

The History of Bridgewater State Hospital, Bridgewater, Massachusetts

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And thus continued the recurring history of the prison's failure and reinvention as a reactive vision designed to fix the failures. – Ashley T. Rubin, That Time We Tried to Build the Perfect Prison: Learning from Episodes Across U.S. Prison History, describing the lengthy, ongoing history in the United States of trying to construct the perfect prison.¹

Executive Summary

Bridgewater State Hospital (BSH) is Massachusetts' prison for men with serious psychiatric needs who also have pending criminal charges or convictions or who have been found not guilty by reason of insanity. It is called a hospital but is operated as a secure facility by the Massachusetts Department of Correction (DOC) and has the appearance and feel of a correctional facility.

To understand BSH today, one must understand its history. The state first opened an almshouse on the same site in Bridgewater in the 1850s. Since that time, the purpose of the buildings and the populations occupying them have changed. BSH has consistently been used to house people identified as undesirable and removed from society, sometimes on the basis of pseudo-scientific labeling. Moreover, decade after decade, at facilities nominally charged with providing care and treatment but failing to be operated as licensed clinical operations, those confined there have suffered.

This paper traces that history, marked by a cycle of segregation of populations, provision of suboptimal services, decline of conditions, exposure, and attempts at reform. As we assess the current conditions at BSH, we should view the facility in this larger context.

Themes

In this history, certain themes stand out as consistent reminders of the challenges at the institution.

First, BSH's mission has been and remains confused. Over time, it has become the state's primary facility for forensically involved psychiatric patients. In that incarnation, the state has repeatedly called upon BSH to be a mental health hospital and a prison, both at the same time. This has remained true even as we have learned about the harms to people with mental illness who are subjected to the carceral system. Despite calls for decades for the Department of Mental Health (DMH) to manage the public forensic mental health facility, as is the practice in every other state in the U.S.,² BSH has remained under DOC's operation and control.

Second, BSH has been the site of inexcusable injury and death, including deaths attributable to the overuse of restraint. Additionally, BSH has historically and continues to be a place where many individuals are left for years on end, well beyond the periods for which such persons need strict security, and for many detainees and insanity acquittees beyond the time they would have spent in jail or prison had they been tried and convicted. To the extent that periodic reforms have occurred to address these harms, they have largely been due to external forces, including bold legal interventions and media exposés.

Third, the rights of men at BSH to receive care in the least restrictive setting possible, guaranteed by state law, and to receive services in the most integrated setting possible, guaranteed by federal law, have not been sufficiently considered when evaluating the need for strict security confinement.

Fourth, over time, the DOC has moved to contract out medical and mental health care for BSH patients, with a trend towards relying on for-profit, national corporations, raising questions about quality of care. These questions exist today under the present vendor, whose recent persistent and significant reliance on illegal forced emergency medication in violation of state law is a matter of serious concern requiring corrective action by DOC.

Fifth, after years of deterioration, the physical plant at BSH is now beyond repair. Convicted BSH patients held at Old Colony Correctional Center live in a building that does not pretend to be anything but the prison it is.

Recommendations

This paper traces the history and these themes and then offers suggestions for reform to better serve BSH patients. These recommendations include the following.

First, the Commonwealth must finally commit to the transfer of responsibility for the care of state forensically-involved patients with serious psychiatric issues from DOC to DMH.

Second, the Commonwealth must construct a new therapeutic facility for those who require strict security and place its administration in the hands of DMH. Such a facility must incorporate emerging ideas on how to best create dignified healing environments. The Commonwealth must also carefully consider the implications of construction of such a facility on other forensically involved individuals in the state, including incarcerated women and those who have received treatment in DMH-operated facilities.

Third, the Commonwealth must commit to a review of its reliance on for-profit and out-of-state corporations for the provision of health care services to individuals confined to public institutions. If DOC continues to rely on for-profit and/or out-of-state providers, DMH should enlist behavioral health professionals to provide robust and meaningful oversight of those providers.

Fourth, the Commonwealth must establish an empowered and sufficiently resourced oversight body that is independent of both DMH and DOC with authority to review all aspects of care. Part of that oversight must involve addressing root causes of the racial and ethnic disparities in the BSH patient population and any resulting disparate treatment. Oversight must also involve patients, family members, and advocates and be undertaken with transparency.

Introduction

To describe Bridgewater State Hospital (BSH) as an historically troubled institution is to diminish the lives and ignore the suffering of the people who have been incarcerated there. Throughout its history, one constant at BSH has been change: in response to scandal, in response to amendments in the law, in response to lawsuits, in response to new treatment philosophies, and in response to new priorities of continually changing state leadership. Another constant is that despite even well-meaning change in how BSH operates, nothing much of real substance has changed for the men who are committed there. The hospital at Bridgewater has cycled between crisis and reform and deterioration and repair, with improvements typically following public revelation of some failure or misfortune. Throughout these cycles, it has remained a place with serious deficiencies in care and environment.

BSH is a medium security prison administered by the Massachusetts Department of Correction (DOC) and located on DOC's Bridgewater large multi-facility campus.³ The BSH facility has two locations – a hospital building which opened in 1974 and the other BSH campus buildings that abut it behind a fence and barbed wire, and two units, which opened in 2017 in Old Colony Correctional Center (Old Colony or OCC), a medium and minimum-security prison on the same campus.

This paper traces the history of the Bridgewater facility from its inception to its present status as the sole carceral facility in Massachusetts housing male patients with serious psychiatric needs who also have pending criminal charges or convictions or who have been found not guilty by reason of insanity.⁴

This account begins in the 1850s, when the predecessors to BSH first emerge. We will proceed through the decades to the present, watching a series of configurations, populations, crises, and reforms. No matter what the iteration, it is always obvious that successfully using a prison as the provider for people with serious mental health needs – even those with criminal legal system involvement – is impossible.

1850s-1920s – The predecessors to Bridgewater State Hospital – the Bridgewater Almshouse, Workhouse, and State Farm – absorb a rolling cast of populations unwanted by our larger society

The Bridgewater Almshouse accept a wide range of categories of disfavored people, including those labeled “insane”

In the mid-1800s, Massachusetts communities were responsible for poor people living within their borders. However, persons without a legal residence could not claim relief from any town.⁵ Thus, in 1852, the Legislature established three institutions to receive such persons⁶ and in May 1854, the Commonwealth opened, in Bridgewater, Monson, and Tewksbury, almshouses for poor people without a legal residence in Massachusetts or for whom a town or city of settlement was unknown.⁷

The almshouses were soon accepting persons whose classifications included sick, drunk, insane, healthy, “bad,” pregnant, lame, feeble, consumptive, syphilitic, having “sore eyes,” blind, aged, and paralyzed.⁸ The numbers of people identified as needing such services increased over time.⁹ Additionally, when other almshouses were too crowded, persons were sometimes transferred to the Bridgewater Almshouse.¹⁰ Some people lived out their lives at the almshouse.¹¹

In its early years, the Bridgewater Almshouse served “insane” persons, but not exclusively. Between 1854 and 1855, the Almshouse accepted approximately 100 insane poor, mostly from “lunatic asylums.”¹² In the first ten years of operation, 150 of 500 to 600 yearly admittees were “insane.”¹³ However, between 1854 and 1887, a sampling of data shows that only 4.7% of female admissions and 5.9% of male admissions were designated insane.¹⁴

The influence of Dorothea Dix reinforces an ongoing dichotomy between the care provided in State Mental Asylums and in the Bridgewater Almshouse and its successor institutions

While the almshouses were opening, Massachusetts-reared Dorothea Dix was shaping the mission of the Commonwealth with respect to state mental hospitals. Between 1840 and 1841, Dix investigated the care of the poor persons with mental health issues confined in Massachusetts institutions.¹⁵ In 1843, she petitioned the state Legislature to expand Worcester State Hospital,¹⁶ which had been established ten years earlier. Taunton State Hospital was established in 1854 and Northampton State Hospital in 1858. These rural retreats were supposed to provide treatment and a setting for work and restoration in a bucolic environment. However, paupers with mental illness were considered incurable and many remained in almshouses.¹⁷

Bridgewater Almshouse expand to include a workhouse and hospital, leading simultaneously to the gradual admission of more persons labelled insane and a more prison-like operation

In 1866, the Legislature established a State Workhouse and hospital at the Bridgewater Almshouse.¹⁸ Over time, the Workhouse housed paupers (including persons convicted of misdemeanors) and incorrigible juveniles.¹⁹ By the early 1870s, the almshouse function had declined, and the Workhouse and Hospital had expanded.²⁰ A new manager, assuming control in 1871, enlarged the Hospital.²¹

In 1872, the Legislature abolished the state almshouses,²² and the Bridgewater complex remained a State Workhouse. It held multiple categories of people, including poor, criminal, and insane persons.²³ Due to crowding in the Commonwealth's mental health facilities, the Workhouse continued to accept insane persons, but the institution offered "little in the way of medical care."²⁴ In 1880, the State Board of Health, Lunacy, and Charity identified the Workhouse as a prison.²⁵

The care provided at Bridgewater facilities during this time was questionable. In the late 1870s, staff resorted to confinement and straightjackets to punish patients.²⁶ After an 1877 newspaper article alleging the severe beating of an inmate, the Legislature investigated conditions and management at Bridgewater.²⁷ Inmates told the Legislature they had been "choked, strangled, beaten, kept of diets of bread and water and place in close confinement."²⁸

In 1883, fire destroyed the Bridgewater complex.²⁹ Then Governor Benjamin Butler proposed rebuilding with a new "insane hospital."³⁰ Much of the rebuilding was completed by the end of 1884.³¹

In 1886, the Legislature authorized the construction of an asylum building at the State Workhouse at Bridgewater for "chronically insane men."³² The asylum was under the control of the State Board of Lunacy and Charity,³³ the State Board of Health having been pulled out of the State Board of Health, Lunacy, and Charity to form its own entity that same year.³⁴ The asylum building opened in 1887 and began accepting patients – often ones seen as troublesome – from other state asylums.³⁵ The Workhouse closed at the same time.³⁶ This transition led to features to confine those considered more violent.³⁷

The establishment of the State Farm at Bridgewater and the Asylum for Insane Criminals, while ostensibly an attempt to eliminate the stigma of placement at a workhouse, leads to growing segregation of large numbers of men labeled insane, including those with criminal histories

In 1887, the Bridgewater institutions, including the Almshouse and the Workhouse, became the State Farm at Bridgewater – containing almshouse and hospital departments.³⁸ The name change was to reflect the admission of "insane paupers," who were not considered responsible for their circumstances or worthy of the stigma of the term "workhouse."³⁹ In 1895, the Legislature designated "[s]o much of the hospital and almshouse departments of the state farm at Bridgewater as was established for the care and maintenance of insane men" as the "State Asylum for Insane Criminals" at Bridgewater.⁴⁰ While no longer a workhouse in name, the residents were still required to work, performing the farm functions that maintained the institution.

In subsequent years, the population of Bridgewater grew as courts continued to commit "insane" men charged with or convicted of crimes there and other facilities also sent convicted men labelled insane, resulting in overcrowding and the eventual construction for more capacity.⁴¹ State prisons, the Massachusetts Reformatory, and jails all sent persons to the newly-named asylum.⁴² Hollis Blackstone, Bridgewater Superintendent from 1883 to 1922, advocated for such expansion, resulting in the construction of 300 additional prison rooms in 1897.⁴³ In 1904, Blackstone again seeking to address

overcrowding, suggested that the State Board of Charities ask the courts to stop sentencing intoxicated individuals to Bridgewater.⁴⁴

In 1909, the division of the State Farm for insane criminals became “Bridgewater State Hospital.”⁴⁵

While historian Michael Maddigan describes the State Farm as a generally well-run facility,⁴⁶ he catalogues serious problems. In 1912, an attendant lethally assaulted a disorderly and resistant hospital patient.⁴⁷ In 1913, an attendant testified before the Massachusetts Hospital Reform Society regarding cruel and harmful treatment of patients.⁴⁸ Maddigan chronicles, between the late 1880s and 1910s, numerous escapes⁴⁹ and a number of suicides.⁵⁰

Poor conditions at the State Farm would not be surprising given the larger historical context. Historian Alex Green notes that during this period most institutions, even the best, were severely overcrowded and, during World War I, short on staff, administrators were left to hire less qualified people, who then abused patients.⁵¹

In 1919, the Legislature transferred control of the State Farm from the State Board of Charity to the Massachusetts Bureau of Prisons (later DOC).⁵²

The manufacturing of a new category of persons for confinement – the “defective delinquent”

Momentum was growing for a new population to label and confine. As Alex Green explains, around 1904, Dr. Walter Fernald, the Superintendent of the Waverly School for the Feeble-minded, created the pseudo-scientific term “defective delinquent” to describe individuals who had both mild intellectual disability and a consequent propensity for mischief and violence.⁵³ For the next twenty years, he led efforts in the Commonwealth and elsewhere to involuntarily commit individuals who fit this categorization in facilities that combined features of prisons and institutions for persons with disabilities.⁵⁴ In his own facility, Fernald confined such categorized individuals without the opportunity for release, leading to overcrowding and rebellion.⁵⁵ In response, Fernald sought – unsuccessfully – to build a prison-like facility at his school.⁵⁶ He then sought to create a defective delinquent department at some other state institution.⁵⁷ Correspondence between Fernald and the Superintendent of the Massachusetts Reformatory in the mid-1910s reveals the difficulty at the time to identify an appropriate facility to house this population.⁵⁸

Fernald chaired a state Commission to Investigate the Question of the Increase of Criminals, Mental Defectives, Epileptics and Degenerates.⁵⁹ The Commission included Superintendent Blackstone – in an unfortunate evolution of thought towards expanding the responsibilities of Bridgewater’s institutions.⁶⁰ The Commission’s 1911 report advocated for the legal recognition of “defective delinquents” as a new category of persons in need of permanent custodial care.⁶¹

That same year, the state Legislature passed the “Defective Delinquent Law,” allowing the state to indefinitely commit, with no due process, defective delinquents” – a term only loosely defined in statute.⁶² According to the statute, one could be found to be a “defective delinquent” if “it shall appear” that a person has committed an offense which could result in being sentenced to state prison (other than offenses punishable by death or life imprisonment), is “mentally defective,” and is not a proper subject for the schools for the feeble-minded or for commitment as an insane person.⁶³ Thus, people with some uncertain level of disability who had been determined to be likely to commit crimes (even if they had not actually done so) could be subject to indefinite confinement. Thus, the vague definition granted the state great power to control and remove people considered to be deviant.

To provide the necessary custodial care, the statute required the establishment of a department for defective delinquents at the State Farm at Bridgewater and two other facilities; all men 21 or older committed under the act were sent to the State Farm while the other facilities housed youths and women.⁶⁴

As Green describes the events that followed, while the legislation passed quickly after the Commission's findings, state officials were reluctant to assume responsibility for implementation.⁶⁵ The category of "defective delinquent" was new so there was no precedent to rely on for setting up an institution.⁶⁶ Neither the Department of Mental Diseases (later the Department of Mental Health (DMH)) nor the DOC wanted the responsibility.⁶⁷

In the late 1910s and early 1920s, debate ensued in the state Legislature about sending defective delinquents to prison settings.⁶⁸ In January 1918, the Annual Conference of the Massachusetts Society for Mental Hygiene included an evening devoted to the topic of the defective delinquent. One presentation was entitled "What shall be done with the Defective Delinquent in the Penal Institutions," presented by Colonel C.B. Adams and Jessie Donaldson Hodder.⁶⁹ Hodder was a reformer who had been appointed Superintendent of the Massachusetts Prison and Reformatory for Women at Sherborn (later annexed by Framingham and operated as MCI-Framingham).⁷⁰ Two years later, Hodder would write to the state House Committee on Ways & Means, opposing legislation to send to prisons, including the Reformatory for Women, the Massachusetts Reformatory at Concord, and the Bridgewater State Farm, those designated as defective delinquents.⁷¹ While Hodder did not reject the concept of the defective delinquent or the severity of their afflictions, she warned that creating "life prisoners in a prison" of this population, as opposed to "treating of the individual for his defect" would result in failure:

Do not put upon them and their families arbitrarily the burden of being called criminals. To this the answer comes back: This is but an experiment. We know there will be a terrible time trying out this scheme...It will break up the organization of the Reformatory Institutions. In short, one man told me: "There will be Hell, but when the Hell has gone on long enough we will all rally around you and come back to the legislature, tell it the whole truth and ask it for the right sort of an institution."⁷²

Hodder suggested that the history of the almshouse, and the gradual creation of specialized treatment facilities for the "insane," "feebleminded," and "epileptic" should lead one to reject the use of prisons for this population.⁷³ She said that the bill's supporters sought these persons to fill empty prison and jail cells.⁷⁴ Rejecting that attempt, she urged: "Our empty jails and prisons cells should be matters of great rejoicing. Let them decay, but do not let us use them for the housing of the incurable sick."⁷⁵

Unfortunately, Hodder's voice was not heeded. In 1922, the Legislature passed legislation implementing the 1911 law.⁷⁶ From 1922, the State Farm at Bridgewater admitted persons falling into this definition (including children),⁷⁷ establishing a defective delinquent department for men in 1922 and for women in 1926.⁷⁸ Their presence – yet one more population to absorb – concerned officials at the time.

Green writes that, from the very beginning, even the advocates for the identification and confinement of "defective delinquents" acknowledged that the categorization had questionable value and that the existing institutions and treatments for such persons were insufficient.⁷⁹ Consequently, Green continues, upon committing individuals to Bridgewater pursuant to the law, staff never provided a differentiated program of treatment for the population they had claimed to identify.⁸⁰

Still, over the long term, the creation of a category of individuals whose alleged deficits were both biological and criminal, their placement at Bridgewater, and the ongoing pursuit of control that combined both involuntary commitment and carceral confinement would have a great influence on the evolution of that institution. In the passage of the law and the sending of persons committed under it to Bridgewater, the facility not only once again received a new category of unwanted individuals under the excuse of providing care, but it also was encouraged to control its population through an unhealthy blend of treatment and punishment.

1930s – The State Farm at Bridgewater houses a mix of populations who receive little care and deteriorating conditions

By the 1930s, the State Farm at Bridgewater housed a mix of male and female prisoners, male paupers, male insane persons, male and female “defective delinquents,” and male drug addicts;⁸¹ this mix of populations and the lack of appropriate rehabilitation led to deteriorating conditions.⁸²

In 1934, Commissioner of Correction Arthur Lyman called for the Department of Mental Diseases to assume oversight of the hospital.⁸³ In July 1935, the Legislature passed a statute authorizing, upon the allocation of funds, a state hospital for the criminally insane to be built on land transferred to that department from the state prison colony at Norfolk.⁸⁴ Once built, all prisoners from BSH would be transferred to this new Norfolk State Hospital or to some other state hospital under the control of the Department.⁸⁵ However, this planned transfer did not come to pass.

1940s – The State Farm at Bridgewater sees the brutal consequences of poor conditions

On January 1, 1942, three inmates escaped from the State Farm at Bridgewater, killing three guards in the process. Two of the inmates were convicted; in letters, they wrote about the poor conditions at the facility.⁸⁶

In 1947, the Legislature passed a law requiring immediate psychiatric examination of all individuals committed as defective delinquents,⁸⁷ and, after a constitutional challenge in 1953, the defective delinquent department was “largely discredited as a cruel institution.”⁸⁸

1950s – The State Farm at Bridgewater becomes Massachusetts Correctional Institution (MCI) – Bridgewater, the population shifts exclusively to persons with behavioral health issues, and a proposal to transfer the hospital to the Department of Mental Health fails

In 1955, the Legislature renamed the State Farm at Bridgewater the Massachusetts Correctional Institution (MCI) – Bridgewater, which included the existing hospital.⁸⁹ With that change, MCI-Bridgewater could no longer house aged or infirm state prisoners, those with misdemeanor convictions, or almshouse paupers.⁹⁰ In 1956, the Legislature sent sentenced men convicted of drunkenness to MCI-Bridgewater.⁹¹ The prison population (aside from the hospital) was almost entirely those with alcohol or drug-related convictions.⁹²

MCI-Bridgewater could now admit only those with alcohol and drug addiction problems, “defective delinquents,” and persons determined to be insane.⁹³ As Alex Green observes, based on his review of civil commitment records from this time, the facility served an ongoing public appetite for permanently removing individuals deemed by the community to be undesirable.⁹⁴

As part of the same 1955 legislative reform, a Medical Director position was established for BSH, appointed by the DOC Commissioner with, as required by statute, the DMH Commissioner’s approval.⁹⁵

Maddigan observes that MCI-Bridgewater authorities in the 1950s “were hampered in their efforts to stem deteriorating conditions because of limited funding and public apathy.”⁹⁶

In August 1958, Governor Foster Furcolo submitted legislation which, among other changes, would have transferred control of the Bridgewater facility from the DOC to DMH.⁹⁷ He stated: “The human suffering of the criminally insane, the defective delinquents and the alcoholic population at Bridgewater State Hospital is a challenge to the moral conscience of the Commonwealth.”⁹⁸ The transfer was necessary

in order to make available to the inmates the best care and treatment that is possible for us to supply. Medical knowledge in the field has made great strides, and it is now necessary to adjust our administrative arrangements in order to bring the advantages of research to those who are afflicted.⁹⁹

Conditions for these individuals were “shocking.”¹⁰⁰ Moreover, the problem was substantial as a report by DOC’s Committee on Building Needs made clear: “The human beings relegated to this hopeless bastille constitute the largest population in any penal institution in the state.”¹⁰¹ In addition, Furcolo noted that “It will not be sufficient, however, to transfer the administration of this institution from the Department of Correction to the Department of Mental Health. Adequate facilities must be provided if the Department of Mental Health is to care adequately for these unfortunates.”¹⁰² Furcolo’s legislation proposed funds for plans and site acquisition for a new hospital for the criminally insane.¹⁰³ However, the Legislature did not act.

In 1959, Charles Gaughan became Superintendent at MCI-Bridgewater, and soon began a multi-year effort to raise attention to poor conditions and implore the Legislature to make improvements.¹⁰⁴ According to Maddigan, “With public disclosure of these conditions, Bridgewater came to be regarded as among the worst penal institutions in the nation.”¹⁰⁵

The 1960s - Observers Reveal Rights Violations and Mistreatment at Bridgewater State Hospital

In the 1960s, a range of types of media – the mainstream press, legal researchers, and documentarians all revealed troublesome practices of confinement at Bridgewater State Hospital. These practices included the detention of many who did not actually fit the definition of being a danger to themselves or others and the horrid conditions facing those who were confined. While in the past the public was more likely to treat reports of life at Bridgewater as entertainment or curiosity, in this era, faced with devastating accounts of institutional practices, public sentiment began to shift.

Questioning the bases for civil commitments and their indefinite duration

In February 1963, *The Boston Globe* exposed 240 “forgotten men” held at Bridgewater State Hospital.¹⁰⁶ These patients, confined for an average of 30 years, had petty crime convictions or no convictions at all.¹⁰⁷ DOC Commissioner George McGrath blamed DMH – for refusing to accept persons who were no longer dangerous and for using Bridgewater in previous years as a “dumping ground for anyone whom the mental hospitals couldn’t handle.”¹⁰⁸ Superintendent Gaughan became a strong advocate for what he called “poor, burned out old men” forced to “mingle with 150 insane murderers.”¹⁰⁹ In 1966, Gaughan said, “It doesn’t make sense that anyone who has finished his sentence should continue to be locked up in a correctional institution.”¹¹⁰

On January 15, 1967, *The Globe* asked whether the facility was “a hospital or a stable.”¹¹¹ A Superior Court Justice, the Chief Counsel for the legislative committee investigating the state’s prisons, and the Massachusetts Bar Association President all strongly criticized conditions.¹¹² The DMH Commissioner at the time, Harry Solomon, urged legislative action or “Bridgewater will always be a problem.”¹¹³

Maddigan describes Bridgewater in this era as a facility with an “absence of genuine psychiatric treatment.”

Meanwhile, on January 18, 1967, Albert DeSalvo, known as “the Boston Strangler,” escaped from BSH while serving a life sentence and remained at large for over a month.¹¹⁴ The event drew attention back to Bridgewater where Superintendent Gaughan was still calling for legislative action.¹¹⁵

In November 1967, the Massachusetts Supreme Judicial Court (SJC) ruled, in *Robert Rohrer, petitioner*, that a patient indefinitely committed to Bridgewater after a period of observation and without due process was entitled to be discharged.¹¹⁶ Following the decision, Massachusetts Attorney General Elliot Richardson established a Bridgewater Release Project, which found that nearly half of the 300 patients at Bridgewater were unlawfully confined.¹¹⁷ After hearings, 96 of these men were committed to DMH hospitals.¹¹⁸

In 1968, Steven Engelberg, a Legal Fellow at Georgetown University Law Center writing in a law journal, questioned the long-term problem of indefinite pre-trial commitments to Bridgewater of persons who often did not present a danger. Two men had been held at Bridgewater for decades upon criminal charges that never resulted in trial.¹¹⁹ One man arrived in 1915 and spent his remaining 43 years there; another was admitted in 1896 with a charge of vagrancy and spent 63 years at the facility, dying there in 1959.¹²⁰ These two cases were not isolated incidents; a 1961 study revealed that only two of 197 patients confined on indefinite pre-trial commitments since 1896 had been released from Bridgewater.¹²¹

Engelberg criticized the Massachusetts courts’ reluctance to conduct pre-trial evaluations of criminal defendant’s mental condition without commitment – evaluations that were allowed by Massachusetts statute.¹²² The SJC did not clarify (as others states had) that competency to stand trial was the criterion for forensic commitment: “The Supreme Judicial Court ... has confused the test for competency to stand trial and the test for criminal responsibility, and it has stated that a defendant could not stand trial if he lacked criminal responsibility.”¹²³

These judicial failures continued to cause numerous indefinite confinements into the 1960s of persons who might not ever have posed a danger. There were 254 indefinite commitments out of 1111 defendants sent to Bridgewater for observation between fiscal year 1959 and fiscal year 1964.¹²⁴ Engelberg recommended limiting civil commitment for the restoration of competency to one year.¹²⁵

Engelberg also took note of Bridgewater’s institutional environment. He argued that Bridgewater was a “security institution,” where “the prison-like atmosphere ... does not aid an individual’s recovery.”¹²⁶ “Furthermore,” he added, “it has been shown that Bridgewater is understaffed and that it is difficult for patients there to receive adequate treatment.”¹²⁷

Frederick Wiseman documents the horror and absurdity of life within Bridgewater State Hospital in Titicut Follies

In spring 1966, law-professor and filmmaker Frederick Wiseman shot footage at Bridgewater State Hospital for 29 days.¹²⁸ Wiseman had secured permission from Lieutenant Governor Elliot Richardson and Attorney General Edward Brooke.¹²⁹ Wiseman recorded guards taunting patients, the forced feeding of a patient and his subsequent death and embalment, naked patients held in solitary confinement, and an annual patient talent show called “Titicut Follies.”¹³⁰

In September 1967, Richardson instructed Wiseman that the resulting documentary film, *Titicut Follies*, invaded the privacy of the men portrayed and prohibited Wiseman from distributing the film

within the Commonwealth.¹³¹ Wiseman, meanwhile, made an agreement to distribute the film elsewhere in the U.S. and in Canada and it was shown publicly and privately in New York City in the fall of 1967.¹³²

In January 1968, a Massachusetts trial court judge ruled that the film was an unwarranted intrusion into the privacy rights of the patients pictured and forbid its showing.¹³³ In June 1969, the SJC affirmed and extended the ban on showing the film to the general public. In reaching this decision, the SJC, for the first time in its history, recognized a right to privacy in Massachusetts law. The Court held that the Commonwealth has standing and a duty to protect reasonably, and in a manner consistent with other public interests, the inmates from any invasions of their privacy substantially greater than those inevitably arising from the very fact of confinement.¹³⁴ Wiseman and others criticized the Court's decision to invoke such a right for the first time in a case exposing patient mistreatment.¹³⁵

However, the SJC did allow for the film's showing to

legislators, judges, lawyers, sociologists, social workers, doctors, psychiatrists, students in these or related fields, and organizations dealing with the social problems of custodial care and mental infirmity. The public interest in having such persons informed about Bridgewater, in our opinion, outweighs any countervailing interests of the inmates and of the Commonwealth (as *parens patriae*) in anonymity and privacy.¹³⁶

Despite these constraints, *Titicut Follies* was seen by thousands of Massachusetts residents and had a significant impact. Journalist and academic Bruce Jackson included BSH in a 1968 piece in *The New York Times* on U.S. prisons:

Even now Massachusetts has one of the most wretched institutions in the country, the Correctional Institution at Bridgewater, designed to handle the "criminally insane." Fred Wiseman's portrayal of this place in "Titicut Follies" did not exaggerate; it is the worst place I have visited, North or South.¹³⁷

The Court's ban was finally retracted on July 29, 1991, when Massachusetts Superior Court Justice Andrew Gill Meyers ruled that the film could be released since most of the patients appearing in it had died.¹³⁸ But several years earlier, attorney Steven Schwartz decried the ramifications of the ban. Representing a BSH patient who had choked to death on food after being extensively restrained and over-medicated, he asserted: "There is a direct connection between the decision not to show that film publicly and my client dying 20 years later, and a whole host of other people dying in between."¹³⁹ Despite being banned and the limitations to change that resulted from that ban, the film had a profound effect.¹⁴⁰

Nason v. Superintendent of Bridgewater State Hospital spurs reforms including transfers from the facility, but the Supreme Judicial Court rejects the contention that Bridgewater State Hospital patients should be housed in DMH facilities

In 1968, a year before issuing its opinion regarding the ban on *Titicut Follies*, the SJC issued its opinion in *Nason v. Superintendent of Bridgewater State Hospital*, a case brought by a BSH patient.¹⁴¹ While the SJC established that confinement in the absence of treatment raised due process and equal protections objections which could only be effectively met by instituting a program of appropriate treatment for patients,¹⁴² it also found evidence of certain improvements in the provision of care at BSH and rejected the contentions that DOC could not provide patients with adequate care and that these patients needed to be housed in DMH facilities.

