December 15, 2014

Christine Griffin, Esq.
Executive Director
Disability Law Center
11 Beacon Street, Suite 925
Boston MA 02108

Re: Disability Law Center Investigation of Bridgewater State Hospital

Dear Ms. Griffin,

On behalf of all of the state participants at the meeting, I wanted to thank Attorneys Stan Eichner, Rick Glassman and you for taking the time to meet with us on September 22, 2014, at the Executive Office of Public Safety and Security (EOPSS). As a result of that meeting, and subsequent discussions, this letter is intended to set forth the terms of the Agreement between the Disability Law Center (DLC) and the Commonwealth (Agreement).

The parties agree and acknowledge that this Agreement constitutes the exchange of good and valuable consideration. This Agreement is intended to memorialize the actions that the Commonwealth and its agencies are undertaking and will undertake in response to the July 11, 2014, findings of the Investigation by the DLC regarding Bridgewater State Hospital (BSH), referenced here as the DLC Investigation. It also sets forth the further actions to be taken by DLC regarding its Investigation of BSH. This Agreement is intended to recite the real, substantive changes that have been and continue to be undertaken; to

demonstrate that these changes have lasting structural permanence; and that they are measurable, verifiable and concrete.

This letter also constitutes the agreement of DLC that for a twenty-four month period following the execution of this Agreement, it will not initiate any legal action regarding the findings of its Investigation as long as the actions in this letter take place (or, as appropriate, continue) as set forth below. The parties expressly acknowledge that, notwithstanding DLC's agreement not to initiate any legal action regarding the DLC Investigation as long as the actions in this letter take place, nothing in this Agreement is intended to limit DLC's statutory authority under 42 U.S.C. § 10805(a) or 42 U.S.C. § 15043 as the Protection and Advocacy (P&A) System for Massachusetts to advocate on behalf of individual BSH patients. If, during the pendency of this Agreement, DLC believes that the Commonwealth is in substantial non-compliance with any material provision of this Agreement, DLC shall provide the Commonwealth, in writing, the specific reasons and grounds for such belief, including an identification of the specific provision(s) with which DLC believes there was substantial non-compliance. The purpose of doing so will be to give the Commonwealth a reasonable opportunity to review, discuss and correct any alleged substantial non-compliance. "Substantial non-compliance" shall be defined as failure to follow the terms of this Agreement, provided however, that DLC and the Commonwealth agree that minor, incidental or isolated delays in compliance shall not constitute substantial non-compliance with this Agreement. DLC agrees that it will not, for a period of sixty days after receipt of such notice by the

Commonwealth, file suit in state or federal court. During that sixty-day time period, DLC will meet with the Commonwealth to attempt to address issues of alleged substantial non-compliance. This sixty-day period may be extended by mutual agreement. If the time period is not extended by mutual agreement, DLC may file suit concerning conditions at BSH that are alleged to be in substantial non-compliance with the provisions of this Agreement beginning on the 61st day following the Commonwealth's receipt of notice of alleged substantial non-compliance.

The Office of the Governor, EOPSS and the Massachusetts Department of Correction (DOC) are committed to providing appropriate and quality care for the patients and inmates at BSH. EOPSS and DOC look forward to continuing to work with the DLC and all other constituencies to address the concerns raised by the DLC's Investigation.

As DLC's report noted, this Administration has taken meaningful steps to address concerns that DLC has identified with existing resources, and, where needed, has sought additional resources. The Administration described the steps it has taken, and those it intends to take (at times, contingent upon appropriation and receipt of funding) in a report entitled, "Appropriate Care in the Appropriate Setting: Reforming Bridgewater State Hospital & Strengthening the Commonwealth's Mental Health System." That report and the subsequent legislation filed by the Governor on July 7, 2014 arose out of several meetings with numerous stakeholders, including DLC and other advocacy groups. We are grateful for the recent appropriation of $1.8 million to increase BSH clinical staffing on the off-shifts and weekends, and continue to

push the Legislature for approximately $8 million more in clinical staffing funding.(Details concerning this additional staffing are attached to this letter.) In addition, we are hopeful that the legislature will authorize an enhanced security mental health facility (to be operated by the Department of Mental Health) in the near future, so that BSH may devote its resources to caring for the sentenced patient population.

