COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss

SUPERIOR COURT
CIVIL ACTION NO. 2084CV01407

JAMES DOE, Alias, *et al.,*
Plaintiffs

VS.

Joan Mikula, *et al.*,
Defendants

Plaintiffs' Memorandum of Law in Support of Their Emergency Motion for Preliminary Injunction
(Leave to file brief exceeding page limit granted July 13, 2020)

INTRODUCTION

Plaintiffs are patients confined in the Department of Mental Health-operated Hathorne Units of the Tewksbury Hospital ("Tewksbury"),[1] where they are confined so they can receive mental health treatment. Plaintiffs, along with 167 other Hospital residents, 17 of whom have died,[2] were sickened by the COVID-19 virus. During the current pandemic, they have been forced to live in miserable and disheartening conditions while confined in their bedrooms almost all the time. They have not received the treatment that justifies their confinement. Many are ready for discharge, but Defendants have failed to assess any of them in a way that accounts for the physical and emotional harm that is caused by inpatient confinement during the pandemic. The due process clauses of the state and federal constitutions entitle Plaintiffs and those similarly situated to a Preliminary Injunction requiring Defendants to assess all persons confined in

[1] The Hospital is operated by the Department of Public Health ("DPH"). By agreement with DPH, DMH operates four 40 bed psychiatric units dubbed the Hathorne Units.
[2] *See* data published by Defendants: "EOHHS state-operated facilities," June 9, 2020, Ex. B ("dashboard") regarding the infection and death rate the Massachusetts facilities, including Tewksbury Hospital. The DMH did not disaggregate data for different parts of Tewksbury. The proportion of infections and deaths that occurred among those using the 160 beds in the Hathorne Units, therefore, is not known as of this writing.

Department of Mental Health ("DMH") operated psychiatric units and hospitals to determine if they may be safely discharged.[3]

It is widely acknowledged that congregate settings like Tewksbury are often "hot spots" for COVID-19. To protect Plaintiffs from harm, Defendants must alter its normal discharge analysis. Plaintiffs ask the Court to order Defendants to consider whether continued confinement in institutional settings, given limitations in treatment necessitated by controlling contagion during the pandemic, outweighs substantial medical risks and the psychological harm that comes from confinement in a dangerous congregate facility during these times. In conducting this analysis, Defendants should be ordered to presume that anyone who does not need institutional confinement in order to prevent an imminent threat to self or others should be discharged. Injunctive relief framed in this fashion should allow for placements in less restrictive settings,[4] and also reduce institutional populations so that only one person occupies each bedroom. This will protect not only those who are discharged, but also those who remain hospitalized, since population reduction throughout Defendants' facilities will allow for Centers for Disease Control-mandated social distancing and also facilitate the provision of treatment for those who require inpatient-level care.

The Supreme Judicial Court ("SJC") recently required courts hearing motions for discharge from persons seeking relief from confinement for substance abuse disorder under G.L. c. 123, § 35 to consider the impact of the pandemic.[5] This is particularly critical for persons with

[3] Plaintiffs raise claims of disability discrimination under federal and state law in their Complaint but do not seek preliminary relief at this time on the basis of these claims.
[4] Options for this include placement with family member(s); in an independent living situation, with supports; or a Group Living Environment ("GLE").
[5] *Foster v. Commissioner of Correction (No. 1),* 484 Mass. 698, 730-31 (2020).

high risk characteristics.[6] Since there should be no legal difference between the Commonwealth's exercise of its police power for the purpose of treating substance use disorder and treating psychiatric problems,[7] there is no reason to depart from that assessment standard.

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[6] *Id. at* 730. The Court held that: "Given the high risk posed by COVID-19 for people who are more than sixty years of age or who suffer from a high-risk condition as defined by the CDC, the age and health of [the individual] should be factored into [the] determination." *Id*. (quoting *Comm. for Pub. Counsel Servs. v. Chief Justice of the Trial Court*, 484 Mass. 431, 449 (2020). Plaintiffs James and Mason Doe both have high risk characteristics. *See* Affidavit of Mason Doe, ¶ 4, Ex. E (66 years old with Parkinson's Disease); Affidavit of James Doe ¶ 3, Ex. G (hypertension).

[7] Though only James Doe is subject to a formal order of commitment, all the Plaintiffs are involuntarily confined as a matter of fact. Plaintiffs Susan, Mason, and John Doe are all long-term DMH patients unwilling to attempt recission of conditionally voluntary commitments because of the consequences they would face. *See* their affidavits ¶ 16, ¶ 8, and ¶ 1, respectively, Ex. D, E, and F. In *McNamara vs. Dukakis*, Civ.A. No. 90–12611–Z, 1990 WL 235439 (D. Mass. Dec. 27, 1990), the Court held that the difference between "conditionally voluntary" placement in a psychiatric hospital and involuntary commitment is not legally significant. Such patients are not "free to leave when they please: they must give three days written notice if they intend to withdraw, and they may be retained indefinitely by the institution if the superintendent files a petition for involuntary commitment during the notice period." *Id. at* 4 (internal citations omitted). Since "DMH thereby imposes limits on their freedom to act on their own behalf . . . conditionally voluntary patients have liberty interests similar to those who are involuntarily confined." *Id*. Several other federal courts have recognized that an ostensibly voluntary commitment may become *de facto* involuntary when voluntariness is conditional. *See Kennedy v. Schafer*, 71 F.3d 292, 295 (8th Cir.1995); *Torisky v. Schweiker*, 446 F.3d 438, 447 (3d Cir. 2006). *See also Monahan v. Dorchester Counseling Center Inc*., 961 F.2d 987, 992 (1st Cir. 1992), in which the Court held that DMH had no constitutional duty conferring potential liability for an injury suffered by a patient who resided for six days in a DMH group home and jumped from a van in transit. The Court's reasoning, however, supports Plaintiffs' position that their confinement is *de facto* involuntary. The *Monahan* plaintiff was in DMH custody only briefly and did not contend, as do Plaintiffs, that he was effectively barred from leaving, a fact upon which the Court specifically relied. *Id*. Further, Plaintiffs allege they believed they would be disadvantaged if they acted on the theoretical option to "sign themselves out." Several claim they were threatened with involuntary commitment. *See* John Doe Aff., ¶ 1, Ex. F and Mason Doe Aff., ¶ 8, Ex. E ("blackmailed" into agreeing to conditional voluntary expiration of involuntary term, under "duress," as he was apparently persuaded it was his quickest way out of confinement). *See also* Affidavit of James Tabner, ¶ 5, Ex. C (Mason reluctantly agreed to conditional voluntary commitment to avoid commitment petition). Susan Doe testifies that she was "discouraged" from rescinding her voluntary commitment and, based on her observations in other cases, believed she would be involuntarily committed if she tried. *See* Susan Doe Aff., ¶ 16, Ex. D. Defendants should not be permitted to take responsibility for Plaintiffs' care, confine

FACTS

A. Congregate Care Facilities Such as Tewksbury Hospital are Inherently Dangerous.

The crisis faced by Plaintiffs and class members is generated by a worldwide pandemic, the worst in more than a hundred years.[8] The COVID-19 virus has infected millions worldwide, with a disproportionate number in the U.S.,[9] and killed hundreds of thousands.[10] Massachusetts has been a hotspot for the spread of the virus.[11]

There is no worse place to reside during the COVID-19 pandemic than congregate facilities. According to Yale School of Medicine and School of Public Health epidemiologist Dr. Gregg S. Gonsalves, whose recent work focuses on the effects of COVID-19 in congregate care settings,[12] such places face "special, extraordinary challenges in containing outbreaks."[13] Even with the implementation of mitigating measures, they are "inherently dangerous."[14]

> Congregate settings share common characteristics. They are not constructed to minimize disease transmission. These facilities are enclosed environments, much like the cruise ships that were the site of some of the largest concentrated

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them for years, coerce them into relinquishing their right to leave, allow them to languish needlessly in a dangerous setting, and then hide behind what is effectively a technicality in order to avoid responsibility.

[8] The Spanish Flu of 1918-19 infected roughly a third of the world's population and killed 50,000,000, including 675,000 in the U.S. *See History of the 1918 Flu Pandemic,* CTR. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/flu/pandemic-resources/1918-commemoration/1918-pandemic-history.htm (last visited June 30, 2020).

[9] *See* Affidavit of Gregg S. Gonsalves, Ph.D., ¶ 10, Ex. J, (7 million infected worldwide; 1.9 million in the U.S.). "It is clear that, currently, the numbers of people diagnosed reflect only a portion of those likely infected." *Id*., ¶ 14.

[10] *Id*. As of June 11, 408,000 and more than 100,000 in the U.S. – "By July 4, the CDC expects 124,000 to 140,000 deaths in the United States."