In the eyes of the Court, the situation at BSH presented a mixed picture. The facility had “a population of 600 persons under indefinite commitment and of about thirty patients under observation,” all “deemed to constitute a danger to themselves or to others if confined outside of a maximum-security setting.” Citing a Special Commissioner Report that informed its decision, the Court in *Nason* noted that BSH offered little except for “uniformed guards, locked wards, and ... seclusion rooms.”¹⁴³ Its “basic inadequacy” was “a serious lack of adequate professional staffing.”¹⁴⁴ A more than tripling of patients annually admitted for observation in the previous ten years meant that staff had “little time ... for the others.”¹⁴⁵ Moreover, the Court concluded, each of the eleven DMH hospitals would be better sites than BSH for treating Nason.¹⁴⁶ While more generously staffed, these DMH hospitals were “moving towards an open-door policy and away from ... locked wards and seclusion rooms” in an effort “to encourage patients to [make] progress towards out-patient status.”¹⁴⁷

The Court came to the brink of doing something, but ultimately concluded that the Commonwealth was not obliged to operate maximum security facilities at DMH hospitals, even for persons not serving criminal sentences. Care could be provided in a DOC facility, if the treatment provided there was adequate. And the Court found it to be adequate for Nason, noting efforts to improve BSH and provide it with proper staff. The court took into account reforms including increased recreation and work activities and transfers out of BSH.¹⁴⁸ The Court concluded: “Although the progress to date may have been slow, now that BSH's serious deficiencies as a mental hospital have become apparent, we will not assume that ‘the necessary action to ... [provide there] fully adequate treatment ... already begun, will not be carried to completion.’”¹⁴⁹ The reforms spurred by the lawsuit may have averted a judicial finding that forensic patients should be treated in DMH facilities. The SJC saw the problems and declined to take meaningful action to redress the harms. As they would again and again defer to correction officials, relying upon a promise of progress that went largely unfulfilled.

The 1970s – Allegations of horrid conditions lead to a new campus and new mental health services provider

A citizen’s committee finds horrible conditions at Bridgewater State Hospital

Indeed, five years later, in 1971, despite the SJC’s optimism, a citizens’ committee appointed by Governor Francis Sargent to investigate the need for prison reform, “found conditions at Bridgewater unchanged since 1966.”¹⁵⁰ The Departmental Segregation Unit for problematic patients was “a medieval chamber of horrors.”¹⁵¹ Patients were confined to this “filthy hole” with only a bed and pot for 23½ hours a day, without toilet or running water.¹⁵² The committee’s finding led to that unit’s closure in 1972.¹⁵³

Repealing the statute regarding “defective delinquents, the Legislature limits who may be confined at Bridgewater State Hospital

The Massachusetts Legislature finally repealed the statutory provision for the confinement of “defective delinquents” in 1970,¹⁵⁴ and in 1972, the U.S. Supreme Court invalidated the concept of defective delinquency.¹⁵⁵ In 1971, the Legislature abolished the crimes of public intoxication and alcoholism.¹⁵⁶ One could still be civilly committed to MCI-Bridgewater for treatment of alcohol or drug use, but such persons would be housed and treated separately from those persons with criminal convictions.¹⁵⁷ Later, other DOC facilities assumed responsibility for those persons with civil commitments for substance use treatment.¹⁵⁸

Poor living conditions and a lack of adequate treatment persist, even with a new facility

In the early 1970s, two federal court lawsuits successfully challenged conditions of patients on the Bridgewater campus.¹⁵⁹ In 1972, a federal circuit court judge allowed a class of patients at MCI-Bridgewater held for observation or pursuant to Chapter 123A (the statute governing sexually dangerous persons) to proceed in an action alleging “grossly inadequate heating.”¹⁶⁰ In a March 1975 decision in *Bel v. Hall*, a district court judge adopted a report of a U.S. Magistrate sitting as a special master, including the special master’s finding that inhumane living conditions in the facility’s BX Unit constituted cruel and unusual punishment.¹⁶¹

During this time, mental health patients at BSH were regularly controlled with the sedative Thorazine and were provided little other treatment.¹⁶² Attorney James Pool, who had brought the *Bel* case, blamed the poor quality of care on the difficulty attracting qualified medical personnel due to low pay and lack of any medical school affiliation.¹⁶³ At the time, the Clerk of Suffolk Superior Court Edward Keating suggested that a new facility alone would not be enough to reform Bridgewater and that control should be transferred to DMH.¹⁶⁴

Tom Ryan was a volunteer beginning in 1972 and then, for 18 months between 1974 and 1975, a guard, at BSH. He later published a devastating book about his experiences.¹⁶⁵ He describes fellow guards who taunt, physically and mentally abuse, and generally terrorize the prisoners. With respect to treatment, Ryan observed:

I saw no doctors; nurses appeared only to issue drugs.... I saw no psychiatrists or counselors, no therapy sessions. Many patients were kept drugged which the guards liked, with no assessment as to what the drugs did. Some lay in the yard all day, too sick to care, until sun and medication turned their faces scarlet. To refuse medication meant to be dragged to F [unit] for ‘reevaluation.’¹⁶⁶

He describes how an advocacy group, the New England Prisoners Association, had been trying to enter the facility and meet with patients, to teach them about their legal rights and help them organize to improve conditions.¹⁶⁷ In July 1974, Superintendent Gaughan posted a memo on BSH bulletin boards describing these outside organizations as employing “Hitlerian techniques.”¹⁶⁸

Responding to court orders, in 1974, the state built a new \$10M, 450-bed hospital to replace the old hospital.¹⁶⁹ The new facility had eight buildings and a campus-like configuration with a central courtyard.¹⁷⁰ As of December 1974, the hospital building was still under construction and empty,¹⁷¹ but in January 1975, Ryan began working there.¹⁷² The building was clean and had single cells, Ryan describes, but the guards were still abusive and the medical care was still poor.¹⁷³ The “Med Building” had seclusion rooms where patients were strapped to beds for indefinite periods in violation of state law.¹⁷⁴ Ryan ultimately left his job and in the “Afterthoughts” to his book he urges his readers to “assert our right to control the administration of public, tax-supported institutions to stop them from destroying those of our brothers and sisters who inhabit them.”¹⁷⁵

DOC contract with McLean Hospital brings a period of improved mental health care, but overall conditions at Bridgewater State Hospital limit any benefit from that arrangement

In 1975, DOC contracted with McLean Hospital, which was affiliated with Harvard School of Medicine and Massachusetts General Hospital, to provide mental health services at the hospital. The McLean contract brought positive changes to BSH. According to a policy report of the Legislature’s Senate Committee on Ways and Means, the contract brought “remarkable improvements” in the quality of forensic evaluations conducted at the facility.¹⁷⁶ And, guided by McLean, BSH established a mandatory gym program and expanded educational, supportive, and spiritual programs.¹⁷⁷

However, improvements in the level of psychiatric services were accompanied by an overall decline in conditions.¹⁷⁸ A 1979 BSH staff review found that half of BSH patients did not belong at the facility; 400-600 of the 1100 patients admitted between July 1978 and June 1979 had been inappropriately admitted.¹⁷⁹ By the mid-1980s, BSH would face overcrowding, brutality, and languishing patients.¹⁸⁰

The 1980s – Lawsuits target the admission of civilly-committed patients who lack criminal involvement and the use of restraint, but responses to litigation are limited

In the first half of the decade, the respective commissioners for DMH and DOC negotiated a transfer of BSH to DMH, which had support at the secretariat level. The agreement was not executed in the face of unresolved workforce barriers to implementation at the time.

Challenge to civil commitment of patients without criminal involvement fails to effectuate needed change

On September 23, 1985, in *Doe v. Gaughan*, the U.S. District Court rejected a challenge to the civil commitment of patients who had no criminal involvement.¹⁸¹ Attorney Roderick MacLeish and others, representing two civilly committed patients without criminal involvement, contended that their involuntary confinement at BSH violated their constitutional rights to due process and equal protection. The court found no constitutional violation in the practice of confining civilly committed mental patients with patients serving criminal sentences. For the court, the positive features of BSH outweighed any concerns.

As in *Nason*, the district court, apparently willfully blind to the conditions at BSH, compared BSH with DMH facilities and concluded that, while DMH facilities had some advantages, BSH provided adequate care and the security that DMH facilities could not.

The district court also concluded that the presence of uniformed correctional officers at BSH offered therapeutic value to many prisoners and the facility was “a remarkably safe environment given the character of the patients.”¹⁸² A series of suicides did not shake this determination: “There have been no murders in Bridgewater in the last eight and a half years, and only five or six suicides. Given the number of men in Bridgewater who have taken life, this is an extraordinary record.”¹⁸³ While acknowledging crowding and its “deleterious effect upon Bridgewater’s ability to deliver certain services,”¹⁸⁴ the court found that staffing was adequate to provide minimally adequate care to patients.¹⁸⁵ Of the McLean staff, the court wrote: “evidence suggests that no other security institution in the country can match the quality of the Bridgewater staff.”¹⁸⁶

Today it is hard to justify these findings. Even then, the judge recited facts that should have been of significant concern and sufficient to warrant the court’s protection of the plaintiffs. The district court was not dissuaded from reaching its conclusion by the fact that at BSH Doe was “frequently restrained by means of a gerry chair (a wheelchair with straps) or by the use of two and four point restraints” and “[a]t other times he has been secluded in a room which is locked from the outside.”¹⁸⁷ The court noted that while at some points Doe was secluded up to 75% of the time, Doe was free from restraints for the six months before trial.¹⁸⁸ And, while the court cited evidence in the record that restraints and seclusion were, at one time, applied at the discretion and initiative of correction officers which “might well constitute a substantial departure from professional standards,” that was, it held, no longer the practice.¹⁸⁹

Thus, while noting Doe's "abuse at the hands of the correction officers"¹⁹⁰ and that "Doe's circumstances at Bridgewater have been less than ideal,"¹⁹¹ the district court found "the overall level of care and treatment afforded him has been adequate, and in some instances, extraordinary."¹⁹² With respect to Hansen, the court found "Insofar as Bridgewater played an important role in returning Hansen to society, I find that it delivered more than minimally adequate care."¹⁹³ Citing the Supreme Court's 1982 decision in *Youngberg v. Romeo*, the court stated that "A mentally ill person is entitled to only so much treatment as is minimally adequate or reasonable to ensure safety and freedom from undue restraint."¹⁹⁴ The state need not provide an "ideal environment," but only one "in which professional judgment may be exercised."¹⁹⁵

Even as the district court was exonerating DOC, in 1985 DMH established a new Division of Forensic Mental Health. The division provided evaluation and treatment services to the courts and began "to alleviate some of the burden on Bridgewater State Hospital to serve as the major provider of forensic mental health services in the Commonwealth [reducing] inappropriate overreliance on Bridgewater State Hospital."¹⁹⁶ However, with minor and mostly meaningless exceptions such as being consulted on the choice of the medical director, DMH's authority did not extend to within BSH.

DOC contract with Goldberg Medical Associates (GMA) precedes a decline in the quality of mental health care

In 1986, the Commonwealth awarded a Salem, Massachusetts-based provider, Goldberg Medical Associates (GMA), a \$6.9M contract to provide medical and mental health services at BSH, to replace McLean.¹⁹⁷ The award to GMA ultimately resulted in "major turnover of treatment staff" at the hospital¹⁹⁸ and, as the New England Historical Society reported, a deterioration of conditions at BSH.¹⁹⁹

In 1987, BSH separated from MCI-Bridgewater and received its own superintendent,²⁰⁰ Gerard Boyle. In this role, Boyle would witness alarming deaths. He also would advocate for new resources for BSH.²⁰¹

The same year, Old Colony Correctional Center, the medium security prison, opened at the Bridgewater Complex.²⁰² At the time, then, in addition to BSH and OCCC, the complex also included the Addiction Center (an involuntary alcohol and substance abuse treatment facility), the Massachusetts Treatment Center a prison for sexually dangerous persons, and the Southeastern Correctional Center, another medium security prison.²⁰³

Bridgewater State Hospital Working Group findings and a challenge to the use of restraint on civilly committed patients precipitate reforms, but proposals to transfer control or even licensing responsibility from DOC to DMH fail

Nineteen eighty-seven was a busy year. BSH came under increased and intense scrutiny.

In May 1987, Massachusetts Secretary of Human Services Philip Johnston appointed a Working Group on Bridgewater State Hospital, composed of the DMH and DOC Commissioners and senior staff from those agencies and the Executive Office of Human Services, to make recommendations to improve the quality of mental health services and security at BSH.²⁰⁴

On July 17, 1987, Attorney MacLeish filed a class action complaint in Suffolk Superior Court on behalf of two civilly committed BSH patients, Shawn O'Sullivan and James McKellar, seeking to address illegal seclusion and restraint practices, hire more staff, and improve psychiatric and medical care. The

complaint cited six deaths at BSH since November 1986, including 55-year-old Edward Roake, who “wriggled out of hand restraints and choked on an eyeglass lens and sock.”²⁰⁵

Two days after the complaint was filed, a *New York Times* article described BSH as overcrowded, understaffed, and having poor care; the reporter cited eight unexplained deaths in the previous 18 months with four as potential suicides.²⁰⁶ The reporter quoted Secretary of Human Services Johnston stating: “A major issue...is whether the Department of Corrections should run a mental hospital in which most staff are prison guards, or whether the facility should be under control of the Department of Mental Health.”²⁰⁷

In August 1987, the Working Group on Bridgewater State Hospital issued its report, finding that, of the five deaths at BSH since March 1987, three were suicides and one occurred while the patient was in restraint.²⁰⁸ The Working Group recommended immediate action including a “Seclusion and Restraint Monitoring Action Plan” and the staffing and operating of the hospital “as a mental health hospital with maximum security, consistent with the clinical and management standards established for the Commonwealth’s mental health hospitals.”²⁰⁹ Moreover, “Bridgewater State Hospital should be supported to fulfill its mission as a mental health hospital with special security needs. The management and staffing standards of the hospital should be developed on the current model now envisioned for DMH hospitals throughout the Commonwealth.”²¹⁰

On August 25, 1987, ABC Nightline aired a story regarding the series of deaths and raised questions as to whether conditions had improved since *Titicut Follies* was shot.²¹¹ Shortly thereafter, on September 11, 1987, the Superior Court issued a preliminary injunction in *O’Sullivan*, enjoining the defendant state officials from continuing certain seclusion and restraint practices alleged to violate the state law regarding restraint.²¹² Then, between September 28 and October 2, 1987, WCVB broadcast a five-part series – *Inside Bridgewater*.²¹³ On October 12, 1987, a World News Tonight story combined footage from that series with segments from *Titicut Follies*.²¹⁴

On November 8, 1987, the state Senate Ways and Means Committee held a hearing at which testimony supported a supplemental budget allocation for BSH.²¹⁵ Later that month, that Committee recommended “the immediate infusion of additional funds for Bridgewater State Hospital” for more clinical staff and improving services in county correctional facilities.²¹⁶ The Committee also recommended the immediate establishment of a panel of experts to develop, by the end of March 1988, “a comprehensive plan for the improvement of the Commonwealth’s forensic mental health system.”²¹⁷

On November 20, 1987, the parties in *O’Sullivan* entered into an interim settlement agreement under which a panel of experts would analyze the operational, administrative, and clinical functioning of BSH.²¹⁸ The panel had a robust set of recommendations: establishing BSH as a separate and specialized DOC facility; providing a budget for BSH comparable to DMH inpatient facilities and secure treatment facilities in other states; establishing a maximum census limit for BSH; reducing admissions; integrating correctional and mental health programming; implementing recommendations regarding seclusion and restraint contained in an October 1988 Consultant Panel’s Report on Seclusion and Restraint (including developing seclusion areas on housing units); developing comprehensive training for professional staff, correctional officers, and mental health workers; and having a separate classification for officers working at BSH.²¹⁹ As part of that agreement, DOC also would transfer most civilly committed patients from BSH to DMH and end the practice of transferring such patients to BSH, finally resolving the issue raised unsuccessfully in *Doe v. Gaughan*.²²⁰ To this end, on January 7, 1988, the Legislature enacted a provision directing the DMH Commissioner to file a report by March 1989 with a plan to stop transfers

to BSH of men without criminal sentence or charge (except for persons found not guilty by reason of mental illness or mental defect) and to accept at DMH facilities all BSH patients transferred from DMH without criminal sentence or charge (except for persons found not guilty by reason of mental illness or mental defect).²²¹

By early 1988 all the bad attention began to create even more action.

In January 1988, Governor Michael Dukakis signed a \$2.3M appropriation for BSH, resulting in a 90% increase in staff for the hospital and a nearly 70% increase in annual funding.²²² A new management team implemented a wide range of improvements in treatment services, rehabilitative and recreational programs and living conditions.²²³ The team began taking steps towards attaining accreditation by the Joint Commission of the Accreditation of Health Care Organizations (JCAHO), although such accreditation would not be obtained until 2003 and, even then, the accreditation was not as a hospital but, rather as a Behavioral Health Care and Human Services facility.²²⁴

In April 1988, the DMH Commissioner submitted a plan, as required by the January 1988 legislative reform.²²⁵ The DMH report recounted steps that agency had taken over the past few years to improve services for forensically involved people with mental health conditions, including establishing the Division of Forensic Mental Health, expanding court clinics and forensic mental health teams, expanding DMH services for women at MCI-Framingham, and increasing capacity for forensic patients and violent patients in the DMH inpatient system.²²⁶ Further, DMH staff participated in the Bridgewater State Hospital Working Group and the Governor submitted budget proposals to increase inpatient capacity further to serve “behaviorally difficult patients.”²²⁷

The DMH report recorded survey results of reviews of other states’ structures:

Of the [thirty] mental health systems surveyed, all provide care for the seriously mentally ill, including those who act violently within inpatient settings. Massachusetts is rare in having its Department of Correction provide care for seriously mentally ill patients who are not serving criminal sentences. Almost all state mental health systems have a maximum security hospital or hospital units that provide care for civil and forensic patients. During telephone interviews, mental health administrators were specifically asked about whether they separate patients who face, or have faced, criminal charges from civil patients. Typically, the response was, “We did that quite some time ago but stopped because most states do not separate these patients Clinically the patients have, for the most part, similar service needs.”²²⁸

The report recommended, among other steps, that DMH re-assume responsibility for all patients held at BSH on March 31, 1989 who had been transferred from DMH facilities under Section 13 of Chapter 123 and who had no criminal charge or sentence, except those found not guilty by reason for mental illness or defect.²²⁹

Meanwhile, in the 1989 Nightline broadcast, MacLeish told ABC News that BSH was “still admitting people who are civilly committed, mentally ill, neither accused nor convicted of any crimes, almost a year and a half since the commitment was made on national television that the practice would stop.” He said the state had failed to honor the promise Secretary Johnston had made to him, in their settlement agreement in *O’Sullivan*, to move about 80 civilly committed individuals by March 1989. MacLeish also referenced the law passed in January 1988, which he stated mandated the transfers. Johnston disputed

that there was an agreement regarding the March 1989 date but said the state had made a good faith effort to meet that deadline and intended to open a facility at Medfield State Hospital in 1989 to receive the patients.²³⁰

On September 25, 1989, the Governor's Special Advisory Panel on Forensic Mental Health submitted its final report, after 17 months of work pursuant to another provision of the January 1988 legislation.²³¹ The Panel concluded that:

There are many dedicated, experienced and skillful clinicians at Bridgewater State Hospital in the current clinical program, and there are also many other line staff with extraordinary experience and wisdom in the management of difficult and assaultive patients. But there is not yet a coordinated treatment program at Bridgewater. Much of this problem stems from the historical understaffing and overcrowding at the hospital. However, the lack of integration of the correctional and treatment components contribute to the problem.²³²

The Panel applauded "the reorganization and restructuring process that has already begun under the hospital's new leadership and added resources" as most of BSH's problems cannot be resolved internally by its administration.²³³ BSH's role vis a vis the courts, correctional facilities, and DMH required restructuring.²³⁴

However, the Panel fell short of requiring a transfer of control of BSH from DOC to DMH. Noting the shift of non-criminally involved patients from BSH to DMH as a result of *O'Sullivan* and Chapter 1 of the Acts of 1988 (the January 1988 legislation discussed above), the panel concluded that BSH "should continue to serve forensic patients and detainees and inmates of correctional facilities who require inpatient psychiatric care under conditions of maximum security."²³⁵ They reasoned:

DOC has demonstrated its willingness and ability to improve patient care at Bridgewater State Hospital and to undertake major changes to foster a therapeutic environment. Despite the many difficulties at Bridgewater State Hospital over the years, a core of highly experienced, qualified and dedicated staff members among the correctional and clinical staff has developed. The aggregate knowledge and experience of these people cannot easily be matched or recreated. Furthermore, recent improvements at Bridgewater State Hospital under new leadership underscore the conclusion that, with proper resources and support, the Department of Correction has the will and the capacity to build Bridgewater into an accreditable psychiatric hospital.

From the perspective of patient care, the ultimate test of a psychiatric facility is not who administers the facility, but whether the facility provides high quality care. Since staff, experience, and dedication needed to care for substantial numbers of forensic and correctional patients are located in the Department of Correction, it seems advisable at this time to leave the operating responsibility for Bridgewater State Hospital with the Department of Correction.²³⁶

While recommending that the DOC retain the responsibility for operating BSH, in order to ensure that the same standards of care that apply to civil patients also would be provided to forensic patients and prisoners, the Panel further advised that "DMH should license Bridgewater State Hospital as a psychiatric facility."²³⁷ Adoption of such a recommendation would be a substantial change as DMH had no authority of any kind at BSH at this time. Such a DMH license would ostensibly provide some

oversight of the delivery of psychiatric care without requiring DMH to assume responsibility for day-to-day operations. . . This recommendation was not adopted and “Bridgewater [continued] to operate without an outside monitoring or oversight.”²³⁸

The 1990s – A contract with an out-of-state, for-profit medical provider has a rough start, although care improves when that provider subcontracts with University of Massachusetts Medical School

In 1990, thirteen BSH patients were transferred to a newly renovated, secure unit at DMH’s Medfield State Hospital’s R Building.²³⁹ Medfield closed in 2003 and the unit was not replaced elsewhere. Also, DMH opened a psychiatric unit at Taunton State Hospital specially designed to house up to 50 allegedly violent noncriminal patients; however, the unit also closed in 2003, reportedly to save money.²⁴⁰

In 1991, William Weld became Governor of Massachusetts. During his tenure, he would privatize many public human services functions, including in carceral settings and at BSH, in what the Administration claimed was an effort to improve care and save money.

DOC contract with a for-profit, Emergency Medical Services Associates (EMSA), as well as other cost-saving measures, threaten the quality of care

In January 1, 1992, DOC contracted with a Florida-based, for-profit prison health contractor, Emergency Medical Services Associates (EMSA) for statewide prison medical care.²⁴¹ As one observer wrote: “EMSA vastly underbid at \$28.7 million, promising to provide extremely low-cost care by limiting the number of outside hospital visits that inmates could attend.”²⁴² EMSA was the first private firm in the country to provide prison health care for an entire state.²⁴³ EMSA sub-contracted mental health services to the Boston-based Center for Health Development (CHD), but then terminated CHD without explanation.²⁴⁴ With the implementation of the contract with EMSA, DOC sought to reduce costs of care at BSH, asking BSH Superintendent James Matesanz in June 1993 to propose a budget that eliminated \$1.5M from the BSH portion of the EMSA contract with DOC. Matesanz did offer cost cutting proposals, including a proposal that DOC close units and transfer of responsibilities elsewhere: “Possibilities include the courts, Department of Mental Health and or the counties.”²⁴⁵ But just making budget reductions alone, he warned, would pose significant risks to patients, staff, and the public.²⁴⁶ In this same year, while Matesanz was Superintendent, BSH received its first accreditation from an outside agency – the National Commission on Correctional Health Care (NCCHC).²⁴⁷

During the period that EMSA provided care in Massachusetts, several prisoners died in the larger DOC system, including two women who had complained that EMSA had ignored their medical issues.²⁴⁸ Effective June 30, 1994, the state terminated EMSA’s contract when it was underbid.²⁴⁹ A state audit concluded that EMSA overcharged the DOC \$1.5M by filing false or questionable invoices – charges EMSA disputed.²⁵⁰

Bridgewater State Hospital suffers serious and regular environmental catastrophes

Early in 1994, noting Weld’s prioritization of building new prison facilities, Matesanz advocated with the Administration to build a new hospital.²⁵¹ BSH was hot in the summer and cold in the winter and had water leaks leaving the facility swamp-like and the gym flooded.²⁵² Matesanz was dealing with environmental catastrophes regularly.²⁵³ Initially, he received some support for his idea of a new forensic mental health hospital and also a facility for rehabilitative care for people in DOC.²⁵⁴ However,

his meetings with consultants ended when DOC decided not to move forward.²⁵⁵ Matesanz asked to be transferred to run another DOC facility.²⁵⁶

With DOC contract with another for-profit, Correctional Medical Services, Inc. (CMS), the pattern of poor mental health care at Bridgewater State Hospital continues

On July 1, 1994, facing allegations of prisoner neglect and conflicts of interest, Emergency Medical Services Associates lost its Massachusetts contract for DOC medical and mental health services to another for-profit corporation, Missouri-based Correctional Medical Services, Inc. (CMS).²⁵⁷ Writing in the Massachusetts Law Review, Danielle Drissel observed that, by 1996, “the quality of prison mental health care was in question, with only the most acutely ill inmates receiving necessary services.”²⁵⁸

A forensic consultant, funded through the National Institute of Corrections to provide DOC with technical assistance, also noted problems at BSH at this time, particularly the tension between operating a prison and providing mental health care.²⁵⁹ The consultant’s 1996 report stated: “The security vs. treatment issues at BSH seems (sic) to permeate the operating atmosphere, with security being clearly dominant and treatment a secondary consideration.”²⁶⁰ The author continued that he observed “extreme confusion” as to whether their operating facility was in fact a prison or a forensic mental health facility.²⁶¹

Extreme events also occurred at BSH and in the DOC system in this period. In the mid-1990s, Massachusetts Correctional Legal Services (now called Prisoners Legal Services) sued DOC after an officer threw a bucket of acidic detergent on a BSH patient.²⁶² In 1997, a BSH patient died after being left face down in handcuffs; a subsequent lawsuit by the family was settled.²⁶³

This period of Massachusetts prison system history was further marred by the 1996 death by suicide at MCI Cedar Junction of John Salvi, convicted of murder for two fatal shootings at Brookline abortion facilities. Salvi had been at BSH from March 30, 1995 to May 26, 1995.²⁶⁴ While the convicting jury rejected the insanity defense, “it was obvious to almost everyone who encountered him that Salvi was seriously disturbed.”²⁶⁵ DOC never adequately explained why a notorious and seriously disturbed prisoner at a high security prison was receiving no mental health services.

In 1997, UMass. Medical Center Department of Psychiatry issued a report on the psychiatric treatment of Salvi at DOC facilities.²⁶⁶ Among the report’s recommendations was that BSH could not rest upon its existing accreditation from the National Commission on Correctional Health Care, but must obtain Joint Commission of the Accreditation of Health Care Organizations (JCAHO) accreditation:

In specific regard to Bridgewater State Hospital (BSH), it is inappropriate to apply only NCCHC standards to this institution which purports to be an inpatient psychiatric hospital. For such settings, the customary standard for accreditation is the Joint Commission on Healthcare Organizations (JCAHO), and we strongly recommend that consideration be given to seeking JCAHO accreditation for BSH as soon as possible.²⁶⁷

BSH did obtain accreditation from the American Correctional Association (ACA) in 1998.²⁶⁸ However, JCAHO accreditation was still several years away.

Correctional Medical Services subcontracts mental health care to University of Massachusetts Medical School, resulting in improvements in the quality of mental health services

Despite these problems, DOC engaged Correctional Medical Services for another three-year contract beginning in September 1998.²⁶⁹ That month, Correctional Medical Services contracted with UMass Correctional Health at the University of Massachusetts Medical School (UMMS) to provide mental health services at DOC facilities, including BSH.²⁷⁰

Psychiatrist Kenneth Appelbaum, Director of Mental Health for UMass Correctional Health from 1998 to 2007,²⁷¹ later described how he believed UMMS's three-year partnership with CMS benefited DOC prisoners. The collaboration, Appelbaum wrote, combined CMS's "experience in privatized correctional health care with UMMS's experience in public-sector mental health services and training programs."²⁷² Having a mental services program "managed by a respected medical school has a greater likelihood of improving the stature of correctional work and attracting competent clinicians....In addition, medical schools typically have expertise in practical and applied research that can improve the care and treatment that a system provides."²⁷³

Appelbaum recalled the influx of high-quality clinicians that the UMass Correctional Health contract brought: "The number of licensed mental health staff increased by about 40 percent, and some vacancies that had been designated as master's-level positions have been filled by doctoral-level professionals."²⁷⁴ Most significant, in his estimation, was the increase in numbers of psychiatric staffing, from about 10 full-time psychiatrists to 21 (serving more than 10,000 inmates and 300 BSH patients).²⁷⁵ Yet, Appelbaum acknowledged some confusion due to the fact that UMass employed the psychiatrists and doctoral psychologists, while CMS employed the other clinical staff.²⁷⁶

The difficulties with operating in a prison context were also evident to Appelbaum. He described the potential for tensions between security staff and clinicians; in these situations, "[s]ecurity requirements almost always trump clinical needs."²⁷⁷ At BSH, security contracts created obstacles for medical school training programs, particularly for clinicians on short rotations that did not lend themselves to time for full correctional orientation.²⁷⁸ DOC cautiousness and bureaucracy, as well as space and physical plant constraints, limited programmatic innovation.²⁷⁹ And he wrote, "[a]t Bridgewater the challenge has been to augment hospital functions in line with the identity of the facility as a prison."²⁸⁰ With respect to medical school partnerships with a private, for-profit vendor, Appelbaum believed that success required that the school "manage its programs in a fiscally responsible way that recognizes budgetary realities ...it ... needs to deliver services and cover overheads within funding limits."²⁸¹

Correctional Medical Services held the contract with DOC until December 31, 2002.²⁸²

The 2000s – The Department of Correction cannot extricate Bridgewater State Hospital from its ongoing problems as changes in the mental health vendor alternate with patient deaths

As DOC cycled through mental health providers without substantial improvements in mental health care and without implementing meaningful systemic reform, the facility experienced a series of tragic deaths.