The following are the specific steps that (1) have already been taken, (2) are ongoing, or (3) will be undertaken (subject to appropriation and receipt of funding). Where appropriate, references to specific DLC recommendations are included.

I. STEPS ALREADY TAKEN:

As discussed during the September 22, 2014 meeting, BSH has taken the following actions to both reduce and prevent the use of seclusion and restraint, and to improve the manner in which it is utilized when it is necessary to do so:

A) Training (Recommendations #2, 18): The DOC has provided continuing training to BSH staff monthly. Specifically, Dr. Joan Gillece, a nationally recognized expert from the National Association of State Mental Health Program Directors (NASMHPD), has provided foundational training to BSH staff on the issues of trauma-informed care. DOC staff trainings — including those coordinated with the Department of Mental Health (DMH) — have built upon that foundation and will continue to do so. By way of illustration, more than 95% of BSH Correction Officers have received competency-based

training on the proper application of restraints and also enhanced training to reduce staff/patient injuries during violent incidents with disruptive patients. Only those trained in the new protocol are authorized to place a patient in restraints. All physicians and registered nurses have received education on preventing and limiting the use of seclusion and restraint.

B) Collaboration Between DOC and DMH: DOC and DMH staff have collaborated on the following:

1) Transition of BSH Patients to DMH (Recommendation #5): DOC and DMH have deepened their historical commitment to work together to step down patients who no longer require treatment in a strict security setting. The prospect of step-downs is discussed each week at BSH in several forums such as Utilization Review, Clinical Reviews and Clinical Case Conferences and reviews prior to the end of a patient's commitment. In addition, BSH Superintendent Veronica Madden met with Dr. Debra Pinals on October 7, 2014, at which a draft protocol entitled "BSH Step Down to DMH Collaborative Care Coordination Plan" was discussed. A revised draft protocol was sent to Dr. Pinals on November 20, 2014, and a final document is expected by January 15, 2014.

2) Cool-Down Rooms and Other Safe Therapeutic Environments (Recommendation #21): An environmental scan of BSH has resulted in recommendations to improve the environment of care. On September 19, 2014, Dr. Janice LeBel and Dr. Debra Pinals spent the day at BSH completing the environmental scan, interviewing staff and patients, and observing BSH operational procedures. The report on the environmental scan has

been completed and is undergoing final review by DMH. In addition, former BSH Superintendent Robert Murphy visited both the Worcester Recovery Center and Hospital and the Lemuel Shattuck Hospital DMH facility to gather information regarding the use of these and other interventions by those DMH facilities.

BSH will spend up to $500,000 to improve the environment of care, including, but not limited to, infrastructural improvements. In particular, BSH policy allows for use of “quiet rooms” by patients; however, the only rooms currently available for such purposes are the patients’ own rooms. As part of the planned improvements, two BSH Performance Improvement Teams have identified two separate rooms on each unit for such purposes: one for use as a quiet room, and another for use as a "comfort” or "sensory” room, which will have specialized sensory equipment and electronics that will simulate relaxing environments. BSH believes that the planned quiet rooms can be created with existing resources, while comfort/sensory rooms will require some additional funding.

The quiet rooms will be created from the diversion of certain existing patient rooms, in which the beds will be removed; rooms painted, including a chalkboard wall; and the rooms furnished with stress reduction items, including weighted blankets, comfortable chairs, sensory carts and noise reduction headphones. These patient rooms have already been identified and the beds have been been removed from the A1, A2, B1, B2, C1, and both Max Units. Painting of these rooms was completed on December 5, 2014. Furnishings have been identified and their purchase is

in process. The projected completion date for these quiet rooms is December 31, 2014.

Comfort rooms will be created from identified dorm rooms that currently hold six beds each. Beds in the A1, A2, B2, and C1 Units have been removed as of November 19, 2014. Space for comfort rooms for the Max and B1 Units will require some additional re-purposing of rooms. These rooms will then be painted and furnished with specialized furniture, massage chairs, TV/audio stations and a projector, noise reduction head phones, games, soft keyboards and other stress reducing furnishings. The identification and purchase of these furnishings are underway; a detailed cost estimate is not available at this time. The comfort rooms will most likely be completed in a staggered fashion in early 2015.

