COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss

SUPERIOR COURT
CIVIL ACTION
NO.

JAMES DOE, MASON DOE,
JOHN DOE, AND SUSAN DOE, *alias*
Plaintiffs.

v.

JOAN MIKULA, COMMISSIONER OF THE DEPARTMENT OF MENTAL HEALTH; AND THE DEPARTMENT OF MENTAL HEALTH,
Defendants.

CLASS ACTION COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

I. INTRODUCTION

1. Plaintiffs are psychiatric patients confined in congregated units at Tewksbury Hospital (Tewksbury) operated by the Department of Mental Health (DMH), where 17 patients have died during the COVID-19 pandemic, or more than twice as many deaths as in the entire State prison system.

2. Congregate care facilities are inherently dangerous places during a pandemic because of close living quarters that do not permit safe COVID-19 practices recommended by public health authorities. Plaintiffs' lives are threatened by their continued confinement.

3. As many as five patients sleep in a single room in the psychiatric units at Tewksbury, which are called the Hathorne Units. While disaggregated data is not available, in the whole hospital, more than 55% of patients, or 170 out of 308 persons, were infected with COVID-19. 192 out of 924 Tewksbury staffers have come down with the virus. One died.

4. While DMH has belatedly taken steps to protect against the virus' spread among the current population, the Agency failed and apparently does not intend, despite the strong potential for a second virus wave in the fall, to do the single most important thing to protect those in their care: discharge as many patients as possible.

5. Though DMH staff members are aware of the COVID-19 hazard, and state they understand the need to systematically review patients in their custody and assess whether they may be discharged, they have not done a review that factors the dangers associated with continued confinement during the pandemic relative to any benefit of remaining in congregate care facilities. Further, they have failed to discharge significant numbers of patients who were already deemed discharge-ready prior to the onset of the COVID-19 pandemic.

6. Instead, DMH has continued their normal practices, which are skewed in favor of avoiding risks from releasing patients into the community.

7. DMH records and public statements confirm that there have been no patient discharges since the onset of the pandemic that are motivated by the need to increase safety for patients who remain in DMH facilities. All or almost all were planned for discharge prior to the pandemic.

8. There is no justification for failing to release patients from inpatient facilities during the pandemic. Community placements have not been rendered completely unavailable by the pandemic. DMH has failed to employ available measures to move individuals from their inpatient facilities to community-based residences or, if necessary on a temporary basis, empty college dorms or hotels as interim sites for quarantine purposes while they wait for more permanent housing to become available.

9. Though Plaintiffs are confined so they can receive treatment to address acute mental health needs, during the pandemic they have mostly been consigned to their rooms with little or

no meaningful treatment available, either through in-person therapy sessions or via telehealth. Such conditions, in any case, are countertherapeutic. Plaintiffs have lived in the midst of sickness and death and have seen close friends pass away.

10. Reducing the psychiatric patient population of the Hathorne Units and the public psychiatric hospital system generally, as the Supreme Judicial Court of the Commonwealth declared recently in the context of prisons and jails, is "necessary" to avoid preventable deaths and suffering. *See C.P.C.S. v. Chief Justice of the Trial Court*, 484 Mass. 431 (2020).

11. Reducing the inpatient psychiatric hospital population throughout the Commonwealth will decrease exposure to the COVID-19 virus by increasing the physical distance between people in the Units, which will make conditions within these facilities safer, as well as allow for the provision of necessary mental health treatment to those who must remain in Defendants' congregate settings.

12. Though the outbreak of the COVID-19 virus in Tewksbury and other DMH-operated facilities is mostly under control at present, the necessity for reducing the population across DMH inpatient settings remains intact. The COVID-19 pandemic is far from over. A new surge anticipated in the fall is – as SJC Chief Justice Gants put it in his concurring opinion in *Foster v. Commissioner of Correction,* 484 Mass. 698 (2002) – a "now-foreseeable threat."

13. Chief Justice Gants said that the Department of Correction has an "obligation" to "consider and plan its response" to a second COVID-19 wave. DMH has no less an obligation.

