



## Disability Law Center

Massachusetts Protection and Advocacy

### ***A Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital***



*Exterior barbed wire fence and exterior sign at Bridgewater State Hospital.*

***A Report to the President of the Senate, the Speaker of the House of Representatives, and the Chairs of the Joint Committee on Mental Health Substance Use and Recovery, the Joint Committee on the Judiciary, the Senate Ways and Means Committee, and the House Ways and Means Committee, submitted pursuant to the FY 2018 Budget (Acts of 2017, Chapter 47, Item #8900-0001.)***

**May 18, 2018**

## Introduction and Overview:

Two days ago, on May 16, 2018, Bridgewater State Hospital celebrated the one year anniversary of CCRS being the provider of services and programs at BSH. This event reflected a tremendous culture shift at BSH, and probably most significantly a deeper commitment to treatment, rather than punishment for the men at Bridgewater State Hospital.

Much positive change, both big and small has occurred at Bridgewater, from the closing of the inaptly named, Intensive Treatment Unit (ITU) to allowing men to wear their own clothes. CCRS has reinstated a GED program for PS, worked to increase available jobs for PS and offered ear plugs to PS to help them sleep at night. CCRS has hired a Patient Advocate to resolve PS issues and help with filing grievances.

CCRS has updated over 200 policies at BSH and revamped the PS Handbook to be much more user friendly and welcoming. A Governance Committee has been formed. Recognizing the key role that family members can play in a person's recovery, CCRS has hired a Family Engagement Specialist to improve communication with families and friends of PS and to help with the continuity of care at BSH.

DLC wholeheartedly commends CCRS on the wide variety of improvements CCRS has produced, but as CCRS itself acknowledges, the challenges of transforming BSH were even greater than they had anticipated. This is especially true where CCRS must depend upon other agencies and organizations to address an issue fully. Achieving a complete culture shift requires time. This Report sets forth a series of concerns, the changes that have been made, and what still needs to be monitored going forward.

## Extent of Monitoring Effort:

During the period from July 1, 2017 through May 18, 2018, the date of this Report, DLC staff were on site 109 days. Throughout this time, CCRS afforded DLC broad and unhindered access to a range of different meetings, including the morning Safety Huddle, quarterly Governing Body meetings, DOC-DMH quarterly meetings, as well as a wide variety of other meetings and events, including the newly formed Governance meeting. This significant presence on the grounds of BSH and OCCC was particularly important during this period, as there were changes in the overwhelming majority of the senior positions within DOC and CCRS leadership staff.

## Physical Plant:

The physical plant and infrastructure at BSH continually poses challenges both to the safety and well-being of PS and staff. BSH was not designed by current day mental health facility standards and PS and staff are at heightened risk for injury because of the outdated and unsafe physical plant issues.

Temperature control is a constant problem both in individual rooms and in common areas. For example, broken air conditioning units cause temperatures where medication is stored to jeopardize its efficacy, while making working conditions hazardous. Overheating in common areas in the summer time causes walls to sweat and drip causing dangerous slippery conditions and increased health hazards for PS and staff. Overheating has also jeopardized camera equipment and created at least one instance of a fire scare in the Lighthouse. Following a particularly harsh winter and several storms, many of the buildings at BSH continue to have roof leaks that impact areas for both PS and staff.

On any given day at BSH, one may find broken doors, clogged toilets, loose hinges, damaged fences, missing bolts, broken security cameras, missing tiles, falling ceilings, painted over air vents, and a litany of other things due to both the age and use of the facility.

CCRS has begun to repair some of the residential buildings, but overall the physical plant cannot be made conducive to the overall mission and philosophy of treatment and recovery.

## Administration of Medication Issues:

CCRS has been very successful, since it began its work at BSH, drastically reducing the seclusion and restraint of Persons Served (“PS”). Beginning with the closure of the Intensive Treatment Unit, and continuing with the treatment of PS on and off the housing units, which has involved a serious culture shift throughout the hospital, mechanical restraint is now almost nonexistent and seclusion has been significantly reduced. While some months are better than others, DLC notes and commends this effort by CCRS towards the continued substantial reduction of seclusion and restraint.