[11] *Id.,* ¶ 11 (As of June 5, 2020, 7,408 deaths). *See also The Latest COVID-19 Numbers from Massachusetts,* BOS. GLOBE, https://www.bostonglobe.com/2020/03/10/nation/latest-coronavirus-numbers-massachusetts/?p1=Article_Utility (last visited June 30, 2020) (confirmed and probable deaths exceed 8,000).

[12] Gonsalves Aff., ¶¶ 1, 5 Ex. J and CV attached to his testimony.

[13] *Id*., ¶ 17.

[14] *Id*. Mitigating measures include proper sanitation, social distancing, time outdoors, and access to fresh air. *Id.*

> outbreaks of COVID-19. They have even greater risk of infectious spread than other enclosed environments because of conditions of crowding, the proportion of vulnerable populations in confined settings, and often scant medical care resources.[15]

Accordingly, the federal Substance Abuse and Mental Health Services Administration ("SAMSHA") advises that outpatient treatment options be used "to the greatest extent possible" during the COVID-19 pandemic.[16]

The wisdom of this approach is demonstrated throughout the country, where facilities detaining immigrants and persons accused of or convicted of crimes have been beset by explosive outbreaks of contagion infecting as many as 80%, and typically more than half, of institutional populations.[17] Psychiatric hospitals have also been hard hit.[18] These include several Massachusetts facilities.[19] Tewksbury Hospital, with data that is even more eye-popping than in the other troubled psychiatric facilities cited by Dr. Gonsalves, falls squarely within this pattern. Patients there are particularly vulnerable to the spread of contagion. They sleep in rooms with as many as four other patients; share toilets, sinks and showers without disinfection between uses; and eat food that is communally prepared, which runs the risk of surface infection.[20] Further,

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[15] *Id*., ¶ 18.
[16] *Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic,* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (May 7, 2020), https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf. The SJC credited SAMSHA as an authority. *Foster*, 484 Mass. at 725.
[17] Gonsalves Aff., ¶¶ 24 – 35, Ex. J. The institution with an infected population of more than 80% was the Marion Correctional Center in Ohio. *Id*., ¶ 34.
[18] *Id*., ¶¶ 38 – 41 (detailing rapid increases to substantial infection rates in hospitals in Louisiana, Connecticut, and the District of Columbia).
[19] *See* dashboard Ex. B. Besides Tewksbury, a dramatic outbreak also occurred in Lemuel Shattuck Hospital, where, as of June 9, 2020, 100 out of 199 patients contracted the COVID-19 virus. *Id*.
[20] *Id*. *See also* John Doe Aff., ¶¶ 3-4, Ex. F; Susan Doe Aff., ¶¶ 10, 14, Ex. D.

"[s]paces in older buildings such as Tewksbury are poorly ventilated, which promotes highly efficient spread of diseases through droplets."[21]

The danger of contracting the virus is amplified for vulnerable populations.[22] According to SAMSHA, individuals with serious mental illness, particularly those who are older or who have chronic medical conditions, are at higher risk for illness with COVID-19.[23] Plaintiffs Mason Doe and James Doe both have chronic medical conditions that put them at high risk of serious illness from the virus should they contract the disease again.[24]

The best way to reduce infection and death in a congregate facility is to discharge people. "Without reducing the facility population, it will be almost impossible to stop an epidemic."[25] Defendants have failed to do so.

B. Defendants Have Not Accelerated Discharges Nor Factored the Pandemic in Discharge Analyses.

Defendants have authority to discharge patients, even if involuntarily committed, at any time without court authorization.[26] Defendants apparently recognize the need to perform a systematic assessment of the discharge readiness of persons it confines in psychiatric hospitals.[27] DMH has not, however, discharged patients from Tewksbury and other facilities it operates in

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[21] Gonsalves Aff., ¶17, Ex. J.
[22] *Id*., ¶ 18.
[23] *Covid19: Interim Considerations for State Psychiatric Hospitals*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (May 8, 2020), https://www.samhsa.gov/sites/default/files/covid19-interim-considerations-for-state-psychiatric-hospitals.pdf.
[24] Gonsalves Aff., ¶ 52, Ex. J.
[25] *Id*., ¶ 17.
[26] G.L. c. 123 § 4. DMH is obliged, however, under G.L. c. 123 § 16 (e), to provide notice to the applicable District Attorney of its intent to discharge a person committed under that section.
[27] *See* Letter of May 8, 2020 from Defendant DMH counsel Lester Blumberg to Attorneys Tatum Pritchard and Phillip Kassel Ex. L ("Blumberg letter") ("DMH has initiated a concentrated review of each patient in our facilities to determine the potential for safe and appropriate discharge.") *See also* Affidavit of Sera Davidow ¶ 4, Ex. M (DMH claimed that systematic discharge review is "ongoing").

order to address COVID safety concerns. In fact, it has not altered its standard discharge practices predating the pandemic one iota. Discharges have even slowed relative to the pre-pandemic rate.

Subsequently, in a response to a public records request dated May 8, 2020, DMH stated that 18 patients were discharged to the community after March 1, 2020 from the Lemuel Shattuck Hospital.[28] "All of these discharges were planned . . . none were related to the COVID pandemic."[29] At a public meeting by video conference on May 12, 2020, DMH Deputy Commissioner Brooke Doyle was asked if any patients in psychiatric hospitals were discharged in response to the pandemic; she responded "none."[30] She said the same thing at two subsequent public meetings on June 4, 2020 and June 23, 2020. In fact, Doyle said that DMH had not only failed to accelerate discharges, the rate had actually slowed compared to last year, which Doyle attributed to the need to provide treatment.[31] When asked why the rate of discharges had decreased while releases from prisons and jails had accelerated in response to the pandemic, Doyle said that psychiatric facilities were different because of on-site medical resources.[32] She did not explain why the asserted difference between DMH congregate facilities and congregate places of incarceration lessened the need to protect Plaintiff class members from needing medical treatment in the first place.[33]

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[28] *See* Table 1 (DLC/MHLAC Data/Info request), # 4 (Discharge), Ex. L. *Contrast* Blumberg letter (110 discharges since March 10, 2020 "throughout our system," which perhaps refers to facilities, including community residences).
[29] *Id*.
[30] Davidow Aff.,¶ 4, Ex. M.
[31] *See* Affidavit of Elizabeth Clerke, ¶¶ 6, 10, Ex. N. Doyle said that "adequate treatment" was needed "in advance of discharge to help individuals achieve a 'recovery stage.'" *Id*., ¶ 6. *See* Facts, § C regarding the lack of treatment and § D on its lack of efficacy.
[32] *Id*., ¶ 14.
[33] In any case, persons are transferred to a hospital when they become very sick. *See* Susan Doe Aff., ¶ ¶ 4-6, Ex. D.

In failing to discharge patients, DMH is conducting business as usual.[34] Dr. Mark Rudolph, a forensic psychiatrist, has performed approximately 2,000 admission and discharge assessments at facilities throughout Massachusetts for DMH.[35] He testifies that DMH's discharge processes are marked by "excessive risk adverseness."[36] Dr. Daniel Fisher works with clients in various clinical settings operated by DMH and also consults with and trains DMH staff.[37] He agrees that "DMH's overly cautious, unattainable, and unrealistic discharge goals" are responsible, in part, for discharge delays.[38]

Unduly conservative discharge analysis has serious consequences for patients. Dr. Rudolph testifies that "DMH patients who are ready to live in the community are often faced with an excessive number of hurdles before they can be approved for discharge."[39] According to Dr. Rudolph, "[s]taff has great discretion to assess violations and cause [patients] to retreat to a prior privilege level, even when the violation is petty or … merely technical in nature and has little to do with discharge readiness."[40] According to Dr. Fisher, tendencies identified by Dr. Rudolph cause "discharge ready" patients to "remain in overly restrictive inpatient hospital

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[34] DMH has come under criticism for its discharge practice from the Office of the State Auditor ("OSA") prior to the pandemic. The OSA issued a report on August 1, 2019 concluding that the DMH failed to establish "monitoring controls to ensure that anticipated discharge dates were properly recorded or that discharge was as timely as possible." *Official Audit Report,* MASS.GOV (Aug. 1, 2019), https://www.mass.gov/doc/audit-of-the-department-of-mental-health/download.
[35] *See* Affidavit of Mark Rudolph, M.D., ¶¶ 2, 4, Ex. A.
[36] *Id*., ¶ 6.
[37] Fisher Aff., ¶¶ 4, 6, Ex. H.
[38] *Id*., ¶ 9.
[39] *Id*.
[40] *Id*. "In other words, many hoops tend to equal many delays." *Id*. Further, treatment plans typically require patients to demonstrate "insight" before receiving approval for discharge, "whether or not a lack of insight is connected to any particular concern about whether the reasons for the initial commitment have been adequately addressed or whether there is any genuine nexus between the subjectively determined insight and any alleged 'danger to self or others.'" *Id*.

settings for many months for inadequate reasons that have little to do with the reason for their commitment."[41]

It is clear that nothing has changed due to the pandemic. Dr. Rudolph states that he has done 48 assessments since the pandemic struck.[42] He "received no DMH directive to consider the risks of COVID exposure if the patients were to remain hospitalized."[43] He believes no such directive has been issued to DMH staff either – if it was, it would be followed.[44]

C. There Has Been Little to No Treatment Afforded to Hathorne Unit Patients During the Pandemic.

Defendants' failure to discharge Plaintiffs and class members cannot be justified by a need to offer patients mental health treatment during the COVID crisis. Plaintiffs and class members' access to treatment has been severely curtailed during the pandemic, creating unnecessary psychological harm.