14. Plaintiffs, on behalf of a class of similarly situated persons confined in DMH-operated psychiatric units, ask this Court to issue preliminary and permanent injunctions requiring the Defendants to conduct a systematic review of all the persons in DMH's custody who are confined in inpatient settings, regardless of the facility, in order to clear space for Tewksbury

patients and other class members who live in circumstances that keep them from maintaining appropriate protections from contracting COVID-19 consistent with the guidelines of the federal Centers on Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

II. JURISDICTION AND VENUE

15. This Court has jurisdiction in this matter under G.L. c. 214, §1: c. 231A, § 1: and 42 USC § 1988.

16. Venue in this Court is proper under G.L. c. 223, § 1 and c. 214, § 5.

III. PARTIES

17. Defendant Joan Mikula is the Massachusetts Commissioner of the Department of Mental Health (DMH). As set forth in G.L. c. 19, § 1, the Commissioner exercises "supervision and control of the department," and "[a]ll action[s] of the department shall be taken by the commissioner, or under the direction of said commissioner, by such agents or subordinate officers as [s]he shall determine." She is further required to "take cognizance of all matters affecting the mental health of the citizens of the commonwealth," and has "supervision and control of all public facilities, for mentally ill persons," including "all hospitals, comprehensive centers and clinics, and other mental health facilities established within the department . . .." She is sued in her official capacity for prospective relief only.

18. Defendant Department of Mental Health is an Agency of the Commonwealth of Massachusetts. It is responsible for the administration of programs and services for persons with mental illness. Under G.L. c. 123, § 2 it is charged with establishing "procedures" that set "the highest practicable professional standards for the reception, examination, treatment, restraint, transfer and discharge of mentally ill persons in departmental facilities" that are "adaptable to

changing conditions and to advances in methods of care and treatment of the mentally ill." DMH is a "public entity" for the purposes of Title II of the Americans with Disabilities Act (ADA), and it receives federal financial assistance for purposes of Section 504 of the Rehabilitation Act.

19. The Plaintiffs in this matter are identified with pseudonyms in order to protect their privacy. They all qualify as persons with disabilities under State and federal law, as they have mental health conditions that substantially interfere with major life functions. All are DMH clients who have been deemed eligible for DMH services due to their disabilities.

20. James Doe is a patient at Tewksbury and a DMH client. He is fifty-three years-old and has lived in the Hathorne Units for three years. He has hypertension. He came down with the virus and was quite ill but is now recovered. He is involuntarily committed. During the COVID-19 pandemic he has been required to stay mostly in his own room. Before he contracted the virus, he shared a room with four other patients. He has been deprived of outdoor exercise and was not able to participate in groups or receive treatment during the pandemic. He is at high-risk for a life-threatening case of COVID-19 if he were to get sick again. He has a Section 8 housing voucher and would like to receive assistance in obtaining his own apartment with supportive services.

21. Plaintiff Susan Doe is a patient at Tewksbury and a DMH client. She is twenty-six years old and has lived in the Hathorne Units for one and a half years. She contracted the COVID-19 virus as a patient at Tewksbury. Since the pandemic, she has stayed mostly in her own room, typically with one other roommate, while she continues her recovery from the virus. She is being held under a so-called Conditional Voluntary (G.L. c. 123 §§ 10, 11). Though she has not been committed under G.L. c. 123 §§ 7, 8, she believes that if she were to terminate her conditional voluntary status, DMH would file civil commitment papers. Susan was scheduled for discharge

to a group home in April but remains at Tewksbury. She feels she is ready to leave the Hathorne Unit but cannot sign herself out even if permitted because she will be homeless unless DMH places her in the community.

22. Plaintiff Mason Doe is a patient at of Tewksbury and is a DMH client. He has been at Tewksbury for twelve months and confined in DMH-run psychiatric units for two years overall. He is sixty-six years old. He contracted the COVID-19 virus at Tewksbury and is in a high-risk category for medical complications with the virus. While his cough and fever have subsided, he is still battling the effects of virus. His underlying medical condition, Parkinson's Disease, requires ongoing care but he has only seen his doctor in person once since the state of emergency was declared. Since the beginning of the pandemic, he has been confined to his room, which he has shared with three or four other roommates who also contracted the virus. There are no group treatment programs or activities. Until Friday, 6/26/20, he was involuntarily committed under G.L. c. 123 §§ 7, 8. He signed a Conditional Voluntary consent to continue his stay in the Hathorne Units because he was told that he would otherwise be recommitted, and because he inferred from the discussion with DMH staff that consenting to a "voluntary" placement would get him out of the Hospital sooner. He believes he remains confined at Tewksbury because he is difficult to place due to his medical condition.

