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Hand Delivered

July 11, 2014

The Honorable Deval Patrick
Governor of Massachusetts
State House, Room 360
Boston, Massachusetts 02133

Re: Disability Law Center Investigation of Bridgewater State Hospital

Dear Governor Patrick:

I am writing to report the findings of the Disability Law Center (DLC) in its investigation of conditions and practices at Bridgewater State Hospital (BSH) in Bridgewater, Massachusetts. On April 8, 2014, we notified Secretary Andrea Cabral and Commissioner Luis S. Spencer that we intended to initiate an investigation of conditions and practices at BSH, based on our concern that individuals with mental illness were subject to abuse and neglect at that facility, including a deep concern about the excessive restraint and seclusion.

Since the initiation of DLC's investigation, your administration has taken a number of significant steps to address the substantial problems at BSH, including most notably your "Appropriate Care in the Appropriate Setting: Reforming Bridgewater State Hospital & Strengthening the Commonwealth's Mental Health System" proposal and the legislative initiative to effectuate that plan. We commend you for that important beginning, particularly as it represents an acknowledgment that the conditions at BSH call for meaningful and systemic changes. We must, however, continue to take issue with the fact that the proposal and legislative package fail to assign responsibility for the entire BSH population to the Department of Mental Health (DMH). Also since the investigation began, we understand that the number

The Protection and Advocacy System for Massachusetts



and length of seclusions and restraints has decreased significantly as a result of complying with the statutory limits on restraint and seclusion. We further understand that during the same time period patient assaults on staff and patient assaults on and fights with other patients has increased. This is not surprising since none of the other essential changes, such as the administration of BSH by DMH, a significant increase in staffing, creation of adequate treatment space, and an increase in necessary training, have been made.

DLC, as the designated Protection and Advocacy system for Massachusetts, invoked its statutory authority pursuant to the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act¹ and the Developmental Disabilities Assistance and Bill of Rights (DD) Act.² Those statutes provide broad authority to DLC to “investigate incidents of abuse and neglect of mentally ill individuals if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.”³

DLC commenced its investigation with a tour of the facility on April 15, 2014. Over the course of the following six weeks, staff attorneys from DLC conducted 75 interviews with patients at BSH. We also had an opportunity to speak with non-patient prisoners, corrections staff members, and mental health staff members. Before, during, and after our on-site activities, DLC reviewed the records of 64 patients. DLC staff also reviewed , statistical data, and relevant statutes, regulations, and policies.* We also had the opportunity to interview and consult with advocates experienced in the issues and concerns at BSH.

As a threshold matter, we wish to express our sincere appreciation to the staff of BSH and to State officials for their extensive assistance and cooperation during our investigation. We hope to continue working with BSH and members of the Administration in the same cooperative manner in addressing the problems that we found. Further, we wish to thank Superintendent Murphy and other individual BSH staff members who make daily efforts to provide care and treatment to the patients at BSH.

Consistent with our statutory responsibilities under the PAIMI and PAIDD Acts, I now write to advise you formally of the findings of our investigation, the facts supporting them, and the remedial steps that are necessary to address the deficiencies set forth below. We have concluded that numerous conditions and practices at BSH violate the constitutional and federal statutory rights of its patients. Specifically, we find that BSH fails to meet legal requirements in

* Although DLC also sought mortality reports and Use of Force reports early in the investigation, DLC had not received copies of the mortality reports as of the date of this report. Use of Force reports were provided on July 8th. Rather than delay this report until all such materials are received and reviewed, DLC is releasing its report at this time so its findings will be available in a timely manner for those policy makers who are working to address the concerns at BSH. After those materials are received and thoroughly reviewed, DLC may issue a supplemental report.

1) protecting patients from harm; 2) providing adequate psychiatric and psychological care and treatment, see *Youngberg v. Romeo*, 457 U.S. 307 (1982); 3) providing services and programs in the most integrated setting possible, Americans with Disabilities Act (ADA), 42 U.S.C. § 12132, *et seq.*; 28 C.F.R. § 35.130(d); see also *Olmstead v. L.C.*, 527 U.S. 581 (1999); and 4) protecting patients from excessive restraint and seclusion as required by Massachusetts statutes and regulations, G.L. ch. 123, §§ 1 and 23; 103 BSH 651.01 and 651.02.

I. BACKGROUND

Bridgewater State Hospital is a medium security correctional facility administered by the Department of Correction (DOC) pursuant to M.G.L. c. 125 § 18. BSH is the only DOC facility for male patients with severe mental illness who have had some involvement with the criminal justice system, though not all have been convicted of a crime. Female patients who meet these criteria are sent to a Department of Mental Health facility. Most patients are initially admitted pursuant to a court order for observation and evaluation under one of several provisions of G.L. c. 123. Pursuant to Chapter 123, individuals in need of strict security because they may harm themselves or others must be sent to BSH.⁴

II. THE FUNDAMENTAL PROBLEM

DLC's investigation of BSH was precipitated, in large part, by a growing concern about excessive and inappropriate use of seclusion and restraint. As detailed below, DLC found a systemic problem of excessive and inappropriate seclusion and restraint at BSH. At its very core, however, the excessive restraint and seclusion is symptomatic of a more fundamental problem: these patients with serious mental illness are being held and "treated" within a correctional facility, rather than within a mental health facility.

Such a facility, with its correctional policies, practices and culture, is not an appropriate setting for men with significant psychiatric disabilities who need treatment and therapy, not just discipline and control. A significant number of patients, in addition to a psychiatric diagnosis, have trauma histories, including, but not limited to being victims of child sexual abuse. Some had problematic behaviors tied to organic mental disorders, such as traumatic brain injury or AIDS dementia, which were unrelated to psychiatric disabilities. Yet their primary interactions were with DOC correctional officers, who have received minimal training in mental health treatment or trauma-informed care.