Before the pandemic, Plaintiffs saw their assigned doctors regularly.[45] Some report developing good rapport.[46] Additionally, their loss of freedom was rendered more tolerable in a variety of ways. Susan Doe testifies that:

> Before COVID-19, there were a lot of activities. You could go into other buildings and units. There were more privileges like earning money through jobs, cooking groups, CBT (cognitive behavioral therapy), peer-specialist groups, art

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[41] Fisher Aff., ¶ 10, Ex. H.
[42] Rudolph Aff., ¶ 11, Ex. A. This includes 8 discharge assessments of patients DMH-operated facilities and 40 other facilities.
[43] *Id.* Dr. Rudolph believes he would know about it if any instruction had issued.
[44] *Id*., ¶ 12. Dr. Rudolph states that the only new policy relevant to discharge and COVID-19 "makes the discharge of a patient more difficult." *Id*., ¶ 14. DMH inserted a new condition for discharge into a form questionnaire that questions the patient's ability to social distance and observe COVID-19 precautions. "Observed failures to wear masks, for example, would provide a reason" to refuse discharge. *Id*. *See also* Clerke Aff., ¶¶ 15-16., Ex. N.
[45] Susan Doe Aff., ¶ 13, Ex. D; John Doe Aff., ¶ 9, Ex. F (saw doctor and social worker five times weekly).
[46] Susan Doe Aff., ¶ 13, Ex. D.

> therapy, bingo, music groups, and arts and crafts group. I had more freedom and I could go outside.[47]

The need to dampen the spread of contagion changed life at Tewksbury dramatically. Since the onset of the pandemic, Plaintiffs report that they spend most of their time in their rooms.[48] Individual therapy virtually ceased, with no more than check-in calls with assigned therapists.[49] There was no group therapy or activities,[50] no visits from friends and families,[51] and no access to the outdoors.[52]

This has taken a substantial toll on Plaintiffs. Mason Doe is reaching his limit:

> I feel like most days are about survival. Being locked inside has been the worst thing for my welfare. I feel constant dark existential dread. I can't take it any longer.[53]

D. Efficacy of Inpatient Treatment Pre- and Post-Pandemic.

Three experts from wholly different backgrounds giving testimony in this matter concur that psychiatric inpatient treatment should be limited even in non-pandemic times as it often does more harm than good. But particularly under pandemic conditions, confinement of patients who

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[47] Susan Doe Aff., ¶ 14, Ex. D; James Doe Aff., ¶ 11, Ex. G (he's "an outgoing guy" and enjoyed and benefitted from participation in "on track thinking" and peer education groups).
[48] Susan Doe Aff., ¶ 12, Ex. D; James Doe Aff., ¶ 13, Ex. G; John Doe Aff., ¶ 12, Ex. F; Mason Doe Aff., ¶ 5, Ex. E ("I have nothing to do and these conditions are harsh").
[49] Susan Doe Aff., ¶ 13, Ex. D (used to have good half hour conversations, but now just quick check-ins to make sure not suicidal, and not with usual doctor); James Doe Aff., ¶ 12, Ex. G (short check-ins with medication prescriber); Mason Doe Aff., ¶ 4, Ex. E (no therapy).
[50] Susan Doe Aff., ¶ 12, Ex. D (no therapy groups; no activities; but did go to 20-minute arts and crafts class recently); Mason Doe Aff., ¶ 5, Ex. E (no activities now).
[51] Susan Doe Aff., ¶ 15, Ex. D (had visits regularly; none for 3 months; now limited); John Doe Aff., ¶ 10, Ex. F (had lengthy visits before; none for months; now limited).
[52] Susan Doe Aff., ¶ 12, Ex. D (no fresh air until recently); James Doe Aff., ¶ 13, Ex. G; Mason Doe Aff., ¶ 6, Ex. E.
[53] Mason Doe Aff., ¶ 6, Ex. E. *See also* Susan Doe Aff., ¶ 12, Ex. D; James Doe Aff., ¶¶ 13 – 16, Ex. G (being in Tewksbury depressing; sad about woman he liked who died; fears death; fears having to go through experience again in a new virus surge); John Doe Aff., ¶ 12, Ex. F ("[e]very day is basically about survival").

do not pose an imminent threat to their own safety or that of others both risks lives and is destructive of patients' mental health.

When considering the efficacy of inpatient treatment during a pandemic, it makes sense to start by defining a baseline – the benefit of inpatient psychiatry under more normal circumstances. Dr. Morgan Shields, a health services and policy researcher, with a particular focus on studying the quality and accountability of inpatient psychiatry, recommends this approach to the analysis.[54]

There is extensive research on the efficacy of inpatient treatment relative to less restrictive models.[55] "[T]he extant literature favors intensive community-based care over inpatient psychiatry, such as partial hospitalization, for individuals who qualify for inpatient admission, including individuals with severe suicidal ideation."[56] For example, a meta-analysis of 40 years of research reviewed 18 studies, including 10 randomized control trials,[57] concluding that "[t]he weight of the evidence suggested no difference between partial and full hospitalization on clinical outcomes, but greater patient and family satisfaction with partial hospitalization compared to inpatient treatment."[58] Other research, not included in the meta-analysis, found that outpatient treatment "is no different than inpatient treatment on a range of

[54] Affidavit of Morgan C. Shields, Ph.D., Ex. K. Dr. Shields has researched and written extensively on topics relevant to the subject of this litigation. *See* her C.V., attached to her Affidavit. "Whether to accept the additional risks of COVID-19 in order to confine people who are deemed to need treatment must be weighed in light of our knowledge and confidence in the benefits and known risks of inpatient psychiatry even absent a pandemic, before moving to an analysis of what, if any, benefits are retained in a facility where efforts are in place to contain the spread of contagion (e.g., ceasing group therapy, banning visitation.) *Id.,* ¶ 5.
[55] Shields Aff., ¶ 16, Ex. K.
[56] Shields Aff., ¶¶ 17-20, Ex. K for a detailed review of existing research.
[57] The "gold standard" of research design. Shields Aff., ¶ 13, Ex. K.
[58] *Id*., ¶ 18.

clinical outcomes," but confers "superior benefits in improved social functioning."[59] Dr. Shields concludes that there is "no evidence" that inpatient psychiatry is effective.[60] "Hospitalization should be viewed as a *last resort* tool to contain imminent risk of harm to the self (e.g., suicide) or others (e.g., homicide)."[61]

Dr. Andrew Phillips is an experienced administrator of mental health facilities and agencies. He worked for DMH for 20 years as the Western Massachusetts Area Director, during which time he was the CEO and manager of Northampton State Hospital and managed an integrated community-based mental health system.[62] He also ran three state hospitals in Connecticut and one in Washington state.[63] He testifies that "[c]onfinement in an institution beyond the time needed to reduce a person's risk of imminent harm to themselves or others results in repetitive and unnecessary treatment."[64] Patients who have reached their clinical baseline should be discharged as "[h]ospitalization is no longer productive."[65] According to Dr. Fisher, patient stabilization will typically occur in 30 days or less and anything beyond that can be detrimental to recovery.[66] Dr. Phillips testifies that a "conservative estimate" of the percentage of patients who are confined unnecessarily in psychiatric facilities is 50% of the total.[67]

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[59] *Id. See also* Fisher Aff., ¶ 15, Ex. H (85% of patients who experienced first psychiatric episodes treated in small community residential program in Finland experienced a full recovery within 2 years, with a rate of recurrence lower than hospital settings).
[60] *Id*., ¶ 49. Studies looking specifically the efficacy of treatment provided by virtue of involuntary commitment come to the same conclusion: "Again, the evidence does not demonstrate that involuntary hospitalization benefits patients." *Id*., ¶ 22.
[61] Shields Aff., ¶ 52, Ex. K.
[62] Phillips Aff., ¶ 6, Ex. I.
[63] Phillips Aff., ¶¶ 6-7, Ex. I.
[64] *Id*., ¶ 13.
[65] *Id*., ¶ 16.
[66] Fisher Aff., ¶ 8, Ex. H.
[67] Phillips Aff., ¶ 31, Ex. I.