23. Plaintiff John Doe is a patient at Tewksbury and a DMH client. He has been at Tewksbury in the Hathorne Units since November 2019. He is fifty years old. He contracted the COVID-19 virus at Tewksbury and is currently recovering. Since the pandemic, he has not had substantial contact with his doctors and social workers, as they are not permitted onto the COVID-19 positive unit. He can only talk to them over the phone. There are no treatment programs or activities available to him and he spends his days in isolation in his single bedroom.

He is being held on a conditional voluntary under G.L. c. 123 §§ 10, 11 and needs more frequent and effective treatment.

IV. FACTS

A. Background: Psychiatric Hospitals and Housing Units Operated by DMH and their Purpose

24. DMH, according to its own mission statement, set forth in regulation at 104 CMR 25.01 (2)(b), "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 . . .."

25. Despite this community-based focus, DMH also operates facilities for people clinically determined to need inpatient psychiatric care. These include the Worcester Recovery Center and Hospital, which has eleven units containing 290 beds, including a 30-bed adolescent unit; Taunton State Hospital, which has three units and 45 beds; the Solomon Carter Fuller Mental Health Center, with three units and 60 beds; four 40-bed units at the DPH-operated Tewksbury Hospital, and five units with 115 beds at the DPH-operated Lemuel Shattuck Hospital.

26. Persons whose conditions are serious enough to warrant confinement in inpatient psychiatric hospital settings have profound acute needs. The purpose of taking their liberty is to provide treatment that addresses those needs in a manner that protects them from harm.

27. There are a range of ways in which a person can be admitted and/or committed to one of these facilities under various provisions of G.L. c. 123. Patients may voluntarily apply for admission under § 10 and be free to leave when they choose. Patients who want to be placed in a hospital can also, under § 11, agree to conditions on discharge that limit their right to leave. A so-called "conditional voluntary" allows a patient to express their intention to leave a facility at any time, but discharge is delayed for at least three days, during which time the facility can file a

petition for involuntary commitment under § 7. If this occurs, the patient remains confined pending a hearing under § 8.

28. At hearing, a District Court judge considers the petitioning facility's request for authority to confine the person for an initial period of six months. The facility bears the burden of demonstrating that the person is "mentally ill": that, if the person is not confined, there is a likelihood of serious harm due to the person's mental illness, and that there is no appropriate less restrictive setting available.

29. Either a voluntary or involuntary admission may be preceded by an emergency petition under § 12 for short-term confinement founded on a perceived "imminent" threat to safety. While less common, persons charged with crimes may also be confined for purposes of determining their competence to stand trial under § 15, or, if found not competent or not guilty by reason of mental illness, committed for a period of observation and, subsequently, for one year under § 16 A.

30. Conditional voluntary confinement is not truly voluntary. Imposing conditions on release is typically posed to the patient at the onset of admission as an alternative to involuntary commitment. Thereafter, the fact that hospital staff may initiate commitment proceedings and obtain court authorization to hold a patient for six months (and on review, a further full year) is likely to deter a patient who wishes to leave the facility from attempting to withdraw consent before staff think they are ready to leave. Plaintiffs Susan Doe and Mason Doe believe DMH would move to commit them if they attempted to sign out.

31. Further, DMH can effectively hold a confined patient against their will by failing to render an appropriate community-based placement. A person who is facing homelessness is likely to continue to accept an overly restrictive hospital placement rather than withdraw

voluntary consent. This is an onerous consequence, particularly in the midst of a viral pandemic. Susan Doe fears this result and continues to remain in the Hathorne Units at Tewksbury, though she believes she should be placed in the community.

32. DMH claims that it works with community providers to ensure that treatment of its clients "is not in an overly restrictive environment, where they might occupy one of the scarce inpatient beds, if they do not need that level of care."

33. Under G.L. c. 123 § 3, DMH is empowered to transfer any client from any facility to any other facility that the Department deems suitable to provide treatment.

34. Under G.L. c. 123 § 4, DMH has authority to discharge conditional voluntary patients at any time and may discharge committed patients who no longer meet the standard for civil commitment prior to the end of their commitment term without any need for court involvement. DMH is obliged, however, under G.L. c. 123 § 16, to provide notice to the applicable District Attorney of its intent to discharge a person committed under that section.

B. COVID-19 is an Unprecedented Risk to Public Health

35. The coronavirus that causes COVID-19 infection – and death – has produced an unprecedented global pandemic. As of June 10, 2020, 7,145,539 people worldwide have been diagnosed with COVID-19 and more than 408,025 have died.