Many of the specific problems at BSH, such as the lack of adequate treatment space and a lack of sufficient therapeutic staffing, stem from the fact that it is a correctional facility rather than a mental health facility. More fundamentally, the correctional facility philosophy at BSH is not compatible or consistent with treatment. In a correctional facility, the first response

is to control or punish, rather than to calm, de-escalate, and treat. That is why the restraint numbers were literally off the charts. While there can be moderate, time-limited reductions in the use of restraint and seclusion -- particularly when outside scrutiny is at a very high level -- invariably when the spotlight is dimmed, those numbers will inevitably climb back up, due to the essential nature of a correctional facility filled with men with serious mental illness.

Excessively secluding and restraining the patients stems from placing men with serious mental illness in a correctional facility. Just as the cause is apparent, so too is the solution. The treatment agency must be changed from the DOC to DMH. Unless and until that change in the administration of care and treatment occurs, these patients will not be able to receive the treatment to which they are entitled. It is time for Massachusetts to join the other 48 states that provide care and treatment to this population through a state mental health agency rather than a correctional agency.

III. LEGAL BACKGROUND

Patients of state-operated facilities have a right to live in reasonable safety, to receive adequate health care, and to receive habilitation services to ensure their safety and freedom from unreasonable restraint, prevent regression, and facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982); Kurlak v. City of New York, 88 F.3d 63, 75 (2d Cir. 1996) (applying the Youngberg standard to treatment given in a mental health hospital). Although BSH is administered by DOC, the First Circuit has held that it “is not a mere prison but, in fact, is administered so as to provide treatment rather than punishment within the limitations of a high security setting.” Doe v. Gaughan, 808 F.2d 871, 878 (1st Cir. 1986). The First Circuit validated and adopted the district court’s use of a Youngberg analysis when assessing the appropriateness of care at BSH. Id. at 884-86 (“the right, under the due process clause to safe conditions of confinement [and] . . . right to freedom from unnecessary bodily restraint” were identified by the Supreme Court in Youngberg). If a patient is admitted to a psychiatric hospital for care and treatment, the State has a duty to treat the patient. Woe v. Cuomo, 729 F.2d 96, 105 (2d Cir. 1984) (holding that if justification for commitment of psychiatric patients rests, even in part, upon the need for care and treatment, then a State that commits must also treat). In the Second Circuit for the purposes of a patient’s constitutional liberty interests, no distinction exists between voluntarily and involuntarily committed patients. Society for Good Will to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239, 1243 (2d Cir. 1984) (“We need not decide whether . . . residents are [committed] ‘voluntarily’ or ‘involuntarily’ because in either case they are entitled to safe conditions and freedom from undue restraint.”). Determining whether treatment is adequate requires an analysis of whether institutional conditions substantially depart from generally accepted professional judgment, practice, or standards. Youngberg, 457 U.S. at 353. The State is also obligated to provide services in the

most integrated setting appropriate to the individual patient's needs. Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132, *et seq.*; 28 C.F.R. § 35.130(d); see also Olmstead v. L.C., 527 U.S. 581 (1999).

IV. FINDINGS AND LEGAL ANALYSIS

As described in greater detail below, we find that certain conditions and services at BSH substantially depart from generally accepted standards, and violate the constitutional and statutory rights of those patients.

A. Protection from Harm

Patients' constitutional liberty interests require states to provide reasonable protection from harm. Youngberg, 457 U.S. at 315-16; Good Will, 737 F.2d at 1243 (patients of mental health institutions have a right to safe conditions). Based upon our investigation, we conclude BSH fails to provide its patients with a reasonably safe living environment. The facility too often exposes its patients to harm or risk of harm. BSH subjects its patients to an overuse and overreliance on unnecessary and excessive seclusion and restraint. BSH also has an inadequate risk management system in that it fails to collect, organize, and track incidents of harm and abuse for the purpose of identifying and preventing potential incidents of harm and abuse. To the extent that such data is collected, it is not sufficiently tracked so as to identify trends of abuse and mistreatment. Moreover, BSH systematically fails to appropriately develop adequate treatment plans, or to modify existing plans that are unsuccessful, which results in the same problems arising repeatedly, causing the patient to be returned to the Intensive Treatment Unit (ITU) to be restrained or secluded.

B. Limitations on the Use of Seclusion and Restraint

The right to be free from undue bodily restraint is the "core of the liberty protected by the Due Process Clause from arbitrary governmental actions." Youngberg, 457 U.S. at 316. Consistent with generally accepted professional practice, seclusion and restraints may only be used when a patient is a danger to himself or others. See id. at 324 ("[The State] may not restrain residents except when and to the extent professional judgment deems this necessary to assure such safety or to provide needed training."); Goodwill, 737 F.2d at 1243 (holding that patients of mental health institutions have a right to freedom from undue bodily restraint and that excess locking of doors violates patients' freedom from undue restraint); Thomas S. v. Flaherty, 699 F. Supp. 1178, 1189 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990) ("It is a substantial departure from professional standards to rely routinely on seclusion and restraint rather than systematic behavior techniques such as social reinforcement to control aggressive behavior."); Williams v. Wasserman, 164 F. Supp. 2d 591, 619-20 (D. Md. 2001) (holding that the State may restrain patients via mechanical restraints, chemical restraints, or seclusion only

when professional judgment deems such restraints necessary to ensure resident safety or to provide needed treatment). Seclusion and restraint should only be used as a last resort. Thomas S., 699 F. Supp. at 1189.

Similarly, Massachusetts law provides strict limits on the use of seclusion and restraint. Thus, for example, “[r]estraint of a mentally ill patient may only be used in cases of emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide . . .” G. L. c. 123, § 21 (emphasis added). As specifically noted by the Supreme Judicial Court in Sullivan v. Secretary of Health and Human Services, 402 Mass. 190, 194, section 1 of Chapter 123 contains “a stringent definition of ‘Likelihood of serious harm.’” That section of Chapter 123 defines the term “Likelihood of serious harm” as:

(1) a substantial risk of physical harm to the person himself as manifested by evidence of, threats of, or attempts at, suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or (3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.