3) Training Initiatives (Recommendation #18): The development of training and education has assisted all staff in improving de-escalation techniques and preventing the use of seclusion and restraint. This training continues. Dr. LeBel is developing and scheduling training for BSH executive staff members on the Six Core Strategies outlined in Dr. Gillece's Trauma-Informed Care model. Training for these executive staff members was completed as of November 21, 2014. Additionally, on October 30, 2014, the Disabled Persons Protection Commission completed three training sessions that were attended by more than 100 multidisciplinary staff. Following that training, BSH has begun to develop a broader training plan, and will notify DLC regarding the specifics of that training plan. Superintendent Madden is engaging in further

training efforts for the future by costing out an additional sixth day of in service training for BSH staff, subject to collective bargaining and receipt of funding. The goal is to train BSH clinical and correctional staff together as a standard approach going forward. In addition, BSH Occupational Therapist and Rehabilitation staff members visited the Worcester Recovery Center, where they consulted with DMH Occupational Therapy staff in order to share best practices that can be implemented at BSH.

4) Sharing of Policies: BSH and DMH are sharing policies and procedures regarding patients' rights and responsibilities. BSH is considering the degree to which these DMH policies can be adapted for use at BSH. In addition, BSH Superintendent Veronica Madden has met with DMH to review policies and procedures of both BSH and DMH regarding the transition of BSH patients to DMH. BSH will provide status reports to DLC on no less than a quarterly basis, regarding further review of DMH policies, and implementation of any aspects of these policies.

5) Data Collection: BSH has consulted with DMH's Assistant Commissioner of Quality Utilization and Analysis on seclusion and restraint data collection; DMH has shared its seclusion and restraint collection and reporting methods with BSH. Ongoing consultations will have to take into account that DMH will shortly be converting to different software for its electronic health records. In the meantime, a BSH Data Workgroup has been developed; BSH Deputy Superintendent Denise McDonough is the chairperson of this Workgroup. In addition, on November 3, 2014, Terri Anderson, DMH

Assistant Commissioner for Quality, Utilization and Analysis met at BSH with Superintendent Madden, Deputy Superintendent McDonough and Records staff regarding Seclusion and Restraint Data. Staff from the DOC Research Division and BSH have met and are in communication to discuss additional support from the DOC Central Office regarding incorporating BSH-specific data needs into existing databases. Finally, an Electronic Health Record Workgroup was developed and has held one meeting; another meeting is scheduled shortly. This workgroup will continue to work to improve seclusion and restraint reports using methods similar to those utilized by DMH.

C) Reduction in Seclusion and Restraint: In calendar year 2013, the total number of seclusion hours per 1000 patient days was 137,660, and the total number of restraint hours per 1000 patient days was 11,110. During the period from January through August 2014, the use of seclusion has been reduced by 68%. During that same time period, the use of restraint was reduced by 86%. BSH will continue to use its best efforts to maintain seclusion and restraint at levels consistent with the January through August 2014 average rates.

D) BSH has replaced the previous restraint beds by installing the Humane Restraint System — namely, a large, padded, more comfortable restraint bed, in the Intensive Treatment Unit (ITU). The BSH seclusion and restraint policy (which, as indicated below, is currently being revised for issuance as 103 DOC 651) will indicate that only those staff who have undergone specific training are permitted to use this equipment.

E) As a result of the installation of the Humane Restraint

System, BSH has discontinued use of five-point restraints, as reflected in the amendments to ITU Post Orders on May 15, 2014. (The discontinuation of the use of five-point restraints will also be reflected in the revised BSH seclusion and restraint policy.)

F) BSH has increased infirmary staffing so that special treatment plans can be utilized for a small number of patients in order to forestall or address behaviors that they typically exhibited, and which might previously have resulted in the use of seclusion or restraint.

