APPROPRIATE CARE IN THE APPROPRIATE SETTING: REFORMING BRIDGEWATER STATE HOSPITAL & STRENGTHENING THE COMMONWEALTH'S MENTAL HEALTH SYSTEM

The Departments of Correction and Mental Health share the overarching goal that individuals in Massachusetts who suffer from mental illness should receive the appropriate care in the appropriate setting, even where those individuals have come into the custody of the Commonwealth through the criminal justice system. On May 8, 2014, both Departments conveyed that foundational principle at a meeting convened by Governor Deval Patrick at Bridgewater State Hospital, which included numerous stakeholders from the state's mental health and criminal justice systems.

The policy recommendations set forth in this document were discussed in very broad strokes at that meeting and have been developed further over the past month, through (i) extensive discussions and exchanges of ideas with stakeholders; and (ii) extensive internal work at the Departments of Correction and Mental Health and the Executive Offices of Public Safety and Security and Health and Human Services.

Bridgewater State Hospital (BSH) exists by statute, which provides that it shall be operated by the Department of Correction and that patients shall not be admitted to it without a court order committing them, after a finding that, among other things, the patient requires a strict security setting for the safety of that individual and others. For certain patients, particularly those who have been convicted of serious criminal behavior and sentenced to a correctional institution, BSH may — with the appropriate improvements, described below — be the appropriate setting. For others, particularly those who, although charged with a crime, have not been convicted of any criminal wrongdoing, a secure hospital outside of a correctional setting might provide a more therapeutically appropriate environment. No such institution currently exists. As we propose below, the Administration, working with the Legislature, will address that need.

In the more immediate term, the court system, the Department of Mental Health, and the Department of Correction need more options and more resources to address the needs of the mentally ill whose paths have intersected with the criminal justice system. If the appropriate setting for the treatment and assessment of an individual is in the custody of the Department of Mental Health, we need the open beds and funding to

provide that treatment and those assessments. If the appropriate setting is in the community, our court clinics require the resources to allow them to conduct the required assessments outside of hospital or correctional settings. If the appropriate setting is correctional, improved treatment will require additional clinical staffing and more extensive training at BSH. The work has been done to identify and crystalize these needs. Below, we describe the overarching goals of our work and a proposal to seek the resources needed to achieve them.

The issue of how best to treat mentally ill individuals who have come into contact with the criminal justice system is complex and cannot be solved with a "magic bullet." The experience not only of this Commonwealth, but of every state in the country has taught us as much. Nonetheless, we can and must do better.

To that end, DOC and DMH have identified the number of achievable, short-term (60 days or less), intermediate-term (6 months or less), and long-term (more than 6 months) goals for improvements to the continuum of care for mentally ill persons who require assessment and treatment in the context of their involvement in the criminal justice system. Work has already begun, and to extent of available resources, progress has already been made to achieve these goals.

GOAL: To prevent the use of seclusion and restraint at BSH, using a treatment model that is trauma-informed. (Short-term; ongoing)

Steps already completed:

- Substantial Prevention. BSH has significantly reduced the use of seclusion and restraint by implementing a variety of individualized clinical management strategies. Since January 2014, the total number of restraint hours at BSH is down by over 90%. The total number of seclusion hours is down by more than 50%.

- Consultation and Training. BSH leadership and staff have completed a four-day consultation session with nationally-renowned expert Dr. Joan Gillece. Among other prominent roles, Dr. Gillece is the Project Director for the National Center for Trauma Informed Care, which is operated by the federal Substance Abuse and Mental Health Services Administration. The

consultation addressed evidenced-based strategies for trauma informed care and the prevention of restraint and seclusion. The consultation will be ongoing, as Dr. Gillece will assist DOC and DMH as they establish a comprehensive and effective training program for BSH staff designed to prevent the need for seclusion and restraint.

- Expansion of Treatment Options. A key step in the reduction of seclusion and restraint is the introduction of other treatment and de-escalation options for clinicians at BSH. As described below, DMH continues to work with DOC to develop these options, but several already have been implemented at BSH, including, for example, sensory integration and the use of weighted vests. These interventions are among those that have been shown to be effective in providing patients with methods to de-escalate and calm themselves in ways that avoid confrontations that often lead to restraint and seclusion.