G. L. c. 123, § 1.

Again noting the strictness of this provision, the SJC in Sullivan, points out that “[t]he ‘use of the word ‘only’ in G.L. c. 123, §21, means ‘for no other purpose.’” Sullivan, 402 Mass. at 194 (quoting Rogers v. Commissioner of the Dep’t of Mental Health, 390 Mass. 489, 510, (1983)). Continuing to quote from the Rogers decision, the Court in Sullivan emphasizes that “[o]nly when the patient harms, or presents a serious threat of harm, to himself or others, is the use of restraint permitted. Neither doctors nor courts have the power to expand the circumstances in which a patient may be restrained.” Id. In 1990, Chapter 123 § 21 was amended to make explicit that these limits on restraint and seclusion applied to BSH. Chapter 183 of the Acts of 1990.

Chapter 123 provides a wide range of additional limits and protections on the use of seclusion and restraint.⁵ It also requires that “copies of all restraint forms and attachments [relating to BSH] shall be sent to the commissioner of correction, who shall review and sign them within thirty days.” G. L. c. 123, § 21.

DOC has established standards to govern “The Use of Seclusion and Restraint for Bridgewater State Hospital,” 103 BSH 651, which apply the statutory limits of Chapter 123 § 21 to seclusion and restraint at BSH. Those standards state that “[i]t is the policy of BSH to prevent, reduce, and strive to eliminate the use of seclusion and restraint in a way that is

consistent with the mission of this institution and its commitment to provide a safe environment for its patients, staff, and visitors.” Id. at 651.02, ¶ 1. The standards further provide that “[s]eclusion and restraint of a patient may only be used in cases of emergency when non-physical intervention would not be effective.” Id. at 651.02, ¶ A. The standards define “emergency” as “imminent risk of harm to self or others such as the occurrence or serious threat of extreme violence, personal injury or attempted suicide.” Id. at 651.01. Moreover, it is critical to note that BSH’s own standards explicitly state that “**therapeutic restraints are not, under any circumstances, to be used as a disciplinary or punitive measure.**” Id. at 651.02, ¶ M (emphasis added).

Against that backdrop of legal standards and limits on excessive or inappropriate use of restraint and seclusion, the investigation revealed that BSH does not comply with the legal limits on the use of restraint and seclusion. Use of restraint and seclusion is not limited to cases of emergency where there is a likelihood of serious imminent harm; instead it is not uncommon to see restraint and seclusion used as a disciplinary or punitive measure. For a good number of patients there, who may have a traumatic brain injury, dementia, or psychiatric hallucinations, such punishment does not make sense because the individual is simply not capable of “learning the lesson.” Even in those instances where restraint and seclusion may have been appropriately imposed initially, once a patient is in the ITU, that individual is often secluded far beyond the time when that individual poses a likelihood of imminent harm. . The frequent and excessive use of restraint is an indicator that a patient’s treatment plan is inappropriate or inadequate and that staff are using restrictive practices to replace active treatment. In addition, the environment at BSH is simply not adequate or appropriate to meet the needs of a population of patients with significant mental illness. Of particular concern, the ITU is used as a “one size fits all approach” for patients who have a history being violent, patients who have broken rules, patients who are “out of place,” patients who feel anxious about their group living setting and need or crave a single quiet room, and patients who refuse medication orders and are threatened with or subjected to “emergency” administration of medication, despite the lack of a Rogers medication guardianship. Examples of such inappropriate restraint and seclusion are set forth below.

More generally, BSH is under-resourced and inadequately structured to meet the needs of these patients or staff. Furthermore, BSH, as a facility run by DOC, has the attributes, practices, and culture of a prison with a focus on control and discipline, rather than a facility run by DMH with a focus on treatment, trauma-informed care, and recovery. Upon a patient’s arrival, his first point of contact is with a correctional officer (CO), and the message delivered, both explicitly and implicitly, is that BSH is a correctional facility, NOT a therapeutic mental health facility. In fact, a review of records revealed that new patients are assessed in the ITU, sometimes remaining there for days before entering the general population. Although clinical

services are provided by a private contractor, MPCH, the overwhelming majority of day-to-day interaction between patients and staff members is with the COs. This is problematic because COs at BSH come from across the correctional system generally. They do not have specialized mental health background or training to support them in what are unquestionably challenging circumstances. Although the majority of COs do their best to meet the demands of the job, without sufficient mental health training and support, the culture is one of control and discipline. While strict security may be necessary for certain patients, it cannot replace or substitute for appropriate mental health treatment, trauma-informed care, and a vision towards recovery. Significantly more clinical resources for additional mental health professionals and the development of different treatment modalities, including physical spaces such as quiet rooms, must be provided as well as substantially more training and support of the security staff.

Finally, the care and treatment of patients at BSH violate the Olmstead integration mandate of the ADA in two significant respects. First, within BSH itself, the excessive use of seclusion and restraint results in the over segregation of patients within the ITU. These patients could be more appropriately served in less restrictive settings within the facility if adequate treatment programs and staffing were provided. Second, system wide, the Commonwealth is unnecessarily segregating patients at BSH who could be more appropriately served in mental health facilities administered by other agencies. Most obviously, there are a significant number of patients with psychiatric disabilities that could and should be treated at existing DMH facilities. In addition, there are patients with significant co-occurring cognitive and intellectual disabilities that are especially ill-suited for treatment in a prison environment. These patients should be transferred to less restrictive settings which should be administered by the Department of Developmental Services (DDS), and not DOC.

C. Eleven Deficient Practices in the Use of Seclusion and Restraint

- 1. Even in those instances where the legal standard for restraint and/or seclusion is initially met, patients are commonly held in restraints and/or seclusion long past the time of that emergency. Often, once a patient no longer poses a risk of imminent serious harm, that patient is still held in the ITU for days, weeks, or months at a time. Thus, even when the initiation of seclusion and restraint may have been appropriate, when and under what circumstances a patient should be discharged from ITU is ill-defined and inconsistently applied.**

