriefing, they shall have the opportunity to review the videotape with the shift commander and/or team leader in order to critique their performance; information learned from reviewing the video that was not in a report must be added as a written addendum to the report.”³³ The shift commander must submit to the superintendent a summary of the debriefing and any corresponding recommendations for corrective action within 48 hours of the debriefing.³⁴ DOC facility superintendent or designees must then review the written reports and existing video and audio footage of all use of force incidents within no more than five (5) business days and report any inappropriate behavior observed to the regional Assistant Deputy Commissioner.³⁵ The same documentation, along with a Use of Force Reporting form, must then be submitted to the Director of the Special

³¹ *Id.* at 6.14.

³² 103 CMR 505.13(1)-(2).

³³ 103 CMR 505.14(2).

³⁴ 103 CMR 505.14(3).

³⁵ *Id.*

Operations Division within 20 business days of the incident for further review.³⁶ If review at the facility level or by the Director of the Special Operations Division reveals serious misconduct, a formal intake must be submitted to the Office of Investigative Services.³⁷

In the OCCC Units, where correctional officers are still charged with providing security services in the Wellpath-run units, use of force in the context of restraint and seclusion does not appear to be uniformly recorded or reviewed in keeping with Use of Force regulations. A review of incident reports from the RU and ISOU produced daily suggests that correctional officers and other staff adopt a hybrid approach, generally writing incident reports that provide a detailed description of events that led to the restraint or seclusion and that identify each staff member involved by name. Each incident report also identifies the supervisor and shift commander charged with reviewing the report.

In essence, because PS are in DOC facilities run by Wellpath, PS they appear to be getting the worst of both worlds when it comes to use of force – the punitive and, at times, violent treatment received by DOC prisoners at the hands of staff in riot gear without the reporting and oversight functions the DOC requires to safeguard against staff misconduct.

D. Systemic Deficiencies in Recording Chemical Restraint/Emergency Treatment Orders

DLC's review of restraint and seclusion orders produced by DOC – the same documentation that the DOC Commissioner reviews and signs pursuant to M.G.L. c. 123, § 21 – demonstrates that not a single "Medication Restraint" was ordered in the period from December 11, 2021 through June 10, 2022. While this, by law, should establish that no PS were subjected to chemical restraint, restraint and seclusion orders show that **304 ETOs** were administered, almost invariably in conjunction with manual holds, mechanical restraints, or during seclusion.³⁸

| Month | Number of Days | Number of ETOs | ETOs Per Day (avg) |
|---------------------------|----------------|----------------|--------------------|
| December (11-31) | 21 | 30 | 1.4 |
| January (1-31) | 31 | 52 | 1.7 |
| February (1-28) | 28 | 68 | 2.4 |
| March (1-31) | 31 | 46 | 1.5 |
| April (1-30) | 30 | 44 | 1.5 |
| May (1-31) | 31 | 48 | 1.5 |
| June (1-10) | 10 | 16 | 1.6 |
| Total (Dec. 11 - June 10) | 181 | 304 | 1.7 |

³⁶ 103 CMR 505.13(5)

³⁷ 103 CMR 505.13(3), (5).

³⁸ Restraint and seclusion orders ask whether ETO was administered during, before, or after the restraint or seclusion. The orders indicate whether ETO was administered, though not whether it occurred during, before, or after restraint or seclusion. Manual holds or mechanical restraint may be stated to be carried out for the purpose of administering the ETO.

*This total number of ETOs was imposed upon an alarming **130 unique PS** who received at least one ETO over the six-month reporting period. While there were **two PS among the 130 individuals** who were subjected to more than 8 ETOs during this period, the remainder of the ETOs were distributed rather evenly and widely among the population. If the practice of ETO administration was not concerning enough, its reach being this broad within the BSH population is particularly disturbing– indeed, **130 PS is over half the total census of BSH** at a given time.*

Moreover, the 304 total does not account for all ETOs that occurred during the reporting period, but rather those that occurred in conjunction with restraint and seclusion incidents and were documented in the orders. DLC compared the number of ETOs from the period January 2, 2022 until June 10, 2022³⁹ with statistics Wellpath created for the period January 2, 2022 until June 11, 2022. During this same period (minus a single day), DLC counted **275 ETOs** in total, whereas Wellpath reported **324 ETOs** – a nearly **49 ETO discrepancy**. The discrepancy highlights the inconsistent recording and reporting of ETOs. By contrast, DMH-run and -licensed facilities report each use of involuntary medication used to address emergency circumstances pursuant to DMH regulations, which appropriately define medication restraint and adhere to reporting obligations under M.G.L. c. 123, § 21.⁴⁰

BSH's deficit in reporting comes at a serious cost. Until tracking and reporting requirements are enforced, Wellpath and DOC fail to act in accordance with the law and all interested parties lack the ability to oversee this widespread *modus operandi* staff use to control PS behaviors and, seemingly, to inflict punishment upon them for engaging in disruptive, unhygienic, and otherwise unwanted behaviors.

E. Systemic Inequity in Application of Chemical Restraint

DLC has previously recognized that there is a glaring overrepresentation of people of color – particularly, individuals who identify as Black and/or African American – with behavioral health issues deemed to require the strict security of BSH. Utilizing the limited categories and information identified by DOC, the comparison between the racial/ethnic makeup of the populations of BSH and the Commonwealth reveals as follows:

³⁹ DLC obtained this figure through careful review of over 1,000 incidents, primarily in Wellpath restraint and seclusion packets.

⁴⁰ DMH regulations require that at the end of each month, DMH facilities submit to the Department copies of all restraint and seclusion forms with attachments and an aggregate report for each facility unit containing statistical data on the episodes of restraint and seclusion for the month. The Commissioner or designee reviews such aggregate reports and a sample of restraint and seclusion forms and maintains statistical records of all uses of restraint or seclusion, organized by facility and unit. 104 CMR 27.12(8)(i).

| Race/Ethnicity | BSH Population ⁴¹ | Massachusetts Population ⁴² |
|---------------------------|------------------------------|--|
| Caucasian | 43% (96) | 70.1% |
| Black or African American | 33% (74) | 9.3% |
| Hispanic | 10% (22) | 12.8% |
| Other | 12% (27) | 3.3% |
| Asian/Pacific Islander | 2% (4) | 7.6% |

Because DLC's monitoring observations have suggested that Black and Latinx PS may also be disproportionately subjected to ETOs, DLC began gathering and comparing the demographics of PS who received ETOs during the reporting period with those of the BSH population as a whole. While limited access to data prevented a full accounting of race/ethnicity for the 130 PS who received ETOs during the reporting period, DLC was nonetheless able, through a snapshot of 48 PS, to preliminarily substantiate concerns about a racial/ethnic disparity in ETO administration.

ETOs Administered by PS Race/Ethnicity

| Race/Ethnicity | BSH Population ⁴³ | Unique PS Receiving ETOs ⁴⁴ |
|---------------------------|------------------------------|--|
| Caucasian | 43% (96) | 29% (14 PS) |
| Black or African American | 33% (74) | 48% (23 PS) |
| Hispanic | 10% (22) | 19% (9 PS) |
| Other | 12% (27) | 4% (2 PS) |
| Asian/Pacific Islander | 2% (4) | 0% (0 PS) |

DLC plans to pursue comprehensive data sets related to race/ethnicity and the PS population during the next reporting period, allowing a more complete discussion of this issue in the next report.

Unfortunately, however, DMH does not track race/ethnicity data in the aggregate restraint and seclusion data it produces to serve as a point of comparison. To begin to address known racial disparities in psychiatric care⁴⁵ and, particularly, disparities in the

⁴¹ DOC, *January 2022 MA DOC Institutional Fact Cards*, <https://www.mass.gov/doc/institutional-fact-cards-january-2022/download>.

⁴² U.S. Census, *Quick Facts: Massachusetts* (August 25, 2021), <https://www.census.gov/quickfacts/MA>. Please note that the U.S. Census and DOC track race/ethnicity differently. The U.S. Census recognizes, for instance, that one can identify as Latinx based on their heritage regardless of identified race. Because of this overlap, U.S. Census data adds up to over 100%.

⁴³ DOC, *January 2022 MA DOC Institutional Fact Cards*, <https://www.mass.gov/doc/institutional-fact-cards-january-2022/download>.

⁴⁴ ETO data from the full reporting period (12/11/21 to 6/10/22) was compared to May 2022 BSH demographics data, yielding a sample size of 48 PS who received ETOS identifiable by race/ethnicity (out of 130 PS who received ETOs in total).

⁴⁵ See, e.g., Colin M. Smith, et al., *Association of Black Race with Physical and Chemical Restraint Use Among Patients Undergoing Emergency Psychiatric Evaluation*; PSYCHIATRIC SERVICES 2022 Jul; 73 (7): 730-736; Vera Pertsovskaya, et al., *The Role of Race on Restraint Use: Racial Bias in Healthcare, Psychiatric Diseases, and Utilization of Restraints*, URGENT MATTERS (June 25, 2021), <https://smhs.gwu.edu/urgentmatters/news/role-race-restraint-use-racial-bias-healthcare-psychiatric->

use of highly restrictive interventions that may foreseeably result in trauma and/or injury, BSH and the DMH must commit to tracking and transparently reporting this data.