36. The United States has the highest rate of COVID infection in the world. As of June 13, 2020, 2,016,027 people contracted the virus and 113,914 have died.

37. Massachusetts has one of the highest rates of infection in the country. As of June 13, 2020, 104,667 people have contracted the virus, 10,582 have been hospitalized, and 7,492 have died.

38. The virus is highly contagious. It can be spread by persons who are pre-symptomatic and asymptomatic. COVID-19 is particularly dangerous for persons 65 years and older, and for people of all ages who are immunocompromised or have underlying medical conditions such as chronic lung disease, asthma, heart conditions, kidney or liver disease, or diabetes. It also can be deadly for younger healthy people. Nearly 20% of the people hospitalized with coronavirus in the United States are young adults between the ages of 20 and 44. There is no vaccine protecting people from COVID-19 and there is little chance that one will be developed before mid-2021 at the earliest.

39. If persons who have recovered from COVID-19 enjoy any immunity from reinfection at all, it is likely to last no more than several months.

40. The CDC recommends that people always maintain a distance of at least six feet from one another. Other recommended precautions are washing hands often, covering one's mouth and nose with a face mask when around others, and cleaning and disinfecting frequently touched surfaces.

41. COVID-19 is particularly deadly in congregate care facilities because it is impossible to maintain proper social distancing and otherwise follow safe practices as recommended by the CDC. Plaintiffs and other residents utilize common surfaces that can retain viral infection that can be transmitted to others, including toilets, sinks, and showers that are not disinfected between use. Meals are prepared communally and can communicate the virus through surface infection.

42. Even with rigorous adherence to mitigating measures, it is virtually impossible to stop the spread of COVID-19 in a psychiatric hospital, particularly a hospital in an older building like

Tewksbury. Such hospitals were not built in contemplation of the need to resist the spread of viral infection.

43. Congregate care facilities around the country have experienced high rates of infection and death—in Massachusetts alone, over 20% of COVID-19 infections are residents and healthcare workers of long-term care (LTC) facilities, with over 60% of all COVID-19-related deaths in Massachusetts attributed to these LTC facilities.

44. Congregate facilities around the country that detain prisoners, federal immigration detainees, and psychiatric patients have experienced serious COVID-19 outbreaks. These include facilities in Texas, California, North Carolina, Tennessee, New York, Ohio, Arkansas, Louisiana, Connecticut, and the District of Columbia.

45. Disease transmission occurred rapidly in these facilities, mushrooming dramatically in a matter of days from near nothing to, in some places, more than half the institutional population. This was the pattern in both the Tewksbury and the Lemuel Shattuck Hospitals in the Commonwealth.

46. Disease is typically transmitted between congregate facilities and the outside world by employees who enter and exit the facilities.

47. The practice in many such facilities during the pandemic, and in the Hathorne Units, is to attempt to isolate persons who are COVID-positive from those who have not yet contracted the virus.

48. Such "cohorting," however, poses serious risks due to the potential for erroneous testing results and for introducing contagion into the presumed COVID-negative group through staff members who go into both COVID-positive and COVID-negative units. Cohorting is only to be used as a last resort and is no substitute for reducing institutional populations.

49. In order to prevent persons who have contracted COVID-19 from overwhelming hospital capacity and exhausting the availability of life-saving ventilators, many states, cities, and municipalities throughout the U.S. have instituted advisories or mandates limiting group interactions, shutting down non-essential businesses, and requiring people to work remotely from their homes.

50. States, cities, and municipalities, however, have recently begun to loosen restrictions. Some experts trace resurgences of the COVID-19 virus to the lifting of restrictions.

51. Even before efforts to reopen the economy and recent mass protests against police brutality and racism, a renewed viral surge was predicted for the coming fall.

52. Any resurgence is likely to be reflected in spikes of infection in congregate psychiatric facilities statewide, particularly in the places that have seen large outbreaks, such as Tewksbury's Hathorne Units.

53. All of these psychiatric hospitals confine patients who have contracted COVID-19. LSH, like Tewksbury, has had an infection rate of approximately 50%.

54. Patients will be safer and treatment will be more accessible during the pandemic in any of Defendants' facilities if the population is reduced.

C. Life in the Hathorne Units at Tewksbury During the Pandemic

55. Tewksbury is a large facility operated by the Department of Public Health (DPH) and DMH in Tewksbury, Massachusetts, with 370 beds for patients in the main hospital building. A number of other programs for persons with substance abuse disorder and/or mental health issues are placed in and operate out of the hospital.