DOC contracts with the University of Massachusetts Medical School and looks at overuse of restraint and seclusion at Bridgewater State Hospital

On January 1, 2003, UMass Medical School took over the medical services at DOC facilities, beginning a four-year contract²⁸³ UMass and DOC soon had to focus on restraint as *The Boston Globe* reported that BSH "administrators promised to rely less on seclusion and physical restraints in order for Bridgewater to win accreditation as a behavioral health care provider."²⁸⁴

BSH was first accredited by JCAHO as a health care organization in 2003.²⁸⁵

William Mosher's death at the hands of another BSH patient reveals lack of appropriate mental health care

The following year, UMass faced another challenge. On August 28, 2004, BSH detainee William Mosher Jr., awaiting trial for trafficking Oxycontin, was strangled in his room, allegedly by patient Bradley Burns.²⁸⁶ Burns' attorney explained that Burns was diagnosed with paranoid schizophrenia and had believed that Mosher posed a mortal threat to him.²⁸⁷

Just before Mosher's death, on June 30, 2004, the Governor's Commission on Correction Reform had issued a report, "Strengthening Public Safety, Increasing Accountability and Instituting Fiscal Discipline in the Department of Correction," containing recommendations for improving the Commonwealth's carceral system.²⁸⁸ Among the recommendations was for the establishment of a process for an external review of prisoner medical and mental health services. In response to the report, DOC established a Medical Review Panel tasked with, among other things, review of services provided at BSH.²⁸⁹ According to the Office of the State Auditor, the Medical Review Panel recommendations influenced the provisions of DOC's next contract for medical and mental health services, signed in 2007.²⁹⁰

In January 2007, State Auditor Joseph DeNucci issued a report, examining UMass's correctional health care contract with DOC for the period of January 2004 through June 2005.²⁹¹ The DOC Commissioner had requested the audit after UMass began negotiating, during fiscal year 2005, for additional funding from DOC to help cover the net losses UMass claimed to have incurred under this contract.²⁹² UMass officials argued that the changing medical complexity of persons held at the Massachusetts Alcohol and Substance Abuse Center (MASAC) demanded additional services which were not funded by the contract or otherwise covered by DOC.²⁹³ Then, as of May 2005, UMass refused to provide health services at MASAC. In 2007, the dispute still had not been resolved and UMass was still seeking funding to cover care provided.²⁹⁴ At that time, the State Auditor found

the controls UMMS had established over the administration of its contract with DOC needed to be improved. As a result, UMMS was unable to develop requests for additional funding from DOC that were fully supported by its financial records and was not able to substantiate some of the expenses it billed against this contract for the services of certain professional staff members.²⁹⁵

DOC contracts with MHM Correctional Services, as it turns once again to an out of state for-profit vendor

On July 1, 2007, six months after the State Auditor issued his report on UMass's administration of correctional health care services, DOC signed a five-year, \$194M contract with an out-of-state, for-profit provider, MHM Correctional Services of Virginia, to provide mental health services at DOC facilities and medical, dental, and forensic mental health services at BSH.²⁹⁶ The same year, a class of women prisoners in Alabama won a suit against MHM, the provider of mental health services in their facility, for inadequate medical and mental health care.²⁹⁷

Joshua Messier's death at Bridgewater State Hospital

Deaths continued. On March 30, 2007, a man died by hanging while at BSH for a 30-day evaluation.²⁹⁸ Then, on May 4, 2009, 23-year-old Joshua Messier died while spread-eagled in four-point restraints on a bed in BSH's Intensive Treatment Unit (ITU), a unit where patients were brought for the purpose of

seclusion or restraint. Messier was a college freshman when his mother began worrying about him. Ultimately diagnosed with paranoid schizophrenia, he spent several years in and out of psychiatric hospitals, including more than a year at Worcester State Hospital.²⁹⁹ There, he repeatedly assaulted staff and was confined to a small room as punishment.³⁰⁰ After being released from Worcester State Hospital, his parents checked him into Harrington Memorial Hospital where he received criminal charges for assaulting staff and was sent to BSH for evaluation on April 1, 2009.³⁰¹

Messier's suffering and death at BSH were videotaped; Messier turned blue as guards roughly handled him and then stood by inactively as nurses failed to administer CPR.³⁰² The video showed two guards, Derek Howard and John Raposo, pressing down on Messier's back while he was seated with his hands cuffed behind him, folding his chest to his knees. DOC regulations prohibited "suitcasing" due to risk of suffocation.³⁰³ Messier was at particular risk from that technique as he was overweight, a side effect of psychiatric medication for his diagnosis of schizophrenia.³⁰⁴

The state's responses were myriad and inconsistent. In her February 3, 2010 autopsy report, Medical Examiner Mindy Hull ruled Messier's death a homicide.³⁰⁵ A May 25, 2010, DOC Internal Affairs investigation found that Howard and Raposo had engaged in misconduct in their actions in the BSH Intensive Treatment Unit during restraint.³⁰⁶ However, DOC Assistant Deputy Commissioner Karen Hetherson overruled the Internal Affairs report.³⁰⁷ *The Boston Globe* reported that "Hetherson wrote that 'no misconduct was found against staff' [and] recommended that Howard and Raposo 'attend refresher restraining in the use and application of restraints.'"³⁰⁸ Then, on October 7, 2011, the state Disabled Persons Protection Commission (DPPC) found "that there was a preponderance of evidence supporting the conclusion that the actions of [two correctional officers] caused [Messier's] injury."³⁰⁹ Rejecting the Medical Examiner's autopsy and ignoring the DPPC report, DOC Commissioner Harold Clarke did not discipline BSH staff.³¹⁰ In addition, Plymouth District Attorney Timothy Cruz chose not to convene a grand jury, but instead simply decided there was insufficient evidence to pursue criminal charges.³¹¹ He later explained that his course of action was due to the fact that, in a meeting a year after the death, Hull had retracted her finding that the death was a homicide.³¹²

In December 2009, seven months after Messier's death, MHM Correctional Services submitted testimony to the Connecticut Legislature regarding the corporation's experience with the Massachusetts DOC and BSH. Regarding their time at BSH, MHM claimed to have reduced psychiatry vacancies, ratified a union contract, reduced staff overtime by eliminating nursing vacancies, reduced hospital admission rates by increasing case conferences in the carceral facilities, reduced seclusion and restraint hours by 20%, increased psycho-social, recreational and psycho-educational programming, and reduced self-injurious behavior.³¹³

Bradley Burns' death at Bridgewater State Hospital found to be due to a combination and restraints

On May 31, 2010, Bradley Burns, now age 34, who was alleged to have killed William Mosher, died in restraint at BSH. The state medical examiner determined the death was likely the result of a heart arrhythmia resulting from a combination of medication and restraints.³¹⁴ After Mosher's death, Burns had been found incompetent to stand trial and had been committed again to BSH.³¹⁵ In 2008, Burns began hearing voices more frequently and became self-injurious.³¹⁶ In 2009, he tried to gouge out his eyes and staffers isolated him further.³¹⁷ His mother reported that, in addition to injuring his eyes, he would slam his head into walls.³¹⁸ Burns had spent 23 hours a day strapped to a bed in protective gear for 16 months because medical staff felt it was the best way to prevent him from hurting himself or others.³¹⁹

DOC awards contract to the lowest bidder, the for-profit Massachusetts Partnership for Correctional Health

In July 2013, DOC entered into a statewide contract with the for-profit Massachusetts Partnership for Correctional Health (MPCH), a subsidiary of Centurion.³²⁰ Centurion was a joint venture between the then-BSH mental health services provider, MHM Services Inc. of Virginia, and St. Louis-based Centene Corporation, a Fortune 500 company that operated managed care programs for Medicaid in several states.³²¹ The DOC contract was Centene's first contract for prison health care.³²² The five-year prison medical and mental health contract was worth \$500M.³²³

The Massachusetts Partnership for Correctional Health had submitted the lowest bid, which, according to a DOC memo obtained by *The Boston Globe*, was “a key factor” in their receiving the award.³²⁴ DOC was sanguine, believing the state would save money by contracting for medical and mental health services together and benefit by working with parent companies with experience providing health care to the uninsured and underinsured.³²⁵

Paul Correia’s death after three days in a restraint bed at Bridgewater State Hospital

With Massachusetts Partnership for Correctional Health newly installed, on August 26, 2013, 45-year-old Paul Correia died from a blood clot that the medical examiner found was likely exacerbated by spending substantial time over three days on a BSH restraint bed.³²⁶ Correia had been court-ordered to BSH from a county jail where, reportedly, he had refused to take antipsychotic medications and his mental health had deteriorated. Upon his arrival at Bridgewater the Friday night before his death, a Massachusetts Partnership for Correctional Health doctor ordered that Correia be placed in four-point restraints (while noting that he had bruises and scratches on his face and extremities).³²⁷ Even after taking medication and calming down, staff kept Correia in restraints “as a new admission,” in violation of state law requiring the threat or occurrence of extreme violence.³²⁸ Correia was dead by Monday morning. An autopsy listed the cause of death as a blood clot which travelled to his lungs; the medical examiner wrote that it may have been triggered by the restraints and exacerbated by his weight.³²⁹

The 2010s – With all eyes on Bridgewater State Hospital, the Patrick Administration must act, but it is not enough to avoid tragedy

Michael Rezendes’ reports on restraint use and patient deaths at Bridgewater State Hospital bring renewed exposure of risks facing patients

Beginning in early 2014, Boston Globe reporter Michael Rezendes wrote a series of revelatory articles about, among other topics: the Massachusetts Partnership for Correctional Health; the deaths of Messier, Burns, and Correia; and the use of seclusion and restraints at BSH.³³⁰ Rezendes drew renewed attention to the facility and scrutinized a system that made those deaths possible and threatened current patients.

Rezendes began this series of stories on February 16, 2014, writing about Messier’s death: “[The guards] used the forbidden “suitcase” technique, and placed Messier in ‘four-point restraints’ without getting prior medical approval to do so, as is required in almost all cases.”³³¹ Rezendes starkly detailed the correctional officers’ lack of training:

The guards who stood around Joshua Messier's bed as he died did not pretend to have any expertise in caring for the mentally ill. At least four of the seven who were in cell 13 that night — including Howard and Raposo — had only a high school or high school equivalency education, and most of them candidly admitted that they saw themselves as prison guards, not as guards in a mental health facility.

"I don't even know what a schizophrenic attack is so that wouldn't have meant anything to me," said Correction Officer Clifford M. Foster in his deposition in the lawsuit filed by Messier's parents. "I don't recall any training in mental health." ...

Guards also said that although they did receive training in how to use force to subdue inmates or to protect themselves, they received no hands-on instruction in how to put an inmate in four-point restraints. And one of the two guards who "suitcased" Messier by pressing down hard on his back said under oath that he was not aware the practice is barred because it's too dangerous.³³²

On February 20, 2014, days after the article's publication, Governor Deval Patrick announced that he had asked DOC for a full accounting of Messier's death.³³³ Patrick noted the delay between the death and a January 11, 2013 report from DOC's Special Operations Division³³⁴ which found that staff members had been in violation of DOC's Use of Force Policy.³³⁵ A month after Rezendes' story came out, Messier's parents settled a civil suit against the state and MHM Correctional Services for \$3M.³³⁶

In October 2014, Rezendes returned to his examination of restraint at BSH, reporting that, after Messier's 2009 death, "over the next five years, Bridgewater clinicians employed physical restraints on inmates even more frequently, records show."³³⁷ And, Rezendes connected DOC's failure to conduct the mortality reviews required by their own policy (after the deaths of Messier and Burns) to Correia's death, noting that Correia was the third restraint-related BSH death in just over four years.³³⁸

Rezendes noted that DOC did do a mortality review of Correia's death in May 2014. The review found "significant flaws" in Massachusetts Partnership for Correctional Health's performance and required the organization to develop a plan to remedy the problems.³³⁹ Despite their development of such a plan, Rezendes continued, Massachusetts Partnership for Correctional Health was not well serving its patients. He wrote that DOC's summer 2014 audits found that the vendor was providing "poor quality medical care" and was approving seclusion and restraint without documenting the emergency justification for its use; in addition, DOC had fined the company for failing to meet staffing requirements.³⁴⁰

The Patrick Administration finds failures in Messier's death

The following spring, on May 19, 2014, Public Safety Secretary Andrea Cabral issued a report in response to Patrick's instruction.³⁴¹ Cabral found numerous policy violations and evidence of a cover-up of facts.³⁴² Among these violations, the report concluded that BSH Superintendent Karin Bergeron "tried to avoid issuing written findings that might embarrass the DOC and Bridgewater. She attempted to arrange a phone conference regarding Messier's death to avoid filing a written report. She also requested repeated extensions of time to file her report..."³⁴³ Additionally, Cabral's investigation determined that BSH officials had misled the Disability Law Center (DLC), which investigates incidents of abuse, neglect, and death of individuals with disabilities throughout the Commonwealth pursuant to its authority as the federally-designated Protection and Advocacy system for Massachusetts.³⁴⁴ BSH officials had told the DLC that "the guards involved in Messier's death had been cleared by a Plymouth County grand jury,

when in fact the case was never submitted to the grand jury” and that former DOC Commissioner Clarke was unhelpful during the investigation.³⁴⁵

In conjunction with the release of the investigation, the Administration announced that it had disciplined three guards (Howard, Raposo, and George Billadeau) and three high-ranking DOC officials.³⁴⁶ DOC Assistant Deputy Commissioner Hetherson, who had overruled the May 2010 Internal Affairs report finding misconduct, was asked to resign.³⁴⁷ BSH Superintendent Robert Murphy and DOC Commissioner Luis Spencer were reprimanded.³⁴⁸

Further, in September 2014, Attorney General Martha Coakley appointed a special prosecutor who recommended that charges be brought against the three guards.³⁴⁹ On April 30, 2015, a grand jury in Suffolk County indicted the three guards on involuntary manslaughter and other charges for using excessive force that resulted in Messier’s death.³⁵⁰ The case later went to trial and, in December 2017, the officers were found not guilty of involuntary manslaughter. Superior Court Justice Jeffrey Locke found that “the conduct of these three defendants left much to be desired but does not constitute wanton and reckless conduct.”³⁵¹ Ultimately, the court held that the prosecution had failed to show a direct connection between the guards’ actions and Messier’s death.³⁵²

However, by the time of the 2017 verdict, Messier’s death had led to new policies at BSH.³⁵³ Much else had happened at the institution between Messier’s death and that later date that could have contributed to those reforms.

Minich v. Spencer class action challenges use of seclusion and restraint at Bridgewater State Hospital

At the end of March 2014, attorney MacLeish, as well as attorneys from the Mental Health Legal Advisors Committee and Prisoner Legal Services, filed suit against the state and the BSH health care provider, Massachusetts Partnership for Correctional Healthcare³⁵⁴ in Norfolk Superior Court on behalf of Joanne Minich, mother of 31-year-old BSH patient Peter Minich.³⁵⁵ The complaint alleged that Peter Minich’s extended time in seclusion and restraint on the ITU, absent an emergency, violated state law and caused a rapid deterioration of his mental health.³⁵⁶ It further asserted that, due to seclusion and restraint, Minich had been continuously deprived of almost all human contact and exercise for more than 6300 hours since January 2013.³⁵⁷

Peter Minich was not alone. On April 6, 2014, Rezendes reported that in December 2013, BSH had held patients in seclusion and restraints for more than 13,000 hours, which was a rate of 1491 hours per 1000 patient days.³⁵⁸

On April 8, 2014, acting pursuant to its authority under federal law to investigate incidents of abuse, neglect, and death of individuals with disabilities, DLC notified Secretary of Public Safety Andrea Cabral and DOC Commissioner Spencer that the agency intended to investigate “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.”³⁵⁹ On April 15, 2014, DLC staff showed up at the BSH building and announced that they were launching an investigation in the facility in their role as Massachusetts’ federally-designated Protection and Advocacy agency.³⁶⁰

In mid-April, Norfolk Superior Court Justice Paul Wilson approved an agreement to move Peter Minich to the BSH infirmary and only use seclusion and restraint in emergencies as a last resort.³⁶¹ On May 5th, the *Minich* attorneys filed an amended class action complaint in Suffolk Superior Court seeking injunctive relief; Minich, Felipe Zomosa, and an unnamed patient, Doe, were named as plaintiffs.³⁶² The complaint alleged that 175 BSH patients, with mental illness and without criminal sentences, were being

unconstitutionally secluded and restrained and denied adequate medical and mental health care.³⁶³ Rezendes described the named plaintiffs' situations:

According to the class-action lawsuit, all three were referred to Bridgewater for psychiatric evaluations after being accused of assaulting staff members at psychiatric facilities. All three were not convicted of a crime; and all three "have been repeatedly secluded and placed in four- and five-point mechanical restraints on numerous occasions in violation of state law," which limits such tactics to life-threatening emergencies. ... The lawsuit also says that Minich and Zomosa "have spent more time in seclusion and restraint in one year than all 626 patients in state [Department of Mental Health] facilities combined over the same period."³⁶⁴

Doe's situation was also shocking. He had diagnoses of autism, intellectual disability, and schizophrenia and had spent over 1300 hours in seclusion at BSH in less than six months, which included periods of time after the "emergency" used to justify seclusion had ended.³⁶⁵ Doe's treating clinician later stated, while being deposed, that seclusion and restraint hours had increased when "overworked and undermanned staff simply resort to increasing use of seclusion and restraint to address any behavior Bridgewater state deem inappropriate."³⁶⁶ In addition to the data specific to the three named plaintiffs, plaintiffs' attorneys were able to determine that, during 2013, between 300 and 350 BSH patients were secluded and restrained for a total of 148,000 hours, nearly 400 hours per patient.³⁶⁷

On May 30, 2014, the accreditation agency now known as the Joint Commission (formerly the Joint Commission of the Accreditation of Health Care Organizations) conducted a surprise inspection of BSH and gave the facility 45 days to respond to its findings or risk losing accreditation.³⁶⁸ The Joint Commission did finally accredit BSH in September 2014,³⁶⁹ but, like earlier BSH accreditations, this was *Behavioral Health Care and Human Services* accreditation, not *Hospital Accreditation*, which has "more stringent requirements."³⁷⁰

In early July 2014, Justice Wilson granted plaintiff Doe's Motion for Preliminary Injunction enjoining defendants from restraining Doe in ways in which were inconsistent with applicable Massachusetts law, Mass. Gen. L. Ch. 123, § 21.³⁷¹ And it would gradually become clear that the "adverse press attention and the pendency of litigation had a moderating effect" on the use of seclusion and restraints at BSH.³⁷²

The Patrick Administration releases a plan for reform of Bridgewater State Hospital

The Patrick Administration responded by increasing collaboration between DMH and DOC officials and DOC leadership and staff were trained in trauma-informed care strategies to reduce the use of restraint and seclusion.³⁷³ After these steps, DMH reported that between January and May 2014, the number of hours inmates spent in restraints had decreased by more than 90% and seclusion by 50%.³⁷⁴

On June 17, 2014, Governor Patrick released a broad plan for reforms at BSH.³⁷⁵ Among his proposals were staff training to reduce the use of seclusion and restraints, \$10M for 130 new mental health clinicians (with funding proposed in a FY14 supplemental budget), \$1M to increase the number of court clinicians to conduct evaluations including competency to stand trial (to reduce the number of persons confined to BSH for that purpose), \$500K for physical improvements including the creation of de-escalation rooms to reduce reliance on seclusion and restraint, \$500K to study the possibility of retrofitting an existing state facility or building a new facility to treat and evaluate, in a secure setting, potentially violent persons with mental health conditions accused of committing crimes, and \$2M to move 100 DMH patients to the community and use 50 unoccupied beds at DMH's Worcester Recovery Center and Hospital (to accommodate step-down patients from BSH).³⁷⁶

Patrick's proposal for transferring BSH patients to DMH care may have been bolstered by a June 30, 2014 Abt Associates report to the Legislature's Mental Health Advisory Committee. Charged with examining the impact of the planned closure of Taunton State Hospital and the feasibility of developing programs at or near the Taunton campus to meet the needs of certain populations, including non-violent offenders, Abt found that a large number (539) of new admittees to BSH needed secure psychiatric treatment and that some BSH patients needed "safer, treatment-oriented alternatives."³⁷⁷

In summer 2014, the Legislature approved a FY15 budget including Patrick's funding proposal for BSH reforms.³⁷⁸ However, Patrick's goal of hiring 130 clinicians fell short; by the end of 2014, the state had funded only 17 new clinician positions at BSH.³⁷⁹

Disability Law Center files the first of many critical public reports exposing health care and environmental deficiencies at Bridgewater State Hospital

The Disability Law Center released its first report on its investigation of BSH on July 11, 2014.³⁸⁰ The report addressed concerns of abuse and neglect at the facility, including continued excessive use of seclusion and restraint.³⁸¹ While recognizing steps the Patrick Administration had taken since initiating its investigation, DLC lamented that the Governor's proposal failed "to assign responsibility for the entire BSH population to the Department of Mental Health."³⁸² Although noting that the number and length of seclusions and restraints had declined since April 2014, DLC observed that, during the same period, "patient assaults on staff and patient assaults on and fights with other patients has increased."³⁸³ DLC continued: "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."³⁸⁴

The report addressed the problem of caring for patients with "significant mental illness," including patients with a history of violence, who are anxious and need a quiet room, and who refuse medication orders and are threatened with or subjected to "emergency" administration of medication, despite the lack of a court order authorizing forced medication.³⁸⁵ DLC found that BSH was "under-resourced and inadequately structured" to meet patient needs.³⁸⁶ And, DLC found eleven "deficient practices" in the use of seclusion and restraint, ranging from holding patients in restraint or seclusion past the time of emergency, using the response as punishment or discipline, failing to review the cases of patients with repeated episodes in restraint or seclusion, and failing to try less restrictive alternatives.³⁸⁷

The Disability Law Center described BSH as having, like other DOC facilities, 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.³⁸⁸ Although clinical services are provided by the Massachusetts Partnership for Correctional Health, DLC wrote, the "overwhelming majority of day-to-day interaction between patients and staff members is with the [correctional officers]."³⁸⁹

Among the changes DLC recommended was that the state remove the functions of administration, operations, medical and mental health care, treatment, and programming at BSH from the purview of the Executive Office of Public Safety and DOC and place them under DMH and the Executive Office of Health and Human Services.³⁹⁰ DLC also recommended remedies for the excessive and inappropriate use of seclusion and restraint,³⁹¹ a medical ombudsperson to assist patients with concerns about their mental health or medical treatment issues,³⁹² and capital improvements to convert BSH into a modern, secure, therapeutic treatment facility.³⁹³ In subsequent reports, however, DLC would abandon the idea that BSH could be salvaged with capital improvements.

State negotiates with advocates

Disability Law Center

The state was soon settling disputes with the two sets of legal advocates examining BSH: Disability Law Center staff and the *Minich v. Spencer* plaintiff attorneys. On Dec. 15, 2014, the DLC and DOC Commissioner Carol Higgins O'Brien signed an agreement resolving issues raised in DLC's July 11, 2014 report.³⁹⁴ DOC agreed to engage in training, pursue DOC-DMH collaboration (on patient transfer, quiet and comfort rooms), review (with DMH) BSH policies on patient rights, collect data, and reduce seclusion and restraint use.³⁹⁵ DOC would pursue reforms regarding treatment.³⁹⁶ Finally, DLC would have an ongoing role at BSH, funded by DOC, as a monitor of the use of seclusion and restraint and the terms of the DLC-DOC agreement; the role would last for a 24-month period, with extension possible if DOC failed to meet the terms of the agreement.³⁹⁷

DLC completed this period of monitoring and then continued to serve as monitor with a regular, on-sight presence at BSH until the present day, issuing a series of reports regarding the physical plant and the delivery of care.

It is important to note that, at all times, DLC also maintained its status as the federally-authorized Protection and Advocacy Agency for Massachusetts; that role ran concurrently with DLC's role as monitor pursuant to the DLC-DOC agreement (and its role, discussed below, as court monitor of the settlement between the DOC and the plaintiffs in the *Minich* case). That Protection and Advocacy authority was important as it allowed DLC access to additional information about BSH that would not appear in public reports but that informed DLC's ongoing advocacy.

Minich lawsuits trigger reforms and expose failures of contracted health care provider

On Dec. 29, 2014, Justice Wilson granted preliminary approval of a settlement in the *Minich v. Spencer* class action case.³⁹⁸ Like the DLC-DOC agreement, this settlement required reforms, including, notably, in the use of seclusion and restraint at BSH and in the treatment of individuals who were civilly committed but without criminal convictions. DOC's compliance with the *Minich* agreement would be overseen by DLC, serving as a court monitor, for at least two years.

On January 29, 2015, MacLeish and others filed a civil rights damage claim in Suffolk Superior Court on behalf of the three named plaintiffs in the *Minich* class action regarding the periods of seclusion and restraint they had experienced at BSH.³⁹⁹ Justice Wilson once again presided.

As Rezendes reported at the time, it was the first of four cases filed against MPCH and its affiliate MHM alleging abuse of patients at BSH following Messier's 2009 death.⁴⁰⁰ Plaintiffs alleged that Massachusetts Partnership for Correctional Health's low bid for the contract to provide medical and mental health care at DOC facilities meant that the facilities would, by plan, be understaffed, leading staff to turn to seclusion and restraint in place of health care.⁴⁰¹ Rezendes quoted MacLeish's argument regarding the consequence of the DOC-Massachusetts Partnership for Correctional Health contract:

"This case illustrates the catastrophic consequences that can occur for the most vulnerable people in our society when for-profit health care providers contract for their care... To treat the most severely mentally ill men in the state, MPCH proposed a staffing level that was approximately one-third the level of Department of Mental Health facilities, paying psychiatrists at a salary approximately half the market rate."⁴⁰²

Rezendes also reported that Massachusetts Partnership for Correctional Health had received poor performance reviews since winning the July 2013 contract with DOC: “five consecutive audits by the Department of Correction found persistent problems in the way MPCH staffers care for patients in seclusion and restraints.”⁴⁰³

Family coalition arises, spurred on by Leo Marino’s death by suicide

Alongside the legal advocacy of the mid-2010s, a coalition of family members was working to draw attention to conditions at BSH. Formed in 2015, the coalition held a forum at Cambridge Public Library entitled *Bridgewater State Hospital: Keeping a Commitment to Much Needed Change* on April 7, 2016.⁴⁰⁴

The following night, 43-year-old Leo Marino, a father of two teenage boys, died by suicide after being found unresponsive in his BSH cell.⁴⁰⁵ Marino had a history of suicide attempts including, according to his brother and his attorney, three at BSH in the weeks before his death.⁴⁰⁶ Moreover, Marino’s brother and his attorney had visited him a few hours before his death, at which time his brother had “begged prison officials to keep an eye on [Marino].”⁴⁰⁷

At the time of death, BSH staff were holding Marino in the Intensive Treatment Unit, where Joshua Messier had died in restraints in 2009. Marino had been placed in that unit after attempting to suffocate himself with toilet paper on March 30, 2016.⁴⁰⁸ Once on the unit, DOC officials observed Marino on April 7th and 8th ingesting wads of wet toilet paper in attempts to choke himself.⁴⁰⁹

On April 8th, Marino was on suicide watch, a status that should have triggered continuous observation by a mental health worker with the designation of Specially Trained Observer (STO).⁴¹⁰ However, DLC concluded that “STOs failed in their duty to watch Mr. Marino.”⁴¹¹ Moreover, DLC wrote, BSH Specially Trained Observers “continuously provided Mr. Marino with the toilet paper despite clear direction not to do so,” even when he was not using the toilet.⁴¹² In addition, a correctional officer who was supposed to be watching the ITU patients (including Marino) on a monitor, to supplement the Specially Trained Observer monitoring, failed in his duties.⁴¹³

The coalition brought parents and family members of current and former BSH patients to a meeting with Executive Office of Health and Human Services Secretary Marylou Sudders at DLC on April 28, 2016.⁴¹⁴ And, the group issued a follow-up statement to Secretary Sudders, the Office of the Governor, and the Secretary of the Executive Office of Public Safety & Security in August 2016.⁴¹⁵ In the letter, the coalition labeled the building “unfit for use as a hospital,” referenced the DLC’s June 27, 2016 report on Leo Marino’s “horrifying” suicide, and urged the Administration to act on DLC’s recommendations, including transfer of authority of BSH to DMH.⁴¹⁶

Policy papers recommend changes at Bridgewater State Hospital and specifically question the holding of civilly committed patients there

In summer 2016, Public Consulting Group, Inc. conducted an analysis of BSH for the Executive Office of Administration and Finance, evaluating aggregate patient data, policies, and procedures to document compliance with settlement requirements and issuing recommendations.⁴¹⁷

In June 2016, the Pioneer Institute, a Massachusetts think tank, published a paper on pressing concerns within the Commonwealth at the intersection of mental health and criminal justice reform. One of the addressed concerns was the situation at BSH:

There are two issues currently before state government that can point the Commonwealth in a different direction. The first concerns Bridgewater State Hospital which, following a series of hard-hitting reports by *The Boston Globe* and the Disability Law Center promised a handful of policy changes, but have yielded little transparency and seem no closer to fulfilling the long-desired goal of transitioning the facility to Department of Mental Health oversight.⁴¹⁸

The Pioneer Institute called BSH “a frequent source of shame for the Commonwealth,” with the issues exposed by *The New York Times* and ABC News in the 1980s – overcrowding, lack of proper services, and a population of which nearly half has no criminal convictions – still resonating.⁴¹⁹ The Institute pointed to the average daily population of 346 (as of the DOC report of 2013), well above the design capacity of 227.⁴²⁰ And, they wrote, “[t]he percentage of that population which has not been convicted of a crime, a group which was intended to be moved by 1989, is now even higher.”⁴²¹ The Institute called upon the state to rethink the placement of individuals held civilly, absent a criminal conviction, in a prison facility.⁴²² The Institute cited, as a model, Governor Charles Baker’s 2015 fulfillment of a state official’s 1987 promise to move women who were civilly committed for the treatment of a substance use condition out of MCI-Framingham to a public health hospital: “This recognition can and should be extended to Bridgewater State Hospital, which remains a black eye for Massachusetts, and a shame to the Commonwealth’s legacy on mental health issues.”⁴²³

The Baker Administration announces a plan for reform of Bridgewater State Hospital

On September 13, 2016, responding to pressures from the Disability Law Center, the *Minich* lawsuit, and advocates’ efforts to raise awareness of problems at BSH, Governor Baker announced a plan for further reform at the facility.⁴²⁴ Patients with criminal convictions would be transferred from the BSH campus to new BSH units located within Old Colony. (Old Colony was already a DOC facility with a focus on mental health.) Mental health services would be augmented, with all patients receiving an individualized plan of treatment within ten days of admission and patients receiving psychiatric medication receiving timely access to a psychiatrist.⁴²⁵ The state released the plan as part of a request for proposals for new medical services vendor, set to start in 2017.⁴²⁶ *The Boston Globe* quoted Secretary Sudders:

I've read all the reports, I've read all the news stories, I know the experiences of individuals with serious mental illness and their families. There's no question in my mind that this [plan] really lays out a very different expectation of treatment and services.... It will look and feel more like a psychiatric hospital.⁴²⁷

On February 8, 2017, plaintiffs filed a motion in Norfolk Superior Court for a finding of substantial non-compliance with the agreement in *Minich v. Spencer*, seeking equitable relief. On March 6, 2017, Justice Wilson issued an order deferring a decision on the motion until after an evidentiary hearing. In June 2017, plaintiffs withdrew the motion and the next month, the parties filed a joint motion to dismiss.