In one instance, a patient was held in seclusion for nearly five months. While he was brought to the ITU upon admission to BSH for violence at the sending facility, the patient showed no risk of violence at BSH. He was not aggressive, angry, or agitated for most of his five months of seclusion. He repeatedly requested to be let out of seclusion and often responded

positively to staff questioning; nevertheless, BSH held him in seclusion because of his history of assault. A review of his record shows that during his almost five months in seclusion, he was typically resting, sleeping, or pacing. At times during the five months, after being repeatedly denied requests to leave the ITU, he would yell or bang on the door, but not often. In one instance, he was pacing in his secluded cell, yelling “get me out of here,” and in another instance yelled “I want out,” but then sat quietly. Sometimes he exercised in his room. Throughout his seclusion, ITU staff notes, “[p]atient has been well behaved.” At times, the medical staff did not even check the “continue seclusion” box or check any “reasons for continued seclusion,” but rather simply signed a name with a date and time, indicating that proper checks were not being made and seclusion was continued without analysis of need for seclusion. Furthermore, in the progress notes, staff noted “[p]atient secluded secondary to assaultive behavior at sending facility;” “[p]atient was reportedly assaultive at sending facility;” “[p]atient walking in room, calm, states he is doing OK. In view of pt’s long hx of assaultive behavior, he remains at risk of harm;” and “[patient] in good spirits, laughing and joking with staff.” Yet he remained secluded for five months. The progress notes demonstrate that he was not imminently dangerous and spent months too long in seclusion.

Another patient was secluded for a nearly continuous period of 13 months with only four brief releases. He was first secluded for four months immediately following his admission to BSH. Most Progress Notes from this period indicate that he was secluded because of his refusal to answer questions, but some also state that he was secluded due to “disorganized behavior” that endangered himself and others and because he had hallucinations with homicidal content. After he was discharged, he was in and out of the ITU for about two months, after which he was secluded for three months because he asked an officer how he could earn a knife. Following those three months in seclusion, he was discharged for three days and then readmitted to the ITU for a period of six months. Progress Notes alternatively state that the reason for his seclusion was his statement, “I don’t like where I’m at,” and his request for a knife. The patient was secluded for over a year but nothing in his seclusion records shows a risk of imminent serious harm, or even the ability to cause such harm.

➤ ***DLC found the failure to comply with these requirements to be pervasive and nearly universal. To assess the breadth of the problem, DLC tabulated its findings from 44 sets of recent seclusion records. Of these, 84% revealed single or multiple examples of BSH staff continuing to hold patients in seclusion, either in clear violation of the statutory standard, or without adequate written documentation that there was a legal basis for continuing seclusion.***

2. Restraint and seclusion are not limited to cases of emergencies where there is a likelihood of risk of imminent serious bodily harm, but instead are used to punish or discipline patients.

In face to face interviews between patients and DLC, numerous patients reported that restraint and seclusion were often used as punishment and/or discipline. Many patients reported that certain behaviors certainly would lead to a trip to the ITU, including spitting on a CO or disobeying a CO order. Patients reported that such behaviors typically came with a pre-determined unspoken “sentence” in the ITU, whether or not there was a present or continuing risk of imminent serious bodily harm to the patient or others. On the issue of punishment, one CO stated in an interview that the patients “have to be held accountable for their acts,” and suggested that most of the mental health patients were actually aware of when they were violating rules.

One specific example of seclusion being used as punishment is a patient with an organic brain disorder that triggers problematic behavior, including fighting with others. A review of the patient’s records show that he received very different treatment for being in fights with patients, as compared with fights with correctional officers. On the first occasion, the patient was not secluded, because another patient initiated the fight. On the second occasion, less than a month later, the patient hit another patient and was secluded for two days for being “at risk of harm to others.” ITU staff found that the “risk” had been mitigated, and then discharged him back to his unit. Within hours of release, the patient assaulted a corrections officer on the medications line. This time he was secluded for seven days, although records during that period note that he was pleasant and compliant with medication. About ten days later, the patient was brought to the ITU for being an aggressor in a fight with another patient, but this time he was not secluded at all. Two months later he was again brought to the ITU for an “unobserved assault” on another patient and again was not secluded at all. One month after this, the patient committed an assault against a corrections officer, and was placed in restraints and secluded. Ten minute checks to his file show that he spent the time in seclusion standing at the door quietly, lying on his back or side, etc., with no evidence that he was in an agitated state. Nonetheless, seclusion was continuously re-authorized, and he was held in isolation for eight days.

Often, patients are placed in restraints and brought to the ITU for not following orders from COs. In many instances, a patient is secluded for days on end to punish or discipline him for disobeying orders. One patient was secluded for over three days for initially refusing a mouth check and arguing with COs. While he complied with being placed in restraints by the CO, once restrained, he tried (but failed) to head butt the CO and another CO called in an emergency. The patient was pushed to the floor and placed in irons, which caused abrasions on

his wrist and ankle. The COs then took him to the ITU. At the ITU, the patient was calm but placed in seclusion. Even though all seclusion check sheets indicate that the patient was calmly resting throughout the duration of his seclusion, he was secluded for three and a half days. Often, the sections of the seclusion check sheet requesting assessment of observable improvement or appearance of distress were left blank, indicating that he was not being observed for improvement at all. Many of the physician progress notes are identical, with only the date and time of check changed; all of the progress notes say that the patient appears resting, is unable to be fully assessed, that risk for harm remains, and that the patient should continue to be monitored in seclusion.

Patients also may be disciplined with seclusion for exhibiting symptoms of their mental illness, such as this case of a patient with schizophrenia who had delusions that he was on a mission to save the world. On one occasion, a doctor wrote a seclusion order when the patient was, “agitated with rapid speech” and “talked of ‘the mission’” simply because “the IPS officer reported that the patient . . . usually assaulted when in this state.” A Progress Note from later that day stated, “[h]e was locked up by the treatment team as a climate issue.” A later progress note cited the reason for his seclusion as, “[p]atient in seclusion [secondary] to paranoia, and agitation, therefore lockup by [treatment] team.” On the relevant Patient’s Perception of ITU Admission Form, the patient said, “I’m doing good just the nightmares still bother me.” This seclusion occurred even though the patient had been successfully utilizing his coping skills and had refrained from assaulting anyone for over five months.