Patients who are confined for unnecessary periods suffer more than wasted time – they risk serious and debilitating harm. According to Dr. Shields, who studied complaint data at the behest of DMH,[68] the risk of experiences adversely affecting patients' safety, as well as the potential for psychiatric scarring due to the use of restraints and seclusion, are "inherent in inpatient psychiatric settings."[69] The key characteristics of inpatient psychiatry leave patients uniquely vulnerable, and "[h]ospitals tend to be sheltered from scrutiny."[70] "Numerous qualitative studies have described psychological harms experienced by patients confined in psychiatric facilities, especially among those with prior experiences of abuse."[71] Negative inpatient experiences can "develop into symptoms of post-traumatic stress."[72]

According to former hospital administrator Dr. Phillips, "[c]onfinement in an institution severely diminishes a person's ability to engage in the everyday activities of normal life."[73] Dr. Fisher testifies that people who languish in inpatient settings are left "feeling hopeless and subject to what they fear might be irrational whims from their treatment team, as they do not

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[68] Shields Aff., ¶¶ 3, 34, Ex. K.
[69] *Id*., ¶ 32 (2018 study showed high rate of such experiences, which increased monotonically as patient stays increased in length); *Id*. ¶ 35 ("The impact of restraint and seclusion has been extensively studied. Research reveals the physical and psychological harm it can cause, including death"); *Id*., ¶ 25.
[70] *Id.*, ¶ 26. "Key characteristics" include the impact of "structural barriers, such as poverty, insurance, or geography" that limit patients' ability to seek out community-based care on their own; *id.*, ¶ 27; powerlessness in the face of inappropriate behavior by hospital staff and inability to self-advocate "due to their condition, the discounting of their perceptions, or fear of retaliation"; *id*., ¶ 27-28; the inability of friends and families of inpatient psychiatric patients to scrutinize treatment because they "visit in designated areas apart from the patients' own living space during limited allotted time slots" and thus have limited "ability to help assure accountability in the provision of care as they only have the information the patient tells them" relative to other hospital settings where visitors can literally "be at the bedside," which enables them to "observe the treatment environment and apply pressure to maintain or improve quality of care and conditions." *Id.*, ¶ 29.
[71] *Id*., ¶ 37.
[72] *Id.*
[73] Phillips Aff., ¶ 13, Ex. I.

know what they need to do in order to be discharged."[74] They "experience a sense of learned helplessness" and will "often accept what they've learned is their lot and give up."[75]

Dr. Fisher has seen this first-hand as a treating psychiatrist and experienced this phenomenon as a patient.[76] After five months as an inpatient he "left depressed and without a will to live."[77] His "dreams had evaporated."[78] Further, since, as Dr. Phillips puts it, "[c]ontinued hospitalization limits family and social contacts,"[79] Dr. Fisher had "to re-establish ties in the "outside world, with family, my job, and friends," which made his "recovery so much more difficult."[80]

Risks are certainly exacerbated in a pandemic situation, as Plaintiffs' testimony attests.[81] But there is nothing on the other side of the calculus; nothing that compensates for the risk. As Dr. Phillips testifies, "COVID-19 puts a finger on the side of the scale that urges discharge."[82] Treatment is beyond ineffective: it is "impossible."[83]

> Efforts at social distancing eviscerate the value of treatment. The very notion is antithetical to the typical means of offering patient's treatment in psychiatric hospitals . . .. Psychiatric units are designed to facilitate staff and patient interaction. Patients are encouraged with a variety of incentives to attend group treatment, eat, socialize and watch television together in an open area, attend community meetings, and exercise as a group. Avoiding the isolation that is compelled by the virus is so ingrained in treatment protocols that licensing

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[74] Fisher Aff., ¶ 11, Ex. H.
[75] *Id*., ¶ 12.
[76] *Id.*
[77] *Id*., ¶ 13.
[78] *Id*.
[79] Phillips Aff., ¶ 13, Ex. I.
[80] Fisher Aff., ¶ 14, Ex. H.
[81] *See* discussion Facts, part C. *See also* Shields Aff., ¶ 45, Ex. K ("The experience of being confined to an institution in which fellow patients are getting sick and dying can be traumatizing. Trauma is likely heightened for patients who get sick themselves").
[82] Phillips Aff., ¶ 31, Ex. I.
[83] *Id*., ¶ 24. *See also* Fisher Aff., ¶ 16, Ex. H ("It is impossible to treat under such conditions").

> standards typically prohibit staff from requiring patients to stay in their room unless they are an imminent danger to themselves or others.[84]

Dr. Fisher agrees:

> Persistent room confinement and a dearth of activity is enough to make the healthiest person depressed. Most psychiatric concerns will heighten vulnerability to such conditions. Social contact is vital to recovery and cannot be done in isolation. Limiting human interaction is highly anti-therapeutic. It is not only detrimental to the recovery process, it is damaging. It sets patients back. [85]

Dr. Fisher further testifies that, "[e]xcept when a patient is in truly imminent danger, the negative impact of living under such circumstances cannot outweigh any marginal positives." Pandemic "conditions simply do not permit effective treatment."[86]

E. Preparing for the COVID-19 Second Wave.

Despite recent progress in getting the pandemic under control in Massachusetts, it is not over. Dr. Gonsalves testifies that while "some may think the state is out of the woods and has seen the worst of the pandemic,"[87] for a number of reasons a second wave is likely. He points to the fact that the pandemic is on the rise in 17 states, which "means that *as a nation we have an uncontrolled COVID-19 epidemic*."[88] (Emphasis in original). Emerging epicenters in states like Florida and Arizona can easily "re-seed outbreaks across the US," including in Massachusetts.[89] Seeding can also come from visiting tourists and returning students who, according to experts in

[84] Phillips Aff., ¶¶ 26-27, Ex. I.
[85] Fisher Aff., ¶ 18, Ex. H. *See also* Rudolph Aff., ¶ 17, Ex. A (confinement under COVID conditions "is bound to result in regression.").
[86] Fisher Aff., ¶ 18, Ex. H.
[87] Gonsalves Aff., ¶ 48, Ex. J.
[88] *Id.*, ¶ 46.
[89] *Id*.

adolescent psychology, are not the demographic most likely to be meticulous in their observance of COVID-19 precautions.[90]

Even without these contagion-spreading influences, many epidemiologists are predicting a resurgence in the fall anyway due to "the relaxation of social distancing and other disease mitigation efforts."[91] This is occurring now in California, which, like Massachusetts, responded aggressively and with apparent success to control the virus.[92] New outbreaks have occurred already in China, Singapore, and South Korea; countries which, unlike the U.S., successfully brought the first virus wave under control.[93] Finally, some experts believe that a second COVID wave will collide with the annual seasonal flu in the fall and threaten to "swamp hospitals with serious cases of both diseases."[94]

Unfortunately, the most recent data suggests that persons who contracted the virus in the first wave will not necessarily be spared another bout of illness because "antibody responses are low and transient in many people."[95] A leading viral immunologist believes that immunity is "suboptimal and short-lived," thus, that "people who have contracted SARS-COV-2 and recovered, may only have temporary protection that lasts a few months, with susceptibility to a new infection returning afterwards."[96]

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[90] *Id*., ¶ 49.
[91] *Id*., ¶ 50.
[92] *See* Dasia Moore, *As Cases Spike in California, a Warning for Massachusetts,* BOS. GLOBE (July 4, 2:28 PM), https://www.bostonglobe.com/2020/07/04/nation/cases-spike-california-warning-massachusetts/; *See also* Adam Beam, *Coronavirus Spike Prompts Big California About Face on Reopenings*, BOS. GLOBE (July 1, 2020, 4:39 PM), https://www.bostonglobe.com /2020/07/01/nation/coronavirus-spike-prompts-big-california-about-face-reopenings/.
[93] Gonsalves Aff.,¶ 50, Ex. J.
[94] *Id*., ¶ 51.
[95] *Id*., ¶ 52.
[96] Dr. Akiyo Iwasaki, as cited in Gonsalves Aff., ¶ 52, Ex. J.

