MARCH 22, 2025

MASSACHUSETTS DEPARTMENT OF CORRECTION

COMPLIANCE REPORT #4

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DESIGNATED QUALIFIED EXPERT

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BACKGROUND

In October of 2018, the United States Department of Justice (DOJ) initiated an investigation of the Massachusetts Department of Correction (MDOC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. The investigation initially focused on (1) the placement of prisoners[1] with serious mental illness in restrictive housing, and (2) the provision of medical care to geriatric and palliative care prisoners. In November of 2019, the DOJ added a third focus to its investigation: whether MDOC was providing adequate care and supervision to prisoners experiencing mental health crises. By November of 2020, the DOJ had closed the geriatric and palliative care portions of the investigation, as well as the portion of the investigation related to restrictive housing except as it pertained to crisis mental healthcare.

In a CRIPA notice (i.e., Findings Letter) dated November 17, 2020, the DOJ concluded there was reasonable cause to believe that MDOC had violated the Eighth Amendment of the U.S. Constitution through its alleged failure to provide adequate mental healthcare to prisoners in crisis, as well as through its alleged placement of prisoners on mental health watch under "restrictive housing" conditions for prolonged periods of time. The DOJ's report noted problems with MDOC's crisis mental healthcare including:

- Long lengths of stay on mental health watch despite MDOC's goal of discharging prisoners after 96 hours
- Overly restrictive conditions of confinement on mental health watch, including very limited access to clothing and property
- Episodes of self-injury that occurred while prisoners were being observed on mental health watch
- Correctional officers not removing items from mental health watch cells that prisoners could use to harm themselves, including razor blades and batteries
- Correctional officers falling asleep while monitoring prisoners on mental health watch
- Correctional officers being inadequately trained about how to monitor prisoners on mental health watch
- Correctional officers not calling mental health staff for help and/or actively encouraging prisoners in crisis to harm themselves
- Inadequate staffing levels (both security and mental health) to ensure out-of-cell therapeutic activities for prisoners on mental health watch
- Mental health staff not providing meaningful treatment while prisoners are on mental health watch, including group and individual therapy

[1] Although we recognize the importance of person-first, non-pejorative language when discussing individuals experiencing incarceration, we use the term "prisoner" to be consistent with the language of the Settlement Agreement and to enhance the readability of the report.

- Mental health staff not providing adequate follow-up care to prisoners after their discharge from mental health watch

MDOC disputed the DOJ's findings and denied all Constitutional violations. Nonetheless, the parties agreed that it was in their mutual interest and the public interest to resolve the matter without litigation. After a lengthy negotiation, they entered into a Settlement Agreement dated December 20, 2022 (herein "the Agreement") and appointed a Designated Qualified Expert (DQE) for a four-year term to assess MDOC's compliance with the Agreement. Three team members are assisting the DQE with this endeavor: Scott Semple, Ginny Morrison, and Julie Wright. Dr. Wright is a clinical psychologist with expertise in correctional mental healthcare. Ms. Morrison and Mr. Semple have expertise in correctional oversight and security, respectively.

The parties have agreed upon the following timeline for compliance with the Agreement. The provisions highlighted in orange were due prior to the completion of the fourth DQE report. For all provisions not listed here, the DQE team understands that the requirement went into effect with the signing of the Agreement.

Time Frame	Compliance Requirement	Paragraph of Agreement
Immediate	• Notify US and DQE of suicides and serious suicide attempts within 24 hours	147
Within 30 days (Jan 19, 2023)	• Designate agreement coordinator	169
Within 60 days (Feb 18, 2023)	• DQE's baseline site visit	160
Within 90 days (Mar 20, 2023)	• Begin Quality Assurance reporting and report monthly thereafter • Begin Quality Improvement Committee	139 141
Within 4 months (Apr 20, 2023)	• Submit staffing plan #1 to DQE and DOJ	32
Within 6 months (June 20, 2023)	• Officers read and attest to Therapeutic Supervision policy • MDOC administration begins conducting regular quarterly meetings with prison staff • Consult with DQE to draft policies (including Quality Assurance policies) • Suicide prevention training curriculum submitted to DOJ • All security staff trained in CPR (except new hires) • MDOC provides Status Report #1 to DQE and DOJ	94 170 26, 138 42(b) 42(d) 159
Within 1 year (Dec 20, 2023)	• Three out-of-cell contacts or documentation of refusals • TS length of stay notification requirements • Support Persons are retained at each facility where TS occurs • All policies finalized • New hires trained in CPR • ISU policies drafted	67 77 98 27 42(d) 113

	• Status Report #2 to DQE and DOJ	159
Within 16 months (Apr 20, 2024)	• Staffing plan #2 to DQE and DOJ	32
Within 18 months (June 20, 2024)	• Intensive Stabilization Unit operates • Training plan for all new/revised policies is developed • Status Report #3 to DQE and DOJ	114 39 159
Within one fiscal year of Staffing Plan #1 (June 30, 2024)	• Staffing completed in accordance with Staffing Plan #1	37
Within 24 months (Dec 20, 2024)	• All staff trained through annual in-service on new policies • Status Report #4 to DQE and DOJ	40 159
Within 27 months (March 20, 2025)	• Security staff complete pre-service suicide prevention training	42(c)
Within 28 months (April 20, 2025)	• Staffing plan #3 to DQE and DOJ	32
Within 30 months (June 20, 2025)	• Status Report #5 to DQE and DOJ	159
Within one fiscal year of Staffing Plan #2 (June 30, 2025)	• Staffing completed in accordance with Staffing Plan #2	37
Within 3 years (Dec 20, 2025)	• Implement all provisions fully • Status Report #6 to DQE and DOJ	176 159
Within 40 months (Apr 20, 2026)	• Staffing plan #4 to DQE and DOJ	32
Within 36 months (June 20, 2025)	• Status Report #7 to DQE and DOJ	159
Within one fiscal year of Staffing Plan #3 (June 30, 2026)	• Staffing completed in accordance with Staffing Plan #3	37
Within 4 years (Dec 20, 2026)	• Substantial compliance with all provisions maintained for one year • Status Report #8 to DQE and DOJ	177 159
Annual reviews (timing TBD)	• Review policies and submit revisions to DOJ for approval • Review TS data analysis/tracking plan and submit revisions to DOJ	31 139

PURPOSE AND FORMAT OF REPORT

In accordance with Paragraphs 161 and 162 of the Agreement, this report assesses MDOC's progress toward compliance with the Agreement's substantive provisions. The report uses the following definitions when assessing compliance:

1. **Substantial compliance** indicates that MDOC has achieved material compliance with the components of the relevant provision of the Agreement.
2. **Partial compliance** indicates that MDOC has achieved material compliance with some of the components of the relevant provision of the Agreement, but that significant work remains.
3. **Noncompliance** indicates that MDOC has not met the components of the relevant provision of the Agreement if the time frame required for compliance with said provision, as set forth in the Agreement, has elapsed.
4. **Compliance not yet due** indicates that MDOC is working toward compliance with said provision where the time frame for compliance with said provision, as set forth in the Agreement, has not yet elapsed.

"Material compliance" requires that, for each provision, MDOC has developed and implemented a policy incorporating the requirement, trained relevant personnel on the policy, and relevant personnel are complying with the requirement in actual practice.

EXECUTIVE SUMMARY

More than two years into the Agreement's implementation, it is important to take stock of what has been accomplished:

- MDOC is now operating the Intensive Stabilization Unit (ISU) at Old Colony Correctional Center, a 15-bed treatment unit designed to fill the gap between short-term "therapeutic supervision" ([TS], formerly known as mental health watch) and psychiatric hospitalization. In the ISU, patients engage in all-day treatment and recreational activities provided by a multidisciplinary treatment team. As of December 31, 2024, 11 patients had been treated on the unit, and others were being referred.

- MDOC's healthcare vendors have created a new job class, Support Person, to function as an adjunct to the mental health clinicians and provide non-clinical contacts with prisoners on TS (and at other times). Many individuals hired as Support Persons bring experience from working in other psychiatric care settings, and they are enthusiastic about creating a more therapeutic environment within MDOC.

- Prisoners' self-directed violence (SDV) has substantially decreased since the DOJ's investigation in 2019. In December 2024, total SDV was down 19% compared with 2019, and SDV occurring while a prisoner was on TS was down 35%. Rates of cutting while on TS decreased by 72%, attempted hanging by 54%, and insertion of foreign bodies by 33%.

- MDOC has implemented a system of reviewing long TS placements with behavioral health leaders on each weekday, and there has been a substantial decrease in the number of very long placements. MDOC has essentially eliminated TS stays lasting longer than six months, and placements lasting longer than three months have decreased by 80% when compared with the DOJ's investigation in 2019.

- The closures of MCI-Cedar Junction in 2023 and MCI-Concord in 2024 redistributed security staff to the remaining MDOC facilities, resulting in higher staffing levels at many of the facilities where TS occurs. In December 2024, 83% of key correction officer positions were filled, compared with 73% in April 2023. This has led to fewer mandated overtime shifts and has better supported the provision of mental healthcare.

- MDOC is now operating a peer mentorship program for incarcerated women at MCI-Framingham, with over a dozen women trained to provide emotional support, conduct daily "drop-in hours," and publish a quarterly newsletter. MCI-Norfolk is in the process of developing a similar program for incarcerated men; volunteers are currently being recruited and trained.

- MDOC and its healthcare vendors have implemented a more robust, system-wide Quality Assurance program for mental health, with monthly meetings and regular review of key indicators such as self-injury, TS placements, use of force, and referrals to higher levels of care. These meetings have identified areas of concern similar to those raised by the DQE team, signaling the development of an internal auditing process that can continue after the Agreement has ended.

- MDOC's healthcare vendors are actively conducting trainings for mental health staff around essential clinical skills, many of which the DQE team has found lacking in previous monitoring periods. Recent trainings have included treatment planning, risk assessment, recognizing psychosis, and clinical documentation, among other topics.

These are major accomplishments for which MDOC should be congratulated, and the DQE team is pleased that MDOC has come this far in two years.

Looking to the next six months, the DQE team encourages the parties to focus on a few essential aspects of the Agreement that affect the quality of patient care. From the DQE team's perspective, these are the highest priorities needing urgent attention:

- Nearly every data point tracked by the DQE team indicates that mental healthcare at Souza-Baranowski Correctional Center (SBCC) is getting worse, not better.[2] There is insufficient space, time, staffing, and patient access at SBCC to provide meaningful care to prisoners in crisis. The facility now accounts for 42% of TS placements, 44% of self-injury, and 52% of use of force incidents during TS;[3] these percentages have risen since data tracking began. Mental health staffing levels at SBCC are lower than when the Agreement began, with only 48% of contracted mental health professional (MHP) positions filled. As MDOC's own review of a serious suicide attempt in August 2024 found, mental health assessments are too often superficial, brief, and conducted in nonconfidential settings. At each site visit, the DQE team has suggested achievable strategies to begin addressing these issues, such as creating a schedule for using available office space, but little has changed systemically. The poor quality of care at SBCC remains the biggest hurdle for MDOC to achieve success with the Agreement.

- Across MDOC, most direct clinical care is provided by inexperienced mental health clinicians who do not yet have a license to practice independently.[4] Low staffing levels of psychiatrists and psychologists make it difficult to create the type of collaborative, multidisciplinary treatment teams that are common in other mental healthcare settings and allow young clinicians to acquire new skills over time. As a result, many of MDOC's clinicians appear to be checking boxes on forms about "risk assessment" and "treatment planning" without understanding that these concepts are more than just asking a prisoner, "Are you going to be safe?" There is relatively little collaboration with psychiatrists and psychologists, and at some facilities, clinicians continue to rely heavily on distributing packets of games and puzzles in lieu of providing meaningful therapy.

- So-called "institutional factors" continue to drive mental health crises and self-injury across MDOC. Prisoners frequently act out, including by injuring themselves, in an attempt to influence their environment with regard to housing, classification, privileges, and discipline. Mental health clinicians' typical approach has been to avoid getting involved in these matters, seeing them as the purview of security staff. At first glance, this boundary makes sense. However, in the absence of collaboration with security personnel to resolve the underlying matters, mental healthcare becomes disproportionately—and at some facilities almost exclusively—focused on coping with stressful conditions of confinement. Spending time saying to patients, "Let's review your skills to cope with a problem that nobody will help you solve," seems like an inefficient

[2] As noted in previous DQE reports, SBCC has a complex and changing mission, becoming the main intake site for male prisoners after Cedar Junction's closure (in addition to being the maximum-security site). This likely plays a part in the challenges with delivering adequate mental health services.
[3] In December 2024, SBCC housed approximately 18% of MDOC's total prisoner population.
[4] For example, at SBCC, two out of the 10 total MHPs are licensed. MDOC indicated that, statewide, 24 of 59 MHPs are independently licensed.

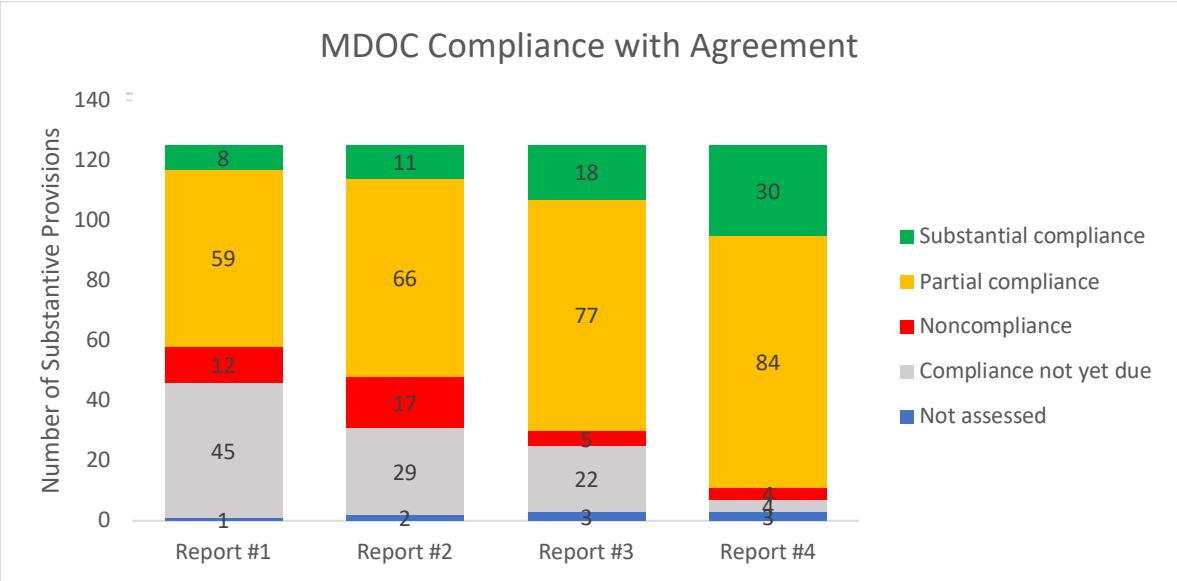
and ineffective use of precious mental healthcare resources. Greater collaboration with security staff is needed.

- Restrictive security practices, such as shackling prisoners behind their backs during mental health contacts and locking down entire housing units when a prisoner "calls crisis," continue to hamper the provision of mental healthcare and prisoners' willingness to engage in it. Moving toward a system of individualized decision-making about restraints, observation, property, and privileges is essential to MDOC's success with the Agreement.

These are not easy problems to solve, but focusing the parties' efforts on the areas most likely to impact clinical care rather than on, for example, technical compliance with the exact time frame for a mental health contact or with the Agreement's committee membership mandates, seems like the most fruitful next step.

Despite this call to look at the big picture, the DQE team is still obligated to assess compliance with each of the Agreement's 125 substantive provisions. During this monitoring period, MDOC improved its compliance ratings for 17 provisions. Another 99 provisions remained unchanged or were assessed for the first time, and two provisions slid backward. Compliance with four provisions is not yet due, and three provisions are not being assessed by agreement of the parties.

As of December 31, 2024, the end of the data collection period for this report, MDOC had achieved substantial compliance with 30 of the substantive provisions, and only four provisions were noncompliant. The figure below illustrates MDOC's progress over the course of the Agreement.



Notably, MDOC made these gains while undergoing a huge transition to a new healthcare vendor, VitalCore Health Strategies, on July 1, 2024. It is encouraging that the vendor transition did not result in a mass exodus of mental health staff from MDOC; mental health staffing levels were actually higher in December 2024 than in June 2024. It is also encouraging that MDOC has continued to progress with the Agreement during a time of significant violence and tragedy in the agency, including at least two homicides of prisoners by other prisoners, two overdose deaths of prisoners, and two officer stabbings at SBCC by prisoners, all since September 2024. The DQE team continues to have faith in the commitment of MDOC's leadership to cooperate with the Agreement and improve the mental healthcare of its 5,800 prisoners. Our hope is that the few Agreement provisions where compliance ratings slid backward during this monitoring period are related to the healthcare vendor transition and/or recent violent events, and they will rebound in the near future.

The following table illustrates MDOC's current compliance with the Agreement. Ratings marked in green indicate that MDOC improved during this monitoring period, while those marked in red indicate a decline. The next section, *Detailed Findings*, describes the basis for each compliance rating.

		Substantial Compliance	Partial Compliance	Non-Compliance	Compliance Not Yet Due
Policies and Procedures					
26	Within 6 months, consult with DQE to draft/revise policies and procedures	X			
27	Within one year, finalize all policies and procedures after approval by DOJ		X		
28	Within 6 months of finalizing policies, modify all post orders, job descriptions, training materials, performance evaluation instruments				X
29	Fully implement all policies within 18 months of DOJ approval				X
30	Follow public hearing process if any policy changes implicate MA public regulations				
31	Review policies annually and revise as necessary		X		
Staffing Plan					
32	Within 4 months, submit staffing plan to DQE and DOJ, and annually thereafter	X			
33	Increase security staffing to ensure out-of-cell activities for prisoners in crisis		X		
34	Rotate security staff on Constant Observation watches every 2 hours		X		
35	Increase mental health staffing and hours on site to ensure meaningful therapeutic interventions		X		
36	Staffing of ISU – supervising clinician, multidisciplinary team, make individual decisions about property/privileges		X		
37	Staff prisons within one fiscal year of each staffing plan		X		

Training					
38	Provide pre-service and annual in-service training on new policies, mental healthcare, suicide prevention, de-escalation techniques	**X**			
39	Within 6 months of policy's final approval, incorporate Agreement requirements and DQE recommendations into training				X
40	Within 12 months of DOJ policy approval, all security and mental health/medical staff trained				X
41	Training uses evidence-based techniques and incorporates videos of prisoners/family	**X**			
42	Ensure that all staff are sufficiently trained in suicide prevention. Offer CIT, pre-service and annual in-service suicide prevention training, CPR certification.		X		
Therapeutic Response to Prisoners in Mental Health Crisis					
43	Staff informs mental health immediately about concerns of suicide/self-injury, holds prisoner on Constant Observation until assessed		X		
44	QMHP responds within 1 hour during coverage hours		X		
45	During non-business hours, staff notify on-call QMHP, prisoner evaluated next business day		X		
46	Prisoners not disciplined for mental health crisis	X			
47	Initial mental health crisis evaluation includes required elements 47a-47f		X		
48	QMHP consults with psychiatrist/ARNP and clinical supervisor during initial assessment, as indicated		X		
49	Document initial assessment in progress note using DAP format	X			
50	If QMHP determines prisoner at risk of suicide/self-harm, will be placed on appropriate level of watch	**X**			
51	Mental health watch not used as punishment or for convenience of staff	X			
52	Crisis treatment plan includes required elements 52a-52k		X		
53	QMHP determines appropriate level of watch (close or constant)	**X**			
54	Prisoner placed in suicide-resistant cell or on constant observation if cell not suicide-resistant		X		
55	Implement cell safety checklist, supervisor reviews checklist if prisoner engages in self-injury		X		
56	Mental health watch conditions based on clinical acuity, disagreements referred to MH Director and Superintendent		X		
57	Individualized clothing determinations		X		
58	Shower after 72 hrs on watch unless contraindications documented, security documents when showers offered		X		
59	Lighting reduced during sleeping hours		X		
60	QMHP makes individualized, least restrictive property determinations		X		
61	QMHP makes individualized privilege determinations, provides access to reading materials after 24 hrs and tablet after 14 days unless contraindicated		X		
62	Individualized determinations about visits, phone, chaplain, activity therapist	X			
63	Outdoor recreation after 72 hrs on watch, security documents when offered. QMHP documents		X		

	contraindications every day. Consider alternatives to strip searches				
64	Prisoners not restrained when removed from cell unless imminent threat, QMHP documents reasons why restraint necessary		X		
65	Meals out of cell after 72 hrs unless insufficient space or not permitted by DPH		X		
66	MDOC committed to providing constitutionally adequate mental healthcare to prisoners on watch				
67	Within one year, provide three daily out-of-cell contacts, document refusals and follow-up attempts		X		
68	Triage minutes reflect refusal of contacts (who/when/why), MH staff review prior triage minutes		X		
69	QMHP updates MH watch conditions daily Mon-Sat, and Sun if constant watch	X			
70	QMHP documents all attempted interventions and success in daily DAP notes	X			
71	Re-assess interventions if prisoner engages in self-injury while on watch		X		
72	Meaningful therapeutic interventions in group and/or individual settings		X		
73	Individualized determinations and documentation of out-of-cell therapeutic activities		X		
74	Therapeutic de-escalation room at MCI Shirley and ISU		X		
75	Consider peer program for prisoners on watch		X		
76	Consider therapy dogs in mental health units		X		
77	Within one year, prisoners transferred to higher level of care if clinically indicated	**X**			
78	Consult with program mental health director and notify Director of Behavioral Health after 72 hrs on watch		X		
79	Consult with Director of Behavioral Health and ADC of Clinical Services after 7 days, document consideration of higher level of care in medical record		X		
80	Consult with Director of Behavioral Health, ADC of Clinical Services, and DC of Reentry and Clinical Services at day 14 of watch and every day thereafter. Document consideration of higher level of care and reevaluation of treatment plan.		X		
81	Develop and implement step-down policy for prisoners released from watch	X			
82	Perform audits to ensure QMHPs are releasing prisoners from watch as soon as possible, after out-of-cell contact and consultation with supervisor or upper-level provider		X		
83	QMHP documents and communicates discharge plan that includes housing referral, safety plan, mental status, follow-up plan		X		
84	Follow-up assessment within 24 hrs, 3 days, 7 days. QMHP reviews and updates treatment plan within 7 days, consults with upper-level provider as indicated.		X		
85	Prisoners interviewed by upper-level provider prior to discharge from watch if clinically indicated		X		
86	If prisoner transferred under 18a commitment, reassessed upon return to MDOC for necessity of continued watch	X			
Supervision for Prisoners in Mental Health Crisis					
87	Establish and implement policies for Close and Constant Observation on watch		X		

88	Observation level determined by QMHP, reevaluated every 24 hrs	X			
89	No placement on MH watch for disciplinary purposes		X		
90	Notification procedures for SIB that occurs on MH watch		X		
91	Staff who discover SIB will report immediately to medical and QMHP		X		
92	Staff who observe SIB document in centralized location		X		
93	Investigate and/or discipline staff violations of policy or rules		X		
94	Security training on new MH watch policies and procedures, sign attestation, post policies on TS units		X		
95	CO remains in direct line of sight of prisoners on Constant Observation		X		
96	CO checks and documents signs of life every 15 minutes		X		
97	Door sweeps in MH watch cells to prevent contraband or foreign bodies		X		
98	Within 1 year, MDOC will ensure Wellpath retains support persons in facilities where MH watch occurs	**X**			
99	Support persons provide additional non-clinical contacts, part of MDT		X		
100	40 hrs of pre-service training and CIT training for support persons		X		
101	QMHP on site to oversee Support Persons and ensure appropriate interventions	**X**			
102	Support Persons work 6 days a week on shifts when most SIB occurs		X		
103	QMHPs discuss Support Person activities during shift change		**X**		
104	Support Person's documentation reviewed during triage meeting		X		
105	Update procedure for responding to SIB that occurs while on watch		**X**		
106	Call Code 99 immediately if SIB is life threatening		**X**		
107	If SIB not life threatening, staff engage with prisoner, encourage cessation, inform supervisor		X		
108	Complete SIBOR within 24 hours for all SDV incidents		X		
109	Officer documents all SIB that occurs while on watch		X		
110	QMHP assesses and modifies treatment plan as necessary within 24 hours of SIB		X		
111	Follow policies on ingestion of foreign bodies outlined in 112		**X**		
112	Update policies on foreign body ingestion to include monitoring procedures, roles of personnel, use of BOSS chair/body scanner/wand		**X**		
Intensive Stabilization Unit					
113	Within 1 year, draft ISU policies and procedures	**X**			
114	Within 18 months, operate ISU	**X**			
115	ISU provides services for prisoners who have been on MH watch and need higher level of care but not 18a commitment	**X**			
116	Treatment and programming in accordance with individualized plan		X		
117	Units that serve same purpose as ISU follow ISU guidelines from Agreement				
118	Prisoners referred to ISU if multiple other interventions have been ineffective, prisoners may request placement and be involved in treatment planning		X		

119	Each prisoner assigned stabilization clinician in ISU	X			
120	Prisoners evaluated daily (Mon-Sat) during initial phases of ISU		X		
121	Group programming in ISU based on individualized treatment plan		X		
122	ISU permits out-of-cell time and congregate activities		X		
123	Access to all on-unit programs without unnecessary restraints		X		
124	Assessment by QMHP at least once weekly	X			
125	Contact visits and phone privileges commensurate with general population		X		
126	Group meals on unit (MDOC to work with DPH)		X		
127	Clothing and property in cell commensurate with gen pop			X	
128	Indoor and outdoor recreation on unit		X		
129	Movement restricted to ISU		X		
130	Track out-of-cell time offered and whether accepted or refused			X	
131	Prisoners not restrained for off-unit activities unless necessary			X	
132	Support persons engage prisoners in non-clinical activities and document response		X		
133	Activities therapists provide group and individual programming		X		
134	Therapeutic intervention utilized prior to initiating MH watch		X		
135	Therapeutic de-escalation area in ISU		X		
Behavioral Management Plans					
136	QMHP creates individualized, incentive-based behavior plans when indicated, based on principles in 136a-136h			**X**	
Quality Assurance					
137	MDOC ensures that vendor engages in adequate quality assurance program		X		
138	Draft quality assurance policies to identify and address trends and incidents related to crisis mental healthcare		X		
139	Within 3 months, begin tracking and analyzing data delineated in 139a	X			
140	DQE reviews records and interviews prisoners re: clinical contacts and property/privileges while on watch	X			
141	Within 3 months, develop Quality Improvement Committee that engages in activities 141a-141f	X			
142	SIB Review Committee meets twice/month and includes required members		**X**		
143	SIB Committee reviews QI committee's data re: self-injury, conducts in-depth analysis of prisoners with most self-injury, conducts MDT reviews of all episodes requiring outside hospital trip		X		
144	Minutes of SIB Committee meeting provided to treating staff		X		
145	Conduct timely morbidity/mortality reviews for all suicides and serious attempts		X		
146	Morbidity/Mortality Review Committee includes required members and conducts reviews in required format/time frames		X		
147	Notify DOJ and DQE and of all suicides and serious attempts within 24 hrs		X		

Other					
159	Within 180 days, provide bi-annual compliance report to DQE and DOJ. Subsequent report due one month prior to DQE's draft report.	X			
169	Within 30 days, designate Agreement Coordinator	X			
170	Within 6 months, conduct quarterly meetings with staff to gather feedback re: implementation of Agreement	X			

ASSESSMENT METHODOLOGY

To accomplish the objectives outlined in Paragraph 162 of the Agreement, the DQE team gathered data from several sources. Members of the team reviewed and analyzed different parts of the data set. Ultimately, the DQE is responsible for all opinions and compliance findings in this report. Data sources included:

1. Site Visits

The DQE team conducted site visits between September and December of 2024 at the eight MDOC facilities where TS occurs. The following activities were included in the site visits:

	Framingham	Gardner	MASAC	MTC	Norfolk	OCCC	Shirley	SBCC
	12/16/24	10/3/24	12/17/24	11/21/24	11/18/24	9/30-10/1/24	10/2/24	11/19-11/20/24
Inspection of TS cells	JW	RK	RK	RK		RK, GM	GM	RK, GM
Interview of prisoners recently/currently on TS	RK	RK, GM	None in facility	RK, JW	GM	GM, SS	GM	RK, JW, GM
Interviews of mental health staff	RK, JW	RK	RK	RK, JW	RK	RK, JW	RK	RK, JW
Interviews of security staff	RK	GM	RK	RK	RK, GM	GM, SS	GM	GM, SS, RK
Observation of MHPs responding to crisis calls	JW	RK		JW	RK	JW		RK, JW
Observation of MHPs conducting TS assessments	JW	RK	None to see	JW	None to see	JW	None to see	RK, JW

Observation of MH group programming			RK	RK		JW, RK		
Observation of other MH contacts (e.g., PCC, intake)			RK					JW
Observation of MH triage meeting	RK, JW	RK	RK	RK, JW	RK	JW, RK	RK	RK, JW
Observation of BAU Interdisciplinary Assessment Team meeting	RK, JW		(N/A)	RK, JW	GM	RK, JW, GM, SS		RK, JW
Observation of Morning Meeting	RK, JW	RK, GM	RK	RK, JW	RK, GM	RK, JW, GM, SS	RK, GM	RK, JW, GM, SS
Observation of Crisis Clinician Sign-Out					RK	RK		RK
Observation of Support Person contacts	None to see			None to see			RK	None to see

During the site visits, the DQE team was given broad access to information and the facilities, as required by Paragraph 158 of the Agreement. In addition to observing the mental health clinicians at work, the team was permitted to interview prisoners, security staff, and mental health staff confidentially, without MDOC leadership or legal representatives present.[5] In total, the DQE team interviewed 42 prisoners, 27 MDOC security staff members, and 24 mental health staff members during this monitoring period. The DQE team also spoke with MDOC's behavioral health leadership about progress with the Agreement during some site visits; this information was also considered when assessing compliance.