3. **As reported by The Boston Globe, (“Bridgewater restraints use rose, even after patient’s death,” April 6, 2014), patients at BSH were placed in restraints or isolation at more than 100 times the rate as patients at other state mental health facilities in 2013. In addition, despite a statutory requirement that the Commissioner of Correction review copies of all restraint forms from BSH, Commissioner Spencer acknowledged in an April 2014 interview with the Boston Globe that he has never personally review or signed the seclusion and restraint authorization forms. (April 6, 2014 The Boston Globe).**
4. **Patients who refuse medication are transferred to the ITU where they are threatened with or, in fact, administered intramuscular medication (ITM). If the patient does not have a court-ordered treatment plan, they are forcibly medicated on an “emergency basis” unless they consent or until a court-ordered treatment plan is obtained. In some instances, patients are administered medication based upon it being “court ordered,” but in fact the medication was not approved or authorized by a court.**

One patient who felt threatened by another patient asked to be transferred to Max I or Max II. Staff pressed him for details but he could not articulate the cause of his fears. Since the patient was noncompliant with medication and “based on agitated /paranoid presentation, pressured speech, disorganized thought process, history of aggression” the social worker referred the patient to the ITU for “assessment of need for seclusion.” In this instance, the patient was seeking a safer quiet space, but was taken to the ITU instead and strapped in four and five-point restraints and involuntarily administered medication. According to the notes in the incident report, he was **administered “court authorized treatment intramuscular medication,”** but in fact, there had been no such court decree authorizing involuntary medication.

In one instance, a patient was placed in four-point restraints in the ITU for the administration of Haldol and Benadryl as “emergency medication,” per the doctor’s order. The patient did not have a court-ordered treatment plan and a review of his records revealed absolutely no explanation of the “emergency.”

Another patient was sent to the ITU about nine times in a two to three month period, where he was held between two and eleven days. Frequently, notes taken during seclusion indicate that the patient was resting quietly, behaving in a passive manner, and not agitated. Yet, treatment staff continued to re-authorize seclusion based on past violent behavior and their perception that he would be less likely to be delusional if he cooperated with all medication recommendations. The patient agreed to take one anti-psychotic medication being prescribed, but not another. In fact, in one particular occasion, the records capture the *quid pro quo* being sought to release the patient from seclusion:

“Pt asks when he would be d/c from seclusion, Pt was told that he should start taking meds and then we can discuss d/c.”

On some occasions, it appears seclusion is re-authorized by clinical staff simply because he was not complying with treatment recommendations, and so he was presumed to be at risk. On other occasions, clinical staff stated only that they were “unable to assess” the patient because he was resting quietly, or refused to engage with them, so therefore they would presume (without any additional basis) that he continues to be at risk.

5. **If a patient is subjected to frequent restraint and/or seclusion, generally accepted professional standards require the treatment team to reassess interventions and, as necessary, modify the patient’s treatment plan. Such frequent use of restraints and seclusion is an indicator of a mistaken diagnosis, an inappropriate treatment plan and/or that staff are using restrictive practices to replace active treatment, as**

punishment or for the convenience of staff. At BSH, seclusion and restraint are repeatedly used to respond to behaviors in lieu of reassessing interventions and/or modifying the patient's treatment plan.

One patient was sent to the ITU about nine times in a two to three month period, where he was held between two and eleven days. He spent most of his first two months at BSH in seclusion. Almost all of his ITU stays are a result of him being the aggressor in fights with other patients. In some cases, he was discharged for only hours or days at a time before getting in another fight. Rather than accept the status quo, and continue to repeat a failed strategy of continued cycling in and out of the ITU, a more constructive approach is needed. If clinical staff cannot devise a more effective strategy, staff should retain an independent consulting expert who would be able to offer alternative strategies for medication, behavioral therapy, or conflict de-escalation.

Another patient's records show continuous cycling in and out of the ITU as a result of fights with other patients and custodial staff throughout 2013 and 2014, thus far. The patient was brought to the ITU ten times and secluded six times during a 16 month period. Staff's failed use of incentives, such as earning the "privilege" to meet with the Chaplain on a weekly basis, did not lead to a revised or improved treatment plan. The patient ultimately was unable to successfully navigate through their tiered behavioral program, despite being amiable with staff and expressing resolve to adhere to their recommendations on how to avoid conflict. Whatever staff has done from a mental health perspective has not worked and there is little reason to be hopeful that the patient will stop cycling in and out of seclusion, unless he is moved to another more therapeutic and appropriate setting.

- 6. Although BSH policies require that consideration be given to less restrictive alternatives first, see BSH 651.02 ¶ 1, DLC's investigation found that, in practice, seclusion and restraint are too commonly BSH's initial response. Contrary to generally accepted professional standards, BSH commonly uses seclusion and restraint as an intervention of first resort, without considering less restrictive alternatives.**

Patients are often sent to the ITU without evaluation, assessment or treatment on their unit. In one instance, a patient told nursing staff he had not been able to sleep for five days and was immediately sent to the ITU. The records showed that the transfer to the ITU was a "treatment team lock up." The patient was then put into five-point restraint and forcibly medicated pursuant to an "emergency." He was then secluded for five days with no indication

in his record of any alternative solutions being considered, proposed, or administered prior to seclusion.

Another patient, a 70 year old man diagnosed with Bipolar Disorder, had a history of medication non-compliance. On at least eight occasions, he refused to take his medication and was sent directly to the ITU. Within a few hours he took the medicine and was released (one incident lasted less than 20 minutes). Seclusion at the ITU should not be the default therapy to treat a patient who is non-compliant with medication. Unit staff should have alternative methods in place to facilitate patient participation in their treatment.

- 7. Patients who need a therapeutic alternative space, such as a quiet or single room, to de-escalate from too much anxiety, fear or stimuli, must resort to the ITU since BSH lacks appropriate clinical spaces. If such patients request a transfer to the ITU and are denied, they may feel compelled to purposely break rules, such as being “out of place” or hitting another patient, to force a transfer to the ITU because there is no therapeutic alternative space available to them.**

One patient with self-harming behavior frequently requested to go to the ITU because he felt that the lights on his unit were too bright and that there was too much noise on the unit. In an interview, the patient repeatedly stated that lights and noise on the unit agitate him and that he needed a place with dimmer lights, less noise, and fewer people. This patient was distressed on his unit because of his sensitivity to lights, sleeping in a dorm with five other men, and his inability to leave the TV room due to his close observation status. The patient was not receiving meaningful treatment and his time at BSH was causing him further harm. He was discharged back to his unit and placed on close observation status twice but he de-compensated further and self-injurious behavior brought him back to the ITU each time, including being found with a noose. This patient highlights the need for alternative units to ITU with less sensory stimulation and quiet space.