While seclusion and mechanical restraint events have been significantly reduced, an issue of concern that has arisen for DLC is the use of involuntary administration of psychotropic medication to Persons Served, without a court order. Massachusetts law provides for two circumstances in which medication can be administered involuntarily, and without a court order following a substituted judgment process. *Rogers v. Commissioner of the Department of Mental Health*, 390 Mass. 489, 510-511 (1983). The first is under the state’s “police power” as a chemical restraint, to prevent an imminent threat of harm to oneself or others, where there is no less intrusive alternative available. This is currently permitted in DMH facilities<sup>i</sup> but not at BSH.<sup>ii</sup> The second is pursuant to the state’s “parens patriae” powers, which permit the state to administer medication involuntarily as an emergency treatment order, but only on a temporary basis until a court hearing can be held, and where the patient otherwise faces an “immediate, substantial and irreversible deterioration of a serious mental illness.” *Id.*

CCRS refers to orders for involuntary medication of PS who are exhibiting behaviors that pose imminent danger to self or others, as Emergency Treatment Orders (ETOs). CCRS is not counting these involuntary medication orders as restraints, although they would appear to fall within the definition of a chemical restraint under G.L. c. 123. By this definition, there is a question as to whether the Emergency Treatment Orders, as they appear to be currently used and labeled at BSH, are in compliance with the relevant law.

During our monitoring activities, DLC staff has attended meetings where these ETOs are discussed. We have also seen them referred to in different documentation that we have reviewed, such as Incident Reports and/or Nursing Reports. They typically involve a Person Served exhibiting dangerous behavior or threatening behavior, and an order being entered for involuntary intra-muscular medication to be administered. These orders generally involve a combination of Haldol, Ativan, Benadryl and/or Thorazine, which are typically the medications used to restrain psychiatric patients in mental health facilities, and which are considered a medication or chemical restraint per the above laws and regulations.

CCRS has its own **Use of Seclusion and Restraint (PC 400-08)** policy, which DLC understands is currently being updated. In reviewing the latest version provided to us, we note a few areas of concern with regards to this issue of ETOs versus medication restraint.

Section 3.3.1 includes: “NOTE: The only behavior that can justify the use of seclusion or restraint is imminent danger to self or others or a manual hold for involuntary medications **based on a finding of imminent danger** or irreversible decline as determined by the physician/LIP.” (emphasis added). This seems to indicate that involuntary medication based on a finding of imminent danger is considered appropriate, and that the manual hold that may be required for the administration of said involuntary medications is considered a restraint, but not the actual administration of medication.

Section 4.1.1 of this same policy refers to, and appears to adopt at least in part the restraint and seclusion standard contained in G.L. c. 123, section 21. Further, section 4.1.2 of this same CCRS policy defines Chemical Restraint as “a drug or medication used as a restriction to manage the persons served behavior or restrict the persons served freedom of movement, and is not the standard treatment or dosage for the persons served condition. Chemical restraint, known as Medication Restraint, is not used at Bridgewater State Hospital.”

To be clear, DLC is not against the use of medication when necessary to treat and alleviate dangerous behaviors associated with the serious mental illnesses with which PS are living. DLC intends to identify this issue of concern to CCRS and work with them to come up with appropriate safeguards for the administration of involuntary medication. Nevertheless, medication should be provided with informed consent first, and if the person served is unable to consent to the medication, by virtue of being incompetent or incapacitated, a court order should be sought. In the meantime, should there be a finding of imminent danger that can only be prevented with medication, the administration of medication involuntarily should be considered a chemical/medication restraint, labeled and documented as such in the records of the persons served. DLC is seeking data on the amount of involuntary medication administered during the

monitoring period. It is in everyone's interest – staff and persons served - to ensure that appropriate safeguards exist to ensure that these processes comport with relevant regulations.

## Person-Centered Treatment:

When CCRS began its tenure at Bridgewater State Hospital, one of its clear goals, based on the company's mission and vision, was to ensure that all Persons Served ("PS") were invited to attend and participate in their own treatment planning, from admission through discharge. To accomplish this, CCRS would have to start creating and maintaining actual individualized treatment plans for each Person Served who was already there but did not have one that was accurate or current, and then continue to create such plans as new PS were admitted. DLC wholeheartedly agrees that for treatment and recovery to work, the person who is being provided with the treatment has to be front and center in the discussion and planning of his treatment. Thus, DLC supported this initiative to bring treatment planning more in line with evidence-based person-centered practices.

