The Commonwealth of Massachusetts

Governor's Special Advisory Panel On Forensic Mental Health

FINAL REPORT

September, 1989

Michael S. Dukakis
Governor

Russell C. Petrella, Ph.D.
Chairman

Honorable Maurice H. Richardson
Vice Chairman

June S. Binney
Executive Director

The Commonwealth of Massachusetts

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September 25, 1989

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Representative Paul Kollios, Co-Chair
Joint Committee on Human Services
and Elderly Affairs
State House - Rooms 436 and 213B
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Dear Governor Dukakis, Senator Harold, Senator Houston, Senator McGovern, Representative Brett, Representative Kollios, and Representative Voke:

The Governor's Special Advisory Panel on Forensic Mental Health respectfully submits its Final Report. This report is the culmination of 17 months of work by the appointed members and staff of the Panel, as well as many individuals representing the Executive Office of Human Services; the Departments of Correction, Mental Health, Public Health and Youth Services; the Parole Board and Probation Department; the Committee on Criminal Justice; various District Attorneys' Offices; the Sheriffs' Association; the legislature and the judiciary.

Chapter 1 of the Acts of 1988 established the Panel and authorized it to make broad-based recommendations regarding mental health and substance abuse services for men and women in the criminal justice system, and others who require treatment in secure settings. The Panel's initial focus was on three of the

facilities which comprise the Bridgewater complex; Bridgewater State Hospital, the Treatment Center for Sexually Dangerous Persons and the Addiction Center. However, the Panel has also addressed many of the systemic issues which have a significant impact upon these facilities, as well as analogous services for women in the criminal justice system.

The Panel has benefited greatly from ongoing support and interest of administration officials and legislative leaders in this project. The Panel appreciates the opportunity to offer these recommendations for system-wide reform and hopes that their adoption will help make Massachusetts a leader in mental health and criminal justice policy.

Very truly yours,

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Honorable Maurice H. Richardson
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COMMONWEALTH OF MASSACHUSETTS

GOVERNOR'S SPECIAL ADVISORY PANEL ON FORENSIC MENTAL HEALTH

FINAL REPORT

SEPTEMBER, 1989

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The Panel is grateful to Saleem A. Shah, Ph.D. of the National Institute of Mental Health who gave his valuable time generously to the Panel and offered his keen and expert insights into our work. The Panel also appreciates the work of Joel Dvoskin, Ph.D. and Larry Fitch, J.D. who ably served as consultants to the Panel on two special projects.

The Panel would also like to express its appreciation to the numerous men and women who work in the public sector who have put significant time and effort into this project despite otherwise chaotic and busy schedules. Many people, too numerous to mention here, were instrumental in their participation on various subcommittees and working groups. Others who provided invaluable support and assistance to the Panel include the following individuals from the Department of Correction: Peter Argeropulos, Associate Commissioner of Administration; Peter Macchi, Ramona Giuffre, Virginia Barrows, and Wendy Johnson of the Business Office; Joseph Ryan and Pamela Gerrior of the Budget Office; Marlene Cronin of the Legal Division; and Linda Holt and Lisa Lorant of the Research Division. Special thanks to Donna Connolly and Frank Servello whose hard work and good humor is deeply appreciated.

The Panel also wishes to offer its thanks to the following Department of Mental Health employees: John Sickel, Patricia Dunn, Margaret Spencer and Jill Galluccio of the Division of Forensic Mental Health; Perry Trilling and Janet Chinian of the Division of Accounting and Operations; Susan Hebert of Human Resources; and Deborah Foti of the Contracts Unit, whose administrative and fiscal support is greatly appreciated. Special thanks to Jay Linnehan, Gloria Albano, Jane Guilfoyle, Robert Burns, Justine O'Donnell, Mark Perry, Michelle Davis, Maureen Martell, Ann O'Brien, Nikki Dotsias, Greca Benjamin and Kim Rivera of the Executive Office of Human Services, and Denise Findlay of the Division of Capital Planning and Operations. Their assistance, especially in the first months of the Panel's work, was essential in the development and completion of this project.

The Panel would also like to express its appreciation to the following individuals who assisted the Panel in an analysis of the legal ramifications of the Panel's recommendations: Honorable Margot Botsford, Allen J. Brown, J.D., Ph.D., Anna Doherty, Esq., Robert Fleischner, Esq., Stan Goldman, Esq., Edith C. Howe, Esq., Honorable George Hurd, Linda Katz, Esq., Richard McFarland, Esq., Honorable Paul Menton, William O'Leary, Esq., Ira Packer, Ph.D., Roberta

Parker, Esq., William Saltzman, Esq., Honorable William Teahan, and Nancy White, Esq.

The Panel is grateful to Superintendent John D. Noonan and his staff at the Addiction Center and the Treatment Center; Ian Tink, the Administrator of the Treatment Center; Superintendent Gerard F. Boyle and Wesley E. Profit, Ph.D. and their staff at Bridgewater State Hospital; and Superintendent Barbara Young and her staff at MCI-Framingham, who directly participated in the work of the Panel and graciously made their facilities accessible to Panel members and staff.

The Panel appreciates extra efforts made on behalf of this project by Dorothy Newton; Betsey Smith and Sister Jeanette Normandin of Social Justice for Women; Terry Theaux of COERS; Alice Jones and Janet Gornick of the Kennedy School of Government; Bea LaBarre and the staff at Massachusetts Osteopathic Hospital; Spring Redd and the staff at the Elizabeth Stone House; Elaine Lord and the staff at Bedford Hills Correctional Facility, New York; Renate Wack and Kin Wah Lee at the Kirby Forensic Psychiatric Center, New York; Marthagem Whitlock and Janice Spilman of the Tennessee Department of Mental Health and Mental Retardation; Paul Benedict, Loren Schechter, Harriet Parker and Steve O'Brien of MCI-Framingham; Jean Fox of Aid to Incarcerated Mothers; and to Janet Johnson, Mary Kent and Sue Neufeld.

Finally, the Panel would like to thank the many people around the state and country who took time out of their schedules to educate Panel members and staff about their work. Though not specifically mentioned here, their efforts were extremely important in the completion of this project. The Panel is grateful for having had the opportunity to work with and learn from this talented and dedicated group of individuals.

FINAL REPORT

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CHAPTER 1

INTRODUCTION

Chapter 1 of the Acts of 1988 provided for the establishment of a "special advisory panel on the organization and structure of the [C]ommonwealth's forensic mental health system and on the appropriate evaluation and treatment of mentally ill men and women who are in need of care in a medium or strict secure setting." The Panel was charged with evaluating the "existing organizational and management structure, purpose, and population of each of the five institutions forming the Bridgewater complex,[1]" and "review[ing] the laws, programs, policies and procedures which govern the referral and admission to, and discharge from each institution." The Panel's mandate was to make specific recommendations regarding the function of the Addiction Center, as well as the efficacy and relevance of the categorization and commitment of "sexually dangerous persons." In recognition that the MCI-Bridgewater complex serves only men, the Panel was asked to examine separately the mental health and substance abuse treatment needs of women within the criminal justice system. The Panel was authorized to formulate proposals for the development of a "statewide forensic mental health policy which meets the needs of both men and women, provides a continuum of services and treatment and examines components within the department of mental health, the department of corrections [sic], the court system, and the county houses of correction, including recommendations on the use of court clinics." Finally, the Panel was mandated to identify any "budgetary, administrative or capital resources or statutory changes necessary to implement its recommendations."

The Governor's Special Advisory Panel on Forensic Mental Health evolved from concern on the part of the legislature and the administration regarding well publicized problems at Bridgewater State Hospital, including the deaths of five patients. Upon examination, it became evident that conditions at Bridgewater reflected more than a century of scarce resources and benign neglect. In May, 1987, a Bridgewater State Hospital Working Group appointed by the Secretary of Human Services was charged with making recommendations to improve the quality of mental health services and security at the hospital. In August, 1987, the Working Group consisting of the Undersecretary of Human Services and the Commissioners of Correction and Mental Health, in recognizing long-standing problems at Bridgewater, concluded that "Bridgewater State Hospital should be supported to fulfill its mission as a mental health hospital with special security needs. The management and staffing standards of the hospital should be developed on the current model now envisioned for DMH hospitals throughout the Commonwealth." (See, Report of the Working Group on Bridgewater State Hospital, August 10, 1987.)

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1. The "five institutions forming the Bridgewater complex" are three specialized treatment facilities: Bridgewater State Hospital, a maximum security psychiatric facility; the Addiction Center, an alcohol and substance abuse treatment facility; and the Treatment Center for "sexually dangerous persons"; as well as two medium security prisons: Southeastern Correctional Center and Old Colony Correctional Center. The Panel focused on the three specialized treatment facilities.

In April, 1988, as part of a settlement agreement in a lawsuit brought on behalf of patients at Bridgewater State Hospital, a group of three experts in the field of forensic mental health began to review clinical and administrative issues affecting patient care at Bridgewater. These experts submitted an initial report which focused on the use of seclusion and restraint at the hospital in October, 1988, and have recently issued a final broader report. (See, Consultant Panel's Report on Seclusion and Restraint at the Bridgewater State Hospital, October, 1988 and Final Report of the Bridgewater State Hospital Consultants, July, 1989).[2]

Administration officials and legislative leaders quickly recognized that Bridgewater's problems were exacerbated by an inadequate and piecemeal approach to the provision of services afforded to mentally ill criminal defendants and offenders, as well as to others who, regardless of their criminal involvement, require hospitalization in secure facilities. These leaders also recognized that many analogous system-wide problems have historically plagued other institutions that comprise the Bridgewater complex; particularly the Addiction Center, a Department of Correction facility which treats men with alcohol and drug abuse disorders; and the Treatment Center, a facility jointly administered by the Department of Correction and the Department of Mental Health which houses men categorized by the courts as "sexually dangerous persons."

A November, 1987 Policy Report of the Senate Committee on Ways and Means which recommended the establishment of the Panel stated that, "[t]hroughout its history, MCI-Bridgewater[3] has provided a reflection of deficiencies in the Commonwealth's policies regarding public health, corrections, juvenile justice, mental health, social services, and forensic services." The Ways and Means' report concluded that, "[a]ny long-term solution of the problems at Bridgewater will require a broader examination of the Commonwealth's forensic mental health system and of the evaluation and treatment of mentally ill men and women who are in need of care in a secure environment." (See, The Bridgewater Correctional Complex, 1855-1987, A Policy Report of the Senate Committee on Ways and Means, Patricia McGovern, Chairwoman, November, 1987.) The Governor, the Secretary of Human Services, and the Commissioners of Correction and Mental Health endorsed the development of a Panel that would be charged with the review and evaluation of these service delivery systems.

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2. In order to avoid a duplication of efforts by the group of experts and this Panel, it was decided that this Panel would focus on broader systemic issues, while the experts would make recommendations regarding the internal administration of the hospital.

3. Until July, 1987, MCI-Bridgewater consisted of Bridgewater State Hospital, the Addiction Center, and the Treatment Center. Currently, MCI-Bridgewater is comprised of the Addiction Center and the Treatment Center. A 1987 Department of Correction initiative created a separate Superintendent's position to manage Bridgewater State Hospital. Since 1987, funding increases have provided for the development of a management team to administer the hospital as a separate facility.

In March, 1988, Shervert H. Frazier, M.D. accepted an appointment by the Governor as Chairman of the Governor's Special Advisory Panel on Forensic Mental Health. At that time, Dr. Frazier was Psychiatrist-in-Chief and General Director of McLean Hospital in Belmont, Massachusetts and is a former director of the National Institute of Mental Health. Soon thereafter, Dr. Frazier asked June S. Binney, Supervising Attorney at Bridgewater State Hospital, to serve as full-time Executive Director of the Panel.

In February, 1989, after Dr. Frazier resigned his post as Chairman, the Governor asked Russell C. Petrella, Ph.D. to assume the chairmanship of the Panel. Dr. Petrella is the Director of Forensic Services in the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services and the Chairman of the National Association of State Forensic Directors. Judge Maurice H. Richardson of the Dedham District Court, was asked to serve as Vice Chairman.

In addition to Dr. Petrella and Judge Richardson, the current members of the Panel are Secretary of Human Services Philip W. Johnston; Commissioner of Correction George Vose;[4] Commissioner of Mental Health Henry Tomes;[5] Renate C. Wack, Dipl. Psych., M.P.H., Executive Director of the Kirby Forensic Psychiatric Center, Ward's Island, New York; Camille G. Camp of the Criminal Justice Institute, Inc. in New York; Robert P. Gittens, Esq. of the Massachusetts Parole Board; Bernard G. Carey of the Massachusetts Association of Mental Health; and Thomas McKean, Esq., an attorney in private practice.

The Panel's enabling legislation, Chapter 1 of the Acts of 1988, provided that, in formulating its recommendations, the Panel may "travel out-of-state and may employ such staff, experts, and consultants, subject to the approval of the chairman, as deemed necessary." Chapter 1 further states that the Panel "shall be guided by nationally recognized models and standards which utilize state-of-the-art methodologies for the provision of mental health services in secure settings."

Start-up delays and budgetary difficulties postponed the initial hiring of staff and the opening of an administrative office until July, 1988. At that time, in recognition of the importance of this project and in order to avoid further delays, the Commissioners of Correction and Mental Health, with the support of the Secretary of Human Services, identified funds in existing accounts to support the Panel and its work.

In July, 1988, the Panel opened an administrative office in Room 1602 of the Leverett Saltonstall Building at 100 Cambridge Street in Boston. A full-time office manager, a part-time Director of Research, and a part-time Budget Director were hired. Two part-time clinical forensic psychologists, one who was assigned to the Panel from the Division of Forensic Mental Health in the Department of Mental Health, and one originally hired as a support staff person to Dr. Frazier, also worked with the Panel. An attorney from the Division of Forensic Mental Health was assigned to assist the Panel on special

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4. Commissioner Michael V. Fair was a Panel member until July, 1989, when he resigned his post as Commissioner of Correction.
5. Commissioner Edward M. Murphy, was a Panel member until May, 1989, when he resigned his post as Commissioner of Mental Health.

projects. Four graduate students in the fields of law, public health and social policy worked part-time as research assistants to the Panel.

From April, 1988, until September, 1989, the Panel met monthly in the Governor's Council Chamber. From the outset, the Panel recognized the extremely broad scope of its mandate and the significance of the issues it was to consider. At the Panel's organizational meeting, it was agreed that the substantive work of the Panel would be divided among four subcommittees which would report to the Panel at its monthly meetings. The four subcommittees focused on the following areas: 1) the forensic mental health system; 2) sex offender treatment services; 3) substance abuse treatment services; and 4) female offenders and pre-trial detainees with special needs. In May, 1988, the subcommittees began meeting at least monthly to review current services, note service gaps, and make recommendations to the full Panel. Each of the subcommittees also developed smaller task forces to address specific issues.

Each of the subcommittees consisted of Panel members or their designees, Panel staff, and other interested and knowledgeable representatives of the Executive Office of Human Services, the Departments of Mental Health, Correction, Public Health, and Youth Services; the Parole Board; the Probation Department; the Sheriffs' Association, various District Attorneys' offices; the legislature and the judiciary. The subcommittees relied heavily on research assistants who were assigned a variety of research and writing projects. The subcommittees also consulted with experts from around the country in developing their recommendations. Panel members and Panel staff visited the relevant programs around the state, and others travelled to other states to view model programs. A two day working session was held in May, 1989 at which judges, lawyers and policymakers experienced in mental health and criminal justice matters, discussed the legal ramifications of the Panel's recommendations and drafted model legislation to reflect the Panel's proposals.

CHAPTER 2

EXECUTIVE SUMMARY

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I. SUMMARY OF MAJOR RECOMMENDATIONS

A. SEX OFFENDERS RECOMMENDATIONS

1) EFFECT SIGNIFICANT REFORM OF THE SEX OFFENDER COMMITMENT STATUTE, CHAPTER 123A, TO STOP PRACTICE OF COMMITTING NEW "SEXUALLY DANGEROUS PERSONS" TO THE TREATMENT CENTER, AND TO PHASE OUT THE STATUTE OVER THE NEXT FIVE YEARS.

2) DEVELOP A PILOT VOLUNTARY TREATMENT PROGRAM FOR SEX OFFENDERS IN THE DEPARTMENT OF CORRECTION.

3) ESTABLISH A TRANSITIONAL TREATMENT PROGRAM FOR CIVILLY COMMITTED SEX OFFENDERS AND OTHERS REMAINING AT THE TREATMENT CENTER.

4) EXPAND TREATMENT SERVICES IN COUNTY AND STATE CORRECTIONAL FACILITIES AND PROBATION AND PAROLE SERVICES TO BETTER MEET THE TREATMENT NEEDS OF SEX OFFENDERS AND ASSURE PUBLIC SAFETY.

5) IMPLEMENT NEW STRICTER SENTENCING GUIDELINES FOR REPEAT SEX OFFENDERS TO ASSURE PUBLIC SAFETY.

B. FORENSIC MENTAL HEALTH RECOMMENDATIONS

6) CONTINUE ADMINISTRATION OF BRIDGEWATER STATE HOSPITAL BY DEPARTMENT OF CORRECTION, WITH DEPARTMENT OF MENTAL HEALTH DEVELOPING STANDARDS TO LICENSE BRIDGEWATER AS A MENTAL HEALTH FACILITY.

7) MOVE BRIDGEWATER STATE HOSPITAL FROM ITS CURRENT FACILITY TO THE TREATMENT CENTER FACILITY AS A DEPARTMENT OF CORRECTION PSYCHIATRIC HOSPITAL.

8) UTILIZE CURRENT BRIDGEWATER STATE HOSPITAL FACILITY AS 500+ BED SPECIALIZED PRISON OR LOW/MEDIUM SECURITY PRISON.

9) ENDORSE RECOMMENDATIONS OF PANEL OF EXPERTS UNDER O'SULLIVAN SETTLEMENT AGREEMENT FOR IMPROVEMENTS IN THE ADMINISTRATION OF BRIDGEWATER STATE HOSPITAL.

10) ENDORSE DEPARTMENT OF MENTAL HEALTH PLANS TO TRANSFER CIVILLY COMMITTED PATIENTS FROM BRIDGEWATER STATE HOSPITAL TO THE DEPARTMENT OF MENTAL HEALTH AND PLANS TO IMPROVE AND EXPAND SECURE EVALUATION AND TREATMENT CAPABILITIES.

11) ENDORSE DEPARTMENT OF MENTAL HEALTH PLANS TO EXPAND COURT CLINIC SERVICES AND ENCOURAGE INCREASED CAPACITY TO CONDUCT OUTPATIENT FORENSIC EVALUATIONS.

12) ENDORSE DEPARTMENT OF MENTAL HEALTH PLANS TO EXPAND MENTAL HEALTH SERVICES IN COUNTY HOUSES OF CORRECTION.

13) EXPAND CORRECTIONAL MENTAL HEALTH SERVICES IN THE STATE PRISONS AND ENCOURAGE DEPARTMENT OF CORRECTION TO DEVELOP SPECIALIZED MENTAL HEALTH UNITS.

14) DEVELOP A POST-RELEASE MONITORING SYSTEM FOR INDIVIDUALS FOUND NOT GUILTY BY REASON OF MENTAL ILLNESS.

15) DEVELOP SECURE EVALUATION AND HABILITATION SERVICES FOR MENTALLY RETARDED OFFENDERS.

C. SUBSTANCE ABUSE RECOMMENDATIONS

16) IMMEDIATELY IMPROVE PHYSICAL CONDITIONS AT THE ADDICTION CENTER.

17) IMMEDIATELY INCREASE STAFF AT THE ADDICTION CENTER.

18) DEVELOP A NEW SITE FOR A DEPARTMENT OF CORRECTION ADDICTION CENTER TO PROVIDE SUBSTANCE ABUSE TREATMENT SERVICES TO INDIVIDUALS IN THE CRIMINAL JUSTICE SYSTEM.

19) TRANSFER VOLUNTARY ALCOHOL AND DRUG ADDICTED INDIVIDUALS FROM THE ADDICTION CENTER TO THE DEPARTMENT OF PUBLIC HEALTH.

20) DEVELOP DEPARTMENT OF PUBLIC HEALTH CAPACITY TO PROVIDE SECURE SUBSTANCE ABUSE TREATMENT SERVICES FOR CIVILLY-COMMITTED INDIVIDUALS WHO ARE NOT INVOLVED IN THE CRIMINAL JUSTICE SYSTEM.

D. SPECIAL NEEDS FEMALE OFFENDERS AND DETAINEES RECOMMENDATIONS

21) INCREASE COORDINATION OF MENTAL HEALTH SERVICE DELIVERY AT MCI-FRAMINGHAM, WITH EVENTUAL CONSOLIDATION OF SERVICES UNDER ONE PROVIDER.

22) DEVELOP SPECIALIZED MENTAL HEALTH UNIT AT MCI-FRAMINGHAM FOR WOMEN WITH MENTAL HEALTH PROBLEMS WHO DO NOT REQUIRE HOSPITALIZATION.

23) INCREASE DEPARTMENT OF MENTAL HEALTH CAPACITY FOR INPATIENT TREATMENT FOR MENTALLY ILL WOMEN WHO REQUIRE SECURE HOSPITALIZATION.

24) DEVELOP COMMUNITY-BASED ALTERNATIVES TO INCARCERATION FOR WOMEN WHO ARE MENTALLY ILL OR WHO HAVE SUBSTANCE ABUSE DISORDERS AND WHO DO NOT PRESENT SECURITY RISKS.

25) DEVELOP DEPARTMENT OF PUBLIC HEALTH CAPACITY TO PROVIDE TREATMENT TO CIVILLY COMMITTED AND INCARCERATED WOMEN WHO REQUIRE SECURE DETOXIFICATION AND SUBSTANCE ABUSE TREATMENT SERVICES.

26) WORK WITH COUNTY CORRECTIONAL OFFICIALS TO ASSURE RANGE OF SERVICES TO WOMEN TRANSFERRED TO COUNTY HOUSES OF CORRECTION.

E. GENERAL RECOMMENDATION

27) ASK THE GOVERNOR AND SECRETARY OF HUMAN SERVICES TO DESIGNATE AN IMPLEMENTATION TEAM TO EFFECT THE PANEL'S RECOMMENDATIONS.

A. SEX OFFENDERS RECOMMENDATIONS

INTRODUCTION

Massachusetts General Laws Chapter 123A allows for the involuntary civil commitment of certain repeat sex offenders to the Treatment Center at Bridgewater for "one-day-to-life." The Treatment Center, a three year old, $22 million facility, is jointly administered by the Department of Correction and the Department of Mental Health, with the Department of Correction providing security and the Department of Mental Health providing treatment services.

Sex offenders categorized by the courts as "sexually dangerous persons," serve criminal sentences concurrently with their civil commitments. There are currently 274 offenders committed to the Treatment Center as "sexually dangerous persons." Civil commitments may extend beyond the expiration of criminal sentences. Offenders are offered annual court hearings to determine whether they continue to be "sexually dangerous." When a superior court determines that they are no longer "sexually dangerous," they may be returned to prison to serve the remainder of their criminal sentences, or, if their sentences have expired, are released to the community.

The treatment program, administered by the Department of Mental Health, includes individual and group therapy, a system of graduated levels of privileges, and a court-mandated "Authorized Absence Program" which allows for the gradual reintegration of offenders into the community. Participation in the Authorized Absence Program ranges from leaving the Treatment Center accompanied by a staff escort for several hours to unescorted overnight absence from the Treatment Center. Currently, 58 men participate in the Authorized Absence Program.

1) EFFECT SIGNIFICANT REFORM OF THE SEX OFFENDER COMMITMENT STATUTE, CHAPTER 123A, TO STOP PRACTICE OF COMMITTING NEW "SEXUALLY DANGEROUS PERSONS" TO THE TREATMENT CENTER, AND TO PHASE OUT THE STATUTE OVER THE NEXT FIVE YEARS.

The Panel recommends that Massachusetts follow a nationwide trend by initiating major reform of the state's sex offenders commitment statute. The Panel views reform as necessary to correct the failure of the current statutory scheme to effectively address public safety concerns and to maximize the potential for successfully treating sex offenders.

Massachusetts remains one of four jurisdictions to retain an involuntary indefinite commitment statute for sex offenders. Questions about the nature and treatability of "sexual dangerousness" have led most of the 31 states which have had similar laws to repeal them or implement significant reforms. Professional organizations, such as the American Bar Association and the Group for the Advancement of Psychiatry, have strongly recommended repeal of these special

dispositional statutes. The two other states and the District of Columbia which have retained statutes similar to Massachusetts' rarely utilize them. A special commission in Illinois, one of the other two states with this type of law, has recently recommended repeal. In fact, Massachusetts, with 274 indefinitely committed "sexually dangerous persons," administers the largest program of its kind in the country.

These laws, which came into vogue in the 1940's and 1950's, were predicated on the assumption that a specific mental illness exists which is characterized by the commission of sex crimes. Closely linked to this assumption is that if "sexual dangerousness" is an "illness," then there must be a "cure." Today, mental health professionals generally question both assumptions and view "sexual dangerousness" as a legal category rather than a clinical diagnosis. In fact, only a handful of men at the Treatment Center suffer from a diagnosable mental illness.

Reliance on these basic misconceptions is troublesome for several reasons. Primarily, mental health professionals are asked to make decisions in areas more traditionally and appropriately within the criminal justice arena. For example, release decision-making with regard to all other sentenced offenders, including decisions regarding community access, has traditionally been the province of probation, correctional and parole officials. At the Treatment Center, these decisions have become the responsibility of mental health professionals. If "sexually dangerous persons" are not mentally ill and only questionably treatable, it is also improbable that mental health professionals can predict their potential for future violence with any degree of certainty.

In addition to its basis on flawed assumptions, the statute as currently structured is problematic in several regards. The statute provides for an involuntary commitment of sex offenders by the courts. Once committed, an offender may refuse to participate in any treatment programs whatsoever, and, in fact, up to 40 percent of the offenders at the Treatment Center have chosen not to receive any treatment at all. Staff do not have the authority to discharge an offender from the treatment program even if he refuses to avail himself of treatment opportunities.

The current system also distributes valuable and limited resources in an inequitable and counterproductive manner. First, the Treatment Center is utilized differentially by various counties, district attorneys and judges. Recent data shows that more than half of the men currently admitted to the Treatment Center came from three counties; Suffolk, Middlesex and Worcester. In addition, 24 percent of the state prison population at any one time are sex offenders. The Treatment Center, with 274 offenders, houses only 20 percent of the sex offenders in the state prison system. Additionally, one to two percent of men incarcerated in county houses of correction have been convicted of lesser sex offenses.

Finally, valuable treatment resources are being targeted at a population of offenders who are least likely to benefit from them. Primarily, offenders at the Treatment Center have already committed

numerous and particularly heinous sex offenses, and are less likely than younger or first time offenders to benefit from treatment intervention. Additionally, as mentioned earlier, Treatment Center staff do not have the authority to evaluate an individual's amenability to treatment, nor are they able to assure that a patient will participate in treatment.

Substantial and valuable treatment resources are thus being expended on a somewhat randomly selected minority of the sex offenders in the state prison system to the exclusion of the vast majority. Few resources are being utilized to treat sex offenders in county correctional facilities or to provide intervention at an earlier stage in an offender's criminal "career." This unbalanced allocation of state funds is particularly unjust given that there are no assurances that the chosen few will even participate in or potentially benefit from treatment opportunities.

The Panel believes that the basic flaws in the current statutory scheme and inequities in resource allocation can be corrected by adopting the following measures:

A. Repeal Massachusetts General Laws Chapter 123A as of June 30, 1994;

B. Retain jurisdiction of the 274 men currently committed to the Treatment Center under the current statute;

C. Transfer men currently at the Treatment Center who have criminal sentences to correctional facilities if it is determined they will be more appropriately served in correctional settings;

D. Develop transitional treatment program for men who no longer have criminal sentences and others remaining at the Treatment Center.

2) **DEVELOP A PILOT VOLUNTARY TREATMENT PROGRAM FOR SEX OFFENDERS IN THE DEPARTMENT OF CORRECTION.**

While seriously questioning the capacity of the sex offenders commitment statute as currently construed to assure either public safety or treatment success, the Panel believes that certain conditions could maximize the potential for effective treatment. The Panel views the prevention of future offenses by sex offenders and other violent offenders as an essential and laudable goal. The Panel therefore proposes that the Department of Correction develop a pilot treatment program for sex offenders in the state prison system, including those offenders returning to the prison system from the Treatment Center.

In formulating its recommendations, the Panel has carefully studied sex offender treatment programs in other states. States which have reported some success in treating sex offenders, such as Oregon

and Vermont, have programs which incorporate many of the same elements of program design. Others, such as California, also have a strong research component built into their enabling legislation in order to assess the effectiveness of the treatment program and to justify its continued funding.

First, these programs are all offered to sex offenders on a voluntary basis. Moreover, offenders are screened by treatment staff prior to admission to assess their amenability to treatment. Once accepted into the program, offenders who do not avail themselves of treatment opportunities must leave the program. Indeterminate sentencing or commitment is not a component of any of the programs. Most of these programs utilize a "relapse prevention" model which is an integrated approach to treatment, incorporating elements of psychodynamic, behavioral, cognitive and biomedical theories. Educating and training offenders to recognize and interrupt patterns of violent behavior is an essential component of a "relapse prevention" program. Each of these states also offers a continuum of services to sex offenders, including careful aftercare planning and community monitoring programs. Finally, these programs have significant research capabilities, in order to objectively assess the success of treatment efforts.

The Panel recommends that Massachusetts develop a voluntary treatment program for sex offenders in the Department of Correction modeled on those in other states.

3) **DEVELOP A TRANSITIONAL TREATMENT PROGRAM FOR CIVILLY COMMITTED SEX OFFENDERS AND OTHERS REMAINING AT THE TREATMENT CENTER.**

If the recommended reforms of the sex offender commitment statute are implemented, many of the 199 offenders still serving criminal sentences will be transferred from the Treatment Center to correctional facilities. These offenders will be offered an opportunity to participate in a new voluntary treatment program. The remaining 75 "sexually dangerous persons" are no longer serving criminal sentences. The Panel has recommended that these offenders remain in a transitional treatment program until the current statute is repealed.

The Panel strongly recommends that these 75 civilly committed men remain at the Treatment Center and that a transitional treatment program be developed for them and others left in the program. The civilly committed patients, all of whom have lengthy criminal histories, have been at the Treatment Center for an average of 12 years. Fifty-six of the civilly committed men engage in some treatment programs at the Treatment Center; 24 are participating in the community access program.

The Panel believes that these men would pose a significant risk to public safety should they be released from the Treatment Center immediately. Accordingly, a transitional treatment program should be developed for these offenders. Among the components of this program

would be graduated tiers of privileges, community monitoring and periodic reviews of their progress in the program.

4) **EXPAND TREATMENT SERVICES IN COUNTY AND STATE CORRECTIONAL FACILITIES AND PROBATION AND PAROLE SERVICES TO BETTER MEET THE TREATMENT NEEDS OF SEX OFFENDERS AND ASSURE PUBLIC SAFETY.**

The Panel does not view the involuntary, indefinite civil commitment of sex offenders as meeting either public safety or treatment needs; however, the Panel is cognizant of the increasing numbers of sex offenders who are coming into the criminal justice system, and the need to provide state-of-the-art services to attempt to meet this problem. Preventive intervention and programs aimed at minimizing the risk of reoffending must be developed.

In 1988, the Department of Social Services substantiated incidents of sexual abuse in the cases of 2,557 children and reported approximately 1800 cases to District Attorneys' Offices throughout the Commonwealth. The Probation Department had 600-700 sex offenders under its authority last year. The Parole Board estimates 10 percent of those on parole or more than 400 persons were convicted of sex offenses. Currently, 24 percent of all state prison inmates or over 2,000 inmates are serving sentences for or have histories of having committed sex offenses. County houses of correction report that between one and two percent of their sentenced population are sex offenders.

These significant and increasing numbers of sex offenders in the criminal justice system call for the development of a uniform and coordinated set of responses to manage and treat this population. Since substantial numbers of sex offenders are in the community either on probation or parole, officers of these agencies should receive specialized training in community monitoring of these individuals. County and state correctional facilities must be able to provide, on a consistent basis, high quality treatment services to sex offenders who are amenable to treatment. Administrators of programs within correctional facilities should develop the capacity to share information about inmates' participation in these programs with appropriate community monitoring agencies, such as the Parole Board and the Probation Department.

The Panel recommends the development of a system of sex offender treatment services for various criminal justice agencies, including the following:

A **Specialized treatment groups should be provided for sex offenders in each prison and house of correction.**

B. **Designated staff should be assigned to work with probationers, houses of correction inmates and parolees who have been previously identified as sex offenders. Specialized training should be provided on an ongoing basis to support these staff.**

C. **Outpatient sex offender groups for persons with histories of sexual aggression should be provided in at least one Department of Mental Health-supported community mental health center in each Department of Mental Health region for probationers and parolees.**

5) IMPLEMENT NEW STRICTER SENTENCING GUIDELINES FOR REPEAT SEX OFFENDERS TO ASSURE PUBLIC SAFETY.

The Panel is recommending a major overhaul of the sex offenders commitment statute. The Panel recognizes however, that the proposed repeal of the "one-day-to-life" commitment provisions of the statute may have implications for the Commonwealth's sentencing structure for habitual or repeat sex offenders. The Panel is therefore recommending that the Legislature adopt strict sentencing guidelines for repeat sex offenders.

The "one-day-to-life" provisions are understandably viewed by certain law enforcement officials and the public as a "safety net." This indefinite commitment is seen as allowing for a more prolonged incarceration than would be otherwise achieved through the traditional criminal sentencing process. Thus, the Panel has learned that district attorneys, who believe that a lengthy sentence may not be imposed in a particular case, sometimes request an evaluation to determine if the defendant is a "sexually dangerous person." The intention in such cases is for the "one-day-to-life" commitment to compensate for a perceived inadequate criminal sentence.

The perception that a "one-day-to-life" commitment incarcerates offenders for life is erroneous, however. An individual committed as a "sexually dangerous person" has the right to petition the court for his release on an annual basis. If the court finds that he is no longer "sexually dangerous," he must return to prison if he is still serving a concurrent criminal sentence, or, if his sentence has expired, he is released. Indeed, 229 "sexually dangerous persons" have been released directly from the Treatment Center to the community by the courts since 1959, and 65 have been released since 1980. Additionally, the court-mandated Authorized Absence Program at the Treatment Center affords 20 percent of the Treatment Center population with various degrees of community access including, on occasion, overnight absences from the facility. Finally, under the current system, all release and community access decision making is the responsibility of mental health professionals at the Treatment Center. Questions about the nature and treatability of "sexual dangerousness," and skepticism regarding the ability of mental health professionals to predict the future dangerousness of non-mentally ill violent offenders raise serious doubts about the current system's ability to protect the public.

The Panel recognizes the serious responsibility of these service systems to protect the public. The Panel has therefore convened a working group of judges and attorneys to review the current sentencing structure for repeat sex offenders and to make recommendations for reform which would better assure public safety.

The working group reviewed current sentencing laws and practices and has recommended more frequent reliance by district attorneys on the habitual offender statute, General Laws Chapter 279, section 25.

The statute allows for imposition of the maximum sentence for any felony in cases where an offender has been twice convicted and sentenced previously for terms of not less than three years.

The working group has further recommended new statutory authority which would enable prosecuting attorneys to pursue imprisonment of a repeat offender in the state prison for a minimum term of not less than ten years and a maximum term of life. This tougher sentencing law would apply to a repeat sex offense for which the offender was originally convicted or for other sex offenses, as specified by statute. No repeat offender sentenced under this stricter law would be eligible for furlough, temporary release, or education, training or employment programs established outside a correctional facility until he has served two-thirds of the minimum sentence or, if the person had two or more sentences to be served, two-thirds of the aggregate of the minimum terms of the several sentences.

B. FORENSIC MENTAL HEALTH RECOMMENDATIONS

INTRODUCTION

Bridgewater State Hospital is the Commonwealth's only maximum security psychiatric facility. In this capacity, Bridgewater is charged with the evaluation, treatment and custody of men who are seen as mentally ill, and who by reason of their histories of or potential for violent behavior, require hospitalization in conditions of maximum or "strict" security.

Until recently, Bridgewater State Hospital has served as the provider of virtually all of the Commonwealth's forensic mental health services. In the late 1970's, the Department of Mental Health shifted its focus from inpatient care to community services and became increasingly reluctant and ill-equipped to manage and treat individuals who required secure or long-term care. Thus, as the state's only psychiatric facility which has had the capacity and willingness to provide these services, Bridgewater has been further required to treat men who are not subjects of the criminal justice system. Often, men who have not required the level of security offered at Bridgewater, have been nonetheless hospitalized there for a lack of viable dispositional alternatives. For judges and mental health professionals responsible for deciding between alternative placements of mentally ill men who require hospitalization, the choice became one of Bridgewater or the community.

Massachusetts, through its overuse of Bridgewater State Hospital, has more patients hospitalized in conditions of maximum security than states of comparable size. Recent problems at Bridgewater have to be seen in the context of this overutilization of the hospital, coupled with its history of scarce resources and lack of control over the quantity and quality of its admissions. Moreover, inappropriate utilization of the highest level of secure mental health beds is costly and ill-suited to meet the treatment needs of patients and the safety needs of the community.

In 1985, a new Division of Forensic Mental Health was established within the Department of Mental Health. This Division has begun to expand and improve evaluation and treatment services in the courts, the county houses of correction and in Department of Mental Health inpatient hospitals. These improvements have begun to alleviate some of the burden on Bridgewater State Hospital to serve as the major provider of forensic mental health services in the Commonwealth. It is anticipated that the provision of these services across a system, rather than at one central facility, will reduce inappropriate overreliance on Bridgewater State Hospital.

The 134 years of Bridgewater's history show a pattern of too few resources to care for too many patients. The years of neglect eventually led up to a major crisis or tragedy, followed by intense public scrutiny. Most recently, in 1987, a series of five deaths at Bridgewater State Hospital led to renewed public attention on the hospital. Since 1987, substantial long-awaited and greatly needed improvements have been initiated by the administration and the legislature. In January, 1988,

Governor Dukakis signed a $2.3 million (or $5 million on an annual basis) appropriation for Bridgewater State Hospital. This major infusion of resources produced a 90 percent increase in staff for the hospital and a nearly 70 percent increase in the hospital's annual funding. A new management team has utilized these resources to implement a wide range of improvements in treatment services, rehabilitative and recreational programs and living conditions, and strides are being made towards the hospital's goal of accreditation by the Joint Commission of the Accreditation of Health Care Organizations (JCAHO).

A major policy decision by the Secretary of Human Services in 1987 has led to plans to transfer most civilly committed patients from Bridgewater to the Department of Mental Health and to end the practice of transferring these patients into Bridgewater. This decision was subsequently reflected in a settlement agreement in the O'Sullivan, et al. v. Dukakis, et al. case in November, 1987, and in Chapter 1 of the Acts of 1988. By January, 1990, it is anticipated that a new Department of Mental Health secure facility at Medfield State Hospital will open to house 50 civilly committed patients. A panel of consultants has recently issued a blueprint for improvements in the internal administration and organization of Bridgewater State Hospital, which has been endorsed by Department of Correction officials and Bridgewater State Hospital staff. Finally, this Panel was given a broad mandate to make recommendations regarding all services provided to mentally ill individuals who are subjects of the criminal justice system or who require hospitalization in secure facilities, and to reassess the role of Bridgewater State Hospital in the overall forensic mental health system.

The Panel lauds the improvements at Bridgewater made by the Department of Correction and at other settings through the Division of Forensic Mental Health. The Panel supports continuing efforts for further improvements and sets forth these recommendations to bolster ongoing progress and to further the goal of establishing a system of forensic mental health services in the Commonwealth which will serve as a national model.

MAJOR RECOMMENDATIONS

6) CONTINUE ADMINISTRATION OF BRIDGEWATER STATE HOSPITAL BY DEPARTMENT OF CORRECTION, WITH DEPARTMENT OF MENTAL HEALTH DEVELOPING STANDARDS TO LICENSE BRIDGEWATER AS A MENTAL HEALTH FACILITY.

The Panel, after careful consideration of other alternatives, recommends that Bridgewater State Hospital continue to be administered by the Department of Correction. The Panel further recommends that the Department of Mental Health, in conjunction with the Department of Correction, develop standards to license Bridgewater as a mental health facility which would assure that services are equivalent to those provided at Department of Mental Health facilities.

The Panel has specifically chosen not to recommend that the Department of Mental Health assume responsibility for the

administration of Bridgewater State Hospital. The Panel has based its recommendation on several factors. Although the Department of Correction has administered Bridgewater State Hospital for over a century with scant resources and little support, the past several years have seen an infusion of funding and the support of administration officials, which have resulted in substantial improvements at the hospital. A change in the administrative agency at this time would be sufficiently destabilizing to undermine these very significant efforts. Moreover, the Department of Correction is best equipped to provide adequate security for violent individuals in order to assure public safety. Finally, the Department of Mental Health is already undergoing expansion of services and programs to increase its capacity to provide secure evaluation and treatment services. The new services include a unit currently under construction at Medfield State Hospital for civil patients who require security, "Difficult to Manage" units at the major state hospitals, and an increase in beds available for women who require secure evaluation and treatment services at the Taunton Secure Care Unit. The Panel commends these improvements and recommends that the Department of Mental Health should be supported to continue to improve and expand its capacity to provide secure services, while allowing Bridgewater to realize ongoing improvements and assure public safety.

In order to assure that Bridgewater patients receive equivalent services to those patients in Department of Mental Health facilities, the Panel recommends the Department of Mental Health develop standards to license Bridgewater as a psychiatric hospital.

These recommendations are consistent with the findings of the panel of consultants appointed to review the internal administration of Bridgewater State Hospital. In recognizing the hospital's progress toward achieving accreditation and in setting forth a blueprint for future improvements, the panel of consultants recommended that Bridgewater be established as a separate and specialized Department of Correction facility, that the hospital's budget be increased to bring Bridgewater's funding to that of comparable Department of Mental Health inpatient facilities and secure treatment facilities in other states, and that the Superintendent's position at Bridgewater be reevaluated to reflect the position and salary of Department of Mental Health facility directors. These goals could be met through the continued administration of Bridgewater by the Department of Correction, with licensing by the Department of Mental Health of Bridgewater as a psychiatric hospital.

7) **MOVE BRIDGEWATER STATE HOSPITAL FROM ITS CURRENT FACILITY TO THE TREATMENT CENTER FACILITY AS A DEPARTMENT OF CORRECTION PSYCHIATRIC HOSPITAL.**

The Panel views the physical facility at Bridgewater State Hospital as a major hindrance in the hospital's efforts to provide quality evaluation and treatment services in a safe and secure environment. The Panel therefore recommends the transfer of Bridgewater State Hospital patients to the building which currently houses the Treatment Center.

Bridgewater State Hospital has existed in some form at or near its present site since 1955 when it was known as the Almshouse for Paupers. Since 1919, it has been administered by the Department of Correction, or its forerunner, the Bureau of Prisons.

Though the current physical facility is only 15 years old, it has, for some time, proven to be severely inadequate to meet the needs of the patients and staff at the hospital. First opened in 1974, the new hospital was hailed as a substantial improvement over the old facility where most of the buildings had been constructed in the latter part of the nineteenth century. However, it very quickly became evident that the new facility was obsolete for its purpose as a hospital. Over the last few years in the course of operating the hospital, its physical limitations have become more evident and, with time, have become increasingly problematic. Severely limited office space for clinical staff, a configuration of rooms that compromise security, and inadequate heating and electrical systems are just some of the problems which impede the effective administration of the hospital.

The Panel recommends that plans be developed to transfer patients currently at Bridgewater State Hospital to the Treatment Center Building. Though a substantial infusion of resources could remedy some of the hospital's structural defects and complete basic repair work, the facility's design will never be properly suited to serve as a hospital.

As discussed previously, the Panel recommends that the sex offender commitment statute, General Laws Chapter 123A be significantly reformed. The recommended reforms would transfer many of the sex offenders who are concurrently serving criminal sentences to appropriate correctional facilities to continue to serve their sentences and offer, to those interested in receiving treatment, the opportunity to do so in a new Department of Correction voluntary treatment program. A further recommendation that the patients who are committed to the Treatment Center remain there, requires that a new program be developed to effect the transition of that population from the Treatment Center over the next several years. The census at the Treatment Center is currently 274. The facility can comfortably accommodate 225 patients.

With current plans to transfer 50 civil patients from Bridgewater State Hospital to the Department of Mental Health and planned expansion of forensic mental health services in the courts and county houses of correction, it is anticipated that admissions to Bridgewater and the hospital's average daily census, currently at 380, will continue to decline.

Since states with populations comparable to the Commonwealth's (e.g., Virginia and Maryland) have approximately 200-250 maximum security beds, the Treatment Center facility would be well-suited in size to serve this population. Furthermore, the Treatment Center facility has ample program and treatment space to provide high quality evaluation and treatment services to the Bridgewater State Hospital population. Indeed, national experts in the field of forensic mental health who have

viewed the Treatment Center building have reported that the facility is well-suited to serve as a forensic hospital.

The Panel recommends that the planning process begin immediately to achieve the goal of re-siting Bridgewater State Hospital.

8) **UTILIZE CURRENT BRIDGEWATER STATE HOSPITAL FACILITY AS 500+ BED SPECIALIZED PRISON OR LOW/MEDIUM SECURITY PRISON.**

The Panel views the physical facility currently housing Bridgewater State Hospital as inadequate to serve as a hospital. However, the Panel believes strongly that the current facility, with minor repairs and renovations, would be ideally suited to serve as a 500 bed prison.

The Panel recognizes the Commonwealth's acute need for additional prison beds. The Bridgewater State Hospital facility would be capable of housing 500 prison inmates soon after the current population is transferred to the Treatment Center facility.

Ideally, the Panel envisions that the current hospital facility would be utilized as a specialized unit for state prison inmates who, because of special program needs or status, cannot be adequately or appropriately managed in a general prison population. The Panel, however, is cognizant of the immediate need for housing space for prison inmates, and would defer to the judgment of state prison officials regarding the most appropriate utilization of the facility. A compromise position would be to use the facility on a short-term basis as a low/medium security prison to offer immediate relief to other overcrowded facilities, while planning on a long-term basis for a more specialized use, pending the development of additional prison sites.

9) **ENDORSE RECOMMENDATIONS OF PANEL OF EXPERTS UNDER O'SULLIVAN SETTLEMENT AGREEMENT FOR IMPROVEMENTS IN THE ADMINISTRATION OF BRIDGEWATER STATE HOSPITAL.**

Under the provisions of the 1987 settlement agreement in the case of O'Sullivan et al. v. Dukakis, et al., a panel of experts has been reviewing and analyzing the internal operational, administrative and clinical functioning of Bridgewater State Hospital and has recently issued its findings. In order to avoid a duplication of work efforts, this Panel has deferred to the O'Sullivan panel of experts on recommendations regarding the internal administration of Bridgewater State Hospital. Instead, this Panel has focused on systemwide issues regarding the provision of forensic mental health services and the role of Bridgewater within the forensic mental health system.

After carefully reviewing the findings and recommendations of the O'Sullivan experts, the Panel endorses that group's proposals for improvements at Bridgewater. Specifically, the Panel endorses the following major recommendations of the O'Sullivan panel:

1. Establish Bridgewater State Hospital as a separate and specialized Department of Correction facility.

2. Provide a budget for Bridgewater State Hospital which makes the funding level per bed comparable to Department of Mental Health inpatient facilities in Massachusetts and to secure treatment facilities in other states.

3. Establish a maximum census limit for Bridgewater State Hospital.

4. Reduce the number of admissions to Bridgewater State Hospital.

5. Redesign the current organizational structure at Bridgewater State Hospital to more thoroughly integrate traditional correctional and mental health programs.

6. Establish a unit management system for both clinical and security staff.

7. Implement the recommendations regarding seclusion and restraint which were described in the October, 1988 Consultant Panel's Report on Seclusion and Restraint, including the development of seclusion areas on patient housing units.

8. Develop a comprehensive orientation training program for new professional staff, correction officers and mental health workers.

9. Define a separate classification of Correction Officer to be specially selected, trained, and assigned to Bridgewater State Hospital.

10) **ENDORSE DEPARTMENT OF MENTAL HEALTH PLANS TO TRANSFER CIVILLY COMMITTED PATIENTS FROM BRIDGEWATER STATE HOSPITAL TO THE DEPARTMENT OF MENTAL HEALTH, AND PLANS TO IMPROVE AND EXPAND SECURE EVALUATION AND TREATMENT CAPABILITIES.**

General Laws Chapter 123 authorizes the commitment to Bridgewater State Hospital of mentally ill men who require hospitalization in maximum or "strict security." The statute provides for the transfer of male criminal defendants and offenders to Bridgewater, from the courts for pre-trial or post-trial evaluations and treatment, and from county houses of correction and state prisons where they are awaiting trial or serving sentences. Chapter 123 also allows for the transfer of those men from the Department of Mental Health to Bridgewater, who are seen by the Department of Mental Health

as unmanageable due to assaultive or other violent behavior. This "mixing" of civil and criminal populations in a secure psychiatric hospital, though the practice in several other states, is not seen by experts as the best model for the provision of these services. Moreover, the housing of these civil patients in a Department of Correction facility is highly unusual and raises serious questions.

In this vein, and in recognition of the state's inappropriate and overuse of Bridgewater, administration officials in 1987 made a major policy decision to work toward ending the practice of placing civilly committed patients at Bridgewater State Hospital. This decision was subsequently formalized in a settlement agreement in the O'Sullivan, et al. v. Dukakis, et al. lawsuit and in Chapter 1 of the Acts of 1988.

Shortly thereafter, a plan was developed to transfer most civilly committed patients from Bridgewater to the Department of Mental Health, and to stop the practice of transferring civilly committed patients to Bridgewater. It is anticipated that in January, 1990, a new Department of Mental Health secure facility will open at Medfield State Hospital to house 50 of these civil patients. Most recently, the Secretary of Human Services has placed significant restrictions on the transfer of civil patients from the Department of Mental Health to Bridgewater.

The Department of Mental Health has also developed plans to increase its capacity to provide secure evaluation and treatment services to mentally ill individuals. A 13 bed secure care unit for men at Taunton State Hospital has been in operation for over a year and a 12 bed secure care unit for women has recently opened on the same site after being moved from Metropolitan State Hospital. Plans are in place to have specialized services in the admissions units of each state hospital and community mental health center for criminal defendants and offenders charged with, or convicted of, minor crimes. Forensic evaluation units, like the Taunton Secure Care Unit, will provide evaluation services for men and women who need some level of security below that which is provided by Bridgewater State Hospital. Finally, long-term and special security units are planned for almost all of the state hospitals to offer treatment services to men and women who require some level of security and those who require long-term treatment.

The Panel supports these efforts and urges continued funding to implement plans to end the practice of placing civil patients at Bridgewater State Hospital. Furthermore, the Panel endorses Department of Mental Health plans to increase its capacity to provide secure evaluation and treatment services. These initiatives will serve to ease the burden on Bridgewater State Hospital of providing the majority of forensic mental health services in the Commonwealth and will establish a more cost-effective and comprehensive continuum of services.

11) ENDORSE DEPARTMENT OF MENTAL HEALTH PLANS TO EXPAND COURT CLINIC SERVICES AND ENCOURAGE INCREASED CAPACITY TO CONDUCT OUTPATIENT FORENSIC EVALUATIONS.

The Panel recommends that court clinic services be available to every court in the Commonwealth. This goal could be reached through the implementation of plans by the Department of Mental Health to continue to expand court-based evaluation services.

The Panel views court clinic services as an essential component of a forensic mental health system which can both assist the courts in decision making regarding dispositional alternatives for mentally disordered individuals, as well as respond to the person's need for mental health services. Moreover, mental health evaluations provided at the court level are at the center of a cost-effective and comprehensive forensic mental health system. These services, provided at the earliest stages of a person's court involvement have successfully reduced the use of costly and inappropriately restrictive inpatient hospitalizations to perform these same evaluation services. Similarly, court-based mental health intervention serves to increase public safety as potentially violent mentally disordered individuals are seen by trained mental health professionals who are authorized to recommend secure hospitalization or other detention.

Virtually every state in the country recognizes the value of court-based mental health services. In Massachusetts, as early as 1917, mental health services were provided in the Boston Juvenile Court. Since that time, evaluations of individuals who come before the courts have become commonplace. In 1949, the first court clinic in Massachusetts was established in the Dedham District Court. A Division of Legal Medicine was created within the Department of Mental Health in 1956 for the purpose of providing psychiatric services to courts and correctional institutions. However, a 1985 evaluation of the court clinic system by the Court Clinic Services Committee noted that substantial numbers of courts in the Commonwealth had no court clinic services and that services offered were inconsistent as to quality and need. The Court Clinic Services Committee report recommended that court clinic services be available to each of the state's 102 trial courts, that these services be centrally administered and that a new Assistant Commissioner's position be established to oversee administration of the court clinics.

Since 1985, the Division of Forensic Mental Health has reorganized and expanded court clinic services. Currently, on-site and emergency services are provided at 62 of the 69 district courts, at the Boston Municipal Court and at juvenile courts and sessions throughout the Commonwealth. Services are also provided by the Division of Forensic Mental Health to 13 Superior Courts. The use of outpatient forensic evaluations has already increased and needs to be further supported. Many states have already recognized the cost-effectiveness of providing these services in the community or in houses of correction, in cases where inpatient hospitalization is not required.

Court-based services are an integral element of a fiscally responsible and comprehensive forensic mental health system which meets the needs of the courts, the community and the individual. The Panel commends the work of the Division of Forensic Mental Health in the provision of court-based services and supports plans to make these important services available to every court in the Commonwealth.

12) ENDORSE DEPARTMENT OF MENTAL HEALTH PLANS TO EXPAND MENTAL HEALTH SERVICES IN THE COUNTY HOUSES OF CORRECTION.

Over the past two decades, county correctional facilities around the country have become the repository for individuals who have multiple social service needs. The need for mental health and substance abuse services in county correctional facilities has far exceeded most states' ability to provide them. Conditions of severe overcrowding and aging facilities have resulted in both, an inability to focus on needed services provision and, a sharp increase in the need for these services.

In Massachusetts, in 1984, the Crime and Justice Foundation, in conjunction with the Massachusetts Sheriffs' Association and the Executive Office of Human Services, sought assistance from the National Institute of Corrections to assess mental health services in county correctional facilities. The Crime and Justice Foundation found wide disparity in the type and level of mental health services provided in county houses of correction. The Foundation recommended an expansion of services and found that the provision of mental health services to county correctional inmates should be consistent with a philosophy of community services.

The Division of Forensic Mental Health in 1987 prioritized the provision of mental health services in county correctional facilities. In keeping with the recommendations of the Crime and Justice Foundation, the Department of Mental Health's plans are based on a community mental health model of service delivery, drawing largely on court clinic and community resources to assist in the reintegration of the detainee or offender back into the community. Chapter 167 of the Acts of 1987 also mandated that newly constructed county correctional facilities include special mental health units.

The Panel endorses current Department of Mental Health plans for the additional provision of mental health services in county correctional facilities. It is anticipated that these services will reduce numerous inappropriate admissions to Bridgewater State Hospital. Over the past few years, while admissions to Bridgewater from the state prisons have been steadily decreasing, admissions from the county houses of correction have been significantly increasing. Many of these county admissions are viewed as inappropriate, and are seen as a reaction to overcrowding, antiquated facilities, and inadequate on-site mental health services.

Current Department of Mental Health plans include the provision of screening, assessment, triage, crisis intervention and outpatient services. Furthermore, the Department of Mental Health is planning to

perform release planning and liaison services, as well as training, research and consultation. The Panel supports these long-needed services. The Panel further supports the Department of Mental Health's ongoing efforts to develop specialized mental health units in the new county correctional facilities, scheduled to be constructed in Bristol, Essex, Hampden, Suffolk and Norfolk counties.

13) EXPAND CORRECTIONAL MENTAL HEALTH SERVICES AND ENDORSE DEPARTMENT OF CORRECTION PLANS FOR THE DEVELOPMENT OF SPECIALIZED MENTAL HEALTH UNITS.

During the past decade, significant attention has focused on the needs of mentally ill men and women in correctional settings. This focus has been based on several social factors including deinstitutionalization of psychiatric hospitals, litigation in this area, overcrowding and aging correctional facilities.

It has been estimated that seven percent of men and women in correctional settings are mentally ill. It is clear that not all mentally ill inmates require inpatient hospitalization to treat their mental illnesses. Some may require only sporadic short-term hospitalization. In fact, the majority of this group might be best served through crisis or outpatient services or on short-term specialized housing units within correctional facilities. Offering a range of services to correctional populations, as to any other population, is a more rational and cost-effective approach to service provision.

In Massachusetts, Bridgewater State Hospital provides inpatient hospitalization to mentally ill men from the state prison system. However, with access to mental health services in correctional facilities, the numbers of transfers to Bridgewater have been reduced.

The quality and quantity of correctional mental health services in the state prison system have improved and expanded significantly in the past 10 years. However, the Panel has found that services should be expanded, alternative treatment dispositions should be developed and coordination between mental health service providers needs to be enhanced.

The Prison Mental Health Program is a contract program developed in 1979 to provide additional mental health services to those already offered at MCI-Walpole, MCI-Concord and MCI-Norfolk by Department of Mental Health staff. By 1982, the five major prisons (MCI-Walpole, MCI-Norfolk, MCI-Concord, MCI-Framingham and Southeastern Correctional Center) all had Prison Mental Health staff. Over the past five years, the Department of Mental Health reduced its staff in the prison system so that currently, only MCI-Framingham continues to have Department of Mental Health staff presence.

In addition to the Prison Mental Health Program, mental health services are provided by the Department of Correction's Division of Psychological Services. Though these efforts have substantially improved mental health services in the state prisons, alternative

treatment dispositions are limited and coordination between service providers needs to be improved.

Currently, service gaps force the state correctional system to over-rely on Bridgewater State Hospital. Though admissions to Bridgewater from the state prison system have decreased over the past few years, there are currently few specialized housing alternatives for mentally ill inmates who do not require hospitalization. All too frequently, mentally ill inmates are either inappropriately housed in the general prison population or on protective custody or disciplinary units where their access to programs and certain services is limited.

The Panel recommends the development of a mental health service delivery system with four progressive levels of care, ranging from "outpatient" prison-based services to inpatient hospital services. This proposed system would serve to decrease inappropriate admissions to Bridgewater and would better meet the treatment needs of mentally ill inmates. This system would further enhance the ability of the correctional system to properly manage mentally ill inmates.

