'Daily tragedies' at Massachusetts mental health hospital require immediate action, report shows

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Prison guards aren't mental health professionals and that needs to change at Bridgewater State Hospital. A new report recommends shifting away

from the Department of Correction to the Department of Mental Health to avoid the "daily tragedies" taking place there.

The Disability Law Center said that following "report after report" of patients at the facility facing "illegal restraint and seclusion practices, disproportionate and unnecessary uses of force, a culture of intimidation, and the absence of a therapeutic milieu," that the only path forward is to change the state laws that allow those "with the most significant mental health disabilities in the Commonwealth" to be placed under the authority of prison guards instead of the care of mental health professionals.

"The Commonwealth must immediately place BSH operations under the authority of DMH to ensure current and future (persons served) access to trauma informed, person-centered mental health treatment," the Center wrote in their report.

After that's done, the state must then "urgently construct a modern DMH hospital facility designed to provide all individuals in need of 'strict security' psychiatric evaluation and/or treatment in a safe, therapeutic environment and finally close BSH," they wrote.

The report, released publicly this week but apparently provided a full week prior to Senate President Karen Spilka, House Speaker Ron Mariano, the Chairs of the Joint Committee on Mental Health Substance Use and Recovery, Joint Committee on the Judiciary, Senate Ways and Means Committee, and House Ways and Means Committee, shows that after a decade of monitoring at the so-called hospital, there are still "daily tragedies occurring within BSH."

"Every day the law remains unchanged, individuals involuntarily committed to BSH on the basis of their mental health condition suffer. And every day, individuals with serious mental health disabilities suffer,

the Commonwealth fails to uphold its legal and moral obligations to PS and the general public," they wrote.

The state facility, which, despite its name, is not an accredited hospital, was built in 1974 and is in very serious need of repairs. It was built as a jail instead of a hospital, according to the report, featuring cells instead of treatment rooms.

It is, by statute, designed to be occupied by men determined to require "strict security," though according to DLC that term is undefined enough under state law that a person's need for "strict security" is left up to "decision-maker bias based on an individual's race and ethnicity."

"The impact of racial bias in Massachusetts' mental health and criminal systems on the BSH population is as true today as it was 20 years ago when a study found that Black and Hispanic/Latinx male defendants were more likely than White male defendants to be referred for an inpatient evaluation in a strict security facility, regardless of diagnoses and the level of severity of the criminal charges," they wrote.

The report authors, who are tasked under federal law to monitor conditions at facilities that serve those with disabilities, say they have informed both the Department of Corrections and Wellpath, the private company tasked with day-to-day operations at BSH, of a need for change, but that their calls have for the most part gone unanswered.

"Unfortunately, even with the lines of communication open and positive changes stemming from DLC's recommendations, improvements fall short of addressing the counter-therapeutic conditions and legal violations that dominate the experiences of BSH Persons Served," they wrote.

A spokesperson for the DOC said they cannot comment on proposed

legislation, nor do they have any say in what facilities might fall under their purview according to the state's laws, but that while Bridgewater is under their control it is run in accordance with the high standards of the department.

"The Massachusetts Department of Correction remains deeply committed to serving patients who have complex needs and require strict security hospitalization," they told the Herald.

Adding, "It is the DOC's goal to provide the highest quality of care, forensic evaluation, and treatment. The DOC has enhanced staff training , increased independent oversight by behavioral and mental health experts who review policies to ensure alignment by Department of Mental Health policies and regulations, and worked diligently with our external medical provider to implement trauma-informed principles."

DOC also pushed back on several of the report's findings.

In response to allegations in DLC's report that Bridgewater has a mold problem, DOC said the facility is inspected quarterly for mold remediation and serviced daily by a contract cleaning agency.

When restraints must be used on a patient, they say, the procedure is tracked and videos of restraint instances reviewed after the fact to ensure the act was appropriate. Events requiring further review are escalated to executive leadership at a "Serious Clinical Episode Committee" and further investigation ordered if necessary.

The facility staffs a "qualified mental health professional" with "extensive behavioral experience," the spokesperson said, and retains the services of a nationally renowned mental health expert to review practices there.

Wellpath did not return a request for comment.