DLC staff has reviewed various CCRS policies in its Policies and Procedure Manual, specifically in the Provision of Care category. The policies are well written to reflect this goal of true person-centered treatment, where the persons served participate in the creation, and updating of the treatment plan, as well as in the discharge planning, as much as possible. It is noteworthy that the policy entitled PC 200-01 Treatment Planning, at paragraph 5.4 states, "The Person Served will be expected to participate in treatment team meetings. If the individual is unable or unwilling to participate, the issue of engagement becomes the first behavioral recovery goal and interventions are designed to engage this individual in his or her team."

This goal has been moving forward in the right direction. Individualized treatment plans are being created and Persons Served are being invited and encouraged to attend and participate in planning meetings. Going forward, the DLC team will continue to monitor the progression of person-centered treatment goals and begin interviewing PS specifically on the issue of their inclusion and participation in the treatment and discharge planning process. Additionally, DLC may interview treatment teams to learn about challenges faced and plans to overcome them in order to ensure that person-centered treatment is a reality across units and teams at BSH.

## Programming:

**Issues identified:** Prior to the current vendor, the level and quality of the programming offered and provided to persons served at BSH was quite limited with very uneven quality. In addition, very little programming occurred during evenings and weekends. Not surprisingly, the level of participation was low. Men at BSH would describe the prior programming as not being compelling. It was not uncommon to see men sleeping on the stairs to the gymnasium or jammed into the library, watching movies or listening with headphones. In addition, the competency restoration programming was not conducted in an effective or timely manner, leaving the needs of many men unaddressed.

**Changes that have taken place:** CCRS has made a series of concerted efforts to significantly improve the variety and quality of the programming offered to the men at BSH. Additional staff

has been hired, including those with specialized backgrounds, such as music therapy and occupational therapy. All programs are co-facilitated to attempt to increase quality, continuity and safety. CCRS is also trying to experiment with different types of incentives to motivate persons served to increase participate in their programs. CCRS is also more focused on competency restoration and tracking the metrics with a view toward shortening the time that it takes for a person served to have his competency restored. CCRS has stated that it is about to completely redesign its master programming schedule, with a goal of having more evidence-based programming, promoting greater attendance and participation in treatment, and fostering a greater sense of community within group programs. CCRS is also in the midst of improving their data collection to measure the level of participation by persons served at BSH.

**Concerns pending:** Over the course of their time at BSH, CCRS has implemented a series of changes to their programming to improve the popularity and effectiveness of the programs. The most recent announcement concerning the complete redesign of their programming schedule is the most recent example of those efforts. At this point, many of these changes/improvements are aspirational. Concurrently, CCRS is in the midst of improving their data collection on program participation, which will provide them and DLC, as the monitor, with a more accurate picture of engagement level. Despite positive intentions, it remains to be seen whether this latest set of modifications will in fact move the programming to the quality that CCRS intends to provide and that the men of BSH deserve. Further monitoring is needed to ensure that these new program offerings and their new master programming schedule will in fact result in widespread and systematic participation/engagement by the persons served at BSH. The new and improved system for tracking and compiling data on program participation will be an essential component of future monitoring.

## Developmental Service Program (DSP) and Persons Served With Intellectual and Developmental Disabilities:

DLC continues to spend a considerable amount of time working with PS with intellectual and developmental disabilities. This includes both limited individual advocacy, but also larger systemic advocacy related to services in their day program, the Developmental Services Program (DSP).

### Issues and concerns identified:

- a. Traditionally, BSH has lacked meaningful habilitation services for people with I/DD beyond the DSP, which offers only social and recreation activities (videos, computer games, cards, music, companionship) and some efforts to reinforce soft skills (socially appropriate behavior etc.). Services to these patients are currently inadequate for many reasons:
  - i. The DSP needs to be supplemented with evidence-based practices for treating forensic patients with I/DDs, such as modified dialectical behavioral therapy (DBT).
  - ii. DDS provides funding only for a small handful of Persons Served (an average of 3-5) who have entered BSH with a previous determination of eligibility for DDS



adult community services. However, in the past as many as 25 PS, and currently as many as 10 -15 PS, may be using the DSP room at any one time. These are individuals who could be DDS eligible or who are otherwise vulnerable and need services in a safer, more controlled environment. DDS and DOC should work together to supplement funding to acknowledge the needs of these individuals.