In light of these realities, Dr. Gonsalves believes that the "only viable public health strategy available" continues to be "risk mitigation."[97] He recommends that "congregate care mental health facilities should immediately take the steps necessary to provide for the release of any persons who can safely be released," which is necessary not only for "the safety of all inpatient individuals" but also the "broader community."[98]

Defendants should not be caught unawares by a second COVID-19 virus wave. However, unless institutional populations are decreased, DMH will have no option but to try again to separate COVID-positive from COVID-negative patients ("cohorting").[99] The CDC advises that this practice is an option of last resort.[100] It is unlikely Defendants are capable of complying with CDC guidelines setting out how cohorting should be done properly, particularly in an older facility like Tewksbury.[101]

Defendants' ability to reduce populations in their inpatient facilities in response to the pandemic is hampered by their failure to allocate resources for community placements and services prior to the onset of the outbreak of COVID-19.[102] Nonetheless, much can be done to

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[97] *Id*., ¶ 47.
[98] *Id*.
[99] Susan Doe Aff., ¶¶ 3-4, Ex. D; John Doe Aff., ¶¶ 3, 5, Ex. F; James Doe Aff., ¶ 10, Ex. G.
[100] Gonsalves Aff., ¶ 21, Ex. J.
[101] *Id*., ¶ 22. CDC guidelines are "quite specific about the conditions required for cohorting," requiring patients "be placed in large, well-ventilated rooms," and separation of persons "who are higher risk of severe illness" from "other infected individuals," which requires allocating "more space for a higher-risk individual within a shared medical isolation space." *Id*.
[102] Rudolph Aff., ¶ 8, Ex. A (DMH is and has been aware of a dearth of community placement beds for years); Fisher Aff., ¶ 20, Ex. H (same; further, DMH does not dispute effectiveness of "alternative discharge placement options," but, "refuses to adequately fund them," despite cost efficiency).

move people into available community placements and create new resources. This is more than feasible because community placements are far less costly than congregate care facilities.[103]

Due to his aforementioned extensive experience closing hospitals,[104] Dr. Phillips is an expert in shifting patients from inpatient psychiatric facilities to community settings. He also served as a court-appointed monitor in Georgia and Washington.[105] In Georgia, he supervised the transition of patients in three psychiatric hospitals to community placements.[106] In Washington, he moved 120 patients from a congregate facility into the community.[107] His experience gives him "keen insight into the difficulties encountered in accomplishing such transitions and how they may be surpassed."[108] He knows what needs to be done.

"The first step," according to Dr. Phillips, "is to conduct a general review of all patients who reside in DMH-operated hospitals."[109] A statewide review is "necessary because patients who are deemed to still need hospital care and now reside in what have been COVID hotspots could be moved to a more modern place like WRCH,[110] where patients have their own rooms."[111] In addition to creating a safer environment, "the more that the inpatient populations are spread out the more it will be possible to actually provide treatment while observing COVID precautions."[112] The number of persons in the DMH inpatient population that may be safely

[103] Phillips Aff., ¶ 19, Ex. I (analyzing costs of running Hathorne Units relative to community placements – closing one unit will fund transitions).
[104] *Id.* Phillips Aff., ¶ 9, Ex. I.
[105] *Id*., ¶ 10.
[106] *Id*., ¶ 11.
[107] *Id*., ¶ 12. Dr. Phillips also closed two geriatric wards and placed 60 patients in skilled nursing facilities. *Id*.
[108] *Id*., ¶ 8.
[109] *Id*., ¶ 30.
[110] Worcester Recovery Center and Hospital.
[111] Phillips Aff., ¶ 30, Ex. I.
[112] *Id*.

placed in the community, "should be at least enough to allow all patients who remain in hospitals to sleep one to a room."[113]

Dr. Phillips recommends that discharges should be determined under a new standard in light of COVID-19. There should be a "presumption in favor of discharge," rebuttable only for "patients at imminent risk of serious harm if discharged to the community."[114] Unavailable services in the community should not prevent discharges, as this "can be remedied with careful discharge planning and the funding of required services."[115]

Once the statewide assessment process identifies individuals for community transfer, "proposals for services can be developed and issued to providers for their review."[116] "If the services required are carefully identified for each individual and sufficiently funded, providers will respond."[117] Requests for proposals should focus on "small one to two person living arrangements," which are "preferable to hospitals and large congregate settings such as nursing homes" and are "easy to develop."[118]

While doing what is necessary to clear congregate facilities will take "an intensive effort, the process of evaluation and development of resources can happen quickly over the course of the summer."[119] While "[f]inding permanent housing is the biggest challenge," if "permanent arrangements cannot be made before the fall for some patients who may be safely discharged,

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[113] *Id.,* ¶ 31.
[114] *Id.,* ¶ 30.
[115] *Id.,* ¶ 32.
[116] *Id*., ¶ 33.
[117] *Id*.
[118] *Id.,* ¶ 34. DMH currently funds such "community-based residential sites," which are "primarily homes and apartments overseen by DMH and run by various contracting state agencies." On June 18, 2020, there were "3,295 people living in these settings;" all "homes or apartments with 24-hour staffing or as needed 24-hour staff support."
[119] *Id*., ¶ 35.

motels, hotels, and college dormitories can be set up as temporary placements."[120] Washington State employed such places on a "short-term basis to shelter people who need to be quarantined due to being at risk for testing positive for the virus."[121] Discharged persons in temporary settings should receive services from "community providers" that "can engage them in the full range of treatment options specified in their treatment plans."[122]

Dr. Phillips believes that the plan he lays out can and must be implemented:

> The coronavirus pandemic presents serious but not insuperable obstacles to overcome for DMH administrators who see their mission as maintaining safe conditions and providing treatment to people whose liberty is taken away from them for that purpose and no other. Surpassing these obstacles is a moral and clinical imperative. I recommend that DMH staff begin in earnest an effort to assess every person it now maintains in inpatient facilities to determine those who may be safely placed in communities. This evaluation must be imbued with the realities of the present situation in the Commonwealth of Massachusetts, the nation, and the world: disease and death are much more likely to result from congregate confinement than effective treatment.[123]

"Alternatives," according to Dr. Phillips, that are "preferable" in normal time are "mandatory now," and the "DMH needs to begin utilizing these alternatives before a new wave of contagion costs more lives."[124]

ARGUMENT

Defendants have a duty under state and federal due process clauses to provide safe conditions of confinement in the least restrictive environment possible. Both the SJC and the

[120] *Id*.
[121] *Id.*, ¶ 36.
[122] *Id.,* ¶ 37.
[123] *Id*., ¶ 38.
[124] *Id*.

legislature have affirmed this duty.[125] Defendants have failed to discharge their duty here, which continues to put Plaintiffs and fellow class members at substantial risk of suffering serious physical and emotional harm, including potential death.

It is beyond dispute that residence in congregate care facilities is dangerous during a highly contagious pandemic. DMH administrators have stated publicly that the agency has not altered its typical discharge analysis to account for COVID-19. This case, therefore, presents a clear question of law: in rendering discharge determinations, are Defendants obliged under the present circumstances to change their discharge process for their congregate facilities in a way that factors the pandemic and will reduce facility populations?

DMH clearly has the discretion to discharge patients at any time without Court authorization.[126] Plaintiffs claim that Defendants must utilize this power to protect them from harm and must avoid keeping them in a dangerous and unduly restrictive environment at a time when they cannot receive treatment, which is the reason they are confined.

I. Preliminary Injunction Standard

This Court may grant a preliminary injunction after evaluating the following: the moving party's claim of injury, the chance of success on the merits, and whether failure to issue the

[125] *See* G.L. c. 123, § 4 (". . . any patient who is no longer in need of care as an inpatient shall be discharged or placed on interim community leave"); *Commonwealth v. Nassar*, 380 Mass. 908, 918 (1980) (in fulfilling duty to protect persons confined for mental health treatment "from physical harm" and to accomplish "rehabilitation of the person we think it natural and right that all concerned in the law and its administration should strive to find the least burdensome or oppressive controls over the individual . . . "). *See also Gallup v. Alden*, No. 320A, 57 Mass. Ex. Dec. 41, *58-59 (Mass. Dist. Ct. App. Div. Aug. 20, 1975) (G.L. c. 123, § 4 requires consideration of "all possible alternatives to continued hospitalization or residential care").

[126] *See* G.L. c. 123, § 4. *See also* G.L. c. 123, § 10 (discretion to discontinue voluntary patients and outpatient care). There is one exception: before discharging patients committed under G.L. c. 123, § 16, DMH must give notice to local District Attorneys under subsection (e).

injunction would subject the movant to "substantial risk of irreparable harm."[127] Even if both questions are answered in the affirmative, the court must also consider any injury to the non-moving party if the injunction is granted, and whether in light of the parties' likelihood of success, the balance of relative harms weigh in favor of granting or denying injunctive relief.[128] Finally, since the instant case involves the government, the Court must also consider whether the public interest mitigates in favor of granting or denying the preliminary injunction.[129]

II. Plaintiffs Are Likely to Succeed on the Merits Because Their Continued Confinement Will Violate Their Substantive Due Process Rights.