F. Personal Safety Plans Implementation Updates

On a note of improvement during this reporting period, Wellpath staff have been completing the Personal Safety Plans (PSP) required under its Restraint and Seclusion policy. The forms for the plans are also revised, and are now similar to Individual Crisis Prevention Plans, which are an essential part of DMH facilities' strategic plans for reducing, and, wherever possible, eliminating the use of restraint and seclusion. As discussed in our last report, a PSP is supposed to be started at the onset of the hospital admission, documenting PS preferences and recommendations for intervention if a situation arises that could lead to seclusion and restraint. The PSP is to be reviewed and updated after each seclusion and restraint event, and as otherwise needed. DLC reviewed a sample of PS records, and found that, beginning in March 2022, staff began using the revised form and completed them for PS who had not had the form completed at admission. However, the plans were not revised, even for PS who experience multiple episodes of restraint, ETOs, and/or seclusion. Wellpath has reported that BSH staff post the plans in patient rooms, so that staff on all shifts should be aware of and have access to the plan. However, DLC has not observed that plans are so posted.

DLC urges staff to ensure that the plans are posted in PS' rooms, and review and update the plans with PS to reflect any changes in triggers and strategies, as well as following any restraint or seclusion episode.

G. The Impact of BSH Involuntary Medication, Seclusion, and Restraint Practices: Persons Served Perspectives

i. Psychological Impact:

For PS at BSH, the psychological impact of experiencing an ETO can be foreseeably profound. Unsurprisingly, many PS strongly endorse the viewpoint that forced medication is inhumane, all while faced with the reality that they and every PS around them are vulnerable to it. PS who have experienced ETOs – personally or by observation of another PS – report feeling paranoid, threatened, and racked by memories of violence when they see TSTs walk by. One PS, unfortunately, felt this way about nurses coming through the unit with the medical cart. Still another PS reported that, after he received an ETO, the traumatizing experience made him not want to speak with staff at all, even if when he was feeling depressed and suicidal.

PS speak of experiencing trauma because of BSH forced medication practices, with one describing his experience receiving an ETO as “like nothing I’ve ever experienced before, and nothing I’d want anyone to experience.” Some PS described the experience

[diseases-and-utilization-restraints#:~:text=For%20example%2C%20one%20study%20found,restrained%20while%20in%20the%20ED; Shaun M. Eack, et al., *Racial Disparities in Mental Health Outcomes After Psychiatric Hospital Discharge Among Individuals with Severe Mental Illness.*, SOCIAL WORK RESEARCH 2012 Mar 1; 36 \(1\): 41-52; Annelle B. Primm, et al., *The role of public health in addressing racial and ethnic disparities in mental health and mental illness*, PREVENTING CHRONIC DISEASE 2010 Jan; 7\(1\): A20.](#)

as “humiliating,” with one highlighting the damage it could do to PS who have been sexually assaulted, given that staff forcibly pull down their pants and hold them while they are penetrated with needles against their will. A PS who received an ETO and identified as having PTSD said that his symptoms were exacerbated by the knowledge that staff can involuntarily medicate you “at any time.”

As in other stressful and frightening situations, individuals often have a “fight or flight” response. Yet, when staff violently impose intramuscular injections in PS rooms – small prison cells – there is no opportunity to flee or escape to a safe space. While some PS are able to remain calm or cower before a team of TSTs wearing riot gear barreling into their rooms, other PS become fixated on being prepared for the aggressive confrontation inherent in ETOs at BSH. One such PS described himself as being always ready to fight with staff, and training to do so in his free time, based on his experience with previous ETOs. This is not a sign that the PS is dangerous, but a human reaction to the trauma of chemical restraint.

ii. Environmental Impact:

The persistent threat of involuntary medication affects the overall milieu on BSH units. During the course of monitoring on the housing units, DLC observed occurrences of restraint and seclusion, frequent precursors to ETOs. Such events often involve: the immediate clearing of unit hallways; the temporary sequestering of PS in the closest room; a stream of backup TSTs coming in from other units; and frequently, yelling, physical struggle, and slamming metal doors. In short, a palpable climate of alarm takes over PS’ living space. Given the ever-present possibility of this type of emergency, it follows that a number of PS expressed feeling a sense of hypervigilance, needing to always “watch their back,” and to “keep your head down and your mouth shut in this place” to avoid restraint, seclusion, and forced medication.

One PS advocated getting rid of the “move team” altogether– including the riot gear, shields, and TSTs using force – specifically citing how traumatic it is for everyone else on the unit to hear other PS being restrained and involuntarily medicated. Another PS recounted hearing the screams of other PS being restrained and involuntarily medicated who were pleading with staff to stop, as a disturbing feature of his time at BSH. It is this environment of imminent violence that many PS DLC interviewed reported has a distinct effect on their behavior, making them more likely to engage in conflict, less grounded, and feeling generally worse than they might otherwise.

iii. Physical Impact:

Involuntary medication and the violence that often accompanies it can have physical consequences for PS in addition to psychological impact. Beyond the pain of receiving multiple injections themselves (usually four), PS frequently endorse feeling pain in their buttocks for days after being “IM’d”, sometimes making it difficult to sit without significant discomfort.

Additionally, some PS report sustaining serious physical injuries during the TST uses of force for the purposes of restraining them for the application of involuntary medication.

PS have reported to DLC multiple incidents resulting in the need for x-rays and MRIs, and even diagnosed fractures. PS have described being pushed violently to their knees by staff; their arms and legs being twisted and bent painfully; bruising and swelling thereafter. One PS, who was too afraid of retaliation to report his injury, described his shoulder being contorted in such a way that he found his arm popping out of his shoulder socket for days after. This avoidance of seeking medical attention, in addition to engaging in mental health treatment, for fear of staff mistreatment or extension of their time at BSH was a common theme in interviews with affected PS.

iv. Impact on BSH Staff Behavior and Culture:

The general culture around restraint, seclusion, and involuntary medication among unit staff is of particular concern. Poor staff behavior may be related to hiring practices and limited job qualifications; staff turnover; orientation and training; the strain of job responsibilities, the BSH environment, and responsibilities in enforcing restraint and seclusion orders; or some combination thereof. In charged situations, TSTs may experience the same fight or flight response, but, unlike PS, they are in a position of authority and wearing protective riot gear.

One PS reported his impression that staff lack training in dealing with struggling individuals, resulting in “staff abuse” and use of “unreasonable force.” Another PS reported staff instigating PS by asking them repeatedly, with increasing volume, if they wanted to take their medications, without letting them answer, thus making it look like a refusal and rationale for involuntary medication. PS have described staff challenging PS by asking if they wanted to fight staff; suggesting that they fight staff or other PS; calling PS all manner of derogatory names; and otherwise taunting, antagonizing, and provoking them. Particularly concerning are reports of direct threats by staff to physically assault PS as a consequence for undesired behaviors.

PS frequently recount staff laughing at, ignoring, or provoking PS in the lead up to ordering and administering ETOs. One even recalled TSTs laughing and joking while administering forced medication, then saying to the recently force-medicated PS, “you did it to yourself.” Indeed, according to multiple accounts by PS, staff refer to intramuscular medications by the disturbing nickname “booty juice,” a callous reference to the usual injection point in the gluteus region, accessed by forcibly pulling down an individual’s pants.

Perhaps most concerning, one PS reported that the workplace culture among BSH staff was such that the “best part of their day is when they get to kick someone’s ass.”

Recommendations:

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

The Commonwealth must demand that DOC and Wellpath accurately document and report all uses of chemical restraint, physical restraint, and seclusion in

keeping with applicable law and engage DMH or another external party to conduct an in-depth investigation into BSH practices. Without accurate documentation and data concerning restraint and seclusion, the care and treatment PS receive at BSH and in the OCCC Units cannot be measured against the data and standards in DMH facilities.

DLC recommends that, to fully address the restraint and seclusion practices to which PS are subjected, the care of all individuals found to need “strict security” for psychiatric evaluation and/or treatment must be placed under the DMH. Based on DLC’s observations, maintaining DOC’s control over BSH will foreseeably permit variation in both quality of care and compliance with legal requirements.

All policies and practices concerning the involuntary medication, restraint, and seclusion of PS should be amended to conform with DMH regulations and policies, including provisions regarding staff training requirements, tracking less restrictive alternatives, de-escalation efforts, debriefing with PS, and accurately reporting all restraint and seclusion to the Commissioner.

DLC strongly recommends that BSH and DMH commit to tracking and analyzing race/ethnicity data concerning application of restraint and seclusion – including ETOs at BSH – on individuals who are subject to psychiatric hospitalization in the Commonwealth.

Wellpath must prioritize timely creation of Personal Safety Plans upon admission and updating of Plans after every incident of seclusion or restraint to reflect current PS triggers and strategies to help the PS and staff intervene with de-escalation techniques and avoid the use of restraint and seclusion.

3. Insufficient Language Access for Persons Served

PS at BSH who have limited English proficiency (LEP) report struggling to access treatment and programming due to limited – and sometimes no – options in their primary language and difficulty communicating with BSH staff. Miscommunication for some PS with LEP has led to frustrated interactions with staff and use of restraint and seclusion that may have been avoided if the PS had adequate language access. The information DLC gathered during this reporting period indicates that BSH fails to provide adequate language access and, in turn, accessible mental health services to many PS with LEP.

A. Legal Obligations Regarding Language Access

Title VI of the Civil Rights Act of 1964 (Title VI), 42 U.S.C. 2000d *et seq.*, protects persons from discrimination based on their race, color, or national origin in programs and activities that receive “Federal financial assistance.”⁴⁶ Title VI’s national origin nondiscrimination provision requires recipients of Federal financial assistance to take reasonable steps to make their programs, services, and activities accessible by eligible persons who have limited English proficiency. DOC has failed to ensure that PS receive this critical access at BSH. DOC and Wellpath, as its contractor, have fallen far short of achieving the goals laid out in state and federal guidance for how recipients can fulfill Title VI’s requirements.