- iii. There is no process in place to provide expedited eligibility determinations for persons who may not have previously applied for DDS services, and minimal advocacy resources are available to pursue those applications. Eligibility determinations are important for discharge planning, and also to ensure adequate funding for the DSP while PS are at BSH. DDS appears to be holding BSH applicants to the same standards as other applicants, without providing them with accommodations based upon their circumstances under Title II of the ADA. For example, DDS expects individuals to be interviewed by DDS staff, but they are not willing to send their evaluators to BSH. We have also been told that DDS requires state IDs, which BSH applicants cannot readily obtain. Finally, DDS, CMHS (the vendor running the DSP), DOC and CCRS need to apply more resources to assist applicants with completing applications for eligibility and gathering school and treatment records.
  - iv. DOC and EOHHS need to identify funding and develop programming for other vulnerable patients, including persons with developmental disabilities, whose disabilities may not correspond with DDS eligibility criteria.
- b. The process by which the program is funded, and the level of funding allotted, needs to be revisited. It has been operated by a nonprofit, CMHS Inc. since 1984. DLC conducted research into the DSP, looking at requests for proposals since the 1990s, speaking with DSP staff (who have been working there for many years) and consulting with CCRS and DDS General Counsel. In addition, we also sent a FOIA request to DDS to review documents. We learned that the DSP program had gone out to bid in 1993 and 2009 and is now currently funded using the Community Based Day Supports (CBDS) line item. This seems inappropriate given that the DSP is an institutional and not a community based program.
  - c. There is an overall lack of coordination between DDS, DOC, CCRS, and the DSP (run by CMHS, Inc.) around eligibility, services and discharge. Our perception, shared by others, is that DDS is disengaged from issues related to serving current or potential DDS clients who are at BSH. There may be multiple reasons for this. First, the staff of DDS, DOC (and their contractor, CCRS) and DMH all work within separate silos that not only represent different state agencies, but also different executive offices. We believe that staff of these departments need strong encouragement from executive leadership to coordinate more closely their departmental functions. Second, there is a perception that DDS staff are reluctant to provide or coordinate services to PS with intellectual disabilities at BSH. It is believed that the department is risk averse and disinclined to associate with persons with intellectual disabilities that have complex behavioral challenges and might be associated with unfavorable media coverage. One judgment that contributed to this perception was the decision by the DDS employee charged with coordinating with DDS PS to no longer attend periodic interagency meetings scheduled

between DOC, CCRS, DMH (and formerly, DDS). Finally, DDS appears reluctant to either prioritize or accommodate PS at BSH who are in a more disadvantageous position compared to DDS clients or applicants in the community.

- d. On the grounds of the former Templeton Developmental Center, DDS already provides a high security environment for persons with intellectual disabilities, some of whom also have mental health and behavioral challenges. This includes residential units with high staffing ratios and alarmed bedroom and house doors. DOC and DDS should undertake an analysis of the relative security of both facilities and periodically assess if any BSH patients are eligible for transfer to less restrictive environments.

#### Changes that have taken place:

- a. One vulnerable PS with an intellectual disability (ID) and significant limitations was moved to the Lighthouse (medical) building, after many years being on a regular residential unit. This PS had been targeted by other PS who took his canteen and otherwise abused him. This had resulted in violent altercations in which the PS with an ID was both a victim and a perpetrator. As a result of this change in residence and a change in medication, this individual is doing much better. He is more alert and engaged and able to participate in basic conversation. These changes were too long in coming, but we appreciate that CCRS identified changes needed for the benefit of this individual.
- b. We appreciate CCRS's decision to bring a forensic expert in to evaluate a PS with an ID who has been stuck at BSH for approximately 30 years. This expert will assess the individual's treatment needs and readiness for discharge.
- c. CCRS is making an effort to provide alternative programming for PS with IDs or who are otherwise vulnerable, in addition to the DSP. As important as the DSP is, it was unfortunate that most PS spent their entire day there engaged in the same social/recreational activities without other meaningful programming. This is beginning to change, and it is now more common to see DSP participants spend some of their time in groups.
- d. The DSP was moved from two rooms next to the library which was considered a "prime" BSH location, to one classroom in a modular building. The relocation of the program does allow for closer tracking of who does and does not go to the DSP; however, this goal might have been achieved through other means. Oddly, while the former art room for the DSP is now occasionally used by other programs, the former main room for DSP does not appear to be used regularly for any other programming. The limited size of the new DSP space does seem to restrict options available for programming there.
- e. More effort has made to identify what PS should go to the DSP and what PS should not be allowed to attend. The program is now more restricted to PS with I/DDs, and others who are more vulnerable. This is generally a positive change and has resulted in fewer altercations and PS being victimized.
- f. DDS may be ending its contract with Comprehensive Mental Health Systems, Inc. (CMHS) the entity that operates the DSP. See <http://www.cmhsma.org/services/developmental-services-forensic-day-habilitation-services/> This change could happen as early as the end of June or the beginning of July.