First, acute psychiatric inpatient care should continue to be offered at Bridgewater State Hospital. Second, at least three comprehensive prison mental health centers should be developed, each of which should include a six to ten bed crisis residence unit, a 45-60 bed community residence unit, an "outpatient" clinic and consultation services. A smaller prison mental health center should be developed for women at MCI-Framingham. Third, "outpatient" mental health clinics should be developed in each medium security prison which does not have a prison mental health center. Finally, consultation and liaison services should be provided across the correctional system.

14) DEVELOP A POST-RELEASE MONITORING SYSTEM FOR INDIVIDUALS FOUND NOT GUILTY BY REASON OF MENTAL ILLNESS.

The Panel was asked to examine "the Commonwealth's policies relative to the evaluation, disposition, treatment, and release of persons who are found not guilty of a crime by reason of mental illness or defect, with an analysis of the need for post-release monitoring or conditional release of such persons, including the feasibility of establishing a psychiatric review board."

There are few issues in the American criminal justice system as controversial as the insanity defense. In addition, individuals acquitted by reason of insanity have presented special management problems to the mental health and criminal justice systems. Any individual who is mentally ill and commits a criminal act is doubly stigmatized as "mad and bad." Such notoriety increases the need for special handling of these individuals that assures appropriate treatment interventions, in conjunction with protection of the public.

The controlling state statute, General Laws Chapter 123, section 16, provides only a general structure for the legal disposition of

insanity acquittees. Furthermore the Commonwealth thus far has no clearly articulated policies for the management of these individuals. The Panel has carefully examined the current system and is recommending significant legal and policy changes.

The Panel finds that the current statutory scheme is flawed in a number of respects. Primarily, the statute provides only the broadest outlines of a procedure for disposition of insanity acquittees. No provision is made for the conditional release of insanity acquittees. Either the patient is in the hospital or the patient is released to the community with no mandated follow-up treatment or care. The present scheme does not permit appropriate monitoring of treatment compliance or, more importantly, monitoring of the reemergence of the psychotic symptoms which may have led to criminal behavior in the past. The Panel believes that, in order to protect the patient and the public, a mechanism should exist to carefully monitor the unique group of individuals who have been adjudicated not guilty by reason of mental illness. The Panel studied the experiences of three states, Connecticut, Oregon and Maryland, which have developed innovative systems to handle insanity acquittees that both protect the public and insure that patients get needed services. In developing a model for Massachusetts, the Panel also adopted recommendations of the Criminal Justice Mental Health Standards Committee of the American Bar Association.

The Panel recommends the development of special commitment procedures for persons found not guilty by reason of mental illness. These special procedures would allow for commitment to a hospital by specially designated judges, court-ordered conditional release, and revocation of release for failure to comply with conditions. The Panel further recommends the development of a Mental Health Review Board to monitor the treatment and management of individuals found not guilty by reason of mental illness. The Board would consider all reports for discharge, conditional release, or termination of conditional release and make recommendations to the specially designated judges. The first priority of the Board would be to assure public safety by the careful monitoring of these individuals.

The Panel views the implementation of special commitment procedures for insanity acquittees and the development of a Mental Health Review Board to monitor them as the best response to meet the needs of both the individuals and the community.

15) DEVELOP SECURE EVALUATION AND HABILITATION SERVICES FOR MENTALLY RETARDED OFFENDERS.

General Laws Chapter 123B, section 1 provides that "[n]o mentally retarded person shall be considered mentally ill solely by virtue of his mental retardation." This 1987 amendment recognizes the differences between individuals who are mentally ill and those who are mentally retarded. This distinction, while important and valid, raises legal and public policy problems in the provision of services to mentally retarded individuals who require secure evaluation and habilitation services.

While mentally ill individuals can be involuntarily committed for treatment under certain circumstances, no authority exists for the involuntary commitment of mentally retarded individuals. Additionally, neither the 1987 statute dealing specifically with mental retardation nor, Chapter 123, the mental health statute, addresses dispositional alternatives for mentally retarded individuals who are charged with or convicted of criminal offenses. Moreover, no facilities for the mentally retarded are equipped to provide secure services.

At times, these gaps have led existing service delivery systems to blur the distinction between mentally ill and mentally retarded individuals. In difficult cases, mentally retarded individuals are scrutinized for signs of mental illness in order to find secure placements for them. Though incarceration in a correctional facility is always potentially available as a placement alternative, a need exists for specialized housing and secure evaluation and habilitation services for some mentally retarded individuals.

The Panel recommends a set of coordinated responses to address the needs of mentally retarded individuals charged with, or convicted of, crimes. Recommended services include diversionary community programs for mentally retarded individuals who do not pose a threat to public safety, secure residential programs for mentally retarded individuals who do pose a risk to others, specialized services in correctional facilities for mentally retarded individuals and a mechanism for admission of mentally retarded individuals to secure facilities through guardianship procedures.

C. SUBSTANCE ABUSE RECOMMENDATIONS

INTRODUCTION

The Addiction Center is a Department of Correction facility at MCI-Bridgewater for men who require treatment for alcohol or drug abuse.

Since the mid-1800's when the Bridgewater site was known first as the Almshouse for Paupers and later as the State Farm, individuals who require treatment for alcoholism have been transferred to the Addiction Center. Since 1922, drug-addicted individuals have also been committed to the Addiction Center.

Today, the Addiction Center admits a mixed population of prisoners, civilly committed persons, and voluntary civil patients. Approximately 8,300 men are admitted annually. There are approximately 23 admissions and 23 discharges per day, seven days a week. Virtually no one is ever refused admission. Most of the voluntary population is made up of homeless alcoholics. Many need specialized nursing care. The average daily census at the Addiction Center is 430, which severely overcrowds the institution.

In recent years, changes in admissions trends and in the controlling state statutes have resulted in population that is, on the average, younger and more violent than that of past years. These changes, and a steadily increasing census, have exacerbated already severe staff shortages in the areas of counseling, security, nursing, and recreational programs. Although many patients exhibit serious mental health problems, there is no regular psychiatric coverage at the Addiction Center. The Addiction Center buildings, constructed between 1890 and 1920, are outmoded and in disrepair.

The Panel is encouraged by recent efforts by the Administration to increase treatment and security staff at the Addiction Center. Moreover, funds have been allocated for additional equipment and to repair the physical plant, including additional funds for plumbing improvements and roof repairs.

With regard to long-term recommendations, however, the current physical facility, even with substantial improvements and repairs will never be ideally suited to meet the needs of the Addiction Center patients. An alternate site for the Addiction Center should be found, and new or renovated existing space should be developed to serve this population.

Additionally, in the Panel's view, men who are not subjects of the criminal justice system should not receive substance abuse treatment services at the Addiction Center. Rather, the Department of Public Health should be funded to provide secure detoxification and treatment services to voluntary civil patients and to civilly committed patients who are not also involved in the criminal justice system.

The Panel believes these recommendations are consistent with the administration's policy to stop the placement of civilly committed psychiatric patients at the Department of Correction's Bridgewater State Hospital. Additionally, the Panel views these recommendations as meeting, in a more rational and appropriate manner, the sharply increasing need for quality public sector substance abuse services for individuals who are in the criminal justice system and those who require secure care.

MAJOR RECOMMENDATIONS

16) IMMEDIATELY IMPROVE PHYSICAL CONDITIONS AT THE ADDICTION CENTER.

The Addiction Center, constructed between 1890 and 1920, is in need of substantial repair. Plumbing is inadequate, walls are crumbling, and certain wards have been closed because of health and safety considerations, resulting in an exacerbation of conditions of severe overcrowding. On one ward, 65 men, many of them elderly and disoriented, share two toilets that are in full view of the entire ward.

No single Panel endeavor had greater impact on its members than its visit to the Addiction Center. The Panel believes that individuals who require public substance abuse treatment services should receive them under safe and dignified conditions.

The Panel recognizes that the administration has funded improvements in the physical plant over the past year, and it supports the efforts that have been made. Nevertheless, the Panel believes that additional immediate steps must be taken to upgrade the conditions under which Addiction Center patients are housed and treated. The Panel recommends additional emergency funds for basic capital improvements and repairs at the Addiction Center, including electrical improvements, additional plumbing repairs, painting and plastering.

17) IMMEDIATELY INCREASE STAFF AT THE ADDICTION CENTER.

The Panel recommends that expansion funds be provided at the Addiction Center for additional staff in several areas, including security, counseling, mental health, and nursing. The Panel finds the Addiction Center to be seriously understaffed. At times, only one correction officer and one nurse are available on the night shift to monitor patient areas. A small counseling staff, with the support of only one clerical person, must administer more than 8,300 cases per year. There is no psychiatric or other mental health coverage, even though many Addiction Center patients have documented histories of mental illness and suicidal behavior.

At the Addiction Center, many patients spend almost all of their time in sedentary and unsupervised inactivity. Even the most basic recreational programs are non-existent or significantly limited at the Addiction Center.

The Panel has learned that patients are used to help meet the institution's clerical needs, and that members of the prisoner population have been asked to function as leaders of treatment groups for the civilly committed population. Until recent roof repairs were begun, on rainy nights, one patient would volunteer to stay awake at night, emptying buckets from leaking ceilings in exchange for a quieter room in which to sleep during the day.

The Panel believes that current staffing levels at the Addiction Center are grossly inadequate. Recent additions of staff in the areas of counseling and security are encouraging. However, even with these new positions and in spite of the best efforts of current staff, it is difficult for meaningful treatment to occur. Without sufficient resources, the Addiction Center will continue to be little more than a shelter. For the Addiction Center programs to operate at an acceptable level of competence and for the protection of the safety of patients and staff, there must be a renewed commitment to provide additional personnel to the facility.

18) DEVELOP NEW SITE FOR DEPARTMENT OF CORRECTION ADDICTION CENTER TO PROVIDE ALCOHOL AND DRUG TREATMENT SERVICES TO INDIVIDUALS IN THE CRIMINAL JUSTICE SYSTEM.

Despite limited resources and an aging and dilapidated physical facility, officials of the Department of Correction and MCI-Bridgewater have done an admirable job of attempting to create a clean and safe environment for Addiction Center patients and staff. Implementation of the Panel's recommendations for emergency capital improvements will contribute significantly to that effort. However, the Panel believes that appropriate long-term solutions to the Addiction Center's problems must include a re-siting of the institution, either on the grounds of MCI-Bridgewater or elsewhere. Existing unused state buildings should be explored for their feasibility as a new Addiction Center site.

No significant new construction has occurred at the Addiction Center since 1920. The buildings are antiquated and uncomfortable. Basic repair work is a continuing problem and keeping the facility clean is difficult. There are insufficient numbers of lavoratories, showers, treatment rooms, and recreational spaces. The provision of security is hindered by the size and configuration of the rooms. There is little, if any, privacy for most patients since many of the units house up to 65 men in large open rooms.

The Panel is cognizant of current overcrowding in state and county correctional facilities, as well as the fiscal constraints militating against construction of new state facilities. However, it is the Panel's view that the existing Addiction Center will never be ideally suited to serve as a secure treatment facility, and that it should be relocated as soon as such an effort could be undertaken.

19) TRANSFER VOLUNTARY ALCOHOL AND DRUG ADDICTED INDIVIDUALS FROM ADDICTION CENTER TO THE DEPARTMENT OF PUBLIC HEALTH.

Historically, the vast majority of Addiction Center patients have been admitted on a civil, voluntary basis. Most of these men are homeless chronic alcoholics who are transported to the Addiction Center from the Pine Street Inn. Many require specialized nursing care. Most have been admitted to the Addiction Center numerous times. Massachusetts is the only state in the nation that allows a correctional facility to receive voluntary admissions.

In recent years the increased demand upon Addiction Center beds by the civilly committed and prisoner populations has caused a significant decrease in the number of voluntary patients that the facility can accommodate. On May 1 of this year, voluntary patients constituted 42 percent of the total population, down from 76 percent one year earlier.

The Panel believes that only individuals who are subjects of the criminal justice system should receive services at the Addiction Center. Thus, the public health system should be held accountable for the provision of substance abuse services to individuals who seek them. The Panel believes that the Department of Public Health should assume sole responsibility for the treatment of the voluntary civil patients at the Addiction Center.

Certainly, no transfer of responsibility for this population should be made until appropriate resources are made available to the Department of Public Health for expanding its services. The Panel recommends that funding be provided to the Department of Public Health for alternative programs for the voluntary population currently served by the Addiction Center.

20) DEVELOP DEPARTMENT OF PUBLIC HEALTH CAPACITY TO PROVIDE SECURE ALCOHOL AND DRUG ADDICTION TREATMENT SERVICES FOR CIVILLY-COMMITTED INDIVIDUALS WHO ARE NOT INVOLVED IN THE CRIMINAL JUSTICE SYSTEM.

Massachusetts is one of only two states with statutory authority to use its correction department as a substance abuse treatment provider for civilly committed individuals. As was noted above, the Panel believes that only those who are involved with the criminal justice system should be evaluated or treated in correctional settings. Thus, in principle and in practice, the public health system should be responsible for providing services to those individuals who are civilly committed under General Laws Chapter 123, section 35, and who are not also subjects of the criminal justice system. It is estimated that approximately one-quarter, or 50, of the men civilly committed to the Addiction Center fall into this category.

The Panel believes that the Department of Public Health should assume sole responsibility for the treatment of individuals who are not subjects of the criminal justice system. No transfer of responsibility

for this population should be made until appropriate resources are made available to that Department for providing services to that population.

Once these treatment programs are created by the Department of Public Health, civil commitments to the Addiction Center should be limited to those men who have outstanding criminal charges, or who have been determined to be in violation of conditions of probation or parole. All other civil commitments should be channeled into the new Department of Public Health programs. The statute should be amended to reflect these dispositional alternatives.

D. SPECIAL NEEDS FEMALE OFFENDERS AND PRE-TRIAL DETAINEES RECOMMENDATIONS.

INTRODUCTION

Specialized services for women in the criminal justice system have developed completely separately from analogous services for men. In general, female offenders have been provided with fewer mental health and substance abuse services than have male offenders. While the Commonwealth has made services available to male offenders at a variety of institutions, including Bridgewater State Hospital and the Addiction Center, MCI-Framingham has, until very recently, been virtually the only provider of these services to women.

During recent years MCI-Framingham has functioned, either in fact or in effect, as a jail, county house of correction, state prison, secure mental hospital, and substance abuse treatment facility. As a result, MCI-Framingham has been affected disproportionately by the overcrowding of the entire correctional and mental health systems. The treatment service system has been stretched beyond its limits both by overcrowding and by the diverse needs of the female offender population.

These problems have not gone unrecognized by the administration and legislature. Several successful initiatives have been undertaken to better serve these women, including a 20 bed program at the Massachusetts Osteopathic Hospital for women who are civilly committed for substance abuse, the Neil Houston House for pregnant inmates with substance abuse histories, a 13 bed secure forensic evaluation unit for women at Taunton State Hospital, and a day treatment program at MCI-Framingham for women with serious mental health treatment needs. There are also plans to return awaiting trial and county sentenced women to the county jails and houses of correction so that they can be closer to their communities. While all of these initiatives are praiseworthy, there is more to be done.

The Panel believes that the treatment needs of female offenders differ from those of their male counterparts. The majority of female offenders are single mothers with young children. More than 85 percent of the population report substance abuse problems, and most have histories of serious physical and sexual abuse.

The Panel believes that many of the women at MCI-Framingham would be appropriate for alternatives to incarceration. In contrast to the incarcerated male population, the female population contains relatively few persons who have manifested violent behavior. Indeed, less than one third of the women at MCI-Framingham are incarcerated for crimes against other persons. A wider range of diversionary and community-based services need to be developed to allow these women to remain close to their children, families, attorneys and support systems.

The Panel has built its recommendations upon the comprehensive November 1988 Report of the Female Offenders Advisory Group which was co-chaired by then Correction Commissioner Michael V. Fair and Amy Singer, Assistant Secretary for Criminal Justice Policy in the Executive Office of Human Services, both of whom have been instrumental in the work of this Panel. Additionally, the Panel endorses and restates many of the recommendations of the recently issued Gender Bias Study.

MAJOR RECOMMENDATIONS

21) INCREASE COORDINATION OF MENTAL HEALTH SERVICE DELIVERY AT MCI-FRAMINGHAM WITH EVENTUAL CONSOLIDATION OF SERVICES UNDER ONE PROVIDER.

Currently, mental health services are offered at MCI-Framingham by three separate providers. Each of these providers serves a specific segment of the Framingham population based on legal status, time of day and clinical needs. Despite highly qualified professional staff, inadequate coordination between providers and the lack of oversight have resulted in both redundancy and gaps in service provision. Additionally, the lack of a single clinical program at Framingham has created impediments in developing uniform protocols for the treatment of mentally ill inmates and has lead to conflicts between mental health and security staff regarding issues of inmate management.

The Department of Correction's Psychological Services, provides mental health services to the sentenced population and to awaiting trial women at night and on weekends. The Department of Mental Health's Division of Forensic Mental Health, provides services to the Awaiting Trial Unit up until 5:00 p.m. on weekdays, and to sentenced inmates who are seriously mentally ill. People Care, Inc., a private vendor with one full-time psychiatrist position, provides psychotropic medication screening and monitoring as well as other psychiatric consultation.

This configuration of service provision creates problems on several levels. Primarily, having three separate mental health service providers seems unnecessarily complicated and inefficient. For example, under the current structure, the same woman could be in a Department of Mental Health day treatment program, receive individual therapy from a Department of Correction staff person, and be on medication prescribed and monitored by People Care, Inc. If the woman needs inpatient hospitalization for mental illness, People Care will perform the evaluation required to precipitate a transfer to a hospital, and the Department of Mental Health will see that the transfer is completed. Under the best circumstances, this type of overlap would require good coordination and communication. At Framingham, coordination of services among the three providers is sometimes problematic.

The recent appointment of a Chief Psychologist to oversee mental health service provision is a welcome change. However, in the

Panel's view, a consolidation of services under one provider would be a more desirable long-term goal. In light of the Department of Mental Health's policy of providing mental health services to county correctional inmates and detainees, the Panel recommends that once county inmates and detainees are transferred out of Framingham, Department of Mental Health staff should be re-deployed to county houses of correction. No transfer of staff should be effected until it is certain that equivalent staff coverage is in place at Framingham. Allowing the Department of Correction to be fully responsible for mental health services for state prison inmates would be consistent with the model of service delivery throughout the rest of the state prison system.

Until the transfer of county inmates is effected however, it is essential that all three providers meet more regularly to jointly conduct treatment planning, oversight, staff training and clinical policy development.

22) DEVELOP SPECIALIZED MENTAL HEALTH UNIT AT MCI-FRAMINGHAM FOR WOMEN WITH MENTAL HEALTH PROBLEMS WHO DO NOT REQUIRE HOSPITALIZATION.

The need for an improved plan of mental health service delivery at MCI-Framingham has been recognized. It is the Panel's belief that any future planning to address this issue should consider the development of a mental health unit within the prison which would offer an array of acute and long-term services to mentally ill women who do not require inpatient psychiatric hospitalization. This type of unit, run by clinical staff with correctional staff providing security, would serve to coordinate and consolidate mental health services, decrease the need for inpatient hospitalization and assist in the management of mentally ill inmates.

Currently, mentally ill women are sometimes housed on the prison disciplinary ("MAX") unit, or on the Health Services Unit. Sentenced inmates who have histories of mental illness are often housed in the Algon Cottage at Framingham.

In the Panel's view however, a prison mental health unit, similar to those proposed for other state prisons in the Forensic Mental Health section of this report, would be appropriate for consideration at MCI-Framingham. The special unit at Framingham should include the following services:

1. Crisis Residence - Three to five beds should be developed for mentally disordered inmates who are assaultive or acutely suicidal.

2. Long-Term Residential Treatment - 15-20 beds should be developed for inmates who require specialized housing because of mental health problems. Structured day programs, like the current day treatment program should be developed for inmates who live on this unit.

3. "Outpatient" Clinic - This would function within the prison setting as a traditional outpatient clinic, providing supportive psychotherapy (both individual and group), psychotropic medication, crisis intervention, and triage services for inmates requiring transfer to a Department of Mental Health hospital.

4. Consultation Services - The staff of this unit would also be available to assist correctional staff in the management of mentally ill inmates and would develop and coordinate mental health training programs for correctional staff.

23) INCREASE DEPARTMENT OF MENTAL HEALTH CAPACITY FOR INPATIENT TREATMENT FOR MENTALLY ILL WOMEN WHO REQUIRE SECURE HOSPITALIZATION.

General Laws Chapter 123, section 18 allows for the transfer of mentally ill state and county inmates and detainees to Department of Mental Health facilities for a 30 day evaluation of their need for continued psychiatric hospitalization. The statute allows for mentally ill male inmates and detainees to be transferred to Bridgewater State Hospital for evaluation and treatment if they require hospitalization in maximum or "strict" security; however, there is no analogous placement alternative for mentally ill female inmates and detainees.

Until recently, Department of Mental Health facilities were reluctant to accept transfers of mentally ill female offenders from MCI-Framingham. If a female inmate or detainee was transferred to a Department of Mental Health facility, most often she would be returned to MCI-Framingham at the conclusion of the 30 day evaluation period. In 1988, a new nine bed evaluation unit was opened at the Metropolitan State Hospital by the Department of Mental Health's Division of Forensic Mental Health. Two of the nine beds were reserved for long-term treatment of mentally ill female offenders. For a variety of administrative reasons, these beds were never fully utilized. In July, the Metropolitan State Hospital unit was closed and moved to Taunton State Hospital. The Taunton Secure Care Unit currently operates as two companion programs, a 13 bed unit for men, and a 12 bed unit for women. It is anticipated that the new unit will offer quality evaluation services for female criminal defendants who are committed for pre-trial evaluation and for female inmates and detainees at MCI-Framingham. In cases where continued hospitalization is indicated however, the Secure Care Unit relies largely on the Department of Mental Health inpatient hospital system. The Department of Mental Health's inpatient system is initiating a set of improvements to increase its capacity to provide secure treatment services. Among those improvements are the development of long-term and special security units at almost all of the state hospitals.

The Panel recognizes the ongoing quality, short-term evaluation services provided to mentally ill female offenders and pre-trial detainees by the Department of Mental Health, and supports plans

to increase the Department's capacity to provide long-term inpatient hospitalization for mentally ill female offenders.

24) **DEVELOP COMMUNITY-BASED ALTERNATIVES TO INCARCERATION FOR WOMEN WHO ARE MENTALLY ILL OR WHO HAVE SUBSTANCE ABUSE DISORDERS AND WHO DO NOT PRESENT SECURITY RISKS.**

Female offenders are prime candidates to participate in alternative supervision or treatment programs in lieu of incarceration. Women are less likely to have committed crimes against people, are less violent, and more likely to receive relatively short sentences.

In many cases, crimes committed by women suggest that a structured program of treatment for mental health or substance abuse, can promote change in behavior necessary to avoid recidivism. Keeping women out of penal environments, when appropriate, accomplishes a number of important goals: minimizing the potential for breaking key social supports and relationships (e.g., family, children, local services); easing the transition for women back into their communities (retention of jobs, housing, welfare benefits); and reducing the dockets of criminal courts (if diversion is explored pre-trial). Providing alternatives to incarceration also serves to reduce overcrowding in correctional facilities, which the Panel has identified as paramount in the goal of improving conditions and services at MCI-Framingham.

The Executive Office of Human Services, in developing guidelines for the distribution of $1.5 million dollars in alternatives to incarceration funds, requires programs to give priority to women. Despite this prioritization of programs for women, there are still an insufficient number of alternatives programs to significantly decrease the incarceration rate of female offenders in the Commonwealth. Recently, the Department of Correction has contracted for 52 community-based substance abuse beds for women on pre-release status in the correctional system. The Panel is encouraged by these new programs and urges that similar services be made available to women in order to avoid the necessity of incarceration in appropriate cases.

The Panel supports similar recommendations of the Female Offender Advisory Group and the Gender Bias Study to develop increased alternatives to incarceration programs for female offenders. Fortunately, models for the provision of community-based services are already in place in the Commonwealth and merely need to be replicated to facilitate greater access to them. Programs such as the Massachusetts Osteopathic Hospital Program for women who have been civilly committed for substance abuse treatment, the Longwood Treatment Center for men and women convicted of driving under the influence of alcohol, the Neil Houston House for pregnant offenders with substance abuse problems, and the Elizabeth Stone House for mentally ill women (including many with criminal histories), are

examples of model programs which provide alternatives to incarceration.

25) **DEVELOP DEPARTMENT OF PUBLIC HEALTH CAPACITY TO PROVIDE TREATMENT TO CIVILLY COMMITTED AND INCARCERATED WOMEN WHO REQUIRE SECURE DETOXIFICATION AND SUBSTANCE ABUSE TREATMENT SERVICES.**

General Laws Chapter 123, section 35 provides for the involuntary civil commitment of individuals who create a likelihood of serious harm to themselves or to others by reason of substance abuse. Under General Laws Chapter 111E, section 10, a defendant charged with a drug offense may request a judicial determination that he or she is a drug dependent person who would benefit from treatment in a treatment facility. Section 11 of Chapter 111E allows for a drug-dependant person, convicted of a non-drug related offense, to receive treatment during the period of incarceration in a treatment facility.

Men who are subjects of these civil or criminal substance abuse commitment statutes are admitted to the Addiction Center at Bridgewater. The Addiction Center, though not without its own problems, nonetheless, is available to offer secure substance abuse detoxification and treatment services to men committed by the courts for that purpose. Women in the same categories however, rarely have equivalent treatment options.

Until recently, women who were civilly committed for substance abuse treatment were transferred to MCI-Framingham. The prison was ill-equipped to offer these women substance abuse treatment services, and many of the them languished in rooms alone on the Health Services Unit for the duration of their 30 day commitment period. Additionally, since 85 percent of women awaiting trial or sentenced to Framingham report substance abuse problems, a significant number of Framingham admissions require immediate detoxification services.

In the past year, the Executive Office of Human Services has recognized that MCI-Framingham is an inappropriate placement alternative for civilly committed women, and has directed the Department of Public Health to develop a 20 bed treatment program at the Massachusetts Osteopathic Hospital and, most recently, a 20 bed program in Fall River. These facilities offer comprehensive substance abuse treatment services to Section 35 women and are viewed as model programs. The Panel commends the development of these new programs. However, certain service gaps still exist which need to be addressed.

First, the programs are not sufficiently large to meet the increasing need for Section 35 beds. When beds are not available, women are still civilly committed to MCI-Framingham. Second, these programs are not equipped to accept women who are viewed as requiring secure settings. Given that the nature of the Section 35 process is one of involuntary commitment, an inability to offer services on the basis of security needs seems particularly

unreasonable and impractical. The Massachusetts Osteopathic Program is unable to accept women until after the detoxification process is completed. Both Department of Public Health programs report an inability to accept women who require nursing or medical care.

While accepting women who are civilly committed for substance abuse treatment, these programs have not been asked to provide services for drug dependent women under Chapter 111E. There are thus no treatment facilities available for women under these statutory provisions, leaving MCI-Framingham as the only placement alternative for Chapter 111E women. Finally, there continues to be a pressing need for new and expanded secure detoxification services for newly admitted inmates and detainees. While the Panel recognizes the need for a wide range of improvements at the Addiction Center, it also appreciates the inherent unfairness in having no analogous services for women whatsoever.

The Panel recommends the expansion of existing and development of new quality secure substance abuse detoxification and treatment services for civilly committed and incarcerated women.

26) WORK WITH COUNTY CORRECTIONAL OFFICIALS TO ASSURE RANGE OF SERVICES TO WOMEN TRANSFERRED TO COUNTY HOUSES OF CORRECTION.

The issue of whether a single centralized prison is more desirable for female offenders and detainees than a decentralized county-based correctional system has been a frequent subject of debate for over a century. The question has been couched as whether it is necessary to have a "critical mass" of women at a single site in order to assure cost-effective and comprehensive service delivery. The other side of the argument is that women are better served in regional facilities which are closer to their home communities, children, attorneys and other support networks, even if there are fewer of them.

In Massachusetts, there has been a centralized women's prison since 1870. In 1978, inadequate county facilities for women and a low census at Framingham lead the Commissioner of Correction to authorize the placement of all awaiting trial and sentenced county female offenders and detainees at MCI-Framingham. Today, almost all state sentenced, county sentenced, and awaiting trial women are housed at MCI-Framingham. However, ongoing efforts are being made to return county women to the houses of correction and long-range plans are in place to effect that goal.

The Panel joins the Female Offenders Advisory Group and the Gender Bias Study in supporting these efforts. Transferring women back to county facilities on a regional basis will serve a number of goals; most notably, the transfer will relieve severe overcrowding at Framingham, and allow women to be housed closer to their families and community support networks.

The Panel recommends that county sheriffs work closely with MCI-Framingham and Executive Office of Human Services officials to effect the transfer of women to the counties and to assure that services currently available to women at Framingham are replicated on the county or regional level.

E. GENERAL RECOMMENDATION

27) ASK THE GOVERNOR AND SECRETARY OF HUMAN SERVICES TO DESIGNATE AN IMPLEMENTATION TEAM TO EFFECT THE PANEL'S RECOMMENDATIONS.

The Panel has made a broad range of recommendations for reform. These recommendations cut across a variety of agency lines and service delivery systems. They require statutory change, policy development and program design. The adoption of some recommendations will require substantial funding; others will rest solely on advocacy and educational efforts. They include both immediate and long-term proposals for improvements in various services and systems.

The Panel believes that these recommendations can serve as a blueprint for a comprehensive and high quality forensic mental health system. Given the range, number and complexity of these recommendations, the Panel believes that successful adoption of these proposals rests upon the appointment of a group of individuals whose function would be to oversee their implementation. The "implementation team" should consist of representatives of the relevant state agencies and institutions and other interested and knowledgeable individuals. It should meet regularly to address and oversee the legal, policy and programmatic implications of these recommendations.

II. CONCLUSION

The Panel was given a broad mandate to evaluate, reform, and, in some instances, create new systems of services for special needs populations in the criminal justice system. The humanitarian justifications for improving and expanding these services are evident. It is equally clear, however, that public safety is at stake when these systems are disjointed or incomplete. The financial and human costs of a flawed system are infinitely higher than the cost of restructuring and maintaining a comprehensive system.

The Panel is cognizant of the current fiscal constraints which militate against immediate broad-based systems expansion and reform. However, the Panel urges that these proposals be seen as a blueprint for a model system which has immediate, short-term and long-term components.

The Panel has appreciated this unprecented opportunity to make these recommendations, and hopes that their adoption will help make Massachusetts a leader in innovative mental health and criminal justice policy.

CHAPTER 3

SEX OFFENDERS REPORT

TABLE OF CONTENTS

"We see special sex offender legislation as an approach to sex psychopaths that has failed, and consequently we feel that these statutes should be repealed." **Group for the Advancement of Psychiatry(1977)(1)**

I. INTRODUCTION

There are few crimes as traumatic for the victim and as intolerable for society as sex crimes. Over the past 50 years, public outrage over these crimes has been reflected throughout the country in very specialized responses to this group of offenders.

The Governor's Special Advisory Panel on Forensic Mental Health has been asked to evaluate the current system of committing certain repeat sex offenders to the Treatment Center at Bridgewater as "sexually dangerous persons." With questions raised about the effectiveness of treatment and the value of involuntarily and indefinitely committing certain sex offenders for such treatment, the Panel has concluded that the current system has neither enhanced public safety nor successfully treated these offenders.

Chapter 123A of the Massachusetts General Laws allows for the disposition of certain repeat sex offenders. The statute provides that courts may send a convicted sex offender to the Massachusetts Treatment Center for the Sexually Dangerous at Bridgewater ("Treatment Center") for assessment as a "Sexually Dangerous Person" ("SDP"). The Department of Correction may transfer an inmate to the Treatment Center for observation in limited cases when the inmate has engaged in inappropriate sexual conduct within a correctional facility. After a recommendation by clinical staff that a sex offender be designated a "sexually dangerous person," the court may authorize civil commitment to the Treatment Center, for "one-day-to-life." In most cases, a criminal sentence is served concurrently with the "one-day-to-life" civil commitment. Release from the Treatment Center may only take place if a Superior Court judge determines that the offender is no longer "sexually dangerous." If the released offender has time remaining on a criminal sentence, he is transferred to a correctional facility. If the offender's criminal sentence has expired however, he is released to the community with no mandatory aftercare or parole. The average length of civil commitment is seven and one half years for "sexually dangerous persons" who have been discharged to the community from the Treatment Center. The offenders who are currently committed to the Treatment Center have been there for an average of eight and one half years.

The Treatment Center has been controversial since its inception. Public policymakers, clinicians, civil libertarians and law enforcement officials have questioned the goals and success of the Treatment Center. The efficacy and value of a one-day-to-life, involuntary commitment for a very small percentage of the violent, repeat sex offenders in the Commonwealth has come under intense scrutiny on numerous occasions in the last 40 years.

With little authoritative research available on recidivism to support treatment techniques, and a recognition that research does not support the previously held notion that repeat sex offenders suffer from a mental illness,

the Panel recognized that certain systemic policy matters warranted careful review. The Panel's inquiry has clearly established that the current system of committing a small number of repeat sex offenders to the Treatment Center has failed to meet either public safety concerns or the treatment needs of those committed.

The current system perpetuates several misconceptions which seriously compromise public safety:

MISCONCEPTION — A sex offender's "one-day-to-life" commitment to the Treatment Center guarantees incarceration for life.

FACT — The average length of stay of discharged sex offenders from the Treatment Center is seven and one half years.

MISCONCEPTION — Sex offenders are mentally ill and therefore can be "cured" by mental health professionals.

FACT — Sex offenders generally are not mentally ill; repeat sexual violence is a criminal behavior, not a mental illness, and therefore cannot necessarily be "cured."

MISCONCEPTION — Repeat sex offenders at the Treatment Center are not eligible for furloughs.

FACT — A federal court consent decree mandated that a community access program be established at the Treatment Center. Through this program, sex offenders are eligible for access to the community after one year at the Treatment Center. Currently, 58 sex offenders have some form of access to the community through this program.

MISCONCEPTION — All repeat sex offenders in the Commonwealth are in the Treatment Center.

FACT — Only 20 percent of convicted sex offenders in the state prison system are in the Treatment Center. The remaining 80 percent are in state prisons serving criminal sentences. Many others are serving sentences in county houses of correction or are on probation or parole.

MISCONCEPTION All sex offenders at the Treatment Center receive treatment.

FACT Sex offenders have the right to refuse treatment. In fact, at any one time up to 40 percent of Treatment Center patients have refused all forms of treatment.

No state in the country utilizes an indefinite commitment law for sex offenders to the extent that Massachusetts does. Most of the 31 states which have had special dispositional provisions for sex offenders have repealed or significantly reformed them. Professional organizations such as the American Bar Association and the Group for the Advancement of Psychiatry have strongly recommended repeal of these laws.(1,2) In 1978, the President's Commission on Mental Health also called for repeal of these statutes.

The Panel recommends that Massachusetts follow a nationwide trend by adopting significant reforms to the current statutory scheme in order to more effectively safeguard the public and to make services available to those most likely to benefit from them.

II. POLICY QUESTIONS

The Panel considered the following policy questions:

1. Does the current system of committing certain repeat sex offenders for treatment succeed in assuring public safety by reducing or eliminating recidivism?

2. Should those offenders who have been convicted of sex offenses be treated differently from those who have been convicted of other violent crimes?

3. Should Massachusetts continue to treat "sexual dangerousness" as a mental health diagnosis, despite general consensus that it is a legal category?

4. Which sex offenders are most amenable to treatment and what services should the Commonwealth provide for them?

III. GOVERNING PRINCIPLES

The following principles governed the Panel's work:

1. Public safety should be the primary consideration when deciding dispositional alternatives for sex offenders.

2. Treatment services should be offered first to individuals motivated to change and who are amenable to treatment.

3. A critical component of any treatment program is an ongoing evaluation of treatment efficacy and its relationship to recidivism.

4. Treatment services should be offered in a variety of settings which balance the needs of the offender and public safety considerations.

5. Early intervention to victims of sexual abuse and juvenile sex offenders is essential to decrease the likelihood of future violence.

IV. SUMMARY OF RECOMMENDATIONS

The following summarizes the Panel's recommendations:

1. Individuals who commit sex offenses should be subjects of the criminal justice system, not the mental health system.

2. Sentences for violent repeat sex offenders should allow for lengthy periods of incarceration to protect public safety.

3. General Laws Chapter 123A should be reformed in the following manner:

   a. End the practice of categorizing and committing newly convicted repeat sex offenders as "sexually dangerous persons";

   b. Retain jurisdiction over the offenders currently committed to the Treatment Center under the current statute by:

      i. authorizing the Commissioners of Correction and Mental Health to determine, on a case-by-case basis, whether certain offenders with concurrent criminal sentences would be more appropriately served in a prison setting;

      ii. developing a transitional treatment program for offenders who no longer have criminal sentences and others remaining at the Treatment Center;

      iii. developing a high quality pilot voluntary treatment program for sex offenders in the Department of Correction; and,

      iv. repealing Chapter 123A in its entirety as of June 30, 1994.

4. Develop services for sex offenders on probation and parole, in county houses of correction and state prisons including the following:

   a. Develop specialized sex offender treatment groups in each prison and house of correction;

   b. designate staff to work with probationers, houses of correction inmates, and parolees who have been previously identified as sex offenders; and

c. provide outpatient sex offender groups in Department of Mental Health supported community mental health centers for probationers and parolees.

5. Expanded delivery of services to high risk populations such as victims of sexual abuse and juvenile sex offenders should be supported in order to decrease the likelihood of future offending.

V. HISTORY

A. HISTORY OF SPECIAL DISPOSITIONAL SEX OFFENDER LAWS

At one time, more than half the states had special dispositional "sexual psychopath" laws. These laws, which came into vogue in the 1940's and 1950's, were predicated on the assumption that a specific mental illness exists which is characterized by the commission of sex crimes. Closely linked to this assumption is the belief that, if "sexual dangerousness" is an "illness," then there must be a "cure." Today, mental health professionals generally question both assumptions and view "sexual dangerousness" as a legal category rather than a clinical diagnosis.

The enactment of most of these "sexual psychopath" laws followed a similar pattern: a widely publicized violent sex crime resulted in a public cry for increased social controls and punishments. In response, legislatures quickly drafted and readily passed legislation designed to quell the public pressures. Such legislation differentiated sex offenders from all other offenders. The legislation usually included a provision that would allow indefinite commitment, incarceration and segregated housing, often in specially designated "treatment" settings within the correctional system or mental health system. The segregation of sex offenders resulted in attempts to "treat" their problems through techniques of psychotherapy and traditional mental health interventions.

The American Bar Association, in its 1984 Criminal Justice Mental Health Standards strongly recommended repeal of special dispositional statutes for sex offenders. In its report, the Bar Association found that this type of legislation was based on six assumptions:

> "...1) there is a specific mental disability called sexual psychopathy, psychopathy, or defective delinquency; 2) persons suffering from such a disability are more likely to commit serious crimes, especially dangerous sex offenses, than normal criminals; 3) such persons are easily identified by mental health professionals; 4) the dangerousness of these offenders can be predicted by mental health professionals; 5) treatment is available for the condition; and 6) large numbers of persons afflicted with the designated disabilities can be cured."(2)

The primary assumption underlying all sexual psychopath laws is that the sexual criminal behavior exhibited is the result of an underlying mental

illness or disease. Thus, it is reasoned, the "illness" of "sexual dangerousness" should be amenable to correction or cure through treatment modalities offered by mental health professionals. At the time these laws were enacted, however, no data existed to either support or reject these assumptions, and treatment was offered as an optimistic intervention for individuals who committed these unacceptable behaviors. Today however, it is generally believed that the basic assumption of an underlying "illness" is faulty, thus demanding a re-examination of a forty year old system of labeling, committing and treating certain sex offenders as "sexually dangerous persons."

B. HISTORY OF CHAPTER 123A

The Massachusetts legislature passed a "sexual psychopath" law in 1947 in response to public outrage over violent sexual crimes.(3) The passage preceded, by one year, the report of a legislative commission created to study the feasibility of such legislation. Between 1938 and 1966 a total of 31 states enacted similar "sexual psychopath" legislation.(4) The legislative report issued in 1948 recommended the repeal of the new 1947 legislation on the grounds that "sex crimes should not be considered apart from the general correctional system."(3) Much of the Massachusetts statute was taken from a Minnesota statute passed in 1939.

Despite passage of the 1947 Massachusetts law, treatment for sex offenders remained elusive for the first seven years of the statute. A major legislative revision in 1954 mandated the development of a "Treatment Center" and substituted the term "sex offender" for the "sexual psychopath" language of the earlier statute. These changes facilitated the development of a post-conviction special dispositional alternative for certain repeat offenders.(2)

Three years later, in 1957, an especially gruesome sexual murder of two young boys brought the public to new levels of outrage. The predictable consequence was yet another revision of the existing law to redefine "sexual dangerousness" to include both "repetitive or compulsive" behaviors and "violence or aggression" in the commission of the act. Subsequently, procedural due process safeguards were introduced which reflected general mental health commitment reforms.

The years following 1957 were characterized by a multitude of law suits, often brought by offenders at the Treatment Center, challenging the nature and quality of the treatment program. In 1972 a law suit brought in federal court, Williams V. Lesiak,(5) resulted in a consent decree which greatly changed the nature of the program offered at the Treatment Center. Among other changes, the role of the Department of Mental Health was significantly strengthened. The term "patients" replaced the previously used term "prisoners." A new treatment setting was required, and the remaining ancient buildings of the old Alms Farm at Bridgewater were slated for alternative use. Specific programming, including a community access program known as the "Authorized Absence Program" was mandated under the consent decree. Additional changes continue to be made by legislation and court order, but Chapter 123A remains largely as revised following the Williams case in 1972.(4)

In 1985 and 1986, the Executive Office of Human Services filed legislation to give the Department of Correction sole responsibility for the Treatment Center. The Joint Committee on Human Services gave these bills an unfavorable report, based in part on the argument of the Williams plaintiffs, that a sole Department of Correction administration would violate the terms of the consent decree.

C. HISTORY OF THE TREATMENT CENTER PROGRAM

The initial Treatment Center was established at MCI-Concord in 1957, ten years after the original statute was passed and three years after legislation was enacted authorizing the creation of a new Treatment Center. Within a year, the small population was moved to Bridgewater where it languished for the next 27 years in the oldest section of the antiquated complex. The 1972 Williams suit resulted in the construction of a new setting for the Treatment Center within the Bridgewater complex. This modern building opened in 1986 and currently houses 274 men. The use of the Treatment Center has increased over the years, although use varies markedly from county to county and from court to court. Today's census of 274 represents a more than 200 percent increase over that of 1970, when the census was just 90. For the past 25 years, the Treatment Center has averaged 60 admissions for evaluations of "sexual dangerousness" each year, with an average of 19 men committed per year. Average annual releases total 11. The fact that admissions rates are higher than discharge rates account for the gradual increase in the population over the years. Of the 325 men committed and subsequently released from the Treatment Center since 1959, the average length of stay to discharge has been seven and one half years. Among the 263 men currently committed to the Treatment Center, the average length of stay has been eight and one half years. These findings contradict the public belief that a "one-day-to-life" commitment ensures incarceration for life.

VI. DESCRIPTION OF CURRENT SYSTEM AND SERVICES

A. CURRENT SYSTEM

The current Treatment Center is a $22 million modern facility set within three rows of razor-topped fences. Security services are provided by correction officers employed by the Department of Correction, while Department of Mental Health staff provide the administrative oversight for the facility as well as treatment services and programs. This joint administration is required under General Laws Chapter 123A, section 2 and the Williams consent decree, which mandated a non-punitive environment at the Treatment Center and an expanded role for the Department of Mental Health.

The current administrative staff, though dedicated and competent, must work within the confines of a predictably cumbersome and problematic management structure characterized by a dual administration. This structure creates unavoidable institutional tension which is a by-product of the correctional concern for security and the mental health concern for treatment. The result is an environment with two contradictory sets of policies, regulations and expectations. For example, offenders who violate institutional rules would be subject to disciplinary sanctions in prison. At the Treatment Center, however, these same offenders are often less effectively

managed solely by clinical interventions. Unfortunately, much time and energy is expended attempting to resolve disagreements which arise under this often conflicting management structure.

Under the current system, sex offenders are generally referred to the Treatment Center by a court subsequent to sentencing for an assessment of "sexual dangerousness." If a judge, based on the Treatment Center assessment, finds that a person is "sexually dangerous," the person is committed to the Treatment Center for "one-day-to-life." A committed offender may annually petition the Superior Court under Chapter 123A, section 9 for an evaluation for discharge. At the hearing on the petition, the Treatment Center is required to prove beyond a reasonable doubt that the offender continues to be "sexually dangerous."

A judge is presented with evaluations of the offender's present condition by the Treatment Center staff, two "qualified examiners" and in most cases, experts retained by the offender. The judge weighs the often conflicting clinical opinions of the experts and determines whether the offender continues to be "sexually dangerous."

On occasion, despite the opinions of Treatment Center staff and other experts, judges have determined that offenders are no longer "sexually dangerous" and ordered them discharged from the facility. Unfortunately, judges have no discretion under Chapter 123A to order follow-up participation in an aftercare program. There is no parole equivalent authorized under the current scheme, thus an individual found to be no longer "sexually dangerous" cannot be subject to community monitoring or be required to participate in any subsequent treatment such as a relapse prevention program.

B. SERVICES OFFERED

Services that are currently provided at the Treatment Center fall into two categories: therapeutic and rehabilitative.

Therapeutic services consist primarily of group treatment, but also include individual therapy. Current Treatment Center data indicates that 61 offenders receive individual therapy. According to the Treatment Center administrator, individual therapy is very costly and not particularly effective for this population and will soon be phased out. Group treatments are generally felt to be the most effective means of dealing with persons who wish to change anti-social life patterns and therefore comprise the majority of therapeutic activities provided. In any case, both individual and group therapies are more likely to have some impact if the offender wants treatment and wishes to change his behavior. It has been estimated that as many as 40 percent of the offenders at the Treatment Center have refused all forms of treatment.

Rehabilitative programs are designed to provide offenders with work and daily living skills, some income, and necessary training and preparation to ready them for potential release and return to the community. The Treatment Center provides an educational program which offers offenders college courses, GED programs and computer classes. Eighty-six men participate in educational programs. One hundred and fifty-seven men are involved in paid job programs such as the print shop and graphic arts

program, or in institution-based work as library aides or maintenance workers.

C. AUTHORIZED ABSENCE PROGRAM

The "Authorized Absence Program" is a program mandated by the federal court, which rests upon the assumption that controlled and gradual community access is an essential component of a treatment program aimed at successful reintegration of sex offenders into the community.

The "Authorized Absence Program" was required to be created by a federal consent decree signed on December 31, 1974 by the Attorney General's Office and entered as an order by the federal court on January 2, 1975.(5) The regulations establishing that program were only written and implemented after a specific court order in response to a contempt motion by the plaintiffs in March, 1976. The regulations themselves were closely reviewed and revised by the court and then issued as a court order in 1978.

Administration efforts to restrict the "Authorized Absence Program" have been rebuffed by the federal court. In 1980, the Attorney General unsuccessfully moved to allow the Department of Mental Health to administer the "Authorized Absence Program" under its own regulations instead of the court-ordered regulations.

In 1986, the legislature attempted to restrict the "Authorized Absence Program" under a bill sponsored by Bridgewater legislators. Among other things, the law renamed the program a "Restrictive Integration Program," gave voting powers to a Department of Correction security person on the board who reviews applications for absences, and doubled the time an offender had to serve before eligibility for absences (from one to two years). The federal court rejected those amendments as a breach of the decrees; this was appealed and has been remanded for further findings.

The "Authorized Absence Program" is designed to enable selected patients gradual access to the community through a carefully designed series of programmed stages. Currently, of the 58 individuals who have access to the community, most must be escorted by Treatment Center staff. The 13 who are unescorted or, who can leave the facility only with other staff-approved escorts, have successfully progressed through all prior stages and are in the final phase of the program. An offender's history of participation in the "Authorized Absence Program" frequently is an important factor considered by the court in determining the patient's suitability for release. Since 1977, there have been 20 identified major incidents involving offenders in the "Authorized Absence Program." Most have involved escapes followed by later capture, but some have involved alleged rapes, assaults and robberies. It is noteworthy that these same individuals might have been ineligible for any programs allowing them access to the community had they been in prison.

VII. CURRENT UTILIZATION OF SYSTEM AND SERVICES

The Treatment Center operates a research unit which allows access to detailed information and research about the offenders who are at the Treatment Center. It is essential however to also look at data regarding

individuals who are charged with, or have been convicted of, sex crimes who are not housed at the Treatment Center.

- As of January, 1988, the Department of Correction estimates that 16.2 percent (over 1,000) of all inmates currently incarcerated in state prisons are serving sentences after having been convicted of sex offenses. Additionally, 24 percent of all state inmates have histories of having committed sex offenses;

- The Commissioner of Probation estimates that 600-700 persons serving probationary sentences are on probation for sex offenses;

- As of December, 1988, the Parole Board estimates that 10 percent of those on parole, or over 400 parolees, were previously convicted of sex offenses; and,

- Recent discussions with district attorneys and judges indicate that many persons initially charged with sex offenses plead to lesser sentences, or are not tried, convicted, or incarcerated because of the difficulties in obtaining evidence from traumatized victims.

Thus, the vast majority of sex offenders in the criminal justice system have never had an evaluation of "sexual dangerousness" or access to specialized treatment programs.

The Treatment Center has provided the Panel with significant data regarding the men currently housed there. Currently, 263 men are committed to the Treatment Center and 11 are being evaluated for "sexual dangerousness." A profile of 263 committed men currently at the Treatment Center yields the following information:

- The majority are white.

- The majority are over 30.

- The majority have been convicted of sex offenses against children.

- As many as 40 percent of those committed have exercised their right to refuse treatment.

- Seventy-five have completed their prison sentence (or never received a sentence) and are committed at the Treatment Center on a civil commitment only.

- Fewer than 5 percent are diagnosed as mentally ill or mentally retarded.

Since most of those committed to the Treatment Center were originally given a criminal sentence, it is important to review the current status of those sentences. Table 1 describes current parole eligibility data for the 263 committed as of July 26, 1989. It should be noted that 75 men are not parole eligible because they are no longer serving a prison sentence or were never sentenced after conviction.

TABLE 1
CURRENT PATIENT PAROLE ELIGIBILITY DATA

Completed Prison Sentences - Parole N/A	49
Civil Commitment Only - Parole N/A	26
Currently Parole Eligible	70
Not Yet Parole Eligible	114
Serving 1st Degree Life - No PE Date	4
TOTAL	263

Table 2 demonstrates that the majority of those committed to the Treatment Center have received a criminal sentence to a set term of years rather than to a life sentence.

TABLE 2
PATIENT ORIGINAL PRISON SENTENCE DATA

Civil Commitment Only - No Prison Sentence	26
Serving Life - 1st Degree	4
Serving Life - 2nd Degree	26
Sentenced to Prison Terms Other Than Life	207
TOTAL	263

Of Those Patients Originally Receiving Prison Sentences:

Completed Prison Sentence	49
Still Serving Prison Sentence	188
TOTAL	237

Currently, 75 men who reside at the Treatment Center are either, no longer serving prison sentences or, they received a civil commitment in lieu of a criminal sentence. Tables 3, 4 and 5 describe these 75 men, first, by listing the counties where the commitment originated; second, their ages; and third, the age of their victims.

TABLE 3
COUNTY FROM WHICH CIVIL COMMITMENT ORIGINATED

Barnstable	4
Berkshire	1
Bristol	7
Dukes	0
Essex	6
Franklin	3
Hampden	4
Hampshire	1
Middlesex	15
Nantucket	0
Norfolk	3
Plymouth	2
Suffolk	14
Worcester	15
TOTAL	75

TABLE 4
AGES OF MEN WITH CIVIL COMMITMENTS ONLY

<21	0
21-25	4
26-30	7
31-35	17
36-40	14
41-45	12
46-50	8
51-55	4
56-60	4
61-65	3
>65	2
TOTAL	75

TABLE 5
AGES OF THEIR VICTIMS

Victims Were Children	43
Victims Were Adults	19
Victims Included Adults and Children	5
Victims Ages Unknown	8
TOTAL	75

VIII. GAPS IN THE SYSTEM

A. FAULTY ASSUMPTIONS

While Massachusetts has been operating under its 40 year old sexual psychopath law, a series of criticisms have arisen throughout the nation that appear to strike at the most basic assumptions of such laws. Initial challenges in other states were based upon the concerns for the lack of due process, the vagueness of the sexual psychopath label and the need for procedural safeguards.

Separate from the legal challenges, mental health and mental retardation professionals began to conduct and examine research focused on the treatment and remediation of "sexual dangerousness." The result of this analysis was a burgeoning tide of criticism which questioned the clinical basis for the statutes and treatment programs.

These criticisms found ultimate voice in the reports of two major professional organizations, the Group for the Advancement of Psychiatry (1) and the American Bar Association.(2) Both reports independently concluded that sexual psychopath legislation had been ineffective and should be repealed. The American Bar Association reported:

> "The assumptions on which legislation of this sort has rested have largely been rejected in the behavioral sciences, and the experiences that accumulated during the administration of such legislation have been disappointing: 1. the categories of mental disorder the statutes address for the most part are no longer viewed to be clinically valid; 2. treatment for special offenders has been nonexistent or largely ineffective; and 3. some offenders have been held longer than community protection requires while other offenders who have been released as cured have committed new offenses."(2)

1. The Questionable Effectiveness Of Treatment

The Panel is acutely aware of the controversies in the professional literature concerning treatment approaches and the predictability of "sexual dangerousness." The Panel began with a review of psychiatric and psychological diagnostic literature for an understanding of the current label of "sexually dangerous person." This review demonstrated that terms such as "sexual psychopath," "sexually dangerous person," "rapist" or "child molester" are legal and criminal justice terms, but not labels used within contemporary mental health diagnostic literature. For example, rape is not a diagnostic category in DSM-III-R (the American Psychiatric Association's Diagnostic and Statistical Manual) but instead is an antisocial behavioral act which cuts across several conventional diagnostic categories and psychiatric conditions.(6) There are a few offenders who commit sexually aggressive acts during periods of mental disorder or transient stress. For the majority however, such acts are intentional criminal behaviors.

It is this latter group of offenders who are targeted by the sex offender laws. Psychosocial theories of human behavior suggest that as a consequence of trauma, abuse, neglect, exploitation, or abandonment during the formative years, sex offenders' psychological maturation is thought to have been adversely affected.(7,8,9,20,21,22,23) At the Treatment Center, it has been estimated that up to 90 percent of the offenders were themselves victims of physical and/or sexual abuse. Often sex offenders will display a variety of behavioral deficits including inadequate social skills, lack of assertive responses, poor impulse control, mismanagement of frustration and aggression, and difficulty expressing feelings.(10)

In addition to the psychosocial theories of sexually deviant behavior, the relationship of hormones to sexually aggressive behavior has also been investigated. There have been numerous studies which show positive correlation between plasma testosterone levels and general aggression (11,12,13,14,15) and some conflicting evidence regarding a correlation with sexual aggression.(11,15) Research centers also have been studying many other physiologic differences between violent and nonviolent offenders.

The debate remains unsettled as to whether the primary cause of these behaviors is organic or functional in nature, or attributable to a combination of factors including biological, interpersonal and environmental factors. Unfortunately, no matter which theory is the prevailing one, treatment effectiveness remains questionable.

a. Research On Treatment And Recidivism Rates

Very little meaningful data on the recidivism rates of treated sex offenders exist. Simply agreeing on a definition of recidivism for the sake of evaluating treatment programs is difficult. For example, should relapse be measured by the number of subsequent arrests, convictions, incarcerations or on self-reported offenses? How long should follow-up studies continue? If recidivism is measured by subsequent arrests, it must be remembered that sex offenders in one study confessed to committing three to six times as many sex offenses as those for which they have been arrested (17), and in another (19) were discovered to have 2.4 unreported offenses for every official arrest and 2.7 undiscovered victims for every reported victim.

Most experts agree that treatment is more likely to be successful when clients are motivated out of a genuine desire to seek assistance in controlling their behavior. Others suggest that sexually aggressive acts may be considered addictive, or compulsive behaviors, and, like other addictive behaviors, may have no treatment with proven superior effectiveness.(18) The data seems to indicate that the efficacy of treatment programs designed for sex offenders has not been proven. Furthermore, determining when a person is no longer "sexually dangerous" as required by the current statute is a complicated, if not impossible task. The report by the Group for the Advancement of Psychiatry complains that "few studies define what 'cure' or successful treatment of sex offenders means. Do we mean a clinical cure, and, if so, in terms of what? In fact, on the basis of subsequent sexual offenses (recidivism rates), treated and untreated groups do not appear to differ." They conclude that "first and foremost, sex psychopath and sex offender statutes can best be described as approaches that have failed."(1)

The early enthusiasm and optimism with which clinicians and policymakers embraced the concept of rehabilitating the sex offender has diminished. The special dispositional statutes which shifted the burden of custody from the penal system to the mental health system may have been misguided. Unquestionably, treatment should continue if there is hope of reducing or even eliminating the commission of repeat offenses. However, high quality program evaluation research must be coupled closely with treatment. Current data do not yet justify wide-scale and costly treatment programs. The treatment industry that has developed following the "sexual psychopath" laws has been innovative, but has effected little in the way of demonstrably successful long-term interventions.

For all concerned, the bottom line of any treatment approach must be whether or not the treatment works. That is, whether the treatment can assure that the offender will not reoffend. Unfortunately, even the most promising behavioral and chemical approaches suffer from not being able to definitively answer this critical question.

Earlier, we identified the primary assumption upon which sexual psychopath laws are based as rooted in the belief of an underlying mental disability. The Panel's research strongly undercuts this assumption and enables us to firmly state that such assumptions are unfounded. Rather, we conclude that criminal sexual violence is best understood as a form of anti-social behavior. Anti-social personality disorders are thought to be at the root of almost all criminal behavior, from drug-related violence to armed robbery. A small number of sex offenders, like any other types of offenders, are mentally ill. However, the commission of sex offenses is not in itself symptomatic of any diagnosable mental illness. Indeed, less than five percent of the men at the Treatment Center have been diagnosed as mentally ill. Sexual violence is clearly not a mental illness --- it is a criminal behavior.