A full time mental health professional was added approximately four months ago to meet the need. Furthermore, additional Massachusetts Partnership for Correctional Healthcare (MPCH) clinical staff have been hired as a result of the recent legislative approval of $1.8 million. (See attached.) As set forth below, and subject to the appropriation and receipt of funds, the special treatment plans may be developed for less acute patients with expanded clinical staffing.

G) Ongoing assessment of seclusion and restraint (Recommendation #14). Effective August 25, 2014:

1) Patients in seclusion are now evaluated by a clinician every two hours (rather than the previous practice of every three hours). BSH is working on reducing the time between rounds of clinicians evaluating patients in seclusion by doctors and nurses.

2) Patients in restraint are currently being evaluated by a clinician every hour (rather than the previous practice of every two hours), subject to continuing need.

3) These changes have recently been implemented by

MPCH. Although they exceed the frequency of the evaluations called for by both statute and BSH policy, MPCH will make ongoing efforts, subject to staffing levels, to maintain this frequency of evaluations.

H) BSH has provided uninterrupted clinical coverage until 10 PM, seven days a week, on units for crisis intervention.

I) Effective September 2, 2014, the BSH A-1 Unit now functions as a "Step Down" unit for Max Unit patients. This step down program is intended to prevent the decompensation, and possible need for seclusion or restraint, of Max Unit patients who are transitioning to a minimum housing unit.

II. ONGOING EFFORTS:

A) Compliance with G.L. c. 123, §21, and Development of Protocols (Recommendations #13, 14): BSH, like other DOC facilities, focuses on the treatment of patients' mental health needs and the ability to assist them in the least restrictive setting. Multiple procedural enhancements continue to be made at BSH in order to further this goal.

B) Training Initiatives (Recommendation #18): All BSH staff are currently receiving training titled, "Acute Intervention Strategies," which is trauma-informed and focuses on how to attempt to manage difficult patient behaviors on the housing units without transfer to the Intensive Treatment Unit. This training is provided to every DOC and MPCH employee working at BSH during the annual in-service site specific training week. This training has been provided for the past few years and will continue to be a permanent course of the training curriculum.

C) Cool Down Rooms and Other Safe Therapeutic Environments

(Recommendation #21): Two Performance Improvement Committees are actively focusing on defining alternatives to seclusion and restraint, and improving the environment of care. Their recommendations, which are likely to include infrastructural improvements, will be adopted to the extent of available funding.

D) Correction officers are routinely attending and participating in unit rounds and patient treatment team meetings. Their participation is tracked by the administrative captain and reported to the BSH Superintendent on at least a weekly basis.

E) Discharges to DMH (Recommendation #5): DOC and DMH have had a long-standing working relationship tailored to ensure that, where appropriate, patients are discharged from the secure BSH setting to a less restrictive DMH setting. The relevant practices underlying this relationship are set forth in the 2010 Memorandum of Understanding (MOU) between the DOC and DMH. For many years, a DMH-funded forensic psychologist has been assigned to work at BSH to facilitate transfers of patients to DMH facilities, where appropriate. DOC and DMH have taken steps to enhance this coordination by developing a policy for enhanced clinical communications between DMH and BSH clinicians as soon as patients are identified as possible candidates for transfer to DMH. As noted earlier, this protocol was discussed in a meeting with Dr. Pinals of DMH, then revised by DOC and sent to Dr. Pinals with changes on November 20, 2014. Finalization is expected shortly. These enhanced communications ensure that clinicians from DMH and BSH share the patient’s treatment history and focus on specific interventions that were most successful. This ensures continuity of care and the best outcomes for each patient under consideration for

transfer to DMH. Additionally, and where feasible, clinical staff from the receiving DMH facility meet with the patient and his Treatment Team at BSH prior to the step-down. BSH continues to have the DMH liaison actively involved in the step-down process. At present, DOC and DMH are in frequent contact to identify individuals who may be appropriately transitioned to DMH care, and to discuss the treatment plans for those patients who may be stepped down in the near future.