### Concerns pending:

- a. As noted above, the future of the DSP is currently unclear. While CCRS has contingency plans, the cloud of uncertainty hanging over the program is causing its participants to experience anxiety. DDS and DOC should act swiftly to decide on the future of this program or its replacement, and should inform affected PS well ahead of time.
- b. The lack of coordination between DOC, CCRS, DMH and DDS, in serving PS with I/DDs, continues despite efforts taken by CCRS.
- c. The processes through which PS with IDs are supported in applying for DDS services remains inadequate.
- d. DDS funding remains inadequate and limited to only a segment of those that could be or are served by the DSP and who could qualify for DDS services.
- e. One DSP participant with a very significant I/DD has been held on competency to stand trial for an extended period, while almost everyone associated with him plainly agree that he will never be restored to competency. Massachusetts claims that he is a resident of another state, which claims he is a resident of Massachusetts. To begin the process of returning him home, CCRS needs to work closely with DMH and work to with counsel to resolve his criminal charges, which will never go to trial.

### Persons Served (PS) Who Do Not Need Strict Security, Including But Not Limited to Some PS with Status under GL c. 123 Sections 7 and 8:

#### Issues and concerns identified:

- a. *Definition of Strict Security*
  - i. BSH provides mental health services to people who are believed to need “strict security.” Each person holds a status that corresponds to the various statutory subsections.<sup>iii</sup>
  - ii. While all subpopulations at BSH supposedly need “strict security,” this term is undefined by statute. While clinical staff have made some internal efforts to define strict security, there is no agreed upon definition being used by judges, counties, the Department of Corrections, and its mental health vendor, CCRS.
  - iii. DOC administrators, clinicians and legal advocates all routinely disagree with each other with various decisions by superintendents, county jail administrators and judges to route Persons Served to Bridgewater or to keep them there. Sometimes all three groups agree that a patient is misplaced, but are at a loss to correct the situation. Adding another layer of complication is the tension between state facilities and BSH, and county facilities and BSH, which sometimes pass the same PS back and forth because of conflicting clinical diagnoses or security assessments.
  - iv. The legislature should codify a specific and uniform definition of “strict security” to clarify this question for the courts, DOC, DMH, Persons Served and their families, and advocates and attorneys. A former DOC/MHM/CCRS forensic evaluator drafted

such a definition, and DLC has also attempted this. We would be willing to furnish both definitions to the legislature as a starting point for examining this issue.

- v. DLC regularly monitors DMH facilities under our P&A authority, just as we monitor BSH. From our work in those hospitals, we have come to know both the levels of risk posed by DMH patients and the security of each hospital. We often find that forensic evaluators at BSH make different assumptions about both of these topics that are at variance with our monitoring experience. It is important that staff at both BSH and DMH spend more time at each other's facilities so their knowledge base is as accurate as possible.

#### Changes that have taken place:

- a. CCRS has been more successful than its predecessor in moving BSH PS to discharge at DMH. Most of these PS have been well received by DMH and are successful at their new placements. There remain some challenges related to BSH PS who may be labeled and face long standing assumptions held by some staff that block their discharge, regardless of their current behavior and progress. Recently, CCRS transferred one such individual, who was held under a 7 & 8 to BSH. We had been advocating for his discharge for a number of years, and were pleased to see that he was finally relocated to a less restrictive environment.

#### Concerns pending:

- a. As noted above, the legislature should amend G.L. c. 123 by adopting a specific definition of strict security.
- b. DOC, CCRS, DMH and DDS should have regular clinical meetings to assess readiness for discharge for persons served who have resided at BSH for long periods with relatively low incidents of behavioral problems. In cases where the treatment team and/or forensic evaluators are nonetheless resistant to discharge, and where there are few recent behavioral problems, CCRS should explore using outside evaluators to assess readiness for discharge or to make other treatment recommendations.
- c. DOC, CCRS, DMH and DDS need to make additional and more specialized efforts to assess readiness for discharge, with court approval, for (1) persons committed under G.L. c. 123 sec. 7 and 8 who have no pending criminal charges; (2) individuals who have dual diagnoses such as I/DD or TBI, or neurological disorders who may be particularly ill suited for BSH, and may benefit from other more specialized services not available at Bridgewater; (3) PS who have complex medical needs or who are advanced in years; and (4) PS who are otherwise vulnerable and who lack the ability to advocate for themselves and/or who have few family, friends or other advocates to act on their behalf.