Given that treatment of men labeled as "sexually dangerous persons" has been based upon the inaccurate assumption that they are mentally ill, it is not surprising that traditional mental health interventions have not yet proved themselves to be effective. Unfortunately, innovative treatment modalities similarly have not yet proven effective. The efficacy of treatment programs is further questioned because of the difficulties surrounding accurate measure of recidivism rates for treatment participants, based on inconsistent definitions of recidivism.

Finally, Chapter 123A requires mental health professionals to assist the courts in determining sexual dangerousness by offering predictions about future sexual violence. In a January, 1987 Department of Mental Health memorandum, then Commissioner Edward M. Murphy wrote with regard to the problem in such attempts at prediction:

> "The standard prediction model used by mental health professionals involves an assessment of a person's history and an analysis of what situations appeared to precipitate previous violence. From that analysis, a prediction can be made of the likelihood that the situation which precipitated the violence may occur again. Therefore, the prediction cannot be used in a global sense (is this

person dangerous?), but rather in a situational sense (under what circumstances may this person who acted violently in the past, again commit a violent act?). Given the limitations of this predictive model, it is not reasonable to assume that mental health professionals can properly judge someone to be sexually dangerous in a prospective sense."(3)

B. PROBLEMS WITH THE MASSACHUSETTS SYSTEM

The Massachusetts sex offender commitment system is not only based on faulty and anachronistic notions about the nature and treatability of "sexual dangerousness," but it is further hindered by serious practical difficulties in the administration of the Treatment Center program. The Panel views these very significant problems as a reflection of the current system's reliance on the misconception that repeat sex offenders should be treated like mentally ill patients and not like violent criminals.

The joint administration of the Treatment Center by the Department of Correction and Mental Health is required both by state statute and federal consent decree. This dual management system has been viewed as extremely inefficient and highly problematic for some time. Differences in philosophy and mission between the state's correction and mental health agencies result in differing, and frequently conflicting policies, regulations and expectations. The distinction between administrative issues which are solely related to security and those which concern treatment is unclear; most often these issues have implications in both areas. Since the Lesiak consent decree requires a "non-punitive" environment with a strong mental health orientation, security and safety are considered secondarily in areas such as responses to "patient" violence and control of weapons, drugs and pornographic material in the facility. Thus, an offender who violates institutional rules, and who in prison would be subject to disciplinary sanctions, at the Treatment Center is often ineffectively managed with traditional mental health interventions.

An additional and significant problem which impedes the management of the Treatment Center is that staff at the facility have no authority to determine whether a potential "patient" would be motivated for or benefit from treatment. This involuntary commitment scheme guarantees that many of those committed are unlikely to benefit from treatment. As noted previously, it has been estimated that up to 40 percent of all offenders at the Treatment Center refuse all forms of treatment.

Nor is the staff able to transfer back to prison an offender who is not interested in availing himself of treatment opportunities. Offenders who refuse treatment yet are legally required to remain in the Treatment Center create serious security and management problems. A Superior Court Judge recently addressed this situation and expressed the frustration of many who work within the confines of this system when he issued an order to return an individual to the Treatment Center who had been placed in the maximum security state prison due to his extremely violent behavior. The order stated:

> "...[The offender] wants no treatment and receives no treatment....sending...[him]...back to Bridgewater [Treatment Center], although required by law, is a sorry solution to a very real problem. And that problem is what do you do with extremely dangerous inmates, who although confined to the Treatment Center, are, in fact, receiving no treatment and are a continuing and extreme danger to staff and other inmates?
>
> And so ...[the offender]... will go back to the Treatment Center where his presence will interfere with the treatment of others and will cause unending security problems for the Center. And all because a well intentioned Legislature created a Treatment Center for Sexually Dangerous Persons without providing for the transfer out of Bridgewater to a more secure facility of men who refuse treatment and whose sole goal in life is to kill, control, harass, bully, dominate, exploit and threaten other inmates and the staff."(24)

The current system is also problematic in that it distributes valuable and limited resources in an inequitable and counterproductive manner. First, the Treatment Center is utilized differentially by the various counties, district attorneys and judges, and only treats a small percentage of all sex offenders statewide. Recent data shows that more than half of the men currently admitted to the Treatment Center come from three counties; Suffolk, Middlesex and Worcester. In addition, 35 percent of all new admissions to the state prison system have been convicted of sex offenses, and 18 percent of the state prison population at any one time are sex offenders. Similarly, one to two percent of men incarcerated in county houses of correction have been convicted of lesser sex offenses.

Valuable and limited treatment resources are also being targeted at a population of offenders who are least likely to benefit from them. Offenders at the Treatment Center havc already committed numerous and particularly heinous sex offenses, and are less likely than younger or first time offenders to benefit from treatment intervention.

Substantial and valuable treatment resources are thus being expended on a somewhat small and randomly selected minority of the sex offenders in the state prison system to the exclusion of the vast majority. Few resources are being utilized to treat sex offenders in county correctional facilities or to provide intervention at an earlier stage in an offender's criminal "career." This unbalanced allocation of state funds is particularly unjust given that there are no assurances that the chosen few will even participate in, or potentially benefit from, treatment opportunities.

Finally, the court-mandated "Authorized Absence Program" creates significant public safety concerns based upon the recognition that "sexually dangerous persons" are not mentally ill, the difficulty in predicting future dangerousness of non-mentally ill violent offenders, and the resulting ill-

conceived requirement that these serious community release decisions be made by mental health and not criminal justice or security staff.

These public safety concerns have been a long-recognized concern of administration officials. As noted earlier, efforts to transfer sole management of the Treatment Center to the Department of Correction and attempts to place limitations on the "Authorized Absence Program" have been made on several occasions, but have thus far been unsuccessful.

Most recently, a federal court decision recognized the problems attendant to the current statutory scheme.(25) In an opinion in two consolidated cases, the Court conducted an exhaustive review and analysis of Chapter 123A and the Treatment Center program. In finding that constitutionally adequate treatment is provided to Treatment Center patients and that the current system of responding to violent or potentially violent behavior is proper, the Court stated:

> "The trials of these consolidated actions lasted only seventeen days, but the conflicts which were revealed have existed since Massachusetts began involuntarily committing sexually dangerous offenders and established a center to provide for their treatment."
>
> "...[T]he Treatment Center ... is a dissonant mosaic, a patchwork in which good intentions rest uneasily alongside benign neglect, in which some impressive (and expensive) facilities and programs collect dust or rust because no one has been hired to operate or supervise them, in which competing philosophies fracture any sense of institutional purpose, and most important, in which patients' therapeutic needs and their earnest pleas for help are overwhelmed and even drowned by the need to respond to the incessant demands of those patients for whom treatment is of secondary importance."(25)

The Court concluded that any efforts to close the Treatment Center program would be "eminently proper in the legislative sphere." (25)

IX. OTHER STATES' RESPONSES

At present, Massachusetts is only one of four jurisdictions that continue to have an involuntary, indefinite commitment law for sex offenders. In April, 1988, when the Panel began its work, only Colorado, Washington, D.C., Illinois and Minnesota maintained statutes similar to that of Massachusetts, which provide for an involuntary, indefinite commitment of persons classified as "sexually dangerous" offenders. At this writing, Minnesota has successfully abolished its statute. Similarly, an Illinois advisory panel has recently recommended the repeal of that state's law. Washington, D.C. rarely uses its law. Fourteen states besides Minnesota have recently repealed their

sex offender laws. Twelve have modified their statutes to allow for treatment only if deemed clinically appropriate, and only for the length of the criminal sentence. Twenty states have no special disposition for those convicted of violent sexual crimes. With 274 indefinitely committed men in its Treatment Center for Sexually Dangerous Persons, Massachusetts is currently administering the largest program of its kind in the country.

Prior to repeal, statutes in many states permitted courts to involuntarily commit sex offenders to treatment programs. Although the express statutory purpose of the commitment focused on rehabilitating the sex offender, often the underlying legislative and judicial purpose included keeping sex offenders in preventive detention for as long as possible. Thus, most sex offenders received indefinite commitments and could remain in treatment beyond the terms of their prison sentence. In all states, either the correctional agency or the mental health agency provided both the clinical and the security staff, but in no state, except Massachusetts, were services co-managed by two different agencies.

A number of factors emerged in reviewing other states' reasons for repealing their involuntary treatment statutes. First, clinical treatment did not prove effective in "curing" most sex offenders. Vague admissions and release criteria provided a weak foundation from which to plan treatment, and clinical staff could rarely screen out the offenders least amenable to treatment. Of those sex offenders admitted to treatment programs, few suffered from mental illness conducive to diagnosis and treatment. Further, involuntarily committed sex offenders could not be required to participate in existing treatment experiments and therapies. The overall penal philosophy began to shift from treatment-oriented rehabilitation of offenders to more punishment-oriented retribution. Other factors precipitating repeal included the higher cost of the involuntary treatment programs compared to prison, and expensive and time-consuming litigation generated by the programs, all bolstering the movement to incarcerate sex offenders in traditional correctional settings. The litigation, brought by, or on behalf of, involuntarily committed sex offenders, tended to focus on equal protection, "one-day-to-life" commitments, and right to treatment issues. The equal protection claims stemmed from the lack of clear criteria designating which sex offenders should participate in involuntary treatment programs and which should remain within the general prison population. This unclear dichotomy also generated controversy over the "one-day-to-life" commitment provisions. In California and Wisconsin, for example, some sex offenders remained involuntarily committed past the maximum sentence while other sex offenders served less time in prison for committing the same crimes. Some sex offenders served less time in treatment than their counterparts served in prison. Litigation also involved a claimed right to treatment. Although sex offenders committed involuntarily to treatment programs could refuse to participate, these offenders nonetheless alleged a constitutional right to treatment. Thus, sex offenders in some treatment programs brought lawsuits demanding treatment that the clinical staff would not or could not provide.

Community safety fears, another factor motivating repeal, appeared quite prevalent in California and Washington. Since sex offenders committed to treatment programs could spend less time in these programs than those offenders sentenced to prison, concern arose regarding whether program participants released "early" posed an increased threat to the community and

generated further fears in both Washington state and California. Heinous crimes committed by "cured" offenders in both states fueled the repeal movement there.

As the momentum to repeal involuntary treatment statutes grew, expanded legislative initiatives were developed to establish alternatives to involuntary treatment and to phase-out the existing statutes. Most of the legislation halted all new admissions to involuntary treatment programs as of a designated date and provided that all sex offenders convicted on or after the date receive traditional prison sentences. The legislation also provided for the gradual release of sex offenders from involuntary treatment. Some repeal statutes required the immediate discharge of program participants whose criminal sentences or treatment orders had expired. Other participants remained in involuntary treatment until either, receiving a conditional discharge grant or, until they reached the end of the sentence or current treatment order, whichever occurred first.

A. PROGRAMS

The shift from involuntary treatment of sex offenders to voluntary treatment has not resulted in a complete elimination of treatment programs. Instead, a number of states allow sex offenders to participate voluntarily in treatment programs in designated prisons or in mental health facilities. States which have reported some success in treating sex offenders, such as Oregon and Vermont, have programs which incorporate many of the same elements of program design. Others, such as California, also have a strong research component which was built into their enabling legislation in order to assess the effectiveness of the treatment program and to justify its continued funding.

First, these programs are all offered to sex offenders on a voluntary basis. Moreover, offenders are screened by treatment staff prior to admission to assess their amenability to treatment. Once accepted into the program, offenders who do not avail themselves of treatment opportunities are removed from the program. Indeterminate sentencing or commitment is not a component of any of the programs. Each of these states offers a continuum of services to sex offenders, including careful aftercare planning and community monitoring programs. Finally, these programs have significant research capabilities in order to be able to objectively assess the success of treatment efforts.

The Panel recommends that Massachusetts develop a program modeled on those of other states. The California model is one worthy of consideration. In 1981, the California sex offender commitment statute was repealed resulting in a cessation of the practice of involuntarily committing sex offenders. The new legislation however, allowed for the voluntary transfer of certain sex offenders to a new Department of Mental Health clinical research program during the last two years of their prison sentences. The new program, opened in 1985, was designed to meet two mandates set forth in the legislation: 1) to operate a small, innovative treatment unit for sex offenders, and; 2) to closely assess the effectiveness of the treatment program on an ongoing basis. The treatment program is housed on a 46 bed unit at Atascadero State Hospital. Formal reports on treatment outcomes must be submitted to the legislature once every two years until 1991, when the program will be up for termination

or renewal. Though the California program is administered by the Department of Mental Health, the Panel believes that similar elements of program design could be incorporated into a Department of Correction voluntary treatment program.

B. TREATMENT APPROACHES

Approaches to treating sex offenders are varied, based on whether the primary cause of these behaviors is viewed as organic or functional in nature, or due to a combination of factors. These approaches include psychoanalysis, aversive behavior therapy, individual and group psychotherapy, stereotaxic neurosurgery, castration, and hormonal or pharmacological therapy.

As mentioned earlier, one school of thought holds that sexually aggressive behavior is learned, or is at least a symptom of functional disorders, while a second holds that sexual deviances are a consequence of organic, or physiologic dysfunctions and should be treated as such. The overwhelming majority of contemporary programs designed to treat repeat sex offenders use a "relapse prevention" model which assumes a functional disorder and involves elements of psychotherapy, sex education, behavioral interventions, resocialization, and occupational therapy.

Virtually all these programs insist that some motivation for change on the part of the offender is required for successful treatment. Involuntary treatment programs, like Massachusetts', are necessarily more certain to have men committed to them who would be least likely to benefit from treatment. Moreover, since in this state and others, patients have the right to refuse any and all treatment offered to them, involuntarily committed men are more likely to exercise this right than those who voluntarily seek treatment.

Programs such as the ones in Vermont, Oregon and California utilize a "relapse prevention" model of treatment. "Relapse prevention" is an integrated approach to treatment which draws upon elements of psychodynamic, behavioral, cognitive and biomedical theories and incorporates educational and training components.(26) Treatment goals include: ongoing assessment of sex offenders, having offenders accept responsibility for their offenses, training offenders to recognize and interrupt patterns of violent behavior, promoting assertiveness and self-esteem and post-release support and monitoring.(26)

Around the country, there are also a limited number of specialized medical centers attempting to treat the problem on an organic basis, primarily through hormonal therapy. Research has demonstrated that some patients treated with hormonal therapies ceased abnormal sexual behavior because of the decreased desire.(10) Unfortunately, the patient's sex drive, including abnormal desires, returned immediately once the treatment was discontinued. There has been a growing willingness among judges to order probation with special conditions, or reduce sentences based upon the offender's participation in such treatment. However, the legal ramifications and the unknown long-term medical risks of these controversial treatment techniques have deterred wide-spread acceptance. Of equal importance is the tendency of most sex offenders to cease taking such medications once court restrictions are lifted. Other treatment modalities exist including castration, aversive conditioning

and estrogen treatment. However, ethical, medical, and legal concerns have also limited the application of many of these modalities.

X. A MODEL FOR MASSACHUSETTS - RECOMMENDATIONS

The Panel views Chapter 123A and the Treatment Center as a legal, clinical, philosophical and practical quagmire. The Commonwealth is long overdue for reform of a system based on faulty and anachronistic notions. Valuable and limited resources are currently distributed in an unfair and counterproductive manner. Treatment efforts have shown no clear success and, most importantly, public safety is at risk. Administration officials, the legislature and, most recently, the judiciary have recognized these problems and have taken steps towards or invited reform.

The Panel recommends that Massachusetts follow a nationwide trend by implementing the following proposals for change:

1. EFFECT SIGNIFICANT REFORM OF THE SEX OFFENDER COMMITMENT STATUTE, CHAPTER 123A, TO INCLUDE ELIMINATION OF THE SEXUALLY DANGEROUS PERSON DESIGNATION, AND TO REPEAL THE STATUTE IN FIVE YEARS.

The Panel proposes legislation to significantly reform General Laws Chapter 123A in the following manner:

a. No new commitments to the Treatment Center for Sexually Dangerous Persons will be permitted after the effective date of the bill. Persons found guilty of sexual offenses after the effective date of the bill will be sentenced to correctional facilities, pursuant to the sentencing laws of the Commonwealth of Massachusetts.

b. The Commissioners of the Departments of Mental Health and Correction may jointly determine that a person committed to the Treatment Center, who is also serving a concurrent criminal sentence, would be more appropriately served at a facility operated by the Department of Correction. Accordingly, the Commissioners may transfer the person to the custody of the Department of Correction, at which time he shall be considered a Department of Correction inmate and subject to all rules and regulations of the Department of Correction. He also may participate in available treatment programs offered by the Department of Correction, as appropriate. Factors to be considered in making transfer decisions may include: willingness to participate in treatment, likelihood of benefiting from available treatment, length of time remaining on sentence, availability of space, need for security and public safety.

c. Persons who have been assessed as not appropriate for transfer to the custody of the Department of Correction will continue to receive services from the Department of Mental Health in a treatment center operated by the Department of Correction. Each individual will be carefully assessed in terms of those factors which will facilitate a successful transition to the community. Such factors should include educational, vocational and

psychological needs. An individualized treatment plan for reintegration will be developed by the Department of Mental Health staff.

d. The standard for retention at a treatment center will remain one of "dangerousness", defined as follows: "...a dangerous person is any person whose misconduct in sexual matters indicates a general lack of power to control his sexual impulses, as evidenced by repetitive or compulsive sexual misconduct by either violence against any victim or, aggression against any victim under the age of sixteen years, and who, as a result, is likely to attack or otherwise inflict injury on such victims because of his uncontrolled or uncontrollable desires."

e. Effective June 30, 1994, General Laws Chapter 123A will be repealed in its entirety.

2. DEVELOP A PILOT VOLUNTARY TREATMENT PROGRAM FOR SEX OFFENDERS WITHIN THE DEPARTMENT OF CORRECTION.

The Panel recommends that a high quality, state-of-the-art treatment program be developed for incarcerated sex offenders within the Department of Correction. This program should be designed to serve offenders who wish to change their life patterns and who are assessed by the staff to be amenable to treatment. This program will serve as a supplement to current counseling sessions available for sex offenders throughout the Department of Correction. An integral component of this program must be an independent research capacity, which should have the primary responsibility to report to the legislature on an annual basis such data that demonstrates the success or failure of attempted treatment modalities. The legislature may use such information in funding determinations.

3. ESTABLISH A HIGH QUALITY TRANSITIONAL TREATMENT PROGRAM FOR THOSE INDIVIDUALS WHO ARE NOT DEEMED APPROPRIATE FOR TRANSFER TO THE DEPARTMENT OF CORRECTION, INCLUDING THOSE WITHOUT A CONCURRENT CRIMINAL SENTENCE.

If the recommended reforms of the sex offender commitment statute are implemented, many of the 199 offenders still serving criminal sentences will be transferred from the Treatment Center to correctional facilities. These offenders will be offered an opportunity to participate in a new voluntary treatment program. The remaining 75 "sexually dangerous persons" are no longer serving criminal sentences. The Panel has recommended that these offenders remain in a transitional treatment program until the current statute is repealed.

The Panel strongly recommends that the 75 civilly committed men remain at the Treatment Center and that a transitional treatment program be developed for them and others left in the program. The civilly committed patients, all of whom have lengthy criminal histories, have been at the Treatment Center for an average of 12 years. Fifty-six of the civilly committed men engage in some treatment programs at the Treatment Center; 24 are participating in the community access program.

The Panel believes that these men would pose a significant risk to public safety should they be released from the Treatment Center immediately. Accordingly, a transitional treatment program should be developed for these offenders in anticipation of repeal of the statute and their reintegration into the community. Among the components of this program would be graduated tiers of privileges, community monitoring and periodic reviews of their progress in the program.

4. IMPROVE THE DELIVERY OF SERVICES TO SEX OFFENDERS AT ALL POINTS IN THE CRIMINAL JUSTICE SYSTEM INCLUDING PROBATION, THE HOUSES OF CORRECTION, STATE PRISONS, AND PAROLE.

The Panel recommends development of sex offender treatment services throughout the criminal justice system, including the following:

a. Specialized sex offender treatment groups should be provided in each prison and house of correction;

b. Staff should be assigned to work with probationers, houses of correction inmates and parolees who have been previously identified as sex offenders. Specialized training should be provided on an ongoing basis to support these staff; and,

c. Specialized outpatient sex offender groups should be provided in at least one Department of Mental Health supported community mental health center in each Department of Mental Health region for probationers and parolees.

5. IMPLEMENT NEW STRICTER SENTENCING GUIDELINES FOR REPEAT SEX OFFENDERS TO ASSURE PUBLIC SAFETY.

The Panel is recommending a major overhaul of the sex offenders commitment statute. The Panel recognizes however, that the proposed repeal of the "one-day-to-life" commitment provisions of the statute may have implications for the Commonwealth's sentencing structure for habitual or repeat sex offenders. The Panel is therefore recommending that the Legislature adopt strict sentencing guidelines for repeat sex offenders.

The "one-day-to-life" provisions are understandably viewed by certain law enforcement officials and the public as a "safety net." This indefinite commitment is seen as allowing for a more prolonged incarceration than would be otherwise achieved through the traditional criminal sentencing process. Thus, the Panel has learned that district attorneys, who believe that a lengthy sentence may not be imposed in a particular case, sometimes request an evaluation to determine if the defendant is a "sexually dangerous person." The intention in such cases is for the "one-day-to-life" commitment to compensate for a perceived inadequate criminal sentence.

As noted earlier, the perception that a "one-day-to-life" commitment incarcerates offenders for life is erroneous. An individual committed as a "sexually dangerous person" has the right to petition the court for his release on an annual basis. If the court finds that he is no longer "sexually

dangerous," he must return to prison if he is still serving a concurrent criminal sentence, or, if his sentence has expired, he is released. Indeed, 229 sex offenders have been released directly from the Treatment Center to the community by the courts since 1959, and 65 have been released since 1980. Additionally, the Authorized Absence Program at the Treatment Center affords 20 percent of the Treatment Center population with various degrees of community access, including overnight absences from the facility. Finally, under the current system, all release and community access decisionmaking is the responsibility of mental health professionals at the Treatment Center. Questions about the nature and treatability of "sexual dangerousness," and skepticism regarding the ability of mental health professionals to predict the future dangerousness of non-mentally ill violent offenders raise serious doubts about the current system's ability to protect the public.

The Panel recognizes the serious responsibility of these service systems to protect the public. The Panel has therefore convened a working group of judges and attorneys to review the current sentencing structure for repeat sex offenders and to make recommendations for reform which would better assure public safety.

The working group reviewed current sentencing laws and practices and has recommended more frequent reliance by district attorneys on the habitual offender statute, General Laws Chapter 279, section 25. The statute allows for imposition of the maximum sentence for any felony in cases where an offender has been twice convicted and sentenced previously for terms of not less than three years.

The working group has further recommended new statutory authority which would enable prosecuting attorneys to pursue imprisonment of a repeat offender in the state prison for a minimum term of not less than ten years and a maximum term of life. This tougher sentencing law would apply to a repeat sex offense for which the offender was originally convicted or for other sex offenses, as specified by statute. No repeat offender sentenced under this stricter law would be eligible for furlough, temporary release or education, training or employment programs established outside a correctional facility until he has served two-thirds of the minimum sentence or, if the person has two or more sentences to be served, two-thirds of the aggregate of the minimum terms of the several sentences.

6. EXPANDED DELIVERY OF SERVICES TO HIGH RISK POPULATIONS, SUCH AS VICTIMS OF SEXUAL ABUSE AND JUVENILE SEX OFFENDERS, SHOULD BE SUPPORTED IN ORDER TO DECREASE THE LIKELIHOOD OF FUTURE OFFENDING.

Though not directly within its mandate, the Panel feels compelled to encourage the provision of services to victims of sexual abuse and to juvenile sex offenders. The vast majority of sex offenders at the Treatment Center and elsewhere have, themselves, been the victims of sexual abuse. The relationship between being a victim of sexual abuse and a perpetrator of sexual violence has been well-documented. Over the past ten years, notice of the increasing numbers and younger ages of perpetrators of sexual violence has led Massachusetts and other states to focus on early intervention.

Last year, the Executive Office of Human Services, the Departments of Mental Health, Mental Retardation, Social Services, and Youth Services, and the Office for Children, in recognition of the need to develop comprehensive services for juvenile sex offenders, entered into an interagency agreement regarding provision of these services. The agencies agreed to provide an array of services including specialized assessment, secure treatment, residential care, outpatient treatment and day treatment services. The Department of Mental Health has begun to develop an expertise in group therapy services for juvenile sex offenders utilizing a "relapse prevention" model. These services allow adolescents who are in community placements and in the custody of the Department of Mental Health, the Department of Youth Services or the Department of Social Services to participate in offender specific therapy when needed.

The Panel commends these efforts and recommends full implementation of the interagency agreement, as well as expanded service delivery to victims of sexual abuse.

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CHAPTER 4

FORENSIC MENTAL HEALTH REPORT

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FORENSIC MENTAL HEALTH REPORT

I. INTRODUCTION

The Governor's Special Advisory Panel was authorized to review "the organization and structure of the commonwealth's forensic mental health system and ... the appropriate evaluation and treatment of mentally ill offenders and mentally ill men and women who are in need of care in a medium or strict secure setting."

The Panel examined the Commonwealth's current forensic mental health system. Forensic mental health services include all mental health evaluation and treatment services to persons in the criminal justice system. The Panel studied the Department of Mental Health's (DMH) court-based forensic service system, its community mental health service system, and current DMH inpatient services for forensic populations and civil patients in need of inpatient psychiatric care in secure settings due to their histories of or potential for violence. The Panel assessed the role and functioning of the Department of Correction's (DOC) Bridgewater State Hospital. In the area of correctional mental health, the Panel reviewed services and plans in county jails and houses of correction, and in the state prison system.

The Panel did not examine the internal administration of Bridgewater State Hospital because a panel of experts, convened as part of a November 1987 settlement agreement in the O'Sullivan v. Dukakis case(1), was asked to examine the operation of Bridgewater State Hospital. In order to avoid a duplication of effort by the O'Sullivan experts and this Panel, it was decided that this Panel would focus on broader systemic issues, while deferring to the experts' recommendations regarding the internal administration of Bridgewater State Hospital. In its deliberations, the Panel reviewed the findings of the O'Sullivan panel and drew on some of its work.

The Panel studied the feasibility of a post-release monitoring system for insanity acquittees, examined several models in use in other states and developed a proposal for a Mental Health Review Board for Massachusetts. In addition, the Panel examined questions concerning mentally retarded persons who become involved with the criminal justice system and set forth proposals for secure habilitation and treatment services for this population.

A. STATEMENT OF THE PROBLEM

Individuals who suffer from mental illness, mental retardation, or substance abuse and come into contact with the criminal justice system have a unique set of problems. Human services systems and the criminal justice system have distinct and, at times, conflicting missions and approaches. The complex social, environmental, physical, legal, mental health, mental retardation, and substance abuse problems experienced by these individuals cannot be appropriately addressed by any single agency or system. The goal of a comprehensive forensic mental health system is to assist the criminal justice system by providing evaluation and treatment services for individuals in need and linking them to other appropriate services.

For a number of reasons, Massachusetts has not yet developed an integrated system to provide comprehensive services to mentally ill persons involved in the criminal justice system. Reasons for the lack of service development include the historical lack of advocacy for forensic patients, and, as a result, a lack of resource allocation. Also, Massachusetts has historically asked its Department of Correction to carry a disproportionate share of responsibility for the care of seriously mentally ill persons who in other states have been cared for by Departments of Mental Health. The DOC's Bridgewater State Hospital, the Commonwealth's only maximum security psychiatric facility, became the major provider of evaluation and treatment services for men in the criminal justice system and those who required secure or long-term hospitalization.

Additionally, in the 1970's, the Department of Mental Health shifted its focus to community-based care and had only minimal capacity to treat patients who presented behavior problems or those who required long-term care. Many of these patients were transferred to Bridgewater State Hospital which was provided limited resources while asked to carry a significant responsibility for the treatment of mentally ill men in the Commonwealth. Consequently, in the 1970's and 1980's, increasing numbers of mentally ill men, many of whom did not require maximum security hospitalization, were nonetheless sent to Bridgewater State Hospital for lack of a viable alternative. At the same time, increasing numbers of men were sent by the courts to county and state correctional facilities, making these systems among the most crowded in the country, resulting in further demands for services from Bridgewater State Hospital.

Historical systemic problems at Bridgewater State Hospital should be seen as symptomatic of these major service delivery gaps in the overall forensic mental health system. Bridgewater has served as the "end of the line" for many other service delivery systems which failed over time to meet the needs of populations they were responsible for serving. Over the years, Bridgewater State Hospital has been over-utilized by the courts, the correctional system, and the mental health system, yet it has virtually no authority to control admissions through its gates. For decades the hospital was woefully underfunded and, in recent years, has been significantly overcrowded.

Recent efforts to improve the provision of services at Bridgewater, as well as a commitment on the part of the Department of Correction and the Executive Office of Human Services to continue improving the quality of patient care at the hospital are evident. In January, 1988, funding for Bridgewater was increased by 70 percent and staffing by 90 percent in response to two emergency requests for funding increases by administration officials. Under the leadership of a new superintendent, major improvements including efforts toward achieving accreditation of the hospital are already underway. The administration and legislature have made plans to transfer civil patients from Bridgewater to the Department of Mental Health by January, 1990. The work of a group of experts reviewing the internal administration of the hospital has been recently completed and implementation of their recommendations will lead to further advancements at Bridgewater.

Other significant events in recent years have already begun to remedy historical deficiencies in forensic mental health service delivery. In 1984, responding to concerns in the judiciary about the need for court-based forensic mental health services, the legislature created the Court Clinic Services Committee. The Committee issued a report in 1985 which called for substantial increases and improvements in court-based mental health services. Recognizing serious problems in the Commonwealth's mental health system, in December, 1985, the Governor called for a five-year plan to reform and upgrade the public mental health system in Massachusetts. The Governor's Special Message (2) was based on the work of a 100-person panel of citizens, professionals, service providers, community leaders, governmental officials, consumers of mental health services, legislators, and parents. The Governor's Special Message called for increasing community mental health services, reinvigorating and rebuilding the state hospital system, increasing the Department of Mental Health's inpatient forensic capacity, and developing substantial numbers of residential housing units for mentally ill persons who are able to reside in the community. The legislature endorsed the Governor's Special Message and funded fully the first three years of increases. In 1987, the legislature passed a capital bill(3) which provided $340 million to rebuild the seven state hospitals, build a new Metro Boston Resource Center, and add several thousand units of community residential housing. In its capital bill, the legislature also mandated that new county correctional facilities being planned and built should have mental health units, with services to be provided by the Division of Forensic Mental Health of the Department of Mental Health.

In 1987, for the first time in fifty years, the legislature rechartered the Department of Mental Health. The new charter of the Department defined a primary mission:

> "The department shall take cognizance of all matters affecting the mental health of the citizens of the commonwealth; provided, that the primary mission of the department shall be to provide for services to citizens with long-term or serious mental illness, early and ongoing treatment for mental illness, and research into the causes of mental illness."(4)

Mentally ill and emotionally disordered persons who come before the courts need a broad range of services. These services should be provided in the community, the courts, in inpatient settings, and in correctional settings. A comprehensive forensic mental health system should provide:

- high quality forensic mental health evaluations;
- consultation regarding diversion of mentally ill persons out of the criminal justice system;
- inpatient treatment of court-involved mentally ill persons;
- community-based mental health services for court-involved mentally ill persons;
- systems of mental health evaluation and treatment services within correctional facilities; and,

- training of professionals who deliver these services.

The Panel is encouraged by improvements in the provision of forensic mental health services in recent years. There is much work that remains to be done however. Despite these recent advances, Massachusetts continues to lag behind many other states in the development of a comprehensive forensic mental health system. The Panel supports continuing efforts for further improvements, and sets forth these recommendations to bolster ongoing progress and to further the goal of establishing a forensic mental health system in the Commonwealth which will serve as a national model.

II. POLICY QUESTIONS

1. Are current evaluation and treatment services for mentally ill persons who become involved with the criminal justice system adequate to address the safety needs of the public, the needs of the courts, and the clinical needs of the individuals?

2. What range of services should be provided in the following settings for mentally ill individuals involved in the criminal justice system:

   a. courts;
   b. the community;
   c. inpatient settings; and,
   d. correctional facilities?

III. GOVERNING PRINCIPLES

1. Services should be available to all mentally ill persons regardless of their legal status or place of detention or confinement.

2. Services should be offered in the least restrictive settings accounting for the person's clinical needs and the protection of the public.

3. All civil patients should be served in Department of Mental Health facilities.

4. The Department of Mental Health should assure that mentally ill persons involved with the criminal justice system are provided the mental health services that they require. To insure that mentally ill persons involved in the criminal justice system are provided the services that meet the same standards of care as those offered other mentally ill persons, the Department of Mental Health may operate services directly, may license inpatient psychiatric facilities administered by other agencies, or may provide training and consultation to other service providers.

5. To provide for public safety, promote effective treatment, and assure cost-effectiveness, mentally ill offenders should receive services within a continuum of care that assures continuity across service settings.

6. Forensic mental health services are best provided in programs that are designed for the specific clinical needs of mentally ill offenders. Such programs should be developed, to the extent possible, on a regional basis, so that these individuals can maintain contact with their families and home communities.

IV. SUMMARY OF RECOMMENDATIONS

A. COURT-BASED SERVICES

1. The Department of Mental Health's Division of Forensic Mental Health should be supported to develop the capacity to provide forensic mental health services at all courts in the Commonwealth.

2. The Division of Forensic Mental Health should develop a state-wide data system, to monitor and improve the efficiency and utilization of these services.

3. The Division of Forensic Mental Health should continue and expand training programs to increase the number of mental health professionals who are trained in forensic issues.

B. INPATIENT SERVICES

4. Bridgewater State Hospital should continue to be operated by the Department of Correction. To insure that patients at Bridgewater State Hospital are provided services that meet the same standards of care as those offered Department of Mental Health patients, DMH should license Bridgewater State Hospital as a psychiatric facility.

5. The census and number of admissions to Bridgewater State Hospital should be reduced. This can be accomplished in the following ways:

   a. The Department of Correction should develop clear admission and discharge criteria and procedures;

   b. Consideration should be given to establishing a maximum census limit for Bridgewater State Hospital;

   c. County correctional facilities should increase and improve the range of mental health services provided to pre-trial detainees and county inmates; and,

   d. The Department of Mental Health should continue to develop specialized units to evaluate and treat forensic patients and others who require hospitalization in secure settings.

6. Bridgewater State Hospital should be provided with sufficient resources to achieve the goal of becoming an accredited secure psychiatric hospital.

7. Bridgewater State Hospital should move from its current location to the building currently occupied by the Treatment Center for Sexually Dangerous Persons.

8. The Department of Mental Health should be supported to continue to develop its inpatient forensic capacity.

9. The Department of Mental Health should further develop the capacity to treat individuals who present behavior problems.

   a. Consistent with the policy of the Secretary of Human Services as ratified by the settlement agreement in O'Sullivan v. Dukakis, and Chapter 1 of the Acts of 1988, the Department of Mental Health should stop the practice of transferring civil patients to Bridgewater State Hospital.

   b. Consistent with the policy of the Secretary of Human Services as ratified by the settlement agreement in O'Sullivan v. Dukakis, and Chapter 1 of the Acts of 1988, the Department of Mental Health should transfer certain civil patients from Bridgewater State Hospital to DMH facilities.

10. The Department of Mental Health should assume increasing responsibility, over time, for mentally ill persons assessed as incompetent to stand trial and for insanity acquittees who need inpatient care.

11. The Departments of Mental Health and Correction should collaborate to develop training and educational programs for judges, sheriffs, correctional administrators, mental health administrators, and attorneys about mental health issues for individuals involved with the criminal justice system.

C. CORRECTIONAL MENTAL HEALTH SERVICES

12. There should be continued development of a state-wide system of county correctional forensic mental health services provided by the Division of Forensic Mental Health. Such services should include:

    - screening, assessment and triage services;
    - crisis intervention;
    - outpatient services;
    - release planning and liaison services;
    - training;
    - research; and,
    - consultation.

13. Consistent with Chapter 167 of the Acts of 1987, the county correctional system should develop "specialized mental health units". These units should provide short-term crisis residence services to inmates requiring acute observation and treatment.

14. The state and county correctional systems and the Division of Forensic Mental Health should develop a computerized database of information concerning mentally ill inmates, which would aid in providing services to inmates during mental health emergencies and would promote

continuity of care for mentally ill inmates as they move from one placement to another.

15. Standards for correctional mental health services should be developed by the Department of Correction, the Sheriffs' Association, and the Division of Forensic Mental Health, and an oversight system should be implemented.

16. Within the Department of Correction, there should be a mental health service delivery system with four progressive levels of care:

    a) Acute psychiatric inpatient care at Bridgewater State Hospital.

    b) At least three comprehensive prison mental health centers, each of which will include:

        - a six to ten bed crisis residence unit;
        - a 45 to 60 bed community residence unit;
        - an outpatient clinic; and,
        - consultation services.

    c) Each medium security prison which does not have a prison mental health center should have an outpatient mental health clinic which would provide psychotherapy, medication, crisis intervention and triage services.

    d) Mental health consultation and liaison services should be available throughout the correctional system.

17. The state and county correctional systems should develop policies which would permit short-term inmate transfers for the purpose of acute mental health treatment and stabilization, without an inmate losing his or her current classification status.

18. The state and county correctional systems and the Division of Forensic Mental Health should develop comprehensive forensic mental health training programs focusing upon clinical, administrative, and legal issues which concern mentally ill offenders. Attention should be given to the development of research programs.

D. COMMUNITY-BASED SERVICES

19. Division of Forensic Mental Health regional management and field staff should be responsible for linking court-involved, mentally ill persons with appropriate case management, housing, rehabilitation, and community treatment services.

20. Special commitment procedures should be developed and implemented for persons found not guilty by reason of mental illness for violent offenses.

21. A Mental Health Review Board should be established with responsibility for monitoring the treatment and management of insanity acquittees who are found to meet special commitment criteria.

E. MENTALLY RETARDED OFFENDERS

22. The Panel recommends that appropriate evaluation and habilitation services for mentally retarded and dually-diagnosed offenders be expanded and developed. Services should include community and case management services to prevent court involvement, programs to provide alternatives to incarceration, on-site correctional services, and secure residential programs. Legal mechanisms should be established which would assure an offender's participation in these programs.

V. THE FORENSIC MENTAL HEALTH SERVICE SYSTEM

A. COURT-BASED SERVICES

1. History

For many years, courts have relied on mental health professionals to evaluate mentally ill individuals before them on criminal and civil matters in order to determine appropriate dispositions and to refer them to needed services. Courts require mental health consultations on a variety of issues including competency to stand trial, criminal responsibility, aid to sentencing, alcohol or drug dependency and commitment, involuntary civil commitment, guardianship proceedings, competency to make treatment decisions, competency to testify and a range of other criminal and civil matters.

Court-based services have been recognized as an essential component of a comprehensive forensic mental health system in virtually every state in the country. In Massachusetts, mental health services have been provided in the courts for over 70 years. Psychiatric services were available to juveniles before the Boston Juvenile Court as early as 1917, and to individuals indicted for capital offenses and repeat offenders since 1921.(5)

In 1949, the first court clinic in the Commonwealth was established in the Dedham District Court with one part-time psychiatrist to serve juveniles who came before the court.(5) Until that time, competency to stand trial and criminal responsibility evaluations were typically conducted in state psychiatric hospitals. In 1950, the Department of Mental Health was asked by the legislature to make recommendations regarding the need for court-based services to the district courts through the use of court clinics.(5) The Department of Mental Health study recommended the establishment of a model court clinic to provide evaluation and treatment services to mentally disordered offenders.(5) Based on these recommendations, the legislature funded a pilot clinic in the Cambridge District Court, which was modeled on the clinic in Dedham.(5) Favorable reports to the legislature and the Governor on the work of the model clinic led to an increased focus on the value of court-based services, and in 1956, the Division of Legal Medicine was created within the Department of Mental Health to oversee court-based and correctional mental health services.(5)

By 1959, nine court clinics had been established throughout the Commonwealth, and by 1967, 16 court clinics were in place.(5) A 1970 survey found that the court clinics were referred twice as many juveniles as adults, that courts referred an average of three and one-half percent of their cases to the clinics, and that these referrals were more likely to be pre-dispositional than post-dispositional.(5) By the mid-1970's, 34 courts had the services of at least a part-time psychiatrist available to them.(5) At that time, the court clinics focused on the provision of services in juvenile and misdemeanor cases where criminal behavior was seen in the context of psychological, economic and familial problems.(5) These services were generally not offered to Superior Courts, where the more serious cases were viewed as outside the mandate of the court clinics, or to any other courts.(5)

By the end of the 1970's, several factors led to a significant decline in the ability of the court clinics to provide services to the courts while, at the same time, courts experienced sharp increases in the need for these services.(5) Decentralization of services offered by the Department of Mental Health resulted in a lack of uniformity in service delivery. Moreover, the national and state policy of deinstitutionalization of the mentally ill led to dramatic increases in the numbers of mentally ill individuals who, once in the community, came to the attention of the courts for lack of appropriate placements or community-based services.(5)

At the same time, a series of class action lawsuits against the Department of Mental Health resulted in a shift in resource allocation to mental retardation services and community-based services and a concomitant decrease in funding for court-based services.(5) Additionally, courts began to require mental health services in increasing numbers due to significant litigation on the areas of competency to make treatment decisions through the Rogers v. Commissioner of Mental Health and related cases, as well as statutory reform in the areas of drug dependency, child protection and juvenile justice. Finally, overcrowding in state and county correctional systems and increased numbers of individuals who came before the courts placed renewed emphasis on the need for diversion of individuals out of the courts and the criminal justice system to appropriate mental health, mental retardation and substance abuse programs. (5)

In 1984, in recognition of the importance of court-based mental health services, the legislature established a Court Clinic Services Committee comprised of the administrative justices of the Trial Court Department and other knowledgeable individuals to make recommendations for improvements in the court clinics system. The Court Clinic Services Committee issued its report in April, 1985 and found that court-based mental health services were of variable quality and were delivered in an unsystematic fashion, generally not related to the actual needs of the courts. Moreover, data about the provision of mental health services to superior, district, and juvenile courts suggested that over 40 percent of courts sampled had no mental health services.(5)

The Court Clinic Services Committee report to the legislature had three major recommendations:

1. Court clinics should be centrally administered within the Department of Mental Health. Included in the centralization should be a clearly defined budgetary account which would be used for no other purpose but the support of the clinics.

2. Within the Department of Mental Health, a Division of Legal Medicine assistant commissioner's position should be created with adequate professional staff appointed to coordinate the court clinics and with whom the courts would have direct lines of communication. The role of the assistant commissioner would be limited principally and primarily to coordination of the court clinics.

3. The Department of Mental Health should commit itself to seeking an expanded level of funding with the ultimate objective of providing court clinic services to each of the 102 trial courts. This would require a substantial increase in the funds for the delivery of mental health services to the courts.(5)

When Edward M. Murphy became Commissioner of Mental Health in August, 1985, he endorsed the views of the Court Clinic Services Committee. With the agreement of the Committee, Commissioner Murphy appointed an assistant commissioner, created the new Division of Forensic Mental Health, consolidated the funds for court clinics in to a single account, and initiated efforts with the legislature to increase the funding for Department of Mental Health court-based mental health services.

The Division of Forensic Mental Health began its efforts by gathering information from court and mental health staff about need for services; developing a mission and functions statement; recruiting well-trained staff who were experienced with courts, the criminal justice system, and the clinical needs of forensic patients; and developing programs for training mental health professionals who might conduct court-ordered evaluations.

Aware of the variability of need for forensic mental health services at different courts and of the importance of utilizing resources economically, the Division of Forensic Mental Health offered to provide a regular presence at courts, evaluations by appointment for those defendants and probationers who were not hospitalized or incarcerated, and emergency coverage. To provide these services, the Division expanded the concept of the "Court Clinic" to include the "Forensic Mental Health Team," a group of mental health professionals who were responsible for serving several courts in a geographic area.

Forensic mental health staff were asked to carry out the following functions:

1. Conduct court-ordered evaluations with persons whom the court considered to have a mental or emotional problem;

2. Refer mentally ill persons to appropriate services;

3. Consult with court, criminal justice, and correctional staff about persons with mental and emotional disorders who come to court attention; and,

4. Advise, supervise, and work with facility-based and community-based mental health staff as they treat and help court-involved persons with mental health problems.

In order to carry out these functions the Division developed a state-wide regional management system. Each of the Department of Mental Health regions has a forensic manager, who is responsible for all court-based and county correctional mental health services in his or her region.

The goals of this service system are both to respond to the needs of the criminal justice system for high quality, forensic evaluations, and to insure that mentally ill persons who become involved in the criminal justice system obtain the services that they need.

2. Current Service System

The Division of Forensic Mental Health currently provides regular on-site and emergency services at 62 of the 69 district courts, at the Boston Municipal Court, and at Juvenile Court Department sittings in Suffolk, Hampden, and Bristol counties and in district court juvenile sessions. The Division of Forensic Mental Health also conducts evaluations at 13 superior courts. Approximately 130 staff state-wide are involved in providing court-based forensic mental health services.

Services offered include: Chapter 123 evaluations under sections 12e, 15a, 15e, 16a, 18, 19; consultation to judges, probation staff, and court officers; and referrals to mental health facilities and service providers for persons before the courts who appear to be mentally ill or in need of mental health services. Increasingly, forensic mental health professionals perform "outpatient" competency to stand trial or criminal responsibility evaluations. These assessments are requested for defendants who present questions of competency or responsibility because of mental health problems, but who do not appear to require inpatient hospitalization. The evaluations take place either at the court or in the local jail. Such "outpatient" forensic evaluations are extremely cost-efficient in that they reduce the need for expensive inpatient services.

A range of forensic evaluation services are also provided for children and adolescents who come before juvenile courts and district courts sitting in juvenile session. These evaluations include competency to stand trial evaluations, evaluations of children in need of services (CHINS), pre-sentence delinquency evaluations, clinical evaluations of youths being considered for transfer to adult courts, and occasionally, care and protection cases.

a. Services in Western Massachusetts

Community and court-based forensic mental health services are well-developed in western Massachusetts. This area of the Commonwealth developed a comprehensive and well-funded community mental health system

following the 1978 Brewster v. Dukakis consent decree. (6) Working in conjunction with the community mental health system, the Division of Forensic Mental Health has built a system of forensic mental health services in western Massachusetts. The forensic mental health services in Western Massachusetts were noted as innovative and exemplary in a recent national assessment of mental health services.(7) The Panel has found that court and community-based forensic mental health services in western Massachusetts should serve as a model for the rest of the Commonwealth.

In its 1985 report (5), the Court Clinic Services Committee noted that one service model employed in a number of locations in the Commonwealth had particular promise for the future expansion of court clinic services in the state. In this model, the Department of Mental Health contracts for court clinic services with community mental health centers. The contract-services model is currently used in a number of locations across the state. It has enabled a rapid expansion of court clinic services and flexible adaptation to the needs of individual courts, and provides additional benefits by locating court clinic teams within the same agencies that serve the community mental health and inpatient hospital systems.

Service delivery may differ from location to location, depending on local need. In some cases, designated staff are assigned to work at individual courts and may appear to be part of the courts' own operations. In other cases, staff may be assigned to more than one court, or may be located at an administrative base and be on-call for one or more courts. The contracting process allows a flexible deployment of personnel according to the level of activity at various courts, and permits the concentration of staff where an unusual level of activity demands.

The contract-service model is used extensively within the four western Massachusetts counties. During the last three years, its use has facilitated extension of court clinic services to each of the 18 courts which operate in the region. The sections which follow provide a brief overview of the model in operation.

i. Overview of the Region

The westernmost part of Massachusetts is comprised of four counties--Berkshire, Franklin, Hampden and Hampshire, constituting a single DMH administrative region. The region includes thirteen district courts, four superior courts, and one full-time juvenile court.

The following Table provides an overview of the various courts in western Massachusetts, their level of activity in terms of annual numbers of new criminal cases and active probation caseloads, and the type of coverage provided by the court clinic team serving each court.

TABLE 1
REGION I COURT ACTIVITY, PROBATION CASELOADS, AND COURT CLINIC COVERAGE

Court	*Annual # of New Criminal Cases*	*Probation Caseload*	*Court Clinic Schedule**
Berkshire County			
Berkshire Superior Court	122	133	5 days, on-site
Berkshire Juvenile District	645	136	5 days, at main site
Pittsfield District Court	2,962	567	5 days, on-site
Lee District Court	699	76	5 days, on-call
Gt. Barrington District Court	1,087	139	5 days, on-call
Adams District Court	624	120	5 days, on-call
North Adams District Court	1,170	277	5 days, on-call
Franklin County			
Franklin Superior Court	52	110	5 days, on-site
Greenfield District Court	2,436	531	5 days, on-site
Orange District Court	1,193	136	5 days, on-call
Hampshire County			
Hampshire Superior Court	77	122	5 days, on-site
Northampton District Court	4,769	1,048	5 days, on-site
Ware District Court	1,031	137	5 days, on-call
Hampden County			
Hampden Superior Court	887	783	5 days, on-site
Springfield District Court	13,759	1,964	5 days, on-site
Springfield Juvenile Court	---	225	3 days on-site, 2 on-call
Palmer District Court	2,509	503	5 days, on-call
Chicopee District Court	2,543	449	5 days, on-call
Holyoke District Court	3,385	297	5 days, on-call
Westfield District Court	2,493	448	4 days on site, 1 on-call
	42,443	8,201	*Days per week

ii. Court Clinic Teams

Five court clinic teams serve the courts in the region. The team operated by the Berkshire Mental Health Center serves the Berkshire Superior Court, the District Courts in Lee and Great Barrington, and supervises court clinic activity in the rest of the Berkshire County Courts. The Northern Berkshire Counseling Center has primary responsibility for the Adams and North Adams Courts, under the temporary supervision of the Berkshire Mental Health Center team. The Mount Tom Institute for Human Services serves the District Courts in Holyoke, Chicopee, Palmer and Ware. The Center for Mental Health Resources in Springfield, the largest of the court clinic teams, serves the Franklin, Hampden and Hampshire Superior Courts, and the District Courts

in Springfield, Westfield, Northampton, Greenfield and Orange. The Child Guidance Clinic of Springfield serves the Springfield Juvenile Court.

iii. Daily Clinic Activity

The operation of a court clinic team under the contract-service model is identical in many respects to the operation of court clinics administered directly through the Division of Forensic Mental Health. A typical day's activities for clinicians at the Center for Mental Health Resources court clinic at the Springfield District Court includes the following:

- Daily report-in with the Clerk of Courts regarding an upcoming day's court activity. The morning session includes a review of new cases and police reports since the previous court session, the identification of cases which may require court clinic involvement, an examination of applications for warrants of apprehension under Section 12e, a review of petitions for commitment for alcohol or drug treatment under Section 35, and review of the court docket to determine if anyone is scheduled to return to the court that day from a mental health evaluation or treatment setting.

- Meetings with petitioners, police and court personnel.

- Discussions with defense attorneys concerning details of any evaluation before the court that day which involve their clients.

- Conducting of mental health evaluations as required by the court.

- Follow-up to evaluations with interviews of family members, mental health professionals, police, attorneys, probation officers, witnesses, medical personnel, etc., as needed to complete each evaluation.

- For returnees from psychiatric hospitals, review of relevant reports with representatives of the District Attorney's office, defense attorney and probation officers to review alternatives available in each case. Contact family members or potential resource agencies as needed.

- Consultation and review of evaluative reports with judges and court personnel as requested.

- Consultation with probation officers concerning persons requiring treatment, treatment alternatives available, and potential conditions of probation.

- Conferences with case managers concerning clients being referred by the courts for treatment.

- Conferences with crisis team members concerning clients who are coming before the court and who may exhibit signs of mental illness, suicidality, assaultiveness, and who may need medication reviews.

- Drug and alcohol evaluations as requested by the court.
- Determination of the need for drug or alcohol detoxification and the availability of appropriate resources.
- Investigation of details related to petitions for warrants of apprehension and interviews of the subjects of such petitions.
- Contact staff at the Hampden County Jail and House of Correction, or other correctional facility, to alert them to potential problem cases, medication needs, medical complications, etc. for cases which they will be receiving later in the day.
- Conduct same functions for the Superior Court of Hampden County, located in the same court complex.

The types of activity undertaken by the Center for Mental Health Resource's court clinic team at the Springfield District Court serve the Court's need for a specifically-trained, professional forensic mental health service and provide an effective interface with the community mental health and hospital inpatient systems. The coverage at the Court provides a mechanism for early identification of persons who require inpatient hospital treatment, and helps insure that they do not spend unnecessary time in jail awaiting hospitalization. In addition, the court clinic presence helps provide for timely warrants of apprehension and quicker hospitalization of those who require it, thereby preventing delays which might lead to further, more serious, involvements with the law.

Staff who work on forensic mental health teams or in court clinics have noted decreases in the number of defendants sent to inpatient facilities in order for the court to get an evaluation of their mental status or capacity to participate in court proceedings. Judges and other court staff report improvements in judicial decision-making concerning mentally ill and emotionally disordered defendants because competent forensic mental health staff are available to conduct evaluations and to consult with the court on options for the defendant.

Forensic mental health staff who are based in district courts carry out a wide range of tasks. In some courts, forensic mental health clinicians meet with court officers and prosecutors to review which recently arrested defendants might need mental health evaluations, including those mentally ill persons arrested on minor charges who might appropriately be diverted from the criminal justice system.

Forensic mental health staff meet with inpatient and community mental health staff to formulate a treatment plan for a mentally ill person sent to an inpatient facility for a pre-trial forensic evaluation. After a plan is developed, the forensic mental health staff will present the plan to the court and then work with court, probation, and mental health staff to implement the plan. Such a system provides continuity of patient care and avoids duplication of effort and miscommunication between criminal justice and mental health systems.

The Panel commends the work of the court clinics, particularly those in western Massachusetts, and recommends the development of similar services to every court in the Commonwealth.

3. Assuring Quality of Court Evaluations

The Division of Forensic Mental Health is responsible for the designation of specially trained psychologists and psychiatrists, who are authorized to conduct court-ordered evaluations and for quality assurance of all forensic evaluations conducted with Department of Mental Health funds. To fulfill these responsibilities, the Division has developed a training and consultation relationship with the Law and Psychiatry Program of the University of Massachusetts Medical Center. Together with the Law and Psychiatry Program, the Division of Forensic Mental Health administers the Qualified Forensic Professional Program. This program implements regulations developed for certifying specially trained psychologists as "Qualified Forensic Psychologists." Parallel regulations for "Qualified Forensic Psychiatrists" are currently being developed.

4. Utilization of the Service System

The Division of Forensic Mental Health reported that utilization of forensic mental health teams and court clinics varies, depending on the busyness of the court, the patterns by which the court operates, the availability of forensic mental health staff, and the relationship between the forensic mental health team or court clinic and the court.

The Division of Forensic Mental Health is building a state-wide information system which will permit recording and compilation of data concerning the utilization of forensic mental services. A data system will permit evaluation of the need for future services, aid managers to assign forensic personnel where they are needed, and support the ongoing evaluation of the effectiveness and efficiency of current services. Over the past two years, the Division has introduced microcomputers into a number of court clinic and forensic mental health team settings. Currently, state-wide utilization can not yet be accurately gauged. However, information is available from a number of sites where forensic mental health services are provided. Regional forensic managers report that demand for forensic mental health services has grown as the quality of services has improved, and as court systems struggle with increasing numbers of persons who appear to have mental health and emotional problems.

5. Gaps in the System

The gaps in the court-based forensic mental health system are caused by a lack of resources and a shortage of skilled mental health professionals who are familiar both with the needs of seriously mentally ill persons and of the criminal justice system. The value of outpatient forensic evaluations as a cost-effective and clinically appropriate method of providing information to the courts while reducing admissions to state inpatient facilities is first being recognized. In certain areas of the state (such as northeastern Massachusetts and parts of Worcester County), the demand for forensic mental health services exceeds the supply of trained staff and the resources available to hire

more forensic mental health staff. Urban areas with busy district courts report increasing need for forensic mental health services.

The state-wide, court-based forensic mental health service system in the Commonwealth is young. Only in the last three years have forensic mental health staff had an explicit mission and function. Many staff have joined the Division of Forensic Mental Health within the last two years and are learning about local courts and probation systems. Regional forensic managers have only been hired within the last year and are developing the relationships with DMH area, regional, and inpatient staff that are needed to guarantee that court-involved mentally ill persons will be offered the range of mental health services that they may need.

Gaps in the system are further created by certain statutory provisions in Chapter 123 regarding competency to stand trial, criminal responsibility and aid in sentencing which warrant careful review. The District Court Committee on Mental Health and Mental Retardation is currently conducting a comprehensive analysis of the statutory scheme which governs the disposition of mentally ill and mentally retarded offenders, and will be making recommendations for reform. Many individuals involved with the Panel's work are also involved with the District Court Committee, particularly Judge Maurice H. Richardson, who serves as both Vice Chairman of the Panel and Chairman of the District Court Committee. In order to avoid duplication of work, the Panel has chosen to defer to the work of the District Court Committee regarding recommendations for statutory reform of Chapter 123.

The specific areas of concern include the following:

1. whether the questions of competency to stand trial and criminal responsibility should be further separated in the statute for purposes of evaluation and disposition;

2. whether outpatient forensic evaluations should be further encouraged through statutory reform;

3. whether statutory reform is needed to assure that information bearing on a defendant's guilt or innocence, or information otherwise inadmissible at trial should be deleted from certain reports;

4. whether criminal responsibility evaluations should be ordered only after the issue has been raised by a defendant as an affirmative defense;

5. whether sentencing a person found guilty of a crime should be a prerequisite to committing the person following an aid in sentencing evaluation; and,

6. whether there should be a statutory mechanism to convert an evaluation of a pre-trial detainee for purposes of determining his or her need for hospitalization to a competency evaluation, when appropriate.

6. Recommendations

1. The Division of Forensic Mental Health should be supported to develop the capacity to provide forensic mental health services at all courts of the Commonwealth. These services include the following functions:

   a. Conduct court-ordered evaluations of persons whom the court considers to have a mental or emotional problem;

   b. Refer mentally ill persons to the mental health services that they need;

   c. Consult with court, criminal justice, and correctional staff about persons with mental and emotional disorders who come to court attention; and,

   d. Consult with facility and community mental health staff as they treat and help court-involved persons with mental health problems.