MDOC graciously allowed forensic psychiatry fellows from the Yale University School of Medicine to join the site visit at OCCC, demonstrating its commitment to transparency and ongoing support for the education of mental health professionals.

2. Document Review

For this report, data from July 1, 2024, through December 31, 2024, across all eight facilities where TS occurred during the reporting period were reviewed, except where stated otherwise in the text. General categories of documents are listed here rather than each document.

a. MDOC Status Report #4, dated December 20, 2024

[5] MDOC agreed to allow security staff to be interviewed privately by the DQE team, provided that no DOJ attorneys are included in the interviews.

b. Electronic health records

To review a representative sample of records from the eight facilities, records were chosen in accordance with the approximate proportion of total MDOC TS placements that occurred at each facility during this monitoring period:

Facility	Approximate % of Records
Framingham	8
Gardner	5
MASAC	3
MTC	4
Norfolk	13
OCCC	19
SBCC	42
Shirley	6

Records were reviewed for technical compliance with the Agreement (e.g., number and timeliness of assessments by mental health staff, completion of property/privilege forms), for appropriateness of clinical interventions (e.g., matching treatment to the patient's documented diagnoses and symptoms), and for adequacy of documentation (e.g., quality of treatment plans and progress notes).[6]

c. Data about crisis contacts and TS placements

1) TS Registry, a list of all prisoners placed on TS, including facility, entry and discharge dates, location of TS, and duration of TS placement
2) A sample of officers' observation logs for TS placements
3) A sample of cell inspection checklists for TS placements
4) Log of all restraints that occurred during TS placements
5) VitalCore Notification spreadsheets (for 72 hrs, 7 days, 14 days, 14+ days on TS)
6) Minutes of Daily Therapeutic Supervision Consultation meetings
7) Daily mental health Triage Meeting notes and End of Shift reports

d. Policies related to mental healthcare

1) Monthly letters from MDOC Clinical Operations Analyst describing the status of MDOC's policy revisions
2) Third revision and fourth revisions of MDOC policy 103 DOC 650 – Mental Health Services

[6] Because Ms. Morrison and Mr. Semple do not have a background in clinical care, only Drs. Kapoor and Wright assessed the appropriateness of medical documentation and clinical interventions.

3) Policy 103 DOC 562 – Code 99 Emergency Response Guidelines (dated 6/27/22)
4) Policy 103 DOC 501 – Institution Security Procedures (dated 3/4/24)
5) Policy 103 DOC 427 – Behavior Assessment Units and Secure Adjustment Units (dated 1/25/23)
6) Policy 103 DOC 506 – Search Procedures (dated 2/25/23)
    a. Standard Operating Procedure for 103 DOC 506: Body Orifice Security Scanner (BOSS) Chair (dated 1/21/25)
    b. Standard Operation Procedure for 103 DOC 506: B-Scan Body Scanner (dated 1/21/25)

e. Staffing data

1) VitalCore mental health staffing matrix from December 2024, including filled, overage, and vacant positions
2) MDOC security staffing matrix from December 14, 2024
3) ISU staffing plan, emailed by Clinical Operations Analyst on February 5, 2025

f. Training data

1) PowerPoint presentation and lesson plans for DOC pre-service training, "Suicide Prevention & Intervention, 2024-2025" (8-hour version)
2) PowerPoint presentation and lesson plans for Therapeutic Supervision training (revised August 20, 2024)
3) Crisis Intervention Training (CIT) attendance records
4) MDOC training records for all staff who completed CPR, suicide prevention, and Therapeutic Supervision training in TY 2024 and TY 2025 (through Nov 2024)
5) Wellpath Recovery Solutions training records for all security staff at MASAC
6) VitalCore's New Employee Orientation (NEO) training records
7) Training materials and attendance logs for various VitalCore staff trainings, including a Support Person training series
8) Draft of TS poster to be displayed in units where TS occurs

g. Intensive Stabilization Unit data

1) ISU triage meeting notes, August to December 2024
2) Referral paperwork for all admitted ISU patients
3) ISU staff training records from June 2024
4) ISU Handbook, dated December 13, 2024

h. Other mental health program information

1) MDOC monthly "Mental Health Roll Up Report"

2) List of all prisoners referred to a higher level of care (Section 18(a), Section 18(a1/2), ISU, RTU, or STU)
3) Summary of all Inter-Facility Clinical Case Conferences

i. Self-injury and Use of Force data

1) Log of all SDV incidents, both on and off TS
2) Self-Injurious Behavior Occurrence Report (SIBOR) for every incident of SDV
3) Incident reports written by security, MH, and medical staff for all SDV episodes that occurred while on TS
4) Incident reports related to five serious suicide attempts
5) Log of Use of Force incidents that occurred while a prisoner was on TS
6) Incident reports and medical/MH documentation from all incidents of foreign body ingestion
7) List of all cells certified as suicide-resistant (February 2025)

j. Quality assurance materials

1) Minutes from monthly Quality Improvement Committee (QIC) meetings
2) Redacted version of QIC's "Professional Conduct Log"
3) Monthly Quality Assurance spreadsheets in accordance with Paragraph 139
4) Morbidity/Mortality Review materials from five serious suicide attempts
5) Self-Directed Violence/Suicide Attempt (SDV/SATT) Review Committee Meeting minutes
6) Minutes from quarterly DOJ/MADOC Agreement Site Meetings

3. **Observation of four MDOC/VitalCore Daily TS Consultation meetings, October-December 2024** (conducted via Microsoft Teams)

4. Stakeholder feedback

In accordance with Paragraph 153 of the Agreement, the DQE continued to receive written feedback from stakeholders identified by DOJ and MDOC. These materials were shared with the parties along with the draft DQE report, in accordance with Paragraph 161.

DETAILED FINDINGS

POLICIES AND PROCEDURES

26. Within six months of the Effective Date, MDOC will consult with the Designated Qualified Expert (DQE) to draft and/or revise policies and procedures to incorporate and align them with the provisions in this Agreement.

Finding: Substantial compliance

Rationale: MDOC continues to consult with the DQE about policy revisions. Policy 103 DOC 650, Mental Health Services, was revised and submitted to the DQE for review three times: on September 20, 2023; April 25, 2024; and September 26, 2024. The DQE returned the draft to MDOC most recently on January 26, 2025, with very few substantive revisions, and MDOC submitted its final version to the DOJ for review on February 12, 2025. On March 5, 2025, DOJ approved policy DOC 650, and it is now being finalized by MDOC's Policy Development and Compliance Unit.

Several other policies are still under revision by MDOC, including 103 DOC 601, DOC Division of Health Services Organization (reviewed by DQE and returned to MDOC in January 2024); 103 DOC 622, Death Procedures (returned to MDOC in July 2024); 103 DOC 562, Code 99 Procedures, (returned to MDOC in January 2025), and 103 DOC 562 Institution Security Procedures (returned to MDOC in January 2025).

After comparing the most recent drafts of MDOC's policies to the substantive provisions of the Agreement, the DQE team has reached the following conclusions:

a. The policies have been adequately revised to be consistent with paragraphs 43-74, 77-89, 92-104, 107-111, 113-137, and 140-144 of the Agreement. This represents continued progress since the last DQE report. All the ISU policies are now aligned with the Agreement, as are the Support Person policies.

b. Some Agreement provisions remain inadequately captured in the policy language, including paragraphs 38-42 (staff training), 75 (peer support), 76 (therapy dogs), 90-91 (response to self-injury), 112 (BOSS chairs and body scanners prior to TS placement), 138-141 (quality assurance procedures), and 145-146 (morbidity/mortality reviews).

MDOC's leadership reported that some of the provisions not yet captured in the policies reviewed by the DQE team will be included in future revisions of policies such as 103 DOC 216, Training and Staff Development, or 103 DOC 601, DOC Division of Health Services Organization.

The new healthcare vendor's policies have not yet been provided to the DQE for review, nor have they been revised in accordance with the Agreement. This remains a significant project to be tackled in the next monitoring period.

27. Within one year of the Effective Date, all policies and procedures that needed to be drafted and/or revised to incorporate and align them with the provisions in this Agreement will be finalized by MDOC. MDOC will consult with the DQE to prioritize policies and procedures to accomplish these timeframes.

Finding: Partial compliance

Rationale: MDOC has made further progress with policy revisions, but it is a long way from completion, with no policies yet finalized. The overall progress of revisions, as of the drafting of this report, is listed in *Table 1*.

Table 1. MDOC Policy Revisions

Policy	Status
103 DOC 601	Revision sent to DQE on 9/20/23, comments sent back 1/13/24. Undergoing second revision by MDOC.
103 DOC 650	Approved by DOJ on 3/5/25, now being finalized and implemented by MDOC.
103 DOC 622	Revision sent to DQE on 4/25/24, comments sent back 7/28/24.
103 DOC 501	Revision sent to DQE on 9/13/24, comments sent back on 1/29/25.
103 DOC 562	Revision sent to DQE on 9/13/24, comments sent back on 1/29/25.
103 DOC 216	Undergoing first revision by MDOC.

The pace of revision has been slower than the timeline mandated by Paragraph 27, which states that all policies should have been revised over a year ago, by December 20, 2023. The DQE team is undoubtedly responsible for some of the delay, but MDOC must hasten its policy revisions if it is to achieve substantial compliance with Paragraph 27.

28. No later than six months after the United States' approval of each policy and procedure, unless the public hearing process pertaining to the promulgation of regulations is implicated and/or subject to the collective bargaining process, MDOC will make any necessary modifications to all post orders, job descriptions, training materials, and performance evaluation

instruments in a manner consistent with the policies and procedures. Following such modifications of post orders, job descriptions, training materials, and performance evaluation instruments, and subject to the collective bargaining process, MDOC will begin providing staff training and begin implementing the policies and procedures.

Finding: Compliance not yet due

Rationale: Nothing has changed since the DQE's last report. MDOC's policies are still undergoing revision to align them with the Agreement, and only one has been submitted to the DOJ for review, comment, or approval. Therefore, MDOC is not yet responsible for modifying post orders, job descriptions, training materials, and performance evaluation instruments. Likewise, the requirement for MDOC to train staff and implement its revised policies and procedures does not begin until after the modification of post orders, job descriptions, training materials, and performance evaluation instruments.

29. Unless otherwise agreed to by the Parties, subject to the collective bargaining process and/or because of the public hearing process that could be implicated and affect the timelines in this Agreement, all new or revised policies and procedures that were changed or created to align with this Agreement will be fully implemented (including completing all staff training) within 18 months of the United States' approval of the policy or procedure.

Finding: Compliance not yet due

Rationale: MDOC's policies are still undergoing revision to align them with the Agreement, and only one has been submitted to the DOJ for review, comment, or approval. Therefore, the 18-month clock for full implementation of the policies has not yet begun. This deadline can be extended if union negotiations or public hearings are necessary after the DOJ has approved a policy.

30. If any new policies or changes to policy implicate Massachusetts state regulations, the Parties recognize that MDOC must follow the public hearing process required by statute, which may affect the timing of policy implementation (G.L. c. 30A, §§ 1-8. See also 950 CMR 20.00 et seq.; Executive Order 145).

Finding: Not assessed

Rationale: By agreement of the parties, this provision is not being actively monitored. MDOC has not asserted that any of its proposed policy revisions would trigger the public hearing process.

31. MDOC will annually review its policies and procedures that relate to this Agreement, revising them as necessary. Any substantive revisions to the policies and procedures will be submitted to the United States for review, comment, and the United States' approval in accordance with Paragraph 27 and, if revisions to Massachusetts regulations are at issue, be subject to the public hearing process.

Finding: Partial compliance

Rationale: As noted in Paragraphs 27-28 above, MDOC's policies are still undergoing initial revision to align them with the Agreement, and only one been submitted to the DOJ for review, comment, or approval. MDOC already has a procedure in place regarding annual policy reviews, which is clearly delineated in policy 103 DOC 104, Internal Regulations/Policies, and involves assigning policies to their relevant MDOC leader (e.g., Deputy Commissioner of Clinical Services and Reentry) to be revised according to a monthly schedule.

The DQE does not yet have any information about VitalCore's process for reviewing its policies. These policies must also undergo annual review by VitalCore/MDOC and, if revised, approval by the DOJ before MDOC can be found in substantial compliance with Paragraph 31.

STAFFING PLAN

32. Staffing Plan Development: Within four months of the Effective Date, and annually thereafter, MDOC will submit to the DQE and the United States a staffing plan to meet the requirements of this Agreement and ensure that there are a sufficient number of security staff and mental health staff to provide meaningful supervision and/or therapeutic interventions to prisoners in mental health crisis. Each staffing plan will be subject to review and approval by the United States, which approval will not be unreasonably withheld. The Parties acknowledge that day to day staffing needs may fluctuate based on increases and decreases in inmate population and clinical acuity of individuals in mental health crisis.

Finding: Substantial compliance

Rationale: MDOC continued to submit monthly staffing matrices for its main healthcare vendor, VitalCore, and a quarterly matrix for its vendor at MASAC, Wellpath Recovery Solutions, to the DQE and DOJ during this reporting period. The most recent security staffing matrix was submitted on December 26, 2024. Paragraph 32 does not require the

DQE's approval of the staffing plan; it only requires that MDOC submit a plan. Thus, MDOC has fulfilled its obligation under Paragraph 32.

The DQE's reservations about the adequacy of MDOC's mental health staffing plan are addressed in Paragraph 35. The substantial compliance finding here refers only to the timely submission of mental health and security staffing plans in April of each year.

With regard to approval of the staffing plan, DOJ indicated its intent to focus on the annual plan due on April 20, 2025, so it did not comment on the staffing plans submitted during the current monitoring period.

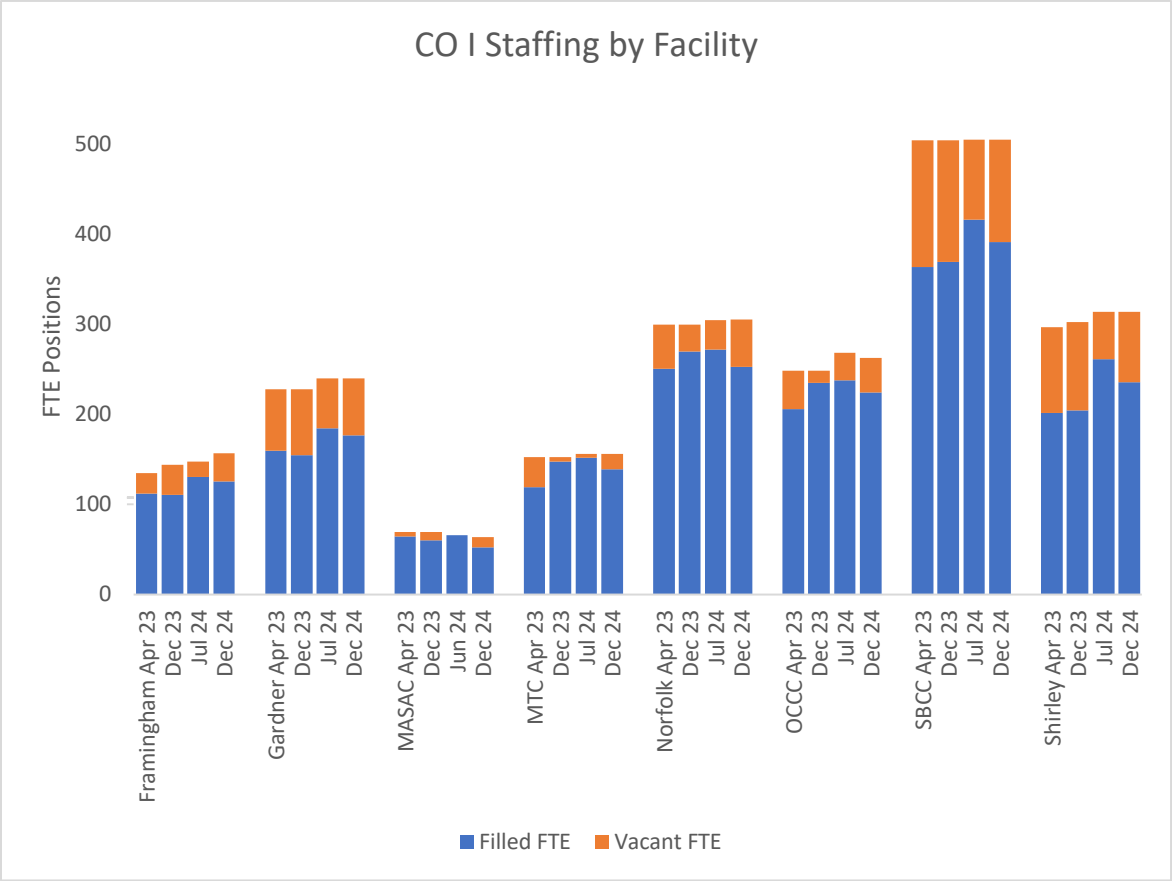
33. Security Staffing Escort: MDOC will increase security staffing as needed to ensure that there are sufficient staff to escort prisoners in mental health crisis to participate in out-of-cell activities such as recreational activities, group activities, etc., in accordance with Paragraphs 62 (Routine Activities), 63 (Exercise), and 65 (Meals out of cell).

Finding: Partial compliance

Rationale: Officers with the title Correction Officer I (CO I) most commonly interact with prisoners experiencing mental health crises; they are responsible for "calling crisis" on behalf of prisoners, observing prisoners while in the TS cell, and transporting prisoners to out-of-cell activities, among other duties. Officers with the title Correction Officer II (sergeants) and Correction Officer III (lieutenants) also play an important role, serving as shift supervisors who make decisions about matters such as use of force and prisoners' restraint status while on TS. The DQE team has tracked staffing levels of these three positions since the Agreement began.

Based on the MDOC security staffing matrix dated December 14, 2024, CO I staffing levels have declined since July 2024 at most facilities, as illustrated in *Figure 1*, but they remain higher than when the Agreement began.

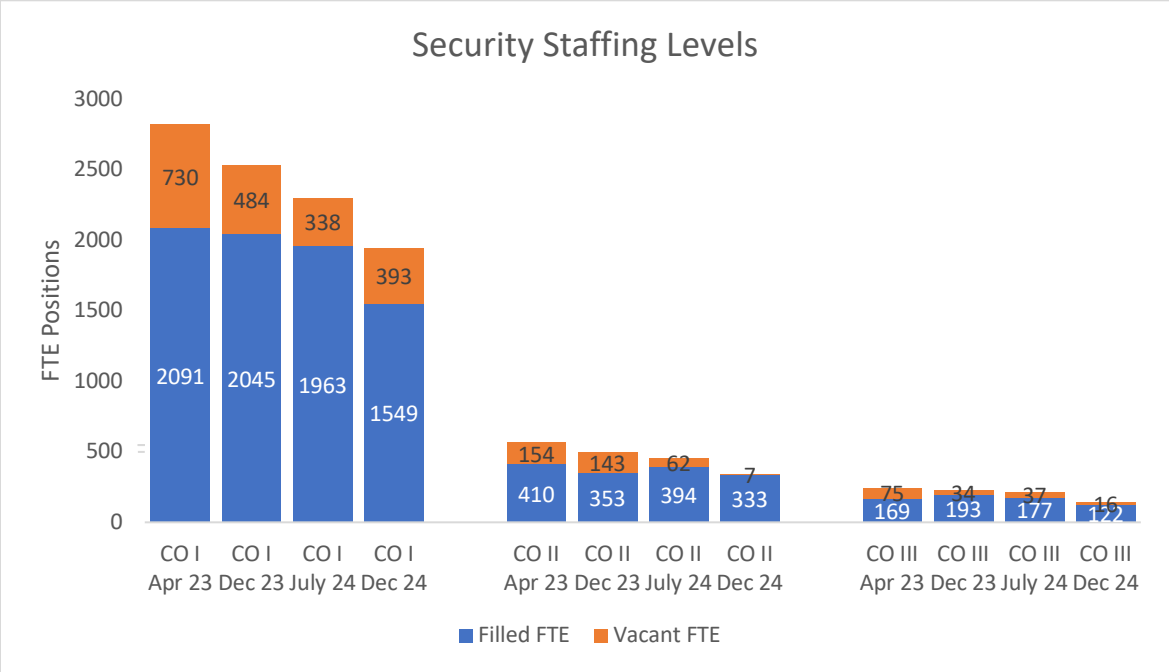
Figure 1. CO I Staffing by Facility[7]



As illustrated in *Figure 2*, the total number of officers (CO I, CO II, and CO III) declined again in December 2024. Since April 2023, when MDOC first submitted a staffing matrix to the DQE and DOJ, approximately 30% fewer security staffing positions are allocated across the facilities where TS occurs. This decrease is largely caused by the closure of MCI Cedar Junction and MCI Concord, though some staffing reductions occurred even after Concord's closure. In December 2024, 83% of CO I, CO II, and CO III positions were filled, compared with 73% in April 2023.

[7] MASAC does not employ correctional officers, but Wellpath's Residential Service Coordinators ("RSC") serve a role similar to a CO I, such as escorting patients while on TS and ensuring cell safety. Thus, the RSC staffing levels were included in the security staffing analysis here.

Figure 2. Security Staffing Levels, April 2023-December 2024



During the DQE team's site visits, facility leadership generally reported that staffing levels were improved since earlier in 2024, and "inverses" (i.e., mandated overtime shifts) were less frequent. SBCC was an exception, where leadership described the ongoing, frequent need for mandated overtime, especially on weekends. "Modified operations" continued to occur due to understaffing, resulting in portions of the facility being shut down (e.g., decreasing yard or gym time) during shifts with low staffing. CO attitudes and practices at SBCC, likely influenced by understaffing, continued to hinder the provision of adequate mental healthcare. The DQE team witnessed, and interviewed MHPs and prisoners confirmed, that officers at SBCC routinely decline to escort patients in the HSU and BAU to a private area for mental health assessment, citing conflicting responsibilities as the reason.[8]

Recruitment for new security staff continued during this monitoring period, with no significant changes in the success of these endeavors. In its December 2024 status report, MDOC stated that new classes of recruits were scheduled to complete the training academy in December 2024 and April 2025. During the DQE team's site visits, facility leaders were not optimistic about the ability of new recruits—only about 30 in each academy class—to solve their understaffing problems.

[8] See Paragraph 72 for further details.

34. Security Staffing Watch: MDOC will rotate security staff assigned to Constant Observation Watch every two hours, except where such rotation would jeopardize the safety and security of prisoners or staff or in the event of an unanticipated event (e.g., institutional emergency, emergency outside hospital trip) or temporary reduction in security staffing (e.g., COVID-19 pandemic) that impacts MDOC's ability to provide relief to security staff assigned to the watch.

Finding: Partial compliance

Rationale: In interviews throughout the last two years, the great majority of correction officers and supervisors have told the DQE team that the practice of rotating responsibility for constant observation every two hours has long been established. This was reinforced in 13 recent interviews across six institutions.[9] Only two people had a different understanding of the requirement.

On the other hand, DQE team interviews also included 14 prisoners with a recent experience of constant observation across five facilities, and fewer than half thought that observing officers changed every two hours. An equal number of prisoners said officers remained on this duty for their entire shifts. This perception was not concentrated at any particular institution.

Documents, too, suggested that MDOC has set a goal of rotating officers as required, but that goal was only met in a minority of cases. The DQE team reviewed a sample of records from 32 TS placements with constant observation in the monitoring period. The sample was drawn from all institutions responsible for TS and from BAU, HSU, RTU, STU, and MASAC's "Housing Unit" settings.[10] Forty-one percent showed officers rotating every two hours or shortly thereafter.[11] The other placements showed some instances of an officer on the task from 2.75 to 9.5 hours.

There appears to be a gap between intention and implementation, and more is needed to reach substantial compliance.

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[9] These officers and supervisors were routinely posted in HSUs or BAUs or served as "STAs," who can be tasked with constant observation.

[10] The review included 53 total records, of which 32 included constant observation. The sample drew from each institution providing TS in proportion to its percentage of TS from July through December 2024. The placements were chosen from the TS Registry to include TS stays in BAU, HSU, RTU, STU and MASAC's "Housing Unit." This sample differs from those described in Paragraphs 45 and 57. It was used as the basis for analyses of the cell inspection checklist and requirements for constant and close observation.

[11] A record was considered substantially compliant if an officer's initials indicated that they were on the post for periods of no longer than 2.5 hours. An exception was made if the reviewer learned the patient went to an outside hospital, as more discussion is needed to clarify implementation expectations in that circumstance.

35. Mental Health Staffing: To ensure constitutionally adequate supervision of prisoners in mental health crisis, MDOC will:
a. Increase mental health staffing, as needed, by ensuring the contracted health care provider hires sufficient additional staff with appropriate credentials, including psychiatrists, psychiatric nurse practitioners, psychiatry support staff, recovery treatment assistants and other mental health staff; and increasing the hours that Qualified Mental Health Professionals are onsite and available by phone on evenings and weekends; and
b. Ensure that mental health staff can provide meaningful therapeutic interventions to engage with prisoners on Mental Health Watch.

Finding: Partial compliance

Rationale: The mental health staffing matrix was significantly revamped under VitalCore in July 2024. When compared with Wellpath's staffing matrix, the biggest changes are the addition of two new job classes, bachelors-level social workers (8.4 FTE) and substance use disorder (SUD) counselors (8 FTE). Additional staffing changes were precipitated by the closure of Concord in June 2024 (e.g., decreasing the contracted number of mental health directors, unit coordinators, and Support Persons). Still other changes, such as an increase in the number of activity therapists, occurred because of opening (or re-opening) specialized units like the ISU.

As a result of all these changes, the total number of contracted mental health positions across the eight MDOC facilities where TS occurs increased from 145.75 FTE in June 2024 to 165.15 FTE in December 2024.[12] These gains come from the addition of BA-level social workers, SUD counselors, and activity therapists. The number of contracted MHPs, psychiatrists, nurse practitioners, and Support Persons remained essentially unchanged.

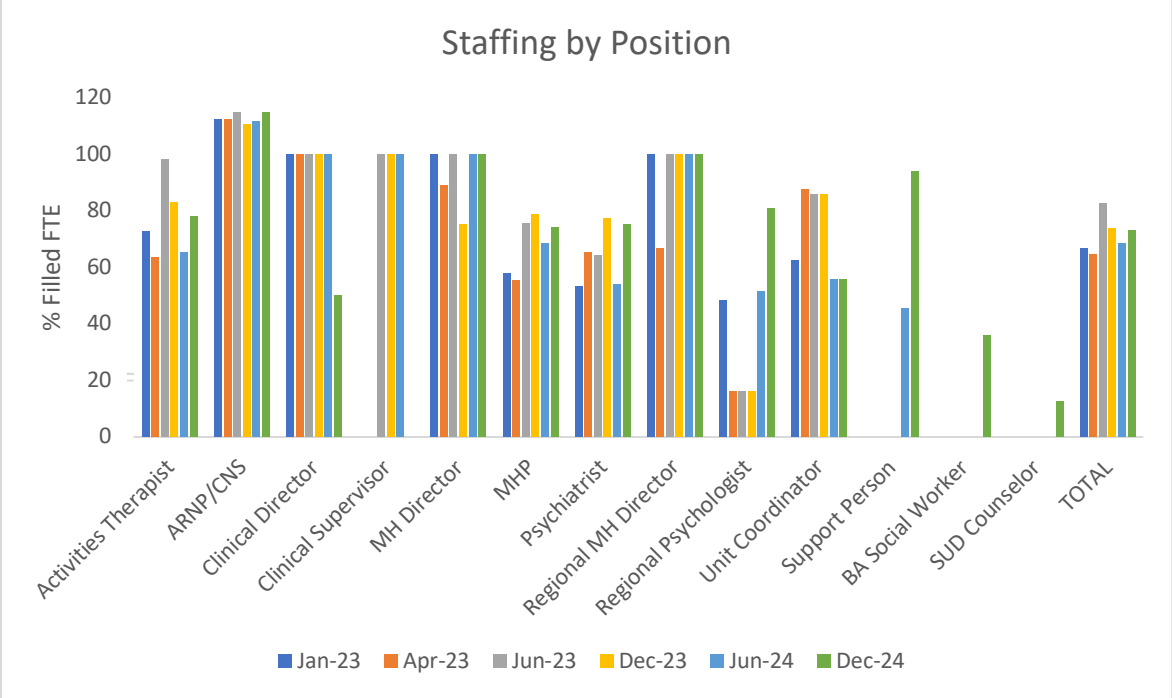
In December 2024, 73% of mental health positions were filled, with the largest number of vacancies among MHPs, as illustrated in *Figure 3.*

[12]The following positions were included in the analysis of the VitalCore and Wellpath Recovery Solutions staffing matrices: Activity Therapist, Psychiatric APRN/CNS, Clinical Director, MH Director, Mental Health Professional, Psychiatrist, Regional MH Director, Regional Psychologist, Unit Coordinator, Support Person, BA-Level Social Worker, and SUD Counselor.