## Persons Served in the RU and the ISOU Units at Old Colony Correctional Center:

**Introduction and Concerns Identified:** Many of the most significant positive changes to the physical and cultural environment at BSH -- such as the change in culture from discipline/punishment to treatment/recovery, the use of the grassy courtyard to de-escalate a person by walking him around, the increasingly effective use of the gym, including a set of exercise equipment, as supported by a recreation therapist and a music therapist, -- have not been afforded to the men almost three dozen men in the Bridgewater “annex” units at Old Colony Correctional Center (“OCCC”). Instead the men who were moved from BSH to those units have been shoehorned into a narrow island within a much larger prison environment, where their programming and recreational needs are generally limited and subordinate to the logistical and administrative needs of that correctional facility.

Under the changes associated with new RFR and new mental health services vendor, CCRS, state prisoners who were serving sentences were transferred to two units at Old Colony Correctional Center (“OCCC”): the Recovery Unit (“RU”) and the Intensive Stabilization and Orientation Unit (“ISOU”). On a typical day there might be about 9-10 men in the ISOU and about 30-32 men in the RU. Because the authority to send men to BSH is tied to the statutory authority under G.L. c. 123, sec. 8(b), fundamental to creation of the “Bridgewater Annex” at OCCC was the underlying principle that the programs and services at OCCC would be substantially equivalent to the programs and services at BSH proper. This was the explicit representation made by the Administration when the OCCC Bridgewater Annex was established. Despite those assurances, however, the programs, services and conditions at the RU and the ISOU at OCCC are far from being substantially equivalent to those at BSH proper.

**Changes that have occurred:** There have been efforts to increase staffing on the units at OCCC. CCRS has been in a series of discussions with DOC officials about the need for access to space for programming, but whatever positive change has occurred has been extremely limited. CCRS has been relegated to the role of asking for improvements, but like the men they serve, the program’s needs are subordinate to the administrative and logistical limits of OCCC.

**Pending concerns:** Logistical physical limitations and rigid rules cause the men in the RU and ISOU to receive inferior programs and services than the men at BSH. Because these two units were shoehorned into an existing very full facility, the amount of space available for programming and exercise is severely limited. For example, the ISOU and the RU, which typically average about 30 men, are generally limited to a single presumptive classroom. Similarly, the amount of space available for outdoor exercise is limited to a relatively small slab of concrete. Those cement slabs afford very limited shady space in the summer and very cold unprotected space in the winter. Moreover, the amount of exercise/recreation equipment is almost non-existent – limited to a few tired sponge balls and a bare metal picnic table. At some earlier point, apparently there had been a basketball hoop on the concrete slab but after one person served had climbed up on it, it was removed as a safety concern. As far as we are aware, no effort was made to replace it with a basketball hoop that would collapse if a person were to climb on it, or replace it with some other type of exercise or recreation equipment.

While there is quite limited access to gym time, especially in comparison to the amount of time the gym is available at BSH, because there is a general rule that the men from the RU and ISOU can never interact with the other men at OCCC, the time slots for gym use are extremely limited. DLC's concern over this issue involves more than equal treatment. There is a well-established body of clinical literature concerning the importance of fresh air and indoor and outdoor exercise in promoting recovery from mental illness<sup>iv</sup>.

There have been other BSH programs and opportunities recently provided to the men at BSH, such as outdoor activities, that have been denied to the men of the ISOU and the RU based upon the fear that it would stir resentment and that it might have a negative effect on the other residents of OCCC. Another problematic rule is the one that prohibits any real interaction between the men on the RU and ISOU units and the rest of the OCCC population. This results in the men from these units not being able to have a job outside the unit, such as working on the chow line or cleaning parts of the facility – jobs that could help the men earn good time. Sometimes the men on these units are denied opportunities because they are not supposed to be viewed as having advantages that the men of OCCC would not have, but at other times the men on these units are denied opportunities that the other men at OCCC routinely receive, such as use of irons or heating devices for drinks, because they need to be treated differently for some reason. In effect, the men on these two units are provided the lowest common denominator when compared to what men at BSH get and what the other men at OCCC receive.