56. By arrangement with DPH, DMH operates four mental health units that have, in total, 160 beds at Tewksbury Hospital. They are called the Hathorne Units.

57. Patients on the Hathorne Units live in bedrooms arrayed along the edges of an “H” pattern, with the nurse’s station and various utility rooms in the center, including communal bathrooms and showers.

58. Bathrooms are cleaned once a day.

59. While posted materials advise patients to wash their hands thoroughly, there is no instruction to disinfect used surfaces, nor are there cleaning materials made available for this purpose.

60. Most bedrooms are shared by two to five people.

61. Beds in shared rooms may be less than six feet apart. Plaintiff Susan Doe sleeps within that distance from her roommate.

62. Susan Doe lives in a room with one other person, who, until recently, coughed incessantly. At previous times during the pandemic, she shared rooms with two or three others. Two of her roommates died from the virus.

63. Plaintiff Mason Doe has lived in a room with three or four roommates during the pandemic.

64. Before the COVID-19 pandemic, Hathorne Unit patients, including the Plaintiffs, were provided treatment during the day in individual counseling and group therapy and engaged in other recreational and treatment activities.

65. Before the COVID-19 pandemic, Hathorne patients, including the Plaintiffs, were allowed to have access to fresh air and had freedom to move freely in the facility.

66. Since the outbreak of the COVID-19 pandemic in March 2020, patients, including the Plaintiffs, have had no access to individual or group therapy, group activities or treatment. The only exception is the recent reintroduction of an arts and crafts group activity.

67. Until very recently, Plaintiffs were denied access to fresh air entirely. Even now, access remains restricted.

68. During the course of the pandemic, Plaintiffs and other Hathorne patients have stayed in isolation in their rooms.

69. Treatment has been limited to short remote check-ins with assigned counselors.

70. Until recently, Plaintiffs and other Hathorne patients were not allowed visits with friends and relatives. Visitation remains restricted to two hours daily for COVID negative patients. Visits may last for no more than 30 minutes.

71. Room confinement and lack of treatment and activities has exacted a painful toll on Plaintiffs and class members. Living in an environment in which people are sick and in danger of illness or death has been extremely stressful, exacerbating mental health symptoms. Rather than concentrating on getting well, Plaintiffs' only focus has been to survive.

72. Susan Doe, for example, became very depressed over the deaths of her roommates and friends. She regressed for a time and considered self-harm. She remains in mourning.

73. Mason Doe has serious medical concerns. He believes he has been denied adequate medical treatment and believes he will die in the hospital.

74. John Doe believes that his rights were violated during the pandemic. He is angry.

75. Due to conditions during the COVID-19 pandemic, Plaintiffs have not received adequate psychiatric treatment nor have they benefitted from remaining in the Hathorne Units to an extent exceeding the negative impact of the conditions of confinement to which they have been exposed.

76. All the Plaintiffs and as many as 50% of class members could be safely and more effectively treated in community settings.

77. Even in non-pandemic times, inpatient confinement for mental health treatment is less effective than treatment in less restrictive outpatient settings. The federal Substance Abuse and Mental Health Services Administration (SAMSHA) advises that mental health treatment is more effectively provided on an outpatient basis.

78. During the COVID crisis, SAMSHA recommends that inpatient treatment be avoided whenever possible.

79. The confinement of persons in such environments risks scarring adverse experiences, such as the use of restraints, placement in seclusion, and the arbitrary denial of rights. These risks increase significantly the longer a person is kept in an inpatient psychiatric setting.

80. People who are confined for psychiatric treatment in inpatient settings for significant periods of time tend to lose confidence in their ability to manage their lives independently. This puts a substantial barrier in the way of ultimate recovery.

81. Inpatient confinement rarely serves any useful purpose if the stay exceeds thirty days, which is the period of time it typically takes to stabilize patients who arrive in distress. Risks of confinement and the potential for accruing learned helplessness increase significantly thereafter.

82. Inpatient confinement is therefore only appropriately used to avert a serious potential for imminent harm, and only for so long as the potential persists.

83. The Plaintiffs have all been in residing in the Hathorne Units for much longer than thirty days. Susan Doe has been confined for a year and a half; Mason Doe for fourteen months; and John Doe for one year.

84. Members of the class have been detained in the Hathorne Units and in other DMH-run facilities long after they were approved for discharge.