F) Treatment of Strict Security Patients at DMH Facilities (Recommendation #6): On July 7, 2014, the Governor filed legislation asking the Legislature to create an enhanced security mental health facility to be operated by DMH, where certain sentenced inmates in need of inpatient mental health care would be treated absent a judicial finding that the particular sentenced inmate could not be safely treated except in a correctional setting. The Administration continues to support this approach. Indeed, the Division of Capital Asset Management and Maintenance (DCAMM) is working together with DOC and DMH to determine where and how such an enhanced security mental health facility may be developed. (A firm has been hired for site selection; DOC and DMH are working with this firm on the process, and a report on feasibility will be available on or about December 18, 2014.) Until a site for the enhanced security mental health facility is developed, and until G.L. c. 123 is revised as the Governor has proposed, the Commonwealth believes that BSH remains the most appropriate facility for certain sentenced inmates.

G) Treatment of BSH patients with cognitive or intellectual disabilities by the Department of Developmental Services (DDS) or DMH (Recommendation #7): BSH administration met

with the DDS on September 9, 2014 to develop a collaborative relationship that will benefit the four (4) patients at BSH who have been identified as DDS clients. It was agreed that DDS would come to BSH and facilitate training for BSH clinicians regarding DDS services and the referral process for any new potential clients. Where appropriate, the DOC, in collaboration with DDS and/or DMH, will develop transition plans for existing BSH patients who are eligible for DDS services to step down to a less restrictive setting. The transition plans will take into account the eligibility of patients for those facilities based on their requirements for security risk, presentation of symptoms, diagnosis, mental health status, and cognitive developmental status. On or before December 19, 2014, DDS will designate an employee responsible for coordinating assessments of BSH patients and, where appropriate, the delivery of services to said patients; that employee will serve as the primary point of contact for the DOC and DLC. DOC and DLC will coordinate in good faith to determine under what circumstances patients will be referred to DDS for assessment. BSH and DDS also discussed the potential for an MOU between the two agencies. If such an MOU is developed, BSH will attempt to include elements of identification and assessment.

H) Prohibiting improper use of seclusion and restraint (Recommendations #12, 13): The use of seclusion and restraint at BSH is a clinical decision that is governed by G.L. c. 123, § 21. It is the Commonwealth's position that neither seclusion nor restraint is used for punishment, convenience, routine discipline or failing to take non-court ordered medication. BSH is committed to ensuring that the law — and the policies that stem from it — are

followed, and that neither seclusion nor restraint is misused. Accordingly, seclusion and restraint usage at BSH is closely monitored by the BSH Medical Director and the DOC Health Services Division. All staff are provided with an initial orientation on statutory limitations and the definition of seclusion and restraint. Additionally, ongoing training on positive behavioral interventions for seclusion and restraint will be provided for staff with a curriculum that includes:

1) Identifying the impact of seclusion and restraint through the lens of the patient.
2) Recognizing trauma and its impact on patients.
3) Creating cultural change by identifying and addressing the myths of mental illness.
4) Case study review and hands on activities based on real stories.

I) Ongoing assessment of seclusion and restraint (Recommendation #14): The BSH Seclusion and Restraint Policy is currently being significantly revised to ensure that seclusion or restraint is only being used in instances in which clinicians have accurately documented that it is justified under G.L. c. 123, § 21. The revised policy (103 DOC 651) will be implemented on or before January 15, 2015.
J) Increased Clinical Staffing: Ensuring that use of seclusion or restraint is based only on recommendations of clinical staff (Recommendation #15): The above-mentioned approval of $1.8 million, and the ongoing implementation of enhanced clinical staffing on evenings and weekends, will reinforce the understanding that the use of seclusion and restraint at BSH is a clinical decision. This is always a point of emphasis to the correctional staff, and has been a focus of increased training. By policy and practice, in

those instances where staffing (and requisite allocation and receipt of funding) allows, assessments are done in the housing units by clinical staff. Where such on-unit assessments are not possible, patients in emergent states are escorted to an area in the ITU by correction officers where such assessments occur. In all instances, the determination of whether to seclude or restrain a patient rests with the psychiatrist or nurse performing the assessment.