Plaintiffs and putative class members continue to be confined in dangerous institutional settings, rather than in safer community placements. They remain in danger of re-contracting COVID-19 and suffering further physical and psychological harm.[130] Further, Plaintiffs and class members who remain confined in congregate care facilities during the pandemic are essentially barred by circumstances from receiving effective treatment, which is "impossible."[131] Both the failure to protect and confinement without treatment violates substantive due process.

Freedom from personal restraint is a "paradigmatic fundamental right,"[132] and the deprivation of this right confers upon the State a "responsibility" to protect persons' "safety and general well-being."[133] Further, under federal law, "[a]t the least, due process requires that the

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[127] *Packaging Industries Group, Inc. v. Cheney*, 380 Mass. 609, 617 (Mass. 1980).
[128] *Id*.
[129] *John T. Callahan & Sons, Inc. v. City of Malden*, 430 Mass. 124, 131 (1999).
[130] *See* Facts, § E. *See also* Gonsalves Aff., ¶¶ 46-52, Ex. J.
[131] *See* Facts, § D. *See also* Fisher Aff., ¶ 16, Ex. H.
[132] *Foster,* 484 Mass. at 728. *See also Pembroke Hosp. v. D.L.,* 482 Mass. 346, 347 (2019), *citing Matter of E.C.*, 479 Mass. 113, 119 (2018).
[133] *Foster*, 484 Mass. at 724, quoting *DeShaney v. Winnebago Cty. Dep't of Soc. Servs.*, 489 U.S. 189, 199-200 (1989). *See also Youngberg v. Romeo*, 457 U.S. 307, 324 (1982) (severely developmentally disabled man entitled to "reasonable care and safety," and "reasonably nonrestrictive confinement conditions").

nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."[134] Under the Massachusetts Declaration of Rights, a more stringent test applies, requiring that deprivations of liberty be "narrowly tailored to further a legitimate and compelling governmental interest" and also be the "least restrictive means available to vindicate that interest."[135] Thus, if "commitment and treatment" does not "effectively promote the government's interest in the individual's health and safety," it "cannot survive strict scrutiny."[136]

1. Plaintiffs have not been and will not be protected from harm unless this Court intervenes.

Defendants have allowed Plaintiffs to live under dangerous and misery-generating conditions. All the named Plaintiffs, and more than half the Tewksbury Hospital population, were sickened. Seventeen died. Plaintiffs have seen roommates and friends die.[137] They have been confined to rooms with little or no therapy, recreation, or outdoor access.[138]

Defendants have failed to discharge patients in response to the COVID-19 pandemic.[139] "Without reducing the facility population," disease spread is "almost impossible to stop."[140] Though many of the Plaintiff class could be safely discharged,[141] there has been literally no

[134] *Foster*, 484 Mass. at 727, citing *Jackson v. Indiana*, 406 U.S. 715, 738-739 (1972).
[135] *Foster,* 484 Mass. at 726*,* quoting *Commonwealth v. Weston W*., 455 Mass. 24, 35 (2009).
[136] *Foster*, 484 Mass. at 729, citing *Grutter v. Bollinger*, 539 U.S. 306, 333 (2003).
[137] *See* Susan Doe Aff., ¶ 6, Ex. D; James Doe Aff., ¶ 14, Ex. G.
[138] *See* Plaintiffs affidavits Ex. D, E, F, and G.
[139] *See* Facts, ¶ A; *see also* Gonsalves Aff., ¶¶ 4, 17, Ex. J (facilities not built to allow for safety during a pandemic, particularly older facilities like Tewksbury, where patients share bedrooms, facilities, and common meals), and ¶ 39-41 (citing long list of congregate facilities with startling outbreaks of COVID-19).
[140] Gonsalves Aff., ¶ 17, Ex. J.
[141] At least 30 patients, including Plaintiff Susan Doe, were designated for discharge (a status difficult to achieve, according to Plaintiffs experts) and not discharged despite the pandemic, and despite the availability of community placements. *See* Susan Doe Aff., ¶ 1, Ex. D; Clerke Aff., ¶ 9, Ex. N; Davidow Aff., ¶ 4, Ex. M.

effort, even for patients at relatively high risk for life threatening illness,[142] to alter usual, highly risk-adverse practices that keep people unnecessarily confined under even normal circumstances.[143] In fact, current discharge practices continue without change because Defendants have refused to factor the pandemic when considering discharge.[144]

The failure to alter discharge standards due to the pandemic has not only adversely affected those who could be safely moved to community placements, but also those who need to receive inpatient care. Crowded conditions render psychiatric treatment untenable. "If the Hospital population was substantially reduced and only those who had a critical, life-saving, need for inpatient treatment remained, not only would those relatively few patients be protected from the virus, hospital staff would be better able to provide the treatment these people need."[145]

B. Plaintiffs have not received treatment during the pandemic.

The evidence shows that providing treatment in a psychiatric hospital during a pandemic is not viable and thus does not happen. Experts submitting testimony in this case agree that efforts to mitigate the spread of disease in a congregate care facility render the provision of treatment infeasible.[146] Institutional expert Dr. Phillips described "social distancing" as

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[142] *See* James and Mason Doe Affs., ¶¶ 1, 3, and 15, and ¶¶ 1, 4, respectively, Ex. G and E. They are older (53 and 66) and have chronic diseases. *See also* Gonsalves Aff., ¶ 8, Ex. J (patients particular risk due to age, chronic diseases, etc.) and ¶ 46 ("Releasing older patients, [and] those with underlying medical conditions" is "critical").
[143] *See* Facts § B. Drs. Rudolph and Fisher both, in part, make a living by contracting with DMH. *See* their Affidavits at ¶¶ 4, 11 and at ¶¶ 4, 6, and 19, respectively, Ex. A and H. They nonetheless were unsparing in their criticism of DMH discharge practices. *Id*. ¶¶ 6-8 and ¶ 9, respectively. Dr. Phillips, who ran hospitals for DMH and other such agencies, estimates "conservatively" that confinement is unnecessary and counterproductive for half of all persons confined in State facilities. Phillips Aff., ¶ 25, Ex. I.
[144] *See* Facts, § B.
[145] Gonsalves Aff., ¶ 55, Ex. J.
[146] *See* Facts, § A.

"antithetical" to treatment.[147] In fact, the conditions Plaintiffs have had to endure are "enough to make the healthiest person depressed,"[148] and are "bound to result in regression."[149]

Expert opinion is borne out by the Plaintiffs' experience.[150] Treatment has mostly been limited to quick check-ins from assigned therapists who normally spend substantially more time in individual psychotherapy with patients at Tewksbury.[151] Group therapy played an important role in the pre-pandemic treatment regimen, but these sessions have not happened since March.[152] Recreational groups have also ceased.[153] Plaintiffs have spent their days in their bedrooms trying to keep themselves occupied with limited stimulation or human contact.[154] It is a small wonder that several believe life has become entirely about "survival."[155] Mason Doe feels "existential dread."[156]

In *Foster*, the SJC recently applied substantive due process analysis under federal law and the Massachusetts Declaration of Rights to a question nearly identical to the one at issue here. Plaintiffs confined during the pandemic for treatment of substance use disorder alleged they did not actually receive treatment in the first 14 days of a 30-day term of commitment.[157] Because the plaintiffs failed to provide an adequate record, the Court held that Plaintiffs did not

[147] Phillips Aff., ¶ 26, Ex. I.
[148] Fisher Aff., ¶ 18, Ex. H.
[149] Rudolph Aff., ¶ 17, Ex. A (conditions will "exacerbate mental health symptoms, increase the need for sedative medications" and delay discharge).
[150] *See* Facts, § C.
[151] *See* Notes 45-46, 49.
[152] Notes 47-48, 50.
[153] Notes 47, 50.
[154] Susan Doe Aff., ¶¶ 12, 14-15, Ex. D; John Doe Aff., ¶¶ 10-12, Ex. F; Mason Doe Aff., ¶¶ 5-6, Ex. E; James Doe Aff., ¶ 13, Ex. G.
[155] Mason Doe Aff., ¶ 6, Ex. E; John Doe Aff., ¶12, Ex. F.
[156] Mason Doe Aff., ¶ 6, Ex. E.
[157] *Foster*, 484 Mass. at 727.

establish a probability of success on the merits and denied a preliminary injunction.[158] In contrast, the record here is more than adequate. Employing the Court's constitutional analysis in *Foster*, the opposite result is compelled.