Next steps:

- Environmental Improvements to BSH. Two senior DMH officials — Assistant Commissioner Debra Pinals, MD and Director of Systems Transformation Janice LeBel, Ph.D. — have conducted an environmental scan of BSH to determine where and how the environment of care (including alternatives to seclusion and restraint) can be improved. Improvement to the environment of care will include increased clinical staffing (addressed further below).

- Infrastructural Assessment of and Improvements to BSH. In the Capital Investment Plan, the Administration will include $500,000 for an infrastructural assessment of and improvements to BSH. The goal of the assessment and resulting renovation is to develop appropriate spaces for patient de-escalation and rehabilitation, which will afford BSH staff additional tools to manage challenging patients and to deescalate episodes that otherwise might require the use of seclusion or restraint.

- Increased Collaboration Between DOC and DMH. DOC will work with DMH to implement, on a day-to-day basis, the approaches

introduced by Dr. Gillece. Dr. LeBel, herself a nationally renowned expert in this field, will be the in-state resource to provide ongoing consultation and technical assistance to staff at BSH regarding restraint and seclusion prevention and the use of trauma-informed care. In addition, and subject to the appropriation of $325,000, DOC and DMH will work together on ongoing, in-depth training for BSH staff.

- More Detailed Data Collection. Within the next month, DMH Assistant Commissioner of Quality Utilization and Analysis Terri Anderson will review the existing seclusion and restraint data collection program at BSH and will make recommendations for an updated and more comprehensive system for recording, tracking and monitoring seclusion and restraint data, including efforts at prevention. This enhanced data will inform the collaborative effort between DOC and DMH to reduce the triggers for episodes giving rise to seclusion and restraint, and to develop effective alternatives to seclusion and restraint.

GOAL: Recognizing that the decision to commit a patient to BSH is a judicial determination that often involves the various District Attorneys, DOC and DMH will work together to ensure that patients at BSH receive the appropriate care, including a treatment plan that, where appropriate, is tailored to achieve a transition to a less restrictive setting. (Short- and mid-term)

Steps already completed:

- DOC and DMH Collaboration. DOC and DMH have had a long-standing working relationship aimed at stepping patients committed to BSH down to a DMH facility, where appropriate. This working relationship has been strengthened and reinforced, to the extent that DOC and DMH are in daily contact to identify individuals who may be appropriately transitioned to DMH care — and to discuss the treatment plan for those who may be stepped down in the near future.

- BSH Review of Patient Population and Resulting Step Downs. In May 2014, DOC, with DMH consultation, has reviewed the cases of each individual committed to BSH pursuant to G.L. c. 123, §§ 7,

8, to determine whether a transition to DMH care might be appropriate. These are individuals whose criminal cases have been resolved, but who were determined by a court to require continued care and treatment in a strict security environment. Within the past month, at least 16 patients have already been stepped down to DMH, and DOC has initiated the process for obtaining judicial approval for transfer to DMH for others.

Next steps:

- Increase in DOC Staffing. Increased clinical staffing at BSH is critical to the success of this initiative in nearly every respect — increased staff yields more effective individualized treatment plans and a greater capacity to deescalate acute events. Working with DMH, DOC and its health care vendor have identified a present need for 130 additional full time clinical employees, at a cost of up to $10 million. These employees will augment the current staff of psychiatrists, psychologists, nurses and mental health workers. If this funding is appropriated promptly, DOC and its vendor believe that these clinical resources may be added by September 1, 2014.

- Enhanced Clinical Care Coordination. DOC and DMH will enhance existing clinical care coordination between BSH and DMH when patients are "stepping down" to a DMH facility, and when patients who have received treatment at DMH are committed by a court to BSH. DOC and DMH will increase collaboration regarding alternative interventions utilized to decrease the use of seclusion/restraint and determine how to incorporate these strategies into the BSH repertoire of alternative interventions to prevent the use of seclusion/restraint.