The U.S. Department of Justice (DOJ) both oversees federal agency compliance with Title VI and is a funder of state corrections programs including DOC.⁴⁷ Each federal agency providing Federal financial assistance has issued guidance to recipients to ensure meaningful access for LEP persons to agency operated or licensed programs and services. In 2011, DOJ reinforced its commitment to fulfilling Title VI’s language access requirements,⁴⁸ and issued its *Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs*, updating earlier guidance to federal agencies.⁴⁹ This DOJ guidance sets forth the compliance standards that recipients of Federal financial assistance must follow to ensure that their programs and activities normally provided in English are accessible to persons with LEP. While agencies have discretion in how they achieve language access, the guidance lays out the elements of a well-functioning LAP. It contains five main elements:

- (1) Conduct Self-Assessment to determine the nature and degree of contact that it has with LEP population: The agency should assess the number or proportion of

⁴⁶ See 45 C.F.R. § 80.13(f) (defining Federal financial assistance).

⁴⁷ DOJ’s Federal Coordination and Compliance Section (FCCS) is responsible for governmentwide coordination with respect to Executive Order 13166. FCCS reviews and approves each funding agency’s external LEP guidance for its recipients and developed DOJ’s external guidance for its own recipients.

⁴⁸ See Attorney General Eric H. Holder, *Federal Government’s Renewed Commitment to Language Access Obligations Under Executive Order 13166*, <https://niwaplibrary.wcl.american.edu/wp-content/uploads/LANG-Gov-MemoAGonExOr1316602.17.11.pdf>.

⁴⁹ See DOJ Civil Rights Division, *Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs* (May 2011), https://www.lep.gov/sites/lep/files/resources/2011_Language_Access_Assessment_and_Planning_Tool.pdf.

individuals with LEP from each language group in its service area and identify and track the primary language and preferred language for written communication of individuals with LEP that seek and receive programs and services. The agency should regularly update this data.

- (2) Ensure oral and written language assistance services are in place to effectively communicate with individuals with LEP: Oral language assistance may be provided by bilingual staff communicating directly in the primary language of the person with LEP, or an interpreter service (in-person, telephonically, or via video). The interpreter must have knowledge in both languages of the relevant terms/concepts particular to the program or activity and the dialect and terminology used by the individual. The agency should identify and translate vital documents to ensure meaningful access to important written information for people with LEP, including: consent and complaint information/forms; written notices of rights; signs; and notices advising LEP individuals of free language assistance services.
- (3) Train staff on language access policies and procedures. Training should be mandatory for staff who may interact or communicate with individuals with LEP, for staff who arrange for language assistance services, and for managers. Training should explain how staff can identify the language needs of a person with LEP, and how to access and provide the necessary language services and track their use. Bilingual staff who communicate with directly with individuals with LEP in their primary language need regular assessment and training in techniques, specialized terminology, ethics, and other topics as needed.
- (4) Provide notice of language assistance services. “[R]ecipients [of Federal financial assistance] must inform individuals with LEP of their eligibility for benefits, programs, and services in a language they understand.”⁵⁰ Notice can take the form of forms, brochures, and language access posters and should be placed in conspicuous locations describing in multiple languages the availability of language assistance services.
- (5) Monitor, evaluate, and update its LAP, policies, and procedures. “For a language access program to continue be effective, an agency must” conduct periodic reviews.⁵¹ A committee or staff person may be designated as the language access coordinator responsible for monitoring and evaluating procedures.

The Massachusetts Executive Office for Administration & Finance’s Office of Access & Opportunity built upon these elements in its guidelines for Commonwealth agencies issued in 2012 and updated in 2015.⁵² The Office instructed agencies to develop their plans following the guidelines and encouraged them to “go beyond these guidelines as

⁵⁰ *Id.* at 6.

⁵¹ *Id.* at 7.

⁵² Executive Office for Administration & Finance, *Language Access Policy and Implementation Guidelines* (March 10, 2015), <https://www.mass.gov/doc/language-access-guidelines/download>.

needs and circumstances dictate.”⁵³ Each Massachusetts government agency must, as part of its LAP, do the following:

- Designate a language access coordinator. The coordinator reports to the head of the agency or a designee and is responsible for agency implementation and compliance with the agency’s LAP;
- Outline tasks to be completed, with timelines and assigned resources. At a minimum, action steps must include conducting a needs assessment that determine priorities for providing services to ensure access for individuals with LEP; gathers data on language makeup of population served; identifies all points of contact with persons with LEP;
- Conduct a Language Resources Assessment. The agency must identify what language resources are available for delivery of services to non-English speakers and people with LEP, including staff who are linguistically, culturally, and technically able to deliver services in a language other than English and available contracted language services;
- Develop language service protocols. The agency must identify resources for providing interpretation and translation and instruct staff how and when to secure language services;
- Translate documentation into “languages regularly encountered.”⁵⁴ Agencies must implement a protocol to review all forms and documents it uses to determine which are vital to providing meaningful access to non-English speaking and persons with LEP;
- Provide interpretation services. Agencies must provide interpretation to persons who are non-English speaking or have LEP who seek to participate in services, programs, or activities of the agency. Each agency is encouraged to provide universal access to interpretation services, but must provide interpretation to “languages regularly encountered”;
- Develop and implement a plan for ongoing, regular training of staff to ensure staff are aware of plan & protocols;
- Inform public of availability of language access services;
- Establish a system to periodically monitor agency compliance and need for changes to the LAP and protocols; and
- Provide an avenue for complaints with Agency Language Access Coordinator.

⁵³ *Id.* at 2.

⁵⁴ The term “languages regularly encountered” shall mean any language spoken by at least 5% of the population served within a particular agency program, service or activity.” *Id.* at 6.

B. Implementation of Language Access at BSH

Although DOC has had a LAP in place since at least 2013, it appears DOC failed to apply that plan to BSH following the transition to Wellpath in 2017. According to the plan, DOC has an agency-wide LEP Coordinator as well as LEP institution monitors at each facility.⁵⁵ The plan's requirements include collecting data on the primary and secondary language of prisoners and detainees and the utilization of LEP services;⁵⁶ translating policies and directives into Spanish as well as intake/orientation materials, vital medical forms, notices, procedures, and instructions; providing programming in Spanish; maintaining lists of bilingual staff and contracted interpreters at each facility; requiring feedback on quality of access; and auditing and monitoring the needs for services. Each booking area is required to have universal signs for requesting interpreter services and identifying the person's preferred primary language.

DOC did not include this plan, and incorporated few of its specific requirements, into its 2017 contract with Wellpath for the operation of BSH.⁵⁷ The contract simply requires that Wellpath provide translation services "to meet the needs of the Patient population," and ensure that "a sufficient number of Personnel are bilingual in English and Spanish." The contractor is supposed to provide DOC a list of bilingual Personnel, identifying their fluency in applicable languages, with quarterly updates.

Owing to these relaxed requirements, language access at BSH is woefully inadequate.⁵⁸ Based on the information DLC received, BSH has no LAP, no identified LEP coordinator or monitor for language access needs and conducts no ongoing tracking and periodic assessment of such needs. Its training of new employees does not include any information or guidance concerning language access assessment needs. In addition, Wellpath failed to provide any lists or updates of bilingual personnel to DOC during this reporting period per its contract requirements.⁵⁹

⁵⁵ DOC, *Language Assistance Plan (LAP)*, (February 15, 2013), <https://www.masslegalservices.org/system/files/library/Department%20of%20Correction%20Language%20Access%20Plan%202013.pdf>. The LEP Coordinator is supposed to coordinate identification of language service needs; secure access to resources to provide oral and written language services; identify criteria for designation of languages for translation (demographic data & usage projections); identify training needs; establish a system for receiving and responding to complaints; and review progress of DOC and its facilities. *Id.* at 4-5. The institution LEP monitors essentially carry out these duties at the facility level, and work with the LEP Coordinator. *Id.* at 5.

⁵⁶ The DOC LAP defines a person with LEP as "someone who is not able to speak, read, write, or understand the English language at a level that allows him/her to interact effectively with Department staff," recognizing that "[a]n individual maintains a right to self-identify as an LEP person" and "LEP may be context-specific." *Id.* at 3.

⁵⁷ See DOC, Request for Responses -Comprehensive Services for Bridgewater State Hospital, RFR# 17-DOC 9004-Bridgewater State Hospital Services (September 12, 2016; Amended October 3, 2016 and November 7, 2016), 5.17 Translation Services at 46-47.

⁵⁸ DLC requested documents and information from Wellpath concerning its assessment of language access needs, and the translation services available, and followed up with questions for the Wellpath administration concerning staffing and coordination of language access services.

⁵⁹ During this reporting period, Wellpath administration informed DLC that there are many staff who speak Spanish & Haitian Creole, without providing the numbers or types of staff who are bilingual. Following the

The BSH booking area is devoid of any non-English signage; it lacks any notice of rights to an interpreter or other language access posters posted in Spanish or other languages. Neither the BSH intake policy nor staff training provided to DLC for review give any standards or guidance in the assessment of language proficiency. Wellpath does not use language cards or other methods for clients to identify the language that they prefer to use for health care.