85. Susan Doe, for example, was approved for Group Living Environment (GLE) placement in April. Mason Doe has been stable for months. His attorney believes that he is still confined because DMH hasn't been able or willing to accommodate his serious medical issues.

D. Defendants' Failure to Discharge Patients

86. Concerns about DMH discharge processes predate the pandemic.

87. The Massachusetts Office of the State Auditor (OSA) criticized DMH in a Report dated August 1, 2019, for "[n]ot ensuring that all clients who are ready for discharge are placed in a timely manner." The OSA stated that "problems responsible for the untimely discharge of patients "were largely the result of DMH not establishing any monitoring controls to ensure that anticipated discharge dates were properly recorded or that discharge was as timely as possible." OSA further stated that identified problems in "ensuring that all clients who are ready for discharge are placed in a timely manner may negatively affect clients' mental health."

88. DMH's discharge readiness assessment processes involve numerous progressions to higher privilege levels. Patients who do not progress along the continuum of privilege rungs may continue to be confined even if they are capable of being appropriately housed in community placements.

89. DMH has not departed at all from its conservative approach to assessing discharge readiness despite the dangers posed to persons in congregate care facilities during the COVID-19 pandemic.

90. The Department began using a revised discharge questionnaire that established new and potentially disqualifying criterion during the COVID-19 pandemic. New questions ask whether the patient, if discharged, would maintain social distancing and other COVID-19 related hygienic practices.

91. The questions related to COVID-19 were not factors prior to the pandemic and are not pertinent to the legal analysis for continued confinement.

92. The natural effect of the new discharge questionnaire, on its face, is to make it harder for patients to be discharged than before the pandemic.

93. DMH administrative staff nonetheless have indicated that they understand the need to reduce institutional populations and are systematically assessing patients.

94. DMH, however, has failed to discharge any persons from the hospitals and psychiatric units it operates specifically in response to the pandemic. Thirty persons, including Plaintiff Susan Doe, were slated for discharge months ago but are still confined within inpatient facilities.

95. On April 23, 2020 at a virtual meeting including Defendant Mikula, other DMH managers, and mental health advocates, Deputy Commissioner Brooke Doyle stated that DMH had discharged some patients since the beginning of the COVID-19 pandemic, but none specifically due to the pandemic. All the discharge decisions were planned in advance of the COVID-19 crisis.

96. A response to a public records request received by Plaintiffs' counsel on May 8, 2020 reported that there were eighteen recent discharges, but all were planned in advance of the COVID-19 pandemic.

97. In a public meeting by video conference on May 12, 2020, DMH Deputy Commissioner Doyle said that patients were being evaluated for discharge readiness.

98. When asked for the number of patients that were discharged by virtue of this process due to the COVID-19 crisis, Doyle said "none."

99. At a subsequent public virtual meeting held on June 4, 2020, Deputy Commissioner Doyle again was asked whether patients were being discharged in order to address the threat of

COVID-19. She stated that there had been a slowdown in the transition between inpatient placements and community placements.

100. Deputy Commissioner Doyle did not report that any persons were discharged specifically in response to the COVID-19 pandemic.

101. Most recently, on June 23, 2020 at a public meeting held by video conference, Deputy Commissioner Doyle confirmed that discharge planning focused on forty-five persons already deemed discharge-ready before the pandemic. She said that only fifteen of these people had actually been discharged.

102. DMH staff members under Defendants' supervision have not informed DMH contractors with doctors and psychologists to perform assessments of patients for admission and discharge. These contractors have not been informed that they should change their analysis during the pandemic to factor medical risks related to living in congregate care facilities or the difficulties of offering treatment under social distancing guidelines.

103. DMH has also not encouraged facility treatment teams to alter their typical readiness analysis to account for the COVID-19 pandemic.

104. At the June 23 public meeting, Deputy Commissioner Doyle said that the standard governing discharge decisions is unchanged from prior to the COVID-19 pandemic.

105. She further stated that, despite the pandemic, there has been no acceleration of discharges. The rate of discharge is no greater in the current year than over the same period last year.

106. Deputy Commissioner Doyle argued that congregate psychiatric facilities were not comparable with prisons and jails, where releases *have* accelerated during the pandemic. She said that DMH facilities have more ready access to medical resources than places of

incarceration. She did not explain why superior medical access did not prevent the deaths at Tewksbury of more than twice the number of persons in the entire State prison system.

107. On June 23, 2020, Deputy Commissioner Doyle said that beds were available in community-based facilities for people discharged from inpatient facilities.

