



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, 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 2020 Budget (Line Item #8900-0001.)

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The Protection and Advocacy System for Massachusetts

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Introduction and Overview

This Disability Law Center (DLC) report covers the monitoring of Bridgewater State Hospital (BSH), pursuant to expanded authority granted by Line Item #8900-0001, for the period from September 2019 through February 2020. During this reporting period, in particular, the Department of Correction (DOC) and Wellpath have worked together to serve individuals at BSH through some difficult times. The past six months have seen challenges ranging from smoothing the transition of a new Superintendent to healing a community in the wake of a fentanyl-related death. While cooperation and collaboration are certainly themes during this reporting period, DLC continues to raise the same concerns regarding the deteriorating physical plant, the administration of medication, and the disparate treatment of individuals served who are under DOC, and not Wellpath, security. This report highlights progress over the past six months and provides an overview of important issues that need continued attention going forward.

During this monitoring period, DLC staff conducted 11 site visits, fielded a high-volume of over 300 phone calls and letters from Persons Served (PS) at BSH, met individually with several PS to offer legal advice and/or referrals, received and reviewed daily reports from both Wellpath and DOC, and held weekly internal staff meetings. As an on-site monitor, DLC continues to enjoy unfettered access to a range of different meetings and events, including several Wellpath Morning Meetings, regular DLC-Wellpath and DLC-DOC meetings, and BSH Governing Body and Department of Mental Health (DMH) quarterly meetings. DLC also had the opportunity to conduct mold testing with our contracted mycology expert. The extent of DLC's monitoring would not be possible without our broad access, and mold testing conducted in December 2019 would not be possible without our expanded authority granted by Line Item #8900-0001.

DLC focused on five issues of concern during this period: (1) deteriorating physical plant; (2) administration of medication issues; (3) disparities in use of force between BSH and Old Colony Correctional Center (OCCC) units; (4) contraband and security at BSH; and (5) continued progress on policies and practices. For each issue, we have made a specific recommendation based upon our expertise of almost six years monitoring at BSH, and upon the progress that has been made over this reporting period.

1) Deteriorating Physical Plant

As previously noted in DLC's last three reports, each entitled *A Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital*, dated May 18, 2018, February 25, 2019, and July 15, 2019, respectively, the physical plant and infrastructure at BSH are potentially hazardous to the health of any individuals on-site and necessitate endless costly and ineffective repairs. During this reporting period, highly anticipated roof replacements and repairs were completed on the administrative building and gymnasium. Unfortunately, with the first heavy rainfall, the administrative

building roof leaked again, continuing the cycle of a crumbling infrastructure and wet, hazardous health conditions.

For over a year now, DLC has raised concerns about these potentially hazardous conditions and has highlighted the narrower issue of mold and adequate mold testing. While DLC remains deeply concerned about other physical plant hazards beyond mold, DLC has focused on this area as a definitive issue for DOC to address to ensure the health and safety of PS and staff alike. For over a year now, DLC has urged DOC to conduct extensive mold sample swab testing throughout BSH (see DLC's recommendation in our February 25, 2019 and July 15, 2019 reports). DOC has repeatedly and consistently not only refused to do such testing but has actively denied DLC access to perform the tests.

Fortunately, during this reporting period, DLC was granted specific authority under Line Item #8900-0001 to conduct mold testing, including areas of the facility where PS do not reside. As such, DLC toured BSH with our expert on December 5, 2019, and returned on December 19, 2019, to conduct mold sample testing throughout the facility. Both observations and sample testing revealed extensive mold in almost every single area swabbed by our expert, including HVAC systems/vents. A copy of the Mold Sample Test Results and the Mold Inspection Report are attached as Appendix A.

Accordingly, DLC again strongly urges DOC to take swift, appropriate action to address the mold and other physical plant issues at BSH.

DLC Recommendation:

Consistent with DLC's prior recommendations in our public investigation findings on July 11, 2014, repeatedly reiterated since then and stated in our February 25, 2019 and July 15, 2019 reports, "[i]nstead of the resource drain of patchwork fixes, the Commonwealth needs to construct a modern facility that can effectively provide humane and appropriate treatment."

2) Administration of Medication Issues

For almost six years now, DLC has raised concerns around the use of forced psychotropic medication at BSH and OCCC Units. DLC detailed these concerns in our public reports to the legislature dated May 18, 2018 at 3-5, February 25, 2019 at 10 and July 15, 2020 at 6-7. During this reporting period, Wellpath finalized its "Use of Involuntary Psychotropic Medication," effective January 24, 2020. This policy is identical to the draft discussed in DLC's July 15, 2019 report at 6. Thus, DLC now renews all of our concerns previously raised.