Figure 3. Mental health staffing by position

This vacancy rate of 27% is improved from June 2024, when the rate was 31.8%, but still higher than June 2023, when it was 19.4%.[13] The staffing changes over time are depicted in *Figure 4.*

Figure 4. Mental Health Staffing, Jan 2023 to Dec 2024

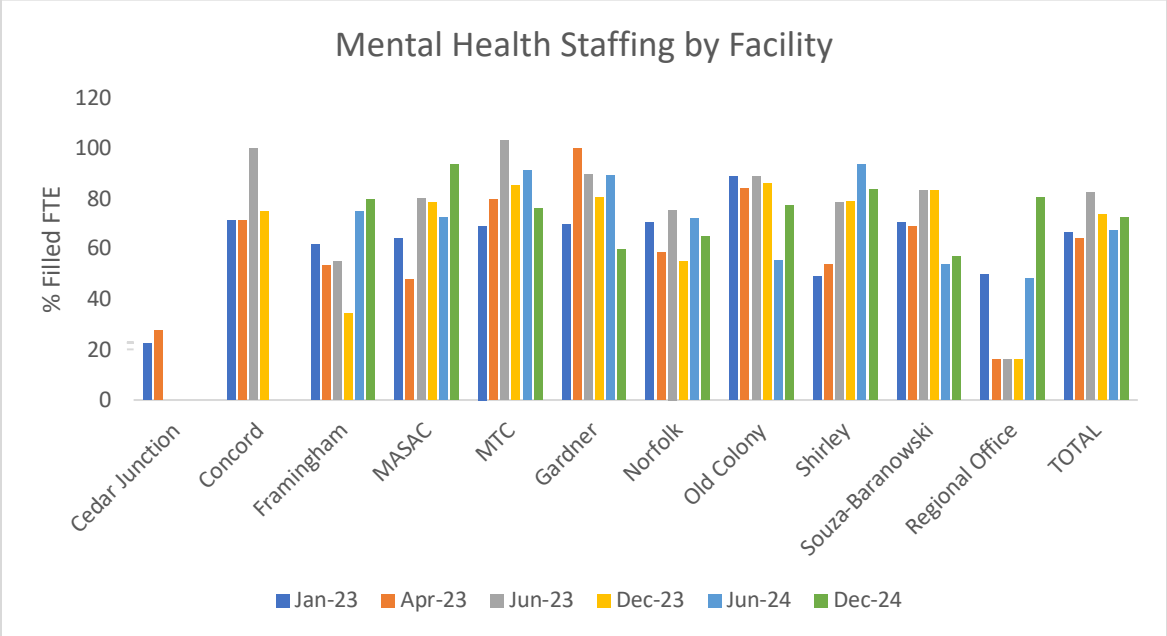


[13] The reported vacancy rates do not include temporary vacancies such as a staff member being on medical or administrative leave, nor do they include per diem employees.

The transition from Wellpath to VitalCore in July 2024 has not adversely affected mental health staffing levels. In fact, the staffing of key positions improved between June and December 2024: mental health professionals from 68% to 74%, psychiatrists from 54% to 75%, and regional psychologists from 51% to 81%. The overall fill rate of mental health positions (73%) is somewhat artificially lowered by BA-level social workers (35% filled) and SUD counselors (12% filled), which are newly created positions for which VitalCore is currently recruiting. Excluding these positions, 78% of contracted mental health positions are filled.

Figure 5 illustrates mental health staffing levels by facility. Among the facilities, SBCC remained worst off, operating with approximately 57% of necessary mental health staff in December 2024, including only 48% of MHP positions (9.6 out of 20 FTE). There has been no significant improvement in mental health staffing levels at SBCC over the past year. On a positive note, staffing levels at OCCC and MASAC improved significantly from June to December 2024, and levels at Shirley and MTC remained relatively strong. Gardner appears to be experiencing a shortage of mental health staff once again, but this drop (from 89% to 60%) must be interpreted with caution given how small the staff at Gardner is.

Figure 5. Mental Health Staffing by Facility[14]



As noted in previous DQE reports, the DQE team remains concerned about the dearth of doctoral-level mental health professionals in the MDOC system. Between VitalCore (for

[14] On this chart, the "Regional Office" site includes only MDOC's Regional Psychologist positions (3.1 FTE total). .

the seven prison sites) and Wellpath (for MASAC), the contracted number of psychiatrists and nurse practitioners is unchanged, with a total of 7.8 FTE psychiatrists and 6.1 FTE nurse practitioners to serve MDOC's approximately 2,700 prisoners on the mental health caseload. Even in the best-case scenario, with 100% staffing levels, each psychiatric provider would have 195 patients, which does not meet the 1:150 physician-to-patient ratio recommended by the American Psychiatric Association for carceral settings.[15] Therefore, the DQE team recommends that the VitalCore staffing matrix be amended to increase the number of contracted psychiatrists/APRNs, with particular attention paid to OCCC and SBCC, where the clinical acuity is very high, and Norfolk, where the current physician-to-patient ratio is approximately 1:475.[16]

MDOC has made progress in recruiting psychologists over the past year, with 2.5 of 3.1 contracted FTE filled in December 2024. This is a positive trend, though psychologists may still be understaffed, based on the near-total lack of behavior plans being developed or implemented in MDOC (see Paragraph 136).

MDOC continues to employ a high proportion of MHPs who are not independently licensed, reporting in March 2025 that 35 of 59 MHPs statewide (59%) fell into this category. During site visits, the DQE team inquired about the percentage of licensed vs. unlicensed staff, and it remained the case that most MHPs do not have an independent license and/or were less than two years out of school. For example, during the November 2024 site visit at SBCC, just two out of the nine MHPs were independently licensed. At Framingham in December 2024, all five MHP positions were filled (a huge improvement from the previous visit), but none were independently licensed.

As noted in previous DQE reports, understaffing and inexperience of mental health clinicians negatively impacts MDOC's ability to provide meaningful therapeutic intervention, as evidenced by:

- Limited multidisciplinary treatment planning (involving nursing, psychiatry, psychology, social work, and recreational therapy) at most facilities, including for those on TS;
- Poor continuity of care, with prisoners in crisis seeing multiple different clinicians within a single day;

[15] The ratio recommended in the APA's *Psychiatric Services in Correctional Facilities, Third Edition* (2016) is 1:150 for "outpatients" in general population. Higher ratios are recommended for specialized settings like the RTU, STP, HSU, and ISU.

[16] This ratio was calculated from the VCHS staffing matrix and "mental health roll-up" spreadsheet. In December 2024, psychiatry/ARNP staffing at Norfolk totaled 0.8 FTE, with 380 patients on the mental health caseload.

- A pervasive practice of MHPs using brief crisis evaluations as "proxy PCC contacts" to fulfill their technical obligation to see patients monthly while not actually providing a meaningful therapeutic contact with the assigned clinician.

Overall, more work must be done on mental health staffing, but the improvement of key staffing levels (MHPs, psychiatrists, and psychologists) under VitalCore during this monitoring period is encouraging.

36. Staffing Plan for the Intensive Stabilization Unit (ISU): The supervising clinician of the ISU will be a Qualified Mental Health Professional, and all mental health staff on the unit will report to him/her. The ISU's Multi-Disciplinary Team will include the supervising clinician, correctional staff, and other staff from other disciplines working within the ISU. The supervising clinician will make determinations about treatment decisions and individualized determinations about conditions that are appropriate for the prisoner, such as clothing, showers, lighting, property, privileges, activities, exercise, restraints, and meals. In the event of disagreement over any of these determinations, the matter will be referred to the Mental Health Director and to the Superintendent of the facility as deemed necessary. The Superintendent or Designee, who will consult with MDOC's Deputy Commissioner of Clinical Services and Reentry or Designee and Deputy Commissioner of Prisons or Designee as deemed necessary, will be responsible for rendering the final decision.

Finding: Partial compliance

Rationale: The ISU's staffing as of December 31, 2024, is outlined in *Table 2:*

Table 2. ISU Staffing Plan

Position	Contract FTE	Filled FTE
Mental Health/Medical		
Psychiatrist	0.5	0
Activity Therapist	1.4	1
Mental Health Professional	4	2
Support Person	3.6	2
Unit Coordinator	1	0
Nurse	4.2	3.6
Administrative Assistant	0.5	0
Security		
CO I	16	16
CO II	2	2
CO III	4	4

Compared with the original staffing matrix (included in the third DQE report), the CO I positions have been decreased from 25.2 to 16, and the supervisory CO positions have been slightly reconfigured from 0 to 2 CO II and 6 to 4 CO III. The mental health staffing matrix is unchanged.

The unit director (i.e., supervising clinician) of the ISU was briefly in place, but this individual left MDOC for another job opportunity in September 2024. In the interim, the facility's Mental Health Director has been filling in. None of the other mental health positions are at full staffing; VitalCore continues to recruit for these positions.

The security staffing levels appear adequate to meet ISU patients' current needs. On the day and evening shifts, four officers and a lieutenant are assigned to the unit, and on the night shift, three officers and a sergeant are assigned. There were no indications from the DQE team's interviews with staff or patients, or in review of medical records, that insufficient officer staffing was hampering treatment efforts.

The ISU's multidisciplinary team seems to follow the same model as other MDOC facilities; mental health staff gather for a daily "triage" meeting in which all major decisions about a patient's care are made. The revised draft of MDOC's policy 103 DOC 650.12 outlines the ISU's treatment team composition:

> The ISUs utilize a multi-disciplinary treatment team. Treatment team membership may include the following: ISU Director; Special Housing Unit Captain; Unit Officer in Charge; alternating correction officers from all shifts; correctional program officer; Qualified Mental Health Professionals, psychiatrists, psychologists, support persons, activities therapists and nurses, as clinically indicated.

On the days of the DQE site visit, the treatment team consisted of the acting unit coordinator, activity therapist, psychiatric nurse practitioner, nurse, Support Person, and one corrections officer, meeting the requirements of Paragraph 36. Similarly, in a review of five months of triage meeting notes, meeting participants consistently included the unit director and usually other MHPs, one security staff representative (generally different supervisors), an activity therapist, and one or more Support Persons. Psychiatry and nursing were present 75% to 80% of the time, and one or more psychologists attended an average of once a week. Because the supervising clinician led these meetings, it is reasonable to infer that he or she is making determinations about treatment decisions. Additionally, an ISU Handbook, reportedly provided to patients, indicates that the supervising clinician is to review and approve all treatment plans.[17]

[17] ISU Handbook dated December 13, 2024

Paragraph 36 also requires that the ISU's supervising clinician make decisions about the conditions appropriate for each patient. MDOC leaders expressed an understanding that each of the conditions specified in Paragraph 36 are to be provided commensurate with general population as a default approach and that only exceptions are to be recorded, but that was not completely clear in documents or interviews.[18]

The DQE's interviews with two ISU patients and one MHP indicate that property is routinely withheld from patients at security staff's discretion (see discussion of Paragraph 127). Notes from the ISU's triage meetings, and a few progress notes, reference concerns similar to those raised in interviews. Those sources are not intended to systematically capture what decisions have been made for a patient regarding the nine conditions specified in Paragraph 36, nor who made the decisions, so data is limited in this monitoring period.

Overall, MDOC's progress with ISU staffing and the other requirements of Paragraph 36 are sufficient for a partial compliance finding.

37. Staffing Plan Implementation: MDOC will staff its prisons within one fiscal year of the completion of each staffing plan.

Finding: Partial compliance

Rationale: This requirement went into effect on July 1, 2024, the start of the fiscal year after the initial staffing plan was due to the DQE and DOJ (April 20, 2023). As noted above, MDOC made some progress in increasing its mental health and security staffing levels in 2024, but it is far from full staffing. This warrants a partial compliance finding.

TRAINING

38. Training: MDOC, in conjunction with the contracted health care provider, will provide

[18] The draft policy 103 DOC 650, provided February 12, 2025, reinforces that contact visits, phone calls, clothing, and "other items" should be allowed commensurate with general population. It mentions several, though not all, of the other listed conditions generally, as does the ISU Handbook. Neither document specifies who makes these decisions. This does *not* indicate the documents are a problem. It only illustrates that the documents leave lots of room for interpretation and do not, on their own, establish that conditions decisions are routinely made consistent with conventional wisdom, nor how and by whom those decisions are made.

security and mental health staff on new policies, mental health care, suicide prevention, and de-

Finding: Substantial compliance

Rationale: MDOC continues to provide pre-service and annual in-service training on mental healthcare, suicide prevention, and de-escalation techniques to all staff. In previous monitoring periods, the DQE has reviewed the training materials and concluded that they meet the Paragraph 38 requirement to use competency-based adult learning techniques. Because no policy revisions have been finalized, MDOC is not yet obligated to train staff about new policies. In practice, it has already begun training staff on its updated policies about therapeutic supervision, suicide prevention, and the Intensive Stabilization Unit.

Outside of the pre-service and annual in-service trainings, VitalCore provided numerous other trainings on mental health topics during this monitoring period, including many in areas where the DQE has previously pointed out deficiencies. Between July and December 2024, trainings included:

- Suicide risk assessment at SBCC, OCCC, and Gardner (Oct-Nov 2024)
- Documentation in a psycho-legal context at MTC (Aug 2024)
- Clinical documentation at SBCC, OCCC, Gardner, and Norfolk (Sept-Nov 2024)
- "Clinical discussions with our teams" at Shirley (Sept 2024)
- Psychosis and Antisocial Personality Disorder at SBCC (Nov 2024)
- "DAP Notes 101" at Framingham (Nov 2024)
- Treatment Planning at Framingham (Nov 2024)
- Several sex offender trainings at MTC (Nov 2024)

Overall, it appears that MDOC's obligation to provide pre-service and annual in-service training is being met. Completion of these trainings by required staff is addressed in Paragraph 42c.

39. Within six months of the date of the policy's final approval, MDOC will incorporate any relevant Agreement requirements and consider recommendations from the DQE into its annual training plan that indicate the type and length of training and a schedule indicating which staff will be trained at which times.

Finding: Compliance not yet due

Rationale: No policy revisions have been completed since the Agreement's effective date, and no new policies have been developed. Therefore, MDOC is not yet required to incorporate new/revised policies into its annual training plan. In reality, it has already incorporated the Therapeutic Supervision policies into its annual trainings, and it has also offered ISU-specific trainings to staff.

40. Subject to Paragraphs 27-31 of this Agreement, the annual in-service training will ensure that all current security staff are trained within 12 months after new policies have been approved by the United States. MDOC will verify, through receipt of training documentation from the contracted health care provider, that all medical and mental health care staff also receive the appropriate in-service training to cover new policies that affect the provision of medical and mental health care. The Parties acknowledge that the training may take longer if the public hearing process pertaining to the promulgation of regulations is implicated. Subject to Paragraphs 27-31 of this Agreement, new security staff will receive this training as part of pre-service training.

Finding: Compliance not yet due

Rationale: No new policies have been developed or approved by the DOJ since the Agreement's effective date, so there are no trainings for the DQE to verify yet.

41. Training on mental health care, suicide prevention, and de-escalation techniques will be provided by trainers using current evidence-based standards on these issues, and will include, if available, video(s) depicting individuals speaking about their own experiences or experiences of their family members who have been on Mental Health Watch.

Finding: Substantial compliance

Rationale: MDOC provides instruction to staff on mental healthcare, suicide prevention, and de-escalation techniques in two main trainings: "Recognizing Mental Illness and Suicide Prevention" and "Therapeutic Supervision." The DQE has reviewed two versions of suicide prevention training, an 8-hour pre-service version and a 2-hour annual in-service version, and MDOC has incorporated all of the feedback provided by the DQE into the training materials. Likewise, MDOC has incorporated feedback from the DQE about its Therapeutic Supervision training. They are well-designed trainings that meet the requirements of Paragraph 41.

Beginning in September 2024, MDOC added a video to the Therapeutic Supervision training that includes incarcerated people discussing their experiences with mental health. With this addition, as well as a good demonstration of staff's completion of TS and

suicide prevention training (documented in Paragraph 42c below), a substantial compliance finding is warranted.

42. Suicide Prevention Training: MDOC will ensure, by providing sufficient training, that all security staff demonstrate the adequate knowledge, skill, and ability to respond to the needs of prisoners at risk for suicide. MDOC will verify, through receipt of training documentation from the contracted health care provider, that all medical and mental health care staff have received sufficient training to demonstrate the adequate knowledge, skill, and ability to respond to the needs of prisoners at risk of suicide.

Finding: Partial compliance

Rationale: This provision remains difficult to assess as a whole because subsections 42a-d address such different aspects of training and mandate compliance on different schedules. However, MDOC has demonstrated further progress in relation to the Paragraph 42 requirements, with three of the four subsections now achieving substantial compliance:

42a (Crisis Intervention Training): substantial compliance
42b (Revise suicide prevention training): substantial compliance
42c (Pre-service and in-service training): compliance not yet due
42d (CPR training): substantial compliance

MDOC's recent progress is discussed in each subsection below.

a. MDOC, in conjunction with its contracted health care provider, will continue its Crisis Intervention Training, a competency-based interdisciplinary de-escalation and responding to individuals with mental illness program for security staff, and, where appropriate, medical and mental health staff.

MDOC's December 2024 status report indicates:

> 8-hour Crisis Intervention Training refresher courses were completed on August 26, 2024, August 27, 2024, August 28, 2024, August 29, 2024, October 21, 2024, October 22, 2024, and October 23, 2024. A 40-hour Crisis Intervention Training commenced on June 17, 2024, and December 16, 2024. As of December 20, 2024, there have been a total of 263 people trained in CIT by the MDOC team.

MDOC provided sign-in sheets from the CIT refresher trainings in August and October 2024, which indicate that 12 staff members from seven institutions completed the trainings.

The Agreement does not create specific benchmarks for MDOC to meet regarding CIT training, so the current scheme is sufficient for a substantial compliance finding.

b. Within six months of the Effective Date, MDOC will review and revise its current suicide prevention training curriculum, which will be submitted to the United States for review, comment, and the United States' approval in accordance with Paragraph 27 and include the following additional topics:
1. suicide intervention strategies, policies and procedures;
2. analysis of facility environments and why they may contribute to suicidal behavior;
3. potential predisposing factors to suicide;
4. high-risk suicide periods;
5. warning signs and symptoms of suicidal behavior (including the suicide screening instrument and the medical intake tool);
6. observing prisoners on Mental Health Watch (prior to the Mental Health Crisis Assessment/Evaluation (Initial) (see Paragraph 47)) and, if applicable, step-down unit status;
7. de-escalation techniques;
8. case studies of recent suicides and serious suicide attempts;
9. scenario-based trainings regarding the proper response to a suicide attempt, and lessons learned from past interventions; and

MDOC submitted its "Suicide Prevention & Intervention" curriculum to the DQE for review twice: in September 2023 and April 2024. After confirming that the materials meet the requirements of Paragraph 42b, the DQE returned the materials to MDOC on August 5, 2024, with no further substantive revisions. The DOJ approved the training materials on October 16, 2024, bringing MDOC into substantial compliance with the Paragraph 42b requirements.[19]

c. Subject to Paragraphs 27-31 of this Agreement, within 15 months of the date of the final approval of all policies, all security staff will complete pre-service training on all of the suicide prevention training curriculum topics for a minimum of eight hours. MDOC will verify, through receipt of training documentation from the contracted health

[19] Because of a clerical error, the DQE and DOJ teams initially approved different versions of the suicide prevention training materials (8-hour pre-service vs. 2-hour annual in-service). MDOC realized the mistake on November 5, 2024, and DQE has since approved both versions of the training.

care provider, that all medical and mental health care staff also receive pre-service suicide prevention training. After that, all correction officers who work in intake, Mental Health Units, and restrictive housing units will complete two hours of suicide prevention training annually.

Since no policies have been finalized, compliance with this provision is not yet due. In practice, MDOC already requires all staff to complete eight hours of pre-service training on suicide prevention, and annual in-service training for all correctional officers already includes two hours of suicide prevention training. Therefore, achieving substantial compliance with the requirements of Paragraph 42c should just be a matter of demonstrating training completion to the DQE.

MDOC has provided voluminous data about training completion to the DQE on a quarterly basis. Since the July 2024 healthcare vendor transition, these documents have been compiled from three different agencies: MDOC (for security staff at the prison sites), VitalCore (for mental health staff at the prison sites), and Wellpath (for all staff at MASAC). Each agency uses different methods to keep track of training completion, and some data sets provided to the DQE appear incomplete. All this makes it nearly impossible to arrive at a compliance determination.

As best as the DQE can tell, and as outlined in *Table 3*, MDOC demonstrated completion of several staff trainings between July and December 2024:

Table 3. Staff Training Completion

	MDOC staff	VitalCore staff	MASAC (Wellpath) staff
Suicide prevention – NEO (pre-service)		Training offered on: 7/19/24 8/16/24 9/18/24 10/14/24 11/14/24	Training offered on: 7/19/24 8/9/24 8/30/24
Suicide prevention – annual	2095 out of 2329 staff completed in TY24 (90%)	12/3/24-12/5/24: 139 staff completed	190 out of 220 staff with current certification as of 9/26/24 (86%)
CPR – NEO (pre-service)		N/A	
CPR – annual	1926 of 2081 staff completed in TY24 (93%)	N/A	215 out of 220 staff with current certification as of 9/26/24 (98%)
TS training - annual	2091 out of 2320 staff completed in TY24 (90%)	N/A	199 out of 227 staff with current certification as of 12/31/24 (88%)
MANDT de-escalation training - annual	N/A	N/A	215 out of 220 staff with current certification as of 9/26/24 (98%)

Although the training records are a mixture of handwritten attendance logs and spreadsheets using different tracking methodology, overall, it appears that MDOC is well on its way to demonstrating compliance with the Paragraph 42c requirements. Substantial compliance can be achieved by demonstrating security staff's CPR and suicide prevention training during NEO, as well as sustaining good overall training completion through the end of TY25 (September 2024 to June 2025).

d. Within six months of the Effective Date (12 months for new hires), MDOC will ensure all security staff are certified in cardiopulmonary resuscitation ("CPR").

CPR certification is required for security staff approximately every two years.[20] MDOC provided CPR certification records to the DQE for review, which indicate that 1,926 of 2,081 staff (93%) at the seven sites where TS occurs maintained an active CPR certification as of September 26, 2024. This demonstrates excellent practice in CPR certification for MDOC security staff.

Wellpath provided evidence of the MASAC staff's CPR certification. These data indicate that 215 of 220 staff members had a current CPR certification as of September 26, 2024 (98%). This also demonstrates excellent practice with CPR certification.

THERAPEUTIC RESPONSE TO PRISONERS IN MENTAL HEALTH CRISIS

43. Mental Health Crisis Calls/Referrals: MDOC will ensure that any staff member concerned that a prisoner may be potentially suicidal/self-injurious will inform mental health staff immediately. The prisoner will be held under Constant Observation Watch by security staff until initially assessed/evaluated by mental health staff.

Finding: Partial compliance

Rationale: MDOC's policies clearly reflect this requirement, and officers, mental health staff, and leadership appeared well aware of these expectations when interviewed during each monitoring period. However, there have also been reports in each monitoring period of substantial gaps in the policy being implemented. For the current report, the DQE team spoke with 11 officers or supervisors regularly posted in BAU, general population, HSU, SAU, or RTU settings; 8 mental health staff; and 34 prisoners about this topic. In addition, the team reviewed a log of allegations against staff.[21]

Over time, mental health and security staff have spoken of officers who refer a prisoner to mental health on an emergent basis because of the officer's own concerns that the prisoner is at risk of self-harm and/or unstable. The DQE team has not undertaken a systematic review of whether other types of staff immediately inform mental health staff of such concerns, but the team has encountered, during chart reviews, examples of these

[20] Completion of CPR training is required in every other Training Year, so the actual dates might be more or less than two years apart. For example, if an officer completed CPR training in August of 2022, they would be required to recertify between July 1, 2024, and June 30, 2025.

[21] MDOC refers to this as the Professional Conduct log, which is managed by the Clinical Operations Analyst, who compiles data from staff's confidential incident reports, tracks and records investigation outcomes, and shares the log with the DQE team on request. See Paragraph 93 for further details.

referrals in nursing notes. In addition, MHPs have spoken of getting referrals from Spectrum or Acadia staff, who provide treatment for substance use disorders.

All types of staff, leaders, and prisoners, over time, have noted that, when a prisoner initiates an emergent request to see mental health staff ("calling crisis"), it is common practice for officers to screen the request by asking whether the prisoner intends to hurt themselves or someone else. There are arguments for and against this practice. It allows the officer to make a judgment about their obligations to refer immediately under the policy and this Agreement (is the "staff member concerned that the prisoner may be potentially suicidal/self-injurious"?), but it also risks making a decision about the seriousness of the situation that mental health staff would strongly prefer to use their own training and experience to make.

Perceptions are then mixed about how often and how urgently officers inform mental health staff of the request. Officers generally acknowledge the obligation to call an MHP with all such requests. A few officers describe also asking the nature of the concern to be able to pass it along to the MHP, or providing the prisoner a chance to vent a complaint and attempt solutions if the issue is one typically handled by security staff. A few describe collaborating to create an urgent, rather than emergent, response if identified as such by the MHP and/or prisoner. Some mental health staff have indicated this is sometimes useful. Other times, prisoners and MHPs understand officers to be trying to convince a prisoner that an emergent contact is not warranted and redirecting them to submitting a sick slip or managing the problem independently. Occasionally, MHPs raised a contrary concern: that they did not learn ahead any information the prisoner had offered, or even his identity, which hampered effective risk assessment.

Prisoners and MHPs consistently identified experiences of officers not conveying that a prisoner has "called crisis'; in the current monitoring period, this was raised at six of the eight institutions. Prisoners and MHPs also commonly reported that MHPs are not informed immediately, as required, but rather there are delays until a prisoner has made multiple requests or escalated their behavior, and some MHPs understood that patients had waited for hours. These allegations were made in half of the facilities.

Fully half of the accusations on the Professional Conduct log in recent months center on not passing along, or delaying notice of, crisis calls. Of note, among those with completed investigations, half found the patient *was* seen for one or more crisis calls on the date mentioned. On the other hand, in the log and at least ten interviews, prisoners said they experienced, and/or MHPs witnessed, officers being disrespectful, antagonistic, taunting, or mocking prisoners with mental illness – a problem on its own, but also potentially an indication that disregarding patients' crisis calls could be more likely.

There was little in the way of patterns. Prisoners and MHPs at Gardner and MTC generally reported positively on the crisis response system in the recent site visits. At nearly every other facility, about half the patients reported officers calling quickly and consistently, and half of the prisoners and MHPs raised one or more of the concerns discussed above. Compliments and criticisms arose out of the same housing units. The great majority of these allegations on the Professional Conduct log were reported at Norfolk; it is unknown whether that is occasioned by greater prevalence or greater rates of reporting.

Given the complexities described above, as well as common knowledge that a substantial number of crisis calls are made in an attempt to address issues other than mental health, the answers to implementing this requirement are not straightforward. Balancing is needed, to be sure. But the suggestions of noncompliance have been consistent enough over two years of monitoring that a closer look, and likely corrective action, is needed to reach substantial compliance.

In terms of the requirement to maintain constant observation until an MHP assesses the prisoner, half of the officers and prisoners who spoke to the point said this is universally done, and most of these officers provided supporting detail. A few MHPs agreed with this, including one who said it is taken so seriously that Inner Perimeter Security (IPS) investigated once when it was not done.

A significant minority of prisoners and officers – about one-quarter each – said constant observation occurs only if the patient said he was thinking of self-harm; otherwise, the patient may wait unsupervised in his cell or in a multi-person holding cell that is monitored. A small number of officers said they do not remain with a person who called crisis, including a supervisor who said officers have discretion unless there is self-harm actively underway. Likewise, one-quarter of patients said an officer does not generally monitor them after they "call crisis," particularly at SBCC. One prisoner sustained a substantial injury in this circumstance in recent months, according to his self-report and notes in the health record.

44. During mental health coverage hours (Monday-Friday 8am-9pm; Saturday 8am-4pm), a Qualified Mental Health Professional will respond within one hour to assess/evaluate the prisoner in mental health crisis.

Finding: Partial compliance

Rationale: During this monitoring period, the majority of interviewed officers and prisoners continued to report MHP response times well within one hour, but a larger number of prisoners than in past monitoring periods pointed to longer response times.

The DQE team interviewed correctional officers, 12 of whom commented on this point; they were posted in housing units and TS treatment settings at seven institutions. Nearly all characterized response times as typically quick, estimating them at 30 minutes or less. A small number of officers at Norfolk and OCCC said that, rarely, a response could take up to one hour and 40 minutes.

About two-thirds of interviewed prisoners also said they met with an MHP within an hour, and usually much sooner. Commenters were concentrated at five institutions and drew on their experiences in intake, general population, BAU, and SAU settings.[22] Others, primarily at SBCC, said the time to see an MHP can be two hours; is short on some units but three to four hours in BAU; or is lengthy in the building but shorter on the recreation yard. Some of these descriptions are consistent with MHP discussions of barriers to accessing patients. Three patients named an instance of being seen the following day or not at all.

It may be that some of these estimates blend the times to notify mental health staff with the response time or may arise from an MHP and Mental Health Director deciding jointly that the referral requires an urgent but not an emergent response. As detailed in the DQE's last report, that could be a system that reasonably fulfills the purposes of Paragraph 44, but the DQE team will need more information about how this system works in practice.

MHPs, officers, and patients noted the settings in which crisis assessments take place. Many are private, but some may hinder an effective assessment when conducted in the booking area or therapeutic modules near activities taking place; on recreation yards; cell-front; or otherwise with an officer very close to the interaction. Additionally, one patient commented on a troubling practice the DQE team has observed in chart reviews, that of MHPs sometimes labeling this brief screening as a primary clinician contact ("proxy PCC contact" in the MHPs' terminology), which lengthens the interval between required therapeutic contacts with one's assigned clinician.