108. During the course of the pandemic, the sole peer respite facility in the Commonwealth continued to accept admissions, but no DMH staff member inquired as to the availability of bed space. Peer respite is a voluntary, short-term program run by persons with psychiatric histories that provides housing and support to people in crisis.

109. DMH has not developed new resources for either COVID-positive or COVID-negative patients to safely allow transfers from facilities rife with infection to other less restrictive and safer settings.

110. For example, there are no special quarantine sites for patients who are convalescing from the virus or who have been in contact with COVID-positive persons for use as interim stops before community placements are effectuated.

111. The conclusion is inescapable that DMH has done virtually nothing to discharge patients from its facilities in order to reduce their populations, allow for greater social distancing between those that remain, and to enhance the potential for actually delivering treatment.

112. An appropriate assessment of patients in all DMH hospitals will reveal that many may be safely discharged to a community placement.

113. All patients in any DMH facility will benefit from such assessments because they will lead to the reduction in the population of that facility, which will reduce the potential for COVID-19 infection and facilitate the provision of indicated treatment.

114. Revising the typical discharge criteria to allow consideration of the impact of the COVID-19 pandemic and its impact within institutions on treatment is a reasonable accommodation to Plaintiff class members that will not wreak a fundamental alteration of the DMH's programs, services, or activities – indeed, it will allow for a more faithful practice of the Agency's community focused mission.

115. The failure to reduce institutional populations will cause irreparable harm to Plaintiffs and class members.

V. CLASS ACTION ALLEGATIONS

116. This action is properly maintained as a class action pursuant to Rule 23 of the Massachusetts Rules of Civil Procedure.

117. The named Plaintiffs seek to represent a class of all persons who are confined involuntarily in DMH-operated inpatient hospital and units, whether court ordered under the provisions of G.L. c. 123 or because they cannot withdraw their voluntary commitment without prompting involuntary commitment proceedings or risking homelessness in the midst of a pandemic.

118. The class is so numerous that joinder of all members is impracticable.

119. Defendants have acted or failed to act in a manner that is generally applicable to each member of the putative class, making class-wide injunctive and declaratory relief appropriate and necessary.

120. The questions of law and fact raised by the named Plaintiffs are common to all members of the putative class. The central issue is whether the Defendants have an enforceable duty to appropriately assess the discharge readiness of the persons it confines in psychiatric facilities in a manner that adequately factors the dangers of congregate settings and DMH's inability to

provide effective treatment during a pandemic. Such assessments are necessary in order to: (1) reduce institutional populations to protect members of the Plaintiff class from harm and ensure that conditions of confinement are consonant with its purpose; and (2) avoid illegal discrimination by virtue of failures to offer appropriate treatment to members of the Plaintiff class in the least restrictive setting and to provide reasonable accommodations from normal discharge assessment practices to see that this occurs. Plaintiffs claim these duties arise out of the substantive content of the due process clauses of the State and Federal constitutions and, with respect to discrimination, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and the Massachusetts Equal Rights Act.

121. The remedy Plaintiffs seek is an Order requiring Defendants to assess each of the patients in DMH custody maintained in congregate psychiatric hospitals to determine if the benefits of continued confinement for each DMH client are outweighed by the risks of remaining in a congregate care facility and if Plaintiff class members may be safely discharged in order to reduce institutional populations. This remedy will commonly benefit class members in either of the following ways:

- By allowing some class members to be transferred to less restrictive placements, such as homes with welcoming families or responsible other relations, or to DMH-licensed GLEs, where they will be not be exposed to the heightened risk of contracting COVID-19 in a congregate care facility, as well as ameliorating the other negative impacts associated with confinement in such facilities during a pandemic, even if this requires an interim placement in a quarantine site;
- By ensuring that Plaintiff class members who, after a systematic assessment, remain in a congregate setting, are less vulnerable to contracting COVID-19 because, among other

reasons, they can occupy rooms in which they sleep separately from any other patients, and can receive the treatment that justifies their confinement, which can be more feasibly provided in less populated institutions.

122. The constitutional and statutory violations of law alleged by the named Plaintiffs and the resultant harms are typical of those that could be raised by members of the putative class in their own right.

123. The named Plaintiffs will fairly and adequately protect the interests of the class. There is no conflict between the interests of the named Plaintiffs and the proposed class.

124. Plaintiffs are represented by counsel who are competent and experienced in class action and complex civil rights litigation and have committed sufficient resources to fully litigate this case through trial and any appeals.