Wellpath's forced medication policy delineates three standards for administering psychotropic medication without a court order, namely: (1) prevention of imminent harm to self or others, or treatment of intolerable distress, also known as Emergency Treatment Order (ETO); (2) restriction of ability to engage in behaviors that are causing serious volitional harm to self or others, or present an imminent risk of doing so, also known as Medication Restraint (MR); and (3) prevention of immediate, substantial, and irreversible deterioration of mental illness, also known as Irreversible Deterioration Order (IDO). This policy does not protect PS rights to the fullest extent required by Massachusetts law and does not align with the exceptions outlined in *Rogers v. Commissioner of the Dep't of Mental Health*, 390 Mass. 489, 510-511 (1983), and as detailed in our May 18, 2018 at 3-5. This is of particular concern given that the Medical Director and psychiatrists at BSH have publicly advocated for limiting the scope of individual rights and narrowing the breadth of rights granted in *Rogers*. See, e.g., Christopher Myers, MD and Jhiam Biswas, MD, *Treatment Delayed is Treatment Denied*, (July 22, 2019) presentation at the International Congress on Law & Mental Health in Rome, Italy (advocating for curtailment of individual rights to independent evaluations and full hearings in an effort to medicate individuals without complete judicial process).

Furthermore, because this forced medication policy carves out a narrow definition of medication restraint when read in conjunction with Wellpath's draft Use of Seclusion and Restraint policy (PC 400-08), Wellpath is not required to track or report the use of all non-court-ordered forced medication to DOC or any other body. As a result, these policies make it impossible to get a firm grasp on how often PS at BSH are being forcibly medicated through a review of records or otherwise. Without full and accurate reporting, there can never be adequate oversight of the practices and treatment of PS at BSH. This is particularly concerning with respect to restraint practices BSH, as it was the excessive and inappropriate use of seclusion and restraint at BSH that gave rise to DLC's investigation in 2014 and subsequent monitoring.

DLC Recommendation:

DLC renews its concerns raised in our May 2018 report that medication should be administered with informed consent first and, if that is not possible, then "...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." In order to fully resolve medication administration issues, all individuals in need of "strict security" psychiatric evaluation and/or treatment should be under the auspices of the Department of Mental Health.

3) Disparities in Use of Force Between BSH and OCCC Units

There are two BSH units at OCCC, the Recovery Unit (RU) and Intensive Stabilization and Observation Unit (ISOU). Wellpath provides mental health and medical services on these units and DOC provides security. This model is drastically different than at BSH where Wellpath provides all services, including security. Currently, Wellpath and DOC security policies, protocols, and practices are not aligned. In fact, much of DOC involvement in the RU and ISOU flies in the face of de-escalation and trauma-informed care that Wellpath strives to achieve at BSH. DLC continues to raise the disparities in the treatment of PS at BSH and the OCCC Units, as they have not even remotely been addressed, and, perhaps, cannot be effectively addressed while BSH is under DOC control.

As monitor, DLC receives and reviews Wellpath's daily 24-hour report and DOC's Incident Reports. DLC regularly compares these reports to determine how well daily care is documented, communicated to others, and shared between the entities, and to note any disparities in treatment between BSH and OCCC Units. While the disparities in the care provided to PS at BSH and OCCC are obvious to someone reviewing these reports, they may not be clear to others.

During the reporting period, individuals at OCCC were subjected to a range of 'security' responses that individuals at BSH were not. From chemical agents to handcuffs, DOC security measures typically escalate situations and are both inflammatory and trauma-inducing to PS. For example, on September 1, 2019, a PS was upset from being subjected to a random cell search in the RU. The interaction between the PS and DOC correctional officers escalated to the point that DOC sprayed chemical agent on the PS. It is important to note that numerous random searches have been conducted at BSH and no such event has ever involved a chemical agent being used by Wellpath. In fact, a chemical agent is not even available at BSH. Another such example that occurred on January 23, 2020, involved another PS in the RU who refused to "lock-in" for an event that was happening outside of the unit. This individual was physically taken down by DOC correctional officers, and once down on the floor, was sprayed with a chemical agent. Again, the individual received no de-escalation interventions and was instead subjected to physical intervention and a painful chemical agent by DOC. DOC's culture of punishment and containment is at the very core of these events. It is particularly important to note that on days where Wellpath has offered additional programming, such as a holiday meal, there are no DOC Incident Reports of these kinds of events. Trauma-informed humane treatment is safer and more effective in every way.

Additionally, each time DOC physically intervenes with hands on an individual in an OCCC Unit, whether for a takedown, handcuffs, chemical agent, etc., it is NEVER recorded by Wellpath as an event or restraint. Thus, the drastically reduced numbers of restraints at BSH recorded since the transition to Wellpath can only be known to be accurate at BSH, not the OCCC Units. Further progress, and parity, cannot be achieved unless and until all BSH, including the OCCC Units, are managed the same. Until this is

resolved, there will be a fundamental disparity of treatment between all PS needing “strict security” in Massachusetts.

DLC Recommendation:

In order to fully resolve disparities at both BSH and OCCC Units, in addition to building a new modern facility (recommended above), all individuals in need of “strict security” for psychiatric evaluation and/or treatment should be under the auspices of the Department of Mental Health.