Another patient was frequently admitted and discharged from the ITU at his own request, whether or not he posed an imminent risk of serious harm to himself or others. The patient was often encouraged to use the ITU for quiet time so he often asked to go to the ITU and would sometimes hit another patient for the sole purpose of being sent to the ITU. He was often re-admitted later the same day he was released, sometimes due to a request to come back and sometimes because he assaulted someone. At times staff would offer him medication or a meeting with the treatment team but the patient would refuse them, insisting that the ITU was the only space that would help.

In an interview, treatment staff expressed their concern that the lack of quiet spaces means that patients do not have opportunities to calm themselves and self manage. The lack of such options and opportunities also explains why some patients strongly resist having to leave the ITU.

8. DLC found that typically a CO initiates the transfer to the ITU and the restraint and seclusion process, rather than clinical staff.

DLC found through its onsite interviews with staff and patients, as well as a thorough review of patient records and incident reports, that COs typically initiate the restraint and seclusion process. Since BSH has the culture of a correctional facility, a CO determines whether to transfer a patient to the ITU. If a patient's behavior does not conform to DOC rules or culture, for example by disobeying an order, engaging in a verbal or physical altercation, or attempting to or destroying property, it is the CO who controls whether to bring that patient to the ITU for assessment. Once at the ITU, the CO reports the "incident" to ITU staff and ITU staff generally rely on the CO's account of the "incident" to determine whether the patient should be restrained and/or secluded. In particularly egregious cases, the CO's very presence and intervention at an "incident" may escalate a patient's behavior and lead to causing further harm. This escalating of an incident may lead to use of four or five-point restraints on the patient and seclusion lasting days, weeks, or even months.

For example, one patient became upset during a medication line and was verbally threatening to the CO who arrived on unit. Medically trained staff did not intervene, attempt to de-escalate, or assess the patient for treatment options. Instead, ten more COs responded and there was a physical altercation, resulting in the patient having to get sutures in his head in the infirmary. Afterward the patient was brought to the ITU, where he was secluded for four days. A review of his records showed that the patient was meal and medication compliant, and rested throughout his time in seclusion. In this case, the COs brought the patient to the ITU in reaction to the altercation based on their evaluation as to the appropriate plan for him. There is no documentation of any treatment staff evaluation recommending seclusion for this patient, yet he was secluded for four days.

9. Clinical, therapeutic, and alternative treatment environments, such as quiet rooms, sensory rooms, trained MH staff, and techniques of de-escalation, that would be present at a DMH facility to reduce seclusion and restraint, are simply lacking at BSH.

As one patient who has been at BSH for more than two dozen years pointedly said in his interview, "I wish this place were run a lot more like a hospital and less like a prison."

In interviews, treatment and correctional staff agreed that there needs to be a wider range of alternative settings within BSH. The absence of a continuum of treatment settings, such as smaller units and quiet places away from the tv room, is a major impediment to effectively treating and managing patients. Staff reported that because BSH is designed as a prison, there are no places where patients can enjoy peace and quiet, read a book, or self-manage their symptoms. Correctional and treatment staff strongly agreed that there needs to be a significant infusion of treatment staff, including psychiatrists, psychologists, social workers and other mental health workers. As an example, treatment staff explained that although they had achieved some dramatic results with the use of a behavioral treatment plan, creating and implementing such plans requires substantial use of staff that is not currently available. Finally, both correctional and treatment staff identified the insufficient number of treatment staff and the fact that the vast majority of treatment staff leaves by 5 p.m., as a very substantial barrier to addressing patient treatment needs.

10. Patients in the ITU are denied the opportunity to enjoy fresh air and outdoor exercise.

Patients in the ITU lack access to fresh air and outdoor exercise. This is a right well established by federal case law, interpreting constitutional norms, the enforcement practices of the U.S. Department of Justice, and international legal standards for confinement of inmates.

For convicted prisoners in Massachusetts, the "D" Wing of Departmental Disciplinary Unit ("DDU") at M.C.I. Cedar Junction is the most secure wing, of the most secure unit in the Commonwealth's correctional system. DOC designates this unit for the one or two of the most dangerous, aggressive, and violent offenders of the 11,000 plus prisoners in its system. Yet even convicted prisoners in the DDU have the right to regular, highly supervised access to fresh air, outdoors and exercise for at least five hours per week.

BSH patients in the ITU have no such rights. Any meaningful reform at BSH must include enforceable regulations requiring that hospital patients have rights to fresh air that are at least equal to that of DOC high security prisoners, and not less than five hours per week of outdoor exercise in a secure environment.

Locating such space for ITU patients presents no significant fiscal or logistical challenges for the entity administering BSH. This would primarily require a commitment by security or clinical staff to escort patients to and from this outdoor space at periodic intervals.

By good fortune, the ITU at BSH has a door leading to an unused, small, grassy exterior courtyard, surrounded entirely by facility walls. This area would give patients access to at least

very limited exercise, fresh air, and sunshine, at least until more suitable outdoor exercise facilities could be arranged. BSH staff informed us that the courtyard would require some minor modifications to ensure that a patient seeking to escape the facility cannot climb on air conditioning units and window ledges to access the roof. In establishing the route to the outside courtyard, BSH would need to relocate the restraint bed so that its use would not preclude patients from the ITU being able to access the courtyard. Apparently, BSH administrative staff previously sought funds for making the necessary improvements.

Any costs in personnel or capital improvements are far outweighed by the obvious benefits of fresh air, sunshine, and outdoor exercise to clear thinking and good mental health.