Wellpath is not properly assessing language access needs, and therefore not meeting the needs of all PS who would benefit from LEP services. The BSH Intake & Orientation Policy displays a distinctively passive approach to the assessment of English language proficiency: “Telephonic interpretative services via language line will be used if requested by the person served or if the admission staff believes it would be helpful.”⁶⁰ The initial nursing assessment notes whether an interpreter is needed. However, staff employee orientation materials make no mention of the need to assess for and offer language access services, let alone guide staff in how to make such assessment.⁶¹

In early May, Wellpath provided DLC a list of 248 PS with their ethnicity and primary language as of March 23, 2022. According to the list, *only five* (5) PS were designated as speaking a sole primary non-English language – only one of whom was Spanish-speaking. Fifteen (15) PS are listed as speaking another language, with English also listed as primary, nullifying any need for language access services. In a state where 8.6% of its households speak Spanish in the home, at least twenty (20) PS ought to have been identified as primarily Spanish-speaking alone.⁶²

While DLC did not have the opportunity to meet with all PS listed, due in part to discharges before DLC received the list, we did meet with several PS identified as speaking two primary languages (English plus another language) and reviewed clinical records for other PS so designated. Records DLC reviewed demonstrate the lack of language access for PS with LEP and the unreliability of Wellpath’s assessment of LEP. For example:

- Required notices of reasonable accommodations under the ADA, as well privacy notices are included in the clinical record in English, not in the PS’s actual primary language.
- Wellpath designated both English and Spanish as primary for a PS whose clinicians repeatedly described his English as “broken.” This PS has a traumatic brain injury in addition to a behavioral health condition. Staff at the prior DMH

reporting period, DLC requested the lists that Wellpath was required to provide DOC on a quarterly basis during the reporting period. DLC received a list that Wellpath provided to DOC only after the DLC made the request. That list, dated July 11, 2022, will inform DLC’s next report.

⁶⁰ Bridgewater State Hospital Policy and Procedure Manual – Intake & Orientation (8/10/2020).

⁶¹ Staff are supposed to inform patients of their rights and guidelines for filing grievances at the time of admission in the person’s primary language and distribute the Patient Handbook; and within first week of admission person served receives orientation in English, Spanish or other translated language. *Id.* However, this assistance depends on a reliable assessment of LEP.

⁶² Languages in Massachusetts is online data based upon the 2010 census, and from the 2012-2016 American Community Survey. <https://statisticalatlas.com/state/Massachusetts/Languages>.

facility found his language barrier presented an obstacle to treatment and identified this refusal to engage with interpreter services as relating to his need to appear independent and that he would benefit from continuing education and support for how he could benefit from language access services, rather than viewing it as negatively reflecting on his abilities. At the DMH facility, he did accept a Spanish interpreter at times. At BSH, he had difficulty using telephone interpretation via Language Line and refused at times to engage with clinicians who spoke Spanish. The record does not indicate any education or ongoing work with this PS to encourage language access.

- For a PS who spoke Haitian Creole, nursing staff assessed his English as limited and determined that PS required a Haitian Creole interpreter. However, following the nursing assessment, the psychiatrist asked the PS whether he would like to continue the conversation in English; the PS agreed to do so, and the psychiatrist determined he was sufficiently conversant. Interpreter services were never offered to this PS. Such a determination fails to consider the power dynamics at play in the psychiatric evaluation – that the PS may have wanted to appear capable of speaking English and compliant to the psychiatrist to increase the odds of a favorable outcome. Instead of reviewing the conflicting determinations, Wellpath never revisited the issue, determined that both English and Haitian Creole were primary languages this PS.

Trained interpreters do not interpret for treatment purposes at BSH. Catholic Charities interpreter services are used only for forensic evaluations and are only available in Spanish and Haitian/Creole. Wellpath relies on video interpreter services via the Voyce tablet, without any apparent push to add bilingual clinical staff and train staff in interpreter services. While there appear to be a sufficient number of TST's and RTA's who are bilingual in Spanish, there are few nurses, rehabilitation staff, psychologists, or psychiatrists who are bilingual. It would not be appropriate for the support staff to interpret in the clinical setting because of potential conflicts of interest, nor are they trained to do so.

While in this absence of live interpreter, Voyce tablets can facilitate 1:1 treatment, the number of Voyce tables did not meet the need during this reporting period: only three Voyce tablets were available; and not all PS with LEP were aware of the availability of the service. Wellpath reported that more tablets are on order, so that one will be available on each unit. However, the service does not substitute for bilingual, culturally competent staff, or for staff who are bilingual and trained to interpret for other staff. Further, the service depends upon strong internet access, which is not always available.

A Voyce tablet is also not well-suited to meet the pervasive need for interpretation in group programming. Two groups are run in Spanish – one for residents of the Adam 1 unit and one in the Attucks building – but none of the groups in Recovery Place are in Spanish. Some Spanish-speaking PS reported not being aware of these groups at all. No groups were offered in Haitian-Creole although three persons served were identified as speaking Haitian-Creole; they were also identified, unreliably, as speaking English as a primary language. PS reported difficulty understanding the groups in English, and

their frustration at not being able to speak in the groups – leading some to stop attending altogether.

PS report lack of access to group programming, insufficient access to interpreter services, and difficulty accessing written materials due to lack of translation. Per PS, there are TSTs who are bilingual in Spanish and in Haitian Creole, but there are far fewer clinicians who are bilingual. PS reported relying on fellow PS or TSTs to interpret for other staff.

The practice at BSH of relying on PS is specifically prohibited in Wellpath’s contract and staff relying on TSTs to facilitate communication is inappropriate, as TSTs who lack training in providing interpretation and may have a conflict of interest as security staff, and whose presence reduces the confidentiality of the clinical session.

With respect to written translation, Wellpath reported the BSH Patient Handbook is available in Spanish and Haitian-Creole, and reported using Google Translate to create versions of the handbook in other languages. Wellpath reported no other documents as having been translated during this reporting period, such as privacy notices, reasonable accommodations policies, grievance forms, health care proxies, or other essential documents. Wellpath reported that it regularly provides worksheets and therapeutic materials in other languages using Psychology Tools and other translator services; yet several PS reported a lack of access to written materials.

The isolation of PS who have LEP, and the consequences of this language barrier in the volatile environment of BSH, are illustrated by the below of seclusion and restraint of a PS whose primary language was Spanish:

Example – “Leo”

*PS “Leo” punched an RTA in the unit hallway and a manual hold was used to bring Leo to seclusion, where he received an IM ETO approximately 45 minutes later. Wellpath renewed the seclusion order on the basis that Leo fought with TST during IM ETO administration, threatened unit clinician, and is described as “angry and threatening; **limited by language proficiency but uncooperative nonetheless.**”*

*Once Leo is sleeping after the ETO, seclusion is discontinued, with the comment that specific strengths, skills, or supports the PS can utilize to manage future risk are “unclear – **not much known about him**; psychotic illness, such as there is, should be responsive to med tx and in turn reduce ongoing risk if he is adherent.”*

*Records state that Leo could not be debriefed following the seclusion and restraint because of a language barrier – “**PS does not speak English and refused to talk.**”*

The commentary in the records is nothing short of alarming. At the time of the incident, **Leo had been at BSH for four (4) weeks** and “not much [was] known about PS.” No mention is made of any bilingual staff engaging with Leo in this report. Three days later this PS was secluded again, with only the telephonic service Language Line utilized during a risk assessment, following further reported behavior of “posturing aggressively at staff.” During the assessment, the PS talked over the interpreter on the line as well as

the English-speaking staff present. Wellpath discontinued the safety assessment and PS received another ETO. Bilingual, culturally competent staff would have offered the greatest possibility for engaging with this PS. Ultimately, four days later, the PS was again secluded following an assault on a peer, with seclusion renewed when the PS “seems confused about his situation but difficult to assess - no Spanish speaking staff are currently available to assist with interpretation.” Two (2) hours after seclusion was initiated, this PS is administered an IM ETO.

Further, there is no plan for assessing language needs in other languages, although Massachusetts has become more diverse,⁶³ and likely this is a continuing trend.

C. DMH Language Access Plan

Language access needs are yet another reason why BSH should be a part of the DMH system. In comparison to the DOC LAP, DMH’s LAP language access plan is far more appropriate for individuals with behavioral health conditions: it is oriented to carry out the mission of the agency.⁶⁴ Its mission is not only language access, but cultural competency: “Recognizing that mental health services are an essential part of healthcare, DMH establishes standards to ensure effective and culturally and linguistically competent care to promote recovery.” This approach meets specific clinical standards. DMH emphasizes recruitment and retention of bilingual and bicultural staff as a first strategy, and to use interpreters when bilingual staff are not available.

Bicultural and bilingual staff is especially important in the mental health field.⁶⁵ Individuals who cannot connect with a clinician who is understanding of the person’s culture and language remain isolated. Quality translation is essential to therapy and mental health treatment to ensure that concepts are being understood. This underscores the importance of training, even for bilingual staff, concerning PS language access services and the importance of tone and communication in interpreting for mental health treatment.⁶⁶

DMH offers support from the agency to its vendors, including specialized cultural and linguistic programs to support the provision of culturally and linguistically effective mental health care.⁶⁷ DMH’s Office of Multicultural Affairs assists vendors with creating LAPs to address the needs of their LEP populations and offers resources for translation services of clinical materials and monitors translation usage.⁶⁸

PS themselves who have experienced both BSH and DMH facilities can best compare: DLC interviewed a PS at BSH during this reporting period who compared his experience at Worcester Recovery Center and Hospital (WRCH). He recounted working with a

⁶³ WBUR, *Massachusetts Has Become More Diverse, New Census Data Shows* (August 12, 2021), <https://www.wbur.org/news/2021/08/12/massachusetts-more-diverse-census-data>.

⁶⁴ DMH, *Language Access Plan* (January 10, 2011), <https://www.masslegalservices.org/system/files/library/DMH%20Language%20Access%20Plan.pdf>.