There is no distinguishing the legal principles governing the *Foster* Court's § 35 analysis from what controls in this case. In considering § 35, the Court noted that the purpose of commitment is "inpatient care for the treatment of an alcohol or substance use disorder."[159] Like treatment for mental illness,[160] "[t]his treatment is intended to promote the health and safety of the individual committed and others, as demonstrated by the statutory requirement that a committed individual pose a danger to him or herself, or a member of the community."[161] Given this purpose, it violates substantive due process if patients confined either for substance abuse disorder or for psychiatric concerns do not receive "meaningful and reasonably effective treatment," even under a minimal scrutiny standard.[162] The Court, however, denied relief under this theory because it found the *Foster* plaintiffs' evidence wanting in several important respects.

The Court held that the plaintiffs failed to prove that confinement under § 35 violated the "professional judgment" standard.[163] Plaintiffs relied on SAMSHA guidelines advising that inpatient treatment should be avoided to "the greatest extent possible" during the COVID

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[158] *Id.* at 701.
[159] *Id*. at 727.
[160] *See* citations at Note 125 regarding the purpose of psychiatric commitment.
[161] *Id*. at 727, citing G. L. c. 123, § 35.
[162] *Id*.
[163] *See Id.* at 724-25 ("The test is whether a 'decision by [a] professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.'" Citing *Hopper v. Callahan*, 408 Mass. 621, 626-627 (1990), quoting *Youngberg*, 457 U.S. at 322.

pandemic in favor of "outpatient treatment options."[164] They argued that confining persons for treatment, given these guidelines, was contrary to "professional judgment."[165] The Court agreed that inpatient commitment should not be employed if there is another "plausibly available option,"[166] but noted that SAMSHA did not advice against it in all cases.[167] The Courtdenied the *Foster* plaintiffs relief because they failed to provide evidence that patients were confined in the face of viable outpatient alternatives and also because the record lacked "expert guidance."[168]

Moreover, the Court held that the *Foster* plaintiffs' evidence failed to show that commitments for substance use disorder treatment bore no "rational relationship" to the purpose of confinement. The Court accepted that the plaintiffs would have a "strong claim" if they were able to demonstrate "no real treatment, or only minimal treatment" took place for even just the first 14 days of confinement.[169] However, the Court found that the plaintiffs' failed to provide sufficient "information regarding the limited treatment provided" and also lacked "expert testimony regarding the efficacy of that limited treatment."[170]

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[164] *Foster*, 484 Mass. at 725, quoting *Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic,* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (May 7, 2020), https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf: "Therefore, '[b]ecause of the substantial risk of coronavirus spread with congregation of individuals in a limited space such as in an inpatient or residential facility, SAMHSA is advising that outpatient treatment options, when clinically appropriate, be used to the greatest extent possible.'"

[165] *Foster*, 484 Mass. at 725.

[166] *Id*. "If outpatient treatment, or any other plausibly available option, would "bring the risk of harm below the statutory thresholds that define a likelihood of serious harm," a judge may not commit the subject of a petition to any facility, secure or unsecure." *Id.*, citing *Matter of a Minor*, 484 Mass. 295, 310 (2020).

[167] The guidance did not advise against inpatient commitment when "outpatient measures are not considered an adequate clinical option." *Foster*, 484 Mass. at 726.

[168] *Id*.

[169] *Id*. at 727-28.

[170] *Id.* at 728.

Finally, the *Foster* Court held that the plaintiffs' presentation was inadequate to show a violation of due process rights even under the more "stringent standard embodied in the Massachusetts Declaration of Rights,"[171] which specifies that actions depriving individuals of fundamental rights "must be narrowly tailored to serve a compelling governmental interest" and "also be the least restrictive means available to vindicate that interest."[172] The Court cited inadequate evidence of record on "whether the pandemic changes the need for or the efficacy of commitment to a secure facility for substance use disorder treatment," or "evidence indicating that a less restrictive alternative would have been sufficient to avoid a likelihood of serious harm for any currently committed individual."[173]

The holes the Court identified in the *Foster* plaintiffs' case are plugged here. Plaintiffs supply substantial evidence of unnecessary confinement – certainly more than a sufficient basis in justification of their request for an Injunction requiring Defendants to appropriately assess patients for discharge. They also provide ample evidence of Defendants' failure to provide treatment; the lack of efficacy of treatment in a pandemic; and the availability of less restrictive alternatives to confinement.[174]

Plaintiffs provide both lay and expert testimony that many Plaintiff class members are unnecessarily confined, particularly in the face of this pandemic.[175] Plaintiff Susan Doe, along

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[171] *Foster*, 484 Mass. at 728.
[172] *Id*., citing *Massachusetts Gen. Hosp. v. C.R.*, 484 Mass. 472, 489 (2020).
[173] *Foster*, 484 Mass. at 729-30.
[174] The Court also noted that the *Foster* plaintiffs offered expert testimony on the "general risk of transmission in correctional facilities," but did "not specifically address conditions" in the institutions issue in the case. This is not true here. Plaintiffs' expert epidemiologist looked into the history and construction of Tewksbury Hospital, reviewed drawings of the Hathorne units, and testified specifically regarding dangers in older facilities with shared bedrooms and bathrooms. Gonsalves Aff., ¶¶ 17,19, Ex. A.
[175] *See* Facts, § C.

with at least 30 others, has been approved for release for some time.[176] An Office of the State Auditor report criticized DMH for discharge failures,[177] and experts with close knowledge of DMH practices state that they are ordinarily cumbersome and haven't changed a whit in response to the pandemic.[178] Defendants do not deny that they have failed to accelerate discharges, and suggest it is justified.[179]

Further, Plaintiffs offer substantial evidence on the lack of treatment in the Hathorne Units during the pandemic compared to what was offered to the *Foster* plaintiffs, who were comparatively unaffected by COVID-19. Plaintiffs here testify that they were offered "no real" or "minimal" treatment for nearly four *months*, as opposed to the first 14 days of a 30-day internment, as in *Foster*.[180] While Defendants might dispute their contentions (as did the *Foster* defendants),[181] Plaintiffs' testimony is consistent with predictable restrictions on human interaction required by "social distancing" imposed to address the dramatic COVID-19 outbreak at Tewksbury Hospital.[182] By comparison, populations in the substance use disorder treatment centers at issue in *Foster* were reduced by more than half and no members of the *Foster* plaintiff class shared sleeping quarters.[183] Only several cases of COVID-19 were reported at one of the facilities, with no deaths.[184] Under less critical circumstances than those faced by the Plaintiffs

[176] Note 142.
[177] Note 35.
[178] Notes 35-39.
[179] Facts, § C; *Foster*, 484 Mass. at 727.
[180] *See* Facts, §§ A, C.
[181] *Foster*, 484 Mass. at 727.
[182] Facts, § C.
[183] *Foster*, 484 Mass. at 710-11 (facilities in question at twenty-nine seventeen percent of its operational capacity).
[184] *Id*. at 711.

here, who claim they received little or no treatment, it stands to reason that treatment was at least potentially more available to the *Foster* plaintiffs.[185]

Further, Plaintiffs have provided considerable expert testimony on the inefficacy of inpatient treatment.[186] Five experts with different orientations and backgrounds agree that inpatient treatment, except in limited circumstances and for short periods of time, has little value in normal times and none at all during a pandemic,[187] when "disease and death are much more likely to result from congregate confinement than effective treatment."[188] Under the Court's analysis in *Foster,* Plaintiffs' showing here is sufficient to establish that there is neither any rational relationship between the nature of their confinement and its purpose nor any "compelling interest" in continuing to confine people who can live safely in the community in a dangerous setting on the theory that they will be afforded treatment that cannot be delivered.

Plaintiffs also provide evidence regarding the availability of alternatives, both existent and capable of creation. The failure to discharge patients into the community cannot be entirely explained by a lack of placement options. In a public meeting, DMH Deputy Director Doyle stated that community placements were available and there was no need to utilize short-term options like college dorms.[189] Further, Plaintiffs present evidence that there are plausible alternatives to continued congregate care residency even if established community sites are presently not available in sufficient quantity.[190] Dr. Phillips closed hospitals in four states.[191] He

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[185] The *Foster* defendants denied that plaintiffs received no treatment, except for the first 3 days.
[186] *See* Facts, § D.
[187] *Id*.
[188] Phillips Aff., ¶ 38, Ex. I.
[189] Clerke Aff., ¶ 12, Ex. N. Plaintiffs also present an affidavit from a "peer respite" provider who received no inquiry any point during the pandemic regarding the availability of beds. Davidow Aff., ¶ 5, Ex. M.
[190] Phillips Aff., ¶¶ 32-37, Ex. I.
[191] *Id*. ¶¶ 6, 8-12.

lays out a viable roadmap for getting Plaintiffs and class members out of hospitals and into community-based settings.[192]

If the *Foster* Court had been provided the information offered here, it would have ordered relief. This Court should find a probability of success on the merits of Plaintiffs' substantive due process claim and do the same.