2. The Division of Forensic Mental Health should develop a state-wide data system to monitor and improve the efficiency and utilization of these services.

3. The Division of Forensic Mental Health should continue and expand training programs to increase the number of mental health professionals who are trained in forensic issues.

B. INPATIENT SERVICES

In Massachusetts, individuals involved in the criminal justice system and in need of inpatient psychiatric care may be hospitalized at Bridgewater State Hospital which is administered by the Department of Correction or any of the mental health facilities administered by the Department of Mental Health. The factors in determining a person's placement include the need for treatment in a secure setting, geographic area, current charge and the person's psychiatric or criminal history.

The Panel reviewed the inpatient services currently available in the Commonwealth for forensic patients and made numerous recommendations for change. Given the Panel's mandate to focus on the Bridgewater complex, Bridgewater State Hospital received careful scrutiny.

1. Bridgewater State Hospital

a. Introduction

Bridgewater State Hospital is the Commonwealth's only maximum security psychiatric facility. In this capacity, Bridgewater is charged with the evaluation, treatment and custody of men who are seen as mentally ill, and who by reason of their histories of or potential for violent behavior, require hospitalization in conditions of maximum or "strict" security.

Until recently, Bridgewater State Hospital has served as the provider of virtually all of the Commonwealth's forensic mental health services. In the late 1970's, the Department of Mental Health shifted its focus from inpatient care to community services and became increasingly reluctant and ill-equipped to manage and treat individuals who required secure or long-term care. Thus, as the state's only psychiatric facility which has had the capacity and willingness to provide these services, Bridgewater has been further required to treat men who are not subjects of the criminal justice system. Often, men who have not required the level of security offered at Bridgewater, have been nonetheless hospitalized there for a lack of viable dispositional alternatives. For judges and mental health professionals responsible for deciding between alternative placements of mentally ill men who require hospitalization, the choice became one of Bridgewater or the community.

Massachusetts, through its overuse of Bridgewater State Hospital, has more patients hospitalized in conditions of maximum security than states of comparable size. Recent problems at Bridgewater have to be seen in the context of this overutilization of the hospital coupled with its history of scarce resources and lack of control over the quantity and quality of its admissions. Moreover, inappropriate utilization of the highest level of secure mental health beds is costly and ill-suited to meet the treatment needs of patients and the safety needs of the community.

Current conditions and recent problems at Bridgewater State Hospital have to be seen in historical context to be understood properly.

b. History

From its beginnings as an Almshouse for Paupers (1854-1886), through the years as the State Farm (1886-1955), and its establishment as a State Hospital (1955-present), Bridgewater State Hospital has always housed those who were excluded from mainstream society.

The Bridgewater State Almshouse began operations during May, 1854, and admitted 860 women, men, and children of all ages that year.(8) It served as the regional facility for the counties of Norfolk, Bristol, Plymouth, Barnstable, Nantucket, and Dukes. Two sister Almshouses were opened at Monson and Tewksbury concurrently. The three were established to relieve crowded local poor houses and to permit consolidation of services.(9) The Almshouse had 503 paupers remaining at the end of its first year of operation.

Community leaders argued that it was the state's responsibility to provide shelter and rehabilitation for the wayward poor.(10) Many poor immigrant families had the Almshouse as their first place of settlement. There they could recuperate from the illnesses developed during long journeys and plan for permanent settlement elsewhere.

Upon entering the almshouse, new admissions were classified as sick, drunk, insane, healthy, "bad," "P-T" (pregnant), lame, feeble, consumptive, syphilitic, with "sore eyes," blind, aged, or paralyzed. Entire families, unwed mothers, and single males often resided together. The old and feeble were sometimes housed with more violent residents because space was limited. More than a fifth of those paupers sent to the Almshouse died during their first year or residency.(10)

In 1880, then Almshouse superintendent, Captain Nahum Leonard described some of the difficulties he encounted as superintendent:

> "In the course of time, it was found that many were receiving aid who were not entitled to it. Vagrancy had become systematized. Farming was then the chief employment of the institution."
>
> "On the approach of winter, when farming operations were suspended, there was usually a large influx of able-bodied vagrants, who seemingly came to make a holiday of winter. When spring came and they were invited to the fields, they usually demanded and received their discharge, there being no legal power to detain them."
>
> "There was another class of paupers who, by their own folly, crime and self-abuse, had become dependent. These were continually seeking admission to the Almshouse, and, immediately upon their return to health, would claim their discharge. In a few months they would return again with the loathsome diseases of which they had once been cured, and in due time would again demand and receive their discharge, to pursue the same evil practices as before."(11)

In 1866, the Legislature established a "State Workhouse" for "vicious paupers" at the "State Pauper Establishment at Bridgewater."(12) The revised law permitted sentencing for tramps, chronic drunkards, and panhandlers from three months to three years. Criminalization of these behaviors permitted greater control over the same population. It was argued that detainment for a certain length of time would require inmates to "contribute something towards defraying the expenses incurred for their benefit; believing, also, that a longer restraint would tend to wean them from their vices, and induce them to lead a better life."(11)

In May, 1872, the Almshouse, by Act of the Legislature, was abolished, "since which time the institution has been essentially a penal institution, bearing the name of State Workhouse."(13) Bridgewater historian Ellis described the State Workhouse's inspectors and trustees: "Their labors have been to make the institution an influence for the improvement of our unfortunate and defective fellow-men and an agent for the protection of society."(14) Chapter 219 of the Acts and Resolves of 1886, entitled "An Act to provide a building for the Chronic Insane at the State Workhouse at Bridgewater" appropriated $50,000 for that purpose. The new building was designed to accommodate 140 patients, 15 more than was called for in the Act.(15) As Charles Gaughan, Superintendent from 1959-1985, later described, "Its purpose was to take over the more agitated and dangerous of those in civil hospitals but who had become mentally ill."(16,19)

The years between 1895 and 1910 were a period of growth and expansion at the State Farm. The name was changed from the Massachusetts Workhouse

to the Massachusetts State Farm following construction of the new building for the chronically mentally ill. It was believed that this would remove the penal stigma from those who were mentally ill and not criminals.(17) The new wards filled quickly as other "lunacy asylums" sought transfer of their chronic mentally ill patients.(17)

One year after opening, Chapter 89 of the Acts and Resolves of 1888, provided funds for the construction of "strong buildings" to house additional "insane male criminals" and permit expansion of the existing hospital. This construction was necessary because increased admissions and transfers from other state hospitals and prisons led to overcrowding. Also reflected in this growth was the increasing diversification of the types of people admitted to the Bridgewater Hospital, including: indigenous and immigrant paupers of all ages and both sexes, alcoholics and drug addicts, panhandlers, homeless people, insanity acquittees, defective delinquents, female offenders (1909-1930), sex offenders, criminal defendants who were not competent to stand trial, and mentally ill prisoners.

By 1895, the violent "criminally insane" had become too burdensome for the State Lunatic Hospitals and the State Farm at Bridgewater became a depository for them.(18) The Massachusetts legislature formalized the transfer process in 1895 by statutorily mandating that "all male prisoners who are announced insane after an examination are removed, if the Governor decides, to the State Asylum for Insane Criminals which is a State Farm at Bridgewater." Until the end of the century, an average of 85 prisoners were transferred to the Asylum yearly.

In the late nineteenth century, it was generally believed that improved mental health would result from involvement with labor or crafts.(18) Then Superintendent Hollis Blackstone, however, discovered that the patients were "more anxious to exhibit their skills as fence jumpers and lock pickers than as agriculturalists."(18) He requested that the "strong buildings" for the mentally ill male criminals be separated and managed independently from the rest of the State Farm.(18) The legislature refused, citing economic and administrative reasons, but authorized the appointment of a medical director "to care for and have custody of the inmates of the Asylum."(19)

Alternative treatment modalities to work were limited. Personnel were selected arbitrarily and the prime requisite for employment as an attendant was "physical prowess in the handling of patients."(19) Methods included the use of alcohol as a tranquilizer, wet sheets, calming baths and restraint equipment including shackles and cages.(19) The primary concern of those treating the dangerous mentally ill was combating assaultive behaviors.(20)

The number of criminals and violent mentally ill at the State Farm continued to increase. Supervision of the Bridgewater State Farm was transferred from the Board of Charity to the Massachusetts Bureau of Prisons, several years prior to Superintendent Blackstone's retirement in 1922 after 39 years of service.(17) Although few administrative changes occurred, the placement of Bridgewater State Hospital under the authority of the Massachusetts Bureau of Prisons demonstrated the Commonwealth's commitment to house its most dangerous mentally ill at Bridgewater (21), as well as the belief that penal supervision was most appropriate for this population.

Henry J. Strann was appointed superintendent in 1922. During the first year of his appointment, a Drug Addiction Unit and the Department of Defective Delinquents (DD) opened under the Prison Bureau's supervision.(19) The Department opened with only about thirty-three boys, but had between five and six-hundred in the 1940's.(10) Young mentally retarded males with behavior problems from Waltham and Wrentham State Schools were the first members of the new Defective Delinquent Department. Described by the color of their uniforms, the Defective Delinquents were known as "Blue Boys".(19) Later during the 1960's, there were between 100 and 200 "defective delinquents." The average age of the now adult men was 43.(19) Mental processes were described as at the primary school level, and Superintendent Gaughan wrote in the 1960's that their "criminal background stems primarily from their low intelligence and lack of inhibitions."(10)

Chapter 770 of the Acts and Resolves of 1955 changed the name of the State Farm to the Massachusetts Correctional Institution at Bridgewater (MCI-Bridgewater). Establishment of a Treatment Center for Sexually Dangerous Persons was also authorized at that time. Charles W. Gaughan, Harvard University educated in social work, became superintendent on February 1, 1959, and remained until 1985. Upon his arrival, he found approximately 2,000 inmates and patients, and approximately 400 employees, 250 of whom were correction officers.(22) Superintendent Gaughan sought improvements at the State Hospital, Treatment Center, and Addiction Center. Upgrading the electrical system, use of pastel paints, better meals, and average lock-ups of nine hours or less were some of his reported accomplishments.(22) During the mid-1970's, with a population of approximately 1000 inmates and patients, the number of correction officers had increased to 450 out of a total of 700 employees.(19) Gaughan established 75 programs through the institution and noted that most developed due to the ability and motivation of certain correction officers and volunteers from the community who supervised the programs. Some of these new programs included Alcoholics Anonymous, Schizophrenics Anonymous and art, sculpture, and pottery classes.(19)

Despite these accomplishments, multiple problems persisted at MCI-Bridgewater. Numerous lawsuits, as well as renewed interest and reforms in mental health treatment, characterized the next years as MCI-Bridgewater was drawn into the public spotlight for the first time in several decades.

In 1965, Frederick Wiseman had requested permission from Superintendent Gaughan and from the Commissioner of Correction to make an educational documentary film concerning Bridgewater. His 1967 film, "Titicut Follies," led to legal challenges aimed at banning the showing of the film as the Commonwealth claimed its release violated the privacy rights of Bridgewater patients. "Titicut Follies" was later described by Superior Court Judge Henry Kalus as "a nightmare of ghoulish obscenities"(23) and became the only film in United States history to be banned for reasons other than national security or pornography. To this day, restrictions on the showing of "Titicut Follies" continue to be in place though a request to lift the restrictions which is supported by administration officials and the Attorney General's Office, is currently pending before the court.(24)

At the same time "Titicut Follies" brought attention to Bridgewater, changes in mental health law were occurring throughout the country. In

1966, the U.S. Supreme Court ruled in a landmark decision, Baxstrom v. Herold, that mentally ill persons convicted of a crime could not be held in a psychiatric hospital longer than they could be held for a criminal sentence without a hearing on the substantive issues of that commitment.(25) Between June and October of 1968, the cases of 267 Bridgewater men were reviewed. Twenty-two were evaluated as dangerous, and only nine were recommitted.(26)

Between 1960 and 1970, the Bridgewater State Hospital population decreased from 741 to 245 patients.(26) The census, however, declined less than did those of other state hospitals; the open hospitals run by the Department of Mental Health preferred to transfer their violent patients to Bridgewater.(26) Judges favored sending any security risks to Bridgewater as many believed that the Department of Mental Health made few attempts to enforce security.(26) Courts were also referring greater numbers of men to Bridgewater for pre-trial observation. Between 1957 and 1968 the number of men sent to Bridgewater for pre-trial observation increased from 137 per year to 395, an almost 200 percent increase.(26)

In 1968, the case of Nason v. the Superintendent of Bridgewater State Hospital, (27) alleged that understaffing and lack of treatment programs at the facility limited the opportunities to recover from mental illness. The Massachusetts Supreme Judicial Court ruled that cases like Nason's presented serious constitutional, legislative, and budgetary problems for the Commonwealth.(27) Because Nason was not convicted of any criminal offense, his commitment for mental illness could not be justified as a penalty for a crime, but only as non-penal confinement for his treatment and protection of the public.(27) The court found that if such treatment were not available on a reasonable, non-discriminatory basis, there was "substantial risk that constitutional requirements of equal protection of these laws would not be satisfied."(27)

The Mental Health Reform Act of 1970 was the Commonwealth's response to the Baxstrom and Nason decisions. Formalization of deinstitutionalization policies and improved recognition of the rights of the mentally ill followed. Processes for civil commitments and criminal referrals were created and special standards for commitment to Bridgewater were established. A committed person had to be mentally ill, not a proper subject for a mental health facility and in need of "strict security."(28) The Mental Health Act of 1970 also abolished the Defective Delinquent Department, required a hearing before each patient's recommitment, and established mandatory periodic reviews for each patient.(28)

A new Bridgewater State Hospital facility opened in December, 1974. The reformed mental health laws, Chapter 123, established new criteria for admissions and commitments, and the campus-like buildings, surrounded by see-through fencing, marked the shift to a modern facility. A recognition of the lack of treatment resources at Bridgewater led to an expansion of mental health services, which the Department of Correction decided to provide through a contract with McLean Hospital, a private, psychiatric facility, affiliated with the Massachusetts General Hospital and the Harvard Medical School. The resulting influx of staff, largely unfamiliar with correctional attitudes and traditions, who espoused progressive mental health ideology caused some friction. However, learning occurred between clinicians and

correctional staff, and a unique clinical and forensic program emerged. Through the McLean affiliation, training programs in forensic psychiatry and psychology were established, and well-known clinicians were brought in as consultants. Bridgewater State Hospital slowly entered the mainstream of mental health care.

Yet despite these encouraging developments and an increasingly competent correctional and mental health staff, the facility had difficulties in providing the evaluation and treatment services required by increasing number of patients sent to Bridgewater by the courts, the correctional system and the mental health system. The lack of space for treatment, lack of a clearly defined clinical environment and control structure, too few correction officers to provide security for treatment activities, lack of control over admissions, and increasing demand for pre-trial forensic evaluations created recurrent crises.

These same problems were inherited by the vendor who followed McLean Hospital in 1986 as the provider of clinical services, Goldberg Medical Associates. The transition to a new vendor, the 1985 retirement of Superintendent Charles Gaughan who had served at Bridgewater since 1957, and subsequent changes in correctional and medical leadership contributed to a destabilization of the organizational fabric of Bridgewater State Hospital, which compounded the problems of overcrowding and lack of resources.

Until recently, Bridgewater's lack of resources and its location created a sense of isolation for staff and patients. Even for part of its recent history, Bridgewater has been a "forgotten" place, which survived without public scrutiny until a major crisis would bring it into the limelight of public attention. Twenty-two years ago, the release of "Titicut Follies" brought Bridgewater into the public eye; most recently the deaths of five patients in 1986 and 1987 brought renewed focus on the hospital. Although these tragedies once again placed Bridgewater State Hospital at the center of controversy, since 1987 considerable progress has been made. There appears to be a strong interest and commitment to reform and improve conditions at Bridgewater State Hospital, as well as a recognition that this cannot be achieved without a major reorganization of the mental health service system for forensic and other seriously disturbed patients.

An interim settlement agreement in O'Sullivan, et al. v. Dukakis, et al. (1987) (1) provided for "expert consultants to make recommendations regarding the treatment and security needs of Bridgewater State Hospital patients." This Panel was asked to make recommendations regarding Bridgewater's role in the overall forensic mental health system.

A consultant from the Joint Commission on Accrediation of Health Care Organizations (JCAHO) has been working with Bridgewater staff with the goal of achieving hospital accreditation. The administration's and legislature's commitment to improvement has been demonstrated by an allocation of substantial funds and other resources to Bridgewater. The appropriations signed into law by Governor Dukakis in January 1988 increased funding for Bridgewater State Hospital by 70 percent and staffing by 90 percent. As a result of these initiatives, and due to the leadership of the new Bridgewater State Hospital superintendent and the dedication of his staff, the facility is

currently in a state of transition. The movement is in a positive direction and significant progress is being made.

c. Current Service System

Bridgewater State Hospital continues to serve multiple roles for various agencies in the Commonwealth. It serves as the maximum security backup for the Department of Mental Health, as psychiatric hospital for the jails, houses of correction, and prisons, and as an evaluation center for the criminal courts of the Commonwealth. In addition, men seen as incompetent to stand trial and men found not guilty by reason of insanity are committed to Bridgewater State Hospital.

From a clinical perspective, Bridgewater State Hospital's function is to stabilize, evaluate and treat male patients in a secure setting. However, some features set Bridgewater State Hospital apart from comparable facilities in other states. First, there are an unusually broad set of legal circumstances that can lead to an admission to Bridgewater. Second, the hospital is administered by the Department of Correction and is solely responsible to care for all patients needing hospitalization in secure conditions, including, for now, many who are not involved with the criminal justice system. There are states in which small numbers of patients with no legal charges are housed in the same mental health facility with forensic patients; and, there are a few states in which prisoners with psychiatric disorders are housed together with forensic patients. But only Massachusetts has housed substantial numbers of civil patients in a maximum security program with forensic patients and prisoners. Finally, Bridgewater State Hospital is distinguishable from secure hospitals around the country in that it has virtually no control over its own admissions. The hospital is thus left to care for individuals sent by other agencies and systems and is unable to control overcrowding.

d. Utilization of the Service System

Bridgewater State Hospital receives patients from three major sources, the courts, state and county correctional facilities and the mental health system. Specifically, individuals are transferred through the following routes:

1. Court evaluations: A district or superior court may send an individual directly to Bridgewater State Hospital for any of the following evaluations, for up to 20 to 40 days, depending on the type of evaluation:

   - pre-trial evaluation for competency to stand trial;
   - pre-trial evaluation concerning criminal responsibility;
   - post-conviction aid to sentencing evaluation;
   - evaluation after finding of incompetency to stand trial; and
   - post-trial evaluation following an insanity acquittal.

   The determination of need for an evaluation is made by a judge, generally after a court-based evaluation conducted by a Department of

Mental Health clinician. In addition to ordering the evaluation, the judge also decides where the evaluation should be conducted; that is, at a Department of Mental Health facility or at Bridgewater State Hospital. Typically individuals charged with violent felonies are committed to Bridgewater State Hospital. The Medical Director of the hospital may petition for the commitment of an individual for up to six months based on the results of the evaluation.

2. Correctional transfers: Men awaiting trial or sentenced to a county jail, county house of correction or state prison, may be transferred to Bridgewater State Hospital for a 30-day evaluation, stabilization and treatment. If they are determined to be in need of longer-term treatment, the Medical Director of Bridgewater State Hospital may petition for their commitment under General Laws Chapter 123, section 18(a). Admissions under Section 18(a) are initiated by a petition of a superintendent or master of the correctional facility where the detainee or inmate was housed, after a clinical evaluation at that facility.

3. Department of Mental Health transfers: Patients from Department of Mental Health facilities (community mental health centers or state hospitals) may be transferred to Bridgewater State Hospital under General Laws Chapter 123, section 13 on an emergency basis if they are found to present a likelihood of serious harm by reason of mental illness if not held in "strict security," and the patient's behavior constitutes an emergency.

The determination of whether a transfer is warranted is made by clinicians designated by the Commissioner of Mental Health, usually after consultation with Bridgewater State Hospital staff. Chapter 123 provides that within five days the Medical Director of Bridgewater State Hospital must make a determination of whether failure to keep the patient under conditions of "strict security" would create a likelihood of serious harm. If the evaluation affirms the need for strict security, the Medical Director may file a petition for commitment to Bridgewater State Hospital for up to six moths. If the evaluation suggests that the "strict security" of Bridgewater State Hospital is not warranted, the Medical Director of Bridgewater State Hospital requests that the Commissioner of Mental Health transfer the patient back to a Department of Mental Health facility under General Laws Chapter 123, section 14. Recently, the Secretary of Human Services has placed restrictions on the transfer of civil patients from DMH hospitals to Bridgewater by requiring approval of such transfers by him and the Commissioner of Mental Health.

Attempts to institute an admissions policy have been made difficult by referring courts, correctional facilities and mental health facilities which rely on an open admissions policy at Bridgewater. Approximately 45 percent of Bridgewater's admissions come from the courts for pre-trial and post-trial evaluations, approximately 45 percent from the correctional system, and approximately 5 percent from the Department of Mental Health. At any one time, approximately two-thirds of the patients at Bridgewater are committed and one-third are there for evaluation.

In the late 1970's, the Administrative Executive Board, precursor of the current Governing Body of Bridgewater State Hospital, determined the "safe management level" census of the hospital to be 311. Since January, 1979, the census has continually been well above that level. In April of 1985, the census was over 500, but dropped to 420 by November, 1986. During 1987 and much of 1988, the census averaged 430. In August and September 1988, the census dropped significantly, going below 390, its lowest point in more than seven years. The current census hovers between 380 and 400, approximately 80 above the designated safe management level.

The proportions of admissions by legal section to Bridgewater State Hospital have varied over the years. The major increases in the late 1970's came from court-ordered pre-trial evaluations for competency and criminal responsibility which rose to a high of 544 in 1978, and then slowly declined to 375 in 1988.

Admissions from Department of Mental Health facilities remained relatively constant between 1975 and 1985, averaging about 80 per year. These transfers increased substantially in 1986, but declined in the following years to an average of 58 admissions per year.

Admissions from county jails and houses of correction have kept the total admissions on an upward climb since 1976. While state prison admissions remained relatively constant for the years 1976 to 1982, admissions from the jails and houses of correction more than doubled during that time (from 163 to 335). The ratio of admissions from the county houses of correction relative to admissions from state prisons has changed from 2:1 to 3:1. Analysis of admissions clearly indicates that the county houses of correction, with no or very limited mental health services, rank highest in referring patients to Bridgewater State Hospital.

e. Gaps in the System

Bridgewater State Hospital has experienced major problems in the areas of physical plant, budget, staffing, and internal organization. Though the current physical facility is only 15 years old, it has, for some time, proven to be severely inadequate to meet the needs of the patients and staff at the hospital. First opened in 1974, the new hospital was hailed as a substantial improvement over the old facility where most of the buildings had been constructed in the latter part of the nineteenth century. However, it very quickly became evident that the new facility was obsolete for its purpose as a hospital. Moreover, over the last few years in the course of operating the hospital, its physical limitations have become not only more evident but, with time, have became increasingly problematic. Severely limited office space for clinical staff, a configuration of rooms that compromise security, and inadequate heating and electrical systems are just some of the problems which impede the effective administration of the hospital.

The 134 years of Bridgewater's history show a pattern of many years of too few resources to care for too many patients. Most recently, in 1987, a series of five deaths at Bridgewater State Hospital led to renewed public attention on the hospital. Since 1987, substantial long-awaited and greatly needed improvements have been initiated by the administration and the legislature.

In January, 1988, Governor Dukakis signed a $2.3 million (or $5 million on an annual basis) appropriation for Bridgewater State Hospital. This major infusion of resources produced a 90 percent increase in staff for the hospital and a nearly 70 percent increase in the hospital's annual funding. A new management team has utilized these resources to implement a wide range of improvements in treatment services, rehabilitative and recreational programs and living conditions, and strides are being made in the hospital's goal of accreditation by the Joint Commission of the Accreditation of Health Care Organizations (JCAHO).

Bridgewater State Hospital has a complicated organizational structure. As a Department of Correction facility, it is managed by a superintendent, whose position was created in 1987. Formerly, the hospital shared its superintendent with the Addiction Center and the Treatment Center. A Medical Director, appointed by the Commissioner of Correction with the approval of the Commissioner of Mental Health, works for the contract vendor. Clinical services are provided by both DOC and contract employees. Correction officers and mental health workers, each with their separate reporting structure, work on the patient units. The clinical unit director, who is an employee of the clinical vendor, does not have line authority over all the staff that comprise the treatment team on the unit. This can lead to schisms that negatively affect patient care and that make clinical management cumbersome. There are many dedicated, experienced and skillful clinicians at Bridgewater State Hospital in the current clinical program, and there are also many other line staff with extraordinary experience and wisdom in the management of difficult and assaultive patients. But there is not yet a coordinated treatment program at Bridgewater. Much of this problem stems from the historical understaffing and overcrowding at the hospital. However, the lack of integration of the correctional and treatment components contribute to the problem.

Bridgewater State Hospital is the "end of the line" in the mental health and criminal justice systems in Massachusetts. For many Bridgewater patients who have proved refractory to treatment in the past, continuity of care is the only hope that the course of their illnesses could be changed. Therefore, the reorganization and restructuring process that has already begun under the hospital's new leadership and added resources, is of paramount importance. Most of Bridgewater's problems cannot be resolved internally by the Bridgewater State Hospital administration. They require the allocation of resources and the redefining and restructuring of Bridgewater State Hospital's role in relation to the courts, correctional facilities, and the Department of Mental Health.

f. Agency Responsibility for Bridgewater State Hospital

The Panel addressed the question of whether Bridgewater State Hospital should continue to exist in its current form. There is certainly a need in Massachusetts for the capacity to house and treat mentally ill men and women in secure settings. The number of appropriate admissions to Bridgewater justifies its existence in this regard. There are two related questions:

1. Should Bridgewater continue to serve the same mix of civil, forensic and correctional patients?

2. Which agency should operate the facility?

The Commonwealth has already decided that the Department of Mental Health should develop the capacity to care for most mentally ill persons not involved with the criminal justice system. A settlement agreement in the O'Sullivan case and Chapter 1 of the Acts of 1988 ratified the administration's policy to stop the placement of civil patients at Bridgewater. The Department of Mental Health has slowly begun to develop the capacity to provide secure services. It is anticipated that a new unit for 50 civil patients currently at Bridgewater will open in January, 1990 at Medfield State Hospital. However, in the Panel's view, Bridgewater State Hospital should continue to serve forensic patients and detainees and inmates of correctional facilities who require inpatient psychiatric care under conditions of maximum security.

The Department of Correction has operated the facility for numerous years under adverse conditions. DOC has demonstrated its willingness and ability to improve patient care at Bridgewater State Hospital and to undertake major changes to foster a therapeutic environment. Despite the many difficulties at Bridgewater State Hospital over the years, a core of highly experienced, qualified and dedicated staff members among the correctional and clinical staff has developed. The aggregate knowledge and experience of these people cannot easily be matched or recreated. Furthermore, recent improvements at Bridgewater State Hospital under new leadership underscore the conclusion that, with proper resources and support, the Department of Correction has the will and the capacity to build Bridgewater into an accreditable psychiatric hospital.

From the perspective of patient care, the ultimate test of a psychiatric facility is not who administers the facility, but whether the facility provides high quality care. Since staff, experience, and dedication needed to care for substantial numbers of forensic and correctional patients are located in the Department of Correction, it seems advisable at this time to leave the operating responsibility for Bridgewater State Hospital with the Department of Correction. To insure however, that the same standards of care that apply to civil patients will also be assured to forensic patients and prisoners, the Panel recommends that the Department of Mental Health should have a licensing role in relation to Bridgewater State Hospital.

g. The Physical Facility

Despite many recent improvements in patient living conditions at Bridgewater, the Panel views the physical facility at Bridgewater State Hospital as a major hindrance in the hospital's efforts to provide quality evaluation and treatment services in a safe and secure environment. The Panel therefore recommends the transfer of Bridgewater State Hospital patients to the building which currently houses the Treatment Center for Sexually Dangerous Persons.

Though a substantial infusion of resources could remedy some of the hospital's structural defects and complete basic repair work, the facility's design will never be properly suited to serve as a hospital. As discussed previously, the Panel recommends that the sex offender commitment statute, General Laws Chapter 123A, be significantly reformed. The recommended reforms would transfer many of the sex offenders who are concurrently

serving criminal sentences to correctional facilities to continue to serve their sentences, and offer, to those interested in receiving treatment, the opportunity to do so in a new Department of Correction voluntary treatment program. A further recommendation that the patients who are committed to the Treatment Center remain there, requires that a new program be developed to effect the transition of that population from the Treatment Center over the next several years. The census at the Treatment Center is currently 274. The facility can comfortably accommodate 225 patients.

With current plans to transfer 50 civil patients from Bridgewater State Hospital to the Department of Mental Health and planned expansion of forensic mental health services in the courts and county houses of correction, it is anticipated that admissions to Bridgewater and the hospital's average daily census, currently at 380, will continue to decline. Since states with populations comparable to the Commonwealth's (e.g., Virginia and Maryland) have approximately 200-250 maximum security beds, the Treatment Center facility would be well-suited in size to serve this population. Furthermore, the Treatment Center facility has ample program and treatment space to provide high quality evaluation and treatment services to the Bridgewater State Hospital population. The Panel recommends that the planning process begin immediately to achieve the goal of re-siting Bridgewater State Hospital.

h. Recommendations

The O'Sullivan experts have made recommendations specifically geared toward improving internal problems at Bridgewater State Hospital. The Panel generally endorses these recommendations which pertain to the integration of correctional and clinical staff, the development of a comprehensive treatment program, the use of restraint and seclusion, changes in unit management, continuity of care, quality assurance and staff training and retention.

Additionally, the Panel makes the following recommendations:

1. Bridgewater State Hospital should continue to be operated by the Department of Correction. To insure that patients at Bridgewater State Hospital are provided services that meet the same standards of care as those offered Department of Mental Health patients, DMH should license Bridgewater State Hospital as a psychiatric facility.

2. The census and number of admissions to the Bridgewater State Hospital should be reduced. This can be accomplished in the following ways:

    a. The Department of Correction should develop clear admission and discharge criteria and procedures.

    b. Consideration should be given to establish a maximum census limit for Bridgewater State Hospital.

    c. County correctional facilities should increase and improve the range of mental health services provided to pre-trial detainees and county inmates. The legislative directive in Chapter 167 of the Acts of 1987, mandating that new county correctional

facilities be built with specialized mental health units, with services to be provided by the Division of Forensic Mental Health, should be implemented.

d. The Department of Mental Health should continue to develop small, specialized units to evaluate and treat forensic patients. The courts should refer only defendants to Bridgewater State Hospital whose pre-trial evaluations need be conducted in an inpatient setting and whose charges are of such a nature that maximum security is required (e.g. felony charges involving violence).

3. Bridgewater State Hospital should be provided with sufficient resources to achieve the goal of becoming an accredited secure psychiatric hospital.

a. The budget and staffing of Bridgewater State Hospital need to reflect the hospital's mission. Allocations for Bridgewater State Hospital need to be equivalent to other state psychiatric hospitals, so that Bridgewater State Hospital can meet licensing requirements developed by the Department of Mental Health.

4. Bridgewater State Hospital should move from its current location to the building currently occupied by the Treatment Center for Sexually Dangerous Persons.

2. Department of Mental Health Inpatient Services

a. History

Public mental hospitals were developed in Massachusetts in the mid-nineteenth century. The first hospitals were designed to be small, pastoral environments where mentally ill persons could be cared for apart from the stress and strain of growing city environments. As waves of immigrants came to the Commonwealth in the late 19th century, the number and size of mental hospitals grew. By 1900, state mental hospitals had become large custodial institutions, each with thousands of patients. These facilities remained large and understaffed through the first half of this century. Psychiatric, ideological, and economic changes in the 1950's and 1960's resulted in policies that led to the closing of thousands of inpatient beds and to the discharge of thousands of patients from DMH state hospitals. For example, in 1955, there were about 22,000 inpatients in DMH facilities. By 1981, the number had dropped to about 2,200. Currently, the number of inpatients is approximately 2,400.

In the 1970's, policies of deinstitutionalization that attempted to link the community with the hospital resulted in substantial de-emphasis of inpatient hospital care. Staff left, patient care buildings were closed, preventive maintenance budgets were slashed, and in many facilities, the quality of inpatient care declined. Each inpatient unit, whether part of a state hospital or part of a community mental health center, was assigned to provide the range of care needed by all mentally ill persons in a Department of Mental Health catchment area. State hospitals were broken up into area-run units, not

conceptualized or managed as coherent organizations designed to provide a range of care to mentally ill persons with differing histories and clinical needs. Each DMH unit became a "generic" unit, expected to provide acute and long-term care, as well as the range of specialized services that patients with particular problems needed. Transfers between units became bureaucratically complex, leading to situations where, for example, it was easier for an administrator to transfer a difficult male patient to the Bridgewater State Hospital than to another treatment unit within the same facility.

One of the side effects of deinstitutionalization was an increase in the number of seriously mentally ill persons who came to the attention of the criminal justice system. Increasingly, district court judges, faced with mentally ill persons charged with minor offenses, became gatekeepers for stressed, inpatient systems that faced growing pressures to move patients rapidly through the inpatient services and out to the community. Inpatient units that, in past years, had provided both substantial safety for patients who were at risk of acting violently, and security to a public concerned about the escape of involuntarily committed mentally ill persons, lost much capacity to provide either internal safety or external security.

The changes in the public mental health system of the 1970's and early 1980's were chronicled in the admissions to the Department of Correction's Bridgewater State Hospital. Admissions to Bridgewater State Hospital from the courts and Department of Mental Health facilities rose rapidly. For many long-term mentally ill men, Bridgewater State Hospital became an overutilized placement in the midst of chaotic, underfunded and dilapidated Department of Mental Health inpatient hospitals. DMH staff, however well-meaning, were generally frightened of and unprepared to treat mentally ill, violent patients. Yet still Bridgewater State Hospital was staffed at a much lower rate than DMH facilities. The ability to transfer difficult patients to Bridgewater further reinforced DMH's lack of attention to developing the resources necessary to provide for these patients.

In 1984, Secretary of Human Services Philip W. Johnston convened the Mental Health Action Project, a group of 100 officials, service providers, legislators, community leaders, consumers, and parents. The Mental Health Action Project developed a blueprint for changes in the DMH service system. Following the Project's recommendations, in December, 1985, the Governor issued a Special Message for Mental Health(2), which outlined a comprehensive program to improve the public mental health system. Central to the Special Message was the commitment to rebuild and reinvigorate the state hospital system.

The Governor's Special Message for Mental Health included a five year plan to reorganize the state hospitals, increase the number of clinical and management staff in each hospital, and use capital funds to rebuild the state hospitals, with the goal of achieving HCFA certification and JCAHCO (Joint Commission on the Accreditation of Health Care Organizations) accreditation. The Legislature endorsed the Special Message and provided funds for the needed increases in staffing and for reconstruction of the seven state hospitals (Northampton, Worcester, Westborough, Danvers, Medfield, Metropolitan, and Taunton) and for a new Metro Boston Resource center.(3)

In 1987, as part of the capital appropriation bill, the legislature required the Executive Office of Human Services and the Department of Mental Health to submit a plan for the renovation, construction, and operation of the mental health system. The capital plan, Quality Treatment on a Human Scale, was submitted in September, 1987(29). The plan included the principle that hospital campuses would have acute, specialized, and extended care inpatient units. The plan included several provisions for inpatient services for court-involved mentally ill patients:

- three forensic evaluations units for women and men who appear to be mentally ill, are court-involved, and need short-term evaluation and treatment. Units were planned for Taunton State Hospital, Worcester State Hospital, and Metropolitan State Hospital.

- two "extended care intensive" units for long-term mentally ill men and women who have been adjudicated as incompetent to stand trial or not guilty by reason of mental illness and are seen to need long-term care in a secure setting. One such unit is planned for Worcester State Hospital, the other for the Metro Boston Resource Center.

- seven "extended care intensive" units for mentally ill men and women who are seen as at special risk of acting violently in an inpatient setting.

Over the last two years, Executive Office of Human Services and Department of Mental Health staff, together with the Division of Capital Planning and Operations (DCPO) have worked with hospital staff, citizens, members of the Alliance for the Mentally Ill, and others to develop master plans for each of the seven state hospital campuses and for the Metropolitan Boston Resource Center. Following acceptance of the Master Plans, design work and construction will begin.

b. Current Service System

The current Department of Mental Health inpatient forensic service system is evolving and developing toward the system described above. Over the last four years, each of the seven hospitals has been organized into a coherent, centrally managed psychiatric hospital, with functional units providing short-term, longer term, and specialized care. Each admission unit receives court-ordered patients for evaluation. Each hospital admits and treats patients who have been adjudicated incompetent to stand trial or not guilty by reason of mental illness (NGI), though the generic inpatient units have not developed special expertise with these patients.

Two forensic evaluation units for mentally ill, court-involved women and men were opened in 1988 in buildings at Taunton State Hospital and Metropolitan State Hospital that were renovated for relatively short-term use. At Worcester State Hospital, specialized forensic staff have been hired to develop a hospital-wide enhanced forensic service capability. Because of fiscal constraints brought about by the current budgetary climate and by program start-up difficulties, services for men and women have been consolidated at the Taunton Secure Care Unit. As a result of the development of female

forensic beds, specialized services for women with a wide range of criminal charges, including women awaiting trial or serving county or state sentences at MCI-Framingham, who are mentally ill and in need of psychiatric hospitalization, are now available in the DMH system.

c. Utilization of the Service System

Current data suggest that there are about 50 admissions per month to DMH facilities for evaluations of competency to stand trial, criminal responsibility, or as an aid in sentencing. Current practices call for men charged with serious offenses (such as murder, rape, arson) who need pre-trial inpatient forensic mental health evaluations to be sent to Bridgewater State Hospital and men charged with less serious offenses to DMH facilities. Since there is no equivalent facility to Bridgewater State Hospital for women, court-involved women who appear to be mentally ill are sent to DMH facilities for pre-trial forensic evaluations.

Currently, there are about 52 men in DMH inpatient facilities who have been adjudicated as incompetent to stand trial or not guilty by reason of mental illness (NGI) for serious offenses, and about 20 women in these categories. These numbers do not include another 20 to 30 men and another 10 women who are in DMH facilities after having been found incompetent to stand trial or NGI on minor charges (trespassing or disturbing the peace), or persons found NGI of serious crimes a number of years ago who have been seen as not committable but who still need inpatient care and consent to it on a conditional voluntary basis.

In Fall 1987, because of concern about the practice of transferring civil patients who acted violently in inpatient settings to Bridgewater State Hospital, the administration and legislature decided that the Department of Mental Health should develop the capacity to care for all civil patients within DMH facilities. In December, 1987, an interim settlement agreement formalized this policy in the O'Sullivan v. Dukakis(1) case, in which the administration pledged to move ahead to develop DMH inpatient programs which would enable DMH to cease transfer of patients to Bridgewater State Hospital under Section 13 of Chapter 123 and to transfer about 60 civil patients to DMH inpatient settings. In the Spring of 1988, a plan was submitted to the Legislature by which the Department of Mental Health could assume these responsibilities.

Working together with the Executive Office of Human Services and the Division of Capital Planning and Operations, the Department of Mental Health decided that the most rapid and clinically sound way to accomplish these goals was to:

1. enhance the capacity of state hospital inpatient units to prevent and manage instances of inpatient violence, and

2. renovate the "R" building at Medfield State Hospital and develop a new program of specialty secure care services to respond to the needs of patients with histories of serious inpatient assaultive behavior.

Several mental health professionals have been hired to plan and develop these services and are working on-site at Bridgewater State Hospital with Bridgewater staff and the civil patients. Renovations have begun on the "R" building, with plans to have the building ready for patient occupancy in January, 1990.

d. Gaps in the System

The Department of Mental Health does not currently have any programs or facilities that might be considered "maximum security." While efforts have been made to improve services for patients at risk of acting violently on an inpatient basis, DMH does not yet have specialized assessment or treatment units for mentally ill civil patients who have histories of major inpatient violence. These concerns are especially acute in Boston, where there are four community mental health centers and no state hospital facilities.

e. Plans for Expansion

The inpatient DMH service system that is currently being planned and developed will have several levels of services available to court-involved mentally ill adults. At each state hospital and community mental health center, admissions units and services will be available for court-ordered patients who have been charged with minor crimes. Generally, these patients will be persons with long-term mental illnesses known to local service systems, who have become acutely ill, and have come to court attention.

At a second level are the forensic evaluation units. These units are designed for persons who appear to be mentally ill, who are charged with crimes, who appear to need a level of security greater than that provided on an admissions unit, and who need a comprehensive forensic evaluation.

A third level of care will be provided by the extended care intensive units for long-term mentally ill persons who have been court-involved and are seen to need care for an extended period of time in settings that provide special security. Patients who are at risk of serious inpatient violence or have histories of such violence may also be treated on these units. None of these planned units will have the level of security currently provided by Bridgewater State Hospital.

Persons with long-term mental illnesses who have been court-involved and are seen to need long-term care, but do not need environments with special security, may be cared for on extended care units.

TABLE 3
CAPITAL PLANS FOR DMH INPATIENT CAPACITY UNITS THAT WILL SERVE FORENSIC PATIENTS

Hospital	*Admissions*	*Forensic Evaluation*	*Extended Care*	*Extended Care Intensive*	*Specialty Secure Care*
Northampton	yes	no	yes	no	no
Worcester	yes	yes	yes	yes	no
Danvers	yes	no	yes	yes	no
Medfield	yes	no	yes	yes	yes
Westborough	yes	no	yes	yes	no
Metropolitan	yes	yes	yes	yes	no
Taunton	yes	yes	yes	yes	no
Metro Boston	yes	no	yes	yes	no

f. Recommendations

1. The Department of Mental Health should be supported to continue to develop its inpatient forensic capacity.

2. The Department of Mental Health should further develop the capacity to treat individuals who present behavior problems.

   a. Consistent with the policy of the Secretary of Human Services as ratified by the settlement agreement in O'Sullivan v. Dukakis(1) and Chapter 1 of the Acts of 1988, the Department of Mental Health should stop the practice of transferring civil patients to Bridgewater State Hospital.

   b. Consistent with the policy of the Secretary of Human Services as ratified by the settlement agreement in O'Sullivan v. Dukakis,(1) and Chapter 1 of the Acts of 1988, certain civil patients should be transferred from Bridgewater State Hospital to Department of Mental Health facilities.

3. The Department of Mental Health should assume increasing responsibility, over time, for mentally ill persons assessed as incompetent to stand trial and for insanity acquittees who need inpatient care.

4. The Departments of Mental Health and Correction should collaborate to develop training and educational programs for judges, sheriffs, correctional administrators, mental health administrators, and

attorneys about mental health issues for individuals involved with the criminal justice system.

C. CORRECTIONAL MENTAL HEALTH SERVICES

1. Introduction

During the past decade, significant attention has focused upon the needs of mentally ill individuals in correctional settings. This interest has been generated by both humanitarian concerns and concerns about liability stemming from increased litigation in this area.

There has been wide variation in reports of the incidence of mental illness in correctional settings. A lack of clarity regarding identification and diagnosis of mental illness is understandable given that correctional officials have tended to define mental illness with regard to behavioral rather than clinical considerations. Thus, the quietly psychotic inmate has often gone unnoticed, while the inmate who is suicidal is considered mentally ill, when his behavior may in fact be predicated upon environmental or other considerations. Recent data indicate that the prevalence of incarcerated mentally ill individuals is increasing, that the nature of that population is changing and that the greatest numbers of mentally ill individuals are housed in short-term custodial settings

Increasingly, correctional mental health practitioners have recognized that the clinical needs of incarcerated mentally ill individuals can most efficiently and effectively be served through a system of services. It is generally believed that 7 percent of an incarcerated population may be mentally ill.(31) However, this statistic does not indicate that all mentally ill inmates require inpatient hospitalization. In fact, the majority might be best served through crisis intervention services or outpatient support in general population. The nature of the custodial setting, (eg. police lock-up, jail, house of correction or prison), the make-up of its population, and the length of time served by inmates may determine the priority of required services. In any case, a system of services should include access to screening, crisis intervention, outpatient, inpatient, and post-release planning programs.

a. Description of the Massachusetts Correctional System

The Massachusetts correctional system is tripartite, consisting of police lockups, jails and houses of correction, and state correctional facilities.

i. Police Lock-ups

In cities which have a population greater than 5,000, police lock-ups house pre-trial detainees awaiting arraignment. Police lock-ups are operated by city, town and state police departments. A 1984 legislative report indicated that there were 257 lock-ups maintained across the state which together have more than 1300 beds.

ii. County Jails and Houses of Correction

Pre-trial detainees who have been arraigned (as well as detainees who have not been arraigned but were arrested in towns with a population of less than 5,000) are held in county jails. Inmates sentenced to two and one half years or less are held in houses of correction. The Massachusetts system is somewhat unique in terms of the length of stay of sentenced county offenders. In most states, jails and houses of correction hold inmates for very short periods of time, usually less than 60 days and seldom exceeding one year. Although jails and houses of correction are defined by the legal status of the persons they hold, they may in fact be the same building or housing unit. Approximately 5,700 sentenced and pre-trial inmates are housed currently in the county system. County houses of correction and jails are operated under the authority of the county sheriffs.

iii. State Correctional System

Inmates sentenced to longer than two and one half years are housed in the state correctional system. Approximately 7300 sentenced inmates are currently housed in the state prison system. The state correctional system is operated under the authority of the Commissioner of Correction.

The Massachusetts correctional system is antiquated and seriously overcrowded. The Bureau of Justice Statistics has indicated in recent years that Massachusetts has the first or second most overpopulated correctional system in the country. Since 1985, the Massachusetts Senate Committee on Ways and Means has published a series of reports ("Crisis in Corrections") documenting crowding, judicial intervention and problems in siting and constructing correctional facilities.

2. County Correctional Facilities

a. History

In 1655, the General Court of the Bay Colony ordered that "there shall be a house of correction provided in each county at the counties' charge". The colonial legislature ordered the county sheriff to be responsible for the "custody, rule, keeping and charge of every of the king's common goals, prisons and prisoners". Today, fourteen sheriffs and the Penal Commissioner of Boston preside over the county correctional system in the Commonwealth.

The authority of the sheriffs and the Penal Commissioner is derived largely from Chapter 127 of the Massachusetts General Laws. Although the sheriffs have independent authority, they have a regulatory relationship with the Commissioner of Correction who sets minimum standards for the operation of all correctional facilities in the Commonwealth. Historically, funding for county corrections was the responsibility of the counties. Thus, the budget process was directed to the County Commission. In 1979 the voters passed Proposition 2 1/2 which capped the property tax, resulting in the availability of less local funding. As a result, the sheriffs have increasingly sought state financial assistance. With increased state aid, there is a blurring of authority. Over the years, there has been debate in the legislature and administration as to whether the state should assume all of the costs of the county correctional

system or whether that system should be subsumed within the state correctional system.

Until recently, there were few regulatory or statutory requirements for program services in county correctional facilities. Consequently, development of programs was largely effected by the initiative of individual sheriffs. Work release was introduced in 1965 in Barnstable, Norfolk and Plymouth counties, and two years later was extended through legislation to all counties. Availability of federal funding in the 1970's inspired pre-release and education release programs in some counties. In 1978, the Commissioner of Correction promulgated Minimum Standards for County Correctional Facilities, including provisions relating to counseling, education, furloughs, and medical services. In the late 1970's, increased litigation focused sheriffs' attention on medical and education services. By 1980, a number of the counties had achieved American Medical Association accreditation. Further, the County Correctional Human Service Directors Association had successfully negotiated with the Department of Education for special education and adult education services.

With respect to mental health services, despite a decade of protests from the sheriffs, it was not until 1987, that the Department of Mental Health began to develop a county correctional service system. In addition, some counties have received funding from the Department of Public Health for substance abuse services; others have gotten grants from the Executive Office of Human Services for the development of alternatives to incarceration programs. Despite the limited assistance from state agencies, with the exception of medical services, many county correctional facilities have not developed an infra-structure to coordinate service provision. Over half of the facilities have limited or no case management services. Although the sheriffs have an increased awareness of the need for program services, their limited resources have precluded, in many cases, systematic program development for mentally ill inmates.

In recent years, Massachusetts has had the most overcrowded correctional system in the country. As of April 14, 1989 there were 5720 county inmates (4225 sentenced and 1475 pre-trial) housed in a system with a bed capacity of approximately 3500 (163 percent of capacity). Since January, 1985, the county population has increased by more than 70 percent from 3350 inmates. In addition to being the most crowded, the county correctional facilities are among the oldest in the country. With the exception of the Worcester and Hampshire Houses of Correction, the average age of the institutions is in excess of 100 years.

An additional complicating factor is that the county facilities are housing different populations than they were a decade or more ago. Changes in alcohol-related offenses have resulted in a significant increase in Driving Under the Influence (DUI) offenders. Facilities report a significant increase in the percentage of offenders with substance abuse problems, gleaned from both criminal record and self-report. Also, the incidence and risk of AIDS is now being recognized and is posing serious management and medical problems.

b. Current Service System

In 1984, the Crime and Justice Foundation, in conjunction with the Massachusetts Sheriffs' Association and the Executive Office of Human Services, sought assistance from the National Institute of Corrections to assess mental health services and needs in county correctional facilities. The result was a survey conducted by the Foundation and reported through the National Institute of Corrections.(30)

The Crime and Justice Foundation reviewed each county correctional facility regarding mental health services including pre-admission screening, institutional screening, clinical and casework services, treatment responses to discreet populations, use of volunteers, housing and transfer provisions, use of antipsychotic medications, and assistance at release. Additionally, the Foundation interviewed correctional and human services personnel to determine how those practitioners perceived mental health problems in their facilities.

The Foundation found that the county facilities utilized a wide range of responses to mental health problems. It recommended that clinical resources be directed at screening for mental illness; such resources would "allow for a pro-active treatment plan prior to the occurrence or reoccurrence of a debilitating episode". Further, the Foundation found that facility staffs' perception of the incidence of mental illness was largely dependent upon behavioral considerations, particularly, behavior that was deemed to be disruptive or self-injurious. Thus, a decision to initiate a transfer to Bridgewater State Hospital was predicated largely upon inmate management considerations. Finally, the Foundation commented upon the utilization of state mental health resources:

> "In a continuum from community to prison, the offender in the local jail is the closest in time and proximity to the community in which he resides. The county jail offender is optimally located to access community mental health and court clinic services...Likewise, the offender is residing within the jurisdiction of judicial, probation and parole authorities to which he is likely to be a client...If the Department of Mental Health is to continue providing services to the incarcerated population, the provision of services to county jail inmates would be most consistent with a philosophy of community service provision."(30)

In 1987, the Division of Forensic Mental Health placed a high priority on the provision of consultation and services to the county correctional system. A community mental health model of service delivery was planned, which would draw largely from court clinic and community resources to retain or reintegrate the mentally ill offender into the community.

The framework for county correctional mental health includes the development of the following services:

1. screening, assessment, triage;
2. crisis intervention;
3. crisis residence;
4. outpatient;
5. inpatient referral;
6. community planning and liaison;
7. training (i.e. identifying symptoms of mental illness and managing violent and suicidal persons); and,
8. research.

Screening, crisis and outpatient services: The initial focus of service development has been upon screening, triage, crisis and outpatient services, as well as upon community planning and referral. There have been two reasons for this. First, the short term nature of the county correctional setting calls for acute and reintegrative services. Second, where there have been inadequate screening and crisis intervention services in the past, there has been an over-reliance upon inpatient hospitalization.

Crisis residence - specialized mental health units: A significant impediment to providing mental health services in county facilities is the physical settings themselves. There has been little structural flexibility to separate distinct classifications of offenders. This is of particular concern regarding inmates in emotional crisis. Even where a crisis intervention service is available, when the facility is unable to physically separate the offender in crisis from general population, often times the only available option is to transfer the inmate to an inpatient setting. Recognizing these concerns, the legislature amended Chapter 167 of the Acts of 1987, providing for construction of county correctional facilities in Bristol, Essex, Hampden, Suffolk and Norfolk Counties and inserted language requiring "specialized mental health units" in each of those settings.

Chapter 167 of the Acts of 1987 mandates that new county correctional facilities should be built with mental health units in them. Since the bill's enactment, the Division of Forensic Mental Health has worked with the Division of Capital Planning and Operations, the Department of Correction, and county correctional facilities to plan the development of county correctional mental health units in new county correctional facilities. The general plan for these units is for 12-16 beds for each new facility, with services available for acute services for inmates experiencing mental health crises.

Inpatient services: In planning the new county correctional mental health units, it was anticipated that Bridgewater State Hospital would continue to serve as an inpatient facility for county inmates who could not be stabilized or managed in an acute setting or on outpatient status. Furthermore, an expansion of DMH's capacity to manage and treat county correctional inmates on an inpatient basis is anticipated.

Training and Research: The Division of Forensic Mental Health and the Sheriffs' Association have collaborated to develop a series of

correctional mental health training efforts. In May, 1989, a two-day correctional mental health law seminar was provided for administrative, clinical, and security staff of all county facilities in the state. In Fall, 1989, two-day screening and prevention seminars will be provided in three regions of the state. Additionally, joint research concerning suicidality and incidence of mental illness is underway.

County correctional forensic mental health services are most advanced in central and western Massachusetts. In those settings there is a history of community mental health support for the forensic population, backed by both mental health resources and program service resources at the facilities. Further the sheriffs have actively sought the support of the Department of Mental Health for over a decade. In other settings, like those in parts of southeastern Massachusetts, although the county correctional facilities have sought mental health assistance, less correctional or mental health support services are in place; therefore, development will occur at a slower pace.

c. Utilization of the Service System

Table 3 summarizes levels of services that were provided by the Division of Forensic Mental Health to the county corrections system on December 31, 1988. The "Populations" column, notes each county facility correctional population on October 14, 1988; in the "§18(a)'s" column are the number of each county's inpatient transfers to Bridgewater State Hospital(under Chapter 123, section 18(a)) from July 1, 1987, through March 31, 1988.

TABLE 3
FORENSIC MENTAL HEALTH SERVICES IN COUNTY CORRECTIONAL FACILITIES

Facility	*Screening/ Triage*	*Crisis*	*Outpatient*	*Inpatient Referral*	*Community Liaison*	*§18a's*	*Population*
Berkshire	x	x	x	x	x	4(1%)	108(2%)
Hampshire	x	x	x	x	x	3(1%)	243(4%)
Hampden	x	x	x	x	x	12(4%)	843(15%)
Franklin	x	x	x	x	x	7(2%)	62(1%)
Worcester	x	x	x	x	x	11(4%)	715(13%)
Essex						49(16%)	586(10%)
Salem	---	x	---	x	---	---	---
Lawrence	x	x	x	x	---	---	---
Suffolk						24(8%)	861(5%)
Jail	x	x	x	?	x	---	---
House	x	---	---	---	x	---	---
Norfolk	x	x	x	---	x	12(4%)	243(4%)
Plymouth	x	x	x	x?	x	57(18%)	412(7%)
Middlesex						79(25%)	998(18%)
Jail	---	x	---	---	---	---	---
House	---	---	---	---	---	---	---
Bristol	---	---	---	---	---	33(11%)	328(6%)
Barnstable	---	x	---	---	---	22(7%)	147(3%)
Dukes	---	---	---	---	---	0	16(.3%)

In addition to summarizing services, the table highlights the relationship between levels of services at a given site and that site's reliance upon Section 18 to initiate inpatient transfers to Bridgewater State Hospital.

Berkshire, Hampshire, Hampden, Franklin, and Worcester County correctional facilities, which have the most comprehensive mental health services, represent approximately 35 percent of the total county population, yet account for only 12 percent of Section 18 transfers.

Systems with few Division of Forensic Mental Health or other mental health resources depend heavily on transfers to inpatient settings. For instance, Barnstable, Plymouth and Bristol Counties housed only 16 percent of the state's county inmates, yet were responsible for 36 percent of Section 18 transfers.

Two other points should be made. The table does not identify mental health resources which a few counties have developed through their own funding. For example, Charles Street Jail and Deer Island House of Correction have developed medical and mental health services. Although those facilities house 15 percent of the state-wide county population, they account for only 8 percent of Section 18 transfers.

The presence of mental health staff may have less of an impact upon stabilizing an individual in crisis, to the extent that the correctional facility is experiencing other problems. Thus, where a facility is severely overcrowded

or understaffed, its reliance upon transfers to other systems is likely to be great. This overrelience on Bridgewater State Hospital has been seen in the transfer rates of the Essex County facilities.

d. Gaps in the System

Gaps in services can be attributed to lack of resources, inadequate system coordination, limited standards and oversight. There are currently no standards for county correctional mental health services, and little attention is paid to the minimum standards set for county mental health services by the Commissioner of Correction in his role as standard setter for the county correctional system.

County correctional mental health services have been historically unfunded, or seriously underfunded. The legislature's requirement for "specialized mental health units" under Chapter 167 of the Acts of 1987 has resulted in significant planning among state and county correctional agencies. When the new county correctional facilities are constructed, operational funding will be required to provide services in the new mental health units.

Regarding systems coordination, greater attention needs to be given to cross-agency training, development of a database, and research. For example, the manner in which the community mental health crisis team, the police lock-up, or the house of correction responds to a court-involved person they perceived to be "suicidal" is likely to have administrative implications for other systems. Training and the development of interagency policy agreements could benefit all involved. Even where mental health or correctional systems maintain adequate data concerning their clients, such data is often not communicated to receiving systems. There needs to be improvement in the flow of relevant data between court clinics, lock-ups, county correctional settings, prisons, correctional facilities, inpatient units, and community programs.

Finally, the Massachusetts system suffers, along with most other states, from a lack of empirical data concerning the incidence and type of mental illness prevalent among correctional settings. Further planning, and resource allocation requires greater attention be placed upon research to study and monitor this population.

e. Plans for Improvement

The Panel takes cognizance of the age of Massachusetts custodial settings, overcrowded conditions, increasing litigation, and resource limitations. These concerns highlight the importance of developing a system of services for mentally ill offenders. These individuals are best served when their mental illness is screened early, ie., at the court or in the community. Effective crisis intervention can often circumvent further debilitation which may result in inpatient hospitalization. The Panel supports development of a system of services which will vary in priority by custodial site, but which should be available to all custodial settings in which mentally ill offenders are housed. These services include:

1. **screening, assessment, triage**: A review of the national literature suggests that at least 7 percent of a population of convicted felons are likely to be seriously or significantly psychiatrically impaired.(31) While their needs will vary greatly, this fact mandates that any correctional system have an ability to screen incoming inmates to identify those who need further assessment and possible mental health care. This is best accomplished as part of the normal reception and classification process, which can efficiently serve as the first level screening. At any point, where an inmate's history or current behavior merits further assessment, such should be conducted by clinical staff. The clinical assessment and triage would determine whether a question of mental illness exists, the nature of the problem, treatment options, and immediate and longer term management plans.