K) Improved services provided by Specially Trained Observers (Recommendation # 16): Existing BSH policy and procedures ensure that every patient in seclusion or restraint is assigned to one of the Specially Trained Observers (STO) to understand, assist and reinforce treatment goals, either personally or by calling for the assistance of appropriate clinical staff. If an STO is not available, clinical staff must notify the Superintendent and Medical Director, and an incident report must be submitted for immediate corrective action. The specialized training that STO's receive regarding seclusion and restraint procedures has been augmented to include interactions with the patient focused on goal-setting aimed at assisting the patient in his reentry into the general population, by explaining to him the process by which he can achieve release from seclusion or restraint. A new clinical procedure is in place to document and assure that every patient understands (when feasible) why he was placed into seclusion or restraint and what clinical goal must be met for discontinuation of the seclusion and/or restraint order.

L) Provision of Individual Crisis Plans and other alternatives to restraint and seclusion, including comfort

rooms and sensory items, and debriefing patients when restraint or seclusion is used; adoption of trauma-informed care practices designed to eliminate the use of restraint and seclusion (Recommendation #17): MPCH is in the process of hiring clinical staff to develop, where appropriate, Individual Crisis Prevention (ICP)Plans which shall be age and developmentally appropriate and which shall identify triggers that may signal or lead to agitation or distress in committed patients. These ICP plans shall also identify patient specific strategies to help patients and BSH staff (both correctional and clinical staff) intervene with de-escalation techniques to reduce agitation and distress so as to decrease and/or avoid the use of seclusion or restraint. Very often patients are able to articulate interventions that will help calm them during periods of agitation and anxiety. These interventions, when applicable, will be articulated in the ICP Plan.

M) Training Improvements (Recommendation #18): DOC is implementing approaches utilized by national and local experts, including Dr. Gillece and the DMH Director of Systems Transformation, Janice LeBel, Ph.D. There is a training committee at BSH, to which BSH Superintendent Madden has added some members and will be scheduling a meeting. The committee will outline all training now provided at BSH; will assess efficacy/necessity of what is currently offered; review suggestions for new training; compile relevant and necessary curricula and develop a plan for how all necessary training can be integrated. On November 21, 2014, Dr. Janice LeBel presented a two hour overview of the Six Core Strategies for Reducing Seclusion and Restraint to multidisciplinary senior leadership staff at BSH to ascertain the feasibility of implementing these

strategies at BSH. The favorable response from the BSH leadership team has resulted in a request for a full presentation to them. An early January, 2015 date for this presentation is anticipated. BSH will continue to incorporate trauma informed patient centered care. The training agenda has included (or will include):

1) Understanding mental health, including an analysis of causes;

2) Understanding the consequences of trauma, including behavior responses;

3) Detailed review and explanation of the law and DOC policy as it relates to seclusion and restraint practices;

4) Emphasizing the consequences for inappropriate uses of seclusion and restraint, patient abuse, and mandated reporting requirements;

5) Goal setting to help staff and patients recognize positive behavior changes, leading to improved health outcomes (medical and mental health); and

6) “What’s in Your Toolbox?” - a discussion of tools, resources, skills, knowledge and abilities required and available to manage patients in place of resorting to seclusion and restraint.

N) Implementation of Exercise for Seclusion Patients (Recommendation #19): BSH protocol now requires that when clinically indicated, all patients in the ITU for longer than 24 hours are clinically evaluated for several interventions such as fresh air, occupational therapy activities, and music/reading opportunities. Unless clinically contraindicated, therapeutic recreation is provided for such ITU patients within the Max Unit Yard. (This is a temporary alternative until security

modifications are completed in the ITU Yard.) The recreation period is for one hour daily.

O) Establishment of "Cool Down" Rooms or other safe therapeutic spaces on residential units (Recommendation #21): Senior DMH officials — Assistant Commissioner Debra Pinals, MD and Dr. Janice LeBel — conducted an environmental scan of BSH on May 27, 2014 to determine where and how the environment of care (including alternatives to seclusion and restraint) can be improved. The DOC and DMH have set meetings to identify and address the dual mission of BSH and how best to retrofit the current infrastructure to accommodate treatment alternatives. Improvement to the environment of care will include a plan to make immediate changes as well as proposals for longer range plans. BSH has identified potential rooms that can be converted to "cool down" space with cost estimates and feasibility of funding in house. The infrastructural cost of establishing comfort rooms or other therapeutic spaces should be covered by the $500,000 in capital money allocated to infrastructural improvements at BSH. In addition, new therapeutic options have been implemented at BSH, including, for example, sensory integration and the use of weighted blankets and vests.