DOC contracts with for-profit Correct Care Recovery Solutions to implement reforms at Bridgewater State Hospital demanded by advocates

In February 2017, on the heels of the *Minich v. Spencer* lawsuit, DOC entered into a \$37M contract with the Nashville-based for-profit medical provider, Correct Care Recovery Solutions (CCRS), a division of Correct Care Solutions (CCS). Correct Care Solutions had been founded in 2003 by Gerard Boyle, the prior BSH Superintendent.⁴²⁸ The contract was set to run until June 30, 2022, with two options to renew for up to two years for each option.⁴²⁹

In 2017, in a period of promise, Correct Care Recovery Solutions hired a well-known mental health reformer, Kevin Huckshorn, PhD, to, in her words, transform the facility from a prison to a hospital.⁴³⁰ Huckshorn later explained that she and her colleagues had expertise in stepping in when “a hospital is at risk,” winning a bid or receiving a call asking them to take over.⁴³¹ She describes BSH, when she arrived, as a facility that was entirely locked down, with patients spending most of their time in their wards or cells:

All of the patients had a cell with big clanking doors that would lock automatically. The facility was staffed by uniformed correctional officers who carried batons, and patients had to wear Department of Corrections clothing. There were few activities, which most patients couldn’t attend anyway, and visiting hours were restricted.⁴³²

Huckshorn updated the facility’s mission, implemented a hospital patient bill of rights, oversaw the closing of the seclusion and restraint ward, and brought in behavioral health staff, including staff to perform security functions.⁴³³ Correct Care Recovery Solutions eliminated uniforms, incorporated therapy dogs, established electronic medical record-keeping, added peer support staff and advisory councils with seats for patients and families, and offered new groups, exercise, and social activities.⁴³⁴ The vendor also pursued trauma-informed, person-centered care.⁴³⁵ The Intensive Treatment Unit was closed.

As part of the reforms agreed to in the *Minich v. Spencer* settlement, BSH guards moved outside the BSH facility housing units to the facility periphery and Correct Care employees began providing security on the BSH units in the original facility building.⁴³⁶

And, in mid-2017, DOC transferred approximately 40 sentenced persons from the BSH building to two new BSH mental health units at Old Colony, the Intensive Stabilization and Observation Unit (ISOU) and the Recovery Unit (RU), both of which continue to operate today.⁴³⁷ The ISOU is a short-term BSH unit where patients receive a 30-day evaluation period to determine if they should be committed to the ISOU or sent back to their sending facility. The RU is a long-term unit for those evaluated there and then committed to BSH. On these two BSH units at Old Colony, DOC correctional officers still engage with patients on the units.

On September 9, 2017, Rezendes reported that five months after Correct Care Recovery Solutions took over and these changes were instituted at BSH, “the staff has cut the seclusion of patients by 99 percent and the practice of strapping them down by their wrists and ankles by 98 percent.”⁴³⁸ Rezendes quoted Governor Baker’s account of the changes:

"This is long overdue. It's something that's troubled me for a while," [Baker] said, adding that credit for the changes also belongs to the Legislature, which approved a 39 percent increase in Bridgewater funding, an additional \$19 million, as well as the union representing the guards, which supported the staffing changes. "We're very pleased by the early progress here on every level," he said.⁴³⁹

On September 21, 2017, Boston television station WCVB contrasted earlier days at BSH to the present. Former patient Tim Grabosky recounted having been in restraints at one point for 18 hours straight, noting that staff ruled with “an iron fist.”⁴⁴⁰ Governor Baker explained that the facility was “now operating using a clinical model, so that people are actually given an opportunity to get better.”⁴⁴¹ WCVB reporter Karen Anderson noted that “there were questions about whether removing the corrections officers would lead to an increase in violence against staff members.” So far, she reported, data showed the number of assaults was nearly unchanged.⁴⁴²

In December 2017, disability rights advocates joined the chorus of those applauding the changes at Bridgewater. Sitting on a panel with the Massachusetts Secretary of Public Safety and Security, Boyle, and others, DLC's Director of Litigation Stan Eichner observed, "I think the headline of the last nine months is that there's been incredible change in both practice and culture." Eichner continued, however, with a prescient warning: "When people take their eye of the ball, that's when things go back."⁴⁴³

DOC renews contract with Correct Care Solutions, which is then acquired and combined with another company to create Wellpath, its present-day health care provider

In fall 2017, a private equity firm H.I.G. Capital acquired Correct Care Solutions and combined it with another company, Correctional Medical Group Companies, to create Wellpath.⁴⁴⁴ DOC revised its contract to reflect the new company name, maintaining the June 30, 2022 contract end date.⁴⁴⁵

A February 2019 *New Yorker* article reported that between 2013 and 2018, 1500 suits had been filed against Wellpath and Corizon Health (into which Correctional Medical Services had merged in 2011), with over 1000 being against Corizon and nearly 500 against Wellpath.⁴⁴⁶ In September 2019, Wellpath's president estimated that the company provided services in 10% of counties nationwide, making it the country's largest correctional health care company.⁴⁴⁷

Disability Law Center reports on Bridgewater State Hospital continue, with initial praise of reforms giving way to pressing concern

While the Baker Administration was implementing its reforms and Wellpath was assuming Correct Care Recovery Solutions' role as medical provider at BSH, the Disability Law Center continued to produce reports, resulting in a series of documents that echoed and augmented concerns that DLC had raised in its report regarding Leo Marino's death.⁴⁴⁸

The first of these DLC reports, published on May 18, 2018, focused on DOC and Correct Care Recovery Solutions (because the latter entity had not yet been acquired by H.I.G. Capital). The report praised the "tremendous culture shift" and the "deeper commitment to treatment, rather than punishment" that Correct Care Recovery Solutions had brought to BSH in one year as the provider of medical services.⁴⁴⁹ DLC listed specific accomplishments:

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 [persons served (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.⁴⁵⁰

After noting these successes, however, DLC flagged a series of issues that the agency would come back to repeatedly in subsequent reports on DOC and Wellpath activities at BSH. These issues included:

- problems with the physical plant including temperature and decay due to age;
- the involuntary administration of psychotropics without complying with any legal requirements that would allow such an action;

- the need to continue to work toward actualizing person-centered treatment;
- the need to implement the thus-far “aspirational” goal of remedying the limited amount, lack of variety, and poor quality of programming;
- the need to supplement the inadequate services for patients with intellectual and developmental disabilities;
- addressing a cohort of patients who do not need the strict security of BSH, but who could receive treatment in other settings, include DMH and DDS facilities and programs;
- meeting the needs of the “almost three dozen” patients on the Recovery Unit and Intensive Stabilization and Observation Unit at Old Colony, who, DLC notes, were not afforded “[M]any of the most significant positive changes to the physical and cultural environment at BSH” but who “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.”⁴⁵¹

Subsequent DLC reports would return to these issues, while at the same time drawing attention to shifts in policy and practice resulting from Wellpath’s assumption of the responsibility to provide medical care. In fact, DLC’s next report, published on February 25, 2019, while highlighting the “constant day-to-day deficiencies of the physical environment, affecting virtually every aspect of the infrastructure” (including asbestos and mold, which would take a prominent place in many DLC’s reports on BSH),⁴⁵² also pointed to, as a “second ongoing challenge to the forward progress at BSH ...the substantial and near-constant change in the senior staff and leadership, both at the vendor Wellpath (formerly Correct Care Recovery Solutions) and at the Department of Corrections (DOC).”⁴⁵³ DLC went on to report “turnover among eleven key leadership positions at Wellpath. Except for three positions that remained the same, every other leadership position changed at least once and some positions changed more than once, including Administrator.”⁴⁵⁴ With respect to DOC, DLC wrote, “the one constant was the presence of the Superintendent, Susan Thibault, although virtually every other position, both higher and lower than hers did change.”⁴⁵⁵

The 2020s – Conditions at Bridgewater State Hospital remain troubling with new issues emerging; calls for more sweeping reforms gain traction

Bridgewater State Hospital today operates in two buildings, but neither is a true hospital

Today, BSH and the two BSH units at Old Colony serve individuals who require evaluation and treatment and who need of strict security because they may harm themselves or others by virtue of mental illness. Patients are sent by state courts, as well as by administrators of a range of other institutions, including county jails, state prisons, and DMH facilities.⁴⁵⁶ With the consent of the DMH Commissioner, a DMH Superintendent may pursue such a transfer if it believes that a male patient requires strict security to avert a likelihood of serious harm by reason of mental illness and that the person's violent behavior constitutes an emergency.⁴⁵⁷ After five days, the patient must be returned to the DMH facility unless the superintendent of the DMH facility or the medical director of BSH has filed a petition for his commitment to BSH.⁴⁵⁸

The hospital houses pre-trial detainees admitted for evaluation after having been charged with a crime, pursuant to a court order for observation and evaluation to assist in the criminal legal process.⁴⁵⁹ The hospital also houses individuals who have been civilly committed (but not criminally sentenced).⁴⁶⁰ As of July 1, 2022, BSH (excluding the two units at Old Colony) held 233 individuals, 167 committed and 88 for observation.⁴⁶¹ The average length of stay in 2020 for civil patients was 632 days and for criminal patients was 49 days.⁴⁶²

The two BSH units at Old Colony house BSH patients serving criminal sentences and civilly committed.⁴⁶³ As of January 1, 2023, the Old Colony units held 24 individuals.⁴⁶⁴

Despite its name, BSH is not a hospital. The Joint Commission's accreditation of BSH and the BSH State Sentenced Unit at Old Colony, including accreditation on March 19, 2022, remains as a Behavioral Health Care and Human Services facility and not a hospital.⁴⁶⁵

And, DMH has only limited involvement with BSH operations, either with respect to oversight or actual delivery of mental health services. DMH's involvement is focused primarily on patients being discharged from BSH commitment to DMH responsibility.⁴⁶⁶ That topic is the focus on quarterly meetings between DMH, BSH, and Wellpath staff.⁴⁶⁷ And, while there has been a legally binding Memorandum of Understanding with DMH that formalizes the communication and collaboration between the two agencies,⁴⁶⁸ that document is presently under revision.⁴⁶⁹

In June 2022, DOC and Wellpath amended their contract for services at BSH, so that the contract would run from July 1, 2022 until June 30, 2024.⁴⁷⁰

BSH population data raises concerns about disproportionate representation of people of color

The data regarding the current population at BSH should raise concerns. There is currently a disproportionate representation of people of color at BSH and the BSH Old Colony units. As of July 1, 2022, of patients held at BSH excluding those on the two Old Colony units, 39% were white, 26% were Black or African-American, 11% were Hispanic, and 2% were Asian or Pacific Islander.⁴⁷¹ As of January 1, 2023, of the patients on the two OCCC units, 58% were white, 21% were Black or African-American, 17% were Hispanic, and one person was of unknown race/ethnicity.⁴⁷² The Massachusetts population is 80.6% White, 9% Black/African-American, 12.4% Latinx/Hispanic, and 7.2% Asian.⁴⁷³

The overrepresentation of people of color in the Massachusetts criminal legal system has been flagged as being outside the U.S. norm. A Harvard Law School report commissioned by former Chief Justice Gants of the Massachusetts Supreme Judicial Court found that "the Commonwealth significantly outpaced national race and ethnicity disparity rates in incarceration."⁴⁷⁴

The Center for Public Representation (CPR) has noted the implications of such overrepresentation in light of DOC and Wellpath's illegal use of Emergency Treatment Orders. As CPR explains, the use of forced medication orders raises racial disparity concerns (even apart from the overrepresentation of people of color at BSH): "a 2021 study by Mass General and Harvard found that found that Black people experience disproportionately higher rates of chemical and physical restraint in psychiatric settings."⁴⁷⁵ CPR has alerted the Legislature on this issue:

The over-representation of people of color in carceral settings in Massachusetts, in addition to studies showing the disproportionate application of chemical and physical restraint on Black people in psychiatric and emergency department settings, raises additional concerns with respect to DLC's findings on the use of chemical and physical restraints at BSH.⁴⁷⁶

Based on these and other concerns, CPR urged the Legislature to transfer jurisdiction of BSH to DMH administration and oversight.⁴⁷⁷

DLC also focused on the potential for disparate racial impact in the use of restraint, seclusion, and ETOs in its July 2023 report on BSH. DLC highlighted that "glaring deficiencies in gathering and/or reporting [of race and ethnicity data] prevent[] accurate analysis of systemic inequities around race/ethnicity and Wellpath's use physical restraint, seclusion and ETOs."⁴⁷⁸

Wellpath refuses to discontinue its extensive use of Emergency Treatment Orders

Despite DLC's tenacity and vision in its published reports on BSH, DOC and Wellpath have minimized or rejected certain criticisms, particularly DLC's warning in January 2022 that DOC and Wellpath's current conduct with respect to the involuntary administration of psychotropics to BSH patients violates state law. Wellpath delivers these doses, which they term Emergency Treatment Orders (ETOs), outside any of the legal parameters that could legitimate their use.

In its January 2022 report regarding BSH, DLC found that, between June 26, 2021 and November 25, 2021, 370 Emergency Treatment Orders were administered at BSH in conjunction with manual holds, mechanical restraints, or seclusion.⁴⁷⁹ The actual numbers of orders is higher, as DLC noted that a "significant number of ETOs" were recorded in patient medical records that occurred either without manual holds or with manual holds and other restraints that were omitted from restraint packets provided to the DOC Commissioner.⁴⁸⁰ DLC concluded that "ETOs were widely used to control behaviors that do not justify chemical restraint, i.e., where no imminent threat of serious harm to self or others existed."⁴⁸¹ DLC found that DOC and Wellpath used this method to "control [patient] behavior and, possibly, to inflict punishment upon them for engaging in disruptive, unhygienic, and otherwise unwanted behaviors."⁴⁸² Moreover, in a subsequent report, DLC recounted the administration of ETOs as documented in 15 official facility videos. In these videos, staff in riot gear held down patients and injected them with medication, often while the patient protested and often without an indication of an emergency.⁴⁸³ Other legal advocacy organizations also have criticized Wellpath and DOC's use of these orders at BSH.⁴⁸⁴

Wellpath has insisted that the practice is legally permissible, and DOC has defended that position. In a March 2022 letter to DLC's Director of Litigation Tatum Pritchard, DOC Commissioner Carol Mici argued the injections were for treatment, and not a form of restraint.⁴⁸⁵ In his April 1, 2022 letter to Representative Michael Day, Chair of the Joint Committee on the Judiciary, Executive Office of Public Safety and Security Secretary Terrence R. Reidy repeated that "DOC and Wellpath continue to employ ETOs as treatment and not restraint."

The general rule in Massachusetts is that medication may be administered only with the informed consent of the person receiving the medication. There are, however, exceptions. First, involuntary medication may be used as a restraint of a person with mental illness in an emergency "such as the occurrence of, or serious threat of, extreme violence, personal injury or attempted suicide."⁴⁸⁶ Second, if a person lacks the competency to provide informed consent, a court may authorize the administration of the medication upon a substituted judgment finding that, were the person competent, they would choose to accept the medication. This rule was articulated in *Rogers v. Commission of the Department of Mental Health* and has long since been the common accepted practice.⁴⁸⁷ There is one narrow exception to when medication may be administered for the purpose of treatment (not restraint) without informed consent or a court order. That is, in exercising its *parens patriae* power, the facility may administer medication involuntarily to prevent "'immediate, substantial, and irreversible deterioration of a serious mental illness,' ... in cases in which 'even the smallest of avoidable delays would be intolerable.'"⁴⁸⁸

In *Rogers*, the SJC cautioned that the basis for invoking this exception would occur only "in rare circumstances."⁴⁸⁹ Such emergency medication only may be administered to an "incompetent patient, or to one whom doctors, in the exercise of their professional judgment, believe to be incompetent."⁴⁹⁰ If doctors determine that the involuntary medication should continue to prevent irreversible deterioration and the patient objects, "the doctors must seek an adjudication of incompetence."⁴⁹¹ If, after hearing, the judge finds the patient to be incompetent, "the judge should make a substituted judgment treatment plan determination."⁴⁹² Thus, the administration of medication pursuant to this emergency

exception may only occur when a number of stringent conditions have been met. Moreover, should medication be administered pursuant to this exception, those seeking to continue to medicate involuntarily must proceed to court for a judicial adjudication of incompetence and authorization of a treatment plan. That process, one would expect, would alleviate altogether the need for subsequent ETOs for that individual. DLC says that as many as half of the BSH residents have been subjected to ETOs. If Wellpath is following the law, half of the men at BSH have been at risk of “immediate, substantial, and irreversible deterioration of a serious mental illness, ... in cases in which ‘even the smallest of avoidable delays would be intolerable.’” It is no wonder that DLC and other legal advocates believe that the way Wellpath uses ETOs inconsistent with the narrow exception created by the *Rogers* case and that DOC’s defense of the practice is wrong.

Kevin Huckshorn, who instituted many of the reforms, ended her active engagement with BSH in 2019.⁴⁹³

DLC reports continue to raise serious issues regarding care at Bridgewater State Hospital

DLC has continued to report on BSH in the 2020s, issuing reports in March 2020, October 2020, July 2021,⁴⁹⁴ January 2022, July 2022, January 2023, and July 2023.⁴⁹⁵

DLC’s July 2023 report describes ongoing concerns, including but not limited to:

- leadership turnover (excepting Wellpath’s announcement of its intended transition to a new Hospital Administrator which DLC strongly supported).
- presence of mold, sanitation issues, and ineffective heat mitigation efforts;
- use of Emergency Treatment Orders and, relatedly, systemic violations of Massachusetts law regarding chemical and physical seclusion and restraint (including with respect to adopting de-escalation practices, training, and culture);
- inadequate language access for individuals with Limited English Proficiency;
- lack impediments to of sufficient access to treatment for individuals with substance use disorder and inappropriately tapering and terminating of access to Medication Assisted Treatment (MAT) by BSH providers;
- concern regarding BSH’s use of an atypical antipsychotic treatment taken via inhalation – despite the medication’s association with increased risk of bronchospasm and contradictions for people with respiratory conditions and aging individuals with dementia;
- lack of access to medical care; and
- impediments to continuity of care for following discharge from BSH.⁴⁹⁶

In its July 2023 report, DLC outlined DOC’s response to these issues, as provided in a June 7, 2023 letter. Generally speaking, DOC’s responses indicate state agency attention to these issues and some steps at addressing the problems. In a particularly welcome move, DOC indicated that it had retained Psychiatrist Debra Pinals as an independent expert consultant “to examine the use of Seclusion, Restraint, Emergency Treatment Orders (ETO) and Involuntary Medication Practices at BSH to ensure that practices at BSH are in line with the best interests of the [persons served] and nationally recognized best practices.”⁴⁹⁷ Additionally, DLC cites DOC implementation of a new Serious Clinical Episode review process for instances of sue of force and administration of seclusion, physical restraint, and ETOs.⁴⁹⁸ However, DLC details how the problems listed above (particularly with respect to the use of ETOs and restraint and seclusion), as well as others, continue to pose significant and potentially dangerous threats to BSH patients. Moreover, DLC reports that it “did not observe any marked progress by DOC and

Wellpath in addressing issues and PS complaints about the OCCC Units.”⁴⁹⁹ Issues on those units include heat in cells, lack of access to treatment, and reliance on intimidation and force.⁵⁰⁰

As DLC has previously recommended, in releasing its July 2023 report, “[a]fter almost a decade of monitoring, DLC again urgently calls on the Commonwealth to transfer oversight of the BSH population to the Department of Mental Health (DMH) and to construct a new psychiatric hospital.”⁵⁰¹

Advocacy efforts reinforce the need for radical change at Bridgewater State Hospital

In addition to the advocacy already summarized, particularly that of DLC, others also have investigated BSH and advocated for change at the facility.

The media have covered DLC’s reports, particularly with respect to the use of Emergency Treatment Orders. Reporting on DLC’s July 2022 report, WGBH amplified DLC’s finding that over half of the patient population of BSH had been subject to an ETO in the six months preceding the report.⁵⁰² WGBH reported that these injections were not being properly documented, even though they were almost invariably administered in conjunction with manual holds, mechanical restraints, or during seclusion.⁵⁰³

In addition to funding DLC’s ongoing monitoring of BSH,⁵⁰⁴ the Massachusetts state legislature has looked closely at the institution. A number of state legislators, including members of the Legislature’s Criminal Justice Reform Caucus, have visited the facility.⁵⁰⁵ And, on December 20 and 21, 2022, the Commonwealth’s Joint Committee on the Judiciary held oversight hearings to examine issues related to the implementation of Chapter 69 of the Acts of 2018, *An Act Relative to Criminal Justice Reform*, as well as prisoner and correctional officer welfare. The Committee sought information in writing and in person appearances from both DOC and the county sheriffs. DOC did not answer all inquiries and “flatly refused to appear at any time” before the Committee.⁵⁰⁶ Nonetheless, a slate of other witnesses provided compelling testimony regarding the status of patients at BSH.⁵⁰⁷

The Massachusetts state legislature also has addressed concerns with the aging building. A 2022 General Governmental Bond Bill instructed the Division of Capital Asset Management and Maintenance (DCAMM) to conduct a pre-design study to plan for the development of a forensic psychiatric hospital.⁵⁰⁸ This study, to be conducted in consultation with designated public agencies and non-governmental entities, involves determination of state hospital property for potential location; program needs of potential patients; design features of a forensic psychiatric facility; construction cost estimates and financing strategies; and timelines for development and construction.⁵⁰⁹ The state failed to meet Bond Bill’s requirement of a report to the Legislature with these elements by an April 2, 2023 deadline. However, Governor Maura Healey included funding for this study in her June 2023 capital investment plan:

In addition to addressing the needs of its own facilities, the Human Services leadership and agencies will also be engaged with their colleagues in Public Safety and Corrections around the long-term strategy for Bridgewater State Hospital. Recent legislation directed DCAMM to study the development of a new Forensic Psychiatric Hospital to be under the direction of the Department of Mental Health (DMH) – which would mean moving those services from DOC to DMH. This study was initiated in 2017 but never brought to conclusion. The [Capital Investment Plan] provides funding to restart and conclude this study.⁵¹⁰

The next step the Massachusetts state legislature could take is to pass Representative Ruth Balser and Senator Cynthia Creem’s bill, which they have filed in multiple legislative sessions, which would transfer responsibility for the operation and oversight of BSH from DOC to DMH, including responsibility for all

medical and mental health treatment.⁵¹¹ This shift would effectively remove DOC from any role in the care and confinement of men sent to BSH or the BSH units at Old Colony. As Representative Balsler explained to WGBH:

There have been a series of reports that have been really alarming, and they all make me continue to believe that we should ultimately transfer oversight of that facility from the Department of Correction to the Department of Mental Health,” she said, adding that the skill level for staff dealing with patients would be higher than through the Department of Correction.⁵¹²

Such a legislative change would place Massachusetts in line with the rest of the nation. In nearly every other U.S. state, the maximum-security forensic hospital is operated by the state mental health agency.⁵¹³ Other state legislators have indicated strong support for the bill.⁵¹⁴ Advocates enthusiastically support the legislation.⁵¹⁵

Massachusetts State Representative Marjorie Decker also filed legislation in the 2023-2024 Massachusetts legislative session which would allow DMH to move forensic patients more efficiently through the competency evaluation and restoration processes, by requiring DMH to contract with service providers who could conduct competency determinations and competency restoration in community-based settings.⁵¹⁶ Expanding the use of community evaluations potentially could reduce the number of individuals confined to BSH for these reasons.

Voices of families with loved ones at BSH have been prominent in efforts to gain reforms at BSH. BSH families met with the Criminal Justice Reform Caucus and members of the advocacy groups Family and Friends of Individuals with Mental Illness (FFIMI) and the Bridgewater Families Group testified at the Judiciary Committee’s December 2022 oversight hearing.⁵¹⁷

Families have consistently advocated for improved medical and mental health care. Families have mixed impressions of the care delivered by Wellpath, as well as diverse opinions about whether the contract with Wellpath should continue. (Some family members are concerned with Wellpath but worry that the vendor could be replaced with another that performs more poorly.⁵¹⁸) This ambivalence was less apparent in an April 2023 letter from the BSH Family and Friend Advocacy Group (“Family Group”) to the state Legislature in which the group raised concerns about Wellpath’s provision of care at BSH and DOC’s extension of its contract.⁵¹⁹

Many family members of BSH patients have united behind the goals of stronger oversight and the transfer of that oversight of BSH from DOC to DMH. In April 2022, the Massachusetts chapter of the National Alliance on Mental Illness (NAMI) issued a statement on BSH pressing for such transfer of responsibility:

From 2015- 2017, NAMI Massachusetts was part of an advocacy coalition whose efforts culminated in the Commonwealth bringing in the outside company Correct Care Solutions to provide quality treatment, security, and shift the culture at BSH. Though BSH remained under the oversight of the Department of Corrections (DOC), the goal of this change in daily operations was to create a real commitment to clinical support instead of punishment. It is tragic to understand that the benefits of that effort are no longer improving the lives of those at Bridgewater State Hospital. Massachusetts is one of only a handful of states that house individuals under these circumstances in a facility overseen by the Department of Corrections rather than the state’s Department of Mental Health (DMH). ... Massachusetts should be aligning with other states by having the DMH oversee BSH.⁵²⁰

Likewise, in January 2023, Family and Friends of Individuals with Mental Illness and the Bridgewater Families Group proclaimed that BSH must be under DMH, not DOC, control.⁵²¹ The Family and Friends coalition noted that “Wellpath’s contract with DOC requires that DOC review and approve Wellpath policies.⁵²² This means penal system policies push the type of care, or lack of care, for those with serious mental illness at BSH.”⁵²³ The Bridgewater Families Group coalition explained that “their loved ones who are moved from BSH to DMH receive improved treatment, resulting in less suffering and a better quality of life due to DMH’s superior policies for people with mental illness, focus on a therapeutic and healing environment, individualized treatment, and facilitation of loved ones’ involvement.”⁵²⁴ The Bridgewater Families Group’s April 2023 letter to the Legislature had a more specific recommendation: “The Legislature should combine Bridgewater State Hospital with Worcester Recovery Center and Hospital by building an additional facility at the Worcester location. This would allow for a much easier transition and allow the Department of Mental Health complete oversight.”⁵²⁵

Most importantly, patient voices are coming to the fore. On December 9, 2022, the advocacy group Hear Our Voices released a series of five dramatizations based on real-life experiences of BSH patients. The scripts, with titles such as “Isolation,” “Heatwave” and “Hard to Breathe,” incorporate the accounts of persons with serious mental illness who have been incarcerated for behavioral issues.⁵²⁶

Recommendations for a better future

The history of BSH and the institutions that preceded it on that site reveals repeated reevaluation of who we confine at BSH and how we care for them . As the history suggests, the beliefs about who should be confined, the definition of mental health conditions, the methods of treatment, the purposes and expected durations of detention, the need for and role of security, the roles and types of staff, the relationship between the public and private sectors, and the expectations for discharge have all changed over time. This history should alert us that the system reflects shifting societal views and can be further altered. We offer these suggestions for change.

Rethink who we confine

Over the last one hundred and seventy years, society has changed its view of whom we feel a need to exclude from the larger community and banish to custodial institutions, whether they be almshouses, workhouses, state farms, asylums, state schools, prisons, jails, or hospitals. Over and over, one group of people is replaced with another as we redefined deviancy.

For example, once the state sought to remove poor people and new arrivals to the nation from its communities. Later it isolated, for lengthy periods or even life, people with substance use problems. And, similarly, once the Commonwealth confined certain persons who were designated with a formal label of “bad.” Later it identified and detained other persons who were identified as “defective delinquents” (i.e., people who might present as having cognitive disabilities and who were determined to be likely to commit crimes), until we decided that this categorization too made no sense.

These are early examples. What they reveal is a repeating pattern of labelling and then confining persons only to subsequently determine that such populations were inappropriate for confinement, and then moving on to identify and categorize other groups to replace those subsequently deemed inappropriate for separation.