Much of MDOC's practice is strong on these requirements, but some barriers to patient access appear to be taking a toll. Additionally, the DQE team will work with MDOC to

[22] There were 19 patients who commented directly. Others called for crisis after hours, self-escorted to the mental health department, or were unable to recall response times.

ensure that its system of categorizing referrals initially labeled as crisis calls is operating in alignment with Paragraph 44.

45. During non-business hours, the referring staff will notify the facility's on-call system. The facility's on-call Qualified Mental Health Professional will confer with the referring staff regarding the prisoner's condition. The facility's on-call Qualified Mental Health Professional will determine what, if any, intervention is appropriate and offer recommendations to the appropriate MDOC personnel and medical staff. The prisoner will be evaluated by a mental health staff member on the next business day or sooner as determined by the facility's on-call Qualified Mental Health Professional.

Finding: Partial compliance

Rationale: As noted in previous DQE reports, the mental health staff's "business hours" are Monday-Friday 8 am to 9 pm, Saturday 8 am to 4 pm, and Sunday only if a patient is on 1:1 TS. Outside of those hours, nurses respond to crisis calls, and MDOC policy states that they must discuss appropriate interventions with the on-call MHP. The next business day, an MHP conducts a follow-up visit with the patient.

To assess this system in practice, the DQE reviewed the triage notes from all eight facilities where TS occurred in December 2024, trying to find cases where an MHP conducted a follow-up visit after an overnight crisis call. In hundreds of pages of triage notes, only one such case, at Norfolk, was found.[23] The dearth of overnight crisis cases in the triage notes is likely related to MHPs' documentation practices rather than any change in MDOC's policy or practice from the previous monitoring periods. It is likely that some of the mental health contacts listed simply as "crisis" in the triage notes included follow-up contacts from overnight crisis calls, but there is no way to determine which ones in retrospect.

In over two years of monitoring, it appears that the practice of MHPs following up with patients after overnight crisis calls is well established across MDOC. All MHPs who were asked by the DQE team knew of the requirement to see patients on the next business day after an off-hours crisis contact, and the DQE team witnessed them discussing such contacts during the daily triage meetings. The practice of nurses consulting with on-call MHPs has been less consistent, as documented in previous DQE reports. In the one case found at Norfolk in December 2024, notes in the electronic health record indicate that

[23] The triage minutes contained dozens of "overnight BAU" assessments, indicating that a prisoner was screened for BAU placement overnight and then seen by an MHP on the next business day. Because of the lack of clarity about whether BAU assessments should be included as "crisis calls" under the terms of the Agreement, these cases were not assessed by the DQE in relation to the Paragraph 45 requirements.

MDOC's policy was not followed; the nurse did not contact the on-call MHP after assessing the patient. However, an MHP did follow up with the patient on the next business day, conducting a substantive, out-of-cell assessment.

One other source of data provides information relevant to Paragraph 45. In the DQE team's study of 52 therapeutic supervisions,[24] almost one-quarter of the TS placements were initiated after hours by a nurse in conjunction with an on-call MHP, according to nursing notes. In all cases, an MHP met with the patient on the next business day or the day the patient returned from an outside hospital trip. This auditing method would not capture any instances of staff not placing a prisoner on TS after an evaluation, but the data set is one part of the compliance picture.

With consistent demonstration of nurses consulting with on-call MHPs after hours, as well as meaningful, out-of-cell follow up contacts on the next business day, MDOC can achieve compliance with the Paragraph 45 requirements.

46. If a prisoner requests to speak to mental health staff because he or she believes they are in mental health crisis, that prisoner will not be disciplined for that request.

Finding: Substantial compliance

Rationale: In the last monitoring period, the DQE team found this requirement to be in substantial compliance because, consistently, there has been a low number of identified disciplinary cases, the institutions have a cultural understanding that such cases are highly discouraged, and administrations routinely identify and dismiss these cases, while issues of concern are a small percentage of the tickets the DQE team has reviewed.

[24] As in previous monitoring periods, the DQE team studied a sample of TS placements to assess different aspects of the Agreement. To construct the study sample, the team drew upon the spreadsheets referred to as the TS Registry, which MDOC provides monthly to demonstrate all TS placements. Cases were selected from all eight institutions where TS occurred from July through December 2024, in proportion to their percentages of the systemwide total. The sample was chosen to capture stays in all housing areas where TS takes place (HSU, BAU, STU, ISU, RTU, and MASAC's "Housing Unit"), drew from each month in the period, included a variety of reasons for placement, and favored stays of three days or longer. The sample size is smaller than in previous monitoring periods because there were patterns of (a) consistency with past practice observed in more than 300 previous charts reviewed, or (b) consistent absence of information, likely resulting from the change in documentation structures after a change in healthcare vendors, leading to an inability to reach fully supported conclusions.

This sample was used to assess a number of Agreement requirements in this report. In some instances, conclusions may have been reached based on fewer than 52 TS placements because the requirement only occurs in the circumstances of a smaller number of patients. For some requirements, additional cases were selected to reach an adequate sample size for the question being examined. Not all method variations will be captured in this report, but descriptions are available on request.

During the current monitoring period, the DQE team learned about and sought to review five potential disciplinary cases for misuse of crisis. Disciplinary tickets show misuse of crisis charged in only one of these cases, and ultimately that charge was dismissed.

In two of the other reported instances, auxiliary behavior in the incident was charged (for example, kicking a door), but there were no charges brought for misuse of crisis. Two other potential cases could not be substantiated.

All of the other 18 interviewed patients said they had not been disciplined for requesting a crisis contact. Some MHPs confirmed that they do not see such tickets being written.

The DQE team interviewed 14 officers drawn from BAU, HSU, RTU and general population units across six institutions. Each said they have not personally written such tickets in recent years. Several volunteered that a case would only be initiated by mental health staff, or with their agreement, and they noted this does occur occasionally.

MDOC remains in substantial compliance with this requirement. Of note, the DQE continues to recommend that MDOC's current practices around issuing misuse of crisis disciplinary reports be formalized in policy. This deficit is addressed in the *Policy* section rather than in relation to Paragraph 46, which assesses how the system is functioning in practice.

47. Mental Health Crisis Assessment/Evaluation (Initial): MDOC will ensure through an audit process that, after the crisis call, the Qualified Mental Health Professional's evaluation will include, but not be limited to, a documented assessment of the following:
a. Prisoner's mental status;
b. Prisoner's self-report and reports of others regarding Self-Injurious Behavior;
c. Current suicidal risk, ideation, plans, lethality of plan, recent stressors, family history, factors that contributed to any recent suicidal behavior and mitigating changes, if any, in those factors, goals of behavior;
d. History, according to electronic medical records and Inmate Management System, of suicidal behavior/ideation - how often, when, method used or contemplated, why, consequences of prior attempts/gestures;
e. Prisoner's report of his/her potential/intent for Self-Injurious Behavior; and
f. Prisoner's capacity to seek mental health help if needed and expressed willingness to do so.

Finding: Partial compliance

Rationale: MDOC indicated in March 2025 that VitalCore continues to follow Wellpath's policies until its own are implemented, including with quality assurance. No documentation of any vendor's quality assurance process was shared with the DQE team during this monitoring period, so it is not possible to determine whether an audit process is being used to ensure that MHPs' crisis assessments contain the components delineated in Paragraph 47.

The DQE team reviewed a sample of 50 MHP crisis assessment notes to perform an independent audit.[25] This review was hampered by the change to VitalCore's electronic health record in July 2024, as MHPs' progress note templates no longer contained prompts to consider the factors outlined in Paragraph 47. As a result, MHPs' documentation did not contain any notation that the clinician had reviewed important historical risk factors about suicide. In fact, during the DQE team's site visits, clinicians noted that the only way to access information from the medical record prior to July 1 was to log into Wellpath's electronic health record, ERMA, since none of the information had been imported into the VitalCore system. Some clinicians, especially those who were hired after July 1, were not given ERMA login credentials, so they were dependent on their peers and supervisors to look things up in ERMA on their behalf. They said that, in practice, this was not happening routinely.

As was the case in earlier monitoring periods, MHPs inconsistently reviewed important historical information when conducting crisis assessments observed by the DQE clinicians, mostly relying upon the prisoner's report of being "safe" when deciding whether to initiate TS. In the DQE's study of crisis contacts, only one of the 50 cases contained any notation that the MHP reviewed the chart prior to meeting with the patient. At SBCC, OCCC, and Gardner, MHPs said they still were being called on the radio by correction officers who did not tell them the patient's name, making it impossible to review historical information before responding. Since there is no access to the electronic health record in the spaces where clinicians are meeting with patients, there was also no opportunity to review historical risk factors during the contact.

Another persistent problem is that of cell-front crisis assessments. Again, the change of progress note template makes it difficult to discern MHPs' practice. In the DQE team's study, 24% of crisis contacts were conducted cell-front, 68% were conducted in a confidential space, and 8% did not state the location. Of the cell-front contacts, half were due to "institutional" factors or at security officers' discretion, while the other half were reported as "patient preference" or "patient declined [to meet out of cell]." All of the

[25] This is a different sample from the study of 52 TS placements described in Paragraph 45. Here, the reviewer randomly selected 50 crisis contacts from the eight institutions' triage meeting minutes between July and December 2024, in approximate proportion to the TS placements across MDOC. 98% of the studied contacts did not result in placement on TS.

cell-front crisis assessments occurred at OCCC and SBCC, which is consistent with information learned during the DQE's site visits, where MHPs at those institutions routinely encountered barriers to conducting out-of-cell contacts.

Overall, the problem of inadequate crisis risk assessments persists, most notably at SBCC and OCCC. MHPs' clinical practice does not appear to be worse during this monitoring period; it is likely only the documentation that is worse (because of the change in electronic health record and use of different progress note templates). Nevertheless, a significant change in MHPs' assessment practices is needed for MDOC to achieve compliance with the Paragraph 47 requirements. To its credit, the healthcare vendor has focused on this area in recent months, conducting trainings on suicide risk assessment and clinical documentation at SBCC, OCCC, and other institutions in the fall of 2024.[26]

48. During the assessment/evaluation, as clinically indicated, the Qualified Mental Health Professional will consult with a Qualified Mental Health Professional with prescriptive authority for psychiatric medication issues and a clinical supervisor for clinical issues.

Finding: Partial compliance

Rationale: VitalCore's behavioral health progress note template (BH-7.0) provides several "check box" elements for a clinical plan, including psychiatric [healthcare provider] consultation. The template also allows the MHP to choose a "routine" or "urgent" time frame for such consultation.

In the DQE team's study of 50 crisis contacts, first described in Paragraph 47, MHPs checked the box for psychiatric consultation in 12% of cases. The DQE clinicians reviewed the clinical circumstances and found that each of these referrals was appropriate, with indications ranging from patients exhibiting psychotic symptoms to those experiencing side effects or wanting to restart medications. In five of the six cases where psychiatric consultation was sought (83%), the consultation happened quickly, within three days. This is progress from previous monitoring periods, when psychiatric referrals and consultation stemming from crisis contacts occurred even less often.

In reviewing the cases independently, the DQE clinicians agreed with MHPs' assessments about psychiatry in the majority of cases. However, the DQE clinicians found seven other cases (14%) in the study where a psychiatric consultation was warranted but did not occur. The indications for psychiatric consultation in these cases were similar to those where consultation did occur: medication noncompliance, asking

[26] See Paragraph 38 for further details.

specifically to meet with a psychiatrist about medication, exhibiting bizarre behavior, reporting active drug use while being prescribed psychotropic medication, or newly arriving in MDOC and taking psychiatric medications prior to admission.

Overall, MDOC is making progress in this area, more frequently making referrals to psychiatry when clinically indicated. Although there were still cases where the DQE clinicians' independent, retrospective review found that psychiatric consultation was indicated but did not occur, MDOC appears headed in the right direction.

49. The Mental Health Crisis Assessment/Evaluation (Initial) will be documented in the prisoner's mental health progress note using the Description/Assessment/Plan (DAP) format.

Finding: Substantial compliance

Rationale: In the DQE team's review of 50 crisis calls, 48 cases included a progress note (BH-7.0) in the DAP format (96%). In the two cases where TS was initiated as a result of the crisis contact, the MHP documented the contact on a different form, the "Behavioral Health Therapeutic Supervision Contact Note" (BH-5.0). Although this template is not in the DAP format, it contains all the elements of a DAP note. In the DQE team's examination of health records in 52 TS placements,[27] MHPs completed an appropriately formatted note in 90% of those placements.

A substantial compliance finding continues to be warranted for Paragraph 49, which requires only a properly formatted note in the medical record. Of note, in the various analyses conducted for this report, the DQE team encountered, for the first time, a small number of TS placements where there was no note in the health record memorializing the evaluation and placement. Should this occur more often, it would be a concern. The DQE's concerns about the substance and confidentiality of crisis evaluations are addressed in Paragraph 47.

50. Placement on Mental Health Watch: If the Qualified Mental Health Professional determines that the prisoner is at risk of suicide or immediate self-harm, the prisoner will be placed on a clinically appropriate level of Mental Health Watch.

Finding: Substantial compliance

Rationale: As part of the analysis of this requirement, the DQE team reviewed 52 TS placements. In this sample, the MHP determined that the prisoner was at risk of self-harm

[27] See Paragraph 45 for a description of the study's methods.

in 39 cases,[28] and in each instance, the MHP did place the prisoner on TS. While this method necessarily captures only cases that *were* placed, it provides some support that this practice is in use.

Based on interviews of more than 50 mental health staff and 170 prisoners, observation of decision-making, and reviews of more than 350 charts and other documentation over the course of two years, the DQE team is confident that MDOC and its healthcare vendors have a culture that conservatively places prisoners on TS where there is perceived risk or uncertainty about risk. This is sufficient for a substantial compliance finding.

The DQE team continues to be concerned about the quality of clinicians' risk assessments, but these shortcomings are addressed in relation to Paragraph 47 rather than here. The substantial compliance finding for Paragraph 50 applies only to the idea that, once a clinician has identified a patient's risk of self-harm, they consistently place the patient on a level of TS commensurate with their assessment of risk.

To their credit, MDOC and VitalCore continue to work on enhancing clinicians' risk assessment skills, as noted in Paragraph 38 and in MDOC's December 2024 status report:

> The Regional Psychologists and Director of Training are assisting with training initiatives for incoming staff, with a focus on those less experienced or unlicensed clinicians. All clinical staff are supervised by others with experience. Per practice and law, unlicensed or non-independently licensed mental health professions are required to participate in weekly clinical supervision.

This focus on core clinical and risk assessment skills by MDOC's behavioral health leadership is encouraging.

51. Mental Health Watch will not be used as a punishment or for the convenience of staff, but will be used only when less restrictive means are not effective or clinically appropriate. Mental Health Watches will be the least restrictive based upon clinical risk.

Finding: Substantial compliance

Rationale: In the last monitoring period, the DQE team had not encountered, in extensive chart reviews and patient interviews, any indicia that TS placements were initiated for a reason other than the prisoner's request or the prisoner's well-being. On that basis, a

[28] See Paragraph 45 for a description of the study and its methods. The other placements were based on concerns about psychosis or harm to others.

substantial compliance determination was made for that element of Paragraph 51. Recent interviews with 14 prisoners, across five institutions, continued to support these findings.

Paragraph 51 also requires that TS is used only when less restrictive means are not effective or clinically appropriate. In the DQE's review of 200 crisis assessments across four monitoring periods, there have been no indications of over-use of TS. In fact, a remarkably small percentage of crisis contacts result in TS placement—just 10 out of 200 crisis contacts in the DQE's samples over two years (5%). Most crisis contacts are precipitated by institutional stressors, especially at high-volume sites like SBCC and OCCC.[29] Notes from the mental health triage meetings indicate that MHPs review the crisis contacts as a group each business day, and they sometimes use interventions less intensive than TS to supplement a patient's treatment when the patient has been frequently calling crisis. During this monitoring period, frequent utilizers of crisis were provided with more frequent mental health "check-ins" or Support Person contacts, and in a few cases, they were referred to the ISU. Overall, it continues to be the case that MDOC clinicians use TS as a last resort, when less restrictive measures are inappropriate or have failed.

52. Crisis Treatment Plan: Upon initiating a Mental Health Watch, the clinician will document an individualized Crisis Treatment Plan. The plan will address:
a. precipitating events that resulted in the reason for the watch;
b. historical, clinical, and situational risk factors;
c. protective factors;
d. the level of watch indicated;
e. discussion of current risk;
f. measurable objectives of crisis treatment plan;
g. strategies to manage risk;
h. strategies to reduce risk;
i. the frequency of contact;
j. staff interventions; and
k. review of current medications (including compliance and any issues described by the prisoner) and referral to a psychiatrist or psychiatric nurse practitioner for further medication discussions if clinically indicated.

Finding: Partial compliance

Rationale: The DQE team reviewed crisis treatment plans to assess their completeness and clinical appropriateness. Because of the change in July 2024 from Wellpath's crisis

[29] During this monitoring period, a significant number of crisis were also driven by medical concerns at OCCC.

treatment plan template to VitalCore's health record, which contains a less detailed template for TS contacts (BH-5.0), treatment plans during this morning period were routinely missing key elements of Paragraph 52. In the DQE team's review of 52 TS placements,[30] only 29% had anything written in the "treatment plan" section of the note. In other cases, a cursory plan totaling 10 words or less, such as "next-day follow-up with MHP" or "[patient] to be seen per TS protocols" was documented. There was no discussion of the patient's individual risk factors or appropriate treatment modalities (beyond having contact with MHPs or being approved certain property or privileges), let alone any measurable objectives. These cannot be considered adequate crisis treatment plans that fulfill the requirements of Paragraph 52.

MASAC was a notable exception. Their treatment plans were complete in all cases reviewed by the DQE team, likely because their clinicians continue to use the template in Wellpath's electronic health record.

Although, at first glance, this appears to be a drastic decline in treatment planning quality from the previous monitoring period, the DQE believes it to be a change in documentation rather than a change in MHPs' clinical practice. During the site visits, the DQE clinicians saw no substantive change in the way that MHPs approached treatment planning for patients on TS. Most of the important decisions were made in the daily triage meeting, which was attended by MHPs, activity therapists, Support Persons, and usually psychiatrists or psychiatric nurse practitioners. The focus of these discussions remained on property and privilege decisions, but the DQE team did witness substantive, multidisciplinary treatment team discussions at sites such as Gardner, MASAC, Shirley, Framingham, and MTC. Discussions at OCCC and SBCC were more curtailed because of the high volume of patients to review, and those at Norfolk were limited by numerous interruptions that pulled the "crisis clinician" away from the triage meeting to conduct urgent evaluations. On the whole, the DQE clinicians did not appreciate any difference in the quality of treatment planning from the previous monitoring period.

In the DQE team's studies of TS placements, the DQE clinicians reviewed medical records to assess whether patients were being referred to psychiatry when clinically indicated (paragraph 52k).[31] In assessing whether such contact was indicated, the DQE clinicians used the following criteria[32]:

[30] See Paragraph 45 for a description of this study's methods.
[31] For this question, the DQE clinicians reviewed 62 cases drawn from all institutions where TS occurs.
[32] Admittedly, there is some subjectivity about when a psychiatric consultation is indicated. These criteria are based on the DQE clinicians' best professional judgment and experience working in correctional settings.

- Self-injury that led to outside hospital evaluation (precipitating TS placement or while on TS)
- Medication noncompliance or evidence of medication misuse/diversion
- TS lasting >7 days
- More than one TS admission within 7 days
- New admission to MDOC with confirmed medications in the community[33]
- Diagnostic uncertainty after assessment by MHP
- Bizarre symptoms or out-of-character behavior
- Display or self-report of psychotic symptoms (e.g., hallucinations), even if suspected of feigning or exaggeration
- Prolonged hunger strike (to assess whether serious mental illness is contributing to the individual's food refusal)

Using these criteria, the DQE clinicians found that psychiatry referral was indicated in most, but not all TS cases in its study (88%). Of the cases where consultation was indicated, MHPs made referrals in 54% of cases. This rate is similar to the previous two monitoring periods.

Overall, it appears that not much has changed with crisis treatment planning, including referrals to psychiatry, in the latter half of 2024. This warrants a continued finding of partial compliance with the Paragraph 52 requirements.

53. Watch Level Determination: A Qualified Mental Health Professional will determine the clinically appropriate watch level, Close or Constant Observation Watch, as defined above.

Finding: Substantial compliance

Rationale: As noted in the DQE's earlier reports, the wording of Paragraph 53 is so close to that of Paragraph 50 that the DQE cannot distinguish a meaningful difference between the two. Upon agreement by the parties, Paragraph 50's compliance finding is repeated in this section, and no independent assessment was conducted.

54. The Cell: The prisoner will be placed in a designated suicide-resistant cell with sight lines that permit the appropriate watch level as indicated by the Qualified Mental Health Professional. If the cell used is not suicide resistant, then the watch must be Constant Observation Watch.

[33] This applies mostly at Framingham and MASAC, where patients are sometimes admitted from the community rather than from other correctional facilities. If a patient is new to the system, has never seen a psychiatrist in MDOC, and is ill enough to warrant TS, their psychiatric evaluation should be expedited.

Finding: Partial compliance

Rationale: During site visits, the DQE team has observed, in each unit providing TS, the door design, the position of any officers providing constant observation, and the resulting sight lines. In addition, officers were interviewed about their observation practices. Some doors have been modified, in part to improve safety and visibility, since the Agreement went into effect.

There are significant variations in door designs, though a few types are most commonly used. Most have multiple windows of medium to large size. The doors do not contain heavy mesh, cloudy Plexiglas or glass (with one exception), or other features that obstruct a view. Most have the windows positioned above and below a wide band of metal that includes a food port. While the size of the windows is an advantage, the positioning is not always well suited to monitoring of prisoners. Depending on the height of available chairs and the distance from the door,[34] officers can find themselves crouching down to improve the view or looking through the food port. Many cells are plain rectangles, but in some, not all of the cell can be seen at once, with a portion being off to one side. Some officers described practices to overcome these concerns, such as cameras facing a less visible cell section and changing the type of chair and its placement to adapt to the prisoner's position.

Toward the end of the last monitoring period, MDOC proactively examined all cells designated as suicide-resistant as part of its Quality Assurance efforts to prevent prisoners from using items found in the cell for self-harm. Reviewers reportedly identified some cells at each of the institutions providing TS that no longer met their standards for suicide resistance. MDOC informed the DQE that repairs were initiated and that all TS placements in those cells would be monitored under constant observation until reinspection certified that the cells were again suicide resistant.

During site visits between September and December 2024, each institution's leadership described the repairs that had been undertaken and noted that substantial numbers of TS placements had been conducted under constant observation in the interim. In February 2025, MDOC provided a list of all cells certified as suicide-resistant; these are present at five institutions, often in multiple units per site. As of this writing, repairs or upgrades

[34] For example, in one location, officers must sit on a very narrow tier, which can limit the range of vision because one is so close to the door. In another facility, an officer sat in a low chair approximately 10 feet back from the door, which likely brings more of the metal parts of door into focus and does not allow viewing at an angle to see patients on the floor or in corners. Both higher and lower chairs have advantages and disadvantages with this door configuration.

reportedly remain under way for all TS cells at Gardner, MTC, and Norfolk, and in Shirley's HSU.

The DQE team examined the security observation sheets for a sample of TS stays that took place in cells determined not to be suicide-resistant.[35] Two-thirds of them seemed to demonstrate that constant observation occurred throughout the placement, but other cases were unclear.[36] A larger-scale, systemwide study of this issue was not practical or necessary, as hopefully MDOC will complete its repairs of the TS cells within the next few months.

55. Cell Checklist: MDOC will develop and implement a checklist for security staff to ensure that the cell is free from potential hazards prior to placing a prisoner in the cell. If a prisoner later engages in Self-Injurious Behavior, a supervisor will review the checklist as an auditing tool.

Finding: Partial compliance

Rationale: By the beginning of this monitoring period, MDOC had implemented an excellent revised cell checklist; it is well designed to guide staff to think about physical plant risks particular to TS patients, as well as checking on some other Agreement requirements such as lighting dimmers.

Interviews and documents indicated implementation took several steps forward. In DQE team's interviews,[37] two-thirds of officers, across six facilities, said that the form is in routine use, and several gave good supporting detail. Officers and supervisors cited additional safety practices in OCCC"s BAU, noting that all BAU cells are checked daily on each shift. A minority of interviewees were not familiar with the checklist, particularly in SBCC's BAU.

The DQE team also reviewed security staff's records for a sample of 53 TS placements; these packets typically included observation sheets, TS Reports, and cell inspection

[35] The DQE team reviewed the records from 12 stays at Gardner, MTC, and Norfolk since their cells remained in non-suicide-resistant status throughout the monitoring period.

[36] Where the signatures on the security observation sheets changed approximately every two hours, this suggested the rotation that is expected when security staff conduct constant observation. In two-thirds of the study, this occurred during periods where the MHP had designated the patients for close observation as well as those designated for constant observation.

In other cases, signatures over long stretches of time tended to correspond to times when a patient was designated as being on close observation. This suggests that 15-minute checks were taking place, rather than the constant observation required by Paragraph 54, but it could be that constant observation *was* occurring but there was difficulty fulfilling the requirement to rotate officers.

[37] Eleven officers and supervisors spoke on point. They were regularly posted to HSUs or BAUs

checklists, and they sometimes included other related documents.[38] The sample showed correctly completed inspection checklists in 47% of placements. This, too, is an improvement over previous monitoring results. Practice was strong at five institutions. Difficulties were concentrated only at SBCC, where no checklists were present in provided materials, as well as at Shirley and MASAC.

The DQE team did not assess supervisors' use of the checklist after patients' self-injury during this monitoring period.

With sustained practice, improvement at the three facilities that have less adoption, and demonstrated use of the checklist to analyze solutions after a patient injury, MDOC will be able to reach substantial compliance.

56. Mental Health Watch Conditions: The conditions (clothing, showers, lighting, property, privileges, activities, exercise, restraints, and meals) of Mental Health Watch for prisoners in mental health crisis will be based upon their clinical acuity, whether the specific condition has the potential to hurt or help them, and on how long they have been on Mental Health Watch. The conditions identified in Paragraphs 57 to 65 will be documented on the prisoner's Mental Health Watch form. In the event of a disagreement over any of these determinations, the matter will be referred to the Mental Health Director and to the Superintendent of the facility as deemed necessary. The Superintendent or Designee, who will consult with MDOC's Deputy Commissioner of Clinical Services and Reentry or Designee and Deputy Commissioner of Prisons or Designee as deemed necessary, will be responsible for rendering the final decision.

Finding: Substantial compliance

Rationale: During each monitoring period, the DQE team has observed mental health triage meetings at the institutions providing TS, and the first agenda item has typically been a review of the patients on TS. The mental health team's discussions have included an update on the patient's clinical status, as well as decisions about which property and privileges to grant for the day. The discussions have rarely tied the property/privilege decisions explicitly to a patient's length of stay on TS—for example, the DQE team has never heard an MHP state, "It's been 48 hours, so we should be granting clothes." However, MHPs appeared to be fulfilling the main intent of Paragraph 56, basing a patient's conditions of TS on their clinical status and individualized risk factors. In interviews with the DQE clinicians, MHPs reported a reasonable framework for deciding whether to allow certain property, thinking about whether the item can be (or has been) used to self-harm and balancing that with its potential therapeutic benefit. This general

[38] See Paragraph 34 for a description of this study's methods.

approach to decision-making has been consistently observed by the DQE team across four monitoring periods. The few exceptions are discussed in their respective paragraphs (57-65) below.

MHPs' decisions about property and privileges are documented in "TS Reports," and the expectation that these forms be completed daily, at least Monday through Saturday, is well established across MDOC. As noted in Paragraph 69, implementation of this practice remains fairly strong, with all required TS Reports completed in 76% of cases in the DQE team's study, despite a decline during this monitoring period.

When asked by the DQE team how they resolve disagreements about property and privilege decisions, interviewed security and mental health staff gave varying responses. Eight interviewed security staff, across six institutions, recalled only rare instances of disagreement and stated that they would discuss the issue with their supervisor or shift commander if it were to occur. Mental health clinicians, across four institutions, reported that there have been cases of property approved by mental health staff not being given to patients on TS, but they were not sure whether these lapses were due to an officer's disagreement with the decision or for other reasons, such as property not being available.[39]

No clear trends were apparent from the interviews, but some staff did seem aware of a procedure consistent with Paragraph 56, where security and mental health supervisors would work out disagreements about property and privileges, or the issue would be discussed in the triage meetings. No interviewed staff recalled ever needing to involve MDOC leaders outside the facility (i.e., the Deputy Commissioners) in resolving disputes, and only one such instance has come to the DQE's attention in two years of monitoring.

57. Clothing: Throughout the prisoner's time on Mental Health Watch, a Qualified Mental Health Professional will make and document individualized determinations regarding the prisoner's clothing, using the following standards:
a. Prisoners on Mental Health Watch will be permitted their clothing unless there are clinical contraindications, which must be documented and reviewed three times during each day (Monday-Saturday), spaced out throughout waking hours, and one time on Sundays (for prisoners on Constant Observation Watch), to see if those contraindications remain;
b. Removal of a prisoner's clothing (excluding belts and shoelaces) and placement in a safety smock (or similar gown) should be avoided whenever possible and only utilized when the prisoner has demonstrated that they will use the clothing in a self-destructive manner;

[39] For example, sometimes a patient's tablet or other property might still be in their housing unit, and bringing it to the location of the TS may take time even if authorized by the mental health staff.

c. If a prisoner's clothing is removed, a Qualified Mental Health Professional will document individual reasons why clothing is contraindicated to their mental health, and it is the goal that no prisoner should be placed in a safety smock for 24 hours or more; and
d. After 48 hours, all prisoners will have their clothes returned with continued monitoring unless MDOC's Director of Behavioral Health is notified and the contracted medical care provider's Director of Clinical Programs is consulted and approves. Individual reasons why clothing is contraindicated to their mental health will be documented by the assessing clinician in the medical record.