During the course of the monitoring period, CCRS has tried to obtain more space and more flexibly applied rules, but generally those efforts have not been successful. DLC understands that CCRS continues to be involved in ongoing discussions with DOC to redress many of these disparities, but currently they persist. Unless OCCC is modified so as to afford the men in the RU and ISOU units substantially equivalent programs, services and conditions, the men from the so called "Bridgewater Annex" should be returned to BSH proper, where they can participate in the improved conditions at the State Hospital.

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<sup>i</sup> Massachusetts General Laws, chapter 123, section 1, defines restraint as "bodily physical force, mechanical devices, **chemicals**, confinement in a place of seclusion other than the placement of an inpatient or resident in his room for the night, or any other means which unreasonably limit freedom of movement."

Further, 104 CMR 27.10(1)(e), provides that

"[f]or a patient who is believed to lack capacity to give informed consent to treatment with antipsychotic medication... the right to refuse such medication may be overridden prior to an adjudication of incapacity and court approval of a treatment plan only in rare circumstances to prevent an immediate, substantial and irreversible deterioration of the patient's mental illness. If treatment is to be continued over the patient's objection, and the patient continues to lack capacity, then an adjudication of incapacity and court approval of a treatment plan must be sought."

Additionally, 104 CMR 27.12(8)(a)(3) defines restraint in more detail, including a clear definition for chemical or medication restraint, as follows:

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“Restraint, for purposes of 104 CMR 27.00, means behavioral restraint, including medication restraint, mechanical restraint and physical restraint. Restraint means bodily physical restriction, mechanical devices, or medication that unreasonably limits freedom of movement. Restraint does not include the use of restraint in association with acute medical or surgical care, adaptive support in response to the patient’s assessed physical needs, or standard practices including limitation of mobility related to medical, dental, diagnostic, or surgical procedures and related post-procedure care.

a. Medication Restraint. Medication restraint occurs when a patient is given a medication or combination of medications 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. Medication restraint shall not include:

i. involuntary administrations of medication when administered in an emergency to prevent immediate, substantial and irreversible deterioration of serious mental illness, provided that the requirements of 104 CMR 27.10(1)(c) are complied with; or

ii. for other treatment purposes when administered pursuant to a court approved substituted judgment treatment plan.

ii Under DOC regulations, 103 DOC 651, “Restraint” is defined as “bodily physical force, mechanical devices, confinement in a place of seclusion other than the placement of a patient in his room for the night, or any other means which unreasonably limit the freedom of movement.” That regulation further states: “Medications may not be used as a restraint, but may be used: (a) in an emergency to prevent immediate, substantial and irreversible deterioration of serious mental illness, or (b) for other treatment purposes when administered pursuant to a court approved substituted judgment treatment plan.”

iii This includes Persons Served under [G.L. c. 123, sec.] 15(a)s, for whom BSH must determine competency to stand trial or criminal responsibility [NGRI]; Persons Served under sec. 15(b), for whom BSH must provide hospitalization after a 15(a); Persons Served under 15(e)s, for whom BSH aids the court in sentencing after a finding of guilty; (15(e)s may also be committed); Persons Served under 16(a) held by BSH after being found incompetent to stand trial [IST] or lacking in criminal responsibility [NGRI]. (Persons Served may also be committed under 16(b) during a period of observation under 16(a)); and Persons Served under 18(a) from county facilities, because of a need for hospitalization by reason of mental illness, and in need of examination, observation or commitment.

Finally, there are Persons Served committed under 7(b) and 8(b). These are Persons Served without pending criminal charges, who could be committed to a state psychiatric hospital, but are committed instead to BSH under a determination that they are mentally ill and not subject to placement at DMH because the failure to hold them in strict custody would create a likelihood of serious harm. Persons Served who are under 18(a) from state correctional facilities, because of a need for hospitalization by reason of mental illness, and in need of examination, observation or commitment, are now served in the ISOU and RU units of Old Colony Correctional Center, which is technically still considered part of BSH. PS are separated between BSH and OCCC based on an assumption about dangerousness based upon status that is often untrue. While a state 18(a) ay OCCC may pose a higher risk than a county 18(a) at BSH, the state 18(a) may present significantly less risk than a 15(e) or 16(b) at BSH, being held on significant charges.

iv In recent years the legislature recognized this principle in providing a sixth “fundamental right” to fresh air and access to the outdoors for DMH patients, pursuant to G.L. c. 123, sec. 23(f).