Even at the time of these confinements, there was opposition to the designations and the removal of people to Bridgewater facilities and their ongoing detention. Often, vocal opposition came from those within the facility. The history of Bridgewater State Hospital reveals cases of administrators questioning

the merit of assembling these populations in one institution and arguing a lack of adequate space, staff, and expertise to provide for their care. In some cases, official pleas for more resources were successful and in other cases they were not.

Today, the state authorizes different categories of men to be confined at BSH.⁵²⁷ We should question the wisdom of our own practices. One category are men who are undergoing pre-trial evaluation to determine competency or criminal responsibility. When men are institutionalized for such evaluations, they lose their liberty and experience a weakening of ties to the services and supports they might otherwise receive in the community. Further, men found incompetent to stand trial may be then civilly committed to BSH if they meet the commitment criteria and, if they do not become “competent,” may be held for extended periods. If they gain competency within a set period, they are returned to court and perhaps to jail to await trial. Likewise, men who courts determine are not guilty by reason of mental disease or defect (the insanity defense) may be committed for extended periods to BSH. These men are not convicted so when they no longer meet BSH commitment standards they must be transferred to DMH or discharged. Men also may be transferred to BSH from prisons, jails, and houses of correction to BSH, where they may receive access to specialized mental health care but also may experience disruption of existing treatment and social relationships developed in the former carceral setting. There also may be other impacts, such as losing the opportunity to earn “good time” toward a reduction of a sentence through participation in an approved employment, educational, or vocational training program or activity.⁵²⁸ Under a recent amendment to the mental health code, male prisoners may petition for transfer to BSH or to a DMH facility if they have been held in suicide watch conditions at a jail or prison for 72 hours.⁵²⁹

And there are other structural problems. For example, even if beneficial treatment is prescribed at BSH, it often is not implemented on a patient’s return to their original carceral facility. Or a person may be transferred to BSH only to be returned to their sending institution without having received any treatment at all. And, for sentenced patients held on the two BSH units located within Old Colony prison, continued confinement in a prison may not best serve mental health recovery. These prisoners are there because they need an inpatient level of care that cannot be provided at the prison from which they were transferred. But OCCC is still a prison and is run as one. Despite its manifest shortcomings, BSH at least makes attempts to be something less than a prison and something more like a hospital. OCCC patients may not receive the level of therapeutic services that best serves people with mental health needs.

At some future point we may decide that certain categories of people now served at BSH, including the BSH units at Old Colony, do not require strict security of the form currently provided. We might reconsider what strict security means, where it can be provided, and who really needs it. In addressing this question, we must also review the capacity of DOC to provide inpatient mental health care and the quality of that care – whether that be at Old Colony Correctional Center or elsewhere. Advocates also might consider challenging the common assumption that there is a category of forensically-involved people with mental health conditions who must live *long-term* in strict security settings. It is likely that many if not most of the men held at BSH and BSH at OCCC are not significantly different from many patients who are now served by DMH. Indeed, as noted above, a significant percentage of patients in DMH-operated and contracted inpatient facilities are referred by criminal courts.⁵³⁰ It is the individual’s clinical needs that should drive the provision of care and services, not the section of the mental health law under which they are confined. We should reflect on these sorts of questions even as we pursue more immediate reforms.

Find therapeutic locations for those forensic psychiatric patients we conclude we must confine

Constructed in 1971 and now approaching age 50, BSH has an array of physical systems problems and other limitations. These were identified as major problems by its superintendent in the early 1990s. It is fair to say the BSH plant has reached the end of its useful life.

Researchers who conducted a review of over 400 hospitals in the 2000s found that “a 45 year composite life is the norm” for hospitals, with composite life reflecting both structural components of the building and building service elements (*i.e.*, electrical, plumbing, and HVAC).⁵³¹ Even more telling when thinking about the viability of the BSH building, *in 2017 Correctional News*, a prison industry journal that focuses on construction issues, suggested that carceral buildings constructed in the 1980s and 1990s might be experiencing failing systems at that time.⁵³²

Even apart from physical plant issues, the BSH campus is not and cannot be transformed into a therapeutic space for people with mental health conditions. Built long after the age of the “grand palaces of healing” of the 19th century,⁵³³ BSH shares the features of many mental health hospitals of its time: isolation from the larger community,⁵³⁴ institutional feel, claustrophobic wards, sparse cells, all in an unappealing building adjacent to barren courtyard space. Of course, certain BSH features are related to its special nature as a prison. And, while the BSH’s design of buildings around a quad, with separate locations for wards, gym, library, chapel, and programming, reflects a progressive vision for the time, the current physical plant does not recall, in any way, a college campus. In sum, the BSH buildings and campus are not and, in all probability, cannot be made into therapeutic spaces.

Moreover, BSH patients at Old Colony, although in a newer building, are also inappropriately housed in a prison, which is even less therapeutic and more prison like than BSH. While these two BSH Old Colony units have separate rules and programming and are technically part of BSH, for the patients residing there, there is no escaping the carceral experience of the hosting institution. As noted above, advocates from DLC have observed, these patients “have been shoehorned into a narrow island within a much larger prison environment.” Further, unlike the BSH units in the hospital building which, as part of the 2017 reforms, traded correctional officers for mental health staff to provide security, the DOC has not removed correctional officers from the two Old Colony units and reports no plan to do so.

Design a secure forensic mental health hospital with care

As early as the 1950s, architects were offering an alternative vision for the “modern” psychiatric hospital. At that time, the Architectural Study Project, which grew out of an American Hospital Association conference to develop solutions for overcrowded and deteriorated mental hospital buildings,⁵³⁵ recommended a series of features for new facilities (for example, smaller rooms of quality space for people with psychosis so as not to confuse and overwhelm).⁵³⁶ Some also argued for alternatives to large state mental hospitals, such as day hospitals, clinics, community centers, and units in general hospitals.⁵³⁷

Current research suggests that mental health hospitals should look very different from many currently in use, and some new ones do look different. In 2007, the American Psychiatric Association’s *Psychiatric News* proposed, “[t]oday’s facilities still have their boundaries but, more than ever before, are less places of confinement and more places of treatment and preparation for return to the outside world.”⁵³⁸ The author describes the importance of making the mental health hospital building more like a home than an institution, with comfortable and private spaces as well as open shared spaces – both of which have ample daylight and views of the natural world.⁵³⁹ New recovery spaces must recognize the important of features such as nature, private rooms, appealing and multiple communal spaces, and lowered noise levels.⁵⁴⁰ And a movement is underway in the architectural community to embrace

trauma-informed design in a range of settings: “‘We are just out of the starting gate,’ said Kay Sargent, the Washington DC-based director of the Workplace Group at HOK, a global architecture firm that has created a landmark guidebook on trauma-informed design.”⁵⁴¹

Additionally, any new building for BSH patients should be in a location that facilitates family visits. Until we have new spaces, we should support expanded visitation hours and the elimination of unreasonable and unnecessary visitation restrictions.

As we move forward, we also should accept the cautionary message of Ashley Rubin, whose reflections in “That Time We Tried to Build the Perfect Prison: Learning from Episodes Across U.S. Prison History” ring true as we explore BSH’s history. Rubin appreciates the ongoing trend in prison reform to make prisons more humane by borrowing from design decisions and architectural plans aimed at wellness and healing in other fields. She supports designs that incorporate light, nature, space, and other features rarely associated with prisons. However, as she applauds these trends, she also cautions against viewing “these efforts as the latest in a long line of attempts to construct the ‘perfect prison’ – a kind of fantasy version of prison, varying in its ambition and elaboration, that would achieve certain goals in particular ways, smoothly, seamlessly, and efficiently.”⁵⁴² Prison-building (and even secure mental health hospital buildings) should never be our fantasy. They will not solve the problems of their patients and there may not be the best settings for them, even with improved features such as more access to the natural world.

Let our failures inform our decisions regarding treatment and supports

If we do secure a commitment to create a new setting or settings for BSH patients, replacement of the physical structures is insufficient. We also need to continue to evaluate how best to treat and provide support to patients.

Bridgewater’s history, as almshouse, workhouse, farm, and asylum, features a cycle of tragic events followed by reactions and reforms. The cyclical nature is evident in the overcrowding of various populations in the 1930s, the escapes and murders of the 1940s, and the calls for reform in the 1950s. The cycle exists in the forgotten men and rights violations of the 1960s and horrid conditions of the 1970s, followed by the opening of a new building with a new university-affiliated mental health provider. The pattern continues with the series of deaths in the 1980s and the lawsuits, including *O’Sullivan*, that followed, leading to experimentation with new contracts and subcontracts in the 1990s. We see the cycle of tragedy and reform recur in the 2000s with the deaths of William Mosher, Jr., Joshua Messier, and Bradley Burns, as well as the overuse of seclusion and restraint in BSH’s Intensive Treatment Unit, and then the lawsuits, including *Minich v. Spencer*, which led to broad reforms in the 2010s.

Inevitably, observers will ask if BSH has improved since its early days, a question which might have brought different answers at different points in the cycle of calamity and response. A more useful question, so that we might interrupt the cycle entirely, is to ask why the pattern of progress and decline continues. In that way, perhaps we can do more than just lower the amplitude of the ongoing wave of suffering and intervention.

Many of the deaths or injuries of patients are the result of the use of force and control, whether by seclusion or restraint or by involuntary medication. Other tragedies are the result of neglect or indifference. We can be hopeful that these most terrible incidents of restraint and neglect at BSH will not reoccur. We should still worry, however, about current practices which have replaced restraint as

methods of control, particularly Wellpath's widespread and unapologetic use of Emergency Treatment Orders which the Disability Law Center characterizes as an illegal use of chemical restraint.

DLC has repeatedly raised the alarm on DOC and Wellpath's troubling use of forced medication in "emergencies." The legal authority to use forced psychotropics in an emergency is quite narrow and is rarely used in mental health treatment settings. DLC reports describe how this use violates state law. The fact that these ETOs are being used on an ongoing basis – for multiple prisoners and over long periods of time – is deeply concerning. It appears that the DOC and Wellpath have substituted this medication response as an alternative for the use of seclusion and restraint, which DOC curtailed pursuant to its agreements with DLC and with the *Minich* plaintiffs. Further, as the Center for Public Representation has argued to the Legislature, the use of these orders raises serious concerns about the likelihood of disparate racial impact. Disparate impact presents a compelling, urgent reason to discontinue the ETOs. We also should persist in efforts to address disproportionate minority contact with the criminal legal system.

Further, we should worry about present day lack of access to medical and mental health care. We should advocate now, as we have in the past, to rid patients of unauthorized coercive treatment and controlling practices. We should closely examine whether patients are receiving patient-centered medical and mental health care when they need it. And given a history where the state entities responsible for reviewing patient deaths and other incidents have not always operated with transparency and accountability, we should demand that there is independent oversight over all entities involved in the delivery of mental health services, including particularly oversight over the use of restraint and any forced medication and oversight over medical service delivery more generally. Finally, we should work towards a goal of eliminating the practice of restraint, not only at BSH hospital, but also at all state-operated and licensed psychiatric hospitals in the Commonwealth.

Reject national trends in the delivery of medical and mental health care in institutions and instead choose providers that are right for Massachusetts patients

Competent and caring clinical providers and DOC administrators and line staff have worked, and currently work, at BSH. However, as historian Michael Maddigan noted in a 2019 presentation, Bridgewater State Hospital "has arrived at a destination we never intended and this despite all the best intentions of all the good people that have worked at Bridgewater and continue to work at Bridgewater trying to create a better life for the inmates and for the patients there."⁵⁴³

The publicly available history of care at BSH reveals examples of outrageous and devastatingly sad abuse and mistreatment – including many experiences that have prompted legal actions, legislative inquiries, administrative investigations, and media attention. These terrible stories leave a stain that cannot be removed from the facility.

Titicut Follies, while filmed before construction of the current BSH buildings, revealed problems particular to that point in time and problems that resonate today. Some issues have no parallel today – an institutional population swelling to 900 persons, the profound lack of dignity and rehabilitative activity, and the use of punishments and treatments that have since been discredited. However, as attorney Steven Schwartz argued in 1987, much was not remedied even nearly twenty years after the film's release. And, today, reflecting on these issues, we still could argue that at BSH men are held too close together, held too long and in the wrong type of setting (when they would be more appropriate for other settings such as DMH and Department of Developmental Services facilities and programs), held without dignity or sufficient rehabilitative activity, and, in some cases, held so as to endure punishment over treatment.

Since *Titicut Follies* and since the 1980s, changes at BSH in the provision of medical and mental health care have elevated the quality of care available to patients. At the same time, another concerning trend has emerged in the Commonwealth's delivery of care to those in the carceral system – the state's engagement with behemoth, for-profit, out-of-state providers. This trend should worry us all. BSH's history has demonstrated some improvements when DOC contracted with university-affiliated, Massachusetts-based, non-profit mental health vendors. Care also reportedly improved under the 1975 contract with McLean Hospital, which itself was affiliated with local academic programs. Kenneth Appelbaum described successes he experienced at BSH when UMass had a subcontract to provide mental health services.⁵⁴⁴ Other contracts were not with non-profit, local companies and were not of consistent quality.

Nonetheless, advocates initially welcomed the 2017 reforms that brought in the national, for-profit Correct Care Recovery Solutions as part of the solution to the overuse of seclusion and the limitations inherent in having DOC guards providing mental health care. Meetings with Kevin Huckshorn were reassuring to those advocates. Today, DOC still contracts with the company that Correct Care transitioned into – Wellpath, a for-profit company which provides medical and mental health care in facilities in 36 states and Australia.

Unfortunately, advocates are not as sanguine about this contract now as they were in 2017. Since that time, Huckshorn and her team that had reassured advocates left BSH, and other administrators and staff have cycled in and out of Correct Care/Wellpath at a dizzying rate. Today, as mentioned above, Massachusetts legal advocates, families, and patients are shaken by Wellpath's refusal to comply with state law regarding forced medication as they continue to use Emergency Treatment Orders at BSH at rates that are unprecedented for any Massachusetts facility. And, every six months, DLC reports a range of other ongoing and new concerns. There is also a worry that Wellpath, seeking to focus on competency determinations, is increasingly returning patients with certain diagnoses, particularly personality disorder diagnoses, to sending carceral facilities without having allowed the patients to complete the longer periods of treatment that have occurred in the past. Finally, evidence of the state of disarray at BSH is visible in public spheres. Care staff who work or have worked for Wellpath complain online of poor management and disregard for employees and patients.

If considering future arrangements for the provision of medical and mental health services, Massachusetts agencies, whether DOC or DMH, should consider bucking national trends and bringing services back in state where administrative and clinical responsibilities derive from in-state talent and rest with local professionals. We once again should contemplate providers with academic affiliations. And we should rethink the idea that it makes sense to give state dollars which should be going to medical care to companies that siphon them off as profit.

Moreover, any medical provider needs oversight. And a large, out of state, for-profit provider with a history of elevated levels of staff turnover at BSH needs even more oversight. The fact of DOC's support for Wellpath in its use of Emergency Treatment Orders alone suggests that DOC cannot perform the function. As discussed in the next section, the responsibility for oversight of the delivery of mental health services to BSH patients should rest not with DOC, but with DMH.

DMH is the appropriate agency to care for those currently confined at Bridgewater State Hospital

Bridgewater State Hospital patients should be treated in a psychiatric facility, not a prison

Despite reforms, including the removal of correctional officers from the units in the hospital building, BSH remains a prison with the rules and punitive culture that carceral life entails. People with mental

health needs who are held involuntarily by the Commonwealth deserve to be treated by mental health staff in a safe and therapeutic setting. This principle should extend to those in the criminal legal system.

We should work diligently to evaluate the need for secure inpatient settings for our forensic psychiatric patients, commit to the construction of a new, therapeutic facility to house and treat those forensic patients who require inpatient care, and establish an aggressive timeline for placing such patients in a new setting.

This new facility would not be a prison and would not be operated by DOC. As discussed below, it would be a mental health hospital operated by DMH, our state mental health agency.

Bridgewater State Hospital patients should be the responsibility of DMH and DDS, not DOC

DMH's inclusive mission reveals that it is the proper agency to serve BSH patients: "The Department of Mental Health, as the State Mental Health Authority, assures and provides access to services and supports to meet the mental health needs of individuals of all ages, enabling them to live, work and participate in their communities."⁵⁴⁵ DMH's commitment to treatment and belief in recovery for those with mental illness are critical: "We know that recovery from mental illness is possible.... The majority of psychiatric disorders can be effectively treated. Treatment, which often combines medications with therapeutic and social rehabilitation interventions, can effectively alleviate the symptoms of mental illness..."⁵⁴⁶ Moreover, DMH embraces the goal of community reintegration, through the use of community support: "Community support services are a critical component of recovery. Living independently, building social relationships, getting an education and holding a job are goals for most people with mental illness while others may need supports for longer periods to achieve and maintain independence."⁵⁴⁷

DMH can provide BSH patients with access to a range of traditional and alternative mental health services, including services provided by peers with lived experience of mental health challenges and recovery. DMH also can ensure that patients have regular contact with their families and other supportive persons. In addition, DMH can assist patients in accessing educational and vocational services. Most patients will return to live in the community; we should strive to return them in good mental health, with the personal resources to succeed.

Most men at BSH present similarly to patients residing in DMH hospitals. They share similar diagnoses, treatment histories, risk factors, and potential for recovery. In fact, many BSH patients have been and will again be patients of DMH hospitals. Although they may have pending charges, require evaluations, or be serving sentences, such persons could be cared for by DMH. DMH has the capability to provide the level of secure treatment in a therapeutic environment required to meet the needs of the patients now sent to BSH. In fact, today in 48 states, the state mental health agency serves such individuals exclusively, without the involvement of corrections departments.⁵⁴⁸

Likewise, DDS should finally take responsibility for the men with intellectual and developmental disabilities at BSH.

Assess who would be appropriate to receive care in a new forensic psychiatric facility

In anticipation that the Commonwealth will soon undertake, through the Division of Capital Asset Management and Maintenance, “a pre-design study to plan for the development of a forensic psychiatric hospital,” it is essential to think about who might be appropriate for such a facility.

We want to ensure that the plan carefully consider the need among the forensic psychiatric population for strict security so that those persons who do not require strict security are not placed there but instead in the least-restrictive settings appropriate for their security needs. This analysis should be undertaken for all categories of BSH patients (including those on the BSH units at Old Colony),⁵⁴⁹ patients with forensic involvement currently held in DMH inpatient units, and forensically involved women with psychiatric needs.

Take direction from patients, families, and other advocates

Former patients and family members have been vocal advocates for improving conditions of BSH patients. These are essential voices. Often, they also are asked to convey the thoughts and wishes of currently confined individuals. We must incorporate such advocates into future planning and amplify the ability of current patients to participate as well. Other advocates, including legal advocates, also should have a role. DOC’s communications with family members of currently confined patients and the DCAMM study language (which requires that DCAMM consult with a range of advocacy organizations as part of its analysis) are good steps, but fuller integration of these perspectives is essential.

Conclusion

When one looks from the terrible events in BSH history to BSH’s current day operations, one sees that the failures of the past are not simply in the past but resonate in the present delivery of services. DOC’s BSH needs closure and closing. To that end, BSH patients need to be placed within the responsibility of DMH so that they may benefit from that agency’s mission and expertise.

Acknowledgement

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¹ THE PALGRAVE HANDBOOK OF PRISON DESIGN 32 (Dominique Moran ed., Springer International Publishing 2023).

² Iowa’s system is bifurcated. The Iowa Medical and Classification Center, operated by the Iowa Department of Corrections, provides inpatient psychiatric and competency to stand trial evaluation services to non-adjudicated, forensically-involved persons. However, Iowa then provides competency restoration services at two state hospitals run by the Iowa Department of Health and Human Services.

³ See Mass. Gen. L. ch. 125, § 18.

⁴ The term “patient” is used in this paper to refer to those persons held in Bridgewater State Hospital in acknowledgement of the mental health care needs of such persons. Female patients meeting these criteria are not sent to BSH but are confined in a Department of Mental Health-operated facility.

⁵ Michael J. Maddigan, MCI Bridgewater: A Troubled Past, YOUTUBE (May 9, 2018), <https://www.youtube.com/watch?v=Ef7jku89C4>. Those confined included high percentages of new immigrants to

the United States. Lucille O'Connell, *Caring for the Sick Poor: The State Almshouse at Bridgewater, 1854-1887*, 3 BRIDGEWATER REV. 8, 8 (1984), https://vc.bridgew.edu/cgi/viewcontent.cgi?article=1753&context=br_rev.

⁶ MASS. STAT. 1862, ch. 275.

⁷ O'Connell, *supra* note 5, at 12; *see also* MASS. STAT. 1853, ch. 352 (designating the Bridgewater Almshouse).

⁸ O'Connell, *supra* note 5, at 8.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.* at 9 (Table 2).

¹³ *Id.* at 8.

¹⁴ *Id.* at 9 (Table 2).

¹⁵ Dorothea Dix, Memorial to the Legislation of Massachusetts, 1843, BILL OF RIGHTS INSTITUTE,

<https://billofrightsinstitute.org/activities/dorothea-dix-memorial-to-the-legislation-of-massachusetts-1843>

¹⁶ Introduction, Memorial To The Legislature of Massachusetts, DISABILITY HISTORY MUSEUM,

<https://www.disabilitymuseum.org/dhm/lib/detail.html?id=737&page=all#:~:text=In%201843%2C%20Dorothea%20Dix%20petitioned,indigent%20people%20with%20mental%20disabilities>.

¹⁷ O'Connell, *supra* note 5, at 11.

¹⁸ MASS. STAT. 1866, ch. 198; *see also* Massachusetts State Farm (Bridgewater, Mass.), SOCIAL NETWORKS AND ARCHIVAL CONTEXT, <https://snaccooperative.org/ark:/99166/w67m61j2>.

¹⁹ Industry records, 1898-1928 [Massachusetts State Farm (Bridgewater, Mass.)], MASSACHUSETTS ARCHIVES, <http://chc.library.umass.edu/state-archives/2017/04/18/industry-records-massachusetts-state-farm-bridgewater-mass/>. When, in 1866, the Legislature established State Primary School at Monson, in place of the Monson Almshouse, Bridgewater Almshouse children were transferred there. MASS. STAT. 1866, ch. 209; O'Connell, *supra* note 5, at 10.

²⁰ *Id.*

²¹ *Id.*

²² MASS. STAT. 1872, ch. 45; Health and Human Services, Record Groups HS, MASSACHUSETTS ARCHIVES 18 (rev. Aug. 19, 2020), https://www.sec.state.ma.us/arc/arcpdf/collection-guides/FA_HS.pdf.

²³ MICHAEL J. MADDIGAN, MASSACHUSETTS CORRECTIONAL INSTITUTION-BRIDGEWATER: A TROUBLE PAST 37-38 (2018).

²⁴ *Id.* at 9.

²⁵ First [-seventh] Annual Report of the State Board of Health, Lunacy and Charity [1879-1885], HATHITRUST xxiv, <https://catalog.hathitrust.org/Record/001742596>.

²⁶ MADDIGAN, *supra* note 23, at 40.

²⁷ *Id.*

²⁸ *Id.* at 41.

²⁹ *Id.* at 49.

³⁰ *Id.* at 51-52.

³¹ *Id.* at 52.

³² MASS. STAT. 1886, ch. 219.

³³ MADDIGAN, *supra* note 23, at 53.

³⁴ Massachusetts. State Board of Lunacy and Charity, SOCIAL NETWORKS AND ARCHIVAL CONTEXT, <https://snaccooperative.org/ark:/99166/w66q5w85>.

³⁵ MADDIGAN, *supra* note 23, at 53.

³⁶ State Workhouse Board of Inspectors/Trustees Minutes [Mass. State Workouse (Bridgewater, Mass.)], MASSACHUSETTS ARCHIVES, <http://chc.library.umass.edu/state-archives/2017/04/18/state-workhouse-board-of-inspectorstrustees-minutes-massachusetts-state-workhouse-bridgewater-mass/>.

³⁷ MADDIGAN, *supra* note 23, at 54.

³⁸ O'Connell, *supra* note 5, at 12.

³⁹ MADDIGAN, *supra* note 23, at 54-55.

⁴⁰ MASS. STAT. 1895, ch. 390.

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- ⁴¹ MADDIGAN, *supra* note 23, at 59-61.
- ⁴² O'Connell, *supra* note 5, at 12; Industry records, 1898-1928, *supra* note 19.
- ⁴³ MADDIGAN, *supra* note 23, at 61.
- ⁴⁴ *Id.* at 65.
- ⁴⁵ Industry records, 1898-1928, *supra* note 19.
- ⁴⁶ MADDIGAN, *supra* note 23, at 76. He notes that after 1886, the State Farm sought to hire medical students and undergraduates as hospital stewards to improve medical care. *Id.* at 80.
- ⁴⁷ *Id.* at 78.
- ⁴⁸ *Id.*
- ⁴⁹ *Id.* at 80-84.
- ⁵⁰ *Id.* at 85-86.
- ⁵¹ Email from Alex Green, Adjunct Lecturer in Public Policy, Harvard Kennedy School to Jennifer Honig, Co-Director of Public Policy and Government Relations, Mass. Ass'n for Mental Health (June 20, 2023) (on file with author).
- ⁵² MASS. STAT. 1919, ch. 199.
- ⁵³ Email from Alex Green, *supra* note 51.
- ⁵⁴ *Id.*
- ⁵⁵ *Id.*
- ⁵⁶ *Id.*
- ⁵⁷ *Id.*
- ⁵⁸ Letter from Walter Fernald, Superintendent, Waverly School for the Feeble-minded to Guy Fernald, Superintendent, Massachusetts Reformatory (Nov. 30, 1915) (on file with author) ("I am afraid you took what I said about the discussion of the defective delinquent too seriously. No harm can come from the freest possible discussion of the subject and the fullest criticism of any position any of us may take"); Letter from Guy Fernald, Superintendent, Massachusetts Reformatory to Walter Fernald, Superintendent, Waverly School for the Feeble-minded (Dec. 16, 1915) (on file with author) ("You have been a most powerful and valued friend and have helped me more personally and professionally than anyone else and it is most humiliating and distressing to find that I must choose whether I will stick to my opinion and favor, now that a show of hands has been demanded, a single new institution for the defective delinquent or stultify my opinion and support the structure you have so generously and painstakingly built up."); Letter from Walter Fernald, Superintendent, Waverly School for the Feeble-minded to Guy Fernald, Superintendent, Massachusetts Reformatory (Dec. 22, 1915) (on file with author) ("I doubt if we differ very much at all. If we can not isolate these people in existing institutions and if we can not get a new institution, is it not the remedy to get the State to find some unused institution, like the Ipswich Jail, or some other place of that sort and use that for this purpose until the big reclassification of our delinquents is undertaken.")
- ⁵⁹ Email from Alex Green, *supra* note 51.
- ⁶⁰ MADDIGAN, *supra* note 23, at 89.
- ⁶¹ *Id.*
- ⁶² See MASS. STAT. 1911, ch. 595, §§ 1-12.
- ⁶³ MASS. STAT. 1911, ch. 595, § 1. In 1925, Mass. DOC Commissioner Sanford Bates similarly described the population as "a difficult group of mentally inferior criminals" that belong neither in prisons nor in schools for the feeble-minded. Louis N. Robinson, *Institutions for Defective Delinquents*, 24 J. OF CRIM. LAW 352, 367-68 (Summer 1933), <https://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?article=2391&context=jclc>.
- ⁶⁴ MASS. STAT. 1911, ch. 595, § 5.
- ⁶⁵ Email from Alex Green, *supra* note 51.
- ⁶⁶ *Id.*
- ⁶⁷ *Id.*
- ⁶⁸ *Id.*
- ⁶⁹ Agenda, Mass. Society for Mental Hygiene, Annual Conference (Jan. 9, 2018) (on file with author).
- ⁷⁰ <https://socialwelfare.library.vcu.edu/corrections/hodder-jessie-donaldson/>

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- ⁷¹ Letter and testimony from Jessie Hodder, Superintendent, Reformatory for Women, Framingham, MA to Benjamin Loring Young, House Ways & Means Committee (Mar. 11, 1920) (on file with author).
- ⁷² *Id.*
- ⁷³ *Id.*
- ⁷⁴ *Id.*
- ⁷⁵ *Id.*
- ⁷⁶ MASS. STAT. 1922, ch. 535.
- ⁷⁷ Health and Human Services, Record Groups HS, *supra* note 22, at 172-173.
- ⁷⁸ <https://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?article=2391&context=jclc> at 363.
- ⁷⁹ Email from Alex Green, *supra* note 51.
- ⁸⁰ *Id.*
- ⁸¹ MADDIGAN, *supra* note 23, at 111-112; MASS. STAT. 1922, ch. 535.
- ⁸² MADDIGAN, *supra* note 23, at 111.
- ⁸³ *Id.* at 126.
- ⁸⁴ MASS. STAT. 1935, ch. 421.
- ⁸⁵ *Id.*
- ⁸⁶ MADDIGAN, *supra* note 23, at 116.
- ⁸⁷ MASS. STAT. 1947, ch. 684.
- ⁸⁸ MADDIGAN, *supra* note 23, at 121.
- ⁸⁹ MASS. STAT. 1955, ch. 770; Admission and Discharge Registers, 1957-1991 [Cushing Hospital], MASSACHUSETTS ARCHIVES, <http://chc.library.umass.edu/state-archives/category/series/page/17/>
- ⁹⁰ *Id.*; Health and Human Services, Record Groups HS, *supra* note 22, at 172.
- ⁹¹ MASS. STAT. 1956, ch. 173.
- ⁹² Health and Human Services, Record Groups HS, *supra* note 22, at 172; Admission and Discharge Registers, 1957-1991 [Cushing Hospital], *supra* note 89.
- ⁹³ Health and Human Services, Record Groups HS, *supra* note 22, at 172-173.
- ⁹⁴ Email from Alex Green, *supra* note 51. Green cites examples of the commitment of a person based on allegations by neighbors that the person was peering through windows and a person who was incarcerated based on an accusation that he was naked in the window of his apartment. *Id.*
- ⁹⁵ Mass. Gen. L. ch. 125, § 18 (added by MASS. STAT. 1955, ch. 770, § 11). The medical director has historically been employed by the contracted medical vendor. Russell C. Petrella, Maurice H. Richardson & June S. Binney, Governor's Special Advisory Panel on Forensic Mental Health, Commonwealth of Massachusetts 108 (Sept. 1989), <https://archive.org/search?query=finalreport1989mass>.
- ⁹⁶ MADDIGAN, *supra* note 23, at 123.
- ⁹⁷ H.3221, 160th Leg. (Mass. 1958).
- ⁹⁸ *Id.*
- ⁹⁹ *Id.*
- ¹⁰⁰ *Id.*
- ¹⁰¹ *Id.* (citing the Report of Governor's Committee on Building Needs in the Department of Correction (June 1958)).
- ¹⁰² H.3221, 160th Leg. (Mass. 1958).
- ¹⁰³ *Id.*
- ¹⁰⁴ Obituary, *Charles Gaughan, Superintendent of MCI-Bridgewater for 26 Years*, THE BOSTON GLOBE, May 26, 1989, at 21, https://www.newspapers.com/image/439234790/?clipping_id=50023052&article=e2a53d7d-3479-4270-ac67-8d70b01f4c7c&fcfToken=eyJhbGciOiJIUzI1NiIsInR5cCI6IkpXVCJ9.eyJmcmVILXZpZXctaWQiOiQzOTIzNDc5MCIwWF0ljoXNjgxNzYzNzMLCjleHAiOiJE2ODE4NTAxMzZ9.7m5PH5f3RN3LqBh350D1PGtRAObV94G_qln1nqcGtnk.
- ¹⁰⁵ MADDIGAN, *supra* note 23, at 123.
- ¹⁰⁶ *Id.* at 126 (citing *Imprisoned ... Forgotten: Bridgewater Holds Colony of Lost Men*, THE BOSTON GLOBE, Feb. 20, 1963, at 1).
- ¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* at 128.