VI. CAUSES OF ACTION

125. Based on the foregoing allegations, Plaintiffs assert the following claims:

Substantive Due Process

126. By failing to adequately consider the risk to the health and safety of Plaintiffs and other class members due to COVID-19 if they remain confined in congregate care facilities at their current population levels, and by unnecessarily exposing Plaintiffs to serious illness or death, Defendants, without either rational basis or compelling reason, violated the substantive content of the due process provisions of the Federal Constitution, as secured by 42 U.S.C. § 1983, and cognate provisions of the Massachusetts Constitution and Declaration of Rights.

127. By continuing to hold Plaintiffs in congregate care facilities where they are at high risk of contracting COVID-19 and cannot receive the treatment that is the reason for and justifies the deprivation of their liberty, Defendants, without either rational basis or compelling reason,

violate the substantive content of the due process provisions of the Federal Constitution, as secured by 42 U.S.C. § 1983, and cognate provisions of the Massachusetts Constitution and Declaration of Rights.

<u>Discrimination on the Basis of Disability</u>

128. By unnecessarily holding Plaintiffs and others similarly situated who qualify as persons with disabilities in dangerous conditions without adequately exploring the potential or creating opportunities for community integration, Defendants have failed to administer services, programs, and activities in the least restrictive and most integrated setting appropriate to their needs, in violation of the Americans with Disabilities Act, 42 U.S.C.A. § 12132, its implementing regulation at 28 CFR § 35.130(d); Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794; and the Massachusetts Equal Rights Act, G.L. c. 93, § 103.

129. By unnecessarily holding Plaintiffs and others similarly situated who qualify as persons with disabilities in dangerous conditions, and by failing to adequately consider the provision of services in less dangerous settings where treatment may be more effectively provided, Defendants have utilized methods of administration that:

(a) Defeat or substantially impair accomplishment of the objective of treating the Plaintiffs and class members for mental health concerns;

(b) Effectively exclude Plaintiffs and class members from receiving appropriate treatment; and

(c) Fail to allow for the provision of reasonable modifications in typical discharge assessment practices or procedures, even though such modifications are necessary to avoid discrimination on the basis of disability.

Such methods of administration therefore violate the ADA, Section 504 of the Rehabilitation Act of 1973, and the Massachusetts Equal Rights Act.

130. By considering Plaintiffs' ability to observe social distancing and other COVID-19 precautions as a criterion for discharge from confinement from dangerous inpatient psychiatric hospital settings, when no other persons may be deprived of their freedom for this reason, Defendants have imposed discriminatory criteria for determining eligibility for less restrictive programs and activities that Defendants administer, in violation of the ADA, Section 504 of the Rehabilitation Act of 1973, and the Massachusetts Equal Rights Act.

VII. PRAYER FOR RELIEF

131. Based on the foregoing, Plaintiffs respectfully request that the Court order relief as follows:

(a) Issue a judicial declaration that Defendants violated Plaintiffs' rights to substantive due process and to be free from disability discrimination.

(b) Enjoin Defendants from:

1. Failing to, as soon as possible, assess all persons in their custody currently maintained in any DMH-operated congregate facility or unit, regardless of whether they are maintained involuntarily by virtue of an order of commitment, to determine if the benefits of remaining confined, given limitations on treatment imposed by the pandemic, outweigh the risks of confinement in light of individual class members' need for treatment in an inpatient setting and their susceptibility to severe illness because of high risk factors;

2. Failing to reduce the population sufficiently across all facilities so that no person shares a bedroom;

3. Failing to discharge persons who can live safely in the community, with or without supportive services, to less restrictive alternative settings;

4. Failing to provide treatment to the maximum extent feasible to those that remain in congregate care facilities;

5. Failing to allow those that remain in congregate care facilities opportunities for fresh air to the maximum extent feasible.

(c) Appoint a special master to supervise the assessment and discharge process.

(d) Award Plaintiffs attorneys' fees and costs.

(e) Order such other relief as this Court deems just.

DATED: July 1, 2020

/s/ Phillip Kassel__________
Phillip Kassel (BBO. No. 555845)
Caitlin Parton (BBO. No. 690970)
Lauren Roy (BBO. No. 662582)
Mental Health Legal Advisors
Committee
24 School Street, Suite 804
Boston, MA 02108
617-338-2345
pkassel@mhlac.org
cparton@mhlac.org
lroy@mhlac.org