2. **crisis intervention**: These services must be available to all inmates since adequate response to a crisis can prevent an inmate from deteriorating into more serious mental illness. The crisis service must have access to psychotropic medication, supportive psychotherapy, and other therapeutic modalities.

3. **crisis residence**: Many acute mental illnesses can be appropriately treated with immediate access to psychiatric care in a safe setting. Inpatient hospitalization can frequently be avoided through the use of on-site crisis residences, which treat acute suicidal depressions, acute exacerbations of psychosis, severe adjustment reactions, panic disorders, etc., within the correctional setting and at significantly less expense than inpatient care. These individuals require short-term (usually less than 10 days) aggressive intervention, aimed at symptom reduction and stabilization, followed by transfer to more or less intensive care as appropriate.

4. **outpatient**: Many inmates with mental illness or psychological problems are still able to function adequately in the general correctional population, if they are provided with supportive services. These services include psychotropic medication, various types of individual and group psychotherapy, and case management. In addition, certain inmates require special "outreach" services which deal with specific characteristics of their prison experience, their mental illness, or their life experiences. Examples include Vietnam combat veterans, adult survivors of child sexual abuse, abused women, or inmates housed for long periods of time in administrative segregation.

5. **inpatient services**: Some severely mentally ill inmates require inpatient psychiatric hospitalization, either for a short or long time. Inmates who require this degree of care are usually those who cannot be stabilized on an acute service. Such care is currently provided at DMH inpatient settings or at Bridgewater State Hospital.

6. **community planning and liaison**: All offenders face difficult challenges upon release from confinement. Those may include housing, resumption of family relations, and employment. Mentally

ill offenders have a unique set of post-release needs. They are likely to require community mental health services. In some instances they may require inpatient care. An effective correctional mental health program, must provide aftercare planning and linkages to community service providers.

7. **training**: In correctional settings, it is essential that training regarding the needs of mentally ill offenders be targeted to clinical staffs, as well as correctional staffs. Training of both groups is essential to effective delivery of services. At a minimum, training should focus on the needs of mentally ill offenders, the roles of clinical and correctional staffs within the correctional setting, liability issues, suicide prevention, and institutional policies regarding suicidal and mentally ill offenders.

8. **consultation**: Consultation resources for correctional settings should be directed towards the needs of clinical staff members, who operate on a daily basis within a highly specialized field, and towards correctional staff members and administrators, who also require information regarding the identification and management of unique populations within the institutional setting who may require special management.

The Division of Forensic Mental Health plans to introduce crisis intervention and outpatient services to Barnstable, Bristol and Middlesex Houses of Correction during the next fiscal year. Specialized mental health units in Suffolk and Bristol counties should become operational near the end of this fiscal year. Research concerning suicidality and incidence of mental illness will be conducted throughout this year. Training concerning administrative, clinical and legal concerns surrounding suicide will be conducted in three regional seminars. A data collection instrument for county settings will be developed and tested.

f. Recommendations

1. There should be continued development of a state-wide system of county correctional forensic mental health services, provided by the Division of Forensic Mental Health.

2. Consistent with Chapter 167 of the Acts of 1987, the county correctional system should develop "specialized mental health units." These units should provide short term crisis residence services to inmates requiring acute observation and treatment.

3. The state and county correctional systems and the Division of Forensic Mental Health should develop a computerized database of information concerning mentally ill inmates, which would aid in providing services to inmates during mental health emergencies and would promote continuity of care for mentally ill inmates as they move from one correctional or mental health placement to another.

4. Standards for correctional mental health services should be developed by the Department of Correction, the Sheriffs' Association, and the

Division of Forensic Mental Health, and an oversight system should be implemented.

3. State Correctional Facilities

a. History

The availability of mental health services in the state prison system in Massachusetts has changed dramatically since the early 1970's when most such services were provided by one psychiatrist "riding circuit" among a number of different facilities. At that time, most mentally disabled prisoners were held in maximum security at MCI-Walpole, Bridgewater State Hospital, or at the medium security prison at MCI-Bridgewater (which later became the Southeastern Correctional Center), because its proximity to the State Hospital made it easier to transfer prisoners.

The Division of Legal Medicine (DLM) of the Department of Mental Health in the 1950's began providing long-term supportive counseling and mental health services at MCI-Walpole, MCI-Concord, and MCI-Norfolk, but had no responsibility for emergency care or crisis intervention.

In 1979, a new initiative was undertaken by the Commissioner of Correction to establish a comprehensive emergency mental health care system. Calling upon the services of McLean Hospital's Institute for Law and Psychiatry, which was then providing clinical services to Bridgewater State Hospital, a plan was developed to create a prison program within the Division of Health Services of the Department of Correction. This program focused on providing mental health services to those inmates who had a major mental illness, who required psychotropic medication, or who were in need of transfer to Bridgewater State Hospital. The program began at MCI-Walpole with a part-time psychiatrist and a full-time psychologist and within one year was able to place staff at MCI-Norfolk, MCI-Concord, and the Southeastern Correctional Center.

The Prison Mental Health Program (PMHP), as the new service was named, was a contract service through the Division of Health Services of the Department of Correction. It was meant to complement the counseling service provided in the prison by the Department of Mental Health through its DLM. The operating philosophy of the PMHP was that each facility was a community and it was the staff's responsibility to assist a mentally disordered offender in adjusting to his community. Bridgewater State Hospital was the inpatient hospital which would provide backup service in the case of emergencies or ongoing care to those mentally ill inmates who could no longer tolerate the confines of a prison.

The development of the Prison Mental Health Program led to several changes in mental health service delivery in the prisons. There was an increase in the number of facilities to which mentally disordered offenders could be sent, since there were now a number of places where such inmates could receive both psychotropic medication and other necessary treatment. There was increased control over the dispensation and use of medication, including a significant reduction in the use of "minor" tranquilizers. And

there was more orderly transfer and return of patients from Bridgewater State Hospital to prison.

b. Current Service System

By 1982, the five major prisons (Walpole, Norfolk, Concord, Southeastern, and Framingham) all had units of the PMHP in operation. Each unit consisted of a Unit Director, usually a psychiatric social worker, a full-time psychologist, and a part-time psychiatrist. The non-medical personnel screened patients to determine if they should be seen by the psychiatrist, thus using psychiatric time in a cost-effective manner. With the exception of MCI-Framingham, which has psychiatric services provided through the vendor, People Care, Inc., the other four major prisons have psychiatric services provided by the Prison Mental Health Program.

The introduction of PMHP came at a time when the counseling efforts of DLM were being significantly reduced. At Walpole, for instance, DLM had two persons to provide counseling. At Concord and Norfolk, DLM's staff was slightly larger. The work was divided between the organizations, with DLM providing long term psychotherapy for emotionally disturbed inmates, which often focused on reduction of recidivism, and PMHP offering medication, crisis intervention, and hospitalization of inmates with serious mental illnesses. Over the next several years, with the exception of Concord, DLM gradually reduced the scope of its efforts within the prison system. Currently, there are almost no Department of Mental Health staff working within state prisons (with the exception of MCI-Framingham).

Shortly after the creation of the PMHP, the Commissioner of Correction was able to increase the number of state line positions of mental health staff in the prisons. With this increase, and the hiring of a Director of Programs and Treatment, the DOC began to offer a variety of psychological services, including long term counseling, substance abuse programs, and other specialty services. Psychological Services, as this division came to be called, has provided both individual and group therapy throughout all of the facilities of the Department of Correction.

In triage meetings, the staff of Prison Mental Health Program and Psychological Services determine how best to utilize their combined resources to provide mental health services and treatment to a given individual. While some inmates receive treatment from both programs, there is minimal overlap and duplication of services. The mentally disordered offender on psychotropic medication, for example, has his medication needs monitored and met by the staff of PMHP while at the same time, he participates in long-term therapy groups run by Psychological Services.

c. Gaps in the System

There are a number of flaws in the current system related to both capacity and coordination of service. The present system is unable to keep up with increased demands for services. The growing correctional population as well as the higher percentage of mentally disordered offenders among newly admitted inmates results in a broad-based need for increased capacity. The current lack of certain types of services results in increased utilization of

other more costly programs. For example, an inmate who is not appropriately monitored on psychotropic medication may eventually require inpatient hospitalization. All mentally ill inmates are unique and require different levels and types of care. The current system provides few options for residential treatment besides Bridgewater State Hospital.

Mentally ill inmates generally remain within the general inmate population, which is stressful for some, and may exacerbate mental illness. Alternatively, mentally ill inmates may be housed in some sort of protective custody which reduces their programming options and which may have its own stigma, in addition to that of the mental illness. Sometimes mentally ill inmates within the prison population find their way to administrative segregation areas.

As an inmate moves through the correctional system, his mental health care must be provided in a coordinated manner. Continuity of care is essential in mental health services to reduce both human and financial costs caused by gaps in service. In the next section, the Panel outlines a plan for expanded treatment options and makes recommendations regarding service coordination.

d. Plans for Improvement

i. Prison Mental Health Centers

There is a need for at least three prison mental health centers, located within the major prisons. Each comprehensive prison mental health center would include the following services:

1. **Crisis residence**: This unit should consist of six to ten beds, with the capacity (perhaps three beds) to seclude patients who present a danger to others. Suicidal inmates could be housed in a small (six bed) ward setting. This unit would be staffed 24 hours per day with one nurse in addition to a correction officer, with two activity therapists providing programming support. An ideal arrangement would be to assign the activity therapists 10 am - 8 pm seven days per week, each working four ten-hour shifts per week.

2. **Longer-term residential treatment (community residence)**: This unit should range from 45 to 60 beds, depending on facility design and would provide a sheltered environment with day programming for inmates unable to function in general population.

3. **Outpatient clinic**: This would function as a traditional outpatient clinic, providing supportive psychotherapy (both individual and group), psychotropic medication, crisis intervention, as well as triage for patients who might require transfer to Bridgewater State Hospital.

4. **Consultation services**: The prison mental health center's staff would also be available to assist other correctional professionals in dealing with mentally ill inmates.

The mental health center at MCI-Concord would have a somewhat different role, since MCI-Concord serves as the Department's classification center. The unit's role would be the early screening and evaluation of newly arriving inmates in order to determine the appropriate level of mental health care that each inmate needs. The community residence at MCI-Concord would serve a double purpose as well, allowing for an extended look at inmates whose mental health needs cannot be quickly determined.

Besides these three comprehensive mental health centers, the following services are also needed:

- **Outpatient mental health clinics:** There should be mental health outpatient clinics at each medium security prison that does not have a prison mental health center. These programs would include the same services as the outpatient clinic listed above, without the community residence and the crisis residence components. They would provide crisis services on an outpatient basis, but any inmate requiring access to a crisis bed would be transferred on an "out-count" basis to a prison mental health center facility for up to ten days. Staff in the outpatient clinics should be scheduled to provide at least one clinician on weekends and reasonable coverage into the evening hours. By overlapping schedules, this coverage can be accomplished so that there can be weekly treatment team meetings.

- **Liaison and consultation services:** In other facilities, social workers and psychologists might be assigned to provide consultation, follow-up care for successfully treated inmates who have "graduated" from more intensive levels of care, pre-release counseling and discharge planning. These clinical staff would also evaluate inmates for potential transfer to facilities with prison mental health center and outpatient clinic programs as needed.

- **The reception and screening process:** In order for the prison mental health system to be effective, there must be an ability to identify seriously and predominantly mentally ill inmates shortly after arrival in prison. The screening process should have multiple levels. At the first level, the threshold must be exceptionally low. Any inmate who has either an appearance or complains of any present or past mental illness, who has ever been treated for psychiatric illness, or who looks, talks or acts in a manner that leads staff to raise any questions about psychiatric illness, should be referred to the second level. At the second level, there should be a brief interview with the inmate and a review of the record which accompanied the inmate. The third level of screening would involve referral by either a psychologist or psychiatrist in cases where there appears to be a need for intensive mental health services.

ii. Coordination and Continuity of Care

A major problem is the inadequacy of coordination and communication among the various mental health providers within the prison system and at specific sites. The lack of treatment planning meetings and treatment plans are examples of this lack of coordination.

•Coordination among mental health service providers:

If the system is to improve, there should be improved coordination between Bridgewater State Hospital, PMHP, and Psychological Services staff. There are a number of mechanisms for achieving this coordination. One option is to combine all of the mental health providers under a single organizational entity at the state level. A second option is to assign contract time of mental health providers to each superintendent so that direct supervision could be provided by the superintendent, who could contract with the PMHP for various amounts of professional time. A third model requires certain activities which would improve coordination and communication. This would include regularly scheduled case conferences, both at the prison and, at Bridgewater State Hospital, to review the treatment or discharge plans of inmates who are expected to return soon to prison. Nor are these the only options. What is essential is that all of the providers of mental health services within the Department of Correction have a clear understanding of their own roles and that of all other providers, so that the care of each inmate is coordinated and managed.

•Coordination between mental health service providers and classification staff:

Clinical staff need to be able to provide information to correctional classification staff. Communication between clinical and classification staff should deal with the following issues:

1. Necessary treatment options, especially those which are only located in some facilities.

2. Explanations of classification decisions which the inmate does not understand.

3. Explanations to classification staff about the nature of the mental health services being received by inmates.

Superintendents and classification staff need to understand the appropriate role of mental health evaluations in making treatment recommendations. These recommendations will occasionally note that an inmate needs to be in a particular type of setting. However, this must be balanced by security considerations. A classification hearing concerning a mentally ill inmate should be preceded by an interdisciplinary treatment planning conference. This conference should include clinical and correctional staff (especially correction officers who know the inmate well) at the prison, and possibly should include the inmate's participation.

•Coordination of mental health services at a given site:

Prison mental health services function best when there is coordination of care. To achieve such coordination, the following actions are recommended:

1. Every workday morning, on-site mental health staff should review the preceding day's (or weekend's) change sheet. Any move of an inmate currently receiving mental health services to another facility should warrant a telephone call to mental health staff responsible for services in the new location.

2. Any inmate known to be receiving mental health services who is transferred, and especially those moved for ostensible "mental health reasons," should be accompanied by a one page cover sheet which lists current medications (dosage, hours of administration, and last dosage received), diagnosis if known, and most importantly, the name and extension of one person on each shift who knows the inmate and his circumstances.

3. The importance of clerical support to a mental health service cannot be overemphasized. It is much better to have a brief discharge summary available to travel with the mentally ill inmate than a long and detailed summary which arrives a week after the inmate.

4. Inmates who have been prescribed psychotropic medication and who are transferred to another facility should generally be continued on the same medication until a full assessment of their psychiatric status is completed.

5. Mentally ill inmates should have written treatment plans. The absence of a comprehensive treatment plan is a barrier to providers. Correctional staff are seldom informed of treatment goals and may, in fact, work against treatment goals that they have not been made aware of. All seriously and persistently mentally ill inmates should receive clear, straightforward treatment plans. These plans should be updated on a routine basis (e.g., every 90 days).

e. Recommendations

1. Within the Department of Correction, there should be a mental health service delivery system with four progressive levels of care:

   a. Acute psychiatric inpatient care at Bridgewater State Hospital.

   b. At least three comprehensive prison mental health centers, each of which will include:

      - a six to ten bed crisis residence unit
      - a 45 to 60 bed community residence unit
      - an outpatient clinic
      - consultation services

   c. Each medium security prison which does not have a prison mental health center should have an outpatient mental health clinic which would provide psychotherapy, medication, crisis intervention and triage services.

   d. Mental health consultation and liaison services should be available throughout the correctional system.

2. The state and county correctional systems should develop policies which would permit short-term inmate transfers for the purpose of acute mental health treatment and stabilization, without an inmate losing his or her current classification status.

3. The state and county correctional systems and the Division of Forensic Mental Health should develop comprehensive forensic mental health training programs focusing upon clinical, administrative, and legal issues which concern the mentally ill offender. Attention should be given to the development of research programs.

D. COMMUNITY-BASED SERVICES

1. Department of Mental Health Programs

The Department of Mental Health is building the system of community-based services that was outlined in the Governor's Special Message.(2) This system of services includes:

- Twenty-four hour, seven day a week emergency services for persons who are experiencing a mental health crisis;
- Respite care for persons who need specialized community services for a short period of time;
- Case management services for persons with long-term or serious mental illness. Case managers are responsible for working with clients to arrange the set of rehabilitative, psychiatric, housing, educational, and support services that they may need, including;
- Psychiatric services, including psychiatric evaluation, psycho-pharmacology, medication management, and therapy;
- Rehabilitation;
- Day treatment;
- Community residences;
- Social clubs and other socialization programs for mentally ill persons; and,
- Inpatient treatment.

Currently, there is no separate forensic mental health community-based service system. Community-based services are available to persons with serious or long-term mental illness. DMH area offices, which operate case management systems, are responsible for arranging for or providing these services. Mentally ill persons who have been involved with the criminal justice system are eligible for community-based services.

Until the development of the Division of Forensic Mental Health, there was no centralized organizational unit in the Department of Mental Health

responsible for coordination of community-based services for mentally ill, court-involved persons. Regional forensic managers now are responsible for working with area directors and other DMH managers to insure that court-involved mentally ill clients are offered the services that they need. Court-based staff increasingly consult and work with community staff to serve court-involved clients.

2. Insanity Acquittees

a. Introduction

Chapter I of the Acts of 1988 directed the Governor's Special Advisory Panel to examine "the Commonwealth's policies relative to the evaluation, disposition, treatment, and release of persons who are found not guilty of a crime by reason of mental illness or defect, with an analysis of the need for post-release monitoring or conditional release of such persons, including the feasibility of establishing a psychiatric review board."

The insanity defense has a lengthy history of generating controversy. In addition, individuals acquitted by reason of insanity present special management problems to the mental health and criminal justice systems. Any individual who is mentally ill and commits a criminal act is doubly stigmatized as "mad and bad." Such notoriety increases the need for special handling of these individuals that assures appropriate treatment interventions in conjunction with protection of the public. Responses to the needs of insanity acquittees must consider, balance, and integrate both clinical and public safety interests in order to maximize the possibility of successful management of these complex cases.

The statute, General Laws Chapter 123, section 16, provides only a general structure for the legal disposition of not guilty by reason of mental illness (NGI) acquittees. In addition, the Commonwealth has not yet clearly articulated policies for the management of these individuals. The Panel has carefully examined the current system and is recommending significant changes in current statutes and procedures.

b. Governing Principles

1. Public safety is the most important factor in any plan for the disposition of insanity acquittees.

2. Statutes should provide clear guidance to the courts and mental health professionals on the management of insanity acquittees.

3. Insanity acquittees should be provided treatment and rehabilitation opportunities which enhance the possibility of a gradual reintegration into the community.

4. All decisions to increase the level of freedom available to insanity acquittees should occur after careful evaluation of both clinical and security needs.

5. Any release to the community of an insanity acquittee should be made on a gradual basis, with adequate safeguards to insure careful

monitoring, as well as mechanisms that permit prompt rehospitalization or detention of the released patient due to violation of release conditions.

6. The courts should maintain ultimate responsibility for the disposition of individuals found not guilty by reason of insanity.

7. A single organizational entity should be responsible for monitoring the treatment, evaluation, and rehabilitation of insanity acquittees and for serving as an adviser to the courts concerning the ongoing disposition of these cases.

c. Policy Questions

1. Does the current statute provide adequate guidance regarding the management of insanity acquittees?

2. How are insanity acquittees currently managed?

3. Should Massachusetts establish a review board responsible for monitoring the progress of insanity acquittees from the inpatient system to the community?

d. History

There are few issues in the American criminal justice system as controversial as the insanity defense. Although definitions of "insanity" are couched in legal terms, it is clear that this issue is wrought with social and moral value judgments. How should society handle an individual who has violated the criminal law yet, due to mental disability, may not be truly responsible for his or her actions?

Society is comfortable with excusing certain categories of individuals for their prohibited actions. For example, children under a certain age are not held accountable for their criminal acts. Reflected throughout the criminal law, is the belief that it is not "fair" to hold young children fully accountable for their actions because they are viewed as incapable of forming criminal intent, and therefore, are not morally blameworthy.

The criminal law takes mental disability into consideration when determining the degree to which an individual should be held responsible for his or her actions. The insanity defense has evolved as one way for a court to consider the special circumstances when an individual's mental state at the time of an offense may have been significantly impaired by mental illness. The American Law Institute/Model Penal Code formulation of the insanity test, which is in use in most states including Massachusetts, states that a defendant should be seen as not criminally responsible if, as a result of mental disease or defect, the defendant lacks substantial capacity to either: 1) appreciate the wrongfulness of his conduct, or 2) conform his conduct to the requirements of the law.

According to the American Law Institute formulation, to conclude that a defendant lacked criminal responsibility, the trier of fact (judge or jury) must find that the individual was seriously mentally ill <u>and</u>, as a result of that

mental illness, was unable to appreciate the wrongfulness of the prohibited act or unable to control his/her own behavior. Typically, evidence of such a mental condition is provided by mental health experts at trial. The ultimate decision as to whether or not a defendant is acquitted by reason of insanity is a legal determination and not a clinical finding.

Successful insanity defenses are extremely rare. However, over the past ten years, the insanity defense has received significant publicity, reinforcing the public perception that a defendant is "getting away with murder." Following John Hinckley's acquittal by reason of insanity in 1982 for his assassination attempt of former President Reagan, there were numerous calls for reform or abolishment of the insanity defense. The debates which followed obscured many of the critical issues.

The insanity defense is a necessary part of the legal system of any civilized society. The theory and practice of criminal law mandates that there be a mechanism in place to excuse an individual for criminal behavior in the rare instance when the defendant was so significantly impaired that he or she could not appreciate or conform to the law. Although it may be appropriate to make the criteria stringent, the basic concept of an "insanity defense" has been found by legal scholars and criminal justice policymakers to be sound.

Publicity related to the insanity defense has often obscured consideration of questions concerning how criminal justice and mental health systems handle the few persons who are found to lack criminal responsibility for violent acts. The Panel's deliberations have focused on how Massachusetts should deal with these individuals after the criminal justice system has decided they are not blameworthy. Thus, the current inquiry has looked at the vexing issues surrounding the disposition of individuals acquitted by reason of insanity.

e. Current Service System

Currently, Massachusetts law outlines the disposition of insanity acquittees in Chapter 123, section 16. This statute is somewhat confusing since provisions for the hospitalization of both insanity acquittees and persons found incompetent to stand trial are intertwined. Section 16 states that when an individual is found "not guilty by reason of mental illness or mental defect," the court having jurisdiction over the criminal proceedings may order the individual hospitalized at a Department of Mental Health facility or (if male and in need of "strict security") at Bridgewater State Hospital for a period of 40 days for "observation and examination." Within 60 days after a finding of not guilty by reason of mental illness, the district attorney, the superintendent of a Department of Mental Health facility, or the Medical Director of Bridgewater State Hospital may petition the court having jurisdiction over the criminal case for commitment of the person to a DMH facility or Bridgewater State Hospital. Determination is made according to civil commitment criteria as defined in Paragraph A of Section 8, with the burden of proof for commitment resting with the Commonwealth and the standard of proof being beyond a reasonable doubt. The first commitment order is valid for six months. Subsequent commitments (each of which must be occasioned by a new hearing) are for a maximum period of one year each. The district attorney for the county in which the crimes were committed must be notified

of all hearings conducted relative to Section 16 proceedings. Individuals committed pursuant to Section 16 may be restricted in their movements to the buildings and grounds of the facility to which they were committed by the courts.

The statute offers minimal guidance regarding the release process for insanity acquittees. It notes that, if the superintendent or medical director intends to discharge the patient or does not intend to petition for recommitment, he/she must notify the court and district attorney having jurisdiction over the criminal case. Within 30 days of this notification, the district attorney may petition for recommitment.

The Panel finds Section 16 to be flawed in a number of respects. The statute provides only the broadest outlines of a procedure for disposition of insanity acquittees. It is difficult to sort out the provisions intended for insanity acquittees and those intended for individuals declared incompetent to stand trial. No provision is made for the conditional release of insanity acquittees. The statute, therefore, appears to endorse an all or none approach to patient management. Either the patient is in the hospital or the patient is released to the community with no mandated follow-up treatment or care. The present scheme does not permit appropriate monitoring of treatment compliance or, more importantly, monitoring of the reemergence of the psychotic symptoms which may have led to criminal behavior in the past. Since one of the symptoms of mental illness may be that the patient does not recognize or agree with the need for treatment, a system that provides no capacity for monitoring insanity acquittees leaves these patients and society at risk. The Panel believes that in order to protect the patient and society as a whole, a mechanism should exist to carefully monitor the unique group of persons who have been adjudicated not guilty by reason of mental illness of violent crimes.

f. Data Regarding Current Utilization of Service System

Data about of insanity acquittees in Massachusetts are limited and incomplete.

In an attempt to evaluate insanity acquittees currently in state facilities, a survey was conducted of each Department of Mental Health facility and Bridgewater State Hospital regarding insanity acquittees in these facilities under the provisions of Massachusetts General Laws, section 16 as of April, 1989.

TABLE 3
INSANITY ACQUITTEES
COMMITTED TO BRIDGEWATER STATE HOSPITAL AND DMH FACILITIES UNDER MASSACHUSETTS GENERAL LAWS SECTION 16 AS OF APRIL, 1989

	Bridgewater State Hospital	*DMH Facilities*
Gender		
Men	42	25
Women	--	7
Age		
20's	6	4
30's	22	15
40's	8	6
50's	2	4
60's	4	2
70's		1
Offense		
Violent	41	25
Non-violent	1	7

A one-day survey conducted on April 27, 1989, identified 42 NGI patients at Bridgewater State Hospital. The majority of NGI patients were young; 66% (28) were between the ages of 25 to 39. The remaining patients were distributed evenly among the five-year age intervals of 40 to 69. NGI offenses were serious. Forty-seven percent of the patients had been acquitted of murder. Assault was the second most common category, followed by rape.

There is currently no reliable method to determine the yearly number of insanity acquittals in Massachusetts.

g. Other States' Programs

In Massachusetts, a person found not guilty by reason of mental illness is treated by the law fundamentally the same as a mentally ill person who has never been arrested. Other states provide for the indefinite commitment of

insanity acquittees, or for commitment and supervision for considerable periods of time. In other states, frequently the burden is on the insanity acquittee to show that he or she will behave in a non-violent way once released, not on the state to show that failure to hospitalize the patient would create a likelihood of serious harm.

The Panel studied the experiences of three states that have developed innovative systems to handle insanity acquittees that both protect society and insure that patients get the treatment that they need and deserve (Connecticut, Oregon, and Maryland). The experiences of these states are described below.

i. Connecticut:

The Connecticut Psychiatric Security Review Board was established under the provisions of Connecticut Public Act 85-506, Section 1 and described further by General Statutes of Connecticut 306, Section 17-257a-b. The statute provides for a five member autonomous board that includes a psychiatrist, psychologist, lawyer, parole officer, and community member that is responsible for monitoring court committed mentally ill and retarded persons who have been found to be not criminally responsible. State employees are not eligible for Board appointments, which are made once every four years by the Governor. The Board is funded as an independent agency but its offices are provided by the Department of Mental Health. Financial support consists of reimbursement for Board members and staff, including funds for clinical evaluations. The Board has no funds available to contract for community services.

The primary purpose of the Board is to provide intensive follow-up of committed, not criminally responsible, outpatients. For hospitalized insanity acquittees, the Board can recommend conditional release or continued hospitalization without court approval. However, if the Board recommends discharge of an acquittee from its custody, the State's attorney, counsel for the acquittee, and the court must be notified. After receipt of the Board's recommendations, the court must "promptly commence a hearing." At the hearing, the Board has the burden to prove that the acquittee is a person who should be discharged.

In Connecticut, a person found not responsible by reason of mental illness or mental retardation is hospitalized for assessment. The facility superintendent or the Commissioner of Mental Health or Retardation makes a recommendation within 45 days for continued hospitalization, discharge, or outpatient commitment. An outside evaluation may be requested by the state attorney or counsel within ten days following receipt of the first evaluation.

A hearing occurs within fifteen days after receipt of any outside examination or within twenty-five days after filing of the hospital examination report. If the court finds that the person should be confined, it commits the person to a mental health hospital or, if the acquittee is retarded, to the Commissioner of Mental Retardation for custody, care, and treatment. The court fixes a maximum term of commitment, not to exceed the maximum sentence that could have been imposed had the person been convicted of the offense. If the court believes that the acquittee should be conditionally released, it makes that recommendation to the Board.

At any subsequent hearing, the acquittee has the burden to prove by a preponderance of evidence that he or she should be discharged. Hospitalized insanity acquittees must be discharged at the expiration of the maximum term of commitment unless the State's attorney petitions the court for an order of continued civil commitment.

Any time after commitment to a psychiatric facility or placement with the Commissioner of Mental Retardation, the superintendent of the facility, the Commissioner, the acquittee or another person acting on his or her behalf may apply to the Board for an order of conditional release. An application for conditional release or discharge can be filed every six months, and a Board hearing is held within 60 days of the formal request. Hearings are open to the public. Within 25 days, the Board provides the acquittee, his or her counsel, the state's attorney and any victim a copy of their decision. The Board conducts a hearing and reviews the status of each acquittee not less than once every two years. No Board member is personally liable for damage or injury caused in the discharge of their duties. Complaints must be presented as claims against the state.

The Board may designate any person or appropriate public or private agency to supervise the conditionally released acquittee. After receiving an order of conditional release, the designated person or agency assumes supervision of the acquittee. Treatment contracts normally stipulate that the conditionally released person must accept recommended treatment, not possess or use alcohol, non-prescription drugs, or firearms, not leave the state without Board approval, and maintain a current address. The acquittee or the person or agency responsible for supervision and treatment may apply to the Board every six months for the modification of the conditional release order. A Board hearing to consider the request occurs within 60 days of application. If the conditions of release are violated, revocation occurs quickly. A designated Board member will ask the individual to return voluntarily or request the court to issue a warrant for apprehension. Within 20 days after revocation, a Board hearing occurs to evaluate the acquittee's mental condition and a recommendation for confinement, conditional release, or discharge follows.

The majority of the 165 individuals adjudicated not responsible and monitored by the Connecticut Board committed serious felonies. The average maximum commitment for the group is 30 years. Board members report that their clients are well known among community care providers and their requests for rehospitalization receive immediate attention. Victim advocacy groups supported establishment of Connecticut's Board.

ii. Oregon:

The Oregon Psychiatric Security Review Board is a five member autonomous board which includes a psychiatrist, psychologist, lawyer, parole officer, and community member and is responsible for monitoring court committed, mentally ill/mentally retarded insanity acquittees. The statutes mandate that the "Board shall have as its primary concern the protection of society". Established in 1977 under the provisions of Oregon Revised Statutes 380, Section 8, it is the oldest existing outpatient monitoring system in the country for those persons found not criminally responsible. State employees are not eligible for the four year Board appointments, which are made by the

Governor. The Board is funded as an independent agency, although its offices are provided by the Department of Mental Health. Unlike Connecticut, the Board has funds to contract for community services for its clients, in addition to receiving reimbursement for Board members and support staff, and independent clinical evaluations. The primary purpose of the Board is to provide intensive follow-up of committed insanity acquittees and make decisions concerning future hospitalization, conditional release, and treatment. In contrast to the Connecticut system, the Oregon Board does not need court approval of its recommendations for discharge.

In Oregon, insanity acquittees are hospitalized for assessment. The court can order commitment to a state hospital or conditional release. At the same time, the individual is placed under the jurisdiction of the Psychiatric Security Review Board (PSRB) for "care and treatment." The length of time the insanity acquittee is under Board jurisdiction equals the maximum sentence the person would have received, had he or she been found guilty. If the court recommends conditional release rather than hospitalization, it designates someone to supervise the person upon release. This person or agency assumes responsibility under the direction of the Psychiatric Security Review Board and must report monthly in writing. Conditions of release are negotiated among the Board, the acquittee, and the community care provider. Compliance with these conditions is closely monitored by the Board.

When the court orders hospital commitment rather than immediate conditional release, as is often the case, the Board has an initial meeting to determine whether or not the person presents a substantial danger to others. If so, the PSRB can order the person committed to a state hospital. At this initial meeting, Board members are able to familiarize themselves with the acquittee. It is the trial court's responsibility to determine if there are any surviving victims of the crimes for which these individuals were found not responsible. If so, and if victims desire notification, the Board must make reasonable efforts to notify them of any Board hearings, conditions of release, discharge plans, or escapes that involve the acquittee.

The facility superintendent may, at any time, request that the PSRB discharge or conditionally release a committed individual from the facility. Persons eligible for discharge or conditional release are those no longer affected by "mental disease or defect," or who no longer present a substantial danger to others and who can be controlled in the community with proper care, medication, supervision, and treatment. Oregon law states that "a person affected by mental disease or defect in a state of remission is considered to have a mental disease or defect requiring supervision when the disease may, with reasonable medical probability, occasionally become active and make the person a danger to others." The Board holds a hearing within 60 days prior to the scheduled date of release. Hearings are open to the public. The attorney may choose a psychiatrist or licensed psychologist to examine the person prior to the initial hearing or prior to any other Board hearing regarding discharge or conditional release.

At a hearing, the Board may order discharge, conditional release, or a continuance for 60 days or less, pending receipt of additional information. At any time during PSRB commitment, a psychiatrist or licensed psychologist may be asked to examine the person and submit a report. Within 15 days, the

Board must issue a decision to the person, counsel, and Attorney General. Every five years during hospitalization or conditional release, a hearing occurs 30 days prior to the expiration of the five year period. The Board reviews the person's status and determines whether the person should be discharged from the jurisdiction of the Board. If the Board receives information that suggests that discharge or release conditions have been violated, a Board member may request the person to return voluntarily to the hospital or may request the court to issue a warrant for apprehension. Acquittees are normally returned in 2 to 24 hours. A hearing occurs within 60 days after the acquittee's return to the hospital, and the Board may then order continued hospitalization, conditional release, or discharge.

More than 25 percent of the 400 insanity acquittees that the Oregon Board currently monitors committed misdemeanors. Despite efforts to reduce the supervision of nonviolent offenders, public defenders often seek PSRB commitment as a means of obtaining needed treatment for nonviolent offenders, because financial restraints have assured outpatient treatment only to those individuals under PSRB jurisdiction. Board members report that the Oregon public, press, legislature, attorneys, and courts have been pleased with the Board's performance.

iii. Maryland:

In Maryland, there is a Community Forensic Aftercare Program, which is described briefly in the Annotated Code of Maryland Section 10-809. The program consists of one member, with two support staff, who is responsible for monitoring court committed, mentally ill and retarded individuals who have been found not guilty by reason of insanity. The program is affiliated with the Clifton T. Perkins Forensic Hospital. Maryland has operated this administrative outpatient monitoring system for insanity acquittees since the 1950's. During the 1980's, the number of participants in the outpatient monitoring program has increased. The centralized organization and primary program direction are provided by a licensed social worker, who serves as Program Coordinator. The Program Coordinator is responsible for distributing monthly surveys and requests for treatment evaluations, as well as for educating the courts, attorneys, and clinicians regarding the program's role and candidate suitability for assignment to the program. Although the courts have ultimate jurisdiction, the Program Coordinator reports that judges agreed to all 70 revocations requested during 1988.

In Maryland, individuals adjudicated not responsible by reason of mental disease or defect are hospitalized for assessment. The hospital or the patient, with the help of his or her attorney, can request conditional release. The patient, often in consultation with the hospital clinical staff, signs a petition for conditional release. A hospital hearing follows, conducted by the attorney for the Department of Mental Health and Mental Hygiene. If conditional release is recommended at that time, an order is prepared for the patient, the outpatient care provider, and for court review.

Court approval results in patient assignment to the Aftercare Program, which currently monitors 380 participants. Once assigned to the Aftercare Program, the following dispositional alternatives may be pursued: 1) every five years, the Aftercare Program Coordinator may request that the patient be

continued in the program. An acquittee's time in the program may not exceed the maximum allowable sentence the person might have received if found responsible; 2) the patient can sign a hearing waiver and request immediate inpatient commitment; 3) the Aftercare Program Coordinator may terminate the conditional release, requiring the individual to return to inpatient status; 4) the Aftercare Program Coordinator may recommend release of the individual from the program.

h. A Model for Massachusetts:

The Panel has considered a number of concerns which must be addressed in any attempt to reform the current Massachusetts law. The current statute should be amended to include these items, which have been studied in detail by the Criminal Justice Mental Health Standards Committee of the American Bar Association (ABA). Summarized below are several key issues discussed in the American Bar Association report and adapted to Massachusetts.

i. Commitment Following Insanity Acquittal

In most cases, placement in a psychiatric facility is the proper disposition of an insanity acquittee. Most commentors agree that long term involuntary commitment without a formal hearing is not appropriate. A "commitment without hearing" approach fails to take into account changes in the acquittee's mental state between the commission of the act and the verdict. Rather than an automatic commitment, the Panel recommends that persons who are found not guilty by reason of mental illness for a violent offense be placed in an appropriate psychiatric facility for a period of mandatory mental health examination, after which a commitment hearing must be held.

ii. Mandatory Examination Following Insanity Acquittal

The ABA standards suggest, and the Panel agrees, that an insanity acquittal does not, in and of itself, provide enough information to warrant extended involuntary commitment, although it does raise the likelihood of commitability. An insanity verdict indicates that the defendant committed a prohibited act, as well as suffered from a mental disorder. An insanity finding warrants an investigation of the appropriateness of commitment. The Panel recommends that a post-insanity determination evaluation should be ordered by the trial court upon a motion by the prosecutor. This would allow an evaluation in all cases, unless some unusual circumstances warranted the waiver of such a procedure. It is recommended that the evaluation period not exceed 45 days to allow time for a thorough clinical assessment to be completed in a timely fashion. The evaluation should be completed by qualified, specially trained mental health professionals. At court discretion, such an evaluation could occur on an inpatient or outpatient basis.

iii. Special Commitment Procedures

The current system in Massachusetts that utilizes civil commitment criteria for the commitment of insanity acquittees is inadequate. The current system fails to take into account the special nature of insanity acquittees. The Panel recommends that insanity acquittees who are acquitted of a misdemeanor, or a felony which did not involve acts or threats of serious bodily harm, should be handled with the same procedures used for civil

commitment of mentally ill persons not involved with the criminal justice system. Individuals who are acquitted by reason of insanity of felonies which involve acts or threats of serious bodily harm should be processed by a separate set of special commitment procedures. These special procedures for violent insanity acquittees will provide the agencies responsible for monitoring their condition and progress broader latitude in addressing public safety concerns.

As suggested by the ABA standards these special procedures would provide for a commitment hearing following the initial evaluation period. At this hearing, the court may order hospitalization for treatment if it finds that the acquittee is: 1) currently mentally ill or mentally retarded, and, as a result; 2) poses a substantial threat of serious bodily harm to others. The Panel recommends that the court have the option to consider individuals who do not meet this standard solely, due to the effect of treatment or habilitation currently being provided, as committable. The court may also order that an insanity acquittee be released upon the condition that he or she continues to receive required treatment or habilitation. Failure to comply with the conditions of release may result in the revocation of the conditional release. The Panel recommends that all special commitment decisions be made by specially designated judges. All insanity acquittees found committable or granted conditional release pursuant to the special commitment procedures would automatically come under the auspices of the Mental Health Review Board for a period of time that does not exceed the maximum sentence the acquittee might have received if found guilty.

iv. Mental Health Review Board

After carefully reviewing the current system for the disposition and care of insanity acquittees, as well as other states' experiences, the Panel concludes that Massachusetts would benefit from the establishment of an independent entity, which is responsible for monitoring the treatment and management of insanity acquittees, who are found to meet the special commitment criteria. The first priority of the Board would be to assure public safety by the careful monitoring of insanity acquittees. The Board would be responsible for reviewing and approving all significant decisions regarding the management of all insanity acquittees which directly impact upon public safety.

The Board would consider all reports for discharge, conditional release, or termination of conditional release and make recommendations to the specially designated judges. The court would retain the authority to make the ultimate decisions regarding disposition. Members of the Review Board should be immune from liability for their decisions.

The Board should function as an independent entity supported by the Department of Mental Health. It should consist of seven members appointed by the Governor for separate four year terms. Its membership should include a psychiatrist, psychologist, lawyer, district attorney, parole board member or representative, the Assistant Commissioner for Forensic Mental Health (or designee), and a citizen member. The Board would meet on a regular basis to consider issues regarding insanity acquittees.

The Board would have the authority to require that service providers report the progress of insanity acquittees on a designated schedule. The Board would also have the authority to impose, modify, and revise conditions of conditional release. Failure to comply with these conditions would result in the Board revoking the conditional release on an emergency basis for a period of ten days before making a recommendation to the court for commitment.

Persons under the jurisdiction of the Mental Health Review Board may apply on an annual basis to the specially designated judges for a review of their commitment status or the conditions of their conditional release. The Mental Health Review Board shall make recommendations to the court at each hearing. The acquittee shall have the burden of proving to the court that he or she no longer meets the criteria for special commitment or conditional release in order to be discharged outright by the Court.

i. Recommendations

1. Division of Forensic Mental Health regional management and field staff should be responsible for linking court-involved, mentally ill persons with appropriate case management, housing, rehabilitation, and community treatment services.

2. Special commitment procedures should be developed and implemented for persons found not guilty by reason of mental illness for violent offenses.

3. A Mental Health Review Board should be established with responsibility for monitoring the treatment and management of insanity acquittees who are found to meet special commitment criteria.

E. MENTALLY RETARDED OFFENDERS

1. Introduction

"No mentally retarded person shall be considered mentally ill solely by virtue of his mental retardation". (General Laws Chapter 123, section 1)

With these words Massachusetts joined the ranks of the majority of states which have called attention to the differences between mentally retarded and mentally ill individuals. Unfortunately, Massachusetts has also joined a growing number of states that have established this difference in law, while leaving the unique needs of mentally retarded offenders largely unaddressed. General Laws Chapter 123B, effective as of July 1, 1987, included a handful of new provisions specific to persons with mental retardation, but largely left in place the provisions of Chapter 123, the mental health statute, to govern the many legal and programmatic issues involving mentally retarded offenders. While intensive program planning has been undertaken by the Departments of Mental Retardation and Mental Health(32), the development of programs for this population has been hindered by a lack of resources.

A person's status as mentally retarded, mentally ill, or dually diagnosed is extremely important, as it may be the sole determinant of what programming is available and what powers a court may take to compel the

person's participation. Through the enactment of Chapter 123B, the legislature created substantially different procedures for court-involved persons who are mentally retarded and those who are mentally ill. For example, a solely-mentally retarded person cannot be involuntarily committed under any of the provisions of Chapter 123, nor can such a person be transferred out of a place of detention of prison and into a mental health facility pursuant to General Laws Chapter 123, section 18(a). On the other hand, any criminal defendant, regardless of his or her mental retardation or mental illness, may be evaluated on an outpatient or inpatient basis for competency to stand trial, criminal responsibility or as an aid in sentencing under Chapter 123, sections 15 and 16. A defendant's mental retardation may dramatically affect the abilities being evaluated in different ways than would mental illness.

Possibly due to a recognition of existing systemic limitations, mentally retarded offenders may come under increasing scrutiny as to whether they are also mentally ill. While a small proportion of persons with mental retardation are dually-diagnosed as such, this scrutiny may also result from a desire to find services and placement options that do not exist for offenders who are soley mentally retarded.

2. Governing Principles

1. Mentally retarded offenders differ significantly from mentally ill offenders, requiring the development of distinct programs which address their needs.

2. Offenders who are dually-diagnosed as mentally ill and mentally retarded have unique needs for habilitation and treatment which should be made available through close collaboration between the Department of Mental Retardation, the Department of Mental Health, and the courts.

3. Residential programs for mentally retarded offenders should be offered if possible on a voluntary basis, and in the least restrictive setting which is appropriate.

4. Mentally retarded offenders may be ill-equipped to function at a criminal trial or in a correctional setting. Where appropriate, alternatives to prosecution and incarceration should be made available.

5. Identification of the offender's mental retardation at the earliest possible contact with the criminal justice system is critical to all other programming and due process considerations.

3. Policy Questions

1. What additional resources, laws and programs are needed to make the statutory distinction in Chapter 123B, section 1 a practical one for mentally retarded offenders?

2. What type of specialized programs are needed for mentally retarded offenders. Are current programs adequate to serve mentally retarded offenders who need services in a secure setting?

3. What kinds of services should be made available in correctional settings to offenders with mental retardation?

4. Defining Mental Retardation

The American Association on Mental Retardation (AAMR) describes mental retardation in the following clinical terms:"...significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period."

This definition is consistent with the one set forth in Chapter 123B, section 1:

> "A [mentally retarded person is one] who, as a result of inadequately developed or impaired intelligence, as determined by clinical authorities as described in the regulations of the department is substantially limited in his ability to learn or adapt, as judged by established standards available for the evaluation of a person's ability to function in the community."

The statutory definition authorizes the Department of Mental Retardation to further define the term "mental retardation" by regulation. The Department also has established eligibility requirements to determine whether a particular individual is eligible for its services. Thus, it is possible that a court may determine that a person is "mentally retarded" or has a "mental defect" for purposes of court proceedings under Chapter 123, yet still the person may not be considered "mentally retarded" by DMR or eligible for its services.

The AAMR's clinical definition of mental retardation and its statutory complement have three essential components. First, a mentally retarded person is described as having a "deficit" in intellectual functioning, which is generally measured and defined by standard intelligence tests, but it need not be. Currently, the AAMR recognizes an Intelligence Quotient (I.Q.) score of 70 as an approximate threshold, below which a person may be deemed to have such an intellectual deficit.

However, a person's I.Q. scores alone do not determine his or her mental retardation. A second and equally important component has been termed "impact" (or "functional ability") -- that is, the deficit's effect on the person's functioning. A key consideration is whether the person's intellectual deficit has caused a diminished ability to meet the demands of life, and if so, to what degree. In general, a person with an intellectual deficit can, if given the opportunity and appropriate supports, succeed in leading a life filled with responsibilities as anyone else might. However, persons with the same level of intellectual deficit may be impaired to a very different degree, hence the need for individualized assessments. The severity of retardation has sometimes been described along a continuum of mild to profound mental retardation, roughly defined by intelligence test scores and adaptive functioning. The

American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, (DSM-III-R), provides the following general description of this continuum. The presence of additional physical and mental disabilities may contribute to the diagnosis of a higher degree of mental retardation.

> •**Mild Mental Retardation** (Approximately 50-70 I.Q.) Characteristics: May achieve approximately 6th grade academic skills. Adults have usually acquired social and vocational skills adequate for minimum self-support, but may need assistance when under unusual social or economic stress. Virtually all are able to live independently or semi-independently in the community. (Includes 85 percent of mentally retarded persons).
>
> •**Moderate Mental Retardation** (Approximately 35-55 I.Q.) Characteristics: May learn pre-academic skills such as numbers and the alphabet, and may identify certain "survival words" such as "men", "women," and "stop." May live under supervision in the community or with their families (Includes 3-4 percent of mentally retarded persons).
>
> •**Profound Mental Retardation** (Approximately 25 I.Q. or below) Characteristics: Needs constant aid and supervision in a highly structured setting. May learn very basic self-help skills. Many adults live under supervision in the community or with their families. (Includes 1-2 percent of mentally retarded persons).

Generally, the impact of the intellectual deficit on a person's functioning can be lessened through habilitation.

A third component to the clinical definition requires the deficit to be "developmental" in nature, meaning that it must have begun to appear in childhood, sometime before the person's eighteenth birthday. This component distinguishes mental retardation from other intellectual deficits due to accident such as head injury, or deficits due to conditions such as Alzheimer's disease. There are hundreds of identified causes of mental retardation, of which the most commonly cited are:

1. hereditary disorders;
2. other congenital disorders, including damage to the fetus during pregnancy;
3. prenatal damage;
4. acquired disorders;
5. environmental and behavioral factors, for example, lack of parental stimulation; and,
6. unknown origin.

The above definition differs significantly from the definition for mental illness, defined in the Code of Massachusetts Regulations at 104 C.M.R. § 3.01:

> "A substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but [which does] not include alcoholism as defined in G. L. c. 123, § 35."

Thus, the definition of mental retardation emphasizes intellectual functioning and deficits in adaptive behavior, while the definition of mental illness emphasizes impairment and disorientation of normal behavioral processes.

i. Persons with Dual-Diagnosis

Mental illness may occur in any person, including the mentally retarded. The exact cause of certain behaviors, either by mental illness, or impairment associated with mental retardation, or both, may be difficult to determine. However, under the current statutory scheme of Chapter 123 and Chapter 123B, courts are often called upon to make this distinction.(33)

Some persons who are both mentally retarded and mentally ill are referred to as "dually-diagnosed." A crucial question for a court is often whether the person with dual-diagnosis suffers from a degree of mental illness sufficient to apply those provisions of Chapter 123 which govern the disposition of persons with mental illness.

Dually-diagnosed persons have presented unique legal and programming challenges. In psychiatric hospitals they are not likely to receive the habilitative services needed to prepare them for life outside the institution. They may also require treatment for their mental illness, which a mental retardation facility may be unable to provide. Currently, there are few programs specifically designed to meet the diverse needs of the dually-diagnosed. This expertise is being developed by the Department of Mental Retardation, although progress has been slowed by the need for additional resources.

5. Description of Population

Little data is available regarding mentally retarded persons in houses of correction or state prisons. The Department of Mental Retardation has been gathering data over the past year, in Region I (western Massachusetts, including Berkshire, Franklin, Hampshire, Chicopee, Holyoke, Springfield and the Westfield areas). They identified 85 persons with mental retardation, or with a dual-diagnosis who have had recent court-involvement. This represents approximately 3.3 percent of the entire population with mental retardation in Region I and includes persons charged with crimes encompassing the full range of criminal activity. A total of 177 charges were filed on these 85 mentally retarded persons, approximately 49 percent of which involved alleged crimes against persons.

There is little data currently available regarding mentally retarded offenders in other parts of the state.

6. Current System and Utilization of Services

In July 1987, the Department of Mental Health was divided into two agencies by an act of the legislature. The Department of Mental Retardation was identified as having primary responsibility for persons who are solely-mentally retarded, and those who also are mentally ill. The Department of Mental Retardation provides case management, day programs, family support services, residential, respite care programs, and other services for this population. The Department of Mental Retardation is in the process of creating regional clinical teams which will provide or oversee clinical services for any mentally retarded person in crisis, including the forensic population. The Department of Mental Health will continue to provide forensic evaluation services, emergency psychiatric services, hospitalization for persons with both mental retardation and mental illness, and cooperation with the Department of Mental Retardation in service provision to the persons with mental retardation who are court-involved. The dually-diagnosed population has recently been made subject to an agreement between the two Departments on service delivery and protocol.

The following services are available for the forensic mentally retarded population:

i. Services Available Through the Department of Mental Retardation

The Department of Mental Retardation serves approximately 18,500 individuals with an array of day and residential programs and family support services. Case management services are provided through service coordinators at local service centers, who develop and oversee individual service plans A Department of Mental Retardation staff person in each region has been designated to act as a liaison for court-involved mentally retarded persons.

A clinical team in each region will increase the ability of the community services system to support and maintain court-involved persons with mental retardation and those who are dually-diagnosed in homes and community programs, minimizing the need for DMH inpatient and emergency services. The teams will be composed of clinicians with expertise in both mental retardation and mental illness and will be available 24 hours a day. The teams will provide services in the following areas: a. counseling and referral; b. crisis prevention; c. emergency services; d. staff training; e. medication recommendation; and f. monitoring services for individuals who present behavior problems.

ii. Services Available Through the Department of Mental Health

- Forensic evaluation and assistance to DMR; services are provided to court-involved, mentally retarded persons based on an interagency agreement between DMR and DMH.

- Emergency psychiatric services; 24-hour, seven day a week emergency intervention, which will serve as an entry point to all DMH facilities.

- DMH Community Mental Health Centers.
- Contracts with local mental health clinics and general hospitals.
- Operation of Medfield State Hospital program for court-involved, dually-diagnosed persons.
- DMH outpatient services.
- Inpatient beds for acute care (up to 90 days) for dually-diagnosed persons.

Due to budgetary constraints, a program for dually-diagnosed men at Bridgewater State Hospital will no longer be funded by the Department of Mental Health. It is anticipated that the Department of Correction will continue the program through its own funding.

iii. Legal Mechanisms for Admission of Mentally Retarded Offenders into Programs

Frequently, compliance with the directives of program or placement is an issue with regard to mentally ill or mentally retarded offenders. When a person comes before a court, the judge may not have the power to order participation in a particular program, if the person is solely mentally retarded. Because of the mandate of Chapter 123B, a court possesses this authority only with respect to a person who is solely-mentally ill or dually-diagnosed.

A court may order a person who is solely-mentally ill or dually-diagnosed to:

- be evaluated regarding the person's competency to stand trial or criminal responsibility, or as an aid in sentencing, if the person is a criminal defendant, or has been found guilty of a crime, either:on an outpatient basis, at the court or the place of detention or on an inpatient basis, at a mental health facility or at Bridgewater State Hospital (G.L. c. 123, § 15(a) and (b)).
- be evaluated after the person has been found incompetent to stand trial or not criminally responsible, if the person is a criminal defendant (G.L. c. 123,§ 16(a)).
- be involuntarily committed to a mental health facility for a period of 10 days for observation on a civil basis (G.L. c. 123, § 12 (a) - (e)).
- be involuntarily committed to a mental health facility or to Bridgewater State Hospital, if the person is a criminal defendant or offender, either:
  - * while detained, awaiting trial (G.L. c. 123, § 18(a) - (d));
  - * during an evaluation of his or her competency to stand

trial or criminal responsibility (G.L. c. 123, § 16(b) and (c));

* following a finding by the court of his or her incompetency to stand trial or lack of criminal responsibility (G.L. c. 123, § 16(b) and (c));

* following conviction but prior to sentencing (G.L. c. 123, §15(e)); or,

* while serving a criminal sentence in a place of detention (G.L. c. 123, § 18(a)-(d)).

- be transferred out of a place of detention on an emergency basis for observation, care and treatment, if the person is a criminal defendant or offender and he or she becomes unable to remain in a correctional setting. (G.L. c. 123, § 18(a)). Such transfer can be made to a mental health facility or to Bridgewater State Hospital.

A court may order a person who is solely-mentally retarded to:

- be evaluated regarding the person's competency to stand trial or criminal responsibility, or as an aid in sentencing, if the person is a criminal defendant, either:

  * on an outpatient basis, at the court or the place of detention; or,

  * on an inpatient basis, at a mental health facility or at Bridgewater State Hospital (G.L. c. 123, § 15(a) and (b)).

- be evaluated after the person has been found incompetent to stand trial or not criminally responsible, if the person is a criminal defendant (G.L. c. 123,§ 16(a)).

Thus, except in the case of a forensic evaluation, under Chapter 123 and Chapter 123B, a court may not specifically order a person who is mentally retarded but not mentally ill to participate in or be admitted into any kind of program. If, after a forensic evaluation and a hearing, the court finds an offender is solely-mentally retarded and incompetent to stand trial or not criminally responsible, it may order the offender evaluated for a brief period of time for further evaluation, but afterward its only dispositional option under General Laws Chapter 123 and General Laws Chapter 123B is to order the person discharged. Nor can a court transfer a defendant or offender who is solely-mentally retarded out of a place of detention, if the offender ever becomes unable to remain in a correctional environment due to his/her mental retardation. Similarly, no court can order the admission of a defendant or offender who is mentally retarded, regardless of whether he or she is also mentally ill, into a mental retardation program for evaluation or for any other purpose. Even if the court had this authority, programs serving persons with mental retardation have no legal authority to retain the person if admission were ordered.

In the absence of such legal mechanisms for mentally retarded offenders, courts have sometimes reached to find a mentally retarded person to be mentally ill as well, in order to bring the person under the provisions of G.L.c. 123. Other legal means have also been used, based on the court's authority over the pending criminal charges. For example, courts have continued criminal charges for various lengths of time, conditioned on the person's admission into a mental retardation facility. Continuation of charges has been used in this manner even when arguably the person was presently or permanently incompetent to stand trial. Similarly, if the person is sufficiently high-functioning to be found competent to stand trial and criminally responsible, courts have sentenced such persons to probation, conditioned on the person's admission into or participation in a mental retardation program. In either instance, the court's probation department is given the responsibility to monitor the person's compliance with the court's conditions, a responsibility sometimes reluctantly assumed.

Guardianship proceedings are another legal mechanism to compel participation in mental retardation programs for court-involved persons who are mentally retarded. If appointed and authorized by a probate court after a full due process proceeding, a guardian may be empowered to give consent on the person's behalf to admission and retention in a residential facility, or to give consent to the person's participation in other types of programming. However, a guardian may only be appointed on behalf of a person who has been specifically adjudicated as incompetent to manage his or her own affairs. Thus the mechanism of guardianship is unavailable on behalf of the majority of the population of persons who are mentally retarded and court-involved, since they are generally higher-functioning or only mildly mentally retarded.

7. National and State Models

a. ABA Criminal Justice Mental Health Standards

The American Bar Association has developed guidelines for laws and programs to serve court-involved persons who are mentally retarded, drawing on the experiences of the 50 states. Generally, the ABA's Criminal Justice Mental Health Standards (MHS or ABA Standards) emphasize the identification of persons with mental retardation as early as possible in the criminal justice process and the creation of programs to serve such persons in non-correctional environments.

At the pretrial level, MHS 7.21-7.29 calls for early identification of persons with mental retardation when they first come to the attention of law enforcement personnel. The tendencies of persons with mental retardation to attempt to hide their disability and cooperate fully with authority figures can result in the waiver of significant rights early in the criminal justice process. In such matters as confessions, and the right to consult counsel, law enforcement personnel should receive ongoing training in order to recognize when the waiver of such rights may not be intelligently or knowingly made, and is instead the result of the person's mental retardation.