¹¹⁰ Obituary, *Charles Gaughan, Superintendent of MCI-Bridgewater for 26 Years*, *supra* note 104.

¹¹¹ Ray Richard, *A Hospital or a Stable?*, THE BOSTON GLOBE, Jan. 15, 1967, at 1.

¹¹² MADDIGAN, *supra* note 23, at 131-132.

¹¹³ *Id.* at 131.

¹¹⁴ Arnold Koch, *Boston Strangler – 50 Years Later*, MELROSE FREE-PRESS, Jan. 23, 2017,

<https://www.wickedlocal.com/story/melrose-free-press/2017/01/23/boston-strangler-50-years-later/22618384007/>

¹¹⁵ See Obituary, *Charles Gaughan, Superintendent of MCI-Bridgewater for 26 Years*, *supra* note 104.

¹¹⁶ 353 Mass. 282 (1967).

¹¹⁷ MADDIGAN, *supra* note 23, at 128-129.

¹¹⁸ *Id.* at 129.

¹¹⁹ Steven L. Engelberg, *Pre-Trial Criminal Commitment to Mental Institutions: The Procedure in Massachusetts and Suggested Reforms*, 17 CATH. U. L. REV. 163, 163-64 (1968), <https://scholarship.law.edu/lawreview/vol17/iss2/2>.

¹²⁰ *Id.* at 163-164.

¹²¹ *Id.* Engelberg argued that the legal basis for these confinements at BSH was unclear under Massachusetts law. While in theory such commitments were the result of an established common law rule that an accused person could not be required to plead or be tried for a crime when he was so mentally disordered that he could not make a rational defense, "In Massachusetts...the justification for pre-trial criminal commitments has not been clarified." *Id.* at 166. He pointed out: "Obviously, when an individual charged with the crime of vagrancy is committed to a mental institution for the remainder of his life, the purpose of such commitment is not to enable the defendant to return to court and face the charge against him." *Id.* Engelberg outlined the history of Massachusetts law regarding indefinite pre-trial commitment. Prior to the first statutory language on this subject, Massachusetts courts had recognized the common law principle that "one could not be required to plead or be tried while he was insane." *Id.* at 170. If determined insane, the defendant was remanded to prison. Massachusetts statute enacted in 1849 allowed for commitment to a mental institution (but not a prison) if a defendant is considered mentally ill. *Id.* And, there were other methods of determining a defendant's mental condition apart from commitment: court clinicians. *Id.* at 170 - 171.

¹²² *Id.* at 171.

¹²³ *Id.* at 173.

¹²⁴ *Id.* at 191.

¹²⁵ *Id.* at 209-210.

¹²⁶ *Id.* at 192.

¹²⁷ *Id.*

¹²⁸ Titicut Follies, The Documentary Film about a Madhouse So Shocking It Was Banned, NEW ENGLAND HISTORICAL SOCIETY (updated 2022), <https://newenglandhistoricalsociety.com/titicut-follies-documentary-film-madhouse-shocking-banned/>

¹²⁹ Robert Koehler, *Titicut Follies Arrives, 24 Years After the Fact*, LOS ANGELES TIMES, Oct. 14, 1991,

<https://www.latimes.com/archives/la-xpm-1991-10-14-ca-574-story.html>. Richardson, who was subsequently the Health, Education and Welfare secretary and attorney general in the Nixon Administration, later charged Wiseman with "double-crossing" the state by promising to and then failing to protect the rights of the inmates; Wiseman would deny that charge. David Mills, *Mass. Court Lifts Ban on 24-Year-Old Film*, THE WASHINGTON POST, Aug. 2, 1991, <https://www.washingtonpost.com/archive/lifestyle/1991/08/02/mass-court-lifts-ban-on-24-year-old-film/b42e724d-019b-444a-b1b3-8488d43219ff/>

¹³⁰ Titicut Follies, The Documentary Film about a Madhouse So Shocking It Was Banned, *supra* note 128. Titicut is the Wampanoag name for the region. The Occom Circle, Taunton, DARTMOUTH COLLEGE LIBRARY, <https://collections.dartmouth.edu/occom/html/ctx/placeography/place0231.ocp.html>.

¹³¹ See *Commonwealth v. Wiseman*, 356 Mass. 251 (1969).

¹³² *Id.*

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- ¹³³ *Commonwealth v. Wiseman*, Civ. Action No. 875-38 (Mass. Super. Ct., Jan. 4, 1968).
- ¹³⁴ *Commonwealth v. Wiseman*, 356 Mass. at 258.
- ¹³⁵ See Marc Mohan, *Frederick Wiseman talks "Titicut Follies,"* OREGON ARTSWATCH (Apr. 18, 2016), <https://archive.orartswatch.org/frederick-wiseman-talks-titicut-follies/> ("There was a nineteen-day trial, and the decision of the judge was that the negative should be destroyed. He described the film as "a nightmare of ghoulis obscenities," and he found that I had breached the oral contract, and he found that a right of privacy exists in Massachusetts, for the first time. The film then became the only film in American history to be banned on these grounds."); Comment, *The "Titicut Follies" Case: Limiting the Public Interest Privilege*, 70 COLUMBIA LAW REV. 359, 359 (Feb. 1970) ("Ironically, this first judicial recognition of a right to privacy in Massachusetts³ is designed to protect the sensibilities of the criminally insane from the effects of a disclosure which can only improve the squalid circumstances of their lives. The only interests clearly protected are the dignity of the Commonwealth and the public image of her agents.").
- ¹³⁶ *Commonwealth v. Wiseman*, 356 Mass. at 263.
- ¹³⁷ Bruce Jackson, *Our Prisons Are Criminal; "Not one of them really does its job – and the worst of them practice old-fashioned barbarity,"* NEW YORK TIMES, Sept. 22, 1968, at 44.
- ¹³⁸ William H. Honan, *Judge Ends Ban on Film Of Asylum*, THE NEW YORK TIMES, Aug. 3, 1991, at 12.
- ¹³⁹ Miriam Horn, *Shining A Light on Their Follies*, U.S. NEWS & WORLD REPORT, Apr. 12, 1993.
- ¹⁴⁰ Interestingly, in a 2016 interview, Wiseman explained that he hadn't set out to depict abuses at the hospital, and that he doesn't feel comfortable taking credit for any improvements in the mental health system following the release of *Titicut Follies*: "You can't isolate one thing and say that that particular poem or novel or film caused it." Paula Bernstein, *Frederick Wiseman on His Banned Classic Titicut Follies*, FILMAKER (Apr. 22, 2016), <https://filmmakermagazine.com/98264-frederick-wiseman-screening-his-once-banned-classictiticut-follies/#.ZBSKI3bMK5c>
- ¹⁴¹ 353 Mass. 604 (1968).
- ¹⁴² *Nason* at 612; see Charlene Barshefsky & Roberta Liebenberg, *Voluntarily Confined Mental Retardates: The Right to Treatment v. the Right to Protection from Harm*, 23 UNIV. LAW REV. 787, 789, <https://scholarship.law.edu/cgi/viewcontent.cgi?article=2579&context=lawreview>.
- ¹⁴³ *Nason* at 609.
- ¹⁴⁴ *Id.*
- ¹⁴⁵ *Id.*
- ¹⁴⁶ *Id.* at 610.
- ¹⁴⁷ *Id.*
- ¹⁴⁸ *Id.* at 611.
- ¹⁴⁹ *Id.* at 613.
- ¹⁵⁰ MADDIGAN, *supra* note 23, at 135.
- ¹⁵¹ *Id.* at 136.
- ¹⁵² *Id.*
- ¹⁵³ *Id.*
- ¹⁵⁴ MASS. STAT. 1970, ch. 888, § 4. In *Arthur Chouinard, petitioner*, 358 Mass. 780 (1971), the SJC upheld the statute, as amended through 1954, concluding that the provisions for commitment of persons at defective delinquents who are not criminally convicted did not violate the U.S. Constitution and was within the state's *parens patriae* power. However, the Court noted that "that extreme caution must be exercised by the courts in dealing with such cases." *Id.* at 785.
- ¹⁵⁵ *McNeil v. Patuxent Institution*, 407 U.S. 245 (1972).
- ¹⁵⁶ MASS. STAT. 1971, ch. 1076; Admission and Discharge Registers, 1957-1991 [Cushing Hospital], *supra* note 89.
- ¹⁵⁷ MASS. STAT. 1971, ch. 1076; Health and Human Services, Record Groups HS, *supra* note 22, at 173.
- ¹⁵⁸ See MADDIGAN, *supra* note 23, at 137.
- ¹⁵⁹ MCI-Bridgewater had four sections: the Prison Department (BX Unit); the Alcoholic Unit; The Treatment Center for Sexually Dangerous Persons; and the State Hospital for the Criminally Insane. TOM RYAN WITH BOB CASEY, SCREW: A

GUARD'S VIEW OF BRIDGEWATER STATE HOSPITAL 1 (1981). The State Hospital section held 396 patients in April 1974, most of whom were held pretrial and a few of whom were prisoners transferred from other facilities. *Id.* at 2.

¹⁶⁰ *Rozecki v. Gaughan*, 459 F.2d 6 (1972).

¹⁶¹ 392 F.Supp. 274 (D.Mass. 1975) (adopting September 1974 report).

¹⁶² MADDIGAN, *supra* note 23, at 138.

¹⁶³ *Id.* (citing *The Boston Globe*, Treatment at Bridgewater State Hospital Virtually Nonexistent (Apr. 12, 1975).

¹⁶⁴ MADDIGAN, *supra* note 23, at 139.

¹⁶⁵ RYAN, *supra* note 159.

¹⁶⁶ *Id.* at 45-46.

¹⁶⁷ *Id.* at 74.

¹⁶⁸ *Id.* at 73-74.

¹⁶⁹ MADDIGAN, *supra* note 23, at 140.

¹⁷⁰ *Id.*

¹⁷¹ RYAN, *supra* note 159, at 91.

¹⁷² *Id.* at 104.

¹⁷³ *Id.* at 109.

¹⁷⁴ *Id.*

¹⁷⁵ *Id.* at 156.

¹⁷⁶ Patricia McGovern, Chairwoman, The Bridgewater Correctional Complex 1855-1987: A Policy Report of the Senate Committee on Ways and Means, 175th Leg., ii, 2 (Nov. 1987), <https://archives.lib.state.ma.us/bitstream/handle/2452/845260/ocm17606631.pdf?sequence=1&isAllowed=y>.

¹⁷⁷ *Id.* at 7.

¹⁷⁸ MADDIGAN, *supra* note 23, at 140.

¹⁷⁹ *Id.* at 141.

¹⁸⁰ *Id.* at 140.

¹⁸¹ *Doe and Christopher Hansen v. Charles Gaughan, BSH Superintendent and Michael Fair, DOC Commissioner*, 617 F.Supp. 1477 (D.Mass. 1985).

¹⁸² 617 F.Supp. at 1480. The Court also favorably compared BSH correctional officers to DMH mental health aides “who perform comparable duties” in DMH facilities: “Generally, the correction officers are assigned to a regular shift and location, which enables them to become familiar with the patients and their individual needs. In many cases, correction officers and patients develop long-term relationships which provide beneficial stability to the patients' lives.” *Id.* at 1481.

¹⁸³ 617 F.Supp. at 1480. The court also cited a range of educational opportunities including an in-house school with regular and special education program, GED preparation, a night school, summer school, college courses through Massasoit Community College, a full-time artist who works with patients, a carpentry program, and an in-house maintenance program. *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ *Id.* at 1481.

¹⁸⁶ *Id.*

¹⁸⁷ *Id.* at 1482.

¹⁸⁸ *Id.*

¹⁸⁹ *Id.* at 1486.

¹⁹⁰ *Id.* at 1482.

¹⁹¹ *Id.* at 1483.

¹⁹² *Id.*

¹⁹³ *Id.* at 1484.

¹⁹⁴ *Id.* at 1486 (citing *Youngberg v. Romeo*, 457 U.S. 307, 319 (1982)).

¹⁹⁵ *Id.* at 1488. The plaintiffs appealed and on December 30, 1986, the Court of Appeals affirmed the lower court's decision. *Doe v. Gaughan*, 808 F.2d 871 (1986). The Court wrote: “Thus the nature and duration of appellants'

confinement to Bridgewater, a high security facility, clearly bears some reasonable relationship both to the state's public safety needs and to the patients' own therapeutic interests in a secure environment..." *Id.* at 878.

Responding to the appellants argument that civilly committed persons, even if violent and in need of security, are entitled to more than "punishment" at a "penal institution," the Court of Appeals held that although BSH was a DOC facility, "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." *Id.* The Court again cited testimony in the lower court that the psychiatric care supplied by McLean "was outstanding and that there is 'no other institution of Bridgewater's type [department of mental health or correction...] in the country that approaches the quality of that staff.'" *Id.* at 880.

While the Court agreed that more rights are statutorily guaranteed to DMH patients than to BSH patients, this disparity was not violative of the equal protection clause. *Id.* at 880-81.

And there was no violation of *Youngberg*. Despite the record of overcrowding and the lack of staffing in some of the professional positions that made treatment more difficult, the professional staff was still able to exercise its professional judgment and provide adequate treatment to Bridgewater patients. *Id.* at 884-86.

Thus, Massachusetts mental health patients with no criminal involvement but who had been determined to be violent continued to be sent to BSH for extended stays. See Michael Rezendes, *A Death in Restraints After 'Standard Procedure,'* THE BOSTON GLOBE, Feb. 16, 2014,

<https://www3.bostonglobe.com/metro/2014/02/16/homicide-bridgewater-state-hospital-raises-profound-questions-about-care-for-mentally-ill/TqgMJdNZ8SPjLcFQ6hRkTN/story.html?arc404=true>

¹⁹⁶ Petrella, Richardson, and Binney, *supra* note 95, at 17.

¹⁹⁷ Diane E. Lewis, *Continual Restraint Alleged in Bridgewater Case*, THE BOSTON GLOBE, Mar. 25, 1988, at 15. Ronald Goldberg of GMA later was accused of ethics violations for charging the state for personal lawn care and snowplowing. Kimberly Lauren Sue, *Wicked Bad Habits: Governing Women on Heroin in the Carceral-Therapeutic State in Massachusetts* (Mar. 2014) (PhD dissertation, Harvard University), <https://core.ac.uk/download/pdf/28949034.pdf> at 126 (citing Eileen McNamara, *Why Did Robin Peeler Die? On October 16, 1991, A 32-Year-Old Woman Entered MCI Framingham. She Would Not Live Through Her One-Year Sentence for Shoplifting*, THE BOSTON GLOBE, June 7, 1992.)

¹⁹⁸ Patricia McGovern, Chairwoman, *The Bridgewater Correctional Complex 1855-1987: A Policy Report of the Senate Committee on Ways and Means*, *supra* note 176, at 4; MASS. DEPT. OF CORRECTION, BRIDGEWATER STATE HOSPITAL, STUDYLIB (PowerPoint, undated), <https://studylib.net/doc/9524125/department-of-correction-bridgewater-state-hospital>.

¹⁹⁹ *Titicut Follies*, The Documentary Film about a Madhouse So Shocking It Was Banned, *supra* note 128. The report cited the termination of the McLean Hospital contract for the deterioration. *Id.*

²⁰⁰ Health and Human Services, Record Groups HS, *supra* note 22, at 173. Formerly, BSH shared its superintendent with the Addiction Center and the Treatment Center. Petrella, Richardson, and Binney, *supra* note 95, at 108.

²⁰¹ Telecomm. between James Matesanz, Adjunct Faculty, Boston University and Jennifer Honig (Apr. 11, 2023).

²⁰² Admission and Discharge Registers, 1957-1991 [Cushing Hospital], *supra* note 89.

²⁰³ Petrella, Richardson, and Binney, *supra* note 95, at 1.

²⁰⁴ John Mudd, Undersecretary, Executive Office of Human Services, Report of the Working Group on Bridgewater State Hospital 6 (Aug. 10, 1987), <https://ia802205.us.archive.org/24/items/reportofworkingg00mass/reportofworkingg00mass.pdf>.

²⁰⁵ Michael Rezendes, *Patients Sue Mental Facility*, THE WASHINGTON POST, July 18, 1987, <https://www.washingtonpost.com/archive/politics/1987/07/18/patients-sue-mental-facility/1e37160f-5085-41e2-bd89-57276f6a83a2/>.

²⁰⁶ *Deaths at a Prison Hospital Lead to Inquiries*, THE NEW YORK TIMES, July 19, 1987, at 3,

<https://www.nytimes.com/1987/07/19/us/deaths-at-a-prison-hospital-lead-to-inquiries.html>

²⁰⁷ *Id.*

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- ²⁰⁸ John Mudd, Undersecretary, Executive Office of Human Services, Report of the Working Group on Bridgewater State Hospital, *supra* note 204, at 6.
- ²⁰⁹ *Id.* at 10-11.
- ²¹⁰ *Id.* at 15.
- ²¹¹ ABC News Nightline {Bridgewater State Hospital; Fred Wiseman Discusses "Titicut Follies"}, THE PALEY CENTER FOR MEDIA, <https://www.paleycenter.org/collection/item/?q=news&p=8&item=T:11567>.
- ²¹² The applicable law is found at Mass. Gen. L. ch. 123, § 21. On April 19, 1988, the Supreme Judicial Court of Massachusetts upheld the court order. *O'Sullivan v. Secretary of Human Services*, 402 Mass. 190 (1988).
- ²¹³ THOMAS W. BENSON & CAROLYN ANDERSON, REALITY FICTIONS: THE FILMS OF FREDERICK WISEMAN (2nd ed. 2002), at 346.
- ²¹⁴ *Id.* The George Foster Peabody Awards gave the WCVB series a prize in 1988, writing: "As a result of this investigation many citizens of Massachusetts were shocked, the Governor sought additional funding to help relieve some of the problems, and the legislature passed legislation which addressed the situation." Winner – 1987, Inside Bridgewater, WCVB-TV, PEABODY AWARDS, <https://peabodyawards.com/award-profile/inside-bridgewater/>
- ²¹⁵ Patricia McGovern, Chairwoman, The Bridgewater Correctional Complex 1855-1987: A Policy Report of the Senate Committee on Ways and Means, *supra* note 176, at 10.
- ²¹⁶ *Id.* at ii.
- ²¹⁷ *Id.* at iii.
- ²¹⁸ <https://archive.org/search?query=finalreport1989mass> at 21 (citing Interim Settlement Agreement, *Shawn P. O'Sullivan et al. v. Michael S. Dukakis et al.*, Civ. Action No. 87-3881 (Mass. Sup. Nov. 20, 1987)). The following year, *Galenski v. Noonan*, a civil rights damage action filed in Hampshire Superior Court challenging the excessive restraint, inappropriate medication, lack of treatment, and wrongful death of a BSH patient institutionalized for 42 years was also settled – in this case for an undisclosed amount in excess of \$275,000. Amicus Briefs, Damage and Civil Rights Cases, Center for Public Representation, <https://www.centerforpublicrep.org/amicus-briefs-and-other-cases/>.
- ²¹⁹ Petrella, Richardson, and Binney, *supra* note 95, at 22.
- ²²⁰ *Id.* at 18; *see also* District Court Standards of Judicial Practice: Civil Commitment and Authorization of Medical Treatment for Mental Illness 9 (rev. Apr. 2019), <https://www.mass.gov/doc/district-court-standards-of-judicial-practice-civil-commitment-and-authorization-of-medical/download>. In December 1987, on a Nightline broadcast, Secretary Johnston stated that "civil commitments will not and should not be sent to Bridgewater State Hospital." Nightline: Horrors at Bridgewater State Hospital, ABC NEWS (Mar. 31, 2014), <https://abcnews.go.com/Health/video/horrors-bridgewater-state-hospital-23129454> (playing footage of 1987 broadcast).
- ²²¹ 1988 Mass. Acts 1, § 5. The same legislation also established "a special advisory panel on the organization and structure of the commonwealth's forensic mental health system and on the appropriate evaluation and treatment of mentally ill offenders and mentally ill men and women who are in need of care in a medium or strict secure setting." 1988 Mass. Acts 1, § 4. The panel was to examine the five institutions forming the Bridgewater Complex, the applicable laws and policies for each institution, the use of seclusion and restraint at BSH, the delivery of mental health services, and make findings and recommendations by July 1, 1988. *Id.*
- ²²² Petrella, Richardson, and Binney, *supra* note 95, at 18.
- ²²³ *Id.*
- ²²⁴ MASS. DEPT. OF CORRECTION, BRIDGEWATER STATE HOSPITAL, STUDYLIB, *supra* note 198, at 18.
- ²²⁵ DMH, The Plan as Required by Section 5 of Chapter 1 of the Acts of 1988 (Apr. 25, 1988) <https://archive.org/details/planasrequiredby00mass>.
- ²²⁶ *Id.* at 1.
- ²²⁷ *Id.*
- ²²⁸ *Id.* at 19.
- ²²⁹ *Id.* at 22.
- ²³⁰ <https://abcnews.go.com/Health/video/horrors-bridgewater-state-hospital-23129454>
- ²³¹ That plan, required by 1988 Mass. Acts, ch. 1, § 4, is discussed *supra* in note 221.
- ²³² Petrella, Richardson, and Binney, *supra* note 95, at 108.

²³³ *Id.*

²³⁴ *Id.*

²³⁵ *Id.* at 109.

²³⁶ *Id.*

²³⁷ *Id.* at 110. The Panel also recommended accreditation and moving the hospital to the building occupied by the Treatment Center for Sexually Dangerous Persons.

Id. <https://ia804702.us.archive.org/12/items/finalreport1989mass/finalreport1989mass.pdf> at 111.

²³⁸ James Pigeon, Center for Public Representation, *Forgotten Lives: Mentally Disordered Prisoners in Massachusetts*, 47 ADVISOR 11 (Mental Health Legal Advisors Committee, fall/winter 1997), https://www.prisonlegalnews.org/media/publications/jim_pigeon_ctr_for_public_representation_forgotten_lives_mentally_ill_in_ma_prisons_1997.pdf.

²³⁹ John Thompson, A Short History of Medfield State Hospital, 1890-2016, LICENSED SITE PROFESSIONALS ASSOCIATION, https://www.lspa.org/assets/Blog_Photos/Medfield_Hosp_Tour/short%20history%20of%20medfield%20%20state%20hospital.pdf

²⁴⁰ Rezendes, *A Death in Restraints After 'Standard Procedure,' supra* note 195. The Boston Globe reported the state claimed, "that hospital clinicians at private and public hospitals generally had become better equipped to prevent mental health patients from becoming violent, making the specialized unit unnecessary." *Id.*

²⁴¹ Memorandum of Decision and Order on (1) Plaintiffs' Cross-Motion for Summary Judgment on Count IV, and (2) Defendants' Motion for Summary Judgment on All Counts, *Torres v. Dubois*, Civ. Action No. 9484CV00270 (Suffolk Sup. Ct. Feb. 10, 1997), <https://masslawyersweekly.com/fulltext-opinions/1990/01/01/torres-et-al-v-dubois-et-al/>

²⁴² Sue, *supra* note 197, at 126.

²⁴³ *Id.*

²⁴⁴ *Id.* at 126, n.56 (citing The Boston Globe Editorial Board 1992).

²⁴⁵ Memorandum from James Matesanz, Superintendent, BSH to Timothy Hall, Associate Commissioner for Health Services, DOC and Richard Grelotti, Assistant Deputy Commissioner, Bridgewater Correctional Complex regarding "Budget Cuts" 4 (June 25, 1993) (on file with author).

²⁴⁶ *Id.*

²⁴⁷ Email from James Matesanz, Adjunct Faculty, Boston University to Jennifer Honig (April 20, 2023).

²⁴⁸ David Barstow, *EMSA Came Under Criticism for Its Prison Care in Mass.*, TAMPA BAY TIMES, Sept. 16, 2005, <https://www.tampabay.com/archive/1996/05/29/emsa-came-under-criticism-for-its-prison-care-in-mass/> "Later, Massachusetts prison employees accused the company of forging patient records to win accreditation for prison infirmaries." *Id.*

²⁴⁹ *Id.* Subsequent to an earlier report, the New York Times later issued a correction confirming that this was the reason for the contract's termination and not because of the deaths of three prisoners on its watch. *Corrections*, THE NEW YORK TIMES, July 24, 1996, <https://www.nytimes.com/1996/07/24/nyregion/c-corrections-009555.html>

²⁵⁰ Barstow, *supra* note 248.

²⁵¹ Telecomm. between James Matesanz, Adjunct Faculty, Boston University and Jennifer Honig, *supra* note 201.

²⁵² *Id.*

²⁵³ *Id.*

²⁵⁴ *Id.*

²⁵⁵ *Id.*

²⁵⁶ *Id.*

²⁵⁷ Memorandum of Decision and Order on (1) Plaintiffs' Cross-Motion for Summary Judgment on Count IV, and (2) Defendants' Motion for Summary Judgment on All Counts, *Torres v. Dubois*, *supra* note 241; Danielle Drissel, *Massachusetts Prison Mental Health Services: History, Policy And Recommendations*, 87 MASS. LAW REV. 3 (Jan. 2003), <https://www.massbar.org/publications/massachusetts-law-review/massachusetts-law-review-article/massachusetts-law-review-2003-v87-n3/massachusetts-prison-mental-health-services-history-policy-and-recommendations>. In 2011, CMS and Prison Health Services, Inc. merged into Corizon Health, Inc., a privately-held, for-profit prison healthcare contractor operating across many states. *Corizon*, WIKIPEDIA, <https://en.wikipedia.org/wiki/Corizon>.

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- ²⁵⁸ Drissel, *supra* note 257.
- ²⁵⁹ Mass. DOC Bridgewater State Hospital, NIC Technical Assistance #96P1017 (June 21, 1996) (on file at MAMH).
- ²⁶⁰ *Id.* at 6.
- ²⁶¹ *Id.* at 6-7. The consultant also recommended that DOC examine the use of Special Management Status (SMS) (which he interprets as a “hybrid seclusion/segregation status created specifically at BSH) to ensure it was consistent with “either clinical requirements for the use of therapeutic seclusion or the disciplinary requirements of correctional segregation.” *Id.* at 9, 22-23. He observes that on this status, “Individuals are essential placed in a locked cell immediately outside of their seclusion rooms but not under a physician’s medical/psychiatric order for therapeutic seclusion nor a disciplinary order with the administrative procedures of correctional segregation.” *Id.* at 9.
- ²⁶² Kristen Lombardi, *Shame on the Department of Correction*, THE BOSTON PHOENIX. Archived from [the original](#) on April 1, 2013. Prosecutors indicted the guard but he was acquitted; DOC had suspended its investigation during this process. In 1999, the plaintiff prevailed. *Id.*
- ²⁶³ Rezendes, *A Death in Restraints After ‘Standard Procedure,’* *supra* note 195.
- ²⁶⁴ U. Mass. Medical Center Dep’t of Psychiatry, Report on the Psychiatric Management of John Salvi in Massachusetts Department of Correction Facilities 1995-1996, 6 (Jan. 31, 1997), https://static.prisonpolicy.org/scans/1997_salvi_death_report.pdf.
- ²⁶⁵ Pigeon, *supra* note 238, at 3.
- ²⁶⁶ U. Mass. Medical Center Dep’t of Psychiatry, Report on the Psychiatric Management of John Salvi in Massachusetts Department of Correction Facilities 1995-1996, *supra* note 264.
- ²⁶⁷ *Id.* at 12.
- ²⁶⁸ MASS. DEP’T OF CORRECTION, BRIDGEWATER STATE HOSPITAL, STUDYLIB, *supra* note 198.
- ²⁶⁹ Kenneth L. Appelbaum *et al.*, *A University-State Corporation Partnership for Providing Correctional Mental Health Services*, PSYCHIATRIC SERVICES (Feb. 1, 2002), <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.53.2.185>.
- ²⁷⁰ *Id.*
- ²⁷¹ Kenneth L. Appelbaum, UMass Profiles, UMASS, <https://profiles.umassmed.edu/display/132951>.
- ²⁷² Appelbaum *et al.*, *supra* note 269.
- ²⁷³ *Id.*
- ²⁷⁴ *Id.*
- ²⁷⁵ *Id.*
- ²⁷⁶ *Id.*
- ²⁷⁷ *Id.*
- ²⁷⁸ *Id.*
- ²⁷⁹ *Id.*
- ²⁸⁰ *Id.*
- ²⁸¹ *Id.*
- ²⁸² Memorandum of Decision and Order on the Department Defendants’ Motion for Summary Judgment, *Reaves v. Correctional Medical Services*, Civ. Action No. 00-2363-E (Suffolk Sup. Ct. Sept. 19, 2005) at n.2.
- ²⁸³ Memorandum of Decision and Order on the Department Defendants’ Motion for Summary Judgment, *Reaves v. Correctional Medical Services*, Civ. Action No. 00-2363-E (Suffolk Sup. Ct. Sept. 19, 2005) at n.2; Office of the State Auditor, Commonwealth of Massachusetts, Independent State Auditor’s Report on the University of Massachusetts Medical School’s Administration of its Correctional Health Services Contract, January 1, 2004 through June 20, 2005 (Jan. 16, 2007), https://www.prisonlegalnews.org/media/publications/independent_audit_report_on_umass_med_schools_correc_tional_health_services_contract_2007.pdf.
- ²⁸⁴ Rezendes, *A Death in Restraints After ‘Standard Procedure,’* *supra* note 195.
- ²⁸⁵ MASS. DEP’T OF CORRECTION, BRIDGEWATER STATE HOSPITAL, STUDYLIB, *supra* note 198.
- ²⁸⁶ Mark Pratt, Associated Press, *Inmate Death at Bridgewater State Hospital an Apparent Suicide*, SEACOASTONLINE.COM, Aug. 29, 2004, updated Dec. 18, 2010, <https://web.archive.org/web/20160304073834/https://www.seacoastonline.com/apps/pbcs.dll/article/?AID=%2F2>

[0040829%2FNEWS%2F308299973](http://archive.boston.com/news/local/massachusetts/articles/2010/06/08/34_year_old_dies_in_state_hospital/); John M. Guilfoil, *After Long Decline, A Tragic End*, BOSTON.COM, June 8, 2010, http://archive.boston.com/news/local/massachusetts/articles/2010/06/08/34_year_old_dies_in_state_hospital/.