P) Suicide prevention efforts at BSH; capital expenditures for mitigation of suicide risks (Recommendation #22): BSH has previously benefited from independent consultants' reports (e.g., a 2000 report by Lindsay Hayes (and others) of the National Center on Institutions and Alternatives (NCIA)) regarding suicide prevention. In addition, BSH is currently developing Performance Improvement Teams whose responsibility will be to identify and define interventions that are conducive to the mental health population housed

at BSH, with an emphasis on suicide prevention.

Q) Continuity of treatment care (Recommendation # 23): The safety, health and well-being of BSH patients are the principal goals of any patient transfer. BSH staff and personnel provide a baseline mental health screening examination and transfer plan for the patient to the unit before transfer. An appropriate medical/mental health summary accompanies the patient to the receiving unit/provider. The transferring provider informs the patient of the decision and rationale for the transfer and documents this in the medical record. Before each transfer, the patient’s response and consent, if applicable, is obtained and documented.

R) Establishment of a protocol for external peer review (Recommendation #24): A protocol will be added into the 103 DOC 650 (Mental Health) policy, requiring that the DOC’s Director of Behavioral Health and MPCH’s Director of Clinical Programs be notified and consulted in instances when (a) a patient has been admitted to the ITU four or more times in a one week period, or (b) a patient remains on seclusion status or discontinuation status in the ITU for more than seventy-two (72) consecutive hours. The Director of Behavioral Health and the Director of Clinical Programs will consult and determine if a multi-disciplinary case conference should be scheduled to further review the treatment plan in place and to suggest any appropriate revisions to the current plan. They may recommend that an outside consultant be retained to provide assistance, subject to appropriation and receipt of funding.

III. ACTIONS TO BE TAKEN:

A) Upon completion of its revisions, the seclusion and

restraint policy – 103 DOC 651- will be implemented as a DOC policy rather than the current institutional procedure (103 DOC 651). It is anticipated that this revised policy will be implemented no later than January 15, 2014.

B) A new (non-contact) visiting room will be constructed in the Administration Building in order to facilitate special visits for seclusion patients.

C) Modification of Use of Force regulations (Recommendation # 27): Current DOC policies related to Use of Force were reviewed. The DOC is confident these policies sufficiently address a patient's mental health needs when the patient has been identified as having any special needs. Any specific language changes in these regulations that DLC may suggest will be reviewed and considered.

D) Human Rights Officer (Recommendation #28): The DOC has consulted with DMH regarding how to incorporate aspects of DMH's human rights officers and committees (104 CMR 27.14) into the framework of a DOC facility. DOC suggests that this can best be done by establishing independent reviews as part of the existing grievance procedures at BSH. BSH patients have the ability to submit grievances pursuant to both DOC regulations (103 CMR 491) (grievances are limited to addressing access to medical and mental health care) and MPCH policy (RI. 3.1) (regarding medical and mental health care decisions). DOC suggests that the DLC, through its designated Monitor (discussed below) can participate, in an advisory role, in monthly reviews of these patient grievances as part of the appellate review process for both types of grievances, in order to both remedy individual issues and to identify broader issues and trends involving BSH patient care. In this advisory role, DLC will not be the decision-maker regarding individual grievances, but