During trial, the ABA Standards describe how mental retardation may uniquely affect a person's competency to stand trial and/or criminal responsibility, and how criminal proceedings should take this into account. For example, too often at trial the "deficit" component of a person's mental retardation is given exclusive attention, without heed to the level of "impact" the person's functioning has at trial or had at the time of the crime. Thus, a forensic evaluation of a defendant who is mentally retarded may reveal an I.Q. level of 65, which may be deemed "mild retardation", but the impact that such functioning level has on the defendant's ability to participate in his or her defense may be substantial. A statement by an expert witness that the defendant has "...an I.Q. of 65", or even "...an I.Q. within the range of mild retardation", by itself, may cloud the court's consideration of the defendant's competency to stand trial. Following this, the ABA Standards call for improved educative efforts for the benefit of mental health professionals, attorneys and judges regarding the conduct and interpretation of forensic evaluations of persons with mental retardation.

Several positive developments in line with this recommendation are now underway in the Commonwealth. First, a conference focused on the Mentally Retarded Criminal Defendant in Fall, 1989 is being planned and funded by the Department of Mental Retardation, in collaboration with the District Court Department. The audience for this conference will include judges, court personnel, mental health professionals, prosecuting and defense attorneys, and other persons whose responsibilities may affect the course of a defendant with mental retardation through the criminal process. In addition, the Department of Mental Health's Forensic Division recently instituted a program designed to qualify mental health professionals performing forensic evaluations in the courts, which includes testing on the characteristics of mentally retarded persons. Also, the District Court Committee on Mental Health and Mental Retardation has developed detailed educational materials for judges on issues of mental retardation which arise in district court practice.

Following a finding of permanent incompetency to stand trial or an acquittal by reason of mental retardation, the ABA Standards discuss the issue of whether a person with mental retardation who presents issues of dangerousness should be involuntarily committed to a secure residential program. MHS 7-4.13, 7-7.3 describes a special commitment standard for offenders found permanently incompetent to stand trial or acquitted by reason of mental retardation. The offender must be "currently mentally retarded", and, as a result, pose a "substantial risk of serious bodily harm to others". Under the ABA Standards, a person with mental retardation cannot be committed solely because of the mere continuation of his or her mental disability. The ABA Standards provide for a number of procedural due process safeguards similar to civil commitment for mentally ill persons, such as a right to counsel and a right of appeal. However, with a specially-committed mentally retarded person there would be a less frequent periodic review of his or her commitment, and the person would not be able to be discharged without a court order (MHS 7-7.5, 7-7.8, 7-7.9). During such a commitment, the person should have the right to receive habilitative services, based on a similar right for committed mentally ill persons (MHS 7-7.6).

After a finding of competency to stand trial and criminal responsibility, the ABA Standards assert the need for an offender's mental retardation to be considered as a possible mitigating factor in sentencing (MHS 7-9.3). The ABA

Standards propose a system of disposition depending on the severity of a convicted offender's mental retardation (MHS 7-9.10(a), 7-9.7(a)). For a less severely disabled offender, the court should sentence the offender to a correctional facility, where he/she should receive habilitative services for the duration of his/her sentence. For offenders more severely disabled, the Standards recommend that the court commit him/her to a mental retardation facility, "preferably under the supervision of a Department of Mental Retardation or Mental Health" (MHS 7-9.7(b)). Commitment in this case would follow a hearing on a petition from either the prosecutor or the offender, after the court finds by clear and convincing evidence that the offender "requires treatment or habilitation in a mental retardation facility rather than an adult correctional facility" (MHS 7-9.9 (c) and (d)). Under the Standards there would be a right to appeal the commitment decision. The Standards describe a "severely disabled" offender as a person with "very significant subaverage general intellectual functioning existing concurrently with substantial deficits in adaptive behavior." (MHS 7-9.1(b)).

Regarding services for prisoners with mental retardation, the ABA Standards emphasize the need for access to habilitative services in the correctional setting. The Standards also recommend the creation of laws and programming to provide for the transfer of prisoners with mental retardation out of a place of detention and into a mental retardation program. Prior to such a transfer, the Standards describe the need for a hearing to determine the appropriateness of the receiving facility. The Standards provide for the receiving facility to have a role in such a hearing and an interest in assuring that the prisoner can be served at the facility.

b. North Carolina

The North Carolina system emphasizes screening for mental retardation of all prisoners upon admission and the creation of residential programs for mentally retarded offenders. Standardized tests are used in the screening and if a prisoner falls below certain level, the prisoner receives a more individualized assessment. The assessment determines the prisoner's placement in either a specialized mental health/retardation inpatient facility on the prison grounds, or in the general prison population. A prisoner with mental retardation placed in the general prison environment can still receive habilitative and other services on an outpatient basis at the mental health/retardation inpatient facility.

The specialized mental health/retardation inpatient facility on the prison grounds is an intensive intervention program for hard-to-manage prisoners with mental retardation. The facility offers habilitation, education, job training, and other services to prisoners with mental retardation, either on an inpatient or outpatient basis. The prisoner has a right to administratively appeal the inpatient placement. Specially-trained case managers serve those prisoners with mental retardation who are placed in the general prison population.

c. South Carolina

South Carolina has a 32-bed secure mental retardation facility operated by the state's Division of Mental Retardation, located on the grounds of a mental health facility. The program also serves as an evaluation center for offenders with mental retardation, operated in collaboration with the Department of Mental Health.

d. Tennessee

The Tennessee forensic system for offenders with mental retardation is a national model which was created by statute in 1980. The system is administered by the Department of Mental Retardation, in cooperation with law enforcement, courts and the Department of Correction.

The Department of Mental Retardation operates an ACDD-accredited secure facility for male offenders with mental retardation, providing residential care and evaluation services for a maximum of 42 men (both adults and juveniles). The clinical team at the facility performs forensic evaluations and provides recommendations to the courts. An offender found incompetent to stand trial or acquitted by reason of mental retardation can be involuntarily admitted to the facility if he meets the general standard for commitability. The facility also provides some habilitative and job training services for residents, as well as a program to increase the offender's competency to stand trial, if he has been found incompetent by the court.

Members of the facility's clinical team also serve as staff trainers to several developmental centers in other parts of the state which serve persons with mental retardation. The development centers are arranged in three different regions of the state, each having a different capacity for handling persons with mental retardation who present issues of dangerousness. Such persons, who may or may not have previously spent time at the secure facility, may be transferred between the secure facility and the various development centers depending on each person's security needs. Collaboration between the courts, district attorneys, and defense attorneys provides oversight for such transfers.

e. Nebraska

Nebraska has developed an individualized service and placement program designed to provide alternatives to incarceration for non-violent persons with mental retardation.

Individual Justice Plans (IJP's) are set up and overseen through a collaborative interagency effort on behalf of persons with certain characteristics:

1. Mental retardation or other developmental disability.

2. History of primarily non-violent behavior.

3. Contact with, or risk of contact with, the criminal justice system.

As of 1986, 60 IJP's have been developed and implemented through a collaborative effort between Crime and Community, Inc., a non-profit agency, along with state and local representatives of law enforcement, corrections, and social services. A case management team develops the Individual Justice Plans with active participation of the person with mental retardation. Emphasis is on the use of the least-restrictive alternatives to incarceration as early on as possible.

A successful IJP requires linking persons with mental retardation with services in the community, along with supervision by case managers. Specific components of an IJP emphasize how the following factors need to change in order to change the person's inappropriate behavior:

1. Residence
2. Vocational/Employment
3. Educational
4. Social/Recreational
5. Money Management
6. Family (if applicable, how they contribute to the problem/solution)
7. Medical
8. Psychological/Psychiatric
9. Advocacy (i.e., who will assist the person with mental retardation in assuring that his/her needs are met?)
10. Transportation
11. Restitution to Victims (if appropriate, how will the person with mental retardation compensate others whom they have harmed?)

Overriding themes in the development of a mentally retarded person's IJP include:

- Accountability for illegal or inappropriate behavior
- Competency (rebuttable presumption of competence and capability of self-management)
- Due process (some form of opportunity for notice and hearing required where liberty interests are implicated)
- Emphasis on use of least restrictive alternative available
- Normalization
- Adequate control in community as alternative to incarceration.

8. Recommendations

1. Prevent Court Involvement

a. Expand the system of emergency and clinical response teams to reach state-wide to serve persons with mental retardation living at home and in the community.

b. The existing state-wide, intensive case management system should be enhanced to have the capacity to monitor persons with mental retardation who are at risk of court involvement.

c. Increase respite capacity for persons with mental retardation who are living at home or in community residences.

d. Ongoing in-service training in behavior management should be provided for staff in mental retardation programs. Training should also be available to law enforcement staff, judges and court personnel, forensic professionals, and others who come into contact with persons with mental retardation to improve early identification.

e. Collaborative relationships between Department of Mental Retardation regional offices and the DMH regional forensic teams should be strengthened to improve data-gathering and service delivery to persons with mental retardation who are court-involved.

2. <u>Create Appropriate Diversionary Options</u>

a. While awaiting trial, a mentally retarded defendant should receive appropriate services on a voluntary basis.

b. Persons with mental retardation should continue to be evaluated on an outpatient basis regarding competency to stand trial, criminal responsibility, or as an aid in sentencing pursuant to G.L.c. 123, §15(a) and (e).

c. The Department of Mental Retardation should offer consultation to mental health facilities on the needs of persons with mental retardation who may reside there.

d. When an offender with mental retardation is found incompetent to stand trial or not criminally responsible, there should be the option of sending him or her to a program serving the mentally retarded where the offender may be evaluated regarding his or her risk of recidivism or harm to self or others. The offender should then be admitted on a voluntary basis into a specialized program serving the mentally retarded in the least restrictive setting appropriate, based upon the evaluation. The Department of Mental Retardation is beginning to develop specialized residential programs with an intensive supervisory capacity, although progress has been slowed due to limited funding. The Panel calls for the commitment of resources to make such programs available state-wide.

e. When appropriate, courts should grant probation conditioned on the voluntary participation of an offender with mental retardation in a residential or community program designed for behavior management and change.

f. Increased liaison capacity should be established between probation departments and programs serving persons with mental retardation, in order to improve planning for the offender's transition back into the community or a community program.

3. **Develop Services for Incarcerated Offenders with Mental Retardation**

a. Habilitative services should be made available in the county houses of correction and the state prisons for those persons meeting DMR eligibility criteria. Such services, based upon further assessment of needs, might be offered on an outpatient basis, or as an ongoing part of a segregated wing of the correctional facility.

b. When an offender with mental retardation is unable to serve his or her time in a penal environment, he or she should be offered and/or be able to request a transfer out of the correctional facility and into a program serving offenders with mental retardation. Such a transfer request could be made either by the offender or by means of a guardian appointed on his or her behalf, and in effect would be similar to a voluntary admission under General Laws Chapter 123, section 15(b) or 18(b).

c. Increased liaison capacity should be established between the parole board and programs serving persons with mental retardation, in order to improve planning for the offender's transition back into the community or a community program.

4. **Develop Secure Residential Capacity for Persons with Mental Retardation**

a. Secure residential services should be developed for mentally retarded offenders. Guardianship should be considered for those persons who are resistant to voluntary admission, but who present a likelihood of harm to themselves or others, provided that they meet the criteria for appointment of a guardian and would benefit from services offered by the Department of Mental Retardation.

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CHAPTER 5

SUBSTANCE ABUSE REPORT

TABLE OF CONTENTS

I. INTRODUCTION

The Addiction Center at Bridgewater is a Department of Correction facility which houses 450 men who require treatment for alcoholism or drug abuse.

Since the mid-1800's, when the Bridgewater site was known first as the State Almshouse and subsequently as the State Farm, individuals who were sentenced or committed for alcohol abuse have been transferred to Bridgewater. Since at least 1922, drug addicted men have also been committed to the Addiction Center. One hundred and thirty four years later, the Addiction Center continues to house men who admit themselves voluntarily or who are committed by the courts for alcohol or drug treatment. The men at the Addiction Center can be divided into three discrete categories: prisoners, civilly committed patients, and voluntary patients.

The Addiction Center is housed in nine buildings which were constructed between 1890 and 1920. The antiquated physical facility is dilapidated and ill-suited for the patients and staff. The facility is grievously understaffed and severely overcrowded. More than 8,000 admissions and discharges are processed annually, averaging 160 men per week. Admissions are accepted 24 hours a day, 7 days a week. Many are elderly and need specialized nursing care. Most have been admitted numerous times previously. No one is ever refused admission.

The Panel was authorized to study the role of the Addiction Center at MCI-Bridgewater, its appropriateness as a correctional facility, and the treatment needs of Addiction Center patients. The Panel was further asked to review the procedures governing admission into and discharge from the Addiction Center; therefore the Panel also focused on various referral sources including treatment services in other correctional settings, court-based evaluation services, and substance abuse services in the public health system.

II. POLICY QUESTIONS

The Panel sought to respond to the following policy questions:

1. What substance abuse evaluation and treatment services and programs should be available for persons who are subjects of the criminal justice system?

2. What range of services should be available for persons who are civilly committed for substance abuse treatment?

3. What range of substance abuse services should be available for persons who voluntarily seek them?

4. Which agency should be responsible for substance abuse service delivery to:

a. persons who are subject of the criminal justice system;
b. civilly committed persons;
c. voluntarily admitted persons?

III. GOVERNING PRINCIPLES

In formulating its recommendations regarding substance abuse services, the Panel was guided by the following principles:

1. Individuals who require substance abuse evaluation and treatment services in the public sector are entitled to services that are performed competently, that are appropriate to their needs, and that are conducted under safe and dignified conditions.

2. Only persons who are subjects of the criminal justice system should be evaluated or treated in correctional settings. Thus, the public health system should be responsible for providing services to all voluntary and civilly committed persons who are not also subjects of the criminal justice system.

3. The Panel recognizes that one hallmark of substance abuse is the tendency for chemically-dependent persons to deny the existence of their dependency and the destructive effects of that dependency. Thus the Panel believes that treatment must at times proceed under mandated or enforced circumstances.

IV. SUMMARY OF RECOMMENDATIONS

A. THE ADDICTION CENTER

1. The Administration and the Legislature should authorize an immediate infusion of new emergency funds for physical plant improvements and repairs at the Addiction Center.

2. A new site should be developed to serve as the Addiction Center.

3. Department of Public Health contract counseling staff at the Addiction Center should be continued and an additional 18 counselors and a management-level Director of Treatment should be hired.

4. Mental health services should be provided at the Addiction Center.

5. An additional 26 correctional officers should be assigned to the Addiction Center.

6. Additional recreational correctional officers, rehabilitation staff, nurses, and clerks should be provided to the Addiction Center.

7. An Addiction Center Advisory Board consisting of experts in the field of alcohol and drug abuse treatment should be appointed to advise the Superintendent of the Addiction Center in program development and direction.

B. ALTERNATIVE SERVICES FOR ADDICTION CENTER VOLUNTARY PATIENTS

8. The Panel recommends that a 60-bed locked detoxification unit be created under the jurisdiction of the Department of Public Health. The Panel further recommends that Chapter 111B, Section 7 be amended to permit a mandatory 10-day stay in the secure detoxification unit.

9. The Panel recommends that the Department of Public Health should develop 75 chronic-care beds for voluntary patients who require nursing care.

10. The Panel recommends that the Department of Public Health should create seven sober housing units for voluntary patients who require residential care beyond the period of detoxification.

C. SERVICES IN CORRECTIONAL SETTINGS

11. The Panel recommends the development of a three-phase treatment program situated in several Department of Correction settings, which would include education and referral services, counseling services, and several residential programs.

D. ALTERNATIVE SERVICES FOR CIVILLY COMMITTED MEN WHO ARE NOT SUBJECTS OF THE CRIMINAL JUSTICE SYSTEM

12. The Panel recommends the creation of three Department of Public Health 20-bed programs for the treatment of civilly committed men who are not otherwise subjects of the criminal justice system. These new programs should incorporate a capacity for detoxification as part of the treatment process.

13. Once these treatment programs are developed by the Department of Public Health, civil commitments to the Addiction Center should be limited to those men who have outstanding criminal charges or who have been determined to be in violation of conditions of probation or parole. All other civil commitments should be channeled into the new programs. The statute should be amended to reflect this differential disposition.

14. The Panel recommends new statutory provisions which would enable the emergency commitment of persons being held in correctional custody.

15. The Panel recommends new statutory provisions which would enable county and state inmates to apply for voluntary short-term treatment at the Addiction Center.

E. OTHER RECOMMENDATIONS

16. Qualified forensic psychologists should be authorized to conduct evaluations under the provisions of General Laws Chapter 123, section 35.

17. The Panel recommends that General Laws Chapter 111E, sections 10 and 11 be modified to authorize licensed psychologists and social workers to conduct evaluations to determine if a defendant is a drug-dependent person who might benefit from treatment.

V. GENERAL ISSUES

A. PREVALENCE OF SUBSTANCE ABUSE

In its most recent national household survey on substance abuse (1), the U.S. Department of Health and Human Services reported the following nationwide patterns of use of alcohol and controlled substances:

TABLE 1
NATIONAL PATTERNS OF ALCOHOL AND DRUG USAGE FOR PERSONS AGE 12 AND OLDER (1985)

Substance	Used in Lifetime	Used in Past Year	Used in Past Month
Alcohol	86%	75%	59%
Cigarettes	76	36	32
Marijuana	33	15	9
Cocaine	12	6	1
Tranquilizers	8	4	1
Analgesics	7	4	1
Inhalants	7	2	1
Hallucinogens	7	1	--
PCP	3	1	--
Sedative	6	3	1

Alcohol is the most widely used and heavily abused drug.(2) Alcoholism will afflict between three and ten percent of all Americans at some time in their lives.(3) Officials of the Department of Public Health estimate that approximately five percent of the Massachusetts population is in need of inpatient or outpatient treatment for problems related to the abuse of alcohol. The National Institute on Drug Abuse estimates that 400,000 to 600,000 persons in the United States are using controlled substances on a daily basis.(4)

Cocaine use has become a major concern of health professionals and law enforcement officials. Once an expensive drug available only to affluent persons, it has become cheaper and more readily obtainable. Wish (5) found that more than two-thirds of persons arrested for drug-related offenses in East

Harlem had traces of cocaine in their urine, a far higher number than those with traces of heroin. Weiss and Mirin (6) wrote:

> "No drug has attained as much popularity, notoriety, and controversy during the past decade as cocaine....A 1974 survey...revealed that five million Americans had used cocaine at least once. By 1982, that figure had reached 22 million. In 1973, less than 1 percent of university students...admitted to having tried cocaine. [In 1982] 30 percent of the [university] student population had used the drug. A 1985 national survey revealed that 17 percent of American high school seniors had tried cocaine; over one-third of that group had used the drug within the previous month."

The authors reported that, between 1976 and 1985, there was a 900 percent increase in cocaine-related medical emergencies, a 750 percent increase in cocaine-related admissions to drug treatment facilities, and an 1100 percent increase in cocaine-related deaths.

The recent surge in the usage of crack, a cocaine product, is of special concern to care providers and criminal justice officials. A cheap and easily-produced form of cocaine, crack induces a quick and extremely addicting "high."

B. DRUG USE AND ACQUIRED IMMUNE DEFICIENCY SYNDROME

Intravenous drug use is of special concern to care providers and policy planners because of its relationship to the spread of Acquired Immune Deficiency Syndrome (AIDS). The disease can be transmitted when a non-infected person injects himself with a needle that has been used by an infected person.

Intravenous drug users constitute an increasing proportion of the total Massachusetts AIDS population.(7) In 1988, 16 percent of all AIDS cases in the Commonwealth had intravenous drug use identified as the primary risk factor; an additional six percent had intravenous drug use identified as a contributing factor. Officials of the Department of Public Health estimate that 20 percent of the Commonwealth's intravenous drug users (8,000 out of 40,000 persons) are seropositive (i.e., would prove upon blood testing to have been exposed to the virus that causes AIDS).

C. SOCIAL COSTS OF SUBSTANCE ABUSE

One quarter of all adult deaths in America are related to substance abuse.(2) Alcohol and drug use are often cited as causal or contributing factors in traffic fatalities, domestic violence, injuries, decreased labor productivity, child abuse and neglect, prostitution, and serious health problems.

Many studies in recent years have examined the backgrounds of drug users to determine the nature and extent of their criminal involvement and its relationship to their substance abuse.(8,9,10,11,12,13,14,15) There is

substantial evidence of an associational relationship between abuse of controlled substances and crime.

Wexler, Lipton, and Johnson (16) reported that more than three-quarters of the nation's inmates and almost all inmates in New York City report illicit drug use. They further indicate that, in interviews and conversations with street addicts and those in treatment settings, about 60 percent of cocaine users admitted paying for drugs with money derived from illegal sources. The average number of crimes committed by frequent users of heroin was over 200 non-drug offenses as well as hundreds of drug offenses annually. The authors found that heroin users who are not in treatment average over 200 non-drug crimes annually and hundreds of drug related crimes. Inciardi (9) reported that active heroin users commit an average of 248 crime-days (a 24 hour period in which an individual commits one or more crimes) per year when using heroin daily. A 1983 Department of Justice report (17) indicated that prison and jail inmates have a higher incidence of both drug and alcohol problems than the general population. In Massachusetts, at least two-thirds of male state prison inmates and 85 percent of female inmates have a history of substance abuse.(18)

D. TREATMENT ISSUES

People use alcohol and various controlled substances in order to experience a state of intoxication or altered mood that, at least in the short run, is pleasurable. According to experts in the field, excessive use of these substances has been part of the social fabric since the beginning of recorded history. Thus, popular perceptions notwithstanding, it is probably unrealistic to talk about total victory in a "war" against substance abuse. But whether one views chemical dependency as a true primary disease, as a set of learned, maladaptive behaviors, or as a secondary disorder growing out of other psychological, social, or economic problems, there is widespread agreement among experts that the dependency can be controlled with proper treatment.

Treatment is geared toward assisting the individual to make choices in his or her life that will enable him/her to remain drug-free. Treatment for drug and alcohol abusers can be broadly divided into two major categories: pharmacotherapy and psychosocial/psychoeducational therapy.(2,19,20)

Pharmacotherapy (e.g., methadone maintenance treatment) plays a major role in the treatment of heroin addiction and addiction to various other opiate drugs. Pharmacotherapy is currently being explored as a mode of treatment for cocaine addiction, but is not yet a widely accepted practice. Various prescribed medications (e.g., benzodiazepine tranquilizers) are also used to counteract psychological and physical symptoms of withdrawal that occur when use of the target substance is discontinued.

Psychosocial techniques include: individual, group, and family psychotherapy; structured residential therapeutic communities; and community hotlines. Self-help groups for problems in chemical dependency provide a social network free of social pressures to abuse and a crisis response system. Alcoholics Anonymous, founded in 1935, is the best known self-help group.(21) In 1988 it had almost two million members in 63,000 groups in 114 countries.(22) Alcoholics Anonymous is the most common alcoholism

rehabilitation program found in the correctional facilities around the country (23); there are 45,000 members in prisons today.

In an extensive survey of alcohol and drug abuse treatment facilities across the United States in 1984 it was discovered that 73 percent of the facilities provided combined services for both drug abusers and alcoholics.(19) This is indicative of the common treatment needs of both groups and the high frequency of multiple addictions. In 1984 there were more than one-half million patients in the United States reported to be actively in treatment in alcohol and drug abuse rehabilitation facilities (19); eight percent were in an inpatient environment, ten percent were receiving treatment in a residential setting, and the balance were registered as active outpatients.

1. Effectiveness of Treatment

Treatment success for a chemically dependent person depends on the particular abused substance, the degree of addiction, the treatment modality, and the person's motivation to change. Certain substances of abuse have greater inherent addictive qualities. The length of time a person remains in a treatment program is an important indicator of treatment effectiveness.(20) Short retention time (four weeks or less) of a drug abusing offender in a treatment program is strongly related to higher post-treatment involvement in predatory illegal acts(24). Patient characteristics also are predictive of retention in treatment programs and successful rehabilitation.(25,26)

Since substance abusers often resist treatment, coercion has frequently been used to pressure them into treatment. Court commitments serve such a purpose. Porter, Arif, and Curran stated that voluntary enrollment in alcohol and drug treatment programs is required for successful rehabilitation.(27) They stated that the patients' motivation is critical to the effectiveness of any therapeutic modality. In the conclusion of their extensive review of alcohol treatment programs Baekeland, Lundwall, and Kissin also wrote: "Over and over we were impressed with the dominant role the patient, as opposed to the kind of treatment used on him, played both in his persistence in treatment and his eventual outcome."(28) Cohen stated that "prognosis can be directly related to motivation. This is why the highly motivated do well with any type of treatment and those forced into a treatment situation do poorly--unless they can be motivated by the therapist."(29)

Regarding the coercive treatment of heroin dependency, Cohen and Callahan found that the data are inconclusive.(2) They stated that although addiction treatment centers which used civil commitment extensively were strongly criticized, long-term follow-up studies of such programs report impressive rehabilitation rates. Collins and Allison found that "legal pressure does not adversely affect the therapeutic goals of [drug] treatment."(30) Their research focused on 2,276 individuals who entered either outpatient or residential treatment programs in 1979 and 1980. Their conclusion was that "the use of legal threat to pressure individuals into drug treatment is a valid approach for dealing with drug abusers and their undesirable behaviors." Anglin studied the influence of legal coercion in community drug treatment in California.(31) He found that the civil commitment program for drug abusers had an important and dramatic effect on suppressing daily heroin use by narcotics addicts. He concluded that "the results provide a powerful

argument for a general social policy of using (criminal justice system) coercion to bring into treatment as many people as possible by whatever legal means available."

VI. THE ADDICTION CENTER AT MCI-BRIDGEWATER

A. HISTORY

Despite a 40 year history of Department of Public Health responsibility for the provision of public substance abuse services, the Department of Correction's Addiction Center at Bridgewater has served as the cornerstone of secure public sector services.

Services for alcoholics have been provided at the Bridgewater site since 1855 when the institution was known as the Almshouse for Paupers. In 1887, the facility became the State Farm and in its first year received 234 commitments for crimes against public order and decency including tramp, vagabond, drunkenness and escape.

Chapter 535 of the Massachusetts Acts and Resolves of 1922 established the Addiction Center at the Massachusetts State Farm. Similar to the process of commitment of the mentally ill at that time, commitment of drug addicted individuals for up to two years could occur without criminal conviction. Although the State Farm had accepted substance abusers prior to 1922, the statute formalized the commitment process and established a separate division known since as the Addiction Center. The civilly committed could be held for as long as two years while the voluntary admissions had to be released within three days following submission of a discharge request by the patient.

In 1955 the Legislature, acting upon recommendations of the Governor's Committee to Study the Massachusetts Correctional System, enacted various changes in the organizational structure of the Department of Correction. The State Farm in Bridgewater became the Massachusetts Correctional Institution at Bridgewater, and it was divided into three departments: the State Hospital, the Prison Department, and the Defective Delinquent Department.

The Prison Department provided services to men convicted of public drunkenness, civilly committed alcoholics, and men who admitted themselves voluntarily for the treatment of alcoholism. In 1957, there were more than 4,000 annual admissions; approximately 40 percent of the admissions were voluntary. Beginning in 1963, drug addicts were also civilly committed to the Prison Department.

The Prison Department was renamed the Addiction Center in 1968. There was a decline in the number of annual admissions a few years later when laws against public drunkenness were abolished, and by 1972 the average daily population had decreased from 567 in 1966 to approximately 400. The average daily population was consistently between 350 and 400 from 1972 until 1986. More recently the population has been increasing, averaging approximately 425 this year, and reaching a high of 440 earlier this year. In 1978 a health services component was added to the Addiction Center, and since 1980 physicians' services have been provided under a contract with Goldberg

Medical Associates. Beginning in 1987, a small supplementary counseling staff was contracted with funds provided by the Department of Public Health.

B. DESCRIPTION OF CURRENT SYSTEM

Today, the Addiction Center is a 450 bed Department of Correction facility for the treatment of substance abuse. The estimated annual operating budget for the Addiction Center for Fiscal Year 1989, including funds for contract services, was $4.8 million. This translates to a rate of $30.58 per bed per day or $11,163 per bed per year, a rate substantially below that of other Department of Correction facilities, which average approximately $20,000 per bed per year.

The facility's nine buildings were constructed between the years of 1890 and 1920. Three of the buildings are non-secure, situated beyond the perimeter fence. These buildings have a combined capacity of 38 beds and house long-term voluntary patients. Within the perimeter fences, approximately 400 patients are housed in 16 individual rooms and 13 wards. The wards house between 14 and 65 men, with the average ward containing 33 beds.

1. Staffing

a. Security Staff

The Addiction Center is currently funded for 68 security staff, which include: 2 Captains, 4 Lieutenants, 11 Sergeants, and 51 Correction Officers. Approximately one quarter of the budgeted personnel are unavailable for deployment at any given time due to long-term disability or industrial accident. As a result, deployment of security staff follows the following pattern:

	MAXIMUM COVERAGE	AVERAGE COVERAGE
Day Shift	17	15
Evening Shift	13	11
Night Shift	8	7

Thus on the night shift, after coverage is arranged for perimeter security and other permanent posts, it is not uncommon for there to be one correction officer to monitor the 13 sleeping areas for the entire population of 400 patients.

b. Counseling Staff

Until recently, a staff of seven provided all counselling services at the Addiction Center.

At present there are six Correctional Counselors and eight counselors hired by two private vendors through contracts with the Department of Public Health. Each of the fourteen counselors carry an average caseload of 30 patients and each will process more than 600 admissions and 600 discharges annually.

c. Psychiatric and Mental Health Staffing

The Addiction Center does not provide any psychiatric or other mental health coverage for its patients. When an emergency arises (e.g., when a patient becomes psychotic or appears to present a likelihood of suicidal behavior) he is transported for outpatient evaluation at the Department of Mental Health clinic in Brockton by security staff.

d. Medical Staff

Nurses. Nurses occupy 11 full-time equivalent positions at the Addiction Center. The number of nurses working on an average day are: four on the day shift; three in the evening; and one on the night shift. The nurse on the night shift is also responsible for coverage for the Treatment Center for Sexually Dangerous Persons.

e. Physicians

The five institutions at the Bridgewater complex contract for physicians' services with a vendor. The Addiction Center budget includes funding for 1.25 full-time equivalent physicians. Through a pooled arrangement with the other facilities at the complex, there is a physician available at all times. There is also one person working in a full-time position as a physician's assistant.

f. Clerical and Recreational Staff

The ten counselors are supported by one full-time clerk. There are no backup or temporary clerical services available when that clerk is ill or on vacation. There is one Recreation Officer at the Addiction Center.

2. Patient Population

The Addiction Center receives men from four population groups.

a. Court-Committed Civil Patients

Civilly committed patients have been committed to the Addiction Center by district courts under the provisions of General Laws Chapter 123, section 35. Each civilly committed patient has been found by a court to be an alcoholic or a drug abuser, and to be a person for whom the failure to commit would create a likelihood of serious harm to himself or others. The statute permits commitment for 30 days.

The civilly committed population constitutes a steadily-increasing percentage of Addiction Center admissions. Although the Section 35 commitment process is civil in nature, the majority of patients admitted to the Addiction Center through this process are subjects of outstanding criminal charges and are returned to the referring courts at the expiration of commitment.

b. Voluntary Prisoners

Though there is no legal authority allowing for a court to sentence a person to the Addiction Center, correctional inmates or detainees may request court assignment to the Addiction Center for treatment of drug dependency. A patient in this category may remain at the Addiction Center for a maximum of 18 months. Recently, the Addiction Center started a 21 bed unit for parole violators from MCI-Concord who have been identified as having a history of substance abuse or who have been returned to prison because of substance abuse. Negotiations with the Parole Board are ongoing to arrange for an early release date for those parole violators who successfully complete the treatment program.

c. Detoxification Transfers

Patients are sent to the Addiction Center from state and county correctional facilities for a brief period of medically-supervised detoxification.

d. Voluntary Civil Patients

Under the provisions of General Laws Chapter 111B, section 7, an individual may request voluntary admission to the Addiction Center. In contrast to other public-sector voluntary patients, Addiction Center voluntary patients are required to stay for ten days after they sign into the facility.

In its 1987 report entitled "The Bridgewater Correctional Complex," the Senate Committee on Ways and Means stated:

> "[T]oday the Addiction Center tends to be a place of last resort for the homeless. Thus, the Addiction Center has virtually become a homeless shelter that takes in the spill over population from the Pine Street Inn and other homeless shelters throughout the Commonwealth."

Historically, the vast majority of men present on any given day at the Addiction Center have been voluntary patients. Although they still constitute the greatest number of Addiction Center admissions, fewer beds have been available for them as the size of the civilly committed population has increased.

C. UTILIZATION OF CURRENT SYSTEM

Utilization of the Addiction Center in recent years has been characterized by: (a) a steady and marked increase in the number of men civilly committed under Chapter 123, section 35; (b) a steady increase in requests for admission of voluntary prisoners; (c) a concomitant decrease in services available for voluntary patients; (d) an increase in the number of patients admitted with a diagnosis other than alcohol abuse (e.g., drug abuse or poly-substance abuse); and (e) a trend toward a younger, more aggressive population.

Tables 2 through 8 below contain summary information regarding recent trends in admissions to the Addiction Center.

TABLE 2
AVERAGE MONTHLY ADMISSIONS

GROUP	1982	1985	1988	1989 (Through - March)
Voluntary	529	638	550	392
Civil Commitments	6	22	91	126
Prisoner/ Detox	6	6	39	59
TOTAL	**541**	**666**	**680**	**577**

TABLE 3
PERCENTAGE OF TOTAL ANNUAN ADMISSION

GROUP	1982	1985	1988	1989 (Through - March)
Voluntary	98	96	81	68
Civil Commitments	1	3	13	22
Prisoner/ Detox	1	1	6	10
TOTAL	**100**	**100**	**100**	**100**

TABLE 4
SNAPSHOT CENSUS FIGURES: NUMBER OF PATIENTS

GROUP	5/1/88	5/1/89
Voluntary	302	174
Civil Commitments	59	168
Prisoner/ Detox	39	76
TOTAL	**400**	**418**

TABLE 5
SNAPSHOT CENSUS FIGURES: PERCENTAGE OF PATIENTS

GROUP	5/1/86	5/1/87	5/1/88	5/1/89
Voluntary	95 (est.)	90 (est.)	76	42
Civil Commitments	3 (est.)	5 (est.)	15	40
Prisoner/ Detox	2 (est.)	5 (est.)	9	18
TOTAL	100	100	100	100

TABLE 6
ANNUAL ADMISSIONS FROM PINE STREET INN

Year	Number	Weekly Average
1982	5473	105
1983	5292	102
1984	5005	96
1985	5031	97
1986	4235	81
1987	4385	84
1988	1950	38
1989	419	25 (Jan.-April)

TABLE 7
PRIMARY ADDICTION OF PATIENTS ADMITTED TO ADDICTION CENTER

Year	Alcohol (%)	Drug (%)
1980	99	1
1981	98	2
1982	97	3
1983	96	4
1984	94	6
1985	90	10
1986	85	15
1987	62	38
1988	55	45

TABLE 8
REPEAT ADMISSIONS AND NEW ADMISSIONS TO THE ADDICTION CENTER

Year	Repeat (%)	New (%)
1980	94	6
1981	92	8
1982	90	10
1983	90	10
1984	88	12
1985	82	18
1986	80	20
1987	77	23

1. Civilly-Committed Patients

a. Admission Trends

As Tables 2 through 5 demonstrate, the steady increase in admissions of civil commitments is striking. The 1989 admission rate (through April 1) represents a twenty-fold increase over the 1982 rate, and the trend shows no signs of abating. This trend would appear to have several causes:

(1) In 1987, the Legislature amended General Laws Chapter 123, section 35 to include drug addicts, thus widening the population pool from which Addiction Center civilly committed patients are drawn.

(2) The courts are becoming increasingly familiar with the provisions and procedures of the civil commitment statute. Whereas in 1980 only a handful of district courts committed men to the Addiction Center under that section, last year virtually every court did so.

(3) Anecdotal evidence suggests that an undetermined number of Section 35 admissions come as the third step in a circular sequence of events: (a) there is a steady increase in all Section 35 referrals, and the Addiction Center is legally obligated to admit all such referrals; (b) there is a corresponding decrease in bed space available for voluntary admissions; and (c) certain men who would have been admitted voluntarily in years past are now being brought into court by advocates who use Section 35 to gain guaranteed access to a bed at the Addiction Center. This in turn further restricts the amount of space available for voluntary patients.

(4) The shortage of detoxification beds in the Department of Public Health system puts pressure on the courts to use civil commitments for guaranteed access to Department of Correction detoxification beds at the Addiction Center.

b. Patient Characteristics

The following data were compiled on the 88 men who were at the Addiction Center as civil commitments on December 13, 1988. However, it is notable that the Addiction Center's civilly committed population has nearly

doubled in less than five months since then; as of May 1, 1989, there were 168 civilly-committed men.

On December 13, 1988, 40 percent of the civilly committed patients then at the Addiction Center were seen as being addicted only to alcohol. The rest were seen as drug or drug and alcohol addicted. Over 80 percent of the Section 35 patients were unemployed. The average age was 33 years.

More than three-quarters of these "civil commitments" had pending criminal charges. Thus, although Section 35 is a civil commitment statute, it is most often used with men who are already before the courts on criminal matters. With rare exception, men committed to the Addiction Center under Section 35 remain there for the entire allowable 30-day period.

c. Programming

Treatment for civilly committed patients consists of mandatory participation in one hour of group counseling per day and optional meetings of Alcoholics Anonymous and Narcotics Anonymous.

Other than intake interviews (the average length of which is 45 minutes) and discharge interviews (the average length of which is 15 minutes), there is no built-in provision for individual counseling or program planning. Although staff indicate that such individual counseling could perhaps be provided if it were requested, the civilly committed men tend to have a high level of denial regarding their addictions and the destructive impact of those addictions, and thus do not actively seek assistance. Absent from the Addiction Center treatment program for these men, then, is the staff-intensive effort to counter that resistance that one finds in the Commonwealth's civil commitment program for women at the Massachusetts Osteopathic Hospital.

Addiction Center staff estimate that between five and ten percent of the civilly committed patients are recommitted at the end of the 30-day commitment period.

2. Voluntary Prisoners

a. Admission Trends

As Tables 2 through 5 demonstrate, there has been an increase in admissions of voluntary prisoners that is as steady as, though less striking than, the increase in Section 35 admissions. The rate of increase would be much higher, however, if the Department of Correction had not placed a census cap of 75 on this population. Moreover, an additional 21 parole violators from MCI-Concord have recently begun a new treatment program at the Addiction Center.

At present there is a waiting list of more than 200 county prisoners seeking admission under the provisions of Chapter 111E, section 11, and several pre-trial drug dependent men seeking admission under section 10 of that chapter.

b. Patient Characteristics

The following data were compiled on the 77 drug dependent men who were living at the Addiction Center under the provisions of Chapter 111 on December 13, 1988.

Four of the men were admitted on pre-trial status under Chapter 111E, Section 10. One patient was receiving inpatient treatment as a condition of probation under the provisions of Section 12 of that chapter. The rest of this population consisted of sentenced prisoners admitted under the provisions of Section 11 of Chapter 111E; these prisoners came from six Commonwealth houses of correction. The average sentence being served was 14 months. The length of stay for the average Section 11 patient is approximately seven months. The average age of the Chapter 111E patients was 29 years.

c. Programming

Members of this population attend group counseling and mandatory meetings of either Alcoholics Anonymous or Narcotics Anonymous. A handful of Chapter 111E patients seek and receive individual counseling as well.

3. Voluntary Civil Patients

a. Admission Trends

Historically, voluntary civil patients admitted under the provisions of Chapter 111B, Section 7 have constituted the majority of admissions to the Addiction Center. As the tables on previous pages show, however, the rise in admission rates of other population groups has resulted in a precipitous decline in the space available for voluntary civil patients. On a recent day, there were 174 voluntary civil patients at the Addiction Center, compared to 302 such patients one year earlier.

Officially, it remains the position of Addiction Center officials that all voluntary civil patients in need of treatment will be admitted. With the decrease in available space, however, informal efforts have been made to screen or to limit admissions. For example, fewer weekly trips of the van which transports voluntary admissions from the Pine Street Inn to the Addiction Center are authorized.

b. Patient Characteristics

The following data were compiled on the 226 voluntary civil patients who were at the Addiction Center on December 13, 1988. However, it should be noted that, in less than five months since then, this population has decreased 23 percent; as of May 1, 1989, there were 174 such patients.

On December 13, 1988, 96 of the voluntary civil patients were unemployed. Seventy-eight percent of the voluntary patients were homeless. Their average age was 46 years.

Members of this population make frequent use of the 10-day mandatory detoxification provided by Chapter 111B. On December 13, 1988, each of the 226 voluntary civil patients had an average of 44 previous admissions to the Addiction Center. Thus, Table 8 provides additional evidence of the decreasing admissions of voluntary civil patients. Between 1980 and 1988, the number of admissions of men who had never been to the Addiction Center before increased from six percent of all admissions to 30 percent.

Between 60 and 70 of the voluntary patients currently at the Addiction Center are seen as chronic, homeless patients; some of these men have been at the Addiction Center for over 10 years. Another large sub-population consists of men who admit themselves several times per year, essentially using the Addiction Center as a home base between periodic binges in the community.

c. Programming

Occasionally, a member of the voluntary civil population will join one of the counseling groups being provided to committed patients or voluntary prisoners. With the dramatic increase in these other populations, however, there is less room in the counseling groups for the voluntary civil patients. Many men in this group make frequent use of Alcoholics Anonymous. None of them at present receive regular individual counseling.

D. GAPS AND DEFICIENCIES IN THE SYSTEM

In 1987, the Senate Committee on Ways and Means expressed concern about the conditions at MCI-Bridgewater in general, and at the Addiction Center specifically:

> "Throughout its history, MCI-Bridgewater has provided a reflection of deficiencies in the Commonwealth's policies regarding public health, corrections, juvenile justice, mental health, social services, and forensic services. A study of MCI-Bridgewater's population is a study of those who have been excluded by the dominant elements of our social policy. In the nineteenth century they were vagrants, paupers, and tramps; today they are the severely disturbed mentally ill, alcoholics, and the homeless. Each population and sub- population at the Bridgewater complex is a graphic reminder of the flaws in our broader system of criminal justice and human services."
>
> "...[T]he Department of Correction and the staff of MCI-Bridgewater have been expected to cope with an unworkable challenge. Perhaps the best illustration of this point is the fact that in 1987, in a state with a well-deserved reputation for progressive social policy, thousands of homeless individuals per year routinely "check themselves in" to a prison operated within the most severely overcrowded correctional system in America."

The Governor's Special Advisory Panel echoes the Senate Committee's concern.

Many Addiction Center patients spend almost all of their time in sedentary, unsupervised inactivity. The physical plant is in need of substantial repair. Plumbing is inadequate, walls are crumbling, and certain wards have been closed because of health and safety considerations, including leaking roofs and falling ceilings, resulting in an exacerbation of the severe overcrowding. Adequate fire-detection devices are absent in several patient areas. On one ward, 65 men, many of them elderly and disoriented, share two toilets that are in view of the entire ward.

There are serious shortages of staff. At times only one correction officer and one nurse are available on the night shift to monitor patient areas. A small counseling staff, with the support of only one clerical person, must administer more than 8,300 cases per year. There is no psychiatric or other mental health coverage, even though many Addiction Center patients have documented histories of mental illness and suicidal behavior.

The Panel has learned that patients are used to help meet the institution's clerical needs, and that members of the prisoner population have been asked to function as leaders of treatment groups for the civilly committed population. Until recent roof repairs had begun, on rainy nights one patient would volunteer to stay awake at night emptying buckets from leaking ceilings in exchange for a quieter room in which to sleep during the day. Most alarming is the fact that, patients are often pressed into service, especially at night, to monitor the well-being of other patients.

The Panel deplores the current conditions at the Addiction Center. The institution is seriously understaffed. The physical plant is outmoded and in disrepair. The Panel believes that the resources currently available to the patients at the Addiction Center are grossly inadequate. These conditions guarantee that, in spite of the efforts of a conscientious and compassionate staff, little meaningful treatment can occur. For the Addiction Center programs to operate at an acceptable level of competence, and for the protection of the safety of patients and staff, there must be an immediate infusion of funds for emergency repairs, and a commitment to provide additional clinical and correctional personnel.

The above remarks should in no way be read as an indictment against the Addiction Center staff. Indeed, the Panel is impressed by the compassion shown to patients by the Addiction Center's administrative, treatment, and security personnel. But expertise and good intentions are not enough to run an adequate treatment program. Without sufficient resources, the Addiction Center will continue to be little more than a shelter.

Recent efforts on the part of the Administration to provide short and long-term improvements in the physical plant and increases in treatment staff are noteworthy. The Secretary of Human Services has directed the reallocation of funds from the Departments of Mental Health, Public Health and Welfare in order to hire 12 to 15 additional staff. Additionally, roof repairs have begun, and furniture and equipment funds were recently allocated to the facility. Finally, $409,000 in expansion funds have been appropriated for six month funding for increased medical care at the Addiction Center at the request of the Governor. Though these efforts are commendable, the

Addiction Center continues to require a major infusion of capital and staff resources in the short-term and a long-term reevaluation of the adequacy of the current physical facility.

The Panel believes that, with sufficient capital improvements in the short-term, a new site in the long-term and staff augmentation, the Addiction Center can become an effective treatment center for men in the criminal justice system. By reason of history and lack of viable alternatives, however the Addiction Center has been asked to do more than that. It is estimated that approximately one-quarter of the civilly committed patients to the Addiction Center or approximately 50 patients at any one time are men who have not been accused of committing any crime. Thus, if current admission trends continue, as many as 400 court commitments this calendar year may involve men who are not subjects of the criminal justice system.

The problem of housing civilly committed individuals who are not criminally involved in a Department of Correction facility has been recognized by the administration. A 1988 proposal by the Governor to move civilly committed patients from the Addiction Center to a specially staffed Department of Public Health facility was not approved by the legislature. The Panel recommends a renewed effort to transfer responsibility for civilly committed men who are not also subjects of the criminal justice system to the Department of Public Health. This transfer of responsibility would alleviate overcrowding at the Addiction Center, and would be consistent with the administration's goal of removing civilly committed populations from correctional facilities.

Historically, the vast majority of men residing at the Addiction Center on any given day have been voluntary, non-committed men who are not subjects of the criminal justice system. Most of these men are chronic homeless alcoholics with numerous previous admissions to the Addiction Center. Many are elderly and require long-term nursing care. Although fewer beds have been available for these men since court commitments began to increase substantially, they still represent the largest single segment of the Addiction Center population. The Panel believes that these men, all of whom have voluntarily requested admission into a substance abuse treatment program, are clearly within the population that the Department of Public Health is mandated to serve. Massachusetts is the only state in the country that permits the practice of admitting voluntary persons to a correctional treatment facility who are not subjects of the criminal justice system.

Many of these voluntary admissions involve late-stage alcoholics. Due to advanced liver disease and central nervous system deterioration, late-stage alcoholics require a longer period of detoxification; they get sicker more quickly and recover less quickly than earlier-stage alcoholics. They may require higher doses of medication during the detoxification process.

Earlier-stage alcoholics may only require three to five days of detoxification. Care providers are familiar with the phenomenon of late-stage alcoholics who, at the end of such a period, drink just enough to get re-admitted for a second detoxification (often on the same day the first one ended) in order to finish the detoxification process. They are sometimes perceived as "abusing the system." From another perspective, they are being resourceful

in order to get adequate treatment from a system that is geared toward treating persons who have not progressed as far in their alcoholism.

Even when voluntary detoxification is available to these men for longer than five days, many late-stage alcoholics experience so much physical discomfort during detoxification that they discontinue treatment in order to cure the withdrawal discomfort by drinking. Thus many voluntary civil patients seek admission to the Addiction Center because they realize they need an enforced ten-day period of detoxification. They choose the Addiction Center because it is the only site in the Commonwealth that requires them to make a ten-day pledge to treatment as a condition of admission.

The Panel finds that the Addiction Center has, for years, served an extremely important purpose as the sole provider in the Commonwealth of secure or mandatory detoxification services for men. However, the Panel believes that a correctional facility is an entirely inappropriate setting for men who seek detoxification services voluntarily. The Panel, therefore, recommends that the Department of Public Health assume total responsibility for providing services to this population of men who voluntarily seek detoxification and treatment services.

VII. OTHER DEPARTMENT OF CORRECTION SETTINGS

A. RESIDENTIAL PROGRAMS

The Department of Correction operates two substance abuse programs that employ a modified therapeutic community model. A 30-bed program is situated at Old Colony Correctional Center in Bridgewater, and a 50-bed program is in place at North Central Correctional Institution in Gardner.

The units are separate from others within the two facilities and the beds are reserved exclusively for program participants. All treatment groups and activities occur within the unit structures. Qualified substance abuse counselors provided by a contract vendor are responsible for the clinical aspects of the program. Department personnel, including a unit manager, correction officers, and case management staff, provide security, classification services, urinalysis testing, and rule enforcement.

The treatment model in the two therapeutic communities consists of three phases over a 90-day cycle. Treatment activities occur throughout the day and evening hours, six days per week. Treatment programs are routinely supplemented by mandatory participation in a self-help group (either Alcoholics Anonymous or Narcotics Anonymous). The programs require total abstinence from drugs and alcohol by participants. A positive urinalysis test results in immediate removal from the program; prisoners may reapply for admission after 30 days.

B. LONGWOOD TREATMENT CENTER

The Longwood Treatment Center is a 125-bed facility which houses 109 male and 16 female offenders. It serves county offenders whose governing sentences fall under the Commonwealth's driving-while-intoxicated statute. It provides comprehensive substance abuse treatment services, including

education, individual and group counseling, and self-help groups, and is viewed as a model treatment program.

C. OTHER SERVICES

Through vendor contracts, the Department of Correction provides various services to a limited number of inmates at MCI-Cedar Junction and MCI-Shirley. The Division of Psychological Services provides group counseling on issues of substance abuse in several Department of Correction facilities. Inmates at all Department of Correction facilities have access to self-help groups such as Alcoholics Anonymous and Narcotics Anonymous; however, the Panel has learned that waiting lists exist for these programs at some facilities.

VIII. THE DEPARTMENT OF PUBLIC HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES

A. HISTORY

1. Alcohol Treatment Services

Since 1869, the Massachusetts Department of Public Health has been responsible for the regulation and provision of services in various areas, including contagious diseases, air pollution, and fluoridation of drinking water. The Department's powers and duties are set forth in General Laws Chapter 111, section 5.

In 1950, the Legislature authorized the Department of Public Health to establish hospital and clinic programs for the diagnosis, treatment, and rehabilitation of alcoholics. In response, the Department established the Division of Alcoholism. The Division of Alcoholism concentrated its initial efforts on the development of outpatient programs. The 1956 creation of the independent Office of the Commissioner on Alcoholism expanded the Commonwealth's approach to alcoholism. The Office concentrated on researching treatment methods and initiating education programs. The Office also undertook responsibility for coordinating the work of all of the Commonwealth's agencies involved with alcoholism. These two agencies continued their separate functions for approximately three years. In 1959, the Massachusetts legislature combined the Office's powers with those of the Division of Alcoholism. Correspondingly, the Division of Alcoholism's mandate expanded to include research and education programs.

The next significant legislative change occurred in 1971, with the enactment of a comprehensive alcoholism law, General Laws Chapter 111B, the Alcoholism Treatment and Rehabilitation Act. The Massachusetts legislature passed this law in response to the Congressional enactment of the Comprehensive Alcohol Abuse and Alcohol Prevention, Treatment, and Rehabilitation Act of 1970. The Congressional act provided federal assistance for alcohol abuse programs in states that adopted the act's main provisions.

The Congressional act reflected society's steady movement toward viewing alcohol abuse as a disease or a disorder, rather than as a crime, a sign of moral turpitude, or a simple failure of will. It prescribed a comprehensive

program for the treatment and rehabilitation of alcoholics and intoxicated persons and contained a mandate for each state Division of Alcoholism to create standards for the operation of such programs. It explicitly stated that no services are to be delivered in correctional facilities, except to prison inmates.

The Massachusetts legislation did the following: (a) it defined alcoholism as a medically diagnosable disease; (b) it abolished the crime of public intoxication; (c) it permitted the creation of detoxification and other facilities; (d) it strengthened the Division on Alcoholism's powers as the primary agency to achieve a comprehensive and coordinated program to treat and rehabilitate alcoholics and to prevent alcoholism; and (e) it provided for licensing and regulation of alcoholism treatment facilities.

In 1974 the Legislature focused on treatment programs for persons convicted of driving under the influence of alcohol (DUI). Chapter 647 of the Acts of 1974 established alternatives to incarceration for DUI offenders. Convicted "first-offenders" may participate in an outpatient education program and, if necessary, an alcoholism treatment program in lieu of serving a prison sentence. The Division of Alcoholism, the Registrar of Motor Vehicles, and the Secretary of Public Safety received combined responsibility for administering these programs. The 1987 Safe Roads Act permitted courts to sentence offenders convicted for the second time of drunk driving to a 14-day inpatient alcoholism treatment program administered by the Division of Alcoholism. In return for full compliance with court conditions, the offenders receive two years of probation in lieu of incarceration.

2. Drug Rehabilitation Services

In 1969 the Legislature created a Division of Drug Rehabilitation within the Department of the Attorney General. One year later a Division of Drug Rehabilitation was created within the Department of Mental Health.

In 1982 the Department of Public Health assumed control of the Division of Drug Rehabilitation. This legislation required the Division to develop a comprehensive network of prevention and treatment programs including educational programs, emergency treatment, inpatient and outpatient services, residential treatment programs, and treatment programs within prisons. The 1982 legislation also gave the Division of Drug Rehabilitation responsibility for licensing and regulating treatment service providers. The legislation specified due process rights of patients and reimbursement provisions.

3. Consolidation of Alcohol and Drug Divisions into the Division of Substance Abuse Services

Since the Division of Drug Rehabilitation's transfer to the Department of Public Health, that Division and the Division of Alcoholism have cooperated on several jointly funded projects to assist people addicted to both alcohol and drugs. The success of that cooperation has encouraged the Department to consolidate these two Divisions.

This consolidation stems from three observations. First, alcoholics and drug addicts have similar treatment needs. Second, the increasing population of "dually addicted" persons requires that Department providers be familiar with both problems. Third, the joint projects have demonstrated the economic efficiency of merging the divisions.

Administrative merger efforts began in 1986 with the consolidation of personnel and the training of staff for new responsibilities. To finalize the consolidation, the Department of Public Health has drafted and filed in the Legislature a bill combining Chapter 111B (Division of Alcoholism) and Chapter 111E (Division of Drug Rehabilitation) to create the Division of Substance Abuse Services. The bill retains elements of the current chapters while eliminating duplicative or unnecessary sections. The bill also clarifies Department authority to license treatment service providers and simplifies current reporting requirements. Not considered in 1988, the bill is still pending in the Legislature.

B. DEPARTMENT OF PUBLIC HEALTH SUBSTANCE ABUSE PROGRAMS - DESCRIPTION OF CURRENT SERVICES

The following services are available on a voluntary basis to all Massachusetts residents.

1. Residential Services

a. Emergency Treatment

i. Detoxification Programs. The Department of Public Health funds 19 detoxification programs in the Commonwealth. These programs provide settings for medically-supervised withdrawal from drugs and alcohol. The average completed stay (i.e., disregarding persons who drop out of treatment) in these programs for persons withdrawing from alcohol is approximately six days. For persons withdrawing from other substances, the average completed stay is approximately 17 days.

ii. Transitional Care. The Department funds four residential settings for persons who, having undergone detoxification, are awaiting admission to longer term residential care. The average completed stay in these programs is approximately 25 days.

b. Rehabilitative Treatment

i. Short-Term Intensive Treatment Programs (STIT). The Department funds three programs that provide post-detoxification rehabilitative services lasting between two and four weeks. These services include counseling and aftercare planning. The average completed stay in these programs is approximately 22 days.

ii. Recovery Homes. The Department funds 49 intermediate length (three to six month) residential rehabilitation programs. The programs provide counseling, development of daily living skills, vocational re-entry services, and aftercare planning. The average completed stay in these programs is approximately five months.

iii. **Residential Drug-Free Programs.** The Department funds 15 long-term (six to 18 months) residential programs, commonly called Therapeutic Communities for clients who require extended services. The average completed stay in these programs is approximately eight and one-half months.

iv. **Youth Residential Treatment Programs.** The Department funds seven short-term alcohol and drug treatment programs for adolescents. The programs provide comprehensive assessment; individual, group, and family counseling; educational and pre-vocational services; and aftercare planning. The average completed stay in these programs is approximately five months.

v. **DUI Programs.** The Department funds three 14-day programs for persons convicted twice within six months of driving under the influence of an intoxicating substance. These programs provide a structured educational and motivational alternative to imprisonment.

2. Ambulatory Services

a. Counseling Services

i. **Outpatient Counseling Programs.** The Department funds outpatient counseling programs at 77 sites across the Commonwealth.

ii. **Methadone Services.** The Department funds 11 opiate substitution services, of which two are mobile and provide service in multiple settings.

iii. **Non-Traditional Services.** The Department funds 24 programs that provide services such as crisis intervention, case finding, and home visits.

iv. **Criminal Justice Programs.** The Department funds referral services for inmates in 10 county-based criminal justice settings.

v. **Early Intervention Services.** The Department funds a variety of first offender driver education programs and youth intervention services at its outpatient sites.

C. UTILIZATION OF DEPARTMENT OF PUBLIC HEALTH PROGRAMS

Department of Public Health data shows that 73% of their admissions are male, 68% are unemployed, 53% are without health insurance and 25% are intravenous (IV) drug users. The average dropout rate for programs is 30%. The average program user is 30 years of age.

The following figures were provided by the Department of Public Health regarding admissions to their programs for the last six months of 1988.

TABLE 9
AVERAGE MONTHLY ACTIVITY (JULY - DECEMBER, 1988)

Program Type	Admissions	Available Beds
Detox	2548	476
Transitional Care	132	100
STIT	84	80
Recovery	368	1162
Long-term Residential	94	323
Youth Residential	37	150
DUI Programs: First Offense	1371	n.a.
DUI Programs: Second Offense	321	n.a.
Outpatient Counseling	1770	n.a.
Methadone	218	n.a.
Criminal Justice	89	n.a.

IX. COURT-BASED EVALUATIONS

The structure of the Department of Mental Health's system of court-based evaluation services is described in the Forensic Mental Health report. As is indicated in that section, 62 of the Commonwealth's 69 district courts; 13 ofthe 14 Superior Courts; Juvenile Courts in Suffolk, Bristol, and Hampden counties; and the Boston Municipal Court have Department of Mental Health Forensic Mental Health Team personnel available to them. The remaining district and superior courts generally rely on community-based Department of Mental Health services for emergency evaluations.