11. Concerns about Staff

In separate interviews and unprompted, patients and clinical staff said some COs have a history of mistreating and abusing patients. Some patients said they were subject to unnecessary force and brutality that is not effectively addressed despite having filed complaints. It was reported that some officers use more force than is necessary and that there needs to be a better balance between security and the proper treatment of the patients. Treatment staff indicated that certain officers appear not to have the temperament, training, or skill set to deal with the more challenging patients. Patients and some COs independently reported that certain clinical staff routinely overmedicate their patients. Treatment staff expressed their strong belief that correctional staff need more specific training on issues involving the seriously mentally ill. Treatment staff also expressed the importance of having Use of Force Reports reviewed by an outside independent agency.

Recommendations

The Governor, through the Executive Office of Public Safety (EOPS), and the Executive Office of Health and Human Services (EOHHS), should immediately take the following action:

A. General Measures

- (1) Remove the functions of administration, operations, medical and mental health care, treatment and programming at BSH from the purview of EOPS and DOC, placing these responsibilities *under DMH and EOHHS*.
- (2) Reformulate the mission of BSH to achieve goals of effective, secure and compassionate treatment and recovery, rather than punishment.

- (3) Require a systemic re-assessment of BSH, in combination with related facilities, to ensure that, pursuant to Title II of the Americans with Disabilities Act and the Olmstead decision, that all persons with disabilities are receiving treatment and supports in the most integrated setting possible, without unnecessary isolation and segregation.

B. Admissions and Populations Served

- (4) Formulate a proposal by A&F, DCAMM, and EOHHS to make capital improvements as may be necessary to convert BSH into a modern, secure, therapeutic treatment facility conducive to safety, wellness and recovery for such persons.
- (5) Require that EOHHS and EOPS develop a plan within 90 days describing the means by which patients who do not require strict security or serving a sentence will be safely and appropriately treated in existing or proposed mental health facility administered by DMH with sufficient resources to address their treatment and recovery needs.
- (6) Require that EOHHS and EOPS develop a plan within 90 days describing the means by which patients who require strict security and are serving sentences will be safely and appropriately treated at a mental health facility licensed or administered by DMH with sufficient resources to address their treatment and recovery needs.
- (7) Require that EOHHS and EOPS develop a plan within 90 days describing the means by which persons with cognitive or intellectual disabilities will be individually assessed to determine how they can be safely and appropriately treated in existing or proposed facilities licensed or administered by the Department of Developmental Services, and/or DMH, with sufficient resources to address their treatment and recovery needs.
- (8) Develop proposed legislation for the General Court to amend state law as may be necessary to permit such populations referenced above to be treated elsewhere.
- (9) Develop proposed legislation for the General Court to narrow and clarify the definition of “strict security” so as to make judicial referrals clearer and more consistent, across all district and superior courts, and to avoid unnecessary referrals.

- (10) Develop proposed legislation for the General Court to narrow and clarify those circumstances in which prisons and county houses of correction may transfer inmates to BSH as patients.
- (11) Require a joint review by EOHHS and DMH of statutes, regulations and policies related to criminal charges filed against persons in DMH operated or licensed psychiatric facilities, including state hospitals and private hospitals. Such review must consider:
- a. The extent to which such criminal charges have resulted in unnecessary referrals to BSH through criminalization of non-volitional symptoms of psychiatric disabilities;
 - b. Incidents in which criminal charges from non-volitional acts at DMH operated or licensed psychiatric facilities have been followed by incarceration, decompensation, long term segregation, self-injurious behavior, and/or death;
 - c. A review of best practices, and the extent to which safety and security may be better assured through alternative approaches, including other safety measures and lower staffing ratios.
 - d. The need for new legislation to address (a) through (c) above.

C. Seclusion and Restraint

- (12) Prohibit the use of seclusion and restraint for punishment, convenience, routine discipline (e.g., for being “out of place”), failing to take medication not required by a Rogers order, etc.
- (13) Require exact and precise compliance by BSH custodial and clinical staff with the statutory limitations on the use of seclusion and restraint pursuant to G.L. c. 123, § 21, including the requirement that “[r]estraint of a mentally ill patient may only be used in cases of emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide.” (emphasis added). The likelihood of serious harm is a stringent test, and the word “only” in G. L. c. 123, § 21, means “for no other purpose.”
- (14) Develop protocols to ensure that the continuation of seclusion and restraint requires a demonstrated threat of an ongoing emergency manifested by the patient’s continued conduct. Staff shall not interpret passive conduct alone, such as sitting quietly, resting, or sleeping as a manifestation or continuation

of a serious threat of extreme violence or other emergency. Protocols should require active engagement with patients and regular intervals to provide accurate assessments of any continuing risk.

- (15) Ensure that use of seclusion or restraint is, in accordance with G.L. c. 123, § 21, a clinical determination that is entirely independent of opinions or recommendations of non-clinical staff.
- (16) Ensure that wherever required by G.L. c. 123, § 21, a person kept in restraint shall be afforded a specially trained person to understand, assist and afford therapy during the restraint.
- (17) Adopt policies and regulations currently in practice at DMH facilities requiring Individual Crisis Plans, and requiring alternatives to restraint and seclusion, such as de-escalation, the use of comfort rooms and sensory items, and debriefing patients when restraint or seclusion is used. Adopt trauma-informed care practices designed to eliminate the use of restraint and seclusion. Included within such policies must be the recognition and understanding that mental illness is often the result of prior trauma and that restraint, in particular, is re-traumatizing to patients, which can be dangerous for staff and patients.

D. Hiring and Training

- (18) Require a joint written review by EOHHS and DMH, developed within 60 days, and implemented within 180 days, of improvements to be made to the training requirements for both clinical and custodial staff related to nature and symptoms of mental illness and the immediate and substantial reduction and ultimate elimination of seclusion and restraint.
- (19) Require a joint review by EOPS, DOC, EOHHS and DMH, within 90 days and make recommendations related to selection of custodial staff at any remaining portions of BSH. Such recommendations shall include the bidding requirements of any current collective bargaining agreements and the ability of the Commonwealth to require custodial staff at BSH to have the background, skills and training to provide effective, secure, and compassionate treatment to persons with psychiatric disabilities.