4) Contraband and Security at BSH

During this reporting period, Wellpath and DOC continued their collaboration and partnership efforts around safety and security following a death at BSH. On September 19, 2019, Wellpath staff found an unresponsive PS in his room. Staff responded by performing CPR and calling EMTs, who transferred the PS to Morton Hospital where he was pronounced dead. Wellpath and DOC suspected, and later confirmed, that the individual died of a drug overdose from fentanyl that he obtained from another PS at BSH. Wellpath and DOC immediately partnered to conduct an extensive search of BSH for contraband and to identify and respond to any safety threats. DLC commends this partnership, especially in light of the fact that it was the same week that Superintendent Kennedy started at BSH. Wellpath and DOC worked to create improved admission and re-entry screening protocols for PS, including using a body scanner at OCCC to identify contraband is hidden in a person.

The above measures were implemented and, in the weeks and months that followed, more permanent solutions were created. For example, BSH obtained its own body scanner and retrofitted part of the medical building to facilitate scans and the new admission/re-entry process for PS on site. Also, in response to the individual’s death in September 2019, Wellpath obtained naloxone (Narcan) for every unit and trained staff on its use. This was not only an appropriate response but has already proved itself useful and effective in January 2020 at BSH. Both Wellpath and DOC continue to explore solutions to contraband safety and security risks at BSH.

DLC Recommendation:

Wellpath and DOC should continue to collaborate on safety and security improvements while prioritizing the treatment and well-being of the individuals being served at BSH.

5) Continued Progress on Policies and Practices

In addition to those noted above, DLC has raised concerns to Wellpath and DOC about areas where there is a lack of consistency or clarity in policies and practices. The two main areas during this reporting period have been (1) the consent standard pursuant to the Prison Rape Elimination Act (PREA) and (2) the standard for admitting someone to the OCCC ISOU in lieu of BSH.

First, PREA does not define or describe consent, and it does not provide guidance on determining an individual's capacity/competency to provide consent. Likewise, PREA does not provide guidance on an individual's capacity/competency to file a complaint or follow through with the complaint process. As a result, it is unclear whether all PREA related events are reported, and how an individual's capacity impacts the process and findings. At BSH, Wellpath investigates PREA concerns and reports findings to DOC. However, without clarity about consent and capacity issues raised here, it is impossible to know what standards Wellpath should be using in this process. For example, if the PS seems to consent but lacks the capacity/competency to do so, how should that factor into Wellpath's investigation and findings? DLC raised this issue with DOC and expects DOC to provide clarification to Wellpath.

Second, since the transition to Wellpath, there have been two PS who were legally appropriate to be admitted to BSH but were admitted to OCCC ISOU instead. In the first instance, the individual was at BSH and was transferred to OCCC after an incident at BSH. This transfer was immediate, and DOC approved it. More recently, an individual who was going to be admitted to BSH was instead admitted to OCCC ISOU. In this situation, Wellpath requested and DOC approved the individual's admission to OCCC ISOU. DLC has raised concerns over this practice because there is currently no policy (Wellpath or DOC) on such a decision-making process or standard. DLC expects DOC to immediately draft a policy that provides agencies clear guidance to ensure that PS are protected against arbitrary decisions placing them in an OCCC Unit when placement in BSH is appropriate.

Third, since the transition almost three years ago, Wellpath has not consistently and reliably reported out assaults – either PS on PS, or PS on staff. In December 2019, Superintendent Kennedy presented assault information to the Governing Body that did not match that maintained by Wellpath. Since then, Wellpath and DOC have been collaborating to compile similar data that Wellpath may report on during the March 2020 Governing Body meeting. DLC looks forward to reviewing this data, as it is long overdue.

DLC Recommendation:

Wellpath and DOC must continue to identify and respond to issues where there is a lack of clarity and/or no policy guidance. DLC recommends that DOC formulate policies on PREA consent standards and OCCC ISOU admissions as soon as possible and that Wellpath continue efforts to track and report on assaults.

Conclusion

DLC commends the continued partnership and collaboration between Wellpath and DOC because such cooperation best serves the individuals at BSH and OCCC Units. DLC urges all involved to work to protect the overall health and well-being of those at BSH by building a new facility and transferring oversight to the Department of Mental Health. Further, DLC urges all involved to immediately discontinue the use of forced medication outside of the *Rogers* decision, and to track the use of all forced medication for reporting purposes. Similarly, DLC urges uniformity between BSH and OCCC Units security protocols and to discontinue any security measures based on a culture of punishment and control, namely chemical agents and handcuffs. Finally, DLC commends the efforts of Wellpath and DOC when they work together on security issues and looks forward to reviewing DOC policies and Wellpath data, as mentioned above. To ensure the continued improvement of safety and treatment of persons served at BSH and the OCCC Units, DLC calls on DOC, Wellpath, and the Commonwealth to follow the recommendations discussed above.

Appendix A