Finding: Partial compliance

Rationale: Through each monitoring period, including the present one, the DQE team has reached its findings on this requirement after observing triage meetings and MHPs conducting TS contacts, conversations with MHPs and clinical leaders, interviewing patients and security staff, and reviewing health records. For this report, the records review included progress notes for 52 TS placements[40] and a related spot check with TS Reports.[41]

While decisions are made as to each patient, the extent to which they reflect the patient's individual circumstance remains much as it was when the DQE team began its monitoring. With several other components of Paragraph 57, there was noted improvement in the first half of 2024, but practice appears to have fallen back to much lower compliance levels. That is, fewer patients in the sample had clothes at the 24-hour and 48-hour points, and only a minority of patients in smocks had documented clothing-related risk and/or contraindications. Changes in documentation methods may be a factor in the appearance of lower compliance.

Making and documenting clothing decisions: MDOC has established that MHPs routinely make decisions about property and privileges, including clothing, typically in the daily triage meeting. In the current monitoring period, seven security or mental health staff and 24 prisoners interviewed by the DQE team spoke to TS clothing practices. Just over half of interviewed staff observed that clothing decisions seem individualized. More than half

[40] The sample was selected to study nearly all of the property and privilege decision requirements. It overlaps with, but differs from, the sample described in Paragraph 45. Placements were drawn from each of eight institutions in approximate proportion to its percentage of TS placements from July through November 2024. The sample favored lengths of stay longer than three days. Cases were chosen from HSU, BAU, STP, SAU, and ITU placements and a mix of close and constant observation. If information conflicted between progress notes and TS Reports, the analysis relies on the TS Reports.

Where this sample was analyzed for other requirements in this DQE report, supplementary materials and sample size may vary depending on a number of factors. Descriptions of those methods and differences are available on request.

[41] See Paragraph 69 for a description of the spot check methods.

of the patients said they always or usually begin a TS in a smock, while smaller numbers described retaining their clothes from the start or alternating between smock and clothes. Many staff and patients noted that smock use is typically tied to an express intent to hurt oneself and/or being subject to constant observation, rather than being automatic for all placements.

Through four monitoring periods, the DQE team has found clothing decisions consistently documented in progress notes and on the "TS Report" that communicates the decisions to security staff, and some facilities also document the decisions in triage meeting notes. This remained partially true in records reviews for this report, but after the change in healthcare vendor, the progress note format does not expressly call for a clothing decision, which may result in uneven recording of any decisions made and the appearance of lower compliance rates throughout this section.

24-hour goal: In the 52-placement analysis, MHPs authorized half of the patients to retain their clothing during the first day on TS. This represents a continued decline, one that has been evident in the DQE analyses in each successive monitoring period. On the other hand, Framingham, MASAC, and OCCC met this goal at much higher rates than the system average.

Clothing at 48 hours or leadership notice and approval: The analysis determined that, in 75% of placements, patients were permitted to be in clothing by the end of the second day. This is a lower rate than in the previous monitoring period. Others were authorized clothes between the fourth and the seventh days, with only one patient wearing a smock for the entire TS placement.

To satisfy the notice, consultation, and approval requirements, the healthcare vendor and MDOC employ a system described in Paragraph 78 below. The DQE team reviewed progress notes, spreadsheets. and meeting minutes for the dates in which a sampled patient was in a smock for three days or more. Notice was given unevenly, and consultation and approval were not documented for any of the patients. The DQE team also observed four of the daily TS consultation meetings during the monitoring period, and one such patient was presented.

Demonstrated clothing-related risk: When clothing was withheld in this sample, progress notes indicated that only 42% of those patients had demonstrated they would use clothing in a self-destructive manner. The DQE considers this to mean the patient made a specific threat to hang or strangle themselves; had a recent hanging or strangulation attempt, possession of a ligature, or other attempts or threats of self-harm using cloth; or had a

history of one of those. This compliance rate represents a return to the low rates of early monitoring periods.

Specific, individualized contraindications: Additionally, only 44% of patients in smocks had progress notes reflecting contraindications specific to the individual each day that clothing was not authorized. This, too, is a substantial decline.

Frequency of decisions reviewed: Through all monitoring periods, including the present one, documentation shows clothing decisions made once per day, including Sundays for constant observation patients. Occasionally, property and privileges decisions are documented twice in a given day. The DQE team has not encountered evidence of smocks being reconsidered three times per day.

Overall, MDOC remains in partial compliance with the requirements of Paragraph 57. There was a noticeable decline in providing clothing to patients on TS, which may represent a true change in practice or may be related to a difference in documentation under the new healthcare vendor.

58. Showers: If a prisoner has been on Mental Health Watch for 72 hours and has not been approved for a shower, a Qualified Mental Health Professional will document individual reasons why a shower is contraindicated to their mental health. Correctional staff will document when an inmate is offered an approved shower.
a. Similarly, if a prisoner has been on Mental Health Watch for longer than 72 hours and has not been approved for a shower approximately every two days, a Qualified Mental Health Professional will document individual reasons why a shower is contraindicated to their mental health. Correctional staff will document when an inmate is offered an approved shower.

Finding: Partial compliance

Rationale: In previous monitoring periods, based on chart reviews; MHP, prisoner, and security staff interviews; and observations during the site visits, the DQE team has found that MHPs consistently decide daily whether to authorize showers and document these decisions in progress notes and TS Reports. In the current monitoring period, the DQE team reviewed progress notes for property and privileges decisions;[42] in every case, the prisoner was approved for showers well within the required time frame. Findings from related spot checks of TS Reports were consistent with this.[43]

[42] See Paragraph 57 for a description of the study and overall methodology.
[43] See Paragraph 69 for a description of the spot check methods.

Ten interviewed officers or supervisors had knowledge of, and/or responsibility for, showers on a unit that provides TS. Nearly all affirmed that prisoners on TS are offered showers, and some described in detail the routines to ensure showers are offered and provided. Similarly, among the 27 prisoners who commented on showers, 85% said these were regularly offered. A small number of prisoners and officers thought showers were dependent on the prisoner taking the initiative to ask or were not allowed while on constant observation status. A prisoner at Gardner said sometimes showers could not be provided because of low officer staffing levels; an MHP said other prisoners had reported this as well.

MDOC has informed the DQE team that it has designed the method for documenting the offer of showers and other activities, but implementation depends on first issuing the revised mental health policy. Thus, offers of showers are not consistently documented presently.

Overall, practice appears to be strong on this requirement. MDOC should be able to reach substantial compliance once it can provide documentation of showers consistently being offered.

59. Lighting: Lighting will be reduced during prisoner sleeping times as long as the prisoner's hands, restraints (if any), and movements can still be clearly observed by MDOC staff.

Finding: Partial compliance

Rationale: MDOC continued to make progress on implementing this requirement. During site visits, the DQE verified that dimmers have been installed on the majority of units providing TS, and this has been fully accomplished in five institutions. Leadership has described the renovations underway for the remaining units. Different facilities employ light switches, key-controlled lights, or computer-controlled settings; some changes reportedly require significant electrical projects in older buildings.

MHPs recommend whether lighting can be dimmed as part of their property and privileges decisions. In the DQE team's study of these decisions,[44] only 60% recommended dim lighting; this makes it less likely that MDOC will meet the Agreement's requirement that "lighting will be reduced."

While recommending against dim lighting occurred occasionally at several facilities, fully 80% of sampled SBCC placements called for full lighting. On the other hand, MHPs

[44] See Paragraph 57 for a description of the study and overall methodology.

recommended lights be dimmed in every case at Framingham, MTC, Norfolk, and OCCC.

The 11 officers interviewed about this issue were aware of the dimmers; they did not work the overnight shift so they could not speak to the dimmers' use. It is helpful that a revised cell checklist—by asking officers to check whether the dimmer is working—prompts them to think about the dimmers each time a prisoner is placed on TS. A few of the officers thought dimming was not permitted for prisoners on constant observation or noted that supervisors did not always dim the lights when MHPs recommended it.

Among 26 prisoners who commented, they experienced dim lighting at the same rate as in the previous monitoring period – just under one-third. The majority said the lights were fully on, or the prisoner was unsure of the lighting level.

MDOC is in partial compliance with this requirement. MDOC has made continued improvement on physical plant changes, and attention to implementation will be needed as well.

60. Property: Throughout the prisoner's time on Mental Health Watch, a Qualified Mental Health Professional will make and document individualized determinations regarding the prisoner's property, and restrictions should be the least restrictive possible, consistent with prisoner safety.

Finding: Partial compliance

Rationale: In the DQE team's analysis of property and privileges decisions in progress notes,[45] along with TS Report spot checks,[46] MHPs authorized additional property in 42% of the sample. That is a significant decline from the previous monitoring period, when 69% of TS cases were authorized for additional property. Permitted items included medical and ADA supplies, glasses, additional hygiene or bedding, religious items, a radio, and legal materials. Framingham and Shirley MHPs showed the strongest practices. It was not feasible to determine from the documentation the extent to which decision-making was individualized as required, and the DQE team did not undertake a systematic assessment of whether the approach taken was the least restrictive possible. However, in MHPs' interviews with the DQE team, it was clear that they are aware of the expectation to be as liberal as possible with property and privileges, taking risk and clinical factors into account.

[45] See Paragraph 57 for a description of the study methods.
[46] See Paragraph 69 for a description of the spot check methods.

Among interviewed prisoners, almost all felt they did not have additional property. Similar to the chart review, the four patients who mentioned other property said they had been permitted a radio, legal mail, religious items, magazines, cosmetics, and coffee.

61. Privileges: Throughout the prisoner's time on Mental Health Watch, a Qualified Mental Health Professional will make and document individualized determinations regarding the prisoner's privileges (e.g., a tablet, reading and writing material) using the following standards:
a. After 24 hours, prisoners will have access to library books and other reading and writing material unless a Qualified Mental Health Professional documents individual reasons why such materials are contraindicated to their mental health each day, and repeats that same process and documentation each and every day.
b. After 14 days, prisoners will have access to a tablet unless a Qualified Mental Health Professional documents the individual reasons why this is contraindicated to their mental health on the Mental Health Watch form.

Finding: Partial compliance

Rationale: As detailed above, MDOC has established that MHPs decide about privileges and property—including reading and writing material and tablets—usually six days per week, and they document the decisions on "TS Reports."

In the study first described in Paragraph 57, reading material was allowed timely in 92% of the cases, and a few were authorized later in the stays. This has been consistent since the Agreement went into effect. In the remaining cases, however, mental health staff did not document individual reasons that reading material would be contraindicated on each day that the materials were not authorized. Interviewed prisoners expressed a different view, with just over half saying they were allowed to have books and a few saying that it was only permitted for prisoners on close observation. This may indicate differences between authorizations and providing the books, but the reasons for the gap between chart notes and prisoners' views is not known with certainty.

Writing materials were permitted less often, with timely authorizations at 53%. An additional handful permitted it later in the TS. Here, too, there were few examples of MHPs documenting daily the specific, individual reasons that writing material would be contraindicated. However, the rate of timely permissions appears to have made steady, incremental gains during each monitoring period. In interviews, prisoners confirmed at a similar rate that they were allowed writing materials, though a few thought this was never permitted on constant observation, or they noted that receiving the materials was delayed or did not occur.

The DQE team selected additional TS cases to be able to review 10 patients with lengths of stay in which tablets would be required.[47] The compliance rate appeared to fall dramatically – reduced by more than half – to 40%. An individualized contraindication was recorded in only one case.

On the other hand, in the core property and privileges chart review, MHPs continued to allow tablet access for many more patients well before it would have been required. Patients could access this resource in 55% of the reviewed TS stays. Prisoner interviews were even more promising. More than two-thirds said they received their tablets, usually much earlier than Paragraph 61's deadline, and only one prisoner said he was not allowed a tablet during a stay that exceeded 14 days.

Attention is needed to permissions for writing material and potentially for tablets in longer-term TS, as well as thinking about and documenting contraindications for any of these items when disallowed. With the sustained differences between book authorizations and patient perception, it may be warranted for MDOC to look into any barriers to providing allowed books.

62. Routine Activities: Throughout the prisoner's time on Mental Health Watch, a Qualified Mental Health Professional will make and document individualized determinations regarding whether it is clinically appropriate for the prisoner to participate in routine activities (e.g., visitation, telephone calls, activity therapist visits, chaplain rounds). Absent Exigent Circumstances, the prisoner will be allowed to participate in the routine activities deemed clinically appropriate by the Qualified Mental Health Professional. If a prisoner is not approved for a particular activity, due to clinical contraindication, during a day, a Qualified Mental Health Professional will document individual reasons why that particular activity is contraindicated.

Finding: Substantial compliance

Rationale: The DQE team previously found this requirement to be in substantial compliance based on chart reviews; MHP, patient, and security staff interviews; and observation of practice during site visits.

In the current monitoring period, the DQE team continued to observe property and privileges decision-making in triage meetings. In addition, the DQE team analyzed progress notes and 100% of sampled records authorized the patient to have phone calls

[47] This sample size represents 28% of the stays lasting 14 days or longer from July through December 2024. Cases were selected from each of the five institutions where stays of this length took place.

and visits.[48] Spot checks of TS Reports were consistent with this finding.[49] Contact with activity therapists and religious representatives was routinely permitted as well.

In 26 interviews touching on this point, 72% of patients said they were allowed phone calls. Others offered single examples of officers saying the phone was broken, refusing to allow calls, or incorrectly saying MHPs had not authorized them,[50] or the patient had an understanding that calls are not permitted while on "smock" status. These complaints were concentrated in the BAUs of Norfolk and SBCC, but they did not amount to a pattern. Very few interviewees thought they would have been permitted visits; most were unsure or do not receive visits. In all monitoring periods, no one has reported asking for a visit and being denied.

Although prisoners raised some concerns about implementation, on balance, the DQE team finds that MDOC remains in substantial compliance.

63. Exercise: After 72 hours on Mental Health Watch, all prisoners will have access to outdoor recreation/exercise. If a prisoner is not clinically approved such access, the assessing Qualified Mental Health Professional, in consultation with the prison's Mental Health Director or designee, will document on the Mental Health Watch form individual reasons why outdoor exercise is contraindicated to the prisoner's mental health. Correctional staff will document when a prisoner is offered approved recreation.

a. Similarly, if after 72 hours on Mental Health Watch a prisoner is not clinically approved access to outdoor exercise five days per week for one hour, the assessing Qualified Mental Health Professional, must document individual reasons why outdoor exercise is contraindicated to the prisoner's mental health each and every day, and communicate to appropriate security staff. Correctional staff will document when a prisoner is offered approved recreation.

b. During outdoor exercise, escorting officer(s) will provide supervision during the exercise period, consistent with the level of Mental Health Watch. As with considerations regarding use of restraints, MDOC will consider alternatives to strip searches on an individual basis. MDOC may conduct strip searches if deemed necessary to ensure the safety and security of the facility, the staff, the prisoner on watch and/or all other prisoners. In determining whether a strip search is necessary, MDOC may consider factors including but not limited to, whether: the prisoner has a documented history of inserting or hiding implements to self-injure or harm others; the prisoner has a documented history of behavior that may constitute a security risk (e.g., assaulting staff or prisoners, possession of weapons, inserting or swallowing items to use for self-harm or harm of others); the prisoner has a history of engaging in self-injurious behavior; and the property items that have been approved for retention by the prisoner while on watch.

[48] See Paragraph 57 for a description of the study and overall methodology.
[49] See Paragraph 69 for a description of the spot check methods
[50] In the latter, the DQE reviewer verified that records showed phone and visits authorized for that patient.

Finding: Partial compliance

Rationale: The DQE team assessed each aspect of the Paragraph 63 requirements related to recreation:

Approvals: In the DQE team's study, progress notes and TS Reports showed that far fewer patients were approved for recreation than in the previous monitoring period.[51] Most facilities did not meet the mark for one or two patients, authorizing recreation later than the fourth day, or not at all, without specific, individualized contraindications documented daily. This was also the case for 75% of the sampled patients at SBCC. Systemwide, the compliance rate was 57% in this review.

In contrast, Framingham and OCCC MHPs approved all patients by the end of the third day or recorded individualized reasons that recreation was contraindicated.

A few interviewed mental health staff offered a range of views, from disallowing recreation only if the patient is actively engaging in self-injury to a belief that patients well enough for recreation are likely well enough for discharge from TS.

Providing recreation: In terms of offering recreation, the DQE team interviewed officers and supervisors working on units that provide TS on the shift when recreation is offered to the unit's population. At MASAC, MTC, Norfolk, OCCC, and SBCC's HSU, security staff consistently described offering recreation to patients on TS, and several provided good supporting detail. However, in Shirley's HSU, SBCC's BAU, and at Gardner, security staff said recreation is not allowed for TS patients. At Gardner, staff noted there is a designated recreation space but it has not been used; it was unclear whether mental health or security staff did not authorize its use by TS patients.

Among the 20 interviewed patients subject to this requirement,[52] only 40% said they had been offered recreation. This was fairly consistent across facilities. The exceptions were

[51] The DQE team studied privileges and property for 52 TS placements; see Paragraph 57 for a description of the study and overall methodology. To assess recreation authorization within that sample, the reviewer included TS stays that exceeded three days, as well as three-day stays where recreation was already allowed, and did not include cases where the patient was discharged on the morning of the fourth day. This totaled 47 stays. The reviewer also drew on spot checks of TS Reports; see Paragraph 69 for a description of those methods. Where progress notes and TS Reports conflicted, the reviewer relied on the TS Reports.

[52] These are patients who had had at least one TS in 2024 and, where a patient said s/he had not been offered recreation, the DQE team verified on the TS Registry that at least one of that patient's 2024 lengths of stay exceeded three days. Patients in this set were drawn from all six institutions where placements of this length occurred; at MASAC and MTC, there either were no stays of this length or the patients were no longer onsite during the DQE site visit.

Gardner, where all the patients said they were *not* offered recreation, and OCCC, where all patients said it was offered when they were on TS in BAU but not in HSU.

Documenting offers: It is not presently possible to assess documentation of recreation offers, acceptances, and refusals. MDOC reports that it has designed a system for this but that policy 103 DOC 650, Mental Health Services, must be issued before this documentation system can be implemented. Prisoners, MHPs, and officers all noted it is common for TS patients to not want to take advantage of recreation time.

Monitoring use, strip searches: In previous monitoring periods, security staff spoke of routinely posting an officer outside whenever any prisoner is on the recreation yard, and the DQE team observed that in operation. A few officers reaffirmed that protocol during this monitoring period, and DQE team members again observed it in some locations. A handful of officers affirmed that all prisoners are strip searched in conjunction with recreation time, and only two of the interviewed prisoners said they had gone to recreation. The DQE team does not have information sufficient to assess the potential for individualizing a choice of whether to strip search patients using recreation time.

64. Restraints: Prisoners in mental health crisis will not be restrained when removed from their cells unless there is an imminent or immediate threat to safety of the prisoner, other prisoners, or staff, as determined by security staff. Security staff will consult the Qualified Mental Health Professional to determine whether restraints are contraindicated, and where there is such a finding, the Qualified Mental Health Professional will document the individual reasons why restraints are clinically contraindicated.

Finding: Partial compliance

Rationale: The DQE has reviewed MDOC's revised TS training materials and policies and has found that they clearly indicate the intention for all restraint decisions involving prisoners on TS to be individualized and based on risk of harm to self or others.

In practice, it does not appear that prisoners in mental health crisis are only restrained if there is an imminent or immediate threat to safety. In interviews with the DQE team, 25 prisoners from seven institutions spoke about restraint practices when calling for a crisis contact or during TS. A large majority said they are restrained during escorts to crisis assessments. The picture was mixed at most facilities, but Gardner and Shirley reportedly did this for all crisis calls. Gardner security and mental health staff affirmed this practice.

Prisoners indicated more flexibility during the crisis assessment itself, but once placed on TS, nearly all interviewed prisoners, at every institution, said they were restrained during thrice daily contacts with MHPs if they came out of their cells. This was reported even

for a minimum-security patient on TS for depression; some patients restrained behind their backs in restart chairs; and some patients in therapeutic modules where they cannot reach an MHP, which the DQE team also observed during recent and previous site visits. These descriptions were offered by prisoners of all security levels and with and without BAU status.

Officers and supervisors, too, described a universal practice in most facilities of restraining prisoners who have called crisis during their escort and crisis assessment.[53] A few officers at Norfolk, Shirley, and MASAC said it was common to escort prisoners unrestrained or to make a cuffing decision in conjunction with an MHP.

As to MHP contacts during TS, about half of security staff described universal restraint use in the HSU and BAU. A handful of others described individualized decision-making, sometimes in collaboration with MHPs.

Security staff and leaders, mental health staff, and prisoners continue to affirm that all prisoners on BAU status are restrained whenever they are out of cell; it is general practice to uncuff prisoners during TS contacts if they are physically separated in therapeutic modules or visiting rooms, but OCCC MHPs confirm that patients remain restrained behind their backs in these settings. Mental health staff describe other categorical bases on which restraint decisions are made, such as all prisoners of a particular security level or phase in a program. At SBCC, MHPs note TS patients being treated differently: where other prisoners are cuffed in front in a restart chair, TS patients are made to sit handcuffed in back while also connected to the restart chair, an MHP said. An MHP at Gardner, where restraint is uncommon in the general population, said restraint practice for prisoners "calling crisis" deters a number of them from seeking help.

MHPs are asked to designate in progress notes and TS Reports whether restraints are contraindicated for a TS patient. In the DQE team's study of property and privileges,[54] half of the records designated the patients as having contraindications for restraint. Among those, fewer than 20% indicated the reasons.

Practices such as routinely handcuffing patients behind their backs while they are already restrained to a restart chair and keeping patients restrained while they are in split cells or visiting rooms, where they are unable to make contact with mental health staff, have been identified in multiple monitoring periods. These additional measures do not enhance safety, while extended, painful restraint can be a disincentive to engaging in meaningful

[53] 18 security staff commented on this topic

[54] See Paragraph 57 for a description of the study and its methods. The reviewer also conducted a spot check with TS Reports, which is described in Paragraph 69.

therapeutic contact and feed extended or repeated TS placements and oppositional behavior. The DQE team recognizes the complexities in these decisions and remains open to discussing how to balance the different, important factors.

65. Meals out of cell: Absent medical, clinical, or safety/security concerns, after 72 hours on Mental Health Watch, all prisoners will have access to meals out of their cells unless the area where the prisoners are on watch has insufficient space or the Department of Public Health does not permit the space to be used for such purposes.

Finding: Partial compliance

Rationale: In June 2024, MDOC referenced two documents when asserting that meals out of cell are not possible in any location where TS occurs: 105 CMR 590.000: Minimum Sanitation Standards for Food Establishments State Sanitary Code Article X, and 105 CMR 451.200, Food Storage, Preparation, and Service. The DQE understood these regulations to mean—in plain language—that MDOC cannot serve meals in designated healthcare areas because of sanitation requirements. This was a helpful framework to understand why meals out of cell likely cannot happen in HSU settings. However, as noted in Paragraph 139, most TS placements across MDOC during this monitoring period did not happen in the HSU; they occurred in the BAU and other housing units. To date, no regulatory prohibition on out-of-cell meals in those settings has been shared with the DQE.

In its December 2024 status report, MDOC reported the following in relation to meals out of cell:

> This was discussed at the December 9, 2024 Quarterly Site implementation meeting. All sites were encouraged to continue to explore the feasibility of out of cell meals for prisoners. MCI-Norfolk opined that they had a restart chair in a space that could be utilized, and they anticipate having one more restart chair added to that space. MCI-Shirley reported that they would be able to accommodate an out of cell meal in the HSU, but due to the suicide resistant cells being in the BAU, they currently do not have access to that space for meals.

Thus, it appears that meals out of cell are still being actively explored, which the DQE greatly appreciates. A continued finding of partial compliance is warranted. Going forward, the DQE encourages MDOC to make a list of all locations where TS occurs and, if meals cannot be provided out of cell in the location, a brief explanation of why not (e.g., insufficient space or DPH regulations prohibit).

66. Mental Health Watch Mental Health Care: MDOC is committed to providing constitutionally adequate mental health care for prisoners on Mental Health Watch.

Finding: Not assessed

Rationale: Because there is no objective way to assess a system's commitment to providing constitutionally adequate mental healthcare, the parties agreed that this provision will not be assessed.

67. Mental Health Crisis Contacts: Within one (1) year of the Effective Date, MDOC will implement the following requirements. Following the initial mental health crisis assessment/evaluation (see Paragraph 47), MDOC's contracted mental health provider will conduct three daily out-of-cell mental health contacts (either treatment or activity session), document, as applicable, when and why a prisoner requests the contact cell-side or refuses contacts, offer contacts at different times of the day, and document follow-up attempts to meet with a prisoner who refuses contacts.

Finding: Partial compliance

Rationale: As detailed in previous DQE reports, MDOC and its vendors have a well-established system to provide three contacts per day to TS patients, with the exception of Sundays and holidays, when there is a single contact for patients on constant observation status. While this satisfies a substantial amount of Paragraph 67's requirements, MDOC and DOJ disagree about whether this provision allows reduced contact on weekends and holidays.

The DQE's earlier findings were based on staff interviews, onsite observations of contacts and meetings, and review of charts and other documents; the DQE team continued to employ those methods during this monitoring period and found sustained practice.

In the DQE team's chart reviews, progress notes demonstrated 82% of the required contacts.[55] Where contacts were missed, 94% were on a Sunday or a holiday. There was no indication that institutional factors or MHP workload prevented any significant number of contacts. In prisoner interviews across seven institutions, about 70%

[55] See Paragraph 45 for a description of the selection method. The expected number of contacts was prorated to accommodate time of placement, time out of the institution (for example, trips and/or admissions to community hospitals), and approximate time of discharge. A contact was credited whether it was completed or the patient refused.

confirmed being seen three times per day. The DQE team considers this practice to be strong.

On the other hand, nonconfidential contacts continued to increase to at least 63% during this monitoring period.[56] This is a significant decline in practice since the DQE team first began tracking the data in July 2023. Rates of cell-front contacts were high at nearly all institutions during this monitoring period. Norfolk, however, was especially successful in meeting patients in private spaces.

MHPs documented the patient declining to come out of cell, or refusing the contact, as the reason for the majority of cell-front contacts. There was little to no indication in the progress notes or prisoner interviews that they refused because of barriers posed by staff or procedures.

Evidence of follow-up attempts to meet with a prisoner who refuses contacts has been very limited to date. Progress notes and their timestamps illustrate that contacts naturally occur at different times of day. The DQE team has observed, and staff interviews confirm, that MHPs have limited ability to direct contact times for the purpose of reducing refusals, as suggested by the requirement, given the high rate of activities on the units and the multiple departments sharing interview spaces. For example, in the HSU at SBCC, there is only one room where patients can be seen out of cell, and it is frequently in use by other staff.

It appeared that the rate of nonconfidential contacts caused by institutional factors and MHP workload was improving, at 13% of all contacts in the systemwide sample. Given the number of cell-front contacts that did not record a reason, this conclusion is not definitive, but signs are promising.

Of note, 80% of known cell-front contacts in the sample occurred at SBCC, further illustrating the need for structural solutions at that facility. On each site visit, the DQE team has observed, and been informed of, numerous obstacles to patient access, and MHPs estimate their access time at two hours daily on many units. A few interviewed SBCC security staff noted that short staffing among their ranks or mental health staff sometimes leads to cell-front contacts. It was also concerning that Framingham reportedly implemented a new policy that the door must remain open during an MHP contact unless the TS patient is restrained. On the other hand, MHPs at Norfolk reported

[56] Where no location was indicated, the contact was counted as being in a confidential space. This was a fairly small percentage of the overall contacts, but it could increase the percentage a small amount if some of these contacts occurred in non-private settings.

consistent collaboration from officers bringing patients out of cell to private meeting spaces.

About 70% of interviewed prisoners said that contacts are usually out of cell or that patients choose whether to meet in or out of cell. Some observed that offers of confidential space vary greatly by individual MHP, that only the first daily contact can be out of cell (OCCC), or that they had been told they could not come out of cell because of low security staffing levels. The DQE team occasionally encountered notes that patients had asked to be seen privately and could not be accommodated.

Among interviewed security staff, about half said that prisoners determine whether a contact occurs in or out of cell. Officers at Gardner, Norfolk, OCCC, and some at Shirley, thought that most contacts ultimately take place in a confidential setting.

68. Mental health staff will ensure that daily mental health triage minutes identify (1) who has refused the contacts, (2) which contacts were refused, (3) reasons why the prisoner has refused the contacts, if known, and (4) what additional efforts/interventions will be tried by mental health staff. The mental health staff will review prior mental health triage minutes as part of this process.

Finding: Partial compliance

Rational: In the DQE team's study of 52 TS placements,[57] the reviewer assessed the frequency and reasons for refusals and staff's response as described in progress notes and triage meeting minutes. Almost half of the TS stays involved more than *de minimis* refusals to come out of cell or to meet at all. Triage meeting minutes did not capture discussion of refusals in any of the cases, and a change in practice was not apparent in progress notes. This does not demonstrate compliance with Paragraph 68.

However, in the DQE team's observation of triage meetings during this monitoring period, it was apparent that the staff do discuss the reasons for patients' refusal of contacts, at least some of the time. It was common for the assigned "crisis clinician" of the day—the MHP tasked with conducting the first TS contacts—to report in detail about the patients they had seen that morning, whether the patients engaged, and how they responded to the clinician's interventions. Supervisors often suggested strategies to approach the contact refusal, such as returning in the afternoon (when the patient is more likely to be awake/alert), offering a Support Person or activity therapist contact, allowing

[57] See Paragraph 45 for a description of the study and overall methodology

time to recover after an episode of drug/alcohol intoxication, having a different clinician approach the patient, or trying to meet the patient while on recreation time.