⁶⁵ Lindsey Phillips, *Wanted: Bilingual and Bicultural Counselors*, COUNSELING TODAY (February 3, 2021), <https://ct.counseling.org/2021/02/wanted-bilingual-and-bicultural-counselors/>.

⁶⁶ *Id.*

⁶⁷ DMH, *Language Access Plan*.

⁶⁸ *Id.*

Haitian Creole interpreter multiple times at WRCH, and always having language access. At BSH, he reported that live interpretation was sometimes available on the units, no groups were offered in Haitian Creole, and most of the time he could not understand the available groups. Despite the complex treatment needs of so many PS, BSH appears to treat access to mental health services for PS with LEP only as an afterthought.

Recommendations:

The Commonwealth must immediately place BSH operations under the authority of DMH to ensure current and future PS with LEP have access to trauma-informed, person-centered mental health treatment. Until this is accomplished, DOC must ensure that Wellpath takes the following steps to ensure universal access:

- **Appoint a Language Access Monitor, who shall oversee and track language access needs;**
- **Train BSH clinical staff to assess English language proficiency;**
- **Post notices in multiple languages of rights to language interpreter and translation services, in the BSH booking/intake area as well as on the units;**
- **Post language cards for PS to identify their language of choice in booking/intake area;**
- **Recruit bilingual clinical staff and train staff in interpretation for mental health services, offering salary enhancements as needed;**
- **Train all BSH staff in cultural competency;**
- **Track the number of PS with LEP and report those numbers to DOC;**
- **Report the number of bilingual staff and languages spoken;**
- **Expand group programming offerings in Spanish, Haitian-Creole, and other languages as needed to suit the needs of the BSH population;**
- **Ensure that PS are aware of available programming offerings in various languages;**
- **Enhance access to Voyce services and video interpretation technologies, including by improving internet access;**
- **Ensure that all vital documents and therapeutic tools are translated into PS' preferred language, using quality translation services tailored to mental health services;**
- **Create a grievance process for language access complaints, to be reviewed by the LAM, and a feedback process for PS with LEP to provide comments to the LAM on their access to LEP services.**

4. Limitations on Persons Served Access to Medical Care

PS difficulties accessing medical care remain a persistent and pervasive concern. From requesting care and setting up an appointment, to receiving test results and follow-up after a procedure or specialist consultation, PS report a lack of communication with staff that leaves them feeling in the dark about their medical treatment, resulting in anxiety and frustration. Requests for medical attention go unacknowledged or unfulfilled for long periods without communication from staff. PS report a common refrain that Wellpath is “working on it.” PS also report delays of up to multiple weeks in being able to see onsite medical staff—this is especially true of psychiatrists, whom BSH PS describe as being unavailable even when they wish to discuss substantive concerns such as side effects or other issues requiring medication adjustment. Some psychiatrists, even when passing by their patients on BSH units, are reported to ignore their requests to talk, or even to ignore them completely.

Examples of circumstances that PS have described in this reporting period include:

- A PS going without necessary heart medication for over a week upon arrival at BSH, despite reporting his needs to medical staff;
- A PS who came from a county correctional setting where he had been receiving methadone going over three days without his medication after his admission to BSH;
- A PS consistently receiving inappropriate food based on the therapeutic diet he required due to a gastrointestinal condition;
- A PS experiencing reactions to a food allergy and complaining, only to have staff ignore them and wait hours to bring him to the clinic in Lighthouse;
- Multiple PS waiting several weeks to be issued braces for leg injuries, even PS who had a leg brace at the time of their admission; and
- A PS had a painful full body cramp in reaction to medication he received by forced intramuscular injection per an ETO and requested medication that addressed the reaction; he waited four (4) days to receive the medication.

As discussed in DLC’s January 2022 report,⁶⁹ the processes available for PS to access medical care serve as a barrier. PS must rely on TSTs, mental health staff, nursing staff, and other Wellpath personnel who they interact with to convey their concerns or file a formal written grievance to the Persons Served advocate.⁷⁰ In its response to

⁶⁹ DLC January 2022 Report at 30-32.

⁷⁰ DLC strongly recommended in the January 2022 report “that PS be permitted to call the Person Served Advocate and submit grievances over the phone, in person, as well as in a written format, to ensure that those with different communication abilities are able to access the grievance process.” *Id.* at 31. In this reporting period, DOC established a phone line that PS at BSH and the OCCC Units can call and leave a voicemail for the Person Served Advocate.

DLC's report, DOC confirmed that PS can make requests for medical services to nurses, both verbal and written, who are "on every unit, on every shift" and states:

When a Person Served expresses a medical concern, he is assessed immediately. If the issue requests an additional medical referral, the nurse enters the request in [DOC's electronic medical records system], 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.⁷¹

Still, based on the continuing issues described above, there are clearly components of the system that are not working. First, PS with whom DLC spoke are not familiar with a form or other way to submit written requests to a nurse.⁷² In terms of the immediate assessments conducted by extremely busy nurses, perhaps some of them are cursory or flawed. If the nurses are able to uniformly conduct sound assessments and record their requests into the electronic system, as DOC avers, perhaps the delays and lack of response are attributable to the clinic. Whatever the case may be, PS are still reporting difficulty accessing medical care and medical equipment at BSH. Moreover, for PS who have LEP or are experiencing symptoms of a behavioral health condition or other disability related issues that interfere with their ability to succinctly communicate their medical needs, reliance on assessments by rounding nurses to get to the clinic does not provide reliable access.

Recommendations:

DOC and Wellpath must provide more than one avenue for PS to access medical services to ensure that the process is accessible to all PS, including PS with LEP and PS with disabilities that impact their communication abilities.

DOC and Wellpath should adopt a process that allows PS to submit a written request for evaluation and treatment of medical issues directly to a designated member of medical staff.

⁷¹ DOC App. B at 6.

⁷² The relevant BSH policy also makes no mention of a written process. See Bridgewater State Hospital Policy and Procedure Manual – Sick Call (8/10/2021).

5. Daily Barriers to Recovery for Persons Served: Observations of Staff Contact and Access to Programs and Treatment

As DLC has returned to weekly on-site monitoring, we once again focus on the sights, sounds, and smells at BSH. As Wellpath purports to strive for a therapeutic environment of care, PS struggle to focus on recovery while navigating a never-ending bombardment of discomfort, threats, and indignities during their confinement. In addition to the physical plant mold and asbestos contamination discussed above, the 1970s concrete DOC buildings that make up BSH amplify every sound vibration from the correctional metal automatic cell doors to the jingling of keys to unlock treatment rooms. While PS may seek out therapy while confined in this cacophony, only 20% of PS were receiving individual therapy as of June 2022. If PS opt for hydration or a clean change of clothes, they may receive diarrhea and moldy damp clothes instead. Turning to a loved one could be an option, if the shared single phone for the unit of 30 PS is available, functioning and DOC has approved and actually updated your phone list. The strain of these experiences is amplified by ongoing COVID-19 protocols that leave PS isolated for much of the day, including two (2) hours during solitary mealtimes. These COVID-19 protocols, which may foreseeably further destabilize PS with unnecessary isolation, appear to be solely for the convenience of Wellpath at this point. More detailed discussion of the PS experience is attached as Appendix C.

Recommendation:

To fully address the daily barriers to recovery that PS experience, the Commonwealth must immediately place BSH operations as well as the planning, construction, and oversight of the new facility under the authority of DMH to ensure current and future PS access to trauma-informed, person-centered mental health treatment.

6. Persons Served Continuity of Care

With the expanded role granted by Line Item #8900-001, DLC continued to explore discharge from BSH and the transfer of individuals to DOC facilities, county correctional facilities, and DMH facilities, through site visits and discussions with current and former PS, BSH staff and administrators, Sheriff's Department staff and administrators, and family and friends of PS. During this reporting period, in addition to site visits to BSH and the OCCC Units, DLC conducted site visits at two (2) county correctional facilities – Worcester County Jail and House of Corrections and Plymouth County Correctional Facility; and four (4) DMH Hospitals – Taunton State Hospital, Worcester Recovery Center and Hospital, Lemuel Shattuck Hospital, and the Solomon Carter Fuller Mental Health Center.

A majority of former PS interviewed by DLC – whether discharged to a DMH hospital or to a county correctional facility – were told roughly one week prior that they would be transferred to a new facility. Some were told a month before and others were told the day of their transfer. All PS being transferred, regardless of when they received notice of the transfer, only learned the specific facility they would be transferred to either the day before, or the day of, discharge. BSH staff informed DLC that this practice is meant to avoid PS behavioral issues as a result of negative feelings about their destination; of course, this approach may simply defer those issues until after the PS arrives at the destination. Almost unanimously, however, PS reported being unprepared for discharge, not included in discharge planning meetings, and not having an opportunity to ask questions or be briefed on the facility they would next be attending. PS reported that such opportunities would have been helpful with their transition.

A. Continuity of Care: County Correctional Facilities

i. Challenges with Facilitating BSH Transfers

Clinical Coordination and Documentation

Sheriff's Department administrators with whom DLC spoke reported again that the transfer process for BSH PS has improved significantly since DOC instituted the Inter-Facility Case Conference (IFCC) process. Used primarily for PS who are returning to county correctional facilities from outside psychiatric facilities including BSH, the IFCC facilitates helpful – albeit limited – information exchange between sending and receiving facilities. This includes clinical summaries and the answering of basic triage questions, and aids staff in assisting PS in transitioning to the penal environment.

In contrast, for PS who have recently completed competency or criminal responsibility evaluations at BSH and are sent to county correctional facilities from the courthouse, the facility receives no clinical information other than the forensic evaluation, making transition more difficult for the receiving facility and PS.