Courts serve as important entry points into the substance abuse treatment service system. Judicial decisions and clinical recommendations made at this level have profound implications regarding the services a person receives and the timeliness with which he or she receives them. Entry into the substance abuse treatment system from the courts occurs in several ways.

A. CIVIL COMMITMENT

As was described earlier, judges appoint qualified physicians to evaluate subjects of petitions for commitment under General Laws Chapter 123, Section 35. If the subject is found to be a substance abuser whose substance abuse creates the likelihood of harm, he or she may be committed for treatment for up to 30 days.

B. DETERMINATION OF DRUG DEPENDENCY AND NEED FOR TREATMENT

A judge may order an evaluation under General Laws Chapter 111E, Section 10 to help determine whether a criminal defendant is a drug dependent person who can benefit from treatment.

Following such an examination, the court determines whether the person should be given the option of being assigned to mandated treatment while the criminal proceedings are stayed. If a defendant is determined to be a drug dependent person who might benefit from treatment, the court retains authority to monitor the person's participation in a treatment program.

Under the provisions of this statute, a criminal defendant in a drug-related case must be given the option of requesting the court to determine whether he or she is a drug dependent person who might benefit from treatment. The court may then order an examination of the defendant by a psychiatrist. Since there is no statutory requirement that the examiner offer testimony or be subject to cross-examination, these evaluations may be conducted away from the courthouse, and a written report from the examiner may suffice.

C. POST-TRIAL EVALUATION OF SUBSTANCE ABUSE TREATMENT NEEDS

1. Aid-in-Sentencing Evaluation

Subsequent to a guilty finding, but prior to imposition of a criminal sentence, a judge may order an outpatient clinical evaluation under General Laws Chapter 123, Section 15(e) as an aid to the court in sentencing. Assessment of substance abuse treatment needs is often an explicit or implicit aspect of such an evaluation.

2. Probation Pre-Sentencing Evaluation

Subsequent to a guilty finding, but prior to imposition of a criminal sentence, a judge may order a probation officer to conduct a pre-sentencing evaluation. The probation officer may request a clinical examination to assist with that process.

3. Evaluation as a Condition of Probation

A judge may place a person on probation without requesting a formal aid-in-sentencing evaluation and may order, as a condition of probation, that the person be assessed regarding his or her need for substance abuse treatment.

4. Probation Officer's Referral

A person who has already been placed on probation may be referred by his or her probation officer for a clinical evaluation of treatment needs. If the evaluation reveals a need for treatment, the probation officer may ask the court to modify the conditions of probation to include mandated treatment.

X. APPROACHES FROM OTHER STATES

A. USE OF CORRECTIONAL FACILITIES FOR TREATMENT OF CIVILLY- COMMITTED PATIENTS

Massachusetts is one of eleven states with statutes that permit the use of civil commitment to correctional facilities for the treatment of people who have no involvement with the criminal justice system. However, as the following table indicates, only Massachusetts has a civil commitment statute which allows ongoing civil treatment of substance abuse in a correctional setting.

TABLE 11
USE OF PRISONS FOR PEOPLE NOT INVOLVED WITH CRIMINAL JUSTICE SYSTEM

State	Purpose	Statute
Alabama	Quarantine Persons Who Refuse Treatment for Tuberculosis	Ala. Code §22-11A-10
Alaska	"Dry Out" Persons Incapacitated by Alcohol	Alaska Stat. §47.37.170b
California	Drug Rehabilitation	Cal. Welf. & 1 §.100
Idaho	House and Treat "Dangerous and Mentally Ill" Persons	Idaho Code §66-1304e,-1305
Iowa	House and Treat "Dangerous" Mental Patients	Iowa Code Ann. §218.92
Massachusetts	Alcohol or Drug Rehabilitation	M.G.L. ch.123,§35 (civil), ch.111B (voluntary)
	Commitment and Retention of "Dangerous" Mentally Ill Persons	M.G.L. ch. 123, §§7-8
Mississippi	Quarantine Persons Who Refuse Treatment for Tuberculosis	Miss. Code Ann. §41-33-3
New Hampshire	Involuntarily Treat Mentally Ill Persons When Appropriate	N.H. Rev. Stat. Ann. §135-C:20 et.seq.
North Carolina	Quarantine Persons Who Refuse Treatment for Venereal Disease or Tuberculosis	N.C. Gen. Stat. §130A-26b
North Dakota	Isolate and Treat Persons Suffering from Venereal Disease When No Other Facility Available	N.D. Cent. Code §23-07-09(3)
Vermont	"Dry Out' Persons Incapacitated by Alcohol	Vt. Stat. Ann. tit. 18, §9144d

Only four states, Alaska, California, Massachusetts, and Vermont, permit civil commitment to correctional facilities for the treatment of substance abuse. More important, only California and Massachusetts permit more than a brief "drying out" commitment, and only Massachusetts permits the use of a correctional setting for the civil commitment of alcoholics.

In California, the duration of the civil commitment for a drug addict cannot exceed one year; the person may be released any time prior to the 12 month maximum. The Director of Corrections may recommend discharge of an addict who has successfully completed six consecutive months of treatment. The Director may however recommend an earlier discharge.

XI. RECOMMENDATIONS

Consistent with the Governing Principles set forth earlier in this report, the Panel believes that the Addiction Center, as a Department of Correction facility, should provide services only to those chemically dependent men who are subjects of the criminal justice system. In this chapter, the Panel recommends additional staff and capital improvements at the Addiction Center as a short-term response to inadequate conditions, and the siting of a new Addiction Center facility as a long-term solution.

The Panel further finds that two populations currently receiving services at the Addiction Center should instead be served in Department of Public Health facilities. These populations are (1) voluntary civil patients, and (2) those civilly-committed patients who are not subjects of the criminal justice system. Therefore, the Panel recommends the development of additional programs within the Department of Public Health to provide services for these populations.

A. THE ADDICTION CENTER

1. The Administration and the Legislature should authorize an immediate infusion of emergency funds for physical plant improvements and repairs at the Addiction Center.

Due to an aging and dilapidated physical facility, approximately 425 men are being held at the Addiction Center in sub-standard living conditions. The Panel believes it is unacceptable for the Commonwealth to continue holding persons at the Addiction Center unless immediate steps are taken to upgrade the conditions under which they are housed and treated.

The Panel commends the recent allocation of additional funds for capital improvements and staffing increases. However expenditures in the areas of safety, plumbing repairs and other repairs are immediately needed to enable and Addiction Center to upgrade the physical facility.

Significant safety improvements are needed including a hard-wire smoke and fire detection system, an emergency lighting system, and a closed circuit monitoring system. Plumbing repairs of toilets, urinals and showers are also greatly needed. Funds have already been approved for re-roofing of two patient areas; once that work is completed, sheet rock and plastering will

be needed. Painting, electrical improvements, and miscellaneous repairs are also required.

2. A new site should be developed to serve as the Addiction Center.

Despite limited resources and an aging and delapidated physical facility, officials of the Department of Correction and MCI-Bridgewater have made admirable efforts to create a clean and safe environment for Addiction Center patients and staff. Implementation of the Panel's recommendations for emergency capital improvements will contribute significantly to that effort. However, the Panel believes that appropriate long-term solutions to the Addiction Center's problems must include a re-siting of the institution, either on the grounds of MCI-Bridgewater or elsewhere. Existing unused state buildings should be explored for their feasibility as a new Addiction Center site.

No significant new construction has occurred at the Addiction Center since 1920. The buildings are antiquated and uncomfortable. Basic repair work is a continuing problem, and keeping the facility clean is difficult. There are insufficient numbers of lavatories, showers, treatment rooms, and recreational spaces. The provision of security is hindered by the size and configuration of the rooms. There is little if any privacy for most patients since many of the units house up to 65 men in large open rooms.

The Panel is cognizant of the current overcrowding in state and county correctional facilities, as well as the fiscal constraints militating against construction of new state facilities. However, it is the Panel's view that the existing Addiction Center will never be ideally suited to serve as a secure treatment facility, and that it should be re-sited as soon as such an effort could be undertaken.

3. Department of Public Health contract counseling staff at the Addiction Center should be continued and an additional 18 counselors and a management-level Director of Treatment should be hired at the Addiction Center.

The recent hiring of seven counselors resulted in a current staffing level of 14 counselors at the Addiction Center. Six of the counselors are Department of Correction state employees, and eight are contract employees funded by the Department of Public Health.

Even with an increased staff of 14 counselors, each is responsible for an average of 30 patients. The Panel finds this ratio of patients-to-staff to be unacceptably high. At current staffing levels, each counselor will process an average of 600 admissions and 600 discharges in the next year, in addition to his or her treatment responsibilities.

The Panel proposes the hiring of a minimum of an additional 18 counselors. The Panel believes that this is the minimum number of new staff needed to provide adequate coverage.

The proposed expansion of the counseling staff will create a patient/counselor ratio of approximately 13:1. With a staff this size, weekend

and evening coverage of admissions and discharges could be more easily arranged. However, it should be noted that with 18 new counselors, the new patient/counselor ratio would still fall far short of the ratio at the Department of Correction's Longwood Treatment Program, which is viewed as a model for the provision of these services. Each counselor will still process an average of 260 admissions and 260 discharges per year under the proposed conditions. To bring the patient/counselor ratio to that of the Longwood program, a minimum of 35 new counselors would need to be hired.

The Panel further recommends that a management-level position be created within the Department of Correction for a permanent Director of Treatment at the Addiction Center. The position should be filled by a licensed social worker, or other Master's-level health care professional, who has a background in treatment, management, and program development.

4. Mental health services should be provided at the Addiction Center.

Professionals from the fields of mental health and substance abuse recognize that many chemically dependent persons suffer from diagnosable mental illnesses. Hundreds of Addiction Center admissions each year involve patients who have a history of treatment for long-standing and serious mental disorders. In spite of this, there is no psychiatric or other mental health staffing at the Addiction Center.

The Panel believes an interdisciplinary team of mental health professionals should be placed at the Addiction Center. The mental health team would have assessment, treatment, and referral responsibilities for Addiction Center patients who suffer from diagnosable mental illnesses and chronic mental disorders. Existence of the mental health team would provide for early identification of patients who need emergency treatment, either at the Addiction Center or in another setting. Early intervention would decrease the need to transport patients to outpatient settings for these services. The mental health team would have primary responsibility for assessing patients' suicidality, and for prescribing appropriate treatment and management in that area. The team would also be responsible for linking detoxified, mentally ill Addiction Center patients with Department of Mental Health treatment programs.

The Panel envisions a mental health team comprised of the following number of (F.T.E.) full-time equivalent positions:

Discipline	F.T.E.
Psychiatry	.5
Psychology	1.0
Social Work	2.0
TOTAL	**3.5**

5. **An additional 26 correctional officers should be assigned to the Addiction Center.**

The population mix at the Addiction Center has been marked by a steady increase in the percentage of patients who are involved in the criminal justice system and who have histories of acting violently.

Furthermore, the Panel believes that the Addiction Center in the future should house only those patients who are subjects of the criminal justice system, with the Department of Public Health assuming sole responsibility for voluntary patients and for men committed under Chapter 123, section 35 who are not criminally-involved. Thus, it is evident that the current level of security staffing, already noted to be insufficient, will be even less sufficient in the future.

The Panel envisions the following configuration and cost for the proposed additional security staff:

Rank	F.T.E
Captain	2
Lieutenant	3
Sergeant	4
Officer I	17
TOTAL	26

6. **Additional recreational correctional officers, rehabilitation staff, nurses, and clerks should be provided to the Addiction Center.**

The Panel believes that the following configuration of new positions will help remediate the staffing deficiencies at the Addiction Center.

Position	F.T.E.
Nursing	11
Recreational Officers	2
Clerk III	4
Occupational Therapists	3
Vocational/Rehabilitation Counselors	2
TOTAL	22

7. **An Addiction Center Advisory Board consisting of experts in the field of alcohol and drug abuse treatment should be appointed to advise the Superintendent of the Addiction Center in program development and direction.**

The Panel recommends the appointment of an Addiction Center Advisory Board. The Board should consist of experts in the treatment of alcohol and drug abuse and in the development and administration of substance abuse treatment programs from the private and public sectors. The Advisory Board should meet regularly and should be available to the

Superintendent of the Addiction Center and the Commissioner of Correction to advise them on program development and direction.

B. ALTERNATIVE SERVICES FOR ADDICTION CENTER VOLUNTARY PATIENTS

The Panel believes that the Department of Public Health should assume sole responsibility for the public-sector treatment of persons who are not involved with the criminal justice system. The voluntary patients at the Addiction Center clearly fall in this category. A second group is the civilly committed men who are not otherwise subjects of the criminal justice system.

Certainly, no transfer of responsibility for either population should be made until appropriate resources are made available to accommodate them. In order to facilitate transfer of the voluntary population to the Department of Public Health, the Panel offers below several recommendations which have been developed in conjunction with representatives of that Department.

It is important to note that, with the significant increase in the civilly committed population, a de facto transfer of the voluntary population--without the provision of alternative services--is already taking place.

8. The Panel recommends that a 60-bed locked detoxification unit be created under the jurisdiction of the Department of Public Health. The Panel further recommends that General Laws Chapter 111B, section 7 be amended to permit a mandatory 10-day stay in the secure detoxification unit.

The Department of Public Health estimates that 60 beds would be needed to meet the detoxification needs of the Addiction Center voluntary population.

The Panel believes that the men who enter the Addiction Center voluntarily are drawn there by three factors: (1) the Addiction Center personnel are highly dedicated to the patient population; (2) the mandatory 10-day stay appeals to many homeless, chronic men who recognize a need to surrender their liberty for several days in order to force themselves into detoxification; (3) the size of the Addiction Center population provides an atmosphere of anonymity and low-pressure treatment.

Regarding the above three factors, the Panel notes the following: (1) With appropriate expansion funding, the Department of Public Health will be able to replicate the atmosphere of concern and caring; and (2) The statutory modification proposed above will enable the Department of Public Health to provide the period of enforced voluntary treatment that currently makes the Addiction Center an attractive option for many of the voluntary patients.

Operational funds for the Secure Detoxification Unit should be sufficient to provide for adequate staffing and equipment to maintain a secure environment.

9. The Panel recommends that the Department of Public Health develop 75 chronic-care beds for voluntary patients who require nursing care.

As many as 75 of the voluntary patients at the Addiction Center require long-term nursing care. These are primarily older men with physical disabilities or organic brain damage. Younger homeless men suffering from AIDS also require nursing care.

10. The Panel recommends that the Department of Public Health create seven sober housing units for voluntary patients who require residential care beyond the period of detoxification.

Many homeless voluntary patients remain at the Addiction Center beyond the mandatory 10 day detoxification period. For these men, the Addiction Center provides longer-term residential care and sober housing.

The most appropriate alternative to the Addiction Center for this segment of its voluntary population is an alcohol and drug free housing program that emphasizes peer support and case management. The Panel recommends that seven 25-bed houses be added to the public health system to meet the care and treatment needs of these men.

The least costly and most effective way to create sober housing is the use of project-based Chapter 707 rental subsidies. The Panel recommends the funding and allocation of 200 subsidies for the Department of Public Health for single adult sober housing.

C. SERVICES IN CORRECTIONAL SETTINGS

11. The Panel recommends the development of a three-phase treatment program situated in several Department of Correction settings, which would include education and referral services, counseling services, and several residential programs.

There is an ever increasing number of state prison inmates who manifest problems related to substance abuse. Treatment availability in correctional settings has not kept pace with the growing need for services. As a first step toward addressing this problem, the Panel recommends the creation of a three-phase program, which was developed with representatives of the Department of Correction.

a. Phase One

Under the Panel's proposal, two full-time qualified substance abuse counselors would be based at MCI-Concord. These counselors would provide a one-week program of education and referral services for all inmates being processed through the Department's reception center. The counselors would provide information about the deleterious effects of alcohol and drugs and about available Department based programs. Approximately 20 inmates could be enrolled into each one-week program.

b. Phase Two

Under the Panel's proposal, three two-person teams of qualified substance abuse counselors would be hired. Each team would provide counseling programs at several Department settings. Teams might be assigned to facilities as follows:

Team I (North):
MCI-Shirley
NCCI-Gardner
MCI-Lancaster
Northeastern Correctional Center

Team II (Central):
MCI-Norfolk
MCI-Cedar Junction
Bay State Correctional Center

Team III (South):
MCI-Plymouth
Southeastern Correctional Center
Old Colony Correctional Center

c. Phase Three

Under the Panel's proposal, three new 50 bed residential substance abuse programs would be created. These programs would be similar in scope and structure to the residential programs already in operation at Old Colony Correction Center and NCCI-Gardner.

D. ALTERNATIVE SERVICES FOR CIVILLY COMMITTED MEN WHO ARE NOT SUBJECTS OF THE CRIMINAL JUSTICE SYSTEM

12. The Panel recommends the creation of five Department of Public Health 20-bed programs for the treatment of civilly committed men who are not otherwise subjects of the criminal justice system. These new programs should incorporate a capacity for detoxification as part of the treatment process.

13. Once these Section 35 treatment programs are developed by the Department of Public Health, civil commitments to the Addiction Center should be limited to those men who have outstanding criminal charges or who have been determined to be in violation of conditions of probation or parole. All other civil commitments should be channeled into the new programs. The statute should be amended to reflect this differential disposition.

As we have reported, the rate of Addiction Center civil commitments under Section 35 has increased exponentially during recent years. The proposal for five 20-bed units is based on the assumption that the rate of

increase will soon peak, and that the adoption of the Panel's proposals from previous sections will result in the diversion of more persons into voluntary programs in the public health system.

The Panel envisions units similar in structure to that of the Department of Public Health program for women at the Massachusetts Osteopathic Hospital, with an increased commitment to provide secure conditions. It is advisable for the proposed new units to include a capacity for detoxification in addition to treatment services under secure conditions.

Given the involuntary nature of civil commitments, it is reasonable to expect that more intensive treatment is needed to contend with the resistance this population typically manifests to acknowledging their chemical dependency. Additionally, given that each civilly committed patient has been found by a court to pose the likelihood of harm to himself or others, the need for providing intensive and secure treatment is clear.

14. The Panel recommends new statutory provisions which would enable the emergency commitment for detoxification and substance abuse treatment of persons being held in correctional custody.

New statutory language would provide an analogue to the civil commitment procedure for persons in places of detention. A model statute is presented later in this report; its structure and wording is similar to that of General Laws Chapter 123, section 18(a), the statute which authorizes the transfer of mentally ill inmates or detainees to Bridgewater State Hospital or a mental health facility.

15. The Panel recommends new statutory provisions which would enable county and state inmates to apply for voluntary short-term treatment at the Addiction Center.

This statute would enable those county and state inmates who do not currently qualify for admission under Chapter 111E to gain access to treatment services at the Addiction Center.

E. OTHER RECOMMENDATIONS

16. Qualified forensic psychologists should be authorized to conduct evaluations under the provisions of General Laws Chapter 123, section 35.

Licensed psychologists in Massachusetts are not restricted from diagnosing and treating persons with substance abuse problems. Licensed psychologists commonly receive third-party payment for such services, and they commonly report to courts regarding the substance abuse treatment needs of defendants and probationers.

In 1985, Chapter 123 was amended to the Department of Mental Health to designate certain licensed psychologists as qualified forensic psychologists. Once so designated, a qualified forensic psychologist may conduct evaluations under the provisions of sections 15, 16, 18, and 19 of Chapter 123. In 1988 the

statute was further amended to enable qualified forensic psychologists to conduct evaluations under the provisions of Chapter 123, section 12(e).

The Department of Mental Health has implemented a qualifying procedure for licensed psychologists who wish to be designated as qualified forensic psychologists. The course of training includes individualized qualifying plans, a series of lectures, a mentoring and supervision process, a body of required readings, a comprehensive written examination, site visits to several Commonwealth facilities, and a regular review of subsequent work.

The Panel recommends that qualified forensic psychologists be authorized to conduct Section 35 evaluations. The Panel believes this will result in more timely and higher quality evaluations, and fewer unwarranted admissions to the Addiction Center. Since there are more court-based qualified forensic psychologists than psychiatrists, there will be a substantial decrease in the money now being paid out of the Department of Mental Health budget to vendors for consultant psychiatrists.

House Bill Number 75, which would enact this change, is currently pending in the Legislature. The Panel endorses passage of this bill.

17. The Panel recommends that General Laws Chapter 111E, sections 10 and 11 be modified to authorize licensed psychologists and social workers to conduct evaluations to determine if a defendant is a drug dependent person who might benefit from treatment.

At present, a judge may request evaluations of drug dependence only from a psychiatrist or, in the absence of a psychiatrist, another physician. The Panel believes the statute should be amended to allow judges a broader range of services with which they might avail themselves. The Panel notes that licensed psychologists and social workers in Massachusetts are not restricted from diagnosing and treating persons with substance abuse problems. Licensed psychologists and social workers commonly receive third-party payment for such services, and they commonly report to courts regarding the substance abuse treatment needs of defendants and probationers. Finally, since more licensed psychologists and social workers work in court clinics throughout the Commonwealth, these evaluations will be less costly and more accessible to the courts.

APPENDIX A

BUDGETARY IMPLICATIONS

The Panel estimates that it will cost approximately $11.7 to $13.7 million to implement its immediate, short-term and long-term recommendations. This estimate does not include the cost of siting and renovating or building a new Addiction Center facility because of the speculative nature of this type of projection. The costs can be divided into the following categories:

Immediate Needs

Addiction Center Capital Improvements	$ 355,000	
Sub-Total, Immediate Needs		**$ 385,000**

Short-Term Recommendations

Addiction Center staff	$ 2,467,500	
Addiction Center equipment and materials	75,000	
Department of Public Health programs	6,234,000*	
Department of Correction programs	900,000	
Sub-Total, Short-Term Recommendations		**$ 9,676,500**

Long-Term Recommendations

Department of Public Health Programs	$ 3,650,000	
Sub-Total, Long-Term Recommendations		**$ 3,650,000**
TOTAL		**$13,711,500**

*Estimate can be reduced by $2 million if DPH receives rental subsidies for sober housing beds.

The following paragraphs represent an itemization of this estimate.

A. IMMEDIATE NEEDS: ADDICTION CENTER CAPITAL IMPROVEMENTS

The Panel recommends that $385,000 be provided for the following emergency expenditures to improve safety and sanitation at the Addiction Center:

Smoke/fire detection system	$ 75,000
Emergency lighting system	25,000
Closed-circuit monitoring system	60,000
Plumbing repairs	150,000
Sheetrock and plaster	25,000
Painting, electrical, misc.	50,000

B. SHORT-TERM RECOMMENDATIONS

1. Addiction Center Staff

The Panel recommends an expenditure of $2,467,500 for additional Addiction Center staff. The Panel recommends that up to $945,000 be provided for up to 35 additional counselors. The Panel recommends that $40,000 be provided for a management-level Director of Treatment. The Panel recommends that $180,000 be provided for the following mental health professionals:

Discipline	F.T.E.	Annual Cost
Psychiatry	.5	$50,000
Psychology	1.0	$50,000
Social Work	2.0	$80,000

The Panel recommends that $673,000 be provided for 26 additional correctional officers:

Rank	F.T.E.	Annual Cost
Captain	2	$ 68,000
Lieutenant	3	$ 93,000
Sergeant	4	$118,000
Officer I	17	$394,000

The Panel recommends that $629,000 be provided for the following additional recreational correctional officers, nurses, clerks, and for new rehabilitation staff:

Position	F.T.E.	Annual Cost
Nursing	11	$360,000
Recreational Officer	2	50,000
Clerk III	4	77,000
Occupational Therapist	3	90,000
Vocational/ rehabilitation counselor	2	52,000

2. Addiction Center equipment and materials

The Panel recommends that $75,000 in capital funds be provided for the office equipment, assessment tools, and other materials for the proposed new mental health and rehabilitation staff.

3. Department of Public Health programs

The Panel recommends that $3.2 million be provided for the creation of a 60-bed Secure Detoxification Unit. This figure represents a daily cost of $150 per bed.

The Panel recommends that $794,000 be provided for the creation of 75 chronic-care beds, in one or two units, in existing, underutilized state space. This figure represents a daily cost of $29 per bed.

The Panel recommends that $2.24 million be provided for the creation of seven 25-bed sober housing units. This figure represents a daily cost of $38 per bed. The cost of sober housing could be reduced to $200,000 per year for case management plus the cost of 200 rental subsidies. The subsidy plus case management cost is less than $20 per day.

4. Department of Correction programs

The Panel recommends that $900,000 in expansion funds be provided for the three-phase treatment program, described earlier in this report, to be sited in several Department of Correction settings:

Phase One	$ 75,000
Phase Two	225,000
Phase Three:	
MCI-Norfolk	300,000
MCI-Shirely	150,000
SECC	150,000

C. LONG-TERM RECOMMENDATIONS: DEPARTMENT OF PUBLIC HEALTH PROGRAMS

The Panel recommends that $3.65 million be provided for the creation of five 20-bed programs for the treatment of non-criminally involved, court-committed men under the provisions of General Laws Chapter 123, Section 35. This figure represents a daily cost of $100 per bed.

APPENDIX B

GOVERNING STATUTES

The following statutes govern the provision of public-sector substance abuse evaluation and treatment services.

COURT-ORDERED COMMITMENTS: CRIMINAL

Chapter 111E, Section 10

Under the provisions of this statute, a defendant charged with a drug offense may request a judge to find him or her to be a drug dependent person who would benefit from treatment. The judge may order an examination by a psychiatrist to assist in this determination.

After determining that a defendant would benefit from treatment, the judge may assign the offender to a treatment facility. The judge must order the requested assignment if the offender has no outstanding continuances and is charged for the first time for a drug offense that does not involve selling or manufacturing an illegal substance.

The judge may place the offender on probation until treatment is available. The judge may suspend further proceedings for the duration of the assignment. The assignment cannot exceed 18 months, or the maximum possible sentence, whichever is shorter.

During the assignment the treatment facility may transfer the offender to outpatient status. The facility may also transfer the offender back to inpatient status, notifying the court of the change. Every three months the offender may ask the court for a transfer to outpatient status or for a complete discharge from treatment.

Throughout the assignment, the facility provides quarterly reports to the court. At the assignment's termination, either by discharge or premature discontinuation of treatment, the facility must notify the court.

If the offender completes the assignment, the judge must dismiss the pending charges. If the offender has not successfully completed treatment, the judge has the discretion to dismiss or to reinstate the charges and proceedings.

Chapter 111E, Section 11

This statute enables a drug dependent person convicted of a non-drug related offense to receive treatment while incarcerated. To be eligible, prior to sentencing the offender must admit drug dependency and request an examination by a psychiatrist.

If the psychiatrist's report states that the offender is drug dependent and would benefit from treatment, the judge may order the receiving facility

to provide treatment. When the offender no longer benefits from treatment, the prison administrator may terminate treatment.

Chapter 111E, Section 12

This statute permits the judge to impose urinalysis testing and treatment for drug dependence as conditions of probation. The judge may order the offender to receive inpatient or outpatient treatment, at the Commonwealth's expense, for a period not to exceed the period of probation. Breach of probation may occur if the offender disobeys probation conditions or does not cooperate with the facility administrator or probation officer.

Chapter 127, Section 97

This statute permits the Commissioner of the Department of Correction to transfer prisoners among the various correctional facilities in Massachusetts. Transferred prisoners maintain their original sentences.

Chapter 90, Section 24

In Massachusetts, there is a mandatory 14-day sentence for any person convicted twice, within a six year period, of driving while intoxicated. Under the provisions of the governing statute, a judge may place such a person on probation with the condition that he or she complete a 14-day inpatient treatment program.

Any person convicted three times, within a six year period, of driving while intoxicated must serve a minimum sentence of 90 days "in a correctional facility specifically designated by the department of correction for the incarceration and rehabilitation of drinking drivers."

COURT-ORDERED COMMITMENTS: CIVIL

Chapter 123, Section 35

This statute authorizes the involuntary 30-day commitment of persons who abuse alcohol or other substances. Although the commitment itself is civil, the statute is frequently used to commit male criminal defendants to the Addiction Center at MCI-Bridgewater. (As is described in the Female Offenders section of the Panel's report, this statute is also used to commit women, including those who are not subjects of the criminal justice system, to MCI-Framingham).

In contrast to the procedures discussed in the above section, the need for treatment is not, in itself, sufficient grounds for involuntary commitment under Chapter 123, section 35. There must also be a judicial finding that the failure to commit would result in a likelihood of harm as defined in Chapter 123, section 1.

A police officer, physician, spouse, blood relative, guardian, or court official may petition a district court judge for the commitment of a person. Upon receipt of the petition, the judge must immediately schedule a hearing and summon the subject of the petition to the hearing. If the person fails or is

unlikely to appear at the hearing, the judge may issue a warrant for the person's arrest and immediate presence before the court.

When the subject appears before the court, the judge must order an examination by a psychiatrist. Following the examination, there is an adversarial hearing. The subject has the right to counsel, to present evidence, and to cross-examine the psychiatrist.

If the judge finds that the person is an alcoholic or drug abuser and that he or she presents a likelihood of serious harm to himself or herself or others, the judge may order the person committed to inpatient treatment for a maximum of 30 days. The treatment may take place at any treatment facility licensed by the Massachusetts Department of Public Health. If there is no such suitable facility, the person may be committed to MCI-Bridgewater, if male, or MCI-Framingham, if female, providing that the person is housed and treated separately from the prisoners.

The receiving facility may release the person before the thirty day commitment period if the release will not present a likelihood of serious harm. The facility must release the person after thirty days. The statute mandates that the person be encouraged to consent voluntarily to further treatment at the facility.

VOLUNTARY PERSONS

Chapter 111B, Section 7

This statute outlines the procedures to be followed for voluntary admission of an intoxicated person to a detoxification facility licensed by the Department of Public Health. Upon receiving the request, physician supervised personnel must examine the person. If the facility cannot provide treatment, the facility administrator must refer the person to an appropriate detoxification facility. If the person has no funds to pay for treatment, the administrator must arrange for the person to be transported home or to a shelter.

According to the statute, a person may remain at the facility for as long as he or she wishes, or until the administrator determines that he or she will no longer benefit from treatment. An intoxicated person may not be required to remain for more than 48 hours. However, this time limit does not apply to voluntary patients at the Addiction Center, where the required stay is ten days.

Chapter 111B, Section 8

This statute governs the placement of an intoxicated person in police custody. A police officer may assist an incapacitated person home, to a police station, or to a treatment facility, without the person's consent.

If assisted to the police station, the person may request a breathalyzer test. If the test results indicate that the person has a minimum blood alcohol content of ten percent, the police must place that person in protective custody at the police station or transfer the person to a detoxification facility. If the test results indicate a blood alcohol content between five and ten percent, the police may administer speech or coordination tests to determine whether the person needs protective custody. A blood alcohol content less than five percent results in immediate release.

The police officer must attempt to place the intoxicated person at a detoxification facility. If no facility is available, the police officer may keep the person at the station for a maximum of 12 hours.

Although placed in protective custody at the police station or a detoxification facility, the intoxicated person is not arrested or charged with a crime.

Chapter 111E, Section 8

This statute outlines admissions procedures for drug detoxification facilities upon a person's voluntary request for admission. A physician must examine the person to determine drug dependency. Based on the physician's report and the person's past treatment record, the facility director determines whether the facility should admit the person. The director must give a person refused treatment written reasons for the refusal. The director determines whether the admitted person receives inpatient or outpatient treatment. After being informed of the recommended treatment and period of treatment, the person must consent in writing to admission to the facility. A person originally assigned to outpatient treatment must consent in writing to a transfer to inpatient treatment. The person may terminate treatment at any time.

APPENDIX C

STATUTORY IMPLICATIONS OF THE PANEL'S RECOMMENDATIONS

Several statutory changes will be required to implement the Panel's recommendations in the area of public-sector substance abuse services.

AMENDMENTS TO CHAPTER 123, SECTION 35

The Panel has drafted a model amended version of Chapter 123, section 35. Its primary features include the following:

(1) It includes qualified psychologists as examiners, a change proposed in House Bill Number 75, which is currently pending in the legislature.

(2) It mandates that persons who are not subjects of the criminal justice system shall not be committed to any correctional facility for substance abuse treatment.

(3) By enabling any person to petition for the commitment of a person for substance abuse treatment, while allowing discretion on the part of the courts regarding whether to schedule a hearing, the statute brings the petitioning process into line with the one existing in General Laws Chapter 123, section 12(e), the emergency mental health commitment statute.

(4) It provides a mechanism for changing a Section 35 commitment procedure into a Section 12(e) commitment procedure in the event that a presumed substance abuser is found, instead, to need psychiatric hospitalization.

Proposed Amended Version of Chapter 123, Section 35: Commitment of Alcoholics or Substance Abusers

For the purposes of this section, "alcoholic" shall mean a person who chronically or habitually consumes alcoholic beverages to the extent that: (1) such use substantially injures his health or substantially interferes with his social or economic functioning, or (2) he has lost the power of self-control over the use of such beverages.

For the purposes of this section, "substance abuser" shall mean a person who chronically or habitually consumes or ingests controlled substances to the extent that: (1) such use substantially injures his health or substantially interferes with his social or economic functioning, or (2) he has lost the power of self-control over the use of such substances.

Any person may make petition in writing to a district court for an order of commitment of a person whom he has reason to believe is an alcoholic or substance abuser. After considering the written petition and hearing such evidence as he may consider sufficient, a district court justice may schedule a hearing on the petition. If such a hearing is scheduled, the court shall cause a summons and a copy of the application to be served upon the person in the manner provided by section twenty-five of chapter two hundred and seventy-

six. In the event of the person's failure to appear at the time summoned, the court may issue a warrant for the person's arrest.

Upon presentation of such a petition, if there are reasonable grounds to believe that such person will not appear and that any further delay in the proceedings would present an immediate danger to the physical well-being of the respondent, said court may issue a warrant for the apprehension and appearance of such person before it. No arrest shall be made on such warrant unless the person may be presented immediately before a judge of the district court. The person shall have the right to be represented by legal counsel and may present independent expert or other testimony. If the court finds the person indigent, it shall immediately appoint counsel. The court shall order examination by a qualified physician or a qualified psychologist.

If, after a hearing the court finds that said person is an alcoholic or substance abuser and that there is a likelihood of serious harm as a result of his alcoholism or substance abuse, it may order such person to be committed for a period not to exceed thirty days. Such commitment shall be for the purpose of inpatient care in public or private facilities approved by the department of public health under the provisions of chapter one hundred and eleven B for the care and treatment of alcoholism or substance abuse.

The person may be committed to the Massachusetts correctional institution at Bridgewater, if a male, or Framingham, if a female, provided that the person has pending criminal charges or has been found by the court to have violated conditions of probation or by the Parole Board to have violated conditions of parole; and provided, further, that the person so committed shall be housed and treated separately from convicted criminals. Under no circumstances shall the department of public health designate a facility of the department of correction as an approved facility for the inpatient care of a person who neither has pending criminal charges nor has been found to have violated conditions of probation or parole.

A person committed under the provisions of this section may be released prior to the expiration of the period of commitment upon determination by the superintendent that release of said person will not result in a likelihood of serious harm. Said person shall be encouraged to consent to further treatment and shall be allowed voluntarily to remain in the facility for such purposes, provided he neither has pending criminal charges nor has been found to have violated conditions of probation or parole. If the person has pending criminal charges or has been found to have violated conditions of probation or parole, upon his discharge he shall be returned forthwith to the court that issued the order of commitment.

The department of public health shall maintain a roster of public and private facilities available for the care and treatment of alcoholism or substance abuse and shall make it available to the district courts of the Commonwealth on a regular basis.

A person examined under the provisions of this section may be committed to a department of mental health facility under the provisions of section 12, paragraph (e) if the court determines that the person is mentally ill and that failure to hospitalize him would create a likelihood of harm by reason of mental illness.

AMENDMENTS TO CHAPTER 111E, SECTIONS 10 AND 11

In accordance with the Panel's recommendation that district court judges be empowered to request that evaluations conducted under these sections be conducted by any health care professional they deem qualified to assist them, the following statutory amendments are proposed.

SECTION 10

(1) Strike the sentence in the third paragraph that reads: "If the defendant requests an examination, the court shall, unless the court has already determined that the defendant is a drug dependent person, appoint a psychiatrist, or if it is, in the discretion of the court, impracticable to do so, a physician, to conduct the examination at an appropriate location designated by it." Add in its place the following sentence: "If the defendant requests an examination, the court may order a clinical examination to aid in its determination regarding whether the defendant is a drug dependent person."

(2) Strike all subsequent references to "psychiatrist or physician," and substitute instead the words "clinical examiner."

SECTION 11

(1) Strike the first paragraph, and add the following in its place: "Any person found guilty of a violation of any law other than a drug offense, who prior to disposition of the charge states that he is a drug dependent person, and requests an examination shall be examined by a clinical examiner to advise the court regarding whether or not he is a drug dependent person who would benefit by treatment."

(2) Strike all subsequent references to "psychiatrist or physician," and substitute instead the words "clinical examiner."

AMENDMENTS TO CHAPTER 111B, SECTION 7

In accordance with the Panel's recommendation that the Department of Public Health provide care to all voluntary civil patients, the following amendments to Chapter 111B, section 7 are proposed.

(1) In the first sentence of the second paragraph, add the words "and drug dependency" after the word "alcoholism."

(2) In the third sentence of the second paragraph, add the words "or is drug dependent" after the word "alcoholic."

(3) In the third paragraph, strike the words "committed for rehabilitative purposes to the Massachusetts correctional institution, Bridgewater or to the Massachusetts correctional institution, Framingham." Add in their place the words "admitted to a secure detoxification facility."

CREATION OF A STATUTE FOR THE EMERGENCY SUBSTANCE ABUSE TREATMENT OF PRISONERS

The Panel proposes the following statute providing for the emergency commitment of persons being held in a place of detention. Its structure and wording would be similar to that of Chapter 123, section 18(a).

Proposed Statute For Addiction Center Admission Of Prisoners Needing Detoxification.

If the person in charge of any place of detention within the Commonwealth has reason to believe that a person therein confined has need of drug or alcohol detoxification treatment, he shall cause such prisoner to be examined at such place of detention by a qualified physician or qualified psychologist. Such qualified physician or qualified psychologist shall report the results of the examination to the district court which has jurisdiction over the place of detention. Such report shall include an opinion, with reasons stated therefore, as to whether such detoxification is actually required.

The court which receives such report may order the prisoner to be taken to the Addiction Center at MCI-Bridgewater, or to any other facility designated by the commissioner of correction as a detoxification treatment facility, provided that the superintendent of the receiving facility certifies that there is a bed available for such prisoner.

The prisoner shall be received at the treatment facility for examination, observation, and medical treatment for a period not to exceed fifteen days. If, before the expiration of such fifteen day period, the superintendent of the treatment facility determines that an additional period of examination, observation, or medical treatment is required, he may authorize an extension of the fifteen day period. The superintendent shall provide written notice to the court and the person in charge of the place of detention that such an extension has been ordered. In no event shall the period of examination, observation, and medical treatment exceed thirty days.

CREATION OF A STATUTE FOR THE VOLUNTARY ADMISSION OF COUNTY OR STATE PRISONERS INTO SHORT-TERM TREATMENT AT THE ADDICTION CENTER

The Panel proposes the following statute providing for the admission of county or state prisoners into a short-term treatment program at the Addiction Center.

Proposed Statute For Voluntary Addiction Center Admission Of County or State Prisoners.

Any prisoner in a county jail or house of correction or a state correctional facility who is within six months of the expiration of his sentence may apply for voluntary admission to the Addiction Center at the Massachusetts Correctional Institution at Bridgewater for the treatment of problems related to dependence or abuse of alcohol or a controlled substance. Such a prisoner shall be transferred to the Addiction Center for no more than thirty days of treatment, provided that the superintendent of the Addiction Center certifies that there is a bed available, and provided further that such

transfer shall occur no earlier than three months before the expiration of such prisoner's sentence. The superintendent may authorize the return of such prisoner at any time during the thirty day period of treatment.

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CHAPTER 6

SPECIAL NEEDS FEMALE OFFENDERS AND PRE-TRIAL DETAINEES REPORT

TABLE OF CONTENTS

I. INTRODUCTION

The Governor's Special Advisory Panel on Forensic Mental Health was charged with the assessment of current mental health and substance abuse evaluation and treatment services for women in the criminal justice system, and the development of recommendations regarding new and existing service models. The Panel was specifically asked to make recommendations regarding, "the care and treatment of mentally ill women within the mental health and correctional systems." In addition, the Panel's mandate to study the function of the Addiction Center at MCI-Bridgewater has lead to a further inquiry of analogous substance abuse services for women.

Women in the criminal justice system who may need mental health or substance abuse services are not only those serving sentences or awaiting trial. Female state hospital patients who have become involved with the criminal justice system, women who require secure detoxification or substance abuse services, and women who need outpatient or community mental health or substance abuse services after their period of incarceration is concluded, or as an alternative to incarceration, also require the provision of specialized services.

In Massachusetts, female offenders have been provided with fewer mental health and substance abuse services than have male offenders. While the Commonwealth has made specialized services available to male offenders at a variety of institutions, including Bridgewater State Hospital and the Addiction Center, the majority of women are limited to the services provided at MCI-Framingham.

In recent years, MCI-Framingham has been asked to function, in fact or in effect, as a jail, county house of correction, state prison, secure mental hospital, and substance abuse treatment facility. This, as well as the lack of programs which present viable alternatives to incarceration, has resulted in severe overcrowding at MCI-Framingham. Treatment services at the facility have been stretched beyond their capacities by the growth of the population and the diversity of their needs.

In Massachusetts, as elsewhere, the majority of incarcerated women are poor, have little education and few economic skills, and are, in disproportionate numbers, minority women. MCI-Framingham staff also report that the vast majority of the women incarcerated there have histories of physical or sexual abuse.

Historically, criminal behavior in women has been viewed as a reflection of emotional disorder or character weakness. A 1987 report on mentally ill women in the criminal justice system reviewed the literature on theories of criminal behavior in women and noted:

"Traditionally, the etiology of women's crimes has been explained by criminologists almost exclusively in terms of defects in individual psychology or character....[F]emale offenders have historically been characterized in the literature as overly-masculine, atavistic and immoral (Lombroso, 1920); devious, deceitful and emotional (Pollak, 1950); excessively lonely and dependent (Konopka, 1966); and overly anxious to serve and be loved (Herskovitz, 1969)." (1)

In recent years, these anachronistic theories have been largely abandoned, and new premises emerging from the women's movement have suggested that the relationship between women and crime is highly correlated with their lives of abuse and violence, as well as their economic dependence on men.(1) Women with substance abuse problems are more likely than men to have histories of depression, and their substance abuse problems are often linked with their relationships with men.(2)

The Panel finds that the treatment characteristics of female offenders differ from those of their male counterparts in many important ways that should be considered in any analysis of service and program needs:

1. The majority of female offenders are untrained and unskilled single mothers with young children;

2. More than 85% of incarcerated women in Massachusetts report substance abuse problems, and most have been victims of serious physical and sexual abuse; and,

3. In contrast to the incarcerated male population, the female population contains relatively few persons who have manifested violent behavior. Indeed, less than one third of the women at MCI-Framingham are incarcerated for violent crimes.(3)

A system geared to meet the needs of this population should offer diversionary and community-based services which would allow women to remain close to their children, as well as to their social and legal support systems. A range of substance abuse and mental health treatment services must be made available, and linkages between service providers need to be established. A look at the current system of services for female offenders reveals a centralized system, often geographically remote from a woman's home community. There are serious gaps in resource allocation and service coordination. There is a lack of systematic follow-up after incarceration, and because of the short sentences the majority of women serve, fewer than 15 percent of all female offenders are paroled.

This report will describe the current system and make recommendations for needed changes.

II. POLICY QUESTIONS

1. Are existing mental health and substance abuse treatment services adequate to effectively meet the mental health and substance abuse treatment needs of female offenders?

2. How can greater coordination of mental health and substance abuse services for female offenders at MCI-Framingham and throughout the larger system be achieved?

3. What alternatives to incarceration should be developed for women with mental health and substance abuse needs, given their low incidence of crimes against persons?

4. How will the return of women awaiting trial back to county facilities, as well as the presence of women serving sentences in those facilities, effect the provision of mental health and substance abuse services? And, what services should be provided?

5. How should treatment services at MCI-Framingham be designed, given the fact that between 60-70 percent of female offenders are mothers, and a high percentage are primary caretakers of minor children?

6. Given the high percentage of females at risk for HIV infection due to past histories of substance abuse and prostitution, what education and treatment services should be made available to them?

7 How can the barriers to treatment which might discourage female offenders from participating in treatment programs be removed?

III. GOVERNING PRINCIPLES

1. Many assumptions underlying service delivery systems for male offenders do not apply to female offenders. Female offenders are less likely to commit violent crimes, or to act violently while incarcerated, or after release. They tend to serve shorter sentences and are less likely to be paroled. They are more likely to have backgrounds of substance abuse and family violence. The majority have children and are economically responsible for them. These and other unique characteristics require accommodation in the Massachusetts service delivery system.

2. Female offenders must have equal access to those services needed by both men and women.

3. Services cannot be effectively provided at MCI-Framingham until the severe overcrowding at the facility has been alleviated.

4. A continuum of services should be offered to address female offenders' diverse treatment and security needs.

5. Women who are civilly committed for substance abuse treatment should not, as a matter of policy, be committed to MCI-Framingham.

6. The financial and human costs of incarceration are staggering, not only with regard to the offender, but also for her dependents. Community programs which provide support of women and decrease the chance of incarceration or recidivism should be developed or expanded whenever possible.

IV. SUMMARY OF RECOMMENDATIONS

A. GENERAL RECOMMENDATIONS

1. Ongoing efforts to alleviate the serious and chronic overcrowding at MCI-Framingham, as set forth in the November 1988 Female Offender Advisory Group Report, should be supported. Under these conditions, priority, which should be given, cannot be given to essential services such as mental health and substance abuse services.

2. The Panel supports ongoing plans to offer female offenders and detainees the same placement options as those offered in the correctional system for men. Therefore, women awaiting trial and serving short sentences should be housed in county facilities close to their communities, and county houses of correction should develop appropriate specialized services to meet the needs of female offenders and detainees.

3. The Panel supports the recommendation of the June, 1987 Report on Female Offenders, which called for the convening of a small advisory council to participate in long-term state and county planning for female offenders to ensure both continued programmatic gains and effective allocation of available space and resources.

4. MCI-Framingham, through its vendor contract with COERS (Comprehensive Offender Employment and Resource System) and the county facilities, should work with the Departments of Mental Health and Public Health to develop outpatient support services for women with mental health and substance abuse treatment needs, so that they can be referred to necessary services upon discharge from MCI-Framingham.

5. MCI-Framingham and the county facilities should develop an assessment document, to be used at the time of a woman's admission, which would include critical information relating to mental health and substance abuse treatment needs.

6. Correctional staff at MCI-Framingham and in county houses of correction should receive specialized training in the areas of mental health and substance abuse.

B. MENTAL HEALTH SERVICES

7. The Panel recommends increased coordination of mental health services among the three services providers at MCI-Framingham. Once county detainees and county sentenced inmates are returned to the houses of correction, Department of Mental Health resources should be re-deployed to the inmates in the county facilities. Mental health services at MCI-Framingham should then be consolidated under the Department of Correction. Until that time, however, clinical planning, oversight, staff training, and service delivery should be joint ventures between the Department of Mental Health and the Department of Correction.

8. The Department of Correction should develop a specialized mental health unit within MCI-Framingham. The unit should be run by clinical staff with correctional staff providing the appropriate security, and should provide an array of "outpatient" and residential services to inmates who are otherwise able to be maintained in a correctional environment.

9. The Department of Mental Health should expand its capacity to provide long-term treatment to mentally ill female offenders who require hospitalization.

10. MCI-Framingham should work to establish better relationships with the academic community in Massachusetts. Such an effort could include fellowships in forensic psychiatry and psychology; internships for social workers, psychology and law students; conferences; and research opportunities within the institution.

C. SUBSTANCE ABUSE SERVICES

11. Substance abuse assessment, detoxification and counseling services should be given priority at MCI-Framingham, given that 85 percent of female inmates report substance abuse histories.

12. The Departments of Public Health and Correction should develop a program modeled on the Massachusetts Osteopathic Hospital program for incarcerated, civilly committed and voluntarily admitted women who need detoxification or substance abuse treatment services in a secure setting. As a matter of policy, women civilly committed for substance abuse treatment should not be committed to MCI-Framingham. General Laws Chapter 123, section 35 should be amended to reflect this policy.

D. INTENSIVE CASE MANAGEMENT SERVICES

13. An initial framework for an intensive case management system, which has recently been developed through a Department of Public Welfare vendor contract with COERS, and an interagency agreement with a number of human service agencies should be further developed.

E. SPECIAL ISSUES

14. Vocational and housing placement services need to be provided for women who have mental health and/or substance abuse problems upon release from MCI-Framingham. Without jobs or housing, women are at high risk of returning to their lives of substance abuse, prostitution and crime, and are further impeded from getting necessary services.

15. A women's role as mother is critically linked to her mental health and substance abuse service needs. Between 60 and 70 percent of the women at MCI-Framingham are mothers, and most are economically responsible for their children. All mental health and substance abuse program planning must accommodate the parenting responsibilities of female offenders with children.

16. In conjunction with addressing the overwhelming substance abuse problems among female offenders, the importance of comprehensive AIDS education must be recognized. The Panel commends the Women and Aids Project and recommends expansion of existing and development of new substance abuse treatment programs as a means of addressing the AIDS problem.

F. RETURN TO THE COUNTIES

17. The Panel notes that female offenders currently receive a number of important services at MCI-Framingham, which will need to be replicated at the local or regional level to serve women upon their transfer to the counties. Such services include mental health assessment, counseling, therapy groups, psychopharmacology, substance abuse counseling, medical screening, AIDS support therapy and education, pre- and post-natal care, and general health care.

G. ALTERNATIVES TO INCARCERATION

18. Additional programs to provide mental health and substance abuse treatment and services to female offenders who have been appropriately diverted out of the criminal justice system need to be developed. Existing programs, such as the Elizabeth Stone House, which provides housing and support to former offenders who have histories of mental health problems, and the Massachusetts Osteopathic Program, which provides treatment to women civilly committed for substance abuse treatment, should be expanded or used as models for new programs.

V. HISTORY

The history of forensic mental health and secure substance abuse services for women in Massachusetts is almost synonymous with the history of MCI-Framingham. The Massachusetts Correctional Institution at Framingham is the state's only women's prison. Today, MCI-Framingham is, by default, a prison, jail, house of correction, secure substance abuse treatment facility and a psychiatric hospital.

The need for a women's correctional facility in Massachusetts was first sharply felt in the 1860's and 1870's.(4) The movement for a women's facility grew largely out of the efforts of well-known social reformer, Dorothea Dix, who had been working in the Cambridge jail. She was appalled by conditions there and the practice of housing together women who were alcoholics, mentally ill, prostitutes, robbers, murderers and those held as material witnesses. "When the mentally ill became violent they were isolated in the jail's cold cellar," she wrote.(5) She began to lobby for a more humane institution and investigated 320 institutions and almshouses along the east coast. She summarized her report to the Massachusetts Legislature, but being a woman, she was not able to do so in person and had a Cambridge representative act on her behalf. Her report resulted in the formation of a commission which ultimately agreed with many of Ms. Dix's concerns when it publicized its findings three years after its inception. Still, it was to be several more years before the legislature appropriated the money necessary to build the Framingham prison.(5)

Judge Emory Washburn wrote an article in the Boston Daily Advertiser in 1874, advocating for a women's prison, in which he enumerated many of the inadequacies female inmates faced at the time.(4) He complained that women were "infected and degraded" in men's institutions. He noted that average sentences were short, 30 days to six months.(4) He stated that the principal purpose of incarcerating women was to teach them proper employment and instruction, and secondary to that was the need for discipline and detention. He advocated for a prison operated by a female superintendent and staffed with female correction officers because men were seen as too rough. He pointed out that in England and Ireland women were segregated in special facilities, and he believed that the same should be available in this country. Judge Washburn noted that the British prisons stressed reform and kindness, were seen as cost-effective, and represented a model which could be successfully replicated in Massachusetts.

The women's correctional facility at Framingham eventually opened its doors for inmates on November 7, 1877, and was the second prison in the United States designed for adult women, after the opening of Bedford Hills in New York.(5) Framingham was originally known as Sherborn prison and was located in that community. Sherborn, however, was an affluent area, saw the prison as undesirable, and, in 1913, had the town lines changed to place the institution wholly within the town of Framingham.(5)

The first Superintendent at Framingham was Eudora Atkinson who served for three years until 1880.(5) She was followed by Elizabeth Mosher who served until 1883 when Clara Barton, of Red Cross fame took over. Ms. Barton had not yet conceived of the famous Red Cross and served only one year at Framingham.(5)

Ellen Cheney Johnson succeeded Clara Barton and served for fifteen years until 1898. She was followed by Frances Morton who served for eleven years until 1909 and then Jesse Hodder who ran the prison until 1931.(5)

The superintendents at Framingham were perceived as radical for their day and many were social reformers. They refused to change the charter of the institution which required that: 1) Framingham was a reformatory to be

headed by a woman; 2) Framingham should have a resident physician and nursing staff; 3) Framingham should have a female resident chaplain who also served as librarian and teacher; and, 4) the prison should allow women the right of indenture and conditional release.(5)

The right of conditional release (indenture), or work release, was a novel idea that originated at Framingham in 1886. Many women served their sentences in the domestic employment of a family in the neighborhood, as a day laborer on one of the many farms surrounding the prison, or in a factory, laundry, or restaurant in the local community. Their wages were paid into a trust fund, and upon their release they were given the money for their return to the community. At that time, the Commonwealth provided each woman with only 85 cents upon her release from Framingham, so it was of little surprise that many women, with no other means of support, returned to lives of prostitution and vagrancy. The resources accrued by women while in the indenture program, at least, offered them a chance to change these life patterns upon release from the prison.(5)

The inmates at Framingham were not viewed as hardened criminals, and very few were seen as dangerous to the community. The majority of their crimes included drunkenness, prostitution and adultery. In 1931 the sentenced population of Framingham was 436. These included 60 women incarcerated for drunkenness, 57 for lewd and lascivious cohabitation, 51 for being idle and disorderly, 36 for adultery, 14 for vagrancy, 14 for being a stubborn child, and six for abortion.(5) The majority of the crimes did not involve public safety, and many, such as public drunkenness, abortion, and cohabitation, have since been decriminalized.

From 1931 until 1957, one of Framingham's most renowned superintendents used her tenure to establish an impressive range of creative and progressive service models for the inmate population. When Miriam Van Waters assumed her position, she had a Ph.D. from Clark University in Worcester and considerable experience attained during a long career in juvenile reform work. She had interned at Bedford Hills in New York and had done extensive studies of female offenders, including one in the Boston Juvenile Court. She saw her position at Framingham as that of teacher and called the inmates her students. Among her innovations at Framingham were programs to allow inmates to leave the prison for Alcoholics Anonymous meetings, to attend church services in the community, and to engage in recreation activities outside the prison. She allowed former inmates to return with their children for free medical care, employed ex-inmates in staff positions, and allowed inmates to return to the prison for overnight stays and social supports if there were no other alternatives.(5)

Superintendent Van Waters met regularly with her staff of 60 in order to create a forum in which to foster a common philosophy for the prison. She began a prison nursery and founded Wilson Cottage, which was used as housing for 25 mothers and their 33 children. Child care and mothering skills were taught, and children were allowed to remain at Framingham until they were three years old.(1) She started music and drama programs, allowed inmates to keep their own money and receive outside gifts, and started a student government program which allowed inmates to participate in decisions regarding the operation of the institution. She also started a parole

club to address the needs of women who were discharged without prior notice or training of any kind.(5)

During Superintendent Van Waters' tenure, an orientation and assessment program was initiated at Framingham. By 1948, each new inmate was interviewed by the Superintendent, the chaplain, a psychologist, a social worker and every other specialist on staff. The staff met regularly and developed a plan of treatment for each woman within three weeks of her arrival, which included extensive health assessments(5).

Almost none of the funding used for program development came from the Commonwealth, rather, it was contributed from outside private donations and volunteer work. Superintendent Van Waters allied closely with academic institutions such as Tufts, Radcliffe and Harvard and sent inmates for psychiatric treatment outside the prison. Her humane methods and success did not go unnoticed, and she received countless offers to leave Framingham and set up similar programs around the country. During a ceremony at which Bates College conferred an honorary degree on Ms. Van Waters, she was introduced as having an 85 percent success rate with the inmates released from Framingham.(5)

Unfortunately, by 1956, the majority of Superintendent Van Waters' innovative programs had ended, including the mother-infant program, the student government, the famous work release program and the farming program. By 1961, there were only three children of inmates left at Framingham, and the name "Reformatory" had been changed to MCI-Framingham.(5)

The large population at Framingham gradually decreased over the years due to the decriminalization of many offenses. The population at Framingham in 1977 was 145, including 34 men, compared to today's average daily census of 500 female inmates.

In 1974, Framingham had its first male superintendent, John Bates, and it was during his tenure that the institution became co-ed, one of only 16 such facilities nationwide at the time. Framingham was seen as a viable alternative to overcrowded men's institutions, as the relatively few incarcerated women hardly justified the expense of running a separate prison.

The coeducational "experiment" lasted about nine years. The men at Framingham were transferred back to other state prisons under allegations of conducting illegal activities while being housed at the co-ed facility. By 1982 the prison and jail populations had begun to rise, and prison and house of correction beds were badly needed. A plan was thus conceived to bring all awaiting trial and house of correction women sentenced to Framingham to free up space in the counties. The plan was designed to create a "critical mass" that facilitated the development of an array of programs and services specially suited to women.

The policy of housing all awaiting trial and sentenced women at Framingham, as well as the nationwide increase in drug use, resulted in the rapid growth in the number of female inmates at MCI-Framingham. Most of the women currently at Framingham report drug abuse as a principal factor in their incarceration.

Mental health services were first provided to female offenders at Framingham by the Department of Mental Health's Division of Legal Medicine in the late 1950s. During the 1980s, mental health services changed dramatically with the expansion of the Department of Correction's Psychological Services and the Department of Mental Health's Forensic Mental Health Division. Today, mental health services are provided by three clinical groups, DOC's Psychological Services, DMH's Forensic Mental Health Division, and People Care, Inc., a private vendor.