Although the DQE's observation of triage meetings demonstrates reasonable practice in this area, Paragraph 68 requires specific documentation in the triage meeting minutes. If MDOC can improve its documentation to reflect the quality of clinical discussions in the triage meetings, it will move closer to compliance with the requirements of Paragraph 68.

69. Monday through Saturday for all Mental Health Watches and Sundays for Constant Mental Health Watches, the Qualified Mental Health Professional must update the Mental Health Watch conditions (listed above Paragraphs 57-65) on a Mental Health Watch form to communicate with appropriate security staff and complete a mental health progress note.

Finding: Substantial compliance

Rationale: As detailed in previous DQE reports, MDOC and its vendors have a well-established system for generating and updating these documents ("TS Reports") and distributing them to the security staff overseeing the therapeutic supervisions. This finding was based on interviews with corrections officers and leaders and mental health staff, observation on the units and in meetings, and review of charts and meeting minutes. This requirement was previously found to be in substantial compliance.

During this monitoring period, the DQE team conducted spot checks of 29 TS placements[58] to determine whether practice was sustained. Documents appeared to show a moderate decline in practice. While employing the TS Reports is still clearly common practice, five of the eight institutions had one or more placements where TS Reports were present for most, but not all, days in the Monday through Saturday span. In total, 76% of the placements fully met the requirement. In a small number of cases, the absence occurred on a holiday, but in the large majority of cases where a document was missing, the reason was not evident.

On the other hand, for patients on constant observation on a Sunday, TS Reports were on file in all sampled cases.[59]

[58] This represents 55% of the chart review described in Paragraph 45. After the transition to VitalCore, the TS Reports were not present in the electronic health record. The reviewer requested the TS Reports maintained in MDOC's Inmate Management System ("IMS") for the sampled stays.

[59] In the sample, there were four such cases. The DQE team understands that there is not tracking that would be able to identify this particular population, and it is not practical to determine its size. However, in the DQE team's reviews over the last two years, such cases have been rare. Thus, the team believes that this sample gives a reasonable impression of MDOC's practice on this element of Paragraph 69.

In the last monitoring period, the DQE team noted some variability in patients' TS Reports that may not have been intended. That appeared improved in the current sample. In almost one-third of the sampled TS stays, however, there were times when the property and privileges recorded in a progress note were inconsistent with what was captured in the TS Report, so it may be that not all clinical decisions about property and privileges are being conveyed to security staff.

Medical records continued to show at least one progress note per day by an MHP or by a nurse if an on-call professional initiated the placement after hours, which is common documentation practice in mental health settings and consistent with the intent of the Agreement.

The DQE team continues to consider this requirement to be in substantial compliance, but that might change in the next monitoring period if this lower performance continues.

70. Mental Health Watch Documentation: A Qualified Mental Health Professional will document all attempted interventions, the success of the intervention and the plan moving forward in daily DAP notes regarding the clinical contacts.

Finding: Substantial compliance

Rationale: In the change from Wellpath to VitalCore's electronic health record, the DAP format of TS progress notes (BH-5.0) was preserved, and clinicians continued to document their interventions with patients. Notes were written at least once per day, as required by Paragraph 70, and usually three times per day, in alignment with MDOC's TS protocols. Clinicians documented their interventions (e.g., "reviewing coping skills with patient," "attempted to redirect patient," "expressed empathy toward patient's loss") and the patient's response (e.g., "was agreeable" or "was not receptive"). While most notes were brief, they conveyed enough information to satisfy the requirements of Paragraph 70.

The DQE remains concerned about the substantive quality of interventions behind MHPs' documentation, but these concerns are addressed in Paragraph 52 (crisis treatment plans), Paragraph 72 (meaningful, out-of-cell interventions), and Paragraph 73 (individualized interventions).

71. Any prisoner who engages in Self-Injurious Behavior while on Mental Health Watch will be re-assessed for modification of interventions when clinically indicated.

Finding: Partial compliance

Rationale: According to MDOC's log of self-directed violence (SDV) incidents, the majority of SDV incidents occurring on TS involved patients using only their bodies (for example, head-banging, scratching, or jumping from a height). Rates improved for attempted hanging, ingesting or inserting objects, and cutting. In some cases, it would have been very difficult to avoid access to the items used (for example, paint chips and the security smock), though in two cases a patient used a razor blade.[60] There was only one overdose reported.

Some officers regularly posted in the BAU or HSU, across five institutions, also noted that self-injury on TS is uncommon in their experience. More than half of patients who commented indicated they had not harmed themselves on TS.

The DQE team examined a 13% sample of TS placements where self-injury occurred.[61] In this study, MHPs appropriately modified the patient's care after self-injury, or no such modification was necessary, in 78% of cases, according to the DQE's judgment.[62] This is similar to the previous monitoring period, when 90% of such SDV cases were handled as clinically indicated.[63]

72. Meaningful Therapeutic Interventions: MDOC will ensure all prisoners on Mental Health Watch receive meaningful therapeutic interventions, including regular, consistent out-of-cell therapy and counseling, in group and/or individual settings, as clinically appropriate.

Finding: Partial compliance

Rationale: Paragraph 72 focuses on the quality of treatment provided to prisoners on TS, including meaningful, out-of-cell group and individual therapy. In reviewing the new TS note template in VitalCore's electronic health record (BH-5.0), it is very difficult to discern the quality of treatment from MHPs' documentation. MHPs no longer document

[60] See Paragraph 144 for further discussion of contraband being used for self-injury.
[61] Nine TS placements in the study involved a patient harming themselves. The DQE team also examined the VCHS SDV Database spreadsheets and, after controlling for multiple incidents in the same TS placement, determined that SDV occurred in 71 TS placements. Thus, the 9 stays in the study constitute 13% of the 71 relevant stays.
Reviewers also compared the spreadsheets titled VCHS SDV Database and TS Registry for all months in the monitoring period to determine whether the DQE team's chart review was sufficiently representative on this issue. The set of 71 placements in which self-harm occurred is 11% of the 625 placements in the monitoring period systemwide. The cases identified in the DQE team chart review constituted 17% of the chart review. With the frequency in each data set occurring at similar rates (with the DQE team study having slightly more information available), the DQE team sample should fairly represent the systemwide practices.
[62] The DQE reviewed 9 total cases of SDV that occurred on TS. In four cases, no reassessment or treatment modification was warranted. In five cases, reassessment or modification was clearly clinically indicated; reassessment occurred only in three of those cases.
[63] While the rate appears to be a decline, the difference is only one patient in a sample of this size.

consistently the duration of 1:1 contact or whether it was out of cell, though the template does contain prompts for those items. In the DQE team's review of 52 TS cases, at least 52% of the patients' contacts with mental health (457 out of 885 required) occurred in a non-confidential setting (often cell-front), raising concerns about the meaningfulness of the therapeutic interventions. About half of the non-confidential contacts were noted to be at the patient's request. The other half were due to security/institutional factors, at the MHP's clinical discretion, or did not explain the reason.

In addition to the non-confidential contacts, 18% of contacts that should have occurred under the criteria articulated in Paragraph 67 were not completed.[64] This leaves just 30% of contacts required under Paragraph 67 occurring in a confidential, out-of-cell space during this monitoring period. The vast majority of recorded contacts were individual; the DQE team found just one example of group therapy occurring for a prisoner on TS; this occurred in the ISU.

During the DQE team's site visits, the picture was similar to that described in previous monitoring reports. MHPs tried to see patients out of cell at most institutions, but particularly at SBCC, they were unable to do so because of security protocols or "institutional factors." The DQE team witnessed MHPs at SBCC routinely conducting brief, cell-front assessments in the BAU after being told that a private room was unavailable or that officers were too busy to take a prisoner out of cell. Even in the HSU—a designated healthcare environment—officers told MHPs that they would not permit out-of-cell TS contacts until after the nurses' "med pass" was done, a procedure that could take until mid-morning to complete. The DQE team's observations were consistent with data from the study of 52 TS placements, which showed that 80% of cases where security factors prohibited out-of-cell contact occurred at SBCC.

As noted in previous DQE reports, it is not clear to what extent security practices such as shackling prisoners' hands behind their backs during out-of-cell mental health contacts contributed to the rate of cell-front TS contacts that are documented as the prisoner's request. During the DQE team's site visits, shackling practices were not often individualized, with most prisoners on TS in the BAU—whether "BAU status" or not—shackled during mental health contacts. In interviews with the DQE team, patients reported that being handcuffed did sometimes deter them from interacting out of cell with MHPs or Support Persons.

[64] This deficiency rate includes three contacts on Sundays and holidays, which are required under Paragraph 67 of the Agreement but are not currently part of MDOC's TS protocols. Without including the missed Sunday/holidays contacts, only 3% of required TS contacts in the study were not completed.

Each of these factors—speaking through a crack in the door, where the therapist cannot listen and see the patient at the same time, and in a setting where security staff and potentially other prisoners can hear the content, or speaking out of cell but restrained in uncomfortable positions that tend to interrupt attention and lead to a desire to shorten the session—cuts against the ability to provide meaningful therapeutic interventions.

To be sure, the DQE team also observed examples of meaningful, therapeutic interactions between patients and MHPs during the site visits. MDOC's clinicians remain enthusiastic and dedicated to their work, and it was the DQE's impression that over-prioritization of security factors and MHP understaffing are the main drivers of poor-quality contacts when they occur. Overall, the situation was no different than previous monitoring periods except at SBCC, where a noticeable decline in out-of-cell contacts and meaningful interventions on TS occurred.

Significant improvement in this area is needed before MDOC can be considered compliant with the requirements of Paragraph 72.

73. Out-of-cell Therapeutic Activities: Throughout the prisoner's time on Mental Health Watch, a Qualified Mental Health Professional will make and document individualized determinations regarding the prisoner's out-of-cell therapeutic activities. All out-of-cell time on Mental Health Watch will be documented, indicating the type and duration of activity.

Finding: Partial compliance

Rationale: Paragraph 73 focuses on individualization of treatment decisions and documentation of those decisions in the health record. During the DQE team's interviews with MHPs and clinical leadership, it was clear that they intend to provide individualized, out-of-cell therapeutic activities for prisoners on TS three times daily. Generally, the first daily contact is focused on assessing a patient's risk, while the other two might be therapeutic or recreational/activity contacts.

As noted in previous DQE reports, the challenge remains not with the structure of TS treatment, but rather with the implementation and individualization. In the current monitoring period, documentation of treatment provided on TS was particularly poor. If an MHP documented a plan at all the progress note, it was usually just checking a box stating that the patient should be seen the next day. It is very difficult to discern from the medical record how treatment interventions were matched to a patient's presenting problem. In most cases, the MHP did not document a formulation of the patient's problems or suggest any specific interventions to address them.

The DQE's impression is that this is more of a documentation problem than a true decline in the quality of care on TS. In triage meetings and interviews with MHPs, they seemed reasonably thoughtful about patients' reasons for being on TS and how best to help patients move forward. In TS contacts observed by the DQE clinicians, most patients were seen out of cell, and several of the contacts lasted 20 minutes or more, focusing specifically on the patient's frustrations or problems. Thus, it appears that treatment is being individualized at least some of the time; it is just being documented poorly. Hopefully, as clinicians adjust to the new electronic health record, the documentation will improve.

Paragraph 73 also requires the documentation of all out-of-cell time on TS, which is not yet being done in MDOC. Out-of-cell time for MHP and Support Person contacts is inconsistently being documented in the medical record, though there is an expectation to do so. For all other out-of-cell time—showers, recreation, visits, etc.—there is no current documentation system, but MDOC intends to develop this.

74. Therapeutic De-Escalation Rooms: MDOC will maintain the therapeutic de-escalation room at MCI Shirley and develop a therapeutic de-escalation room for the ISU.

Finding: Partial compliance

Rationale: The therapeutic de-escalation room in the HSU at Shirley has existed since the Agreement began. MDOC's December 2024 status update indicates that the room has been used less frequently recently because the HSU cells typically used for TS have not been suicide resistant, and the TS log is consistent with this report, indicating that 85% of TS placements between July and December occurred in the BAU, not the HSU. Interviewed MHPs reported using the room for 1:1 crisis contacts most commonly. None of the interviewed prisoners or staff mentioned using the room for recreation or de-escalation. During the DQE's site visit, the room was outfitted with a restart chair, TV, kiosk for canteen and emails, monitor for video visits, table, and several chairs.

The ISU contains two de-escalation rooms. During the DQE's site visit in September 2024, neither of the two interviewed patients had used a de-escalation room, and OCCC was still working on getting supplies for them (other than rocking chairs, which were already present). MDOC indicated in its December 2024 status report that fidget silicone poppers, games, and journals are now available for patients to use. Once the DQE is able to verify the rooms' use, MDOC will likely achieve compliance with the Paragraph 74 requirements.

75. Peer Programs: MDOC will consider utilizing a peer program for inmates on Mental Health Watch.

Finding: Partial compliance

Rationale: No peers have been involved with the care of TS patients since the Agreement began, but peer activities around MDOC are growing. MDOC leaders reported that, if the peer programs for general population prisoners at Framingham and Norfolk are successful, their expansion to include TS patients would be considered.

A peer support program at Framingham, which existed prior to the Covid-19 pandemic, has now been revitalized. During the December 2024 site visit, Framingham's leadership reported that 18 peers had been trained, and the program officially launched in October. The peers were hosting drop-in hours on campus seven days a week and meeting with individuals upon request outside of those hours. They had also published two issues of a newsletter. Although the peers were not yet working with patients on TS, the eventual plan includes them conducting rounds in the HSU and Intensive Treatment Unit, where TS patients are housed, as well as in the BAU.

MHPs at Shirley reported that one mental health group per week, on Fridays, is led by peers. In addition, mental health staff and peers collaborate on the Toastmasters program, a collaborative, two-day suicide prevention event.

At Norfolk, a formal peer support program is being implemented using the model developed at Framingham. During the November 2024 site visit, staff told the DQE that 25 or 30 prisoners had applied for the program, and interviews were being conducted to narrow the group to 10. A meeting space for peers had been designated, and an MHP had been identified to meet with the peers regularly. The goal was for the program to launch in mid-January 2025.

76. Therapy Dogs: MDOC will consider utilizing therapy dogs in each of its Mental Health Units.

Finding: Partial compliance

Rationale: MDOC's December 2024 status report indicates that VitalCore and Wellpath are both sourcing vendors for a therapy dog program, and the QIC meeting minutes indicate this remains an active area of discussion. In the meantime, MDOC continues to train therapy dogs to help disabled individuals in the community, and these puppies occasionally interact with mental health clients in the prisons. For example, MHPs at

Shirley reported that the therapy dogs being trained on campus sometimes attend mental health groups along with their handlers. The dogs are well behaved, and there have been no reported problems. At Gardner, MHPs reported that puppies who are training to help hard-of-hearing individuals visit with residents in the RTU once a week, which has also gone well.

77. Mental Health Watch Length of Stay Requirements: Within one (1) year of the Effective Date, MDOC will implement the following requirements. When determined to be clinically appropriate by a Qualified Mental Health Professional, MDOC will ensure prisoners are transferred to a higher level of care (e.g., Secure Treatment Program, Behavior Management Unit, or Intensive Stabilization Unit once such unit is operational). When statutory requirements are met pursuant to G.L. c. 123, §18, the individual will be placed at Bridgewater State Hospital or a Department of Mental Health facility in accordance with the orders of the court

Finding: Substantial compliance

Rationale: In over two years of monitoring, MDOC has demonstrated a consistent pattern of expediently transferring patients to psychiatric hospitals once the need for a hospital level of care has been identified. This practice does not appear to have suffered since the healthcare vendor transition in July 2024. Now that the ISU is operating, MDOC has demonstrated that the same is true for that setting, leading to a substantial compliance finding with the requirements of Paragraph 77.

Outside hospital transfers under Section 18(a)

Data from MDOC's log of transfers to higher levels of care indicate that, between July and December 2024, 39 patients were transferred to an outside hospital under Section 18(a). Each of seven prison sites transferred at least one patient, but most transfers were initiated by staff at OCCC (28%) and SBCC (36%).[65] Upon commitment by the court, 31 patients (79%) were admitted to the ISOU at Bridgewater State Hospital, the only option available for male patients. The eight female patients committed under Section 18(a) were transferred to Department of Mental Health (DMH) facilities: Solomon Carter Fuller Hospital and Worcester Recovery Center.

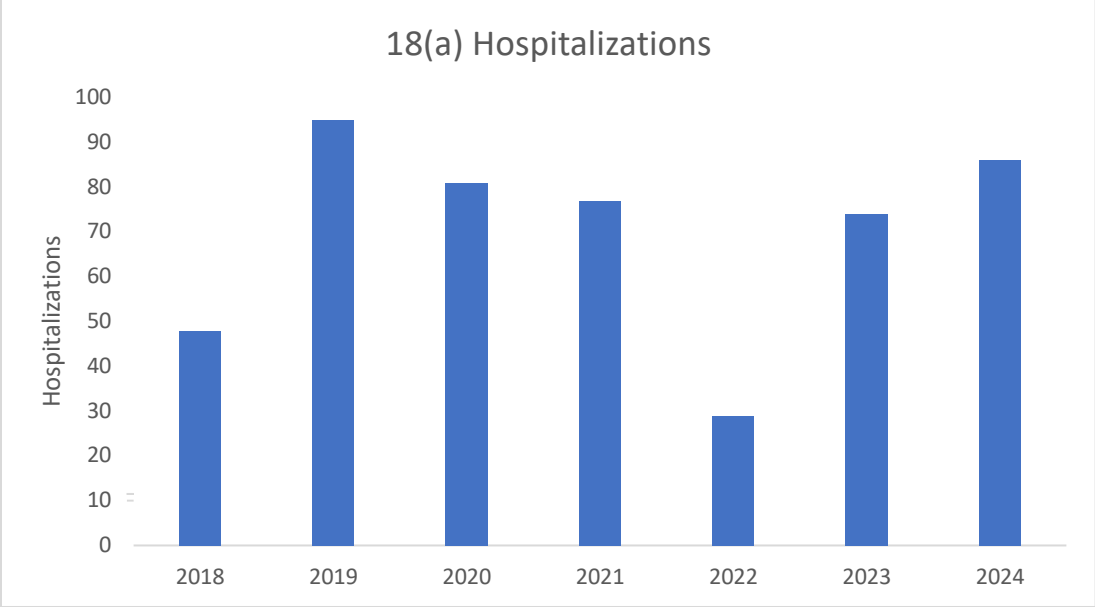
The DQE team has observed in health records that petitions are typically initiated by psychiatrists and submitted to the court on the same day, and there is a court ruling on the same day or the following, day. All of the male patients were transferred on the day they were committed by the court, but the female patients experienced delays of 1 to 6 days because of DMH bed availability. Overall, these data demonstrate excellent practice in

[65] Patients at MASAC are not eligible for 18(a) transfers; they are discussed in relation to Section 12 transfers below.

transferring patients once the need for hospitalization has been identified, though the issue with DMH bed availability for female patients persists.

Figure 6 illustrates the number of 18(a) hospitalizations between 2018 and 2024.[66]

Figure 6. Annual 18(a) Hospitalizations, 2018-2024



The year-to-year variability is too great to draw meaningful conclusions from these data, especially since some years were heavily impacted by the COVID pandemic. However, it is encouraging to see that 2024 was among the highest years for 18(a) transfers.

Outside hospital transfers under Section 18(a1/2)

In November 2022, prisoners and their advocates gained the ability to petition the courts for psychiatric hospitalization, independently of MDOC treatment providers, under M.G.L. c. 123 §18(a1/2). The DQE team has observed MDOC staff, usually MHPs or Support Persons, facilitating these petitions by providing timely notifications to the prisoners of their rights and asking if they would like to pursue an 18(a1/2) petition.

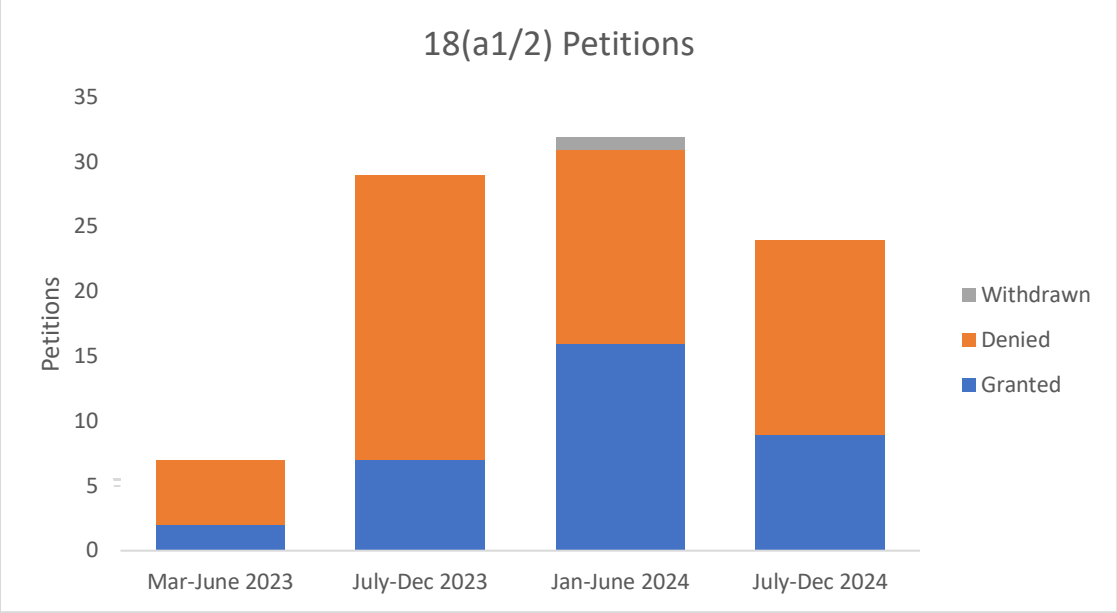
MDOC's data indicate that the law's use declined in the latter half of 2024, as illustrated in *Figure 7*. Between July and December, 24 prisoners petitioned the courts under Section 18(a1/2), and 9 of these petitions were granted.[67] The 18(a1/2) transfers occurred swiftly, with an average of 1.3 days elapsing between the court's notice to MDOC of the petition and MDOC's transfer of the patient to a psychiatric hospital. In all 9 cases, the

[66] Data were compiled from MDOC's suicide prevention training presentation, which includes data from 2018-2023, as well as MDOC's "Higher Level of Care Log."
[67] Of the remaining petitions, 15 were denied by the court, and one was withdrawn at the prisoner's request.

patients were admitted to a hospital for evaluation, but none were determined to need longer-term hospitalization according to DMH's assessment. They returned to MDOC within the 30-day assessment period, usually after just a few days.

Overall, it appears that Section 18(a1/2) is not an effective method for prisoners to receive longer-term hospital-based psychiatric care, as not one of the 92 prisoners who have pursued an 18(a1/2) petition since MDOC began tracking data in March 2023 has been successful in obtaining treatment beyond the brief assessment period at Bridgewater. The 18(a1/2) avenue is particularly fruitless for prisoners at SBCC, where 95% of the petitions submitted in 2024 were denied.

Figure 7. 18(a1/2) Petitions, March 2023-December 2024



Outside hospital transfers under Section 12

When MASAC determines that patients need a higher level of psychiatric care, they are transported to a local hospital's emergency department for evaluation, where they may then be committed under M.G.L.c. 123 §12. Data from MASAC's TS Registry indicate that patients were sent to the hospital for Section 12 evaluation in 17% of TS cases between July and December 2024.

Outside hospital transfers under Section 15(b)

Patients are transferred to outside hospitals for competency to stand trial evaluation under Section 15(b). The number of transfers increased dramatically in the second half of 2024, from 6 cases (Jan-June) to 24 cases (July-Dec). All but two patients were female. It is not clear what accounts for this increase in 15(b) commitments, but it was accompanied

by significant delays in transfers, up to 16 days in one case. Again, this is due to DMH bed availability for female patients, and it is out of MDOC's control.

Secure Treatment Program and Behavior Management Unit transfers

Between July and December 2024, nine patients were referred to the Secure Treatment Program (STP) at SBCC, and no patients were referred to the Behavior Management Unit (BMU). In cross-referencing data from the TS Registry with data from the STP referral log, it appears that only one of these patients was on TS when referred to the STP. This patient was transferred within a week of referral. Overall, the data over three monitoring periods indicate that STP placement is not often utilized as a pathway out of TS.

Intensive Stabilization Unit transfers

Eleven patients were transferred to the ISU between July and December 2024. Seven of these patients were on TS at the time of ISU referral, indicating that the ISU is being used as a pathway out of TS, as intended by the Agreement. MDOC's data indicate that, once ISU placement was approved, transfers happened quickly, in 1.7 days on average (range 0-4 days). The time from identification of need to transfer is not consistently discernible, but all indications are of reasonable time frames.

Residential Treatment Unit transfers

The Residential Treatment Units (RTUs) continued to operate at OCCC, Gardner, SBCC, and Framingham during this monitoring period, with no change in bed capacity. In December 2024, the RTUs remained about 60% full, as described in Paragraph 139. MDOC's data indicate that 11 patients were referred to the RTU in the latter half of 2024, and all were accepted into the program. Nearly all were internal transfers, so it appears there is limited use of RTUs as a resource for patients in other facilities. The time from referral to transfer was highly variable, with some patients were admitted to the RTU before the formal referral was completed, while others waited up to two weeks.

78. 72-hours: If a prisoner remains on Mental Health Watch for 72 hours (three days), consultation will occur with the Program Mental Health Director, and notification will be made to MDOC's Director of Behavioral Health. Documentation of consideration of a higher level of care will be noted in the medical record.

Finding: Partial compliance

Rationale: The DQE team examined progress notes and observed triage meetings to determine whether a higher level of care was considered at the 72-hour benchmark. The reviewer selected 43 TS placements, which represents 20% of the placements exceeding

three days during the monitoring period.[68] The analysis also reviewed notes of "Daily Consultation" meetings for any mention of considering other levels of care. Of note, 65% of TS placements in the monitoring period ended by the close of the third day.

Progress notes almost always checked a box labeled "18A/Higher Level of Care Discussion." It was very rare for a progress note to contain any text on this point. In triage meetings, the DQE team only rarely observed discussions of referrals to higher levels of care; those meetings were more focused on daily property and privilege decisions. Relying on MDOC and its healthcare vendor representing that checking the box reflects that consideration of a higher level of care occurred, there was 98% compliance in the DQE team's sample.

As to the notice and consultation requirements of Paragraph 78, there is a well-established system, detailed in previous DQE reports, in which the healthcare vendor distributes a spreadsheet listing relevant TS cases to MDOC and vendor leaders each weekday except holidays. Additionally, several of those leaders participate in a "Daily Consultation" meeting each weekday, except holidays, to discuss the spreadsheet's cases with the mental health leaders at the sites housing those prisoners.

In the current monitoring period, the DQE team observed four of these meetings and examined the spreadsheets and meeting minutes for the sampled cases. Notice was provided to MDOC's Director of Behavioral Health (and others) in 91% of the sample. Consultation was present in the meeting notes and completely fulfilled the requirement in 67% of the cases. Most often in the remaining cases, the consultation took place with a designee, though about 10% of the sample showed either no meeting or no discussion of the patient meeting the 72-hour threshold.[69] Two patients had already been designated as needing a higher level of care before they were placed on TS, and one was identified through this process.

Overall, MDOC remains partially compliant with the requirements of Paragraph 78.

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[68] This sample overlapped with the sample described in Paragraph 45 but differs in significant ways. All cases had stays of four days or longer during July through December 2024. They were drawn from each institution that provides TS. With several facilities, their proportion of the stays *longer than three days* differs from their proportion of all TS, so their proportions were adjusted within the sample for Paragraphs 78 through 80. Cases were drawn from each type of housing unit that provides TS. Additional cases, beyond those in the data set for Paragraph 45, were selected in order to have a sufficient sample meeting all these criteria.

[69] The reviewer examined the spreadsheets and meeting notes from Day 2 of the patient's TS through two business days after the patient's Day 3. Paragraph 78 does not specify *when* the notice and consultation must take place, so the DQE team considered these actions timely if they occurred by the second business day after a patient's Day 3. The reviewers have no findings based on observing the meetings, as it happens there were no relevant cases on those agendas (that is, one patient was at the 48-hour point and all others had been on TS seven days or more).

79. 7 days: If a prisoner remains on Mental Health Watch for seven days, the Program Mental Health Director and Site Mental Health Director will consult with, and discuss next steps with, MDOC's Director of Behavioral Health and MDOC's Assistant Deputy Commissioner of Clinical Services. The assessing Qualified Mental Health Professional, with input from others as necessary, will document (1) consideration of a higher level of care and (2) specific individualized reasons if a higher level of care is not clinically indicated in the medical record using the Description/Assessment/Plan (DAP) progress note.

Finding: Partial compliance

Rationale: The DQE team has confirmed MDOC's system for accomplishing this consultation and consideration of a higher level of care, as described in relation to Paragraph 78 above. The DQE team analyzed records for 19 TS placements, which represents 40% of placements longer than seven days during the monitoring period.[70]

The reviewer determined that a patient was considered for a higher level of care if the relevant box was checked in the progress notes or if consideration was expressly captured in the Daily Consultation notes. Taken together, 89% of the sample indicated that higher levels of care were considered.

In the 12 cases where staff thought that a higher level of care was not indicated, however, only one recorded specific reasons. The others either did not comment on the reasoning or employed an identical boilerplate conclusion that was not linked to any individualized facts (e.g., "18a not indicated because patient is being managed within facility"). This is a substantial decline from the findings in previous monitoring.