Formulary Issues

As discussed in DLC's January 2022 report, formulary inconsistencies continue to be a barrier to continuity of care for BSH PS transferring to county correctional facilities.

While administrators cite minimal to no discontinuity at all between medications available at BSH and their facilities, DLC interviewed multiple former BSH PS who reported that medications long shown to be therapeutic for them were immediately discontinued upon arrival at county correctional facilities – even facilities in which Wellpath was the contracted mental health provider.

ii. Access to Treatment for County Correctional Facility Prisoners

In general, county correctional administrators reported seeing BSH as a superior facility for prisoners with behavioral health conditions due to the limited programming and space for appointments in their facilities. Similarly, former BSH PS described an overall lack of meaningful mental health treatment as well as limited contact with clinicians and doctors in correctional facilities.

At county correctional facilities, the primary means of contact with clinicians is mental health rounds. Prisoners shared remarkably similar impressions of mental health rounds, describing them as superficial and ineffective, with clinicians going from cell to cell, quickly asking prisoners how they are doing from outside their doors, responding to nearly every answer with a rote response. Most concerning, individuals described the ease with which mental health staff decide to place someone on Mental Health Watch in these interactions, where they may stay for days with only a “suicide smock” to wear and subject to highly restricted movement and privileges. This practice has a chilling effect on prisoners reporting mental health distress and talking about their feelings—without the fear of being forced into treatment that feels distinctly like punishment.

B. Continuity of Care: DMH Hospitals

i. Challenges with Facilitating BSH Transfers

Through meetings with DMH hospital staff and administrators, DLC heard about the limited amount of time hospitals have to prepare for the arrival of discharged BSH PS. DMH hospitals are informed each Wednesday which BSH PS will attend commitment hearings that day and are usually told the next morning who will be admitted to their facility later that same day. Prior to the COVID-19 pandemic, BSH PS still arrived at hospitals on Thursdays, but in the mornings, during the first shift. Now, the dominance of virtual court – and the requirement to procure the judge’s physical signature prior to commitment – has necessitated this change to late-day admissions, creating additional work for evening hospital staff and forcing PS to go through much the intake process twice – upon their arrival and then when their care team arrives the next day. This puts an undue burden on hospital staff, and complicates the process of admission for PS.

Clinical Coordination and Documentation

DLC spoke with administrators at DMH hospitals about the transition process for BSH PS transferring to a DMH hospital. BSH may initiate an “Enhanced Step-Down” for PS who are deemed to require additional support, such as those who have had long stays at BSH, particularly serious charges, or have been found “not guilty by reason of insanity.” While prior to COVID-19 this process previously involved an in-person visit to

BSH by DMH hospital clinicians to meet the transferring PS and his treatment team, it now involves multiple calls with the involved parties.

Apart from the “Enhanced Step-Down” process, DMH hospitals will sometimes have informal consultations between medical providers for a given PS (referred to as “Doc to Doc” conversations), which are often considered preferable to requesting access to an entire psychiatric record.

Access to documentation can be crucial for staff to facilitate a successful transition, particularly when it allows the receiving facility to better understand recent developments of the PS life and clinical context. However, DMH hospital staff consistently describe the challenges of obtaining records from DOC. When BSH PS step down following a court hearing, DMH hospitals – like county correctional facilities – only receive the most recent forensic evaluation from the court. They do not receive the PS medical history, resulting a significant barrier to continuity in PS mental health and medical care. Additionally, hospitals do not consistently receive BSH PS paperwork related to court-ordered *Rogers* treatment plans before their arrival at the hospital. In short, unless BSH and DMH hospitals have been able to quickly set up communication with a BSH PS treatment team or a “Doc-to-Doc” conversation, the receiving hospitals are initially left in the dark without information crucial to the success of the PS transfer.

Patient Funds

In interviews with PS and DMH hospital staff, issues related to the transfer of patient funds arose repeatedly. Specifically, BSH PS experience significant delays in the transfer of funds held at BSH to their receiving facilities. PS were subsequently unable to purchase needed and/or desired items. DMH hospital administrators also reported difficulty in finding who at BSH to contact for assistance.

Benefits

DMH hospital administrators also reported difficulties assisting transferred BSH PS to obtain MassHealth benefits, resulting in delays in medical and dental care upon arrival. According to administrators, PS arrive at DMH facilities with their status as having not been updated to reflect that they are no longer incarcerated (and thus eligible for full MassHealth benefits). BSH administrators confirmed this challenge, having been contacted by numerous former PS and their caseworkers. This indicates failings in MassHealth’s timely processing of status change, inconsistencies in BSH discharge preparations for PS, or both. Either way, this breakdown leads to delayed treatment, and sometimes delayed discharge from DMH hospitals, for discharged BSH PS due to a lack of health coverage.

ii. Experiences of Transferred BSH PS at DMH Hospitals

Former BSH PS at DMH hospitals uniformly rated their experiences at DMH facilities higher than their experiences at BSH. PS find the food to be improved, the environment to be more peaceful and therapeutic, and enjoy expanded access to programs, their phones and other electronics, musical instruments, and art supplies. A PS with LEP

described markedly improved language access services. PS also appreciated the increased availability of peer support workers and the ability to work on-campus jobs.

Former PS did express two main concerns about their experiences at DMH hospitals concerning access to fresh air and opportunities for community integration. While these issues are not strictly related to continuity of the care that PS receive at BSH, they are vital to former PS continuing to gain independence and opportunities to receive services in the most integrated setting appropriate.⁷³

In interviews, the most frequent complaint former BSH PS shared with DLC pertains to their lack of access to fresh air.⁷⁴ PS at every DMH hospital DLC visited, except for Worcester Hospital and Recovery Center, reported that the norm is fifteen to thirty minutes of outdoor time, once or twice per day. At one facility, when more patients want to go outside, staff divide the group and cutting everyone's time in half. When the weather is cold or windy, former BSH PS report that staff will cut their time short simply because staff doesn't want to wait outside. As such, discharged BSH PS describe themselves as having "cabin fever," one even missing BSH for its daily movements and gym access. At WRCH, conversely, individuals report having access to four (4) hours of outdoor time per day, which they describe as sufficient.

Across facilities, former BSH PS expressed frustration with the lack of access to the community through organized trips and day passes, particularly compared to pre-pandemic practices. Some staff at DMH facilities have still managed to take patients on short off-campus outings, but this is the exception. The maintenance of restrictions presents a challenge to the provision of truly effective recovery-based services and demands an increased commitment to finding creative solutions.

C. Continuity of Care: OCCC Units

During this reporting period, DLC explored issues surrounding about continuity of care for PS in the two OCCC Units – the ISOU, where PS are held during the evaluation period, and the RU for PS who have been committed to BSH. The OCCC Units were designed to serve as an annex to BSH for PS who are sentenced state prisoners living in DOC facilities designated for men. Because the authority to send PS to BSH is tied to the statutory authority under M.G.L. c. 123, § 8(b), the OCCC Units and BSH are supposed to have substantially equivalent to the programs and services. However, there remain stark differences, the most obvious of which is that DOC correctional officers maintain security in the BSH Units, not TSTs. Some of these differences significantly impact continuity of care for PS leaving the OCCC Units to return to the state prison population.

As a general matter, DOC prisoners who engage in the most serious self-harm and suicide attempts end up in the ISOU for evaluation and observation. While some may come directly from their housing unit, many endure a stint on Mental Health Watch

⁷³ See 28 CFR § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.")

⁷⁴ While reasonable access to the outdoors is a fundamental right of patients in DMH facilities, there is no defined amount of time that constitutes minimum reasonable access M.G.L. c. 123, §23.

immediately before their arrival. It is worth highlighting that DOJ issued findings in November 2020, that DOC's failure to provide adequate mental health care and supervision to prisoners in mental health crisis constitutes an Eighth Amendment violation.⁷⁵ Per DOJ's findings, looking only "between July 1, 2018 and August 31, 2019, there were 217 instances of cutting, 85 instances of prisoners inserting objects into their bodies, 77 attempted hanging incidents, 34 instances of ingestion of foreign bodies, and 17 attempted asphyxiations, all on mental health watch."⁷⁶

Current and former PS describe the ISOU as a unit controlled by correctional officers that provides very limited contact with mental health clinicians. Though PS have been quite complimentary of RTAs and occupational therapy staff, they report inadequate access to programming and recreation time still being significantly reduced to accommodate new PS in COVID-19 quarantine. As in past reporting periods, PS have reported correctional officers interfering with Wellpath staff responsibilities and purposely creating conflict in the unit. In addition, PS complain about the lack of air circulation in PS cells and food issues with regularity.

These ISOU conditions – particularly the limited access to clinicians and meaningful programming and intrusive presence of correctional officers – do not promote good outcomes for the majority of ISOU PS who are not committed after evaluation and return to their DOC facility of origin. For PS who stay only for the 30-day observation and evaluation period – often due to a determination that their self-injurious behavior is the result of a personality disorder, rather than a mental illness,⁷⁷ the ISOU does provide a change of scenery, but little else positive according to PS with whom DLC has spoken. This is, to put it mildly, a missed opportunity by DOC and Wellpath to interrupt the cycle of self-harm by prisoners on mental health watch with more intensive treatment than is available to the general population and individualized continuity of care recommendations for DOC facility providers.