²⁸⁷ Michael Rezendes, *Restraints Cited in Three Deaths at Bridgewater*, THE BOSTON GLOBE, Oct. 12, 2014, <https://www.bostonglobe.com/metro/2014/10/11/doubts-about-quality-massachusetts-prison-health-care-after-three-deaths-bridgewater-state-hospital/1oRBH0x7JHJxzU2kbn2AIL/story.html>

²⁸⁸ Office of the State Auditor, Commonwealth of Massachusetts, Official Audit Report, DOC – Mental Health Services Contract for the period of July 1, 2009 through June 30, 2012, 1 (Apr. 5, 2013), <https://www.mass.gov/doc/department-of-correction-mental-health-services-contract/download>.

²⁸⁹ *Id.* at 1-2.

²⁹⁰ *Id.* at 2.

²⁹¹ Office of the State Auditor, Commonwealth of Massachusetts, Independent State Auditor’s Report on the University of Massachusetts Medical School’s Administration of its Correctional Health Services Contract, *supra* note 283.

²⁹² *Id.* at i.

²⁹³ *Id.* at 3.

²⁹⁴ *Id.* at 4.

²⁹⁵ *Id.* at i.

²⁹⁶ Office of the State Auditor, Commonwealth of Massachusetts, Official Audit Report, DOC – Mental Health Services Contract for the period of July 1, 2009 through June 30, 2012, *supra* note 288, at 2.

²⁹⁷ Investigate, MHM Services Inc, AMERICAN FRIENDS SERVICE COMMITTEE, <https://investigate.afsc.org/company/mhm-services>.

²⁹⁸ John M. Guilfoil, *Inmate, 27, Hangs Self at Bridgewater Hospital*, THE BOSTON GLOBE, Apr. 1, 2007, http://archive.boston.com/news/local/articles/2007/04/01/inmate_27_hangs_self_at_bridgewater_hospital/

²⁹⁹ Rezendes, *A Death in Restraints After ‘Standard Procedure,’* *supra* note 195.

³⁰⁰ *Id.*

³⁰¹ *Id.*

³⁰² Rezendes, *Restraints Cited in Three Deaths at Bridgewater*, *supra* note 287.

³⁰³ Associated Press, *\$3M Settlement Reached in Death at Bridgewater*, SOUTHCOAST TODAY/THE STANDARD-TIMES, Mar. 26, 2014, <https://www.southcoasttoday.com/story/news/state/2014/03/26/3m-settlement-reached-in/37983780007/>

³⁰⁴ Rezendes, *A Death in Restraints After ‘Standard Procedure,’* *supra* note 195.

³⁰⁵ Mindy J. Hull, State Medical Examiner, Commonwealth of Mass., Report of Autopsy of Joshua K. Messier (May 5, 2009), <https://www3.bostonglobe.com/2014/02/16/documents-death-joshua-messier/7lgOpT5fwYNDITus5ceCcM/story.html?arc404=true#commission>.

³⁰⁶ Memorandum from Sergeant Donald Perry, Internal Affairs Unit, Mass. Department of Correction to Captain John Cappelle, Internal Affairs Unit, Re: DOC-BSH-09-67 - Death of Inmate Joshua Messier 13 (May 25, 2010), <https://www3.bostonglobe.com/2014/02/16/documents-death-joshua-messier/7lgOpT5fwYNDITus5ceCcM/story.html?arc404=true#commission>.

³⁰⁷ Derek Gilna, *Massachusetts DOC, Hospital Officials Disciplined in Prisoner’s Death*, PRISON LEGAL NEWS, May 19, 2014, <https://www.prisonlegalnews.org/news/2014/may/19/massachusetts-doc-hospital-officials-disciplined-prisoners-death/>.

³⁰⁸ Rezendes, *A Death in Restraints After ‘Standard Procedure,’* *supra* note 195.

³⁰⁹ Letter from Erik Nordahl, Deputy General Counsel and Nancy Alterior, Executive Director, Disabled Persons Protection Commission to Michale Cohen, Esq., Department of Correction regarding Petition to Review DPPC Case #87368 (Oct. 7, 2011), <https://www3.bostonglobe.com/2014/02/16/documents-death-joshua-messier/7lgOpT5fwYNDITus5ceCcM/story.html?arc404=true#commission>; *see also* Rezendes, *A Death in Restraints After ‘Standard Procedure,’* *supra* note 195.

³¹⁰ Rezendes, *Restraints Cited in Three Deaths at Bridgewater*, *supra* note 287.

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- ³¹¹ WBUR Newsroom, *3 Former Corrections Officer Found Not Guilty In Death Of Bridgewater State Hospital Patient*, WBUR, Dec. 11, 2017, <https://www.wbur.org/news/2017/12/11/bridgewater-state-messier-verdict>; Rezendes, *A Death in Restraints After 'Standard Procedure,'* *supra* note 195.
- ³¹² Rezendes, *A Death in Restraints After 'Standard Procedure,'* *supra* note 195; *see also* Statement to The Boston Globe from the Office of Plymouth District Attorney Timothy Cruz (undated), <https://www3.bostonglobe.com/2014/02/16/documents-death-joshua-messier/7lgOpT5fwYNDITus5ceCcM/story.html?arc404=true#commission>.
- ³¹³ Testimony of Hal Smith, Forensic Division Director for MHM Correctional Solutions to Connecticut legislators Senator Gayle Slossberg and Representative James Spallone and the Connecticut Commission on Enhancing Agency Outcomes (Dec. 14, 2009), https://www.cga.ct.gov/gae/tfs/20090129_Commission%20on%20Enhancing%20Agency%20Outcomes/20091214/Testimony%20-%20Hal%20Smith,%20MHM%20Correctional%20Services,%20Inc.pdf.
- ³¹⁴ Rezendes, *Restraints Cited in Three Deaths at Bridgewater*, *supra* note 287.
- ³¹⁵ Guilfoil, *After Long Decline, A Tragic End*, *supra* note 286.
- ³¹⁶ Rezendes, *Restraints Cited in Three Deaths at Bridgewater*, *supra* note 287.
- ³¹⁷ *Id.*
- ³¹⁸ Guilfoil, *After Long Decline, A Tragic End*, *supra* note 286.
- ³¹⁹ *Id.*; Rezendes, *Restraints Cited in Three Deaths at Bridgewater*, *supra* note 287.
- ³²⁰ Centene Corporation, Centene Corporation Partners With MHM Services To Serve Massachusetts State Correctional System, Cision PR Newswire (Mar. 18, 2013), <https://www.prnewswire.com/news-releases/centene-corporation-partners-with-mhm-services-to-serve-massachusetts-state-correctional-system-198758061.html>.
- ³²¹ *Id.*
- ³²² Prisoner Legal Services, PLS Notes (June 2013), <https://www.plsma.org/wp-content/uploads/2012/05/201306NE.pdf>.
- ³²³ Michael Rezendes, *Bridgewater State Hospital Patients Sue*, TELEGRAM.COM/TELEGRAM & GAZETTE, Jan. 30, 2015, <https://www.telegram.com/story/news/local/south-west/2015/01/30/bridgewater-state-hospital-patients-sue/35321951007/>.
- ³²⁴ Rezendes, *Restraints Cited in Three Deaths at Bridgewater*, *supra* note 287.
- ³²⁵ *Id.* In September 2013, 130 members of 1199SEIU working as nurses, mental health workers, and other clinical staff at BSH protested an MHM proposal that they said could double their health care coverage costs. 1199 SEIU, Massachusetts 1199SEIU Members at State-Run Facility Fight to Keep Affordable Healthcare, 1199SEIU.ORG (Aug. 23, 2013), <https://www.1199seiu.org/massachusetts/massachusetts-1199seiu-members-at-state-run-facility-fight-to-keep-affordable-healthcare>. MHM sought to replace the workers' existing no-deductible health insurance plan with one with significant annual deductibles. John Laidler, *Union Protests Health Plan Shift*, THE BOSTON GLOBE, Sept. 1, 2013, <https://www.bostonglobe.com/metro/regionals/south/2013/08/31/union-workers-bridgewater-state-hospital-protest-firm-bid-hike-their-health-care-costs/BvjCz7J2EbFdD8x4EBzO2J/story.html>.
- ³²⁶ Rezendes, *Restraints Cited in Three Deaths at Bridgewater*, *supra* note 287.
- ³²⁷ *Id.* Correia had been hospitalized twice after his fight with police, but it was not clear if DOC knew that.
- ³²⁸ *Id.*
- ³²⁹ *Id.*
- ³³⁰ In fact, Rezendes had written about BSH back in 1987, for *The Washington Post*. Michael Rezendes, *Patients Sue Mental Facility*, THE WASHINGTON POST, July 18, 1987, <https://www.washingtonpost.com/archive/politics/1987/07/18/patients-sue-mental-facility/1e37160f-5085-41e2-bd89-57276f6a83a2/>.
- ³³¹ Rezendes, *A Death in Restraints After 'Standard Procedure,'* *supra* note 195.
- ³³² *Id.*
- ³³³ Michael Rezendes, *Patrick Pledges 'Full Accounting' in Bridgewater Homicide*, THE BOSTON GLOBE, Feb. 21, 2014, [https://www.bostonglobe.com/metro/2014/02/21/patrick-pledges-full-accounting-bridgewater-homicide/Ryd8w2ydfcMFXy1QHDLadM/story.html?p1=Article Related Box Article More](https://www.bostonglobe.com/metro/2014/02/21/patrick-pledges-full-accounting-bridgewater-homicide/Ryd8w2ydfcMFXy1QHDLadM/story.html?p1=Article%20Related%20Box%20Article%20More).

³³⁴ Memorandum from Steven P. Ayala, Director, Special Operations Division, Department of Correction to Robert Murphy, Superintendent, Bridgewater State Hospital regarding Joshua Messier (Jan. 11, 2013), https://www3.bostonglobe.com/2014/02/16/documents-death-joshua-messier/Patrick_Pledges_7lgOpT5fwYNDITus5ceCcM/story.html?arc404=true#findings.

³³⁵ Rezendes, *Patrick Pledges 'Full Accounting' in Bridgewater Homicide*, *supra* note 334.

³³⁶ Associated Press, *\$3M Settlement Reached in Death at Bridgewater*, *supra* note 303; Michael Rezendes, *\$3M Settlement Reached in Bridgewater Hospital Death*, THE BOSTON GLOBE, MAR. 26, 2014, <https://www3.bostonglobe.com/metro/2014/03/25/parents-inmate-who-died-bridgewater-state-hospital-receive-million/xK2rdwyLRGuV7dxc9hEKbP/story.html?p1=Article Inline Text Link&arc404=true>.

³³⁷ Rezendes, *Restraints Cited in Three Deaths at Bridgewater*, *supra* note 287.

³³⁸ *Id.*

³³⁹ *Id.*

³⁴⁰ *Id.*

³⁴¹ Gilna, *Massachusetts DOC, Hospital Officials Disciplined in Prisoner's Death*, *supra* note 307.

³⁴² *Id.*

³⁴³ *Id.*

³⁴⁴ The authority derives from the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. § 10801 *et seq.*, as well as the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 6000 *et seq.*

³⁴⁵ Gilna, *Massachusetts DOC, Hospital Officials Disciplined in Prisoner's Death*, *supra* note 307.

³⁴⁶ *Id.*

³⁴⁷ *Id.* EOPPS and DOC terminated Hetherson for failing to discipline certain correctional officers. Hetherson sued EOPSS, DOC, and individual defendants for her termination, arguing gender discrimination in their not similarly terminating men in a comparable position to discipline those same correctional officers. Memorandum of Decision and Order on Defendants' Motion to Dismiss, *Hetherson v. Mass. Executive Office of Public Safety and Security*, SUCV2015-02451-G (Sup. Ct. May 17, 2016) <https://casetext.com/case/hetherson-v-massachusetts-executive-office-of-public-safety-and-security>.

³⁴⁸ Gilna, *Massachusetts DOC, Hospital Officials Disciplined in Prisoner's Death*, *supra* note 307.

³⁴⁹ Enterprise Staff, *3 Ex-guards Indicted for Inmate's Death at Bridgewater State Hospital*, WICKEDLOCAL.COM, Apr. 30, 2015, updated May 2, 2015, <https://www.wickedlocal.com/story/journal-news-independent/2015/05/01/3-ex-guards-indicted-for/34645900007/> In 2008, a mental health worker had filed a complaint against Billadeau for using a racial slur to refer to a Bridgewater patient. Rezendes, *A Death in Restraints After 'Standard Procedure'*, *supra* note 195.

³⁵⁰ Enterprise Staff, *3 Ex-guards Indicted for Inmate's Death at Bridgewater State Hospital*, *supra* note 349.

³⁵¹ Michael Rezendes, *Prison Guards Acquitted in Death of Bridgewater Patient*, THE BOSTON GLOBE, Dec. 11, 2017, <https://www.bostonglobe.com/metro/2017/12/11/prison-guards-acquitted-death-bridgewater-patient/pNjmaISkjr86BH3oAjcFmM/story.html>; see also WBUR Newsroom, *3 Former Corrections Officer Found Not Guilty In Death Of Bridgewater State Hospital Patient*, *supra* note 311.

³⁵² WBUR Newsroom, *3 Former Corrections Officer Found Not Guilty In Death Of Bridgewater State Hospital Patient*, *supra* note 311. On May 24, 2019, the three guards were reinstated to their positions, each with back pay of over \$200K. Shira Schoenberg, *Guards acquitted in death of Bridgewater State patient Joshua Messier were reinstated -- each with back pay over \$200K, state records show*, MASSLIVE, May 24, 2019, <https://www.masslive.com/news/2019/05/guards-acquitted-in-death-of-bridgewater-state-patient-joshua-messier-were-reinstated-each-with-back-pay-over-200k-state-records-show.html>.

³⁵³ WBUR Newsroom, *3 Former Corrections Officer Found Not Guilty In Death Of Bridgewater State Hospital Patient*, *supra* note 311.

³⁵⁴ The Complaint was originally incorrectly captioned, with a former BSH health care provider (MHM Correctional Services) named as defendant but was soon amended to indicate that correct provider.

³⁵⁵ Complaint, *Joanne Minich in her capacity as Guardian of Peter Minich et al. v. Luis S. Spencer, DOC Commissioner et al.*, Civ. Action No. 1482CV00448 (Mass. Sup. Ct. Mar. 31, 2014).

- ³⁵⁶ Michael Rezendes, *Bridgewater Restraints Use Rose, Even After Patient's Death*, THE BOSTON GLOBE, Apr. 6, 2014, <https://www3.bostonglobe.com/metro/2014/04/05/bridgewater-restraints-use-rose-even-after-patient-death/iVt77HVApIzKD5Eh3vaF4M/story.html?p1=Article Inline Text Link&arc404=true>; Michael Rezendes, *Bridgewater Inmate's Family Agrees to Settle Suit*, THE BOSTON GLOBE, Apr. 18, 2014, <https://www.bostonglobe.com/metro/2014/04/17/mental-health-patient-family-agrees-settle-lawsuit-against-troubled-bridgewater-state-hospital/963GQqVvoqcw68m6AvmkShJ/story.html>.
- ³⁵⁷ *Woman Sues State Over Son's Bridgewater State Hospital Isolation*, WCVB, Mar. 31, 2014, <https://www.wcvb.com/article/woman-sues-state-over-son-s-bridgewater-state-hospital-isolation/8198547#>.
- ³⁵⁸ Rezendes, *Bridgewater Restraints Use Rose, Even After Patient's Death*, *supra* note 356.
- ³⁵⁹ Letter and Investigation Report from Christine M. Griffin, DLC to Deval Patrick 1 (July 11, 2014), <http://www.dlc-ma.org/wp-content/uploads/2017/09/BSHReport.pdf>.
- ³⁶⁰ Michael Rezendes, *New Scrutiny for Bridgewater State Hospital After Complaints*, THE BOSTON GLOBE, Apr. 17, 2014, <https://www.bostonglobe.com/metro/2014/04/16/watchdog-group-for-disabled-launches-investigation-troubled-bridgewater-state-hospital/XN2edcSklgF3mMZ2G1pONJ/story.html?p1=Article Inline Text Link>.
- ³⁶¹ Rezendes, *Bridgewater Inmate's Family Agrees to Settle Suit*, *supra* note 356; Interim Settlement Agreement, *Minich v. Spencer*, Civ. Action No. 1482CV00448 (Mass. Sup. Ct. Apr. 17, 2014).
- ³⁶² Amended Complaint of Plaintiffs, *Minich v. Spencer*, Civ. Action No. 1482CV00448 (Mass. Sup. Ct. May 5, 2015).
- ³⁶³ *Id.*
- ³⁶⁴ Michael Rezendes, *Lawsuit Hits Methods at Bridgewater State Hospital*, THE BOSTON GLOBE, May 2, 2014, <https://www.bostonglobe.com/metro/2014/05/01/patients-file-class-action-lawsuit-against-troubled-bridgewater-state-hospital/LDMggoAsR924Ga5G1hiL7l/story.html>.
- ³⁶⁵ Jeremy Weltman, Roderick MacLeish & Jacquelyn E. Bumbaca, *Deference ≠ Abdication: Application of Youngberg to Prolonged Seclusion and Restraint of the Mentally Ill*, 26 STANFORD LAW & POLICY REV. 239, 250, <https://law.stanford.edu/wp-content/uploads/2017/11/weltman.pdf>.
- ³⁶⁶ *Id.* at 251.
- ³⁶⁷ Prisoner Legal Services, *Reform of Treatment of Mentally Ill Prisoners Part Two: Litigation*, PLS NOTES 6 (Jan. 2015), <https://plisma.org/wp-content/uploads/2021/06/2015-01-e.pdf>; Michael Rezendes, *Patrick Unveils Ambitious Reforms for Troubled Bridgewater State Hospital*, The Boston Globe, June 18, 2014, <https://www.bostonglobe.com/2014/06/17/bridgewater/your6h9kFPnQhAgp5TIZLO/story.html>.
- ³⁶⁸ Janine Weisman, *Reforms Proposed for Bridgewater State Hospital*, NEW ENGLAND PSYCHOLOGIST (Aug. 22, 2014), <https://www.nepsy.com/articles/leading-stories/reforms-proposed-for-bridgewater-state-hospital/>; Associated Press/MASSLIVE, *Bridgewater State Hospital Accreditation At Risk*, MASSLIVE, June 10, 2014, https://www.masslive.com/news/boston/2014/06/bridgewater_state_hospital_acc.html.
- ³⁶⁹ *Bridgewater State Hospital Receives Accreditation*, WICKEDLOCAL.COM, Sept. 18, 2014, <https://www.wickedlocal.com/story/journal-news-independent/2014/09/17/bridgewater-state-hospital-receives-accreditation/36379550007/>.
- ³⁷⁰ See DLC, A PUBLIC REPORT ON THE EFFICACY OF SERVICE DELIVERY REFORMS AT BRIDGEWATER STATE HOSPITAL (BSH) AND CONTINUITY OF CARE FOR BSH PERSONS SERVED 4, n.2 (July 2022), <https://www.dlc-ma.org/wp-content/uploads/2022/07/DLC-BSH-Report-July-2022-Final.pdf>
- ³⁷¹ Memorandum of Decision and Order on Plaintiff John Doe's Motion for Preliminary Injunction, *Minich v. Spencer*, Civ. Action No. 1482CV00448 (Mass. Sup. Ct. July 2, 2014).
- ³⁷² Prisoner Legal Services, *Reform of Treatment of Mentally Ill Prisoners Part Two: Litigation*, PLS NOTES, *supra* note 367, at 7.
- ³⁷³ Weisman, *Reforms Proposed for Bridgewater State Hospital*, *supra* note 368.
- ³⁷⁴ *Id.* That trend would continue. Comparing the second week of January to the first week of August of 2014, total restraint hours at BSH went from 357 to 7, and total seclusion hours went from 3057 to 416. Prisoner Legal Services, *Reform of Treatment of Mentally Ill Prisoners Part Two: Litigation*, PLS NOTES, *supra* note 367, at 7.
- ³⁷⁵ "Appropriate Care in the Appropriate Setting: Reforming Bridgewater State Hospital & Strengthening the Commonwealth's Mental Health System" (June 17, 2014), <https://archives.lib.state.ma.us/bitstream/handle/2452/214192/ocn890655829.pdf?sequence=1>; Rezendes,

Patrick Unveils Ambitious Reforms for Troubled Bridgewater State Hospital, *supra* note 367; Letter and Investigation Report from Christine M. Griffin, DLC to Deval Patrick (July 11, 2014), *supra* note 359, at 1.

³⁷⁶ Prisoner Legal Services, Reform of Treatment of Mentally Ill Prisoners Part Two: Litigation, PLS NOTES, *supra* note 367; Rezendes, *Patrick Unveils Ambitious Reforms for Troubled Bridgewater State Hospital*, *supra* note 367.

Additionally, on July 25, 2014, DOC Commissioner Spencer resigned upon Governor Patrick's request. Matt Murphy, *Massachusetts prison commissioner resigns following investigation into abuse at Bridgewater State Hospital*, MASSLIVE, July 25, 2014,

<https://www.masslive.com/news/2014/07/massachusetts-prison-commissio.html>

³⁷⁷ ABT ASSOCIATES, IN PARTNERSHIP WITH THE TECHNICAL ASSISTANCE COLLABORATIVE, MASSACHUSETTS GENERAL COURT MENTAL HEALTH ADVISORY COMMITTEE REPORT PHASE I AND PHASE II FINAL (June 30, 2014),

<https://archives.lib.state.ma.us/bitstream/handle/2452/266272/ocn919775914.pdf?sequence=1&isAllowed=y>.

³⁷⁸ Weisman, *Reforms Proposed for Bridgewater State Hospital*, *supra* note 368.

³⁷⁹ Prisoner Legal Services, Reform of Treatment of Mentally Ill Prisoners Part Two: Litigation, PLS NOTES, *supra* note 367, at 6.

³⁸⁰ Letter and Investigation Report from Christine M. Griffin, DLC to Deval Patrick (July 11, 2014), *supra* note 359.

³⁸¹ *Id.* at 1.

³⁸² *Id.*

³⁸³ *Id.* at 2.

³⁸⁴ *Id.*

³⁸⁵ *Id.* at 7.

³⁸⁶ *Id.*

³⁸⁷ *Id.* at 7-17.

³⁸⁸ *Id.* at 7.

³⁸⁹ *Id.* at 8.

³⁹⁰ *Id.* at 17.

³⁹¹ *Id.* at 19-20.

³⁹² *Id.* at 21.

³⁹³ *Id.* at 18.

³⁹⁴ Letter from M. Patrick Moore, Jr, Office of the Governor, Commonwealth of Mass. et al. to Christine Griffin, Executive Director, DLC (Dec. 15, 2014), http://www.dlc-ma.org/wp-content/uploads/2017/11/DLC_Final_Agreement.pdf.

³⁹⁵ *Id.* at 4-11.

³⁹⁶ *Id.* at 11-20.

³⁹⁷ *Id.* at 22-23.

³⁹⁸ Order Preliminarily Approving Settlement and Scheduling Hearing for Final Approval, *Minich v. Spencer*, Civ. Action No. 148CV00448 (Mass. Sup. Ct. Dec. 29, 2014). Justice Wilson granted final approval on March 3, 2015.

Order Approving Settlement, *Minich v. Spencer*, Civ. Action No. 148CV00448 (Mass. Sup. Ct. Mar. 3, 2015).

³⁹⁹ Complaint and Jury Demand, *Joanne Minich et al. v. Luis S. Spencer et al.*, Civ. Action No. 1584CV00278 (Mass. Sup. Ct. Jan. 29, 2015).

⁴⁰⁰ Michael Rezendes, *Bridgewater State Ho. spital Patients Sue*, THE BOSTON GLOBE, Jan. 30, 2015,

<https://www.telegram.com/story/news/local/south-west/2015/01/30/bridgewater-state-hospital-patients-sue/35321951007/>.

⁴⁰¹ *Id.*

⁴⁰² *Id.*

⁴⁰³ *Id.*

⁴⁰⁴ Email from Rae Simpson to Jennifer Honig (June 8, 2023). The coalition organizing the library event included family members, formerly confined individuals, and advocates from the Cambridge Commission for Persons with Disabilities, NAMI-Massachusetts, NAMI-Cambridge/Middlesex, DLC, and Prisoner Legal Services (PLS). Event flier, *Bridgewater State Hospital: Keeping a Commitment to Much Needed Change*, Cambridge Public Library (Apr. 7, 2016) (on file with author).

⁴⁰⁵ Jan Ranson, *Bridgewater Inmate Allegedly Attempted Suicide 3 Times Before Death*, THE BOSTON GLOBE, <https://www.bostonglobe.com/metro/2016/04/14/bridgewater-inmate-had-trying-suicide-several-times-before-being-found-dead-brother-and-lawyer-say/zc3vymZuX2ep5wKoCfC2oJ/story.html>

⁴⁰⁶ *Id.*

⁴⁰⁷ *Id.*

⁴⁰⁸ DLC, ANOTHER SENSELESS DEATH AT BRIDGEWATER (June 27, 2016), <http://www.dlc-ma.org/wp-content/uploads/2017/11/Public-Report-Another-Senseless-Death-at-Bridgewater-Final.pdf>.

⁴⁰⁹ *Id.*

⁴¹⁰ Ranson, *Bridgewater Inmate Allegedly Attempted Suicide 3 Times Before Death*, *supra* note 405.

⁴¹¹ DLC, ANOTHER SENSELESS DEATH AT BRIDGEWATER, *supra* note 408.

⁴¹² *Id.*

⁴¹³ Ranson, *Bridgewater Inmate Allegedly Attempted Suicide 3 Times Before Death*, *supra* note 405.

⁴¹⁴ Letter from the Center for Public Representation, DLC, the Mass. Ass'n for Mental Health, the Mental Health Legal Advisors Committee, NAMI-Mass., and Prisoner Legal Services to Steven Kadish, Marylou Sudders, and Daniel Bennett (Aug. 3, 2016) (on file with author).

⁴¹⁵ Email from Rae Simpson to Jennifer Honig, *supra* note 404.

⁴¹⁶ Letter from the Center for Public Representation, DLC, the Mass. Ass'n for Mental Health, the Mental Health Legal Advisors Committee, NAMI-Mass., and Prisoner Legal Services to Steven Kadish, Marylou Sudders, and Daniel Bennett, *supra* note 414.

⁴¹⁷ PUBLIC CONSULTING GROUP, PCG ANALYSIS OF THE BRIDGEWATER STATE HOSPITAL (July 2016).

⁴¹⁸ Jordan Harris, *The Abandoned Legacy of Dorothea Dix* (June 2016), <https://pioneerinstitute.org/pioneer-research/better-government/the-abandoned-legacy-of-dorothea-dix/> at 1.

⁴¹⁹ *Id.* at 2-3.

⁴²⁰ *Id.* at 3.

⁴²¹ Jordan Harris, *The Abandoned Legacy of Dorothea Dix* (June 2016), <https://pioneerinstitute.org/pioneer-research/better-government/the-abandoned-legacy-of-dorothea-dix/> at 3.

⁴²² *Id.*

⁴²³ *Id.*

⁴²⁴ David Scharfenberg, *Baker Calls for Change in Treating Mentally Ill Inmates*, THE BOSTON GLOBE, Sept. 13, 2016, <https://www.bostonglobe.com/metro/2016/09/12/baker-plans-overhaul-criminal-justice-system-handling-mentally-ill/KlpXNF1YtFd81TEY1zWvjN/story.html>.