The DQE team also reviewed the notification spreadsheets and Daily Consultation notes for this sample in the days surrounding the patient's seventh day of TS.[71] Consultation was present in the meeting notes and completely fulfilled the requirement in 39% of the cases. In the majority of cases, the consultation took place with a designee, or with some but not all of the personnel listed in Paragraph 79, and 10% of the sample showed either no meeting or no discussion of that patient. Consultation took place in the Daily Consultation meetings observed by the DQE team during the monitoring period, and the staffing makeup was similar to the findings from the document review. These appear to be much lower compliance rates than in the preceding monitoring period.

[70] The selection criteria were similar to those described in Paragraph 78, with additional cases chosen to maintain approximate proportions at this length of stay.
[71] The review methods and compliance criteria were similar to those described in Paragraph 78.

Eight referrals to higher levels of care were initiated through the consultation meetings, which suggests that the process may, nevertheless, be leading to the intended outcomes. Overall, MDOC remains partially compliant with these requirements.

80. 14 days: If a prisoner remains on Mental Health Watch for 14 days, for that day and each day following, the Program Mental Health Director and Site Mental Health Director will consult with, and discuss next steps with, MDOC's Director of Behavioral Health, MDOC's Assistant Deputy Commissioner of Clinical Services, and MDOC's Deputy Commissioner of Re-entry and Clinical Services. Further, each day the prisoner remains on Mental Health Watch without being transferred to a higher level of care, the assessing Qualified Mental Health Professional, with input from others as necessary, will document (1) consideration of a higher level of care and (2) specific individualized reasons if a higher level of care is not clinically indicated in the medical record using the Description/Assessment/Plan (DAP) progress note, in addition to (3) re-evaluating all mental health interventions and (4) updating the Crisis Treatment Plan.

Finding: Partial compliance

Rationale: The DQE team examined health records, notification spreadsheets, and Daily Consultation notes related to 28% of the TS placements with a length of stay exceeding 14 days.[72]

While the vendor's Program Mental Health Director, MDOC's Director of Behavioral Health, MDOC's Assistant Deputy Commissioner of Clinical Services, and MDOC's Deputy Commissioner of Re-entry and Clinical Services do routinely meet with facility mental health leaders to discuss these patients, documents show few cases in which all of these offices were represented daily. All sampled patients were reflected in the discussion notes each day. With meetings scheduled on weekdays but not weekends or holidays, the meeting structure does not demonstrate consulting "each day following."

As to staff considering a higher level of care:

- One patient in the sample had already been transferred to ISU on Day 13 of his TS and remained on TS for a few days of monitoring
- Another patient had an ISU referral in process before this benchmark
- Staff considered and initiated on Day 14 an ISU referral for a third patient

[72] Charts were selected separately for Paragraph 80 analysis. They were drawn from the spreadsheet referred to as the TS Registry from the period of July through December 2024. The sample roughly maintained each facility's proportion of the placements with this length of stay.

- All other patients were considered for a higher level of care, based either on the relevant box being checked in the progress notes or consideration expressly captured in the Daily Consultation notes.

For the sampled patients where staff thought a higher level of care was not indicated, in all cases, staff either did not comment in progress notes about the reasoning or employed an identical boilerplate conclusion that was not linked to any individualized facts.

Evaluation of mental health interventions was most evident in the Daily Consultation meetings that the DQE team observed. There, the patients' clinical picture was presented in detail and sometimes included a response to previous interventions and plans to marshal additional psychiatry and psychology resources or to address institutional stressors. In a few cases, different levels of care were expressly discussed as well. Health records did not appear to contain any updated treatment plans. This process resulted in one patient being referred to a higher level of care.

Overall, MDOC remains in partial compliance with the requirements of Paragraph 80.

81. Mental Health Watch Discharge: MDOC will develop and implement a step-down policy and procedure for prisoners being released from Mental Health Watch.

Finding: Substantial compliance

Rationale: MDOC policy 103 DOC 650.08, Emergency Mental Health Services, contains language about stepping down patients from constant to close observation before discharge from TS, and the proposed policy revisions remain consistent with the Agreement requirements. Wellpath had an identical policy to MDOC's, but no information about VitalCore's TS policies has been shared with the DQE team. Without that information, there is no choice but to decrease the compliance rating from substantial to partial.

Regarding implementation of a step-down process, MDOC's typical practice was disrupted during this monitoring period because, at many facilities, the TS cells were inspected in the summer of 2024, and some were found not to be suicide resistant. MDOC subsequently either concentrated patients in the cells that remained suicide-resistant or implemented a practice consistent with Paragraph 54, which mandates that prisoners be placed on 1:1 observation if the cell is not suicide resistant. Because some cell conditions demanded 1:1 observation regardless of the patient's clinical status and risk, MDOC could not demonstrate the gradual step-down of all prisoners from 1:1 supervision to 15-min supervision as it had previously done.

On the other hand, the DQE team observed, onsite and in health records, that MHPs continued with other aspects of stepping down patients, such as moving from smocks to clothing and gradually adding property to allow patients to adjust to managing those safely while still being supervised. Occasionally, the DQE team learned of TS patients attending groups on their usual housing unit or being offered trial runs with a new cellmate when double-celling was the stressor leading to the TS, both of which assist with transitioning out of TS. As noted in Paragraph 84, the expectation of post-discharge follow-up contacts is also well established.

The lack of information about VitalCore policies and the temporary designation of TS cells as not suicide-resistant will likely be remedied in the next monitoring period. Particularly because the cells' remediation was an unexpected and short-term complication, the DQE will consider MDOC as remaining in substantial compliance, but it is essential that MDOC provides VitalCore's policies and that they be consistent with Paragraph 81 for that to be the finding in the next report.

82. MDOC will ensure through an audit process that a Qualified Mental Health Professional approves discharge from Mental Health Watch as early as possible after an out-of-cell mental health assessment using a suicide risk assessment format and a consultation with the mental health team during the daily mental health triage meeting which will include the Site Mental Health Director and, when clinically indicated, an upper-level provider (i.e., psychiatrist, psychiatric nurse practitioner, advanced practice registered nurse, or psychologist), or a consultation with the Site Mental Health Director prior to the daily triage meeting. The Qualified Mental Health Professional will document that they have determined that the prisoner presents lower risk of imminent self-injury prior to discharge. When clinically indicated, a psychiatrist or psychiatric nurse practitioner will be consulted. In the event that a prisoner is not seen out-of-cell at the time of discontinuation, the rationale for this decision will be documented in the prisoner's record.

Finding: Partial compliance

Rationale: The DQE is unaware of any audit process employed by MDOC or its healthcare vendors to ensure that patients are discharged as early as possible from TS or that a suicide risk assessment has been completed prior to discharge. In the DQE team's own review of 52 TS placements, there was a documented suicide risk assessment in the medical record, almost universally, before discharge from TS.[73] The current version of the risk assessment appears to be more limited than in the past, and in a handful of

[73] Among the cases assessed on this point, 45 required a suicide risk assessment. For others, the TS ended not with discharge but with transfer to a higher level of care, continued TS at another facility, or release from custody. Of the 45 cases, some form of suicide risk assessment was present in 43 of them.

records, the information recorded was extremely minimal. It appeared that fewer than half of the discharge risk assessments were conducted out of cell, and the rationales for cell-front contacts were not always recorded.

In cases where a patient had been placed on TS because of a risk of self-harm, MHPs sometimes documented that the patient presented a lower risk at the time of discharge, but this was far less consistent than in the past, likely because of the change in the progress note template from Wellpath to VitalCore's electronic health record.[74] Just over half of relevant TS cases in the DQE team's study expressly documented this information.

During site visits across eight facilities, the DQE team observed MDOC's standard practice of discussing patients on TS as the first agenda item in the daily triage meeting. The site or regional mental health director usually led the triage meetings, and psychiatrists or nurse practitioners were often, though not always, present (at 7 of the 10 meetings observed). Similarly, in a spot check comparing health records to triage meeting notes, psychiatrists or nurse practitioners were present in 67% of the meetings in which discharge was decided for the sampled patients.[75]

Most commonly, discharge decisions were made during the triage meeting after discussion among the team members present, but sometimes this was not possible because, for example, the patient had not been assessed prior to the 11:30 am meeting. In those cases, the "crisis clinician" assigned to the afternoon/evening shift might circle back with the mental health director or other supervisor after the patient's second attempted TS contact of the day, including to discuss property/privilege or discharge decisions.[76] The DQE team did not witness any consultations with psychiatry about discharge decisions outside of the triage meetings and, from health records, it appears those are very rare.

The DQE's assessment of the clinical indications for psychiatry consultation at the time of discharge is addressed in Paragraph 85.[77] Although it was rare to see evidence of such

[74] In the sample, 39 placements were initiated for risk of self-harm; 20 of those stays documented the required finding. The other examined placements arose from concerns about harm to others or potential psychosis.
[75] Using a subset of the 62 TS placements described in Paragraph 85, the DQE team reviewed 17 cases where a psychiatry consult was indicated but progress notes did not refer to it taking place. The team then examined the triage meeting notes for the days those patients were discharged from TS. The reviewer identified whether a psychiatrist or ARNP was present to determine whether consultation could have taken place in that setting.
[76] The DQE team observed this practice onsite and it has been evident in chart reviews.
[77] Paragraphs 82 and 85 both require the consideration of psychiatry or "upper-level provider" involvement prior to a patient's discharge from TS. The difference seems to be that Paragraph 82 requires *consultation with* psychiatry, while Paragraph 85 requires *interview by* an upper-level provider. These issues are difficult to separate from each other. The general topic of psychiatry's involvement in discharge decisions is discussed in Paragraph 85.

consultation in the medical record during this monitoring period, it is encouraging that, in its December 2024 status report, MDOC reported that the TS documentation template has been improved to facilitate MHPs' thinking about whether an upper-level provider consultation is indicated.

Overall, it appears that MDOC has the basic structures in place for MHPs to consider patients' risk at the time of discharge in consultation with the treatment team, mental health director, or psychiatrist/APRN. However, documentation of MHPs' discharge risk assessments, as well as conducting them in privacy, appeared lacking during this monitoring period. Some of these deficits likely stem from a change in the electronic health record under VitalCore and do not reflect a significant change in clinical practice from the previous monitoring period.

83. When a prisoner is discharged from Mental Health Watch, the Qualified Mental Health Professional will document a discharge plan which will be communicated to appropriate mental health and security staff and will include any recommended referral to clinically appropriate housing, and a safety plan that addresses the risk factors specific to that prisoner, follow-up and continued plan of care, as well as a brief mental status update. This will be documented on a Discontinuation of Crisis Plan form.

Finding: Partial compliance

Rationale: Discharge planning, as required by Paragraph 83, remains one of the most limited aspects of Agreement implementation. During this monitoring period, the shift from Wellpath to VitalCore's electronic health record significantly altered the format and content of MHPs' progress notes, and it was no longer possible for the DQE team to discern a coherent discharge plan from the documentation in most cases. As such, the analysis of Paragraph 83 in this monitoring period was limited.

Within the DQE team's review of 52 TS placements first described in Paragraph 45, there were 45 patients requiring a discharge plan.[78] Records demonstrated a brief mental status examination for all but two of the patients. Safety plans were present in 16% of the sample; in the large majority of cases, there was no plan mentioned or there was reference to a plan being created but it could not be confirmed in the health record. The other required elements were not evident.

Information about discharge plans is typically communicated to appropriate mental health staff by inclusion in the electronic health record. MHPs stated that, in complex cases or when a patient is transferring to another facility, they may have a case conference or

[78] Others transferred to a higher level of care or were released from custody.

informal discussion with the receiving mental health team to prepare for the patient's arrival. More commonly, clinicians who will be assuming care of the patient after TS are present during the facility's daily triage meetings, so they have often been following the patient's progress. Yet another way of communicating between MHPs is through the triage notes and "end of shift reports," which are accessible to all MHPs at the facility. Thus, there are multiple avenues for mental health clinicians to communicate about patients' discharge plans with each other.

When asked how they communicate discharge plans to appropriate security staff, MHPs told the DQE there is not a routine practice of sharing this information with security staff out of concern for patient confidentiality. Officers in the housing area where a patient's TS occurs will be notified that the TS is being discontinued, but no communication with the receiving unit's security staff typically occurs, as would be expected at least in complex cases.

84. All prisoners discharged from Mental Health Watch must receive timely and adequate follow-up assessment and care, at a minimum of within 24 hours, 72 hours, and again seven days following discharge. A Qualified Mental Health Professional may schedule additional follow-ups within the first seven calendar days of discharge if clinically indicated. A Qualified Mental Health Professional will review a treatment plan within seven calendar days following discharge and, if clinically indicated, update the treatment plan in consultation with an upper-level provider (i.e., psychiatrist, psychiatric nurse practitioner, advanced practice registered nurse, or psychologist).

Finding: Partial compliance

Rationale: As detailed in previous DQE reports, the system for providing three follow-up contacts after discharge from TS is well-established; this was determined through observing triage meetings and MHPs providing the contacts, staff and patient interviews, and reviewing meeting minutes and electronic health records. Employing those same methods, the DQE team confirmed that the system has been sustained since the VitalCore transition.

In the DQE team's study of 52 TS placements, 43 patients required MHP follow up after discharge.[79] Progress notes showed that contacts were consistently made within required time frames, with only nine missed or made while the patient was still in TS housing

[79] See Paragraph 45 for a description of the chart review methodology. As to this requirement, 43 patients required follow up. The others transferred to a higher level of care, left MDOC, or were immediately readmitted to TS before follow up could begin.

and/or just a few minutes after TS discharge. Encouragingly, SBCC greatly improved the rate of the latter practice during this monitoring period.

Among interviewed patients who commented on TS follow-up practices,[80] a few affirmed seeing an MHP three times, but most thought it was fewer contacts or were unsure. About 20% said they had not been seen at all. There were no clear patterns in the responses by institution or housing type, and the reasons for the differences between this data source and the charts is unknown.

It remains a concern that many TS follow-up contacts are conducted in nonconfidential settings, including cell-front, at officers' desks in housing units, in dayrooms, or in the recreation yard. However, it appeared there was improvement in both the rate of confidential contacts and the rate of non-confidential contacts occasioned by institutional or staff factors. Confidential contacts were in the majority at 55%; after an extended decline, this approaches the rate observed when Agreement monitoring began. Among the nonconfidential contacts, the majority continue to be recorded as being at the patient's request, or the patient was "agreeable" to this, but 20% of all contacts were nonconfidential for staff or institutional reasons. This is heading in a positive direction from the 28% observed in the last monitoring period.

As for treatment plan updates, only 10% of the relevant records[81] contained an updated treatment plan or a note indicating that the plan had been reviewed and that no updates were needed. This appears to be a very large decline from the previous monitoring period, but this appearance is likely affected by the change in documentation methods after the change in healthcare vendors.

85. Prior to discharge, if clinically indicated, prisoners on Mental Health Watch will be interviewed by an upper-level provider (i.e., psychiatrist, psychiatric nurse practitioner, advanced practice registered nurse, or psychologist) to determine mental health stability and potential mental health diagnosis (if undiagnosed) or misdiagnosis.

Finding: Partial compliance

Rationale: To assess this requirement, the DQE team analyzed a sample of 62 TS placements drawn from all institutions that provide TS.[82] The DQE clinicians reviewed the course of care and determined that psychiatric contact during the TS stay was

[80] Sixteen patients commented on their experience at six institutions.
[81] In this sample, 38 stays were subject to the requirement to review and potentially update treatment plans. The remaining patients in the sample were readmitted to TS before the seven-day deadline for treatment plan review, transferred to a higher level of care, or left MDOC custody.
[82] This is the same sample of TS placements described in Paragraph 52.

clinically indicated in 88% of cases, for reasons delineated in the discussion of Paragraph 52. Of those cases, 54% were seen by a psychiatrists or nurse practitioner. Framingham, MASAC, and OCCC showed the highest rates of psychiatry contacts, while SBCC and MTC showed far fewer psychiatry contacts than were clinically indicated.

Because the DQE clinicians recommended psychiatric contact in such a large proportion of TS cases *generally*, it was difficult to separate out the issue of whether upper-level provider contact was indicated specifically *prior to discharge*, as required by Paragraph 85. Consequently, no firm conclusions about the adequacy of MDOC's practice can be drawn.

During the next monitoring period, the DQE team can spend more time assessing how MHPs and upper-level providers approach the issue of discharge decisions, especially how they determine that a patient needs to be interviewed by the upper-level provider rather than just discussed in the triage meeting. As noted in the last DQE report, there is little guidance on this issue from published guidelines (e.g., National Commission on Correctional Health Care or American Psychiatric Association guidelines). From the DQE clinicians' perspective, upper-level provider interview before discharge from TS is indicated, at the very least, in cases where:

- Patients have not had an initial psychiatric evaluation since their entry into MDOC *(i.e., new admissions to the system who are placed on TS should be prioritized for evaluation by psychiatry)*
- Cases where TS is being discontinued while a patient is still actively threatening harm to self or others (*such discharges may be appropriate at times, but not without psychiatry or psychology seeing the patient and concurring with an MHP's judgment)*
- Before discharge to a setting in which the patient has previously engaged in self-injury *(again, as an added check on MHP's judgment about risk)*

These ideas will need further development in future monitoring periods.

86. When a prisoner on Mental Health Watch is transferred in accordance with G.L. c. 123, §18 (Section 18), the Mental Health Watch at MDOC necessarily terminates, but it would be impossible (and clinically inappropriate) for MDOC to comply with the requirements set forth in Paragraphs 81-85 as the prisoner would then be committed or transferred to either Bridgewater State Hospital or the Department of Mental Health for up to 30 days of observation and examination and possibly further committed for care and treatment at Bridgewater State Hospital or the Department of Mental Health. Whenever a prisoner returns to MDOC from a Section 18 transfer/evaluation/commitment, the prisoner will be reassessed by MDOC mental health staff to determine if a new placement on Mental Health Watch is appropriate at that time.

Finding: Substantial compliance

Rationale: In previous monitoring periods, the DQE team determined that this practice is in substantial compliance. In the current monitoring period, the team reviewed a 20% random sample of the health records of patients who had been placed at Bridgewater State Hospital or a Department of Mental Health facility and had returned to MDOC.[83] In every case, MHPs completed the form and decided whether to readmit the patient to therapeutic supervision. MDOC exceeds the Paragraph 86 requirements by having these patients meet with a psychiatrist as well as an MHP, and this took place for each of the patients in the study.

SUPERVISION FOR PRISONERS IN MENTAL HEALTH CRISIS

87. Mental Health Watch – Close and Constant Observation: MDOC will establish and implement policies and procedures for administering Close and Constant Observations of prisoners who are on Mental Health Watch. These protocols will ensure that:

Finding: Partial compliance

Rationale: MDOC's policy 650.08.B addresses therapeutic supervision and is currently being revised in accordance with the Agreement. The DQE does not yet have any information about VitalCore's corresponding policy. Finalizing the MDOC policy 103 DOC 650, Mental Health Services, will be the next step toward compliance with Paragraph 87, but full compliance will require VitalCore's policies to be revised as well.

88. The level of observation needed will be determined by a Qualified Mental Health Professional based on their assessment of the prisoner's risk of Self-Injurious Behavior, and will be re-evaluated every 24 hours if the prisoner is on Constant Observation. If the prisoner is on Close Observation, the prisoner will be evaluated every 24 hours (with the exception of Sundays and holidays).

Finding: Substantial compliance

[83] The study drew from the spreadsheet titled Higher Level of Care 2024.xlsx, which MDOC provides monthly to demonstrate all referrals to higher levels of care. From the patients shown on the 18a and 18a.5 tabs as having returned to MDOC between July 2024 and January 2025, the reviewer selected every fifth case. The sample includes cases from each of the six institutions that referred to Bridgewater State Hospital or the Department of Mental Health during the monitoring period.

Rationale: As noted in previous DQE reports, it is well established practice for MHPs to determine a patient's level of observation as a key part of daily updates to TS conditions. This determination is based in part on the patient's risk of self-injury, as required by Paragraph 88, though other clinical factors are also appropriately considered. The DQE team observed MHPs assessing the patient's risk as part of the first TS contact of the day and discussing potential changes to the level of observation, property, and privileges during the daily triage meetings. Notes about the patient's level of observation were recorded in the triage meeting minutes, the patient's progress notes, and the Therapeutic Supervision Reports. As required by Paragraph 88, patients who are on 1:1 observation are assessed by an MHP every day, including Sundays, and those who are on close observation are assessed Monday through Saturday.

The DQE team spot-checked the TS Reports for 29 TS placements to see if all required reports had been completed. In 22 cases (76%), all such reports were completed on Monday through Saturday. In the 7 cases (24%) that were missing a TS report, 9 out of 170 total reports were missing (5%). 100% of cases requiring a TS Report on Sundays had one completed. In each of these documents, the MHP had indicated their judgment about the level of observation needed.

Overall, MDOC has demonstrated a sustained strong practice in reviewing prisoners' level of observation every 24 hours, warranting a continued finding of substantial compliance.

89. MDOC policy does not permit placement on Mental Health Watch for disciplinary purposes.

Finding: Partial compliance

Rationale: MDOC's policy 103 DOC 650.08, Emergency Mental Health Services, is in the process of revision. The DQE has reviewed the draft language, and it aligns with Paragraph 89, prohibiting the use of TS for punishment or staff convenience. No information about VitalCore's policies has been provided to the DQE for review. If VitalCore adopts language consistent with Paragraph 89 and if MDOC finalizes policy 103 DOC 650, a substantial compliance finding can be achieved.

90. Procedures will be established to notify appropriate security, medical, and mental health staff about incidents of Self-Injurious Behavior that occur on Mental Health Watch, including following the procedures outlined in Paragraph 105.

Finding: Partial compliance

Rationale: MDOC's policies about the response to self-injurious behavior that occurs on TS are contained in three documents: 103 DOC 650.8 (Therapeutic Supervision), 103 DOC 562 (Emergency Response Guidelines), and 103 DOC 501 (Institution Security Procedures). In the current monitoring period, MDOC revised the policies on Therapeutic Supervision and Institution Security Procedures, while the Emergency Response Guidelines remain under review.

In its December 2024 status report, MDOC stated:

> Draft 103 DOC 562 Emergency Response Guidelines remains under review and will be submitted to the DQE team once complete. It is practice for an incident report to be submitted and mental health to be notified in the moment by security staff or medical staff when incidents of self-injury occur on Therapeutic Supervision. The Clinical Operations Analyst reviews the incident report submissions related to SDV monthly, and there has been an increase in the submitted incident reports for self-directed violence across disciplines.

In the DQE team's review of incident reports and medical records related to cases of SDV on TS, and in interviews with security and mental health staff, it is not consistent practice to notify mental health staff at the time of SDV. Also, as noted in previous DQE reports, it is much more common for security staff to handle SDV with OC spray or a use of force than for a psychiatrist to order therapeutic restraints or medication.

On October 1, 2024, during the DQE team's OCCC site visit, VitalCore's Psychiatric Medical Director and MDOC's behavioral health leadership met with the DQE team to discuss how "mental health restraints" are utilized in practice. This was a very helpful conversation, explaining that VitalCore's psychiatrists would only order mental health restraints when a patient's SDV *stems from serious mental illness*. Because so many of MDOC's SDV incidents involve prisoners trying to achieve a specific objective (e.g., obtain a single cell or transfer to a different housing location), in VitalCore's understanding, most incidents would not be appropriate for the use of mental health restraints and should instead be handled according to security protocols. This accounts for the very rare use of mental health restraints for SDV.

The DQE reviewed incident reports and medical records related to the two incidents of mental health restraint that occurred while on TS during this monitoring period, both at Norfolk. It is difficult to discern a bright line of "serious mental illness" that separates these two cases from the dozens of other SDV incidents that occurred during the monitoring period. However, it did appear that the use of therapeutic restraints in both

cases was clinically reasonable, ordered by a physician, and done for as short a time as possible (1-3 hours).

Two incidents of "security restraint" use on TS occurred during this monitoring period: one at SBCC, and one at Framingham. The incident at SBCC did not involve SDV; it was in response to a "disruptive inmate" covering his cell window and camera. The incident at Framingham is more troubling. Security personnel applied waist chains and mitts to a patient's hands after she scratched herself, and she remained in those restraints for almost eight hours. This patient had just returned from a lengthy stay at a DMH facility and is well-known to have an SMI diagnosis, so it is not clear why security handled these restraints rather than a psychiatrist.

The DQE continues to urge MDOC to consider the use of more therapeutic measures in response to SDV and to review its policies in relation to published guidelines by the NCCHC and American Psychiatric Association.

91. Staff who observe and/or discover an incident of Self-Injurious Behavior will immediately make appropriate notifications to a medical professional and a Qualified Mental Health Professional.

Finding: Partial compliance

Rationale: In the last DQE report, it was recommended that MDOC clarify its policies about who gets notified in the event of SDV. MDOC has now done this, in part, adding language to its draft of policy 103 DOC 650.09.A:

> If the incarcerated individual has attempted suicide or otherwise engaged in self-injurious behavior, the incarcerated individual shall receive immediate medical attention. Notifications of self-directed violence must be made immediately to a Qualified Mental Health Professional.

This language appears to meet the requirements of Paragraph 91. However, policy 103 DOC 562, Code 99 Emergency Response Guidelines, has not yet been updated in accordance with the Agreement.[84] It does not contain any language stating that MHPs should be notified in the event of self-injury, and it does not delineate the responsibilities of the mental health team under these circumstances.

[84] The version of policy 103 DOC 562, Code 99 Emergency Response Procedures, reviewed by the DQE team states that it was reviewed on 6/28/24, but MDOC's December 2024 status report states that the policy is still undergoing revision in accordance with the Agreement. The policy contains a section delineating the medical team's responsibilities in a Code 99, but it contains no similar section about the mental health team.

The DQE team continued to assess how notification of SDV works in practice, relying upon interviews with security and mental health staff, as well as incident reports that document the response to SDV. Based on these data sources, it appears that immediate notification of MHPs does not occur consistently across all institutions. While most interviewed security personnel did not comment on the involvement of MHPs in the response to SDV, one sergeant specifically stated that MHPs are not typically involved in the immediate response, noting that they "might see the [prisoner] afterward." Mental health staff stated that SDV should result in an immediate call to mental health, but it does not always happen in practice. This could be because MDOC's Code 99 policy does not specify that mental health staff will be notified or respond to SDV.

To meet the requirements of Paragraph 91, MDOC must finish revising its Code 99 policy in accordance with the Agreement. In addition, it must demonstrate more consistent notification of MHPs in response to self-injury than is currently occurring.

92. Staff who observe and/or discover an incident of Self-Injurious Behavior will document such incidents in a centralized electronic location, including any statements about self-harm, and/or suicide attempts.

Finding: Partial compliance

Rationale: When an incident of self-injury occurs, MDOC's expectation is that all involved staff will write an Incident Report in the Inmate Management System (IMS), and mental health and medical staff will write a progress note in the health record as clinically indicated. These protocols meet or exceed the requirements of Paragraph 92. The DQE team has reviewed hundreds of such incident reports, and their content also meets the requirements of Paragraph 92, documenting a prisoner's statements and behaviors related to self-harm.

The only barrier to achieving substantial compliance with the Paragraph 92 requirements is the consistent completion of incident reports for all episodes of self-injury. MDOC's audits of incident reports, as completed by the Clinical Operations Analyst and discussed in the monthly QIC meetings, continue to indicate poor completion rates among some disciplines of staff, ranging from 32% to 64%, depending on the month and the staff discipline (security, medical, or mental health). If MDOC continues its emphasis on the issue and retrains staff accordingly, it can likely achieve full compliance with Paragraph 92.

93. Consistent with MDOC policy, behavior that is in violation of MDOC policies or rules by any staff who play a role in observing a prisoner on Mental Health Watch, in connection with their role supervising Mental Health Watch, including falling asleep, will be subject to investigation and/or discipline.

Finding: Partial compliance

Rationale: Among the DQE team's interviews, 10 prisoners, living in five institutions, reported having recent experience with constant observation. A majority reported that officers remained awake when observing them; just under half said they had observed an officer falling asleep at Norfolk, Shirley, and SBCC. All reported that officers otherwise fulfilled their responsibilities to monitor prisoners continuously and did not leave the post unattended or become unreasonably distracted. One officer conveyed that he had received calls about other officers falling asleep, noting the context of substantial numbers of mandated overtime shifts.

MDOC's policy 103 DOC 522, Professional Standards Unit, mandates investigations of all staff misconduct, including that which occurs in related to TS. The DQE team reviewed a redacted version of the "Professional Conduct Log," a document compiled by the Clinical Operations Analyst from staff-generated confidential incident reports and from other issues that come to the attention of top MDOC leadership. This log is one of the only sources of data available to the DQE team to assess the Paragraph 93 requirements.

Twenty-one new allegations of staff misconduct related to crisis/TS were added to the log in the second half of 2024. As in the DQE's last report, most of these allegations stem from Norfolk (62%). The remaining allegations are equally distributed between OCCC and SBCC.

Sixty-two percent of the allegations involved officers refusing or delaying crisis calls; most of these were at Norfolk. Twenty-four percent involved other allegations of staff making harassing or threatening statements. Ten percent involved allegations of physical assault, and one incident (5%) involved an allegation of staff inattention. In a positive development, none of the allegations during this monitoring period involved staff encouraging self-injury.