E. Conditions of Confinement

- (20) Ensure that BSH patients have access to fresh air and exercise for at least one hour per day, including for persons kept in restraint and/or seclusion more than 24 hours. This will require funding to retrofit the outside courtyard adjacent to the ITU.
- (21) Create “cool-down” rooms or other safe therapeutic spaces on residential units, which patients may use voluntarily, so that patients at risk have alternatives to asking for admission to the ITU.
- (22) Conduct a review of suicide prevention efforts at BSH, and seek capital expenditures that may be necessary for the mitigation of suicide risks. Such modifications will also help reduce the unnecessary confinement of patients in the ITU.

F. Quality of Clinical Care

- (23) Develop protocols to ensure that transfers of patients between units does not necessarily involve the transfer to new mental health treatment staff and interrupt the flow and consistency of clinical treatment. Included in such protocols must be the requirement that treatment staff be consulted prior to a patient being transferred between units.
- (24) Establish a protocol for events that trigger an external peer review of the lack of success in the current treatment plan. This should include (a) a threshold number of ITU referrals within a fixed period; or (b) a threshold number of days of confinement in the ITU within a fixed period. Such an external review should offer alternative recommendations for treatment and care, and conflict de-escalation.
- (25) Adopt a robust quality improvement and psychiatric peer review process to ensure quality of mental health care, including the participation of external experts in correctional mental health and community mental health, and the appointment of a medical ombudsman for correctional mental health.
- (26) Appoint a medical ombudsperson, who reports directly to the Superintendent, to assist patients with concerns about their mental health or medical treatment issues.

G. Oversight and Monitoring

(27) Require that the Use of Force regulations, 103 CFR §§ 505.01 *et seq.*, be modified to address the specific needs of patients with serious mental illness, the elderly, individuals with dementia, and other special populations.

(28) Require the appointment of a Human Rights Officer, reporting directly to the Commissioner of the Department of Mental Health, to oversee human rights for any remaining patients at BSH.

(29) During a two year monitoring period, require quarterly filing of incident reports, patient complaints, death reports, mortality reviews, use of force reports, sentinel event reports, and quality assurance reviews with the Disability Law Center, as the Commonwealth's Protection and Advocacy System, (see 42 CFR part 51 subpart d), subject to federal regulations which limit and prohibit re-disclosure of any confidential materials.

Conclusion

The Disability Law Center, as the Protection and Advocacy system for Massachusetts, looks forward to your response to our report and working with you to address the concerns that have been identified.

Sincerely,

Christine M. Griffin
Executive Director

¹ 42 U.S.C. § 10801, *et seq.*

² 42 U.S.C. § 6000, *et seq.*

³ 42 U.S.C. § 10801(b)(2).

⁴ Individuals are transferred there from a myriad of places, including, but not limited to, the county jails, state prisons, and various courts across the Commonwealth. Individuals may also be transferred there when the superintendent of a Department of Mental Health (DMH) facility determines that failure to retain the patient in strict custody would create a likelihood of serious harm. See G. L. c. 123 § 13. Since BSH is the only DOC facility of its kind, individuals from anywhere in the Commonwealth are transferred there. Individuals admitted to BSH may be charged with or convicted of crimes ranging from misdemeanors to felonies.

Individuals admitted to BSH are evaluated to determine: (1) competency to stand trial; (2) criminal responsibility; (3) ability to await trial in penal environment; (4) ability to serve a sentence in penal environment; (5) need for further treatment and/or strict security following a finding of not guilty by reason of insanity; and/or

(6) sentencing. See id. §§ 15-18. BSH also evaluates individuals sent there from DMH to determine if they require strict custody and possibly commitment to BSH. See id. § 13. BSH has eight psychologists contracted to conduct all initial forensic evaluations and any recommitment and competency to stand trial evaluations; these eight psychologists conducted 850-900 forensic evaluations in 2013.

After the evaluation is completed, patients may be committed to BSH for periods ranging from six months to one year, if the court determines that they require additional treatment and evaluation. See id. § 8(b). As such, patients admitted to BSH range from criminal defendants incompetent to stand trial to those who cannot be held criminally responsible, criminals awaiting sentences to those serving sentences, and individuals transferred there from a DMH facility who may be voluntarily civilly committed to those who may be involuntarily civilly committed.

As of January 1, 2014, 64% of BSH patients were committed and 21% were admitted for observation. The remaining 16% of patients are infirmary inmates and inmate workers. The average length of stay for a BSH patient is 781 days.

BSH is divided into 11 distinct housing units. A-I, A-II, B-I, B-II, C-I and C-II are all general populations units, while Max-I and Max-II are higher security units. The Intensive Treatment Unit, or ITU, is the highest security unit where patients are in seclusion 24 hours a day, and where any four or five-point restraints occur. Patients who require medical treatment or special protection are housed in the Infirmary and Med West. BSH has a design capacity for 227 patients, but typically holds over 300 and held as many as 400 patients within the past five years. When DLC attorneys initially visited BSH on May 29, 2014, there were 307 patients in the hospital. Of those 307, there were 223 patients in the general population units, 44 in Max-I and Max-II, 31 in the Infirmary and Med West, and 9 in the ITU.

The BSH physical plant is a mish mash of buildings and trailers that have been cobbled together over the years to handle the increase in the number of patients sent to BSH for commitment or evaluation and the increase in staff necessary to serve them. The physical conditions are deplorable for the patients and staff alike despite best efforts to keep the facility clean and functioning. The HVAC system has been pieced together as each new trailer was added to the system resulting in a facility that provides uneven heat and air conditioning for the patients and the staff. The current configuration makes it impossible for the clinical staff to provide the treatment and/or interventions necessary and as required by their own standards.

⁵ These limits include the following: 1. No order for restraint can be valid for more than three hours after which it must be renewed upon personal examination by the superintendent or authorized staff; 2. No adult may be restrained for more than six hours, beyond which renewal may only occur upon personal examination by a physician; 3. The maintenance of an adult in restraint for more than eight hours in twenty-four hour period must be authorized by the superintendent or other high level official; 4. No person can be kept in restraint without a special trained person in attendance; and 5. No "P.R.N." or "as required" authorization of restraint may be written.