PS in the RU at OCCC report a different experience. The RU is a calm unit and PS have access to enhanced programming and treatment in space outside of the unit. PS did not express concerns about their treatment by unit correctional officers or Wellpath staff; most PS were content there. However, DLC did find out about an unfortunate rule that DOC applies to PS in RU that may interfere with their stabilization and continuity of care. Namely, according to information DLC received from a PS and DOC staff, DOC requires that all PS leaving the OCCC Units return to their facility of origin without regard to whether classification to that facility is appropriate at the time of their

⁷⁵ 4 U.S. Department of Justice, *Investigation of the Massachusetts Department of Correction* (November 17, 2020), <https://www.justice.gov/opa/press-release/file/1338071/download>.

⁷⁶ *Id.* at 5-6.

⁷⁷ Based on information DLC receiving during this reporting period, 104 CMR 27.05(1) ("For the purpose of involuntary commitment, mental illness is defined as a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall not include intellectual or developmental disabilities, autism spectrum disorder, traumatic brain injury or psychiatric or behavioral disorders or symptoms due to another medical condition as provided in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), 5th edition...").

discharge. For example, DLC spoke with a PS who was about to complete a successful six-month commitment to the RU and was very concerned about having to return to loud, high stress maximum security facility where he had decompensated. Despite his concerns and the fact that he no longer had points to justify classification to maximum security, DOC's rule required that he go back and await his regularly-schedule classification hearing. After DOC, Wellpath, and this PS have invested time and effort into his stabilization, his discharge plan dictated by DOC's rule did not prioritize the needs of the PS.

Recommendations:

The Commonwealth, through the State Office of Pharmacy Services or otherwise, implement standardized formularies for BSH and county correctional facilities or, at the least, require that special consideration be given to non-formulary mental health medication requests from individuals who have transitioned from the BSH to a county correctional facility

The Commonwealth should commit DMH resources to further DMH engagement with all county correctional facilities to enhance access to mental health care for all county prisoners, including recently discharged BSH PS. Such engagement should include enforcing minimum standards, promoting best practices, and creating working groups to ensure a collaborative approach to care and responsiveness to the needs of this population.

DLC recommends that BSH prioritize direct consultations with DMH hospitals regarding PS who are to be transferred to DMH facilities in advance of their arrival.

DLC strongly urges DMH to take the necessary steps to ensure daily access to the outdoors of at least two (2) hours per day, weather permitting, and provide increased opportunities for community integration for individuals receiving services in DMH hospitals.

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

DOC should reconsider its policy of requiring PS discharged from the RU to return to their facility of origin. Classification to an appropriate setting is a key component of discharge planning and prioritization of continuity of care.

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

Conclusion

To protect the rights, health, and safety of Persons Served at BSH and in the OCCC Units, DLC calls upon DOC, Wellpath, and the Commonwealth to follow the recommendations discussed above in Sections 1 through 6 and restated below:

DISABILITY LAW CENTER RECOMMENDATIONS

1. Physical Plant Health and Safety Risk Updates

DOC must, in short order, complete mold remediation and asbestos abatement throughout BSH in accordance with expert recommendations and industry standards.

DOC must provide to DLC or, alternatively, release publicly detailed information evidencing that: DOC has conducted mold remediation and asbestos abatement in all areas identified by Gordon Mycology and any DOC contracted experts per industry standards; and DOC has conducted air quality testing and lab testing of surface swab indicating that remediation and abatement efforts were successful.

Until DOC provides information evidencing that the health and safety risks have been resolved, DOC and Wellpath BSH must provide regular health screenings for symptoms of mold and environmental toxin exposure to all PS and staff, provided by a contracted health professional with expertise in the area.

The Commonwealth must protect the health of individuals confined to, working in, and visiting BSH by committing to shutter BSH and construct a modern DMH facility designed to provide all individuals in need of “strict security” psychiatric evaluation and/or treatment in a safe, therapeutic environment.

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

2. Illegal and Unreported Restraint and Seclusion

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

The Commonwealth must demand that DOC and Wellpath accurately document and report all uses of chemical restraint, physical restraint, and seclusion in keeping with applicable law and engage DMH or another external party to conduct an in-depth investigation into BSH practices. Without accurate documentation and data concerning restraint and seclusion, the care and treatment PS receive at BSH and in the OCCC Units cannot be measured against the data and standards in DMH facilities.

DLC recommends that, to fully address the restraint and seclusion practices to which PS are subjected, the care of all individuals found to need “strict security” for psychiatric evaluation and/or treatment must be placed under the DMH. Based on DLC’s observations, maintaining DOC’s control over BSH will foreseeably permit variation in both quality of care and compliance with legal requirements.

All policies and practices concerning the involuntary medication, restraint, and seclusion of PS should be amended to conform with DMH regulations and policies, including provisions regarding staff training requirements, tracking less restrictive alternatives, de-escalation efforts, debriefing with PS, and accurately reporting all restraint and seclusion to the Commissioner.

DLC strongly recommends that BSH and DMH commit to tracking and analyzing race/ethnicity data concerning application of restraint and seclusion – including ETOs at BSH – on individuals who are subject to psychiatric hospitalization in the Commonwealth.

Wellpath must prioritize timely creation of Personal Safety Plans upon admission and updating of Plans after every incident of seclusion or restraint to reflect current PS triggers and strategies to help the PS and staff intervene with de-escalation techniques and avoid the use of restraint and seclusion.

3. Insufficient Language Access for Persons Served

The Commonwealth must immediately place BSH operations under the authority of DMH to ensure current and future PS with LEP have access to trauma-informed, person-centered mental health treatment. Until this is accomplished, DOC must ensure that Wellpath takes the following steps to ensure universal access:

- Appoint a Language Access Monitor, who shall oversee and track language access needs;
- Train BSH clinical staff to assess English language proficiency;
- Post notices in multiple languages of rights to language interpreter and translation services, in the BSH booking/intake area as well as on the units;
- Post language cards for PS to identify their language of choice in booking/intake area;
- Recruit bilingual clinical staff and train staff in interpretation for mental health services, offering salary enhancements as needed;
- Train all BSH staff in cultural competency;
- Track the number of PS with LEP and report those numbers to DOC;
- Report the number of bilingual staff and languages spoken;

- Expand group programming offerings in Spanish, Haitian-Creole, and other languages as needed to suit the needs of the BSH population;
- Ensure that PS are aware of available programming offerings in various languages;
- Enhance access to Voyce services and video interpretation technologies, including by improving internet access;
- Ensure that all vital documents and therapeutic tools are translated into PS' preferred language, using quality translation services tailored to mental health services;
- Create a grievance process for language access complaints, to be reviewed by the LAM, and a feedback process for PS with LEP to provide comments to the LAM on their access to LEP services.

4. Limitations on Persons Served Access to Medical Care

DOC and Wellpath must provide more than one avenue for PS to access medical services to ensure that the process is accessible to all PS, including PS with LEP and PS with disabilities that impact their communication abilities.

DOC and Wellpath should adopt a process that allows PS to submit a written request for evaluation and treatment of medical issues directly to a designated member of medical staff.

5. Daily Barriers to Recovery for Persons Served: Observations of Staff Contact and Access to Programs and Treatment

To fully address the daily barriers to recovery that PS experience, the Commonwealth must immediately place BSH operations as well as the planning, construction, and oversight of the new facility under the authority of DMH to ensure current and future PS access to trauma-informed, person-centered mental health treatment.

6. Persons Served Continuity of Care

The Commonwealth, through the State Office of Pharmacy Services or otherwise, implement standardized formularies for BSH and county correctional facilities or, at the least, require that special consideration be given to non-formulary mental health medication requests from individuals who have transitioned from the BSH to a county correctional facility.

The Commonwealth should commit DMH resources to further DMH engagement with all county correctional facilities to enhance access to mental health care for all county prisoners, including recently discharged BSH PS. Such engagement should include enforcing minimum standards, promoting best practices, and creating working groups to ensure a collaborative approach to care and responsiveness to the needs of this population.

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DOC should reconsider its policy of requiring PS discharged from the RU to return to their facility of origin. Classification to an appropriate setting is a key component of discharge planning and prioritization of continuity of care.

DLC recommends that the care of all individuals found to need “strict security” for psychiatric evaluation and/or treatment be placed under the DMH. Based on DLC’s observations, maintaining DOC’s control over BSH will foreseeably permit variation in both quality of care and compliance with legal requirements.

Appendix A: Glossary of Acronyms Used in the Report

| | |
|------|---|
| BSH | Bridgewater State Hospital |
| DDS | Department of Developmental Services |
| DLC | Disability Law Center |
| DMH | Department of Mental Health |
| DOC | Department of Correction |
| DSP | Developmental Services Program |
| ETO | Emergency Treatment Order |
| HESU | Hampden Emergency Stabilization Unit |
| IDO | Irreversible Deterioration Order |
| IM | Intramuscular |
| ITU | Intensive Treatment Unit |
| ISOU | Intensive Stabilization and Observation Unit in the Bridgewater Annex located at Old Colony Correctional Center |
| LEP | Limited English Proficiency |
| LAP | Language Access Plan |
| MESU | Middlesex Emergency Stabilization Unit |
| OCCC | Old Colony Correctional Center |
| PS | Person(s) Served |
| PSP | Persons Safety Plan |
| RTA | Recovery Treatment Assistant |
| RU | Residential Unit in the Bridgewater Annex located at Old Colony Correctional Center |
| TST | Therapeutic Safety Technician |

Appendix B: Department of Correction Response to the January 2022 Disability Law Center Report on Bridgewater State Hospital (March 23, 2022)



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 all 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.