The Professional Conduct Log indicates that seven of the 21 incidents are still under investigation. The remaining incidents were all closed without further investigation (2 incidents) or determined to be unfounded (12 incidents). None of the cases resulted in staff discipline. At Norfolk, two of the earlier investigations of staff allegedly not calling

crisis identified a systemic flaw with MDOC policy and procedure: there is no definition in policy or officers' post orders about what constitutes a "crisis" (and therefore warrants an immediate call to mental health staff). It is not clear that this problem was subsequently addressed.

Overall, MDOC seems to have a process in place for investigating allegations of professional misconduct. The allegations documented in the Professional Conduct Log mirror the type of behavior reported to the DQE team during site visits, and log has begun to capture incidents that are reported by staff. The next step in demonstrating compliance would be to add other sources of data to the log, such as prisoner-generated grievances or reports during Staff Access hours.

94. MDOC will ensure that any Correctional Officer who observes prisoners on Mental Health Watch has the proper training to appropriately interact with and observe a prisoner in mental health crisis in an appropriate way. This means that Correctional Officers who observe prisoners on Mental Health Watch will participate in in-service training about how to appropriately observe prisoners on Mental Health Watch as that training is available and scheduled. Until the in-service training is available, Correctional Officers will read the new policies about how to observe Mental Health Watch, and attest to the fact that they have read, understand, and will follow those policies. This read and attest will occur within six (6) months of the Effective Date of the Agreement. MDOC will post the current policy about observing Mental Health Watch in visible places on every unit where Mental Health Watches take place.

Finding: Partial compliance

Rationale: Paragraph 94 outlines a two-stage implementation plan for training correctional officers about therapeutic supervision protocols. By June 20, 2023, officers were required to complete a "read and sign" attestation that they were familiar with the TS policies and would follow those policies. Simultaneously, MDOC was required to develop a live TS training to be included in its annual in-service program. Once this live training was finalized and implemented, the "read and sign" would be phased out. Unrelated to this timeline, MDOC would post the TS policy in all units where TS takes place.

MDOC's TS training has been conducted as a live training since the fall of 2023, and its curriculum was most recently revised in August 2024. MDOC provided records of staff training in Training Year 24, which show that 2,092 of 2,329 required staff members (90%) at the seven prison sites where TS occurs completed the training. The training records did not specify the staff members' job class, so it is not possible to say with certainty that staff who "observe prisoners on mental health watch" (the requirement of

Paragraph 94) have the same completion rate as the overall group. Among 13 officers the DQE team interviewed about this training, almost half said they had received it, while a slight majority believed they had not. However, MDOC's overall demonstration of excellent completion of TS training is sufficient to satisfy the DQE.

By the DQE's understanding of Paragraph 94, the TS "read and sign" is no longer needed, but MDOC reported that it intends to implement this document once all TS-related policies are finalized.

Progress has also been made on the TS poster during this monitoring period. The DOJ and DQE reviewed the draft poster and provided minor feedback to MDOC on January 6, 2025. MDOC is now finalizing the poster. Once it is displayed in all units where TS occurs, MDOC will likely achieve compliance with the Paragraph 94 requirements.

95. A Correctional Officer will remain in direct line of sight with the prisoner at all times during a Constant Watch, consistent with MDOC policy.

Finding: Partial compliance

Rationale: As discussed elsewhere in this and previous DQE reports, some previously suicide-resistant cells at each institution providing TS were found to need modifications to restore their suicide resistance. In addition to posing construction challenges, this increased the need for constant observation for extended periods at several facilities. Indications are that security leaders made the adjustments necessary to ensure this responsibility was covered, an especially admirable action in the context of short staffing and managing the integration of the many department-wide changes of recent years.

During site visits, the DQE team observed numerous officers in position for constant observation, and officer interviewees continued to describe maintaining an uninterrupted view as their primary duty when assigned to that role. All interviewed prisoners with recent experience on constant observation said that officers fulfilled their responsibilities to monitor them continuously and did not leave the post unattended or become unreasonably distracted. The exception came from those noting times when they believed officers fell asleep (see Paragraph 93).

The DQE team's study of 32 constant observations[85] raised some concerns. One-third of the placements showed gaps in observation sheet entries lasting more than a half-hour. Some of these occurred at sensitive times during a TS, such as its initial hours or upon

[85] See Paragraph 34 for a description of this study.

return from a hospital trip after self-injury. Some sheets may not have recorded key events, or raise questions about the veracity of recording, such as multiple people completing sheets for the same time period. With the available information, it was not possible to discern whether these were lapses in observation or recordkeeping.

In terms of the visibility available to these officers, the DQE team continued to observe the sight lines for cells in different units used for TS and has tested the seating arrangements and visibility in some locations. While there are some limitations, these are manageable in most locations.[86] The physical plant in Shirley's HSU and OCCC's ISU are particularly conducive to keeping patients safe during constant observation.

Because constant observation practice is so integral to patient safety, this requirement bears further monitoring.

96. A Correctional Officer will check for signs of life in the prisoner every 15 minutes (e.g., body movement, skin tone, breath sounds, chest expansion), and document every 15 minutes.

Finding: Partial compliance

Rationale: The DQE team understands from interviews that the responsibilities outlined in Paragraph 96 have been included in formal training and on-the-job training since before the Agreement began. As one measure of implementation, the DQE team examined the forms on which officers are required to record the checks they have made. The team reviewed forms for 53 TS placements drawn from all institutions that conducted TS.[87]

Only half of the placements had recorded contacts every 15 minutes—or a similar interval if contacts were "staggered"—or missed contacts only very rarely.[88] Among noncompliant records, the absence of recorded contact ranged from 45 minutes to 18 hours, and it was common for a record to have multiple gaps.[89] Compliance rates have vacillated widely during each monitoring period and, despite concerted effort by the Quality Improvement Committee, the current rate is much lower than when monitoring began.

[86] See Paragraph 54 for further discussion.
[87] See Paragraph 34 for a description of the sample selection.
[88] In this analysis, a TS record was considered compliant as long as there usually were entries every 15 minutes and, if there were gaps, those gaps did not exceed a half-hour.
[89] Where there were no records for several hours, the DQE team attempted to control for hospital visits and, for any that were identified and coincided with missing records, those files were counted as compliant.

There also was a decline in staggering of contacts—the practice of making contacts at unpredictable intervals as one means to prevent and quickly identify patients' self-injury—at least as captured in the observation sheets. In the DQE team's study, only 25% purported to employ staggering, and many of those substituted another interval, for example every 14 minutes, or recorded the exact same "varied" schedule of contacts day after day. At minimum, these make the purpose of the practices moot. Given that many of the observation sheets, as well as the sheets showing every quarter hour, appear pre-filled, it also raises questions about truthfulness, as did the times when two or more officers completed sheets saying they had simultaneously monitored the patient during the same one- to two-hour period.[90]

The content of the observations was a much more promising element. A large majority of the records reasonably captured prisoners' activity, and sometimes mood, and some were very well done. These observations have the potential to inform treatment and are quite helpful. The exceptions were concentrated at SBCC, where it was common for officers to solely record the same two-word phrase for very long stretches when it would be very unusual for nothing to be taking place.[91] It is unknown whether this is an issue of documentation or of the quality of observation itself, but there was some indication of known events not being captured. The quality of notes generally was much better during constant observation than with close observation. Framingham and MASAC stood out for their quality of recorded observations, as did Norfolk and MTC for their completeness of records.

With recording gaps occurring at this frequency and questions about the accuracy of the documents, significantly more is needed to demonstrate compliance with this requirement.

97. Where cell door construction allows and if not prohibited by any fire/safety codes, rules or regulations, MDOC staff will use door sweeps in cells designated for Mental Health Watches in an attempt to prevent any contraband and/or foreign bodies that prisoners may try to use to engage in Self-Injurious Behavior.

Finding: Partial compliance

Rationale: During institutional tours, the DQE team observed door construction for TS cells and whether it hinders or facilitates transmission of contraband that could be used

[90] This particularly raises questions when the patient is on constant observation status.

[91] It is understood that this would be the practice when a prisoner is sleeping. The concern is raised when this practice is used during long periods when the prisoner is marked as awake.

for self-harm. MDOC is very close to reaching substantial compliance with this requirement.

The DQE team has verified that, of the 18 units that house patients on TS, 15 have installed door sweeps or have door construction sufficient to prevent harm without door sweeps. In the remaining three units – MTC's BAU, OCCC's ISU, and SBCC's HSU – modifications are underway. Generally, in those locations, some cells meet this requirement, and upgrades are pending for others. The DQE team anticipates that MDOC will come into substantial compliance in the next monitoring period.

98. MDOC will ensure that the contracted health vendor retains Support Persons at each medium and maximum security institution where Mental Health Watches occur within one (1) year of the Effective Date.

Finding: Substantial compliance

Rationale: MDOC created Support Person positions in the healthcare vendor's contract beginning in 2023, and by early 2024, the positions were posted and being gradually filled. By June 2024, all the facilities where TS occurs had posted positions for at least 1.2 FTE (6 days a week) Support Persons, and seven of the eight facilities had filled their full-time positions. Nothing changed when VitalCore became the healthcare vendor in July 2024. During the current monitoring period, VitalCore's staffing matrix indicates that all facilities except Gardner and Shirley had a full-time Support Person on board, Monday through Friday, as of December 2024. The vacancies at Gardner and Shirley were due to staff who had recently left their positions. Per diem Support Persons were covering weekday and Saturday hours at several facilities.

Thus, MDOC's obligation to ensure that the healthcare vendor retains Support Persons at the facilities where TS occurs is fulfilled. Staffing levels are not at 100%, but some turnover among staff is unavoidable and should not stand in the way of a substantial compliance finding here. Concerns about unfilled weekend Support Person positions are addressed in Paragraph 102 below.

99. A Support Person is an individual provided by the health care vendor and is part of the Multi-Disciplinary Team. A Support Person engages in non-clinical interactions with prisoners on Mental Health Watch, provides additional activities outside of the three clinical sessions per day, and documents these interactions and the prisoner's behavior.

Finding: Partial compliance

Rationale: Based on the DQE team's interviews and review of records, including triage meeting minutes and patients' medical records, Support Persons have been integrated into the mental health teams at all facilities where they have been hired. However, they are not interacting with patients on TS consistently at all facilities, and they do not have permission or access to reasonable supplies with TS patients at OCCC.

To assess the Paragraph 99 requirements, the DQE team reviewed health records for Support Persons' activity with TS patients. Among the 100 TS placements that the team examined,[92] Support Persons interacted with 31 of the patients, often on multiple days during the stay. It was very common for patients to see Support Persons at Framingham and OCCC, and contacts occurred in a more limited fashion at MASAC and Norfolk. The other half of the institutions—SBCC, Shirley, Gardner, and MTC—did not appear to utilize Support Persons in the TS setting. Monthly data tracked by MDOC about the use of Support Persons' time similarly shows that one-third of their patient contacts are made during TS.[93]

All interviewed Support Persons knew of their obligation to document their contacts, and the DQE team's review of medical records indicates that they do so in progress notes formatted specifically for them. In the DQE team's sample, those notes generally included a statement that an interaction was attempted or completed, a phrase about the type of activity, and a brief description of the prisoner's behavior. Most notes were captured in two to three sentences.

In interviews with Support Persons and in the DQE team's observation of their patient contacts, it appears that they continue to provide a broad range of ancillary services. These included facilitating video visits, distributing psychoeducational or recreational "packets," leading activity groups, playing games one-on-one, discussing life plans after release from incarceration, encouraging treatment compliance, and encouraging good hygiene.

The difficulty noted by some Support Persons during the previous monitoring period about access to supplies and obtaining permission from security leadership to use them

[92] Elsewhere in this report, the DQE team's studies of TS placements included 52 or 53 cases, but when assessing Support Person contacts, a full 100 cases were reviewed because this is the first monitoring period in which the issue was systematically assessed.

Drawing from the spreadsheet referred to as the TS Registry, the DQE team selected stays from the period of July through November 2024 from all institutions that provide TS. The number of stays per institution corresponded to that facility's proportion of the total TS placements. Various types of TS housing were included (HSU, BAU, STU, SAU, ITU, and MASAC's "Housing Unit.") Almost all placements lasted three days or more.

[93] The data are provided monthly in a document referred to as the Monthly Mental Health Roll-Up. The DQE team analyzed the numbers provided for July through December 2024 for all institutions that provide TS. It is not entirely clear that facilities are reporting this data in the same way.

with patients on TS is slowly being resolved at most institutions. However, at OCCC in October 2024, Support Persons were still not allowed to use, for example, art supplies or puzzles with patients on TS. Staff reported that, in the BAU, where most TS placements occurred during this monitoring period, games and puzzles are not allowed. They stated that, in the HSU, there is no table or other space in which such items could be used.

Overall, MDOC is on its way toward compliance with the Paragraph 99 requirements. More consistent demonstration of Support Person contacts on TS, especially at SBCC (where over 40% of TS placements occur), and ensuring access to reasonable supplies and space for Support Person contacts at OCCC, are important next steps.

100. A Support Person will receive 40 hours of training pre-service training prior to engaging with prisoners on Mental Health Watch, which will include training about how to appropriately interact with, and document interactions with, prisoners on Mental Health Watch. Support Persons will also receive Crisis Intervention Training.

Finding: Partial compliance

Rationale: The DQE team interviewed five Support Persons across four institutions during this monitoring period. Support Persons who were asked about pre-service training reported that they completed two weeks of New Employee Orientation (NEO) with MDOC and the healthcare vendor prior to beginning work, exceeding the requirement of 40 hours.[94] NEO records from July to December 2024 are consistent with this report, including eight hours of Suicide Prevention and Mental Health training during the MDOC week and additional mental health topics during the healthcare vendor's week.

When asked how they learned to interact with patients on TS, interviewed Support Persons pointed to on-the-job "shadowing" experiences with MHPs, their previous experiences working in other mental health settings (e.g., psychiatric hospitals, group homes), or cross-site supervision with other Support Persons. Regarding documentation, Support Persons learned generally how to use the electronic health record during NEO, though specific instruction on how to document their TS contacts did not come until later. It is not clear that these training experiences would meet a strict interpretation of Paragraph 100's requirements—learning how to interact with TS patients and document contacts *during pre-service training*—but they are adequate in the DQE's opinion.[95]

[94] The DQE team interviewed five Support Persons across four institutions during this round of site visits. Most Support Persons had been hired under Wellpath, so they completed NEO with that company.
[95] In the DQE's experience, new employee orientation covers topics that are mandatory for all employees (e.g., PREA reporting, security policies, suicide prevention, abuse/neglect reporting, electronic health record navigation) rather than role-specific topics, which are typically taught on site by a supervisor.

Overall, it appears that MDOC has a good foundation for pre-service training of Support Persons in place. With sustained practice and integration of Support Persons into CIT training, which began in December 2024, MDOC is likely to achieve compliance with the Paragraph 100 requirements.

101. A Qualified Mental Health Professional will be on site to oversee the Support Person and provide guidance on appropriate non-clinical activities and ensure there is efficacy in the interactions with the prisoner on Mental Health Watch. Interactions with the Support Person must be determined to be clinically appropriate for each prisoner on Mental Health Watch.

Finding: Substantial compliance

Rationale: MDOC's supervision practices for Support Persons now meet or exceed the requirements of Paragraph 101. The DQE team has observed Support Person contacts, mental health triage meetings, and supervision groups on Teams; interviewed MHPs and Support Persons; reviewed Support Person training materials; and reviewed documentation in the electronic health record to arrive at this conclusion.

All interviewed Support Persons reported frequently consulting with MHPs throughout the day about their work with patients, and all identified the site Mental Health Director as their main supervisor. Two Support Persons noted that their typical practice is to see patients on TS right after a clinical contact with an MHP so that they can discuss what type of interaction would be most helpful. Support Persons' work schedules align with MHPs' schedules, so they are never alone in a facility without access to a clinician for supervision. All Support Persons reported attending the daily mental health triage meetings, and this assertion is supported by attendance records in the meeting notes. In the DQE's observation of triage meetings, Support Persons participated in the discussions, describing their contacts and the patients' reaction to them. The DQE team also observed Support Persons participating in an agency-wide group supervision meeting led by an MHP on Tuesdays.

There is also evidence that Mental Health Directors are paying attention to Support Persons' boundaries with patients and with MHPs, ensuring that Support Persons do not veer into the territory of clinicians. For example, one Support Person was let go because of concerns that they were providing clinical therapy without the proper training or education to do so. Another Support Person's brief tenure in MDOC ended because their sense of boundaries with patients was not a good fit for the environment.

Overall, it appears that the structures necessary for on-site supervision of Support Persons by MHPs are in place. In approximately a year of monitoring Support Persons' contacts with TS patients, there are no indications of clinically inappropriate contacts or a lack of adequate supervision. This is sufficient for a substantial compliance finding.

102. The Support Persons will be assigned to work at least six days per week, 8 hours per day, on the days and shifts when data indicates that Self-Injurious Behavior is more likely to occur so as to be of the most benefit to inmates on Mental Health Watch.

Finding: Partial compliance

Rationale: According to the December 2024 VitalCore staffing matrix, each of the seven prison sites where TS occurs is allotted 1.2 FTE Support Persons: one full-time position (40 hours a week), plus one 0.2 FTE position (8 hours a week).[96] MASAC's staffing matrix also includes 1.2 FTE Support Persons. Together, these matrices add up to the time required by Paragraph 102: 6 days per week, 8 hours per day, at all facilities where TS occurs. The ISU has an additional 3.6 FTE Support Persons allotted to it. In total, there are 13.2 FTE Support Person positions across MDOC.

As of December 2024, 8.0 out of 13.2 FTE had been filled, including 8 out of 11 full-time positions. Very few of the part-time (0.2 FTE) Saturday positions were filled. These are difficult positions to recruit for because of the weekend shift and limited weekly hours. Overall, three full-time positions at Gardner, Shirley, and the ISU remain to be filled, and eight part-time (0.2 FTE) positions remain to be filled.

In the third DQE report, data from the SDV logs between January and June 2024 were analyzed to determine when most SDV was occurring. That analysis determined that most SDV occurred during the daytime hours on weekdays, which corresponded to the shifts when most Support Persons were working, as required by Paragraph 102. During this monitoring period, the DQE did not repeat this analysis because, even if the timing of SDV had changed substantially in six months, it would not be feasible to shift Support Persons' work schedules at that frequency.[97] The DQE is satisfied with a staffing plan that involves Support Persons assigned to the day shift, Monday through Saturday.

[96] OCCC employs two additional full-time Support Persons for the ISU; most of these hours are considered "per diem" on the VitalCore staffing matrix, but in practice the staff members work regularly, Monday through Friday.
[97] MDOC's internal data, as documented in the August 2024 QIC meeting minutes, indicate that most SDV continues to occur Monday through Friday between 11 am and 1 pm, lending further support to staffing Support Persons during the daytime hours.

103. At each shift transition, the departing Qualified Mental Health Professional will discuss with the oncoming Qualified Mental Health Professional what kind of Support Person activities are clinically appropriate for each of the prisoners on Mental Health Watch.

Finding: Partial compliance

Rationale: During site visits, the DQE observed handoffs between MHPs during shift transitions at OCCC, Gardner, Norfolk, and SBCC. At the other facilities, MHPs and Support Persons were interviewed about how they handle shift changes. Based on these observations and interviews, it appears that the process of integrating Support Person contacts into MHPs' established practice of discussing each TS patient during a shift transition is beginning to take hold.

At OCCC, where a Support Person has contact with TS patients almost every day, the Support Person participated in the shift change discussion. At the other facilities such as Shirley and Norfolk, the incoming and outgoing MHPs discussed Support Person contacts among themselves, with Support Persons joining on a case-by-case basis. At Gardner and MTC, the mental health staff reported that they do not routinely discuss Support Person contacts for TS patients during shift transitions because such contacts rarely occur. They noted that most patients on TS are too acute or agitated to engage with a Support Person, so there would be nothing to discuss. At SBCC, there was no discussion of Support Person contacts during the observed shift transition, nor was there any evidence of such contacts occurring in the medical records reviewed by the DQE team.

Overall, these practices are sufficient for a partial compliance finding. If MDOC can demonstrate a consistent practice of integrating Support Person contacts into shift transition discussions, especially at high-volume sites like OCCC and SBCC, it will move further toward substantial compliance.

104. Throughout each shift, a Support Person will document all interactions. The Support Person's documentation will be reviewed with the clinical team during the following day's triage meeting.

Finding: Partial compliance

Rationale: In the DQE's study of 100 TS placements,[98] 31 patients had documented Support Person contacts, and many had multiple such contacts during the TS. There is no

[98] See Paragraph 99 for a description of the study methods.

way to know whether any additional, undocumented contacts occurred. However, five Support Persons interviewed by the DQE team across four institutions knew of their need to document all contacts and reported doing so in the electronic health record. With consistent demonstration of this practice, MDOC will likely meet the documentation requirements of Paragraph 104.

The DQE team observed triage meetings at all eight sites during this monitoring period, and none included a review of Support Persons' documentation, though several included verbal reviews of the contacts themselves. As noted in comments to the parties in a draft of the third DQE report, Paragraph 104's requirement that Support Persons' notes be reviewed in the daily triage meeting is inconsistent with the DQE clinicians' experience of how mental health team meetings generally work. However, because this is what the parties agreed to in creating Paragraph 104, the DQE will monitor compliance accordingly. For now, MDOC has not demonstrated a practice that would meet the requirements of Paragraph 104, but the DQE is open to further discussions with the parties about whether a verbal review of Support Person contacts in triage meetings would be sufficient.

105. Self-Injurious Behavior: MDOC will update its policy and procedure for responding to Self-Injurious Behavior that occurs during a Mental Health Watch. Upon identification of an incident of Self-Injurious Behavior, MDOC will:

Finding: Partial compliance

Rationale: MDOC submitted policy 103 DOC 562, Code 99 Emergency Response Guidelines, to the DQE team for the first time on September 13, 2024. The document indicates that it was most recently reviewed on June 28, 2024.

In the DQE's review of the policy, its language does not align with some aspects of the Agreement. It does state that staff will activate Code 99 procedures in the event of a life-threatening medical emergency, and some examples of self-injury are included: "suffocation or strangulation by other means," "falls," and "stab wounds." Given that a large percentage of MDOC's episodes of SDV include cutting, jumping from a height, ingestion of foreign bodies, insertion of foreign bodies, and head-banging, the DQE recommends that these examples be more explicitly included in the policy as possibly life-threatening behaviors.

In addition, the policy does not include language that mirrors Paragraph 106 regarding what factors MDOC staff will consider when determining the type of protective

equipment and clothing to use in a Code 99 response—suspected weapons, communicable diseases, barricaded doors, safety of the scene, and severity of harm.

Finally, the policy makes no mention of notifying mental health staff in the event of SDV causing the Code 99. This, too, should be added to policy 103 DOC 562 to bring it in line with the Agreement.

106. If the incident of suicide attempt or Self-Injurious Behavior is life threatening, the Code 99 (103 DOC 562) procedure will be activated immediately.
a. Code 99 Procedures will take into consideration factors such as whether there are suspected weapons in the room, communicable diseases, barricaded doors, safety of the scene, and the severity of the harm when determining the type of protective equipment and clothing to be utilized when responding to a Code 99 for a prisoner on Mental Health Watch.

Finding: Partial compliance

Rationale: MDOC shared its Code 99 policy with the DQE on September 13, 2024, so this is the first monitoring period where it was possible to assess whether the policy is being followed. The only source of data available to the DQE team regarding Code 99 activation is incident reports stemming from episodes of self-injury. The DQE examined 10 such incidents, including the five serious suicide attempts and five other incidents chosen randomly from the SDV log. From this documentation, one can tell that Code 99 procedures were activated by an officer when observing a prisoner engaging in self-injury. It is not possible to determine whether this occurred immediately or what factors were considered when determining the type of protective equipment and clothing to use in the response.

Prisoners and staff across all eight institutions were asked how self-injury is handled, and interviewed officers uniformly reported an obligation to call a Code 99 upon discovering life-threatening self-injury. However, one patient described an incident where he engaged in SDV ("cut up" and made a ligature) for quite a while before the officer noticed; the officer's incident report does not reflect this sequence of events. The DQE team would need to review video footage to determine the veracity of the prisoner's account.

Further attention to these types of reports can be paid in the next monitoring period. MDOC has cooperated with the DQE's requests to view video footage during the site visits, so it should be possible to follow up on reports from prisoners or staff of Code 99 procedures not being activated immediately.

107. If the incident of Self-Injurious Behavior does not require immediate medical intervention, MDOC staff will engage with the inmate and encourage cessation of the behavior. In addition, MDOC staff will notify their supervisor as soon as possible to inform the designated medical personnel and Qualified Mental Health Professional of the incident.

Finding: Partial compliance

Rationale: In security staff interviews, almost two-thirds, from different housing and treatment units in five institutions, said that prisoner self-injury is rare or that the officers had actually not seen any.[99] Of 42 prisoners interviewed, only seven said they had injured themselves in recent years. These statements are consistent with the declining rates of SDV discussed elsewhere in this report.

In the DQE team's interviews in all monitoring periods, security and mental health staff have consistently described an officer's routine response to a prisoner's in-progress self-injury as being an immediate call to a supervisor and nursing and then remaining with the prisoner until the security supervisor directs other action. In recent interviews, officers and prisoners continued to point to these actions as the norm. Some staff said that officers also call mental health staff, including psychiatry at SBCC, although their role was understood to be helping the patient after the incident had concluded.

Many officers over time have said that, after they have made their calls and while waiting for supervisors and officers to respond, they personally attempt to influence the prisoner to stop self-injuring. Half of recently interviewed officers and sergeants described this approach, often including examples, sample language, and other supporting details. These individuals primarily were posted in BAUs and HSUs across five institutions. A few made observations about the skill of others on their units. Over time, many also have said that a routine part of the response is for sergeants and lieutenants also to try to encourage the prisoner to stop the SDV and come out of the cell for a nursing examination.

Among recent interviews of patients who discussed self-injuring, about half said security staff or supervisors tried to convince them to stop and relinquish items they were using. On the other hand, two said an officer saw their attempts at self-harm[100] and did not call a Code or intervene until their behavior escalated.

[99] A total of 19 officers commented on prisoner self-harm. For the 12 who had seen few or no such incidents, they worked at Gardner, MTC, OCCC, SBCC or Shirley in BAU (the highest number), general population, HSU and RTU units.

[100] One said he was punching himself in the head. The other said he tried cutting and hanging himself in a holding cell and the officer did not respond until the patient jumped off the toilet.

Overall, reports from prisoners and staff, as well as data about declining SDV rates, indicate a positive trend with officers deescalating episodes of self-harm and immediately notifying their supervisors during this monitoring period. As noted in Paragraph 91, clarification is needed about Code 99 protocols and mental health notification.

108. Within 24 hours, a Qualified Mental Health Professional will complete a Self-Injurious Behavior Occurrence Report (SIBOR).

Finding: Partial compliance

Rationale: The expectation to complete a SIBOR within 24 hours of an SDV incident is well established among MDOC's mental health staff. Once again, MDOC provided to the DQE a SIBOR for each episode of SDV listed in the tracking spreadsheet as occurring while a prisoner was on TS. Between July and December 2024, every single incident of SDV was accompanied by a completed SIBOR, which extends MDOC's year-long streak of perfection in this regard.

The DQE team reviewed 50 cases for SIBOR completion within 24 hours of the SDV incident. Cases were chosen in proportion to the percentage of SDV incidents that occurred at each facility between July and December 2024. *Table 4* illustrates the results.

Table 4. SDV Incidents with Timely SIBORs

	% of Total SDV	# of cases audited	SIBORs completed on day of SDV or following day	% completed within 24 hrs
Framingham	7	3	2	67
Gardner	3	2	1	50
MASAC	3	2	1	50
MTC	2	1	0	0
Norfolk	12	6	2	33
OCCC	23	11	10	91
SBCC	44	22	7	32
Shirley	5	3	3	100
TOTAL	**100**	**50**	**26**	**52**

Overall, 52% of SIBORs were completed within 24 hours of the event, which is much lower than the previous six-month period (80%). OCCC showed continued improvement, now completing over 90% of SIBORs on time. On the other end of the spectrum, SBCC's performance was notably poor, with just 32% of its SIBORs completed on time. It is not clear what accounts for this substantial drop in performance after two relatively strong monitoring periods.

109. Any Self-Injurious Behavior that occurs during a Mental Health Watch will be documented by the officer who was responsible for observing the prisoner. The documentation will describe the Self-Injurious Behavior as it occurred while the prisoner was on Constant or Close watch.

Finding: Partial compliance

Rationale: Security, medical, and mental health staff in MDOC are all required to submit incident reports documenting prisoners' self-injury, whether it occurs while on TS or not. The DQE team has reviewed hundreds of these reports over two years, and their content meets the Paragraph 109 requirement to describe the self-injurious behavior as it occurred.

As described in previous DQE reports, MDOC performs its own audits on the completion of these incident reports, and the results are then reviewed in the monthly QIC meetings. Minutes from the QIC meetings between July and December 2024 indicate that the completion of incident reports related to SDV remains a work in progress. In August 2024, approximately 40% of required incident reports were completed, and in November 2024, 56% of security officers' reports were completed, with lower numbers for mental health staff (33%). Generally, security officers' completion rates were the highest, but they still fell below 60% of required incident reports each month.

These completion rates are comparable to the previous six-month period, indicating slow progress with the Paragraph 109 requirements. However, MDOC does have a plan to address some of the deficits, including retraining VitalCore staff and adding the matter as a standing agenda item in VitalCore's Mental Health Director's meeting. The plan to address security officers' training is not delineated in the QIC meeting minutes, but the Assistant Deputy Commissioners remain involved in the data tracking.

110. Within 24 hours, a Qualified Mental Health Professional will conduct an assessment and modify the prisoner's treatment plan if clinically appropriate.

Finding: Partial compliance

Rationale: The DQE