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Testimony in Support of

H. 2389/S. 1084, An Act Transferring Bridgewater State Hospital from the Department of Correction to the Department of Mental Health

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H. 2406, An Act relative to the Civil Commitment of Mentally Ill Persons to Bridgewater State Hospital

Jennifer Honig and Phillip Kassel, Mental Health Legal Advisors Committee

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Robert Fleischner, Center for Public Representation

before the

Joint Committee on Mental Health, Substance Use and Recovery

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The Mental Health Legal Advisors Committee and the Center for Public Representation support S. 1084 and H. 2389, which are sponsored by Senator Creem and Representative Balser. Both bills would transfer control of Bridgewater State Hospital (BSH) from the Department of Correction (DOC) to the Department of Mental Health (DMH).

The current problems at BSH can perhaps be traced to an unfortunate history of treating people with mental health challenges as criminals, notwithstanding the efforts of reformers.[1] Until the early 19th century in this country, people labelled "insane" were kept in local jails and county almshouses. Bridgewater State Hospital itself opened in 1855 as one of 219 almshouses in Massachusetts. Almshouses held the homeless poor, people with disabilities, alcoholics, vagrants and persons convicted of crime. As almshouses were closed, some were converted to public asylums, such as Tewksbury. However, Bridgewater was converted to a workhouse for

[1] In 1833, under the leadership of Horace Mann, the first state mental hospital in American opened in Worcester. In 1841, Dorothea Dix, dismayed by the abuse and neglect of people with mental illness in Massachusetts jails and elsewhere, began a public campaign for humane treatment. She promoted proper institutional care with the goal of curability, not punishment, prompting the gradual establishment of asylums at least theoretically focused on treatment.

prisoners and, later, a prison for the "criminally insane." We continue to wrestle with this legacy.

From the vantage provided by virtue of our role as co-counsel in the *Minich* class action, filed on behalf of wrongfully secluded and restrained men at BSH, we have seen meaningful changes in recent months. The litigation, as well as concerns and publicity generated by the deaths of Joshua Messier and many others at BSH, spurred changes in practice. Restraint and seclusion numbers are down (though exponentially higher than rates typical at DMH hospitals and forensic hospitals in other states that house a population similar to BSH). Most recently, guards at BSH were moved outside of housing units to the facility periphery, leaving an increased number of clinicians to address the needs of a smaller number of patients. The new medical/mental health vendor, Correct Care Solutions, now covers both the former sole BSH site and two new BSH units located at Old Colony Correctional Center (OCCC), which house patients convicted of crimes.[2]

We welcome these changes, but we doubt reforms are sustainable over the long run if BSH and BSH/OCCC remain under the control of prison authorities. History tells us that when clinicians and correctional staff share authority, security concerns will persistently trump treatment needs. Correctional staff will dominate, as they did at the Massachusetts Treatment Center when it was run by DMH and DOC.

We are particularly skeptical about the fate of patients transferred to the new BSH units at OCCC, where prison guards are not consigned to the periphery. One unit resembles the old Intensive Treatment Unit (ITU) at BSH – the specific site of past grossly excessive and illegal uses of restraint and seclusion. We are concerned about the importation of this discredited model and the continuation of punitive practices that are common to prisons but antithetical to therapeutic environments.

Doubts also persist for the future of BSH proper. Reorganization must go beyond moving guards to the periphery. While it is too early to assess the impact of reforms, there are some ominous indications already. Patients tell us that mental health vendor staff numbers are inadequate to maintain calm in housing units. In fact, the contract with the provider does not specify staffing levels, and future funding for increased clinical staffing remains uncertain. BSH is still not accredited as a hospital, nor is required to comply with DHM standards that govern every other psychiatric facility in the Commonwealth.

There is little question that a DMH-run forensic hospital would run much differently than a DOC facility managed by a private contractor with no statutory authority. DMH is accustomed to creating a therapeutic environment and would do so at BSH. They would operate BSH like a true forensic hospital, with therapeutic groups and counseling, peer advocacy, a range of recovery-oriented programming, and the opportunity for transition through a continuum of care.

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[2] We do not agree with the rationale for assignments to OCCC or the old BSH building. The distinction between patients that are criminally convicted and those placed for evaluation of competency to stand trial and/or criminal responsibility is more technical than founded on any genuine difference between these populations. There certainly is little difference from a treatment perspective. Many in the OCCC group are desperately in need of mental health care.

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DMH would not engage in the damaging practices that have been so prevalent at BSH for literally generations under DOC management. Recognizing that restraint is a re-traumatizing experience for many patients with often horrible life experiences, DMH is committed to the goal of not utilizing restraints at all. The agency practice is to regularly review data that is disaggregated by facility, housing unit, and individual staff in order to target and address restraint overuse. Even without these measures, the need for restraint and seclusion is minimized in a therapeutic environment that engages patients in treatment. It is very hard to imagine the DOC, which has a culture steeped in the use of punitive restraint and seclusion, supervising a facility operating in this fashion.

There is no reason for concern that DMH would not be able to provide adequate security for the BSH population. In all but one other state, the maximum security forensic hospital is operated by the state department of mental health. Massachusetts stands virtually alone in giving responsibility for this population to its agency in charge of punishing persons convicted of crime.

We endorse a number of other features of S. 1084 and H. 2389, as well as reforms contained in H. 2406, sponsored by Representative Scaccia. The bills would consolidate forensic mental health services within DMH, establishing a forensic division that would provide a wide array of services, including programs of police and pre-trial diversion, post adjudication alternatives to incarceration, and re-entry. DMH has decades of experience operating forensic court clinics. It is thus the best agency to be entrusted with oversight of forensic evaluations of people with mental health issues across the state. S. 1084/H. 2389 would also, we believe appropriately, encourage DMH to expand its capacity to perform evaluations and other forensic services in community and outpatient settings. Finally, S. 1084 would prohibit the retention of persons finishing a criminal sentence at BSH. This is a persistent current practice that is also addressed by H. 2406.[3]

These bills would introduce long-overdue and necessary reforms. There is no need to wait for a new crisis to address ingrained bad practices connected to structural issues. As noted at the outset of this testimony, Massachusetts has not always been at the vanguard in its treatment of persons with mental illness. Bridgewater has a well-deserved reputation around the country for its long history of abuse and mistreatment of patients. We remain in some ways locked in an early 1800s model; defining and treating people with mental illness as criminals. We need to take bold action to move 200 years forward. Shifting control of BSH to DMH will be a giant step in this direction.

[3] In addition to limiting retentions, H. 2406 would tighten standards governing BSH commitments and limit discretion to transfer to, and deny transfers from, BSH. If DMH does not soon take on jurisdiction over BSH, this bill seems to us a good interim measure to minimize unnecessary placements.