will provide suggestions for addressing the issues raised. E) Monitoring Period (Recommendation #29): The DOC will provide the DLC with data (a list of this data is attached hereto) that is submitted to the DOC Governing Body, which, as mandated by the Joint Commission, reviews most of the above-mentioned documents. Such data includes detailed analysis of seclusion and restraint incidents, and injurious and self-injurious behaviors by patients. The DLC, pursuant to its statutory authority as a P&A System, shall also be provided with copies of any completed Mortality Reviews for deaths of BSH patients, as well as informed of any deaths that occur at BSH, regardless of whether a DOC official opts to waive performance of a mortality review. The DLC shall designate a DLC employee as its Monitor. The DLC Monitor will monitor the use of seclusion and restraint in accordance with G.L. c. 123, § 21 and the terms of this Agreement. If the terms of the Agreement are satisfied, the DLC Monitor's role shall terminate twenty-four months after execution of this Agreement. Provisions in this Agreement relating to monitoring are intended to facilitate and clarify DLC's role pursuant to its statutory authority (42 U.S.C. §§ 10805 and 15043) as the P&A System and shall not create any duty or liability to any entity or individual. The DOC shall provide a suitable working space at BSH for the DLC Monitor. Nothing in this Agreement shall restrict or limit DLC from exercising its independent statutory authority as the designated P&A Agency in Massachusetts, including rights to access materials and/or individuals pursuant to its P&A authority, including 42 U.S.C. §§ 10805 and 15043. In addition to whatever materials might be obtained by DLC under its federal P&A authority, including 42 U.S.C. §§

10805 and 15043, the DLC Monitor shall have access to records and patients with the consent of the patient or his legally appointed guardian. To the extent required by law for such access, BSH staff shall facilitate consent of the patients or their legally appointed guardians.

F) The Commonwealth agrees to pay DLC a total of $250,000 to settle DLC's claim for attorney's fees and costs arising out of its investigation of BSH. DLC agrees not to seek further fees and costs with respect to work performed prior to the date of this Agreement. DLC will devote this payment to support the Monitor as described above. This paragraph is subject to appropriation. On or before December 31, 2014, the Commonwealth will pay $40,000 to DLC, and will submit all required documentation to the Office of the Comptroller for payment of the remaining $210,000 pursuant to 815 Code Mass. Regs. § 5.00, et seq. Any action taken by the Executive Branch to interfere with full payment of the remaining $210,000 by the Office of the Comptroller shall constitute a material breach of this Agreement.

G) The parties to this Agreement expressly acknowledge that in the event that the provisions of G.L. c. 123, § 21, or any other relevant statute are amended, the Commonwealth and BSH shall be governed by provisions of the amended statutes (and any policies implementing those amended statutes), rather than the statutory provisions (and implementing policies) that exist at the time of this Agreement.

This Agreement is effective as of the date of execution by all parties. It may be executed as counterparts, each of which, when executed and delivered to all parties, shall be

an original. A signature made on a faxed or electronically mailed copy of this Agreement shall be given effect.

M. Patrick Moore, Jr., Deputy Legal Counsel   Date: 12.15.20

Office of the Governor

State House, Room 271

Boston, MA

Andrea Cabral, Secretary   Date: 12/15/1

Executive Office of Public Safety & Security

One Ashburton Place, Room 2133

Boston, MA 02108

Carol Higgins O'Brien, Commissioner   Date: 12.15.14

Massachusetts Department of Correction

50 Maple Street, Suite 3

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Christine Griffin, Executive Director   Date: 12/15/

Disability Law Center

11 Beacon Street, Suite 925

Boston, MA 02108

ATTACHMENT A

DETAILS REGARDING ADDITIONAL BSH STAFFING

With the recently allocated $1.8 million, BSH is currently filling 19.6 FTE positions. These positions will be utilized for additional clinical staffing during evenings and weekends, as required by the Joint Commission. Many of these new employees underwent New Employee Orientation training the week of November 3-7, 2014. Further details regarding these positions, and those clinical positions that would be filled should the remaining $8.2 million be appropriated, are contained on the attached spreadsheets.

ATTACHMENT B

DATA PROVIDED TO GOVERNING BODY

1. Seclusion Hours
2. Restraint Hours
3. Seclusion and Restraint Hours
4. Patient Assaults and Fights
5. Staff Assaults
6. Self-Injurious Behavior and Suicide Attempts
7. Patient Falls
8. Medical Emergencies
9. Incident Report Summary

This data is provided in a variety of formats, including raw data, and monthly, over two-year period per 1,000 Patient Days and will be shared with the DLC Monitor on a periodic basis no less frequently than monthly.