III. Plaintiffs Have and Will Continue to Suffer Irreparable Harm Without the Intervention of This Court

Plaintiffs and class members have suffered during the COVID-19 pandemic, which is far from over.[193] If patients are to be spared a second wave of misery at Tewksbury and other DMH-operated hospitals, Defendants must immediately assess all patients and accelerate discharging individuals to safer community settings. As Dr. Phillips put it, this is the first step.[194]

The relief requested is required notwithstanding a reported recent downturn in COVID-19 infection at Tewksbury and other hospitals. The virus is spiking again in states which, like Massachusetts, took early and aggressive action to contain it,[195] and a resurgence of the virus is widely expected in the fall.[196]

The preliminary injunctive relief that Plaintiffs seek is consistent with recent COVID-era SJC cases. The Court held, in *Committee for Public Counsel Services v. Chief Justice of the Trial Court,*[197] that population reduction in the prison system is "necessary" to prevent the spread of

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[192] Phillips Aff., ¶¶ 32-37, Ex I.
[193] As Governor Baker put it recently: "We do need to recognize and understand that this [pandemic] is still very much with us." Travis Andersen and Martin Finucane, *With Coronavirus Surging in Other States, Baker Urges Mass. Residents to Keep up the Fight Against Outbreak*, BOS. GLOBE (June 26, 2020, 2:35 p.m), https://www.bostonglobe.com/2020/06/26/metro/baker-mass-residents-dont-let-up-fight-against-coronavirus/.
[194] Phillips Aff., ¶ 30, Ex. I.
[195] *See* Note 93.
[196] Gonsalves Aff., ¶ 50, Ex. J.
[197] 484 Mass. at 445.

contagion and to protect public health during the COVID-19 pandemic.[198] As evidenced by the high death rate at Tewksbury, population reduction in congregate psychiatric hospitals is no less urgent than in places where persons convicted of or charged with crimes congregate. Both are institutional settings with multiple people confined to small rooms, with little or no ability to follow social distancing guidelines.[199]

The SJC strongly suggested that inaction in the face of the threat of a second COVID-19 wave is unacceptable.[200] In *Foster*, it held that the efforts of correctional authorities to address the virus were sufficient to avoid a finding that they acted with "deliberate indifference" toward the health and safety of those in their charge.[201] However, the Court also outlined a number of measures the defendants could have taken to reduce institutional populations but did not.[202] It essentially issued a warning that continued failure to take action to reduce populations could prompt the Court to intervene.[203] The Court was considering whether the confinement of persons convicted of crimes was *excessive* under the 8th Amendment. Plaintiffs here are not permitted to be punished *at all*.

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[198] *Id.* at 445 ("We agree that the situation is urgent and unprecedented, and that a reduction in the number of people who are held in custody is necessary"). "[C]onfined enclosed environments increase transmissibility" of COVID-19, because "maintaining six feet of distance between oneself and others ... may be nearly impossible" in these settings. *Id.* at 436. Further, "proper sanitation is also a challenge." *Id.*

[199] *See* Facts, at pp. 5-6.

[200] *Foster,* 484 Mass at 731-733.

[201] *Id.* at 724.

[202] *Id*. at 709. The Court determined that the Commissioner of Correction incorrectly believed that she lacked statutory authority to allow prisoners to serve sentences under home confinement. *Id*. at 710.

[203] *Id*. at 731-33. Citing the harm caused by persistent cell confinement and denial of exercise, the Court stated that while the pandemic continues, the lockdown conditions instituted by the DOC to prevent a serious risk of harm themselves risk becoming Eighth Amendment violations. *Id.* at 731.

Chief Justice Gants, in a concurring opinion in which Justices Lenk and Budd joined, was even more direct. In urging the Department of Corrections ("DOC") to take steps to reduce the prison population, the Chief Justice set out in some detail the measures available to them.[204] The "immediate and unpredictable threat" that warranted a lockdown in reaction to the first COVID-19 wave would not excuse a failure to reduce the prison population in response to the second wave: "there is time before the fall to accomplish sensible reductions in the size of the prison population," which will afford administrators "better options to protect the physical and mental health of inmates that come with fewer prisoners."[205]

Planning for psychiatric facilities is also required and must begin immediately. As in the prison system, population reduction in Defendants' facilities will take "time, both to identify appropriate candidates for release and to ensure that they have appropriate release plans."[206] Defendants, like the Department of Corrections, in the face of a coming threat that may surpass the first,[207] have the "opportunity and, indeed, the obligation to begin preparing," as "[p]olicies that pass constitutional muster in the face of an unprecedented emergency may not be constitutionally sufficient after the department has had time to consider and plan its response to a now-foreseeable threat."[208]

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[204] *Id*. at 735-39.
[205] *Id*. at 741.
[206] *Id.*
[207] *Id*. Chief Justice Gants accepted this potential as real, citing Lena Sun, *CDC Director Warns Second Wave of Coronavirus Is Likely to Be Even More Devastating*, WASH. POST (Apr. 21, 2020), https://www.washingtonpost.com/health/2020/04/21/coronavirus-secondwave-cdcdirector.
[208] *Id*. *See also Helling v. McKinney*, 509 U.S. 25, 33 (1993) (the constitution protects against threats that are "sure or very likely to cause serious illness and needless suffering the next week or month or year").

Just like the *Foster* defendants, Defendants here did not utilize means at their disposal to discharge patients in response to the first COVID-19 wave that infected a majority of the Tewksbury population and killed 17 patients. There is no excuse for a failure to prepare for the second wave. This Court must oblige the Defendants to make such preparations in order to avoid further irreparable harm. [209]

IV. PLAINTIFFS' THREATENED INJURY OUTWEIGHS ANY HARM THAT GRANTING THE INJUNCTION MAY CAUSE DEFENDANTS

Granting a preliminary injunction will not harm Defendants. On the contrary, compelling the Defendants to perform their functions in a manner more consistent with their obligation to protect patients and treat them in least restrictive environments is not harmful. Since there is no harm to Defendants, the harm Plaintiffs will continue to suffer if they remain in crowded facilities is of greater weight. The Court should find that the balance in favor of the Plaintiffs and Class members' safety greatly outweighs inconvenience to the Defendants.[210]

V. GRANTING AN INJUNCTION WILL SERVE THE PUBLIC INTEREST

The public interest is served when constitutional and statutory rights are protected.[211] "There can be no public interest in exposing vulnerable persons to increased risks of severe illness and death."[212] Moreover, the Court will protect the general public by granting Plaintiffs' motion for preliminary injunction because it will reduce the population at State facilities and

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[209] *See also Mills v. District of Columbia*, 571 F.3d 1304, 1312 (D.C. Cir. 2009) (deprivation of constitutional rights "unquestionably constitutes irreparable injury").
[210] *See Savino v. Souza,* No. 20-10617-WGY, 2020 WL 2404923, at *1 (D. Mass. May 12, 2020) (issued injunction on behalf of immigration detainees held during pandemic, finding the balance of interests analysis tipped "lopsidedly toward the interim equitable relief ordered by the Court").
[211] *Cote-Whitacre v. Dep't of Public Health*, 446 Mass. 350, 357 (Mass. 2006).
[212] *Fraihat v. U.S. Immigration & Customs Enf't*, No. EDCV 19-1546 JGB (SHKx), 2020 WL 1932570, at *28 (C.D. Cal. Apr. 20, 2020) (granting a preliminary injunction, in part, because the balance of equities weighed in favor of plaintiff immigration detainees).

dampen the spread of contagion that endangers the general public.[213] Massachusetts has been one of the states in the country with a significantly high rate of COVID-19 infection.[214] It is essential to continue vigilance to ensure that its public health system, hospitals, and facilities are not overwhelmed by the spread of the virus.[215] The Order Plaintiffs seek will promote the public interest.

CONCLUSION

For the foregoing reasons, the motion for preliminary injunction should be granted.

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Respectfully submitted,

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[213] "COVID-19 threatens the well-being of mental health patients, the staff who shuttle between facilities and outside communities, and members of those outside communities. Staff, visitors, contractors, and vendors who pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of congregate care mental health facilities populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. The health of mental health patients is public health." Gonsalves Aff., ¶ 44, Ex. J.
[214] Gonsalves Aff., ¶ 11, Ex. J.
[215] Gonsalves Aff., ¶ 47, Ex. J (immediate steps to reduce the population of mental health facilities "are necessary for the safety of all inpatient individuals as well as the broader community as we address the rapid global outbreak of COVID-19").