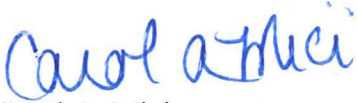
In fact, since the reforms were adopted in 2017, BSH has been operated exclusively by clinical professionals employed by Wellpath under standards applicable to a behavioral health facility. The Joint Commission again certified BSH in July 2021 after finding that BSH meets the Commission's exacting standards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

Appendix C: Daily Life as a Person Served – Observations of Staff Contact and Access to Programs and Treatment

Surely all of those who work at BSH want PS to leave more whole than when they entered, rather than traumatized, fearful, and racked with painful new memories. For this reason, DLC urges DOC, Wellpath, and the Commonwealth to listen to their words. Outside the security trap on Bradford 1 “Treatment with Care and Respect” is painted on the wall. During one interview with DLC, a PS indicated that he wanted to demonstrate something with this image. He walked over to it, read what was written out loud, and remarked: “this is not what they’re doing here.”

Persons Served at BSH do find positive aspects to their experience in the facility such as: building relationships with certain staff members; therapeutic groups; medications that work for them; or merely that it serves as a reprieve from houselessness or their county correctional facility from which they were transferred. However, the vast majority of PS describe their time in the facility in stark terms. PS recognize that they are in a prison, whether by referring to their fellow PS as “inmates” or the treatment they receive as typical “jail treatment.” As one PS lamented, “How I am living is unlike how any patient undergoing psychiatric evaluation should be living.” Another, a former PS and combat veteran, said he had been treated better by his enemies in battle. Of his time at BSH, he said he had “never been treated so badly in my life.”

To amplify the voices of PS, in addition to the areas discussed in the body of the report above, DLC highlights the below issues that may not set off alarms about significant legal, health, and safety issues, but certainly impact quality of life and mental wellness of individuals confined at BSH.

A. Oppressive Environmental Noise

Of particular note when visiting BSH units is the volume. There is the reverberation of PS and staff talking loudly bouncing off the tile walls; the sound of the closing and locking of the heavy carceral doors of PS rooms; the electrified buzzing that accompanies the opening of the unit entrance seemingly every other minute; and the nearly club-volume music coming from the TV in the dayroom— the bass rattling the metal TV encasement as well as the windows of the dayroom. Then there are the intermittent sounds of volatility: the fights between PS or with staff; TST radios being called for backup; the sounds of physical struggles and restraints; and the deadbolts sliding and locking PS into seclusion.

PS frequently report difficulty coping with the volume of the units, especially Bradford 1, and the maximum security units. One PS said the noise made it difficult to sleep and raised his heart rate. Throughout interviews, current PS describe the difficulty of being in such an environment. One former PS described the present quiet of his DMH step-down placement in contrast to BSH as one of the primary advantages of his new environment.

B. Inadequate PS Diet

When asked about quality of life at BSH, some the most common complaints PS raise concern the food: poor quality, limited quantity, and delays in requested special diets received. Countless PS express disappointment in the quality of the food, describing it as “lousy,” “tasteless,” “terrible” and “not cared for.” One PS said it was so revolting that he would sometimes go to sleep without eating; another said he had gone a week only eating snacks because he found it inedible. Still another PS said that the quality of the food was such that no matter how much you eat, you always feel hungry.

An even more consistent complaint is the small meal portion size. PS unanimously say they are unable to receive double portions or seconds beyond what is initially provided, and many are hungry much of time. PS with sufficient funds feel they would go hungry if they were not able to supplement the provided meals with canteen (one PS said he would “starve” if he didn’t have an additional \$30 to spend each week). For those without canteen money, their only options are to rely on negotiating with other PS who have canteen, or to wait for what Wellpath may or may not offer in snacks between meals. Dealing with consistent hunger and feeling insecure about whether there will be enough food has an impact on both individual wellbeing and the likelihood of interpersonal conflict. Choosing to skip inedible meals may also negatively impact health, including medication efficacy and side effects.

DLC has identified BSH’s handling of special diets as an area of concern. BSH staff report that DOC has improved its response time in providing vegan and vegetarian meals to newly admitted PS who have non-religious reasons for their dietary choices. However, these PS are still served standard meals until they demonstrate an outright refusal to eat (for up to four meals, according to some staff) sufficient for medical staff to determine there is a “clinical indication” for the requested food to be provided. Whereas religious diets are granted as an accommodation through a set of faith-specific DOC sincerity questions, those who are vegan, vegetarian, or any other diet for non-religious reasons (even if lifelong, or due to sincere moral beliefs), are subject to a de facto sincerity test of will. PS are forced to choose between being disbelieved because they don’t want to go hungry and short-term starvation in order to overcome institutional suspicion of manipulation. DLC has interviewed numerous PS who had been denied access to their diets of choice (religious or not) for multiple weeks upon admission – their frustration at this denial sometimes leading to restraint, seclusion, and involuntary medication. This is neither trauma-informed care nor person-centered treatment.

C. Limited Access to Individual Therapy

BSH reports that it offers individual therapy to its PS population. Among PS interviewed in the course of DLC’s monitoring, however, the majority reported never having been offered individual therapy. Indeed, according to BSH staff estimates, only a mere 20% of the population at BSH were actively engaged in individual therapy as of the beginning of June 2022. While BSH PS are deemed to be some of the most vulnerable, in-need individuals in the Commonwealth, 80% of them engaged in little more than an optional therapeutic group or so per week, if that. While BSH cannot and should not force PS to participate in any more treatment than they would want for themselves, DLC urges BSH

to make individual therapy more clearly and explicitly available to all PS. Wellpath must thoughtfully and regularly re-prompt and offer individual therapy. BSH staff have acknowledged the need for such changes, and DLC welcomes this.

D. Contaminated Drinking Water, Unpredictable Water Temperature, and Laundry Hygiene Issues

Multiple PS described the quality of the drinking water, particularly on the maximum security units, as poor, and subject to rumors regarding its substandard quality among PS and staff alike. While staff on these units have access to filtered water, PS are forced to drink the water from their room sinks and the hallway water fountain. One PS said that he and others suffered diarrhea from the water; another said that he only drank water at the gym because of the poor quality on the units. DLC heard a variety of complaints around this issue, including that the water “smelled like a swamp,” that it had a “different” flavor, and that it looked “nasty” coming out of the rusty, moldy sink faucets in PS rooms. In a PS Governance meeting, one person raised the issue of the water tasting “heavy” and as if there were particles in it, to which staff responded that the water is tested – and that there is currently an order to put in a filtered water system. It has yet to be installed.

Another consistent complaint, particularly on the maximum units, is the lack of hot water. PS on these units frequently report that showers are cold, or only hot during the day. While showers on the minimum units are more reliable, PS for much of the reporting period faced irregular, mostly cold showers on the most intensive units in the facility. PS reported to DLC that staff would shrug off the issue as a DOC problem or would say they are waiting for a response but would hear nothing for weeks at a time.

Numerous PS, including at PS Governance Meetings, reported that laundry frequently comes back from the laundry service damp, dirty, or late. Additionally, PS are not provided with enough changes of clothes. Especially in the hot days of summer, this could lead to moldy clothes, skin irritation, or other health conditions.

E. Barriers to Phone Access

BSH units each have a single PS phone, meant to accommodate up to thirty PS throughout the day. While staff say that DOC has assured BSH it will install a second phone on each unit in addition to a new fiber optic phone network, this improvement continues to be delayed. In addition, the phone interfaces are known to not be user-friendly, leading to frustration on the part of PS. As evidenced by staff and PS accounts, as well as restraint and seclusion orders, phone access (or lack thereof) continues to be a central culprit in fomenting on-unit conflict.

A related issue is difficulty with PIN numbers for making outside phone calls. DOC contracts with prison communications company Securus to manage phone-related capabilities. Upon admission PS are required to submit a list of 10 legal numbers and five (5) personal numbers they would like to be able to call for their “phone list,” which are subject to confirmation and screening by DOC. Numerous PS report delays of anywhere from three (3) days to over a week in receiving their PINs and thus being able

to make outgoing calls. While this may not seem like a long time, it is critical to recognize that BSH PS – who are not able to receive calls – often arrive at BSH in crisis and being deprived of the ability to reach out to personal supports can be a deeply distressing and destabilizing experience.

F. Disturbing Graffiti on Walls

The walls in numerous rooms in both units of the Bradley building – B-1 and B-2 – have graffiti written on them in pen and crayon. While some is innocuous, other content DLC observed reveal a range of epithets and profanity, gang names, and swastikas – drawn or inscribed. Upon further inquiry, DLC learned that many images had been up for a matter of months without being addressed, or even identified, by staff. In the meantime, PS have expressed felt highly upset being confronted with such images in the cramped rooms, where they are first acclimating to BSH and attempting to gain a sense of safety. DLC has alerted BSH administrators to this issue and commends their plan to address the issue of vandalism in PS rooms.

G. Social Isolation and Purported COVID-19 Precautions

From both observation and the reports of PS, PS are locked for a significant portion of the day to accommodate prison procedures like “count” and shift change. While BSH staff have continually expressed a desire to reopen the cafeteria, and an openness to allowing communal on-unit eating in the dayrooms in the meantime, PS continue to be locked in their rooms for two (2) hours during mealtimes per COVID-19 policies, meaning they sleep, eat, and toilet all in the same small room. The irony of this restriction is particularly pronounced considering that: since June, BSH staff have no longer been required to fill out daily COVID attestation forms upon entry, per DOC; and mask adherence by unit staff is sporadic at best, with many staff wearing their masks below their nose, below their mouth, and not at all. All of these facts communicate an intersecting carelessness around PS health and safety with a selective application of COVID-19 pandemic policies that prioritizes the preferences of Wellpath and its staff over PS.