- Department of Developmental Services (DDS) Assessments. DOC will work with DDS to facilitate on-site reviews for DDS eligibility and, if deemed eligible, explore possible discharge planning to the community.

- Collaborative Review of Practices and Policies at BSH. With DMH, DOC has undertaken a review of existing facility safety programs with a focus on potential enhancements in the areas of rights, responsibilities, and respect across all members of the hospital community, including staff, patients and administration, to

carry consistent messaging about the goal of non-violence in the correctional environment. DMH will also share its current policies in this area so that a greater emphasis on clinical goals can be studied and potentially adopted (e.g., institution of more clinically focused BSH stand-alone procedures). DOC will also review and revise DOC/BSH policies and procedures to reflect the implementation of training initiatives. Policy revisions stemming from this review will be completed on or before September 1, 2014.

GOAL: To enhance the range of options available to the courts when a defendant presents with symptoms of acute mental illness. (Short- and mid-term)

Next Steps:

- Increase Number of Court Clinicians & Decrease Need for Forensic Evaluations at BSH. Throughout the Commonwealth, court clinicians are DMH employees (or employees of a DMH vendor). The court clinics do not presently have the capacity to expand their services to encompass increased numbers of evaluations in community or jail settings. With a $1 million investment in this workforce, court clinicians would be better equipped to conduct forensic evaluations for individuals in the community or, alternatively, individuals held in a correctional setting on bail/dangerousness grounds. We expect this increased capacity will reduce the number of non-sentenced patients committed to BSH.

- Increase DMH Capacity. If DMH and DOC are to work together to step down BSH patients to a DMH setting (where appropriate and with court approval), a DMH placement must be available for that patient. Moreover, if a court determines that a defendant requires an inpatient clinical evaluation, DMH is an option only to the extent that it has a bed available. While DMH has been able to accommodate the need for forensic evaluations under current conditions, any significant increase in admissions from the criminal courts or in step-downs from BSH will exceed its capacity to accept those admissions as well as transfers of patients from private psychiatric hospitals who also require DMH inpatient

continuing care. Meaningfully addressing DMH's inpatient capacity will affect the range of options available to the courts (in making placement determinations) and DOC and DMH (in making placement recommendations). Two steps will address that capacity. First, DMH has identified 100 patients in its continuing care inpatient system who are discharge ready, but for whom there are insufficient community placements. The funding of 100 community supported placements for these discharge-ready patients will free up 100 DMH inpatient beds. Second, funding 52 available (but currently unfunded) beds at the Worcester Recovery Center and Hospital (WRCH), would add an additional 52 beds. We will work with our partners in the Legislature to fund each of these 152 placements.

- Judicial Cooperation. If the range of options available to the court system is enhanced, DOC and DMH will work together with the courts to develop extensive guidance concerning an appropriate placement for individuals in the criminal justice system who present with acute mental health needs. In the longer term, this cooperation may require legislative change, as described below.

GOAL: To develop an inpatient forensic mental health hospital to be operated by the Department of Mental Health, that can provide the range of security necessary for the treatment and forensic assessment of non-sentenced individuals outside of a correctional environment. (Long-term)

Next Steps:

- Capital Expenditure on Feasibility Assessment. At present, the Commonwealth does not have a facility capable of treating individuals who require mental health treatment and clinical assessment in a medium-security setting. Because of the safety needs of the community, other DMH patients, and DMH clinicians and staff, no current DMH facility is equipped to handle this population. Accordingly, with enactment of the General Government Bond Bill (S 2187) which recently passed the Senate, the Administration will commit $500,000 in the FY15 Capital Investment Plan to assess the feasibility of retrofitting an existing

state facility to accommodate this population or, alternatively, to designing a new facility.

- Legislation. Statutory revision will be required to establish such a facility under DMH jurisdiction, to delineate necessary distinctions between that facility and DMH's civil continuing care inpatient facilities and to outline the criteria by which an individual may be committed to its care. We will introduce legislation on or before July 1, 2014 that will set forth the Administration's position on the required revision and we welcome the constructive input of the mental health and criminal justice stakeholders on that important task.