⁴²⁵ *Id.*

⁴²⁶ *Id.*

⁴²⁷ *Id.*

⁴²⁸ Michael Rezendes, *Humane Care Given a Place at State's Harshes Hospital*, THE BOSTON GLOBE, Sept. 9, 2017, <https://www.bostonglobe.com/metro/2017/09/09/humane-treatment-comes-last-bridgewater-state-hospital-where-prisoners-have-become-persons-served/YXvoxK2XUpSQubwV8E4X2L/story.html>. <https://www.linkedin.com/in/jerry-boyle-81204037/>. CCS was Boyle's second company; an earlier one, Prison Health Services, had the Suffolk jail contract in the early 2000s and later became part of Corizon Health. Beth Healy & Christine Willmsen, *Pain And Profits: Sheriffs Hand Off Inmate Care to Private Health Companies*, WBUR, Mar. 24, 2020, <https://www.wbur.org/news/2020/03/24/jail-health-companies-profit-sheriffs-watch>. On February 28, 2022, Boyle was sentenced in a 12-year bribery scheme involving a former Norfolk, VA sheriff Robert McCabe while serving as CCS CEO. Matt Masters, *Health Care Exec Sentenced in Bribery Scheme*, NASHVILLEPOST, Feb. 28, 2022, https://www.nashvillepost.com/business/health_care/health-care-exec-sentenced-in-bribery-scheme/article_58985245-e63e-56b6-b955-e75e68c7a99f.html; U.S. Attorney's Office, Eastern Dt. of Va., Press Release, *CEO Sentenced for Bribing Former Norfolk Sheriff* (Feb. 25, 2022), <https://www.justice.gov/usao-edva/pr/ceo-sentenced-bribing-former-norfolk-sheriff-0>. Boyle received a three-year prison term and a fine of \$35K; he had previously agreed to forfeit \$2.7M to the federal government as part of a plea deal. *Id.* Over the course of the conspiracy, Boyle provided McCabe gifts, cash, entertainment, travel, and campaign contributions and McCabe helped CCS secure a \$3M+/year contract to provide medical services for the Norfolk Sheriff's Office.

Id. Such official acts included, but were not limited to, signing contracts, granting extensions without putting the contracts out to bid, the release of a letter of credit, and awarding other adjustments that increased the value of the contracts. *Id.*

⁴²⁹ Combuys, Operational Services Division, Master Blanket Purchase Order PO-17-1025-DOCFS-FISCM-10000 (2017), <https://www.combuys.com/bso/external/purchaseorder/poSummary.sdo?docId=PO-17-1025-DOCFS-FISCM-10000&releaseNbr=0&external=true&parentUrl=close> (see SCF_BSH executed document.pdf).

Amendments to the contract are also accessible from this web page.

⁴³⁰ Stephanie Hepburn, *Dr. Kevin Huckshorn on Transforming Forensic State Hospitals with Evidence-Based Humanity*, #CRISISTALK, Oct. 6, 2020, <https://talk.crisisnow.com/dr-kevin-huckshorn-on-transforming-forensic-state-hospitals-with-evidence-based-humanity/>.

⁴³¹ *Id.*

⁴³² *Id.*

⁴³³ *Id.*

⁴³⁴ *Id.*

⁴³⁵ *Id.*

⁴³⁶ See Rezendes, *Humane Care Given a Place at State's Harshes Hospital*, *supra* note 428.

⁴³⁷ *Id.*; Tom Relihan, *Three Employees Assaulted, Two Hospitalized, in Separate Bridgewater State Hospital Incidents*, THE ENTERPRISE, Apr. 7, 2017, <https://www.enterpriseneews.com/story/news/local/2017/04/06/three-employees-assaulted-two-hospitalized/21522711007/>.

⁴³⁸ Rezendes, *Humane Care Given a Place at State's Harshes Hospital*, *supra* note 428.

⁴³⁹ *Id.*

⁴⁴⁰ Karen Anderson & Jonathan Wells, *Reform Comes to Bridgewater State Hospital*, WCVB5, Sept. 21, 2017, <https://www.wcvb.com/article/reform-comes-to-bridgewater-state-hospital/12446196>. In 2007, DLC had raised concerns regarding Timothy Grabosky, a former patient, who said he had been held illegally in isolation on numerous occasions. Rezendes, *New Scrutiny for Bridgewater State Hospital After Complaints*, *supra* note 360.

⁴⁴¹ Karen Anderson & Jonathan Wells, *Reform Comes to Bridgewater State Hospital*, *supra* note 440.

⁴⁴² *Id.*

⁴⁴³ Christian Schiavone, *Experts Hail Bridgewater State Hospital Reforms and CRJ Panel Discussion*, CRIME AND JUSTICE INSTITUTE, Dec. 13, 2017, <https://www.cjinitiative.org/news-article/experts-hail-bridgewater-state-hospital-reforms-at-crj-panel-discussion/>.

⁴⁴⁴ Marsha McLeod, *The Private Option*, THE ATLANTIC, Sept. 12, 2019, <https://www.theatlantic.com/politics/archive/2019/09/private-equitys-grip-on-jail-health-care/597871/>. See also Letter from Wellpath to Mass. DOC (Nov. 13, 2018) at Combuys, Operational Services Division, Master Blanket Purchase Order PO-17-1025-DOCFS-FISCM-10000 (2017), *supra* note 429 (Name Change to WellPath).

⁴⁴⁵ See Combuys, Operational Services Division, Master Blanket Purchase Order PO-17-1025-DOCFS-FISCM-10000 (2017), *supra* note 429 (Contract Amendment 3-BSH Amendment 3_executed.pdf).

⁴⁴⁶ Steve Coll, *The Jail Health-Care Crisis*, THE NEW YORKER, Feb. 25, 2019, <https://www.newyorker.com/magazine/2019/03/04/the-jail-health-care-crisis>.

⁴⁴⁷ McLeod, *supra* note 444.

⁴⁴⁸ Monitoring, Investigations, & Reports, DLC, <https://www.dlc-ma.org/monitoring-investigations-reports/>.

⁴⁴⁹ DLC, A PUBLIC REPORT ON THE EFFICACY OF SERVICE DELIVERY REFORMS AT BRIDGEWATER STATE HOSPITAL 2 (May 18, 2018), <https://www.dlc-ma.org/wp-content/uploads/2018/05/May-18-2018-Report-to-the-Legislature-FINAL.pdf>.

⁴⁵⁰ *Id.*

⁴⁵¹ *Id.* at 3-13.

⁴⁵² Deborah Becker, *Chemical Restraints, Isolation Often Used at Bridgewater State hospital, New Report Says*, WBUR, Feb. 14, 2022, <https://www.wbur.org/news/2022/02/14/bridgewater-state-wellpath-disability-law-center-report>.

⁴⁵³ DLC, A PUBLIC REPORT ON THE EFFICACY OF SERVICE DELIVERY REFORMS AT BRIDGEWATER STATE HOSPITAL 1 (Feb. 25, 2019), <https://www.dlc-ma.org/wp-content/uploads/2019/02/BSH-February-2019-Report-combined.pdf>.

⁴⁵⁴ *Id.* at 7.

⁴⁵⁵ *Id.*

⁴⁵⁶ See Mass. Gen. L. ch. 123, § 13 (DMH facilities), § 18 (places of detention). For protocol for pre-arraigned prisoners in police custody, see DMH, Forensic Evaluation Protocol (Jan. 27, 2020), <https://www.mass.gov/doc/mbhp-appendix-a6/download>.

⁴⁵⁷ Mass. Gen. L. ch. 123, § 13.

⁴⁵⁸ *Id.*

⁴⁵⁹ Evaluation occurs pursuant to these sections of Chapter 123:

- Section 15(b) – admission for evaluation to determine competency to stand trial or criminal responsibility for the crime charged.
- Section 15(e) – admission for evaluation as an aid in sentencing.
- Section 16(a) – admission for evaluation to determine whether the person meets the criteria for civil commitment after a filing of incompetence to stand trial or not guilty by reason for mental illness.
- Section 18(a) – admission of a prisoner, transferred from a carceral facility, for evaluation to determine need for hospitalization by reason of mental illness at a DMH facility or BSH.

⁴⁶⁰ Commitment occurs pursuant to these sections of Chapter 123:

- Section 15(e) – commitment of person found guilty of criminal charges but who has not yet been sentenced.
- Section 16(b) & (c) – commitment of person found incompetent to stand trial or not criminally responsible.

⁴⁶¹ Mass. DOC, July 2022 MA DOC Institutional Fact Cards, <https://www.mass.gov/doc/institutional-fact-cards-july-2022/download>.

⁴⁶² *Id.*

⁴⁶³ Mass. Gen. L. ch. 123, § 18(a) (commitment of prisoner transferred from a carceral facility and found to require commitment to BSH pursuant to this section).

⁴⁶⁴ Data provided to Jennifer Honig by Mass. DOC (March 11, 2023) (on file with author).

⁴⁶⁵ 2016 ACA accreditation reports for BSH and OCCO and a 2015 Joint Commission accreditation report are available at Commbuys, Operational Services Division, Master Blanket Purchase Order PO-17-1025-DOCFS-FISCM-10000 (2017), *supra* note 429.

⁴⁶⁶ MASS. DEPT. OF CORRECTION, BRIDGEWATER STATE HOSPITAL, STUDYLIB, *supra* note 198, at 13.

⁴⁶⁷ Telecomm. between Jennifer Honig and Stephen DeLisi, Metro Boston Area Forensic Director, DMH (July 12, 2023).

⁴⁶⁸ MASS. DEPT. OF CORRECTION, BRIDGEWATER STATE HOSPITAL, STUDYLIB, *supra* note 198, at 13.

⁴⁶⁹ Email from Tatum Pritchard, Litigation Director, DLC to Jennifer Honig (March 8, 2023).

⁴⁷⁰ See Commbuys, Operational Services Division, Master Blanket Purchase Order PO-17-1025-DOCFS-FISCM-10000 (2017), *supra* note 429. (BSH Amendment 11_Executed). Hopefully, DOC will work with Wellpath to address current workplace concerns. Reviews of workplace culture posted on Indeed by non-correctional staff at BSH between 2020 and 2022 contain multiple statements of a system with problems:

- One former Recovery Treatment Specialist reports: “Administration is disorganized, staff and culture are toxic, environment is routinely unsafe and staff are not adequately supported.”
- A former Peer Support/Recovery Specialist reports: “If you want to work with two faced, gossiping, hyper vigilant staff than this is the place. The person served are treated like animals ... Awful working atmosphere, but the men I worked with were the most amazing men and deserve so much more...”
- A current Lead recovery treatment assistant writes: “I’ve been working with wellpath correct care for almost 4 years. In my opinion the company does not support staff, mandatory overtime and you will be

working every weekend. The inmates are well behaved for the most part it's the company that you should worry about."

- A former Assistant Director of Nursing writes: "Just awful. Stressful, dangerous working environment with a terrible work culture. No communication. No teamwork or transdisciplinary collaboration. Care given is dismal, even for murderers and psychopaths."
- A current Psychiatric RN states: "The compensation is excellent, but the culture is very unprofessional and catty." <https://www.indeed.com/cmp/Bridgewater-State-Hospital/reviews>

⁴⁷¹ Mass. DOC, July 2022 MA DOC Institutional Fact Cards, *supra* note 461.

⁴⁷² Data provided to Jennifer Honig by Mass. DOC, *supra* note 464.

⁴⁷³ 2020 US Census.

⁴⁷⁴ CRIMINAL JUSTICE POLICY PROGRAM, HARVARD LAW SCHOOL, RACIAL DISPARITIES IN THE MASS. CRIMINAL SYSTEM 1 (Sept. 2020), <https://hls.harvard.edu/wp-content/uploads/2022/08/Massachusetts-Racial-Disparity-Report-FINAL.pdf>.

⁴⁷⁵ Letter from Center for Public Representation to Joint Committee on State Administration & Regulatory Oversight 2 (June 27, 2023) (on file with author) (citing Racial Inequality and Seclusion on an Urban-Med Psych Unit: A 2021 B.I.A.S. Report and <https://ncpsych.memberclicks.net/committing-to-racial-health-equity-in-psychiatry>).

⁴⁷⁶ Letter from Center for Public Representation to Joint Committee on State Administration & Regulatory Oversight, *supra* note 475, at 3.

⁴⁷⁷ *Id.* at 4.

⁴⁷⁸ DLC, Public Report: Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served 34 (July 2023), <https://www.dlc-ma.org/wp-content/uploads/2023/08/DLC-BSH-Public-Report-7.31.2023.pdf>.

⁴⁷⁹ DLC, Public Report: Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served 18 (Jan. 2022), <https://www.dlc-ma.org/wp-content/uploads/2022/02/DLC-BSH-January-2022-Public-Report-2.9.2022.pdf>.

⁴⁸⁰ *Id.* at 18-19.

⁴⁸¹ *Id.* at 19.

⁴⁸² *Id.* at 18-19.

⁴⁸³ Sara Betancourt, *Restraints and Involuntary Medication Are Widespread at Corrections Facility for People with Mental Illness, Report Alleges*, WGBH, Aug. 10, 2022, <https://www.wgbh.org/news/local/2022-08-09/restraints-and-involuntary-medication-are-widespread-at-corrections-facility-for-people-with-mental-illness-report-alleges>.

⁴⁸⁴ See, e.g., Letter from Mass. Ass'n for Mental Health to the J. Comm. on the Judiciary (Apr. 25, 2022), <https://www.mamh.org/library/letter-in-objection-to-the-use-of-emergency-treatment-orders-at-bridgewater-state-hospital>; Letter from Center for Public Representation to the J. Comm. on State Administration & Regulatory Oversight (June 27, 2023) (on file with author).

⁴⁸⁵ Betancourt, *Restraints and Involuntary Medication Are Widespread at Corrections Facility for People with Mental Illness, Report Alleges*, *supra* note 483.

⁴⁸⁶ Mass. Gen. L. ch. 123, § 21.

⁴⁸⁷ 390 Mass. 489 (1983).

⁴⁸⁸ *Rogers*, 390 Mass. 489, 503, 511-512 (1983).

⁴⁸⁹ *Rogers* at 511.

⁴⁹⁰ *Id.*

⁴⁹¹ *Id.*

⁴⁹² *Id.*

⁴⁹³ Apple Podcast, *Six Core Strategies to Reduce Seclusion and Restraint Use with Dr. Kevin Ann Huckshorn*, AASR LIVE, <https://podcasts.apple.com/us/podcast/six-core-strategies-to-reduce-seclusion-and-restraint/id1509810161?i=1000576051574>.

⁴⁹⁴ In its July 2021 report, DLC reported there were six DOC prisoners serving as companions to BSH patients through the DOC Companion Program and urged DOC and its medical provider to expand the program. DLC, A

PUBLIC REPORT ON THE EFFICACY OF SERVICE DELIVERY REFORMS AT BRIDGEWATER STATE HOSPITAL (BSH) AND CONTINUITY OF CARE FOR BSH PERSONS SERVED 8 (July 2021), <https://www.dlc-ma.org/wp-content/uploads/2021/07/BSH-Report-7.27.2021.pdf>. The Companion program has not only benefited BSH patients, but also the prisoners who serve as companions – many with serious convictions. In 2016, ten of 14 prisoners serving as companions were serving 1st or 2nd degree life sentences. James Rioux, *BSH Companion Program*, AROUND THE BLOCK, MASS. DOC, Aug. 2, 2016, <https://macorrections.wordpress.com/2016/08/02/bsh-companion-program/>. Participation in the program has been a factor in the early release of prisoners. William Allen, who was granted parole with his life commuted in April 2022 had been a companion to eight men at BSH. Jean Trounstine, “Unprecedented:” *DA Supports William Allen’s Commutation Petition*, June 15, 2021, <https://jeantrounstine.com/?m=202106>. One factor in the Massachusetts Parole Board’s decision was Allen’s rehabilitative programming and support for the community. Deborah Becker, *William Allen Granted Parole with Life Sentence Commuted*, WBUR, Apr. 20, 2022, <https://www.wbur.org/news/2022/04/20/massachusetts-william-allen-commuted-sentence>. Similarly, Ramadan Shabazz’s 2023 parole, after more than 50 years as a prisoner, followed his work “in multiple programs in Bridgewater State Hospital, assisting in the care of troubled inmates.” Adrian Walker, *Once Condemned, Ramadan Shabazz Enjoys His First Taste of Freedom In More Than 50 Years*, THE BOSTON GLOBE, Mar. 15, 2023, <https://www.bostonglobe.com/2023/03/15/metro/once-condemned-ramadan-shabazz-enjoys-his-first-taste-freedom/>. BSH staff established the program in 2011. MASS. DOC, ANNUAL REPORT 2011 27, <https://www.mass.gov/doc/annual-report-2011-4/download>. DOC credits BSH Deputy Superintendent of Patient Services Pamela MacEachern with developing the program. DOC prisoners volunteer to receive special training to assist BSH patients by providing support and skill building. See DOC, PROGRAM DESCRIPTION BOOKLET 19-20 (Jan. 2023), <https://www.mass.gov/doc/program-description-booklet-2/download>. Unfortunately, since the 2017 transition of convicted BSH patients to the Old Colony units, only BSH patients on those units have received companions. Email from Jordan Goldstein, DLC to Jennifer Honig (May 30, 2023).

⁴⁹⁵ Monitoring, Investigations, & Reports, DLC, *supra* note 448.

⁴⁹⁶ DLC, Public Report: Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served (July 2023), *supra* note 478, at 6-16.

⁴⁹⁷ *Id.* at 10.

⁴⁹⁸ *Id.* at 11.

⁴⁹⁹ *Id.* at 37.

⁵⁰⁰ *Id.* at 38.

⁵⁰¹ DLC, Press Release: Disability Law Center Again Recommends Transfer of Oversight of Bridgewater State Hospital to the Department of Mental Health Due to Continuing Health and Safety Risks and Rights Violations (Aug. 1, 2023), <https://www.dlc-ma.org/2023/08/01/disability-law-center-again-recommends-transfer-of-oversight-of-bridgewater-state-hospital-to-the-department-of-mental-health-due-to-continuing-health-and-safety-risks-and-rights-violations/>.

⁵⁰² Betancourt, *Restraints and Involuntary Medication Are Widespread at Corrections Facility for People with Mental Illness, Report Alleges*, *supra* note 483.

⁵⁰³ *Id.*

⁵⁰⁴ Mass. State Budget Line-Item DOC 8900-0001.

⁵⁰⁵ Betancourt, *Restraints and Involuntary Medication Are Widespread at Corrections Facility for People with Mental Illness, Report Alleges*, *supra* note 483 (in August 2022, five members of the Legislature’s Criminal Justice Reform Caucus toured the facility and met with patients “to check in on heat and health-related complaints about the facility”).

⁵⁰⁶ Hearing Video, Joint Committee on the Judiciary, Mass. Legislature (Dec. 20, 2022),

<https://malegislature.gov/Events/Hearings/Detail/4427> at 25:09.

⁵⁰⁷ <https://malegislature.gov/Events/Hearings/Detail/4427>

⁵⁰⁸ 2022 Mass. Acts, ch. 140.

⁵⁰⁹ *Id.*

⁵¹⁰ COMMONWEALTH OF MASSACHUSETTS, FIVE-YEAR CAPITAL INVESTMENT PLAN: FY 2024-2028 (June 22, 2023), <https://www.statehousenews.com/content/docs/2023/06-22FY24-FY28CAPITAL.pdf> at 26.

⁵¹¹ H.2985/S.1239, *An Act transferring Bridgewater State Hospital from the Department of Correction to the Department of Mental Health*, 193rd Leg. (Mass. 2023-24).

⁵¹² Betancourt, *Restraints and Involuntary Medication Are Widespread at Corrections Facility for People with Mental Illness*, *Report Alleges*, *supra* note 483.

⁵¹³ [Friends and Family of Individuals with Mental Illness, Bridgewater State Hospital Must be Placed Under the Dept. of Mental Health – Not the Dept. of Correction](https://ffimi.blog/2023/01/31/bridgewater-state-hospital-must-be-placed-under-the-dept-of-mental-health-not-the-dept-of-correction/) (Jan. 31, 2023), <https://ffimi.blog/2023/01/31/bridgewater-state-hospital-must-be-placed-under-the-dept-of-mental-health-not-the-dept-of-correction/>.

⁵¹⁴ *See, e.g.*, Shira Schoenberg, *Pervasive Mold Plagues State Hospital for Mentally Ill Detainees*, COMMONWEALTH (Feb. 8, 2022), <https://commonwealthmagazine.org/courts/pervasive-mold-plagues-state-hospital-for-mentally-ill-detainees> (Senator James Eldridge “would certainly support the institution being taken over by state health officials rather than correction officials. If the building is demolished, he would only support rebuilding it as a mental health treatment facility, not a prison.”).

⁵¹⁵ *See, e.g.*, Testimony of the Mental Health Legal Advisors Committee and the Center for Public Representation to the J. Comm. on Mental Health, Substance Use and Recovery (June 13, 2017), <https://mhlac.org/wp-content/uploads/2019/02/testimony-on-H.-2389.S.1084.H.2406.re.-BSH.MHLAC.CPR.6-16-17.-FINAL.pdf>

⁵¹⁶ H.1460, *An Act relative to reforming the competency to stand trial process*, 193rd Leg. (Mass. 2023-24).

⁵¹⁷ Friends and Family of Individuals with Mental Illness, *supra* note 513.

⁵¹⁸ There is a coalition of family members of Massachusetts prisoners and other advocates who are seeking to terminate the state’s reliance on Wellpath. In September 2022, the Deeper Than Water Coalition, made up of currently and formerly incarcerated organizers, their loved ones, and prison abolitionist organizations in Massachusetts, called for the Administration not to renew its contract with Wellpath for care in the state prison system when that contract expired in summer 2023. The coalition pointed to incidents of neglect, including the death of a man at MCI-Norfolk who died of cancer after complaining for months of health problems. The coalition seeks to replace the Wellpath contract with one with a private entity to create greater transparency and accountability. <https://www.baystatebanner.com/2022/09/21/activists-target-medical-neglect-in-mass-prisons/>

⁵¹⁹ Letter from Harry McCue for Bridgewater State Hospital Family and Friends Advocacy Group to the Joint Committee on State Administration and Regulatory Oversight (Apr. 18, 2023) (on file with author).

⁵²⁰ NAMI Mass., NAMI Mass Statement on Bridgewater State Hospital (Apr. 12, 2022), <https://namimass.org/nami-mass-statement-on-bridgewater-state-hospital/>.

⁵²¹ Friends and Family of Individuals with Mental Illness, *supra* note 513.

⁵²² *Id.*

⁵²³ *Id.*

⁵²⁴ *Id.*

⁵²⁵ Letter from Harry McCue for Bridgewater State Hospital Family and Friends Advocacy Group to the Joint Committee on State Administration and Regulatory Oversight, *supra* note 519.

⁵²⁶ The dramatizations are available on YouTube:

- All-In-One: https://youtu.be/H0aHEKc_KSo
- Isolation: https://youtu.be/6DjUK_1pjj8
- Dirty: <https://youtu.be/Zq0T6ZCXw84>
- Heatwave: <https://youtu.be/DHT3p586krq>
- Lockdown: <https://youtu.be/3g7-R7T-1iw>
- Hard to Breathe: <https://youtu.be/mbffKV2sGgU>

⁵²⁷ Among the categories of men who continue to be confined at BSH are persons who are eligible for services from the Department of Developmental Services (DDS) or who are thought to have intellectual or developmental disabilities. These patients are not served on a discrete unit but BSH’s Developmental Services Program (DSP) assesses them and provides specialized treatment. DLC has addressed services to this population in certain of its DLC reports. Email from Nancy Murphy, Managing Attorney, DLC to Jennifer Honig (Aug. 11, 2023). Despite years of advocacy, efforts to have all such patients transferred from BSH to the care of DDS have not been successful.

⁵²⁸ While individuals at BSH may earn good time, 103 CMR 411.04, patients transferred there, particularly for short stays, might not enroll in programming.

⁵²⁹ Mass. Gen. L. ch. 123, § 18(a1/2).

⁵³⁰ In July 2023, DMH, reporting on its operated and contracted inpatient continuing care facilities, counted a total of 664 adult operational beds, a census of 692, and 89 forensic admissions. MASS. DMH, DMH SECTION 114 REPORT – JULY 2023, <https://www.mass.gov/doc/section-114-report-july-2023/download>. Relatedly, in FY22 9,696 individuals were referred to DMH by the Juvenile, District, and Superior Courts. MASS. DMH, FISCAL YEAR 2022 – HIGHLIGHTS, <https://www.mass.gov/doc/dmh-annual-highlights/download>.

⁵³¹ John R. Holmes & David Felsenthal, *Depreciating and Stating the Value of Hospital Buildings: What You Need to Know*, GALE ACADEMIC ONEFILE (Oct. 2009), <https://go.gale.com/ps/i.do?p=AONE&u=googlescholar&id=GALE|A216033645&v=2.1&it=r&sid=AONE&asid=76a80f8c#:~:text=Marshall%20%26%20Swift's%20manual%20Marshall%20Valuation,lives%20for%20some%20building%20components>. The authors note that “[m]any commercial and residential buildings are more than 50, 60, and even 70 years old,” which happens with “repair and maintenance with some remodeling and/or renovations... The list of repairs and renovations will eventually include many or all of the short-lived building components.” *Id.* Deferred maintenance at BSH suggests this longevity may be out of reach.

⁵³² Lindsey Coulter, *How Maintenance Can Make or Break Facilities*, CORRECTIONAL NEWS, Feb. 23, 2017, <https://correctionalnews.com/2017/02/23/maintenance-can-make-break-facilities/>.

⁵³³ Aaron Levin, *Psychiatric Hospital Design Reflects Treatment Trends*, PSYCHIATRIC NEWS, Jan. 19, 2007, <https://psychnews.psychiatryonline.org/doi/full/10.1176/pn.42.2.0009>.

⁵³⁴ Asylums too were isolated from the general community but at least they aimed to create a new rural community of patients and staff working together towards some degree of self-sufficiency.

⁵³⁵ Edmund Ramsden, *Designing for Mental Health: Psychiatry, Psychology and the Architectural Study Project*, in PREVENTING MENTAL ILLNESS: PAST, PRESENT AND FUTURE (Nat’l Libr. of Med. Oct. 17, 2018), <https://www.ncbi.nlm.nih.gov/books/NBK538043/>.

⁵³⁶ *Id.*

⁵³⁷ *Id.*

⁵³⁸ Levin, *Psychiatric Hospital Design Reflects Treatment Trends*, *supra* note 533. Designers of prisons are also rethinking the design of prisons and jails. Correctional News, an industry publication dedicated to carceral facility construction, has acknowledged that contemporary jails typically have “bad acoustics, little privacy, limited daylighting with no views to the outside, harsh artificial lighting, few colors, hard materials like concrete and concrete block, and institutional furnishings in fixed configurations that are not conducive to social activities.” Henry Pittner, *A New Approach to The Architectural Design of Jail Facilities*, CORRECTIONAL NEWS, July 19, 2022, <https://correctionalnews.com/2022/07/19/a-new-approach-to-the-architectural-design-of-jail-facilities/#:~:text=Standard%20jail%20configurations%20typically%20have%20bad%20acoustics%2C%20little,configurations%20that%20are%20not%20conductive%20to%20social%20activities>. Instead, jails should embrace a new “healing and restorative” paradigm, “with the goal of reinforcing the dignity and human worth of each resident.” *Id.* When designing a facility, one should opt for smaller housing units, indoor/outdoor connectivity, enhanced dayroom space, brighter/warmer interiors, and infectious disease control features. *Id.*

⁵³⁹ Levin, *Psychiatric Hospital Design Reflects Treatment Trends*, *supra* note 533.

⁵⁴⁰ Jane Margolies, *A New Tool in Treating Mental Illness: Building Design*, THE NEW YORK TIMES, Jan. 5, 2021, <https://www.nytimes.com/2021/01/05/business/mental-health-facilities-design.html>. One beautiful new facility is the 56,000-square-foot Taube Pavilion, a Californian mental health facility which opened in 2020 at a cost of \$98M. The facility is operated by El Camino Health, which appears to run both public and private facilities. It combines glass, steel, redwood and stone, features private rooms with windows overlooking wooded mountains, airy communal spaces, and landscaped courtyards. *Id.* As a point of comparison, the 428,000-square-foot Worcester Recovery Center and Hospital, which opened in 2012, cost \$302M. Marc Larocque, *Worcester Recovery Center and Hospital Will Meld Modern Facilities with Mental Health Treatment*, TAUNTON DAILY GAZETTE, July 22, 2012, <https://www.tauntingazette.com/story/news/politics/2012/07/22/worcester-recovery-center-hospital-will/41028500007/>. In today’s dollars, Taube costs \$2021 and Worcester costs \$928 per square foot.

⁵⁴¹ Sarah Sloat, *'Impactful and Beautiful': How US Homeless Shelters Are Getting A Radical Redesign*, THE GUARDIAN, June 26, 2023, https://www.theguardian.com/us-news/2023/jun/26/us-homeless-shelters-redesign?CMP=Share_AndroidApp_Other. The guidebook is available at <https://www.hok.com/wp-content/uploads/2022/08/trauma-informed-design-for-homeless-populations-hok-high-resolution.pdf>.

⁵⁴² Ashley Rubin, *That Time We Tried to Build the Perfect Prison: Learning from Episodes Across U.S. Prison History* 21-22, in D. Moran *et al.*, THE PALGRAVE HANDBOOK OF PRISON DESIGN (2023).

⁵⁴³ Michael J. Maddigan, MCI Bridgewater: A Troubled Past, YOUTUBE, *supra* note 5.

⁵⁴⁴ Appelbaum *et al.*, *supra* note 269.

⁵⁴⁵ MASS. DMH, DEPARTMENT OF MENTAL HEALTH RESOURCE DIRECTORY 1 (Apr. 2023), <https://www.mass.gov/doc/dmh-resource-guide/download>.

⁵⁴⁶ *Id.* at 3.

⁵⁴⁷ *Id.*

⁵⁴⁸ Friends and Family of Individuals with Mental Illness, *supra* note 513.

⁵⁴⁹ The DCAMM study includes individuals held pursuant to section 18 of Chapter 123, so presumably will consider the men on those units.