VI. DESCRIPTION OF CURRENT SERVICES

A. MCI-FRAMINGHAM - THE PHYSICAL FACILITY

Though MCI-Framingham's physical plant has been expanded to help accommodate increased numbers of inmates, it continues to be inadequate to serve the approximately 4,000 women admitted annually and the approximately 500 inmates who reside in the facility at any one time. A number of improvements in current living conditions are anticipated through the implementation of the Master Plan for Framingham, which was developed by the Executive Office of Human Services, the Department of Correction and the Division of Capital Planning and Operations.

The current physical plant includes a three story building, with two of the original five wings off of the main corridor still in use, and the former superintendent's residence, which is attached to the main building by an archway. The main building is used for administrative offices, prison industries, treatment programs, kitchen and dining facilities, counseling services, a library, gymnasium, co-op store, education department and housing for the maximum security inmates. Much of this will change under the Master Plan, which calls for the creation of a new administrative building and demolition of the existing building.(3)

In 1936, two minimum security cottages were opened outside of the current perimeter of Framingham, Hodder Hall and Wilson Cottage. Today Wilson Cottage is used as the South Middlesex Detox Center for men, and Hodder Hall, known now as Hodder House, is a pre-release and minimum security center for women. Four additional cottages, Pioneer, Townline, Algon and Laurel, each designed for 34 women, were opened in 1964 within Framingham's perimeter. Each contains a small kitchen, common room, laundry, control station and most contain double bunks so that the census in the cottages is closer to 66 inmates.(3)

A 50 bed, barracks style modular unit was built in 1985 in response to the rapid population growth. It soon proved inadequate in the face of a continuing rise in admission numbers. In early 1989, a new modular unit opened to house another 100 women; and ground breaking for construction of a unit with an additional 126 permanent beds (including a number of Maximum Security beds), as well as staff office space, has recently occurred, with completion scheduled for 1991. This development has enabled the Awaiting Trial Unit to expand to include one of the cottages, a significant

improvement in conditions for awaiting trial women, who, just last year, were held in 23 hour lock-up with up to eight inmates in each 116 square foot room.

B. DESCRIPTION OF THE MCI-FRAMINGHAM POPULATION

Female offenders make up less than 5 percent of the inmate population in Massachusetts.(1,3) They are generally arrested for crimes against property, and are seen as far less dangerous than their male counterparts. Only 29 percent of the women at Framingham are incarcerated for violent crimes,(3) and many of their convictions for such offenses were directed at men who had abused them in the past.(1,3) The average length of sentence at Framingham is only four months, as compared to incarcerated men in Massachusetts whose average sentence is four and one half years.(3) Because of these short sentences, fewer than 15 percent of all sentenced females are paroled from Framingham(3), and, therefore, very few women are monitored once they return to the community.

Framingham currently operates at an average census of 500 in a facility with a rated capacity of 374. There are an average of 100 women in the Awaiting Trial Unit and 400 women in the sentenced population. Only 20 percent of the women on the awaiting trial unit will ever be convicted and sentenced to additional prison time at Framingham, and many of them are being held on outstanding warrants for minor offenses or on bails of $500 dollars or less.(3)

The detention of awaiting trial inmates at Framingham represents a critical difference between the treatment of male and female offenders. Men who are awaiting trial or serving sentences of less than two and one half years are held in county jails and houses of correction. Men serving lengthier state sentences are held according to security classification at various state prisons throughout the state. With the exception of a few beds in Hampden, Hampshire and Berkshire counties and some pre-release programs, all awaiting trial and sentenced women are held at Framingham. Because of their centralized location, these women are often far away from their homes, children, attorneys and local mental health and social service networks.(9)

The mental health service needs of the population at Framingham range from adjustment counseling to intensive inpatient hospitalization and long-term follow-up in the community; that is, their problems range from responses to normal stress reactions to serious and chronic mental illness. Mental health problems arise as a reaction to the prison environment as well as to pre-existing conditions which are exacerbated by incarceration. For some women, the security and routine of the prison enables them to stabilize and even improve. Lacking systematic assessment data, it is not possible to "diagnose" the population. However, clinical practice indicates that there are large numbers of women with personality disorders, affective disorders, substance abuse mixed with emotional problems, and fewer women with psychotic disorders and characterological problems serious enough to greatly impair daily functioning.

C. MENTAL HEALTH SERVICES FOR WOMEN IN THE CRIMINAL JUSTICE SYSTEM

1. Mental Health Services at MCI-Framingham

The focal point of the mental health service delivery system for female offenders since 1982 has been MCI-Framingham, which houses women awaiting trial, those serving county and state sentences, and, on occasion, those committed for drug and alcohol abuse treatment pursuant to Massachusetts General Laws Chapter 123, section 35. Each of these groups of women may, at some point, require mental health services.

Even when a woman has had no previous mental health history, the stress of living in extremely overcrowded conditions may exacerbate underlying problems. Until very recently, when a new modular unit opened, the Awaiting Trial Unit (ATU) housed as many as eight women in a 116 square foot room, for up to 23 hours a day. The early 1989 opening of the 100 bed modular unit has helped to alleviate this problem, but the population at Framingham continues to grow. The 16 room Health Services Unit (HSU) has often been similarly overcrowded, with the added stress of women housed together despite a diversity of medical needs. Four rooms designated for individual use are sometimes used to house acutely mentally ill women.

Another area where women with acute mental illness have been housed is the 18 room maximum security unit (MAX). The Maximum Security Unit consists of single rooms, a high level of structure, and is relatively quiet. However, since its main function is to serve as the prison's disciplinary unit, it is staffed accordingly, with correction officers who are largely untrained in providing specialized care to mentally ill inmates. Because the need arises to inappropriately house mentally ill women on the disciplinary unit, conflicts between security and clinical staff over proper management and treatment of individuals can, and do, arise.

Algon Cottage, one of the four residential cottages at MCI-Framingham for sentenced women, has been designated to house women with mental health problems. Since there are not enough women in this category to fill the entire cottage, women serving long-term sentences, but who are not necessarily emotionally disordered, are also housed here. Approximately 65 women reside at Algon Cottage, mostly double bunked, with little attention given in room assignments to pairing more seriously ill women with roommates who are less seriously ill. Most of the women participate in the outpatient therapeutic services offered by DOC Psychological Services, the DMH Forensic Mental Health Division, and the DOC psychiatric vendor, People Care, Inc.; however, therapeutic programming within Algon Cottage is otherwise nonexistent. Thus, women with chronic mental health problems, though sometimes separately housed, do not reside in a particularly more therapeutic environment than those women in the general population.

There are currently three mental health service providers at MCI-Framingham, each with different responsibilities and client populations:

a. Department of Correction Psychological Services (5 full-time equivalent (FTE) clinical positions filled, 3 FTE clinical positions vacant)

serves the sentenced population providing: mental status assessments; crisis intervention; in-service training; case management; individual therapy; group therapy; and consultation to custodial staff. They also cover the Awaiting Trial Unit (ATU) from 5:00 p.m.-9:00 p.m. and on weekends. One of five newly created positions for mental health assistants to work on "high stress" units has recently been filled; the other four have not been approved for hiring to date.

b. **The Division of Forensic Mental Health, Department of Mental Health** (5 FTE clinical positions filled, 3 FTE clinical positions vacant, .5 FTE clerical position filled), provides services to women on the Awaiting Trial Unit and seriously mentally ill women in the sentenced population; conducts mental status assessments; provides crisis intervention; referral; consultation to custodial staff; conducts support groups (in ATU); offers case management services; provides individual therapy and day treatment; post-release planning and advocacy; facilitates transfers of female offenders to the mental health inpatient system pursuant to General Laws Chapter 123, section 18(a); and provides liaison with courts and court clinics.

c. **PEOPLE CARE Inc.** (1 FTE psychiatrist (several part-time psychiatrists provide coverage), and a .25 FTE social worker who screens referrals) is a private vendor which contracts with the Department of Correction to provide psychotropic medication assessment, prescription and monitoring; consultation to other clinical and custodial staff; and evaluation of female offenders for purposes of transfer to mental health facilities pursuant to General Laws Chapter 123, section 18(a).

As is obvious from the above enumeration of services, the three providers frequently share clients. Under the best circumstances, this type of overlap would require good coordination and communication. For example, the same woman might participate in the day treatment program run by the Division of Forensic Mental Health, receive individual therapy from the Department of Correction Psychological Services, and be on medication prescribed and monitored by People Care, Inc. If the woman needs inpatient hospitalization for mental illness, People Care will perform the evaluation required by General Laws Chapter 123, section 18(a), and, if the transfer is found to be appropriate, the Division of Forensic Mental Health will see that the transfer is completed through liaison with the court and the Department of Mental Health inpatient facility.

Problems have been noted both in identification of service needs and coordination of services. Female offenders are not routinely assessed for mental health problems on admission to MCI-Framingham. Court-ordered mental health evaluations and other mental health records are made available to the staff at Framingham, only with the inmate's authorization. Additionally, with approximately 4,000 annual admissions and a daily census of 500 inmates at MCI-Framingham, caseloads for each of the three mental health providers are high and present complicated clinical and organizational issues. Even though a particular woman may be a client of all three service providers simultaneously, coordination and communication are sometimes inadequate. The three providers meet once every other week for an hour as a group to discuss administrative problems and cases. Once weekly, the supervisors of the

three provider groups meet to discuss more pressing situations and to keep in closer contact. The recent decision by the Department of Correction to name the Chief Psychologist of the DOC Psychological Services group to coordinate service provision, is a needed change and is expected to improve communication among the mental health service providers at the facility.

The need for an improved plan of mental health service delivery within MCI-Framingham has been recognized by the Panel. Primarily, the Panel views the current system of maintaining three mental health service providers at MCI-Framingham as unnecessarily complicated and inefficient. With approximately 15 full-time positions for mental health professionals and 5 full-time mental health assistant positions allocated to MCI-Framingham, a coordinated program should have adequate resources to offer inmates and detainees a comprehensive set of mental health services. Coordinated mental health services are further needed to establish a unified clinical presence at Framingham. Development of uniform protocols in areas such as transfers of mentally ill inmates to the Department of Mental Health, appropriate clinical interventions in the management of mentally ill offenders and housing placements for mentally ill women are needlessly difficult due to the lack of coordinated services. Finally, it is the Panel's belief that any future planning to improve mental health service delivery within MCI-Framingham should consider the development of a mental health unit within the prison which would provide acute and long-term services to mentally disordered women who do not require inpatient psychiatric hospitalization.

A prison mental health unit, similar to those proposed for other state prisons in the Forensic Mental Health section of this report, would be appropriate for consideration at MCI-Framingham. This unit would be similar to prison mental health centers in the New York State prison system. Another model worthy of study in developing a prison-based mental health unit for women is the comprehensive care unit at the Huron Valley Women's Facility in Ypsilanti, Michigan. The Huron Valley unit offers four levels of mental health services, from "outpatient" services to specialized housing for chronically mentally ill inmates. The special unit at Framingham should include the following services:

1. Crisis Residence - Three to five beds should be developed for inmates in acute emotional distress, eg. those who are acutely suicidal or assaultive by reason of mental illness.

2. Long-Term Residential Treatment - 15-20 beds should be developed for inmates who require specialized housing because of mental health problems. Structured day programs, like the current day treatment program, should be developed for inmates who live on this unit.

3. "Outpatient" Clinic - This would function as a traditional outpatient clinic on-site at the prison, providing supportive psychotherapy (both individual and group), psychotropic medication, crisis intervention, and triage services for inmates requiring transfer to a Department of Mental Health hospital.

4. Consultation Services - The staff of this unit would also be available to assist correctional staff in the management of mentally ill inmates and would develop and coordinate mental health training programs for correctional staff.

The special mental health unit should be staffed in the following manner:

1	psychiatrist
2	psychologists (Ph.D.)
3	social workers (M.S.W.)
5	nurses (R.N. and L.P.N.) (24 hour, seven day a week coverage)
2	activity therapists or mental health assistants
5	correction officers (24 hour, seven day a week coverage)
1	clerical staff person
19	full-time equivalent staff

The Panel recommends that current mental health position vacancies, including the mental health assistants positions, be filled, and that planning begin as soon as possible for the development of a specialized mental health unit at Framingham.

2. Transfers of Mentally Ill Female Offenders to DMH Inpatient Facilities

Historically, mentally ill female offenders who require inpatient hospitalization had few options available to them. Department of Mental Health inpatient facilities have been reluctant to evaluate and treat women charged with or serving sentences for crimes. Nor were there any placement alternatives for women which were analogous to Bridgewater State Hospital for men. MCI-Framingham was therefore left to assume most of the responsibility for offering these services to mentally ill women.

Today, the Department of Mental Health provides inpatient evaluation services to mentally ill women at MCI-Framingham who are referred to the mental health system by court order under General Laws Chapter 123, section 18. A few beds are also available to provide long-term treatment to Framingham inmates who require inpatient hospitalization. In the past year, the Forensic Mental Health Division of the Department of Mental Health operated a Secure Care Unit for women at Metropolitan State Hospital. This unit was originally designed for 15 women awaiting trial who were referred by the courts for competency to stand trial, criminal responsibility, or aid in sentencing evaluations; who were under observation to determine whether involuntary commitment was indicated after being found incompetent to stand trial or not guilty by reason of mental illness of a crime; or who were transferred to the unit from MCI-Framingham under General Laws Chapter 123, section 18(a) to determine whether inpatient hospitalization in a Department of Mental Health facility was clinically indicated.

During its initial year of operation, the unit was restructured to serve as a nine bed unit, though it often ran below its nine bed capacity. Although Section 18(a) transfers from MCI-Framingham increased as the year

progressed, neither the Department of Mental Health nor the Department of Correction was satisfied with the utilization rate of the service.

In July, 1989, the Department of Mental Health relocated the women's unit to Taunton State Hospital, where a 25 bed men's secure care unit has been providing forensic evaluation and treatment services for the past two years. The reconfigured Taunton Secure Care Unit will now operate as two companion programs, a 12 bed secure unit for women and a separate 13 bed secure unit for men, on different floors of a newly renovated building. This move will result in three additional beds being available for women in need of forensic evaluation and treatment. The vendor, Justice Resource Institute, who has already amassed significant experience in operating a secure care environment for the past year, has provided additional training to staff regarding women's treatment issues. In order to facilitate full utilization of the service, the vendor is developing closer working relationships with the courts and with the clinical providers at MCI-Framingham.

3. Recommendations for Improvements in the Mental Health Services Delivery System for Women in the Criminal Justice System

1. The Panel recommends increased coordination of mental health services among the three services providers at MCI-Framingham. Once county detainees and county sentenced inmates are returned to the houses of correction, Department of Mental Health resources should be re-deployed to the inmates in the county facilities. Mental health services at MCI-Framingham should then be consolidated under the Department of Correction. Until that time however, clinical planning, oversight, staff training, and service delivery should be joint ventures between the Department of Mental Health and the Department of Correction.

2. The Department of Correction should develop a specialized mental health unit within MCI-Framingham. The unit should be run by clinical staff with correctional staff providing the appropriate security and should provide an array of "outpatient" and residential services to inmates who are otherwise able to be maintained in a correctional environment.

3. The Department of Mental Health should expand its capacity to provide long-term treatment to mentally ill female offenders who require hospitalization.

4. MCI-Framingham should work to establish better relationships with the academic community in Massachusetts. Such an effort could include fellowships in forensic psychiatry and psychology; internships for social workers, psychology and law students; conferences; and research opportunities within the institution.

D. DESCRIPTION OF CURRENT SUBSTANCE ABUSE SERVICES FOR WOMEN IN THE CRIMINAL JUSTICE SYSTEM

1. Substance Abuse Treatment Needs of Women

According to data from the National Institute of Drug Abuse, 28 percent of the clients admitted to federally funded drug treatment facilities are female.(6) It has been estimated that about 20 to 30 percent of the heroin addicted population in the United States is female.(7) A substantial number of female substance abusers are involved with the criminal justice system; in Massachusetts, approximately 85 percent of all inmates at MCI-Framingham report substance abuse problems.(3) Women have been traditionally underserved in most drug treatment programs, however, and existing programs have tended to ignore the unique needs of women undergoing treatment.(8) It was determined that only about 21.8 percent of the estimated female addict population receive treatment.(7) The literature reveals that, despite the growing number of female addicts, treatment programs are not equipped to attract or retain women in need of treatment and most programs are male oriented and do not respond to the particular emotional, vocational, or other needs of female addicts.(7)

Prior to the early 1970's, very little data existed which addressed gender-related outcomes of treatment, development of appropriate treatment intervention specifically geared toward women, and gender-related biases in research design or measurement.(9) A flurry of research in this area was undertaken beginning in the mid-1970's, due to the recognition of a lack of data regarding female addicts and alcoholics. The establishment of a Program for Women's Concerns by the National Institute on Drug Abuse in 1974 led to legislation in 1976 (Public Law 94-371), which gave priority to the funding of women's treatment and prevention programs. The legislation also required states to make efforts to identify and assess drug abuse prevention and treatment needs of women. These efforts and others yielded important data and some concrete recommendations.(10) Women in drug abuse treatment report more physical problems than men and have higher rates of doctor and emergency room visits.(11,12) Medical problems, particularly gynecological in nature, are especially common in women with substance abuse problems, perhaps because of the high frequency of prostitution among them.(10) It appears that the majority of health complaints by women in treatment were primarily the result of respiratory and genital/urinary problems, while men had a tendency to report more problems as a result of accidents/violence.(11) These problems, as well as the recently increasing rate of HIV positive female substance abusers, strongly suggest that medical services should be a fundamental component of substance abuse treatment programs for women.

A review of the literature on the psychosocial characteristics of female substance abusers suggests that female drug abusers are more psychologically disturbed than their male counterparts.(13) Some studies found a greater evidence of depression and anxiety among women. A team of researchers at the McLean Hospital's Alcohol and Drug Abuse Treatment Center found that women are far more likely than men to abuse cocaine in response to psychological stress, and that a greater number of female than male cocaine abusers have a past history of depression.(2) In a cross-sectional study of polydrug abusers, Damman et al.(14) found that men seen by the polydrug

treatment programs were more likely than women to indicate prior contacts with criminal justice agencies, and that women are more likely to have had contact with mental health treatment providers. DeLeon and Jainchill (15) postulate that, one reason women entering treatment had poorer self-concepts and more symptoms of emotional problems is the greater self-stigma they experienced, due to the more socially unacceptable status of female addiction and its associated behaviors, such as prostitution.

An early study of female inmates at MCI-Framingham revealed that heroin users had more frequent adult psychiatric outpatient contacts than nonusers and reported more suicidal thoughts and suicide attempts.(17) The authors point out that female heroin addicts are more serious suicide risks than nonusers, but may also be more receptive than nonusers to psychiatric help and rehabilitation efforts. Burt et al. (13) suggest that mental health services may be more appropriate than other approaches for women who require treatment for drug problems.

Surveys also revealed that employment rates among addicted females are extremely low and that many females in drug treatment view employment and economic security as the primary elements of successful rehabilitation. A 1987 study of clients at a methadone maintenance treatment facility revealed that, while a great majority of the men were employed during the study period, less than half of the women were employed, and more women than men were receiving welfare or disability payments and for a longer mean percentage of time.(17) In a 1978 study of female polydrug abusers, it was discovered that, for both, the welfare-supported and spouse-supported groups, there was a self-perceived lack of vocational options.(14) Many rehabilitation programs fail to recognize that ability to earn an independent income may be essential to rehabilitation, as many of the female addicts are responsible for young children.

Another finding in the same study was that the likelihood is very great that a female addict's spouse or partner is also a narcotics user. It was found that female addicts were highly influenced by their partners, and many females began daily use and/or increased their use because their spouses or partners were abusing substances.(18) While the authors suggest that, in many cases, it may be necessary to encourage the women to end a self-defeating and self-destructive relationship, they also point out that most of the women lack the social and vocational skills necessary to function independently in the non-drug-using world. A successful treatment program, therefore, must incorporate occupational skills training components.

The typical female addict tends to be unemployed, is receiving no financial assistance, is currently unmarried, has children who may or may not be living with her, and tends not to want more children but nevertheless does not use contraception.(17) Because many female drug addicts are mothers, problems relating to children should play a larger role in the treatment of female addicts. Pre-natal and parenting services can be critical in reducing single mother stresses, while also decreasing the probability of creating another generation of dysfunctional adults.

The evidence is thus clear that female drug abusers have treatment needs which are distinct from those of their male counterparts. Unfortunately, treatment programs are often not funded adequately to meet

female clients' needs, and many women return to drug use.(17) In addition, insufficient attention to these requirements has led to low participation of females in treatment and high drop-out rates. The great social costs of substance abuse among women, particularly in relation to their involvement with the criminal justice system and to child rearing, are compelling reasons to devote more energy and resources to this difficult problem.

2. Substance Abuse Treatment Services for Women

Substance abuse services at MCI-Framingham include programs administered by the Women's Health and Learning Center, substance abuse counseling services, and Alcoholics Anonymous and Narcotics Anonymous meetings.

The Women's Health and Learning Center, administered by Social Justice for Women, operates a ten week program at Framingham for women with substance abuse problems. The program can accommodate approximately 30 women at a time and involves the women in intensive programming. Approximately 100 women can participate in the program annually, though women serving short sentences are precluded from the program because of its 10 week duration. The program emphasizes individual and group substance abuse counseling. Other Women's Health and Learning Center programs offer substance abuse educational programs, as well as individual counseling modeled on the Alcoholics Anonymous 12 step program to approximately 300 women annually. A Department of Correction counselor is available on a part-time basis to provide individual substance abuse counseling to up to 10 inmates at a time. Alcoholics Anonymous and Narcotics Anonymous meetings are held on a weekly basis.

Women who enter Framingham for short sentences have little time to access services and are, therefore, often precluded from many substance abuse programs. More flexible programs which are responsive to these special time frames, and which are accessible to more inmates must be developed.

On admission to MCI-Framingham, many women require detoxification services. These women are administered pharmacological therapy to facilitate detoxification, though sufficient staff to monitor inmates who are withdrawing from alcohol or drugs are not always available. No special provisions are made for social detoxification or for longer-term substance abuse treatment services during the initial period of detoxification.(3) Nor are appropriate detoxification services available for high risk groups, including pregnant women or women who have tested HIV positive. While Health Services staff at Framingham makes admirable efforts to assist women undergoing detoxification, current services are inadequate. Moreover, substance abuse programs, while commendable, are not nearly sufficient to serve the large numbers of women with substance abuse problems.

In 1988, the Department of Correction issued a request for proposals for the establishment of community-based treatment beds for female offenders eligible for pre-release placement. Although the response was not overwhelming, qualified vendors representing five different programs were finally selected, and 52 treatment beds for female offenders are now available.

While the establishment of community-based facilities is an important tool in the treatment of addiction, they are accessible to too small of a percentage of the population to have a significant impact on the problem. Outstanding criminal charges, short sentences, and complicated health issues preclude the majority of female offenders from being placed into these community treatment programs.

The Department of Public Health, in conjunction with the Department of Correction, should be supported to develop more community-based substance abuse programs for women. These programs should be available to both divert women from entering Framingham and serve women after they are released. When first arrested, people are most vulnerable and amenable to treatment programs. Lengthy waiting periods for treatment beds decrease both motivation and the effectiveness of treatment.(9,10) The Panel is encouraged by the development of 52 specialized, community-based substance abuse beds for women on pre-release status by the Department of Correction through several contract vendors. Expansion of these services and development of community-based alternatives to incarceration for women with substance abuse problems is needed.

Another problem which has recently reemerged is the increase in the number of women committed to Framingham under General Laws Chapter 123, section 35, which authorizes the involuntary 30 day civil commitment for persons who present a likelihood of serious harm to themselves or others due to substance abuse. Although the commitment is civil in nature, the statute allows for the involuntary commitment of female substance abusers to Framingham. Until recently, all women who were civilly committed for substance abuse treatment were transferred to MCI-Framingham. The statute mandates that these women be kept separate from the rest of the inmate population. The prison was ill-equipped to offer these women substance abuse treatment services, and many of them languished in rooms alone on the Health Services Unit for the duration of their 30 day commitment period.

In the past year, in recognition that MCI-Framingham is an inappropriate placement alternative for civilly committed women, the Executive Office of Human Services directed the Department of Public Health to develop a 20 bed treatment program at the Massachusetts Osteopathic Hospital and, most recently, a 5 bed program in Fall River, which will increase to 20 beds in November. These facilities offer comprehensive substance abuse treatment services to Section 35 women and are viewed as model programs. The Fall River program (SSTAR REHAB), also has access to a detoxification unit which will accept Section 35 women. The Panel commends the development of these new programs. However, certain service gaps still exist, which need to be addressed.

First, the programs do not have sufficient capacity to meet the increasing need for Section 35 beds. When beds are not available, women are still civilly committed to MCI-Framingham. Second, these programs are not equipped to accept women who are viewed as requiring secure settings. Given that the nature of the Section 35 process is one of involuntary commitment, this services gap seems particularly unreasonable and impractical. These programs also report that they are unable to accept women with medical problems, or who require specialized nursing care. Finally, the Massachusetts

Osteopathic Program does not accept women who require detoxification services and will only accept women once they have been detoxified.

The administration at MCI-Framingham reports receiving an average of three to four civilly committed women a week due to a lack of placement alternatives, yet they are able to offer little treatment or programming to these women. At any given time, there are approximately four women, civilly committed to Framingham, housed in one or two rooms on the Health Services Unit. In recent months, the prison has received a woman with multiple sclerosis committed under Section 35 and a 70 year old woman, sent under the same authority. In late August, a women was civilly committed to MCI-Framingham because she required nursing care. The Panel believes that, as a matter of policy and law, civil commitments to Framingham should be prohibited. Allowing civil commitments to Framingham is highly inappropriate and is inconsistent with the administration's policy goal of stopping the practice of mixing civilly and criminally committed populations together, particularly in a correctional facility.

The Panel supports ongoing efforts by the Executive Office of Human Services to stop these transfers into MCI-Framingham. Judges and district attorneys must be made aware that MCI-Framingham is not an appropriate dispositional alternative for civilly committed women. At the same time, the Department of Public Health must expand its capacity to treat civilly committed substance abusers, particularly those who require specialized care or some level of security.

An additional service gap for female offenders is the lack of drug treatment services which are equivalent to those available to male offenders. Under General Laws Chapter 111E, section 10, a defendant charged with a drug offense may request a judicial determination that he or she is a drug dependent person who would benefit from treatment in a treatment facility. Section 11 of Chapter 111E allows for a drug-dependant person convicted of a non-drug related offense to receive treatment during the period of incarceration in a treatment facility.

Men who are subjects of these criminal substance abuse commitment statutes are admitted to the Addiction Center at Bridgewater. The Addiction Center, though not without its own problems, nonetheless is available to offer secure substance detoxification and treatment services to men committed by the courts for that propose. Women in the same categories however, have no equivalent treatment options. Though 52 new beds have recently been developed in the community for women on pre-release status, access to these programs cannot be gained through the Chapter 111E process. Similarly, while the new Department of Public Health programs accept civilly committed women, they have not been asked to admit women under Chapter 111E. There are thus no treatment facilities available for women under these statutory provisions, leaving MCI-Framingham as the only placement alternative for Chapter 111E women.

Finally, there continues to be a pressing need for secure detoxification services for newly admitted inmates and detainees. While the Panel recognizes the need for a wide range of improvements at the Addiction Center, it also appreciates the inherent unfairness in having few analogous services for women. The Panel strongly recommends the expansion of existing and

development of new quality, secure substance abuse detoxification and treatment services for civilly committed and incarcerated women. Increased secure detoxification services, which are available for men at the Addiction Center, are also needed for women who voluntary seek them under General Laws Chapter 111B, section 10.

3. Recommendations for Improvements in Substance Abuse Services for Women

1. Substance abuse assessment, detoxification and counseling services should be prioritized at MCI-Framingham, given that 85 percent of female inmates report substance abuse histories. The Panel strongly supports the recommendations of the Female Offenders Advisory Group report (3) in the area of detoxification and substance abuse treatment services, including: a) the development of short-term programs for inmates serving short sentences which are modeled on the 14-day programs for second offender drunk drivers, and which emphasize assessment and referral; b) the expansion of long-term, intensive treatment programs for women serving longer sentences, which include both residential and "outpatient" components; c) the expansion of individual substance abuse counseling services; and, d) the improvement of detoxification services to newly admitted inmates by increasing medical and nursing coverage of women undergoing withdrawal from alcohol and drugs and by using the period of detoxification to link women with longer-term substance abuse treatment services.

2. The Departments of Public Health and Correction should develop programs similar to the Massachusetts Osteopathic Hospital model for incarcerated, civilly committed and voluntarily admitted women who need detoxification or substance abuse treatment services in secure settings. As a matter of policy, women civilly committed for substance abuse treatment should not be committed to MCI-Framingham. General Laws Chapter 123, section 35 should be amended to reflect this policy.

E. INTENSIVE CASE MANAGEMENT

Female offenders, including those on probation, those incarcerated, and those following release from incarceration, have a wide range of social service needs that include: obtaining mental health services, getting treatment for drug addiction, obtaining assistance in locating and maintaining adequate housing, developing marketable training and employment skills, securing funding and resources to ensure adequate child care, and developing advocacy relationships to assist them in proceedings in the courts. They are often involved with many state agencies, including the Department of Correction, the Department of Mental Health, the Department of Public Health, the Department of Social Services, the Department of Public Welfare, the Department of Employment Training and the Probation Department.

For many women, mental health and substance abuse problems are so overwhelming that it is difficult to deal effectively with any of the provider agencies. The mission and requirements of one state agency may appear to be in conflict or, at cross purposes, with another. In order to enter a substance

abuse program run by the Department of Public Health, the woman must admit an addiction. Yet that same admission may result in the Department of Social Services seeking to remove custody of her children. In order to obtain welfare she may need a permanent address, which may be complicated by the fact that she is residing in an inpatient mental health facility. For women who are dually diagnosed as mentally ill and with substance abuse problems, these types of problems become even more insurmountable.

Often the problem appears relatively minor yet, results in major barriers to service delivery. For example, the director of the Elizabeth Stone House, a private residential facility for women with histories of mental illness, reports that women from Framingham have been denied admission to the program because of their inability to make a phone call or obtain a discharge date from the Department of Correction due to questions about their sentencing structure or outstanding warrants.

Such problems highlight the need for an intensive case management system, a system which can successfully broker services for a woman and encourage her to seek treatment. Mental health service providers, parole officers and programs such as Aid to Incarcerated Mothers, Women's Health and Learning Center and Community Services for Women provide valuable assistance in specific areas of concern; however, coordination of services for women returning to their communities has yet not been adequately developed.

1. COERS and the County Liaisons

Fortunately, models for an intensive case management system do exist in Massachusetts in the COERS (Comprehensive Offender Employment Resource System) and County Liaison programs. Both are beginning to expand services for female inmates by either placing staff at Framingham or, assigning staff to assist in the transition planning of county inmates back to their communities.

COERS began in 1978 primarily as an employment program for male offenders. It has since expanded to nine regional offices which include Boston, Worcester, Springfield, Lawrence, Lowell, Attleboro, Fall River, New Bedford and Saugus. COERS works through an inter-agency agreement with the Department of Public Welfare, the Parole Board, the Division of Employment Security, the Massachusetts Rehabilitation Commission, the Massachusetts Committee on Criminal Justice, the Departments of Mental Health, Correction, and Youth Services, and the Department of Probation. Rather than duplicating services, COERS acts as a broker to make sure the offender gets the services she needs. The COERS counselor at Framingham is an advocate for the woman in the service market and can negotiate on her behalf with various service providers.

A woman enters into a contract if she chooses to participate in a COERS program. The contract may require her to: seek, obtain, and maintain employment; complete a GED; participate in outpatient treatment for substance abuse or mental illness; or agree to random drug testing. A caseworker is responsible for linking the female offender with services and resources, required to fulfill the agreement, and shares monitoring responsibilities with the Probation Department.

The County Liaisons, which are now functioning in seven counties, are funded from a variety of sources, including specially designated funds from the Executive Office of Human Services and individual sheriffs' operating budgets. These workers identify the women who are the responsibility of the counties, act as liaisons between the offender and the various service systems she will require, deal with issues of family violence, assist in the communication between the offender and her attorney, and help in the clearing of outstanding criminal warrants.

Not only are these counselors critical to brokering services for female inmates, but they remain available to monitor their progress throughout their contact with the criminal justice system. They act as advocates for the offenders no matter how many times they have failed in a given program or returned to prison. This philosophy of continuing commitment has been viewed as critical to an intensive case management program.

Both COERS and the County Liaison Program represent effective models of case management and diversionary programming. With additional resources, these programs could provide the court system with viable and far less costly, community-based service alternatives, and a more complete range of options to choose from in dispositional decisionmaking.

2. Recommendations for Improvements in Intensive Case Management

1. An initial framework for an intensive case management system, which has recently been developed through a Department of Correction vendor contract with COERS and an interagency agreement with a number of human service agencies, should be further developed.

VII. SPECIAL ISSUES

A. AIDS (Acquired Immune Deficiency Syndrome)

Over 85 percent of the population at MCI-Framingham report histories of substance abuse, many involving intravenous drug use. Another large percentage have histories of prostitution. Given these two high risk factors for the HIV infection, the problem of AIDS in prison is a critical one.

The Department of Correction began voluntary testing of inmates in 1987. Since then, 403 inmates at MCI-Framingham have requested and received testing for the AIDS virus. Of those tested, 91 inmates have tested positive and one has died from AIDS.

AIDS testing takes place at MCI-Framingham within a day to two weeks after an inmate's initial request. The medical staff must first counsel an inmate which may result in testing being delayed. Upon request, however, the inmate, can receive further counseling through the Women's Health and Learning Center. If the initial test results indicate a positive diagnosis, two additional tests are given to confirm the diagnosis. Only the medical staff has access to the inmate's HIV status so that confidentiality is maintained. The Massachusetts Department of Correction pays for all necessary testing, treatment and counseling.

The medical staff at MCI-Framingham transfers inmates in need of hospitalization due to the effects of AIDS, ARC or other illness brought about by the HIV virus to the Lemuel Shattuck Hospital. Once hospitalization is no longer required, the inmate returns to MCI-Framingham. AZT and other medical therapies prescribed by the medical staff at MCI-Framingham or Shattuck Hospital are available to the inmates at MCI-Framingham.

An inmate's HIV status alone does not affect access to program participation, efforts to receive substance abuse treatment, or visitation rights. The Massachusetts Parole Board does not automatically grant early parole to inmates who have tested HIV positive, although early parole may be considered in certain cases.

All newly admitted inmates are shown an educational videotape on AIDS and are engaged in a discussion on AIDS under the direction of the Health Services Supervisor. The Women and AIDS Project, which is funded by the Center for Disease Control, offers most of the counseling services available to inmates with the HIV positive diagnosis; however, People Care and DOC Psychological Services do assist with additional counseling intervention. The Project provides educational programs, open discussion sessions and case management services, as well as drop-in hours for inmates concerned about AIDS. In the past six months, the Project has provided services to over 1,300 women at Framingham.

B. INCARCERATED PREGNANT WOMEN AND MOTHERS

Between 60-70 percent of the female offenders in Massachusetts are mothers, the majority of whom are single parents. Confinement may suspend the parental relationship in a physical sense, but the emotional relationship and the need for the family to continue functioning constantly asserts itself throughout a mother's incarceration. Not surprisingly, most surveys of incarcerated women consistently identify concerns about their children as paramount. Each of these mothers has pressing needs for ongoing contact with her children, for support services so that her family can continue to function, and for parental training to ensure that she will be in the best possible position to resume her place as head of the family after her release.

Many pregnant women have been incarcerated at MCI-Framingham in the past several years, requiring access to a number of important medical and mental health services during their detention. According to Department of Correction figures, 37 pregnant women were incarcerated at MCI-Framingham in 1987, with nine women delivering their babies while still in custody. In 1988, there were 50 pregnant women and seven deliveries; and in the first half of calender year 1989, there have been 52 pregnant women at Framingham, and seven deliveries.

An excellent resource for pregnant inmates is the recently opened Neil Houston House on the grounds of the Dimmock Community Health Center in Roxbury, providing an alternative to incarceration program in an intensive therapeutic residential setting. The Neil Houston House can accommodate up to fifteen pregnant offenders with substance abuse

problems and their newborn children. The program lasts for six months and offers comprehensive pre-natal care, high risk pregnancy management, substance abuse treatment, and parenting education. Women enter the program through the DOC classification process, although participation is voluntary. Since the program requires that the post-partum stay be at least two months long, some eligible women have chosen not to enter the program, but rather to stay at Framingham pending the birth of their babies. Through a unique arrangement between the Dimmock Center and Social Justice for Women, a high risk pregnancy clinic is run once a week and pre-natal care is offered to women by Beth Israel Hospital in Boston.

C. RECOMMENDATIONS TO IMPROVE SERVICES IN THE SPECIAL ISSUES AREAS

1. Vocational and housing placement services need to be developed for women with mental health and/or substance abuse problems when they leave MCI-Framingham. Without jobs or housing, women are at high risk of returning to their lives of substance abuse, prostitution and crime, and are further impeded from getting necessary services.

2. A women's role as mother is critically linked to her mental health and substance service needs. Between 60 and 70 percent of the women at MCI-Framingham are mothers, and most are economically responsible for their children. All mental health and substance abuse program planning must accommodate the parenting responsibilities of female offenders with children.

3. In conjunction with addressing the overwhelming substance abuse problems among female offenders, the importance of comprehensive AIDS education must be recognized. The Panel commends the Women and Aids Project and recommends expansion of existing and development of new substance abuse treatment programs as a means of addressing the AIDS problem.

VIII. PLANNED TRANSFER OF AWAITING TRIAL AND COUNTY SENTENCED WOMEN TO COUNTY CORRECTIONAL FACILITIES

A. DESCRIPTION OF CURRENT SYSTEM AND POPULATION

Historically, the issue of whether to house female offenders in a centralized prison facility, creating a critical mass for efficient comprehensive services delivery, or to house them in smaller facilities closer to their communities, has been a matter of debate. This question was raised in 1874 by Judge Emory Washburn in an article advocating for a centralized women's facility. Judge Washburn stated that women were "distributed throughout the state, usually in small numbers rendering it impossible for prison officers to so care for them as to meet the most evident requirements of humanitarianism."(4) Since the establishment of Framingham in 1877, the majority of sentenced female inmates have been incarcerated in one centralized facility. Since 1978, almost all awaiting trial and sentenced female offenders and detainees have been housed at MCI-Framingham.

Recently, plans have been developed to transfer those women who are awaiting trial or serving county sentences from Framingham to the various county correctional facilities over the next four years. This transfer will serve a number of goals, although two are paramount: 1) to relieve the chronic and severe overcrowding at MCI-Framingham, and, 2) to allow women awaiting trial and serving short sentences to reside in facilities nearer to their families and community support networks, as do their male counterparts. Successful reintegration of female offenders back into the community after incarceration, another important goal, also depends on the maintenance of essential relationships between family and social and legal support services in the offender's county of residence.

The planned transfer of women to the counties may be affected by conditions of severe overcrowding in the county facilities which now serve the male population. Many of these facilities are under strict court supervision, prompting speculation that plans to move women may be delayed or cancelled.

The Panel recognizes that no significant improvements can occur in conditions or rehabilitative services for females at MCI-Framingham until there is an end to the severe overcrowding at the facility. In light of this, and the recognized constructive effects of housing female offenders in their home communities, the Panel calls for a reemphasis in budget and program plans on the transfer of female offenders back to county facilities as soon as is practicable. These transfers will require a significant increase in county beds for women, as well as the development of support services to assist local sheriffs with special needs inmates and detainees, to meet the diverse needs of this population.

The numbers of offenders involved in this planned transfer are substantial. Based on the February, 1989 population census at MCI-Framingham, space for approximately 210 women serving House of Correction (HOC) sentences and 100 women awaiting trial (AT) will need to be created in the counties over the next four years. These women will return to the counties in order to serve out the remainder of county sentences or to await trial. Those awaiting trial may ultimately end up back at MCI-Framingham if they are convicted and sentenced to "state time," that is a sentence of longer than two and one-half years.

TABLE 1
NUMBERS OF FEMALE OFFENDERS AT MCI-FRAMINGHAM WHO ARE COUNTY RESPONSIBILITY

County of Origin	Number of Inmates Awaiting Trial
Barnstable	2
Bristol	12
Essex	11
Hampden	9
Middlesex	15
Norfolk	2
Plymouth	6
Suffolk	24
Worcester	18

Total No. of AT Inmates at Framingham*	99
Total County Sentenced Inmates at Framingham*	210
Total No. of Inmates at Framingham who are the Responsibility of the Counties	309

*Based on 2/89 Census

B. CURRENT AND ANTICIPATED INCREASE IN COUNTY CAPACITY TO HOUSE FEMALE OFFENDERS

To date, county correctional facilities have few beds for women, nor do they have the support services necessary to manage this population.

TABLE 2
CURRENT BED CAPACITY FOR FEMALE OFFENDERS

Facility	Number of Beds	Eligibility
Hampden County Modular Unit	10	Pre-Release
Berkshire County Jail	7	Awaiting Trial or House of Correction
Hampshire County Jail	6	Awaiting Trial
2 nd Offender DUI Beds	45	County
3rd Offender DUI Beds	45	County
Total Beds As Of 4/89	**113**	

With the census of certain county correctional facilities currently under a court-ordered cap, it is not surprising that counties have expressed reluctance to accept back the substantial numbers of women subject to transfer. Pledges made in previous years by the sheriffs to make room for the women who are the responsibility of the counties were made in a different fiscal climate and on the basis of underestimated census figures. However, substantial planning has been based on the assumption that a majority of female offenders will be returned to county control. In particular the improvement of conditions and rehabilitative services at MCI-Framingham is being planned, based on lower census figures. If the transfer of county women is delayed, these essential improvements will be similarly delayed or cancelled. More important, the overcrowded conditions at MCI-Framingham would continue, fueling the demand for mental health and other facility support services already extended beyond existing capacity. If county inmates and detainees are unable to return to the counties in the near future, measures will need to be taken to relieve overcrowding at Framingham through the construction or renovation of alternative facilities, either on a regional basis, or as an addition to the Framingham facility. Current plans for 126 additional beds and increased support space and visiting areas, due for completion in late 1990, will alleviate overcrowding somewhat, but will not be adequate to continue to accommodate county inmates and detainees.

C. RECOMMENDATIONS FOR SERVICES FOR WOMEN RETURNING TO COUNTY FACILITIES

1. The Panel notes that female offenders currently receive a number of important services at MCI-Framingham which will need to be created at the local or regional level to serve women upon their transfer to the counties. Such services include mental health assessment, counseling, therapy groups and psychopharmacology, substance abuse counseling and therapy groups, medical screening, AIDS support and education, pre and post-natal care, and general health care.

IX. ALTERNATIVES TO INCARCERATION AND COMMUNITY SERVICES

Female offenders are prime candidates to participate in alternative supervision or treatment programming in lieu of incarceration. Women are less likely to have committed crimes against people, are less violent, and more likely to receive relatively short sentences.

In many cases, crimes committed by women suggest that a structured program of treatment, for mental health or substance abuse, can promote change in behavior necessary to avoid recidivism. Keeping women out of penal environments, when appropriate, accomplishes a number of important goals; minimizing the potential for breaking key social supports and relationships (e.g., family, children, local services); easing the transition for women back into their communities (retention of jobs, housing, welfare benefits); and reducing the docket burdens of criminal courts (if diversion is pre-trial). Providing alternatives to incarceration also serves to reduce overcrowding in correctional facilities, which the Panel has identified to be of paramount importance in improving conditions and services at MCI-Framingham.

Requirements for successful alternatives to incarceration include both statutory and programmatic components. Programmatically, diversion must be overseen by a court or agency with the resources to assess a women's potential for success in an sentencing alternatives program. The program itself must have adequate resources to provide a rigorous schedule of treatment and other programs, with monitoring and clear consequences for noncompliance, in a setting with an appropriate degree of security. Programs can address either the broad range of the offender's characteristics which contribute to criminal behavior, or focus on more specific issues, such as the treatment of the offender's substance abuse or mental health problems.

Although the Executive Office of Human Service, in developing guidelines for the distribution of $1.5 million in alternative funds requires programs to give priority to women, there are still an insufficient number of alternatives programs. Based on the potential human benefits and fiscal advantages of such programs, the Panel recommends more centralized coordination of existing services and the provision of resources to create alternatives to incarceration for qualified female offenders.

A. DESCRIPTION OF CURRENT SYSTEM AND POPULATION

Available data suggest that large numbers of the female offender population in Massachusetts would be appropriate for, and benefit from, alternatives to incarceration. Female offenders in Massachusetts tend to commit non-violent crimes and, if convicted, receive relatively short sentences. As described in the recent report by the Female Offender Advisory Group, approximately 39 percent of female offenders in the state have committed non-violent offenses, 27 percent have committed drug-related offenses, while 29 percent have committed violent crimes. The majority of females sentenced to MCI-Framingham are released within six months, and 54 percent are released within 60 days.

This report has documented the prevalence of female offenders who are single parents, whose relationships with, and ability to provide for, their children are greatly disrupted by incarceration for even a short period of time. Based on such demographics, and the pressing need to address severe overcrowding at Framingham, both the Female Offender Advisory Group and the recently issued Gender Bias Study have recognized the wisdom in creating effective alternative programming to appropriately divert female offenders away from MCI-Framingham.

Current law provides a few points of diversion for female offenders, primarily when mental health and substance abuse may have contributed to the criminal behavior. Criminal courts in the Commonwealth have, in some cases, effectively fashioned their own diversionary programs through the exercise of their broad powers either to continue a case without a finding, or to order probation, with each conditioned on an offender's participation in a mental health, substance abuse or other program.

B. FEMALE OFFENDERS WITH MENTAL HEALTH SERVICES NEEDS

The following legal means exist to divert a female offender with mental illness into a mental health facility:

• General Laws Chapter 123, section 10: If the charge is minor, the court, prosecutor and defense may agree to drop the charges in exchange for the woman's agreement to voluntarily enter a mental health facility for care and treatment;

• General Laws Chapter 123, section 12: The same result described above can be obtained involuntarily, through emergency hospitalization pursuant to §12(e). As with a §10 admission, a §12 admission can be used at any time before incarceration and lasts for a maximum of ten days;

• General Laws Chapter 123, section 15(b): Where there is a question of a woman's competency to stand trial or criminal responsibility, the court may send her to a public inpatient facility for a period of evaluation not to exceed forty days. This follows an evaluation on an outpatient basis by the court clinic pursuant to §15(a);

• General Laws Chapter 123, section 15(e): After conviction, but prior to sentencing, a court may have a woman sent to a public inpatient facility for an evaluation to assist the court in sentencing. During this time the facility may petition the court to retain her;

• General Laws Chapter 123, section 16(a)-(c): If a woman is found incompetent to stand trial or is acquitted for lack of criminal responsibility, the court may send her for evaluation for a maximum of forty days at a public inpatient facility (less if 15(b) was used earlier). During this period of evaluation the facility may petition for the woman's commitment; and

• General Laws Chapter 123, section 18: While awaiting trial, a woman may be transferred from a place of detention to a public inpatient facility for a thirty day period of observation. During this period the facility may petition for her commitment for care and treatment.

Currently, women committed under these statutory provisions are transferred to a Department of Mental Health facility, or for court-ordered evaluations under General Laws Chapter 123, sections 15, 16, and 18, to the Taunton Secure Care Unit, if appropriate.

C. FEMALE OFFENDERS WITH SUBSTANCE ABUSE TREATMENT NEEDS

The following laws provide for diversion of women into substance or alcohol abuse treatment facilities before imposition of a prison sentence:

• General Laws Chapter 123, section 35: At any time prior to incarceration, a woman may be involuntarily admitted to a substance or alcohol abuse treatment program for thirty days. The court must find that the woman presents a likelihood of serious harm to herself or others by reason of her substance or alcohol abuse. The statute specifically allows women to be sent to MCI-Framingham in the absence of other appropriate treatment facilities, even though MCI-Framingham has few treatment services available for females sent under §35. Women committed under §35 must also be housed and treated separately from the convicted population;

• General Laws Chapter 111E, section 10-12: A woman may voluntarily choose to admit herself into a substance abuse facility pursuant to Chapter 111E either pretrial or in conjunction with probation or sentencing, in lieu of serving time in a correction facility for a drug-related offense. Such diversion can be for up to eighteen months at an inpatient facility, and after a record of compliance, the offender can switch into a program of outpatient treatment; and,

• General Laws Chapter 90, section 24: Women can participate in second and third offender drunk driving programs operated by the Department of Public Health. These programs are only for alcohol-related vehicular traffic offenders, and are designed as graduated programs of increasing rigor and personal cost to the offender after the first offense.

While the above legal mechanisms may exist to divert women into alternatives to incarceration, few of these programs were designed to serve female offenders. As noted previously, there are no drug treatment programs whatsoever which provide inpatient services to women under Chapter 111E. The following overview of existing sentencing alternatives programs in Massachusetts describes programs which address either the broad range of offender characteristics or focus specifically on a particular problem which has contributed to criminal behavior.

D. SENTENCING ALTERNATIVES PROGRAMS

1. Community Services for Women (CSW) and the Correctional Alternative Program (CAP)

Community Services for Women (CSW) and the Correctional Alternative Program (CAP) currently provide sentencing alternatives for female

offenders in the Boston area. CSW has operated for a number of years serving the Boston Municipal Court, and CAP began operations in 1988 in the Suffolk Superior Court and surrounding district courts as part of the Comprehensive Offender Employment Resource System (COERS). Generally, CSW and CAP provide the option for a female offender, depending on her charges and criminal history, to establish an agreement with the program, the court, and the probation department as an alternative to court proceedings which may result in incarceration. The CSW or CAP caseworker is responsible for linking the offender with services and resources required for the offender to fulfill the agreement and shares monitoring responsibilities with the Probation Department.

2. Day Reporting Programs

In the past three years, seven Massachusetts counties have instituted Day Reporting Programs, which are intensive programs of behavior management and supervision for offenders who can be safely managed in the community. Offenders participating in the program are still under the custody of the Sheriff's Department, but generally are allowed to live at home, following a successful experience in a pre-release setting, shortly before their sentence is completed. Such programs will serve over 1,000 offenders this year, a small number of whom are women. Generally, a day reporting program requires the offender to check in periodically with a designated officer on a daily basis, to maintain or seek employment, to participate in treatment programming, and to agree to daily urine testing.

E. SPECIFIC COMMUNITY BASED ALTERNATIVE PROGRAMMING FOR OFFENDERS WITH SUBSTANCE ABUSE PROBLEMS

1. Massachusetts Osteopathic Hospital Program for Women

The 20 bed Massachusetts Osteopathic Hospital facility in Jamaica Plain serves only a small subset of the female population committed for treatment under General Laws Chapter 123, section 35; that is, primarily those women who have no criminal involvement. The program is well-staffed and the facilities have been newly renovated; however, the program is unable to take women who have not yet completed detoxification. Therefore, though the physical plant and staffing complement is in place to conduct intensive treatment, the program does not offer secure detoxification or treatment services.

As noted previously, the Massachusetts Osteopathic program was not developed to serve women who need a high degree of security, so female offenders with serious charges are often not accommodated. The program has also experienced difficulty serving women with dual diagnoses, for example, substance abuse and mental illness or mental retardation. While the program contains all the necessary elements of an effective therapeutic milieu, its limited size prevents it from being widely available to courts looking for alternatives to incarceration.

2. Western and Eastern Massachusetts Alcohol Centers and the Longwood Treatment Center

Other alternatives to incarceration for women with substance abuse problems include the Longwood Treatment Center located in Boston, the Western Massachusetts Alcohol Center in Springfield, and the Eastern Massachusetts Alcohol Center in New Bedford.

Longwood is a 125 bed (15 beds for women) minimum security treatment facility operated by the Department of Correction for county inmates. Western Massachusetts Alcohol Center is a minimum security facility operated by the sheriffs of western Massachusetts, with three beds for civilly committed women. None of the programs will take women until they have detoxified, nor will they accept those with outstanding charges of any significance, or those who are dually-diagnosed.

Because these are minimum security facilities, a committing court can have some assurance that a women sent there pursuant to Section 35 will be retained for the full thirty day period. However, the small capacity of these programs and the substantial distance of two of the programs from the Boston area means that they are generally out of reach for most courts searching for placement options for civilly committed women.

3. Neil Houston House

As described earlier, the newly-opened Neil Houston House in Roxbury provides an alternative to incarceration program in an intensive therapeutic residential setting for pregnant offenders with substance abuse problems.

F. RECOMMENDATION FOR IMPROVEMENTS IN ALTERNATIVES TO INCARCERATION AND DIVERSIONARY PROGRAMMING

1. Additional programs to provide mental health and substance abuse treatment and services to female offenders who have been appropriately diverted out of the criminal justice system need to be developed. Existing programs, such as the Elizabeth Stone House, which provides housing and support to former offenders who have histories of mental health problems, and the Massachusetts Osteopathic Program, which provides treatment to women civilly committed for substance abuse treatment, should be expanded or used as models for new programs.

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CHAPTER 7

CONCLUSION

The Panel was given a broad mandate to evaluate, reform, and, in some instances, create new systems which cross administrative, legal, and philosophical lines. The Panel has viewed its charge as an extremely important and challenging one. The provision of quality services for special needs populations in the criminal justice system is essential. The humanitarian justifications for improving and expanding these services are evident. It is equally clear, however, that public safety is at stake when these service systems are disjointed and incomplete. The financial and human costs of a flawed system are infinitely higher than the cost of restructuring and maintaining a comprehensive system.

The opportunity to take a fresh and coordinated look at systems and services which have for decades been neglected and fragmented has been welcomed. The Panel's research has revealed that many of the assumptions on which these service delivery systems were based are either long-forgotten or clearly outdated. The Panel has made a wide range of recommendations for reform. These recommendations cut across a variety of agency lines and service delivery systems. They require statutory change, policy development and program design. The adoption of some recommendations will require substantial funding; others will rest solely on advocacy and educational efforts.

The Panel is cognizant of the current fiscal constraints which militate against immediate broad-based systems expansion and reform. However, in developing these recommendations the Panel was careful to remain mindful of its mandate; that is, to propose a "state-of-the-art" forensic mental health system based on national models. The Panel is hopeful that in the current budgetary climate, these recommendations for reform will not be summarily dismissed. Rather, the Panel urges that these proposals be seen as a blueprint for a model system which has immediate, short-term and long-term components. Though many of the recommendations clearly anticipate significant new funding, others can be implemented with only minor policy or statutory revisions, and some may actually be cost-saving.

The challenge before the Panel was to develop a plan for a uniform continuum of services which will humanely and comprehensively serve the individuals who are some of the Commonwealth's most difficult and needy. The Panel has drawn on the laudable efforts of the administration and legislature to begin to grapple with these complex issues. Many of the individuals who have been involved in the Panel's work are looking forward to taking part in a long-term implementation strategy for these proposals. The Panel recommends that a group of individuals be appointed by the Governor and Secretary of Human Services to oversee a plan for implementing the Panel's recommendations.

The Panel has appreciated this unprecedented opportunity to offer these recommendations and hopes that their adoption will serve to make Massachusetts a leader in innovative mental health and criminal justice policy.

ADDENDUM

CHAPTER ONE OF THE ACTS OF 1988

SECTION 4

There is hereby established a special advisory panel on the organization and structure of the commonwealth's forensic mental health system and on the appropriate evaluation and treatment of mentally ill offenders and mentally ill men and women who are in need of care in a medium or strict secure setting.

Said panel shall consist of the secretary of the executive office of human services, the commissioner of the department of correction, the commissioner of the department of mental health, a justice of the trial court to be appointed by the chief administrative justice of the trial court, and six persons to be appointed by the governor including an advocate for the needs of mentally ill men and women, and five experts, one of whom shall be a professional in the field of forensic mental health having national and substantial experience in said field, one of whom shall be a forensic psychiatrist or psychologist, one of whom shall be a criminologist, one of whom shall be an attorney, one of whom shall be an expert in the field of criminal justice management. The governor shall appoint the chairman from the panel of experts.

Said panel shall identify, examine and evaluate the existing organizational and management structure, purpose, and population of each of the five institutions forming the Bridgewater complex, and shall review the laws, programs, policies, and procedures which govern the referral and admission to, and discharge from each institution, the use of seclusion and restraint at Bridgewater State hospital, and shall assess the delivery of mental health services to each identified population.

The panel shall make specific findings and recommendations with regard to the appropriate management and treatment of each identified population, including the allocation of responsibility for the care of said populations among the several state agencies; the development of a state-wide forensic mental health policy which meets the needs of both men and women, provides a continuum of services and treatment and examines components within the department of mental health, the department of corrections, the court system, and the county houses of correction, including recommendations on the use of court clinics; the resources necessary for effective service delivery; and the need for capital improvements to the complex.

In formulating its recommendations, the panel shall address the function of the addiction center and its appropriateness as a correctional facility; the commonwealth's policies relative to the evaluation, disposition, treatment, and release of persons who are found not guilty of a crime by reason of mental illness or defect, with an analysis of the need for post-release monitoring or conditional release of such persons, including the feasibility of establishing a psychiatric review board; the role of the southeastern correctional center; the care and treatment of mentally ill women within the mental health and correctional systems; the need for accreditation of the state hospital; the

efficacy and relevance of the categorization and commitment of so-called sexually dangerous persons and alternatives, if any, to the current system.

Said panel may travel out-of-state and may employ such staff, experts, and consultants, subject to the approval of the chairman, as deemed necessary. Said panel shall be guided by nationally recognized models and standards which utilize state-of-the-art methodologies for the provision of mental health services in secure settings. Said panel may expend appropriated funds for travel, printing, and such other expenses as are necessary and shall be reimbursed for its necessary and reasonable expenses.

Said panel shall file an interim report with the governor and with the committees on ways and means of the house of representatives and the senate, the joint committee on human services and elderly affairs and the joint committee on criminal justice on the results of its review of each matter enumerated herein an its recommendations concerning each such matter, on or before September first, nineteen hundred and eighty-eight. Said report shall identify any budgetary, administrative or capital resources or statutory changes necessary to implement its recommendations. The governor shall file if he deems necessary a special legislative message requesting any amendments to the commonwealth's fiscal year nineteen hundred and ninety appropriation based upon review of said report. The final report of said panel shall be filed with the governor and with the above named committees no later that December first, nineteen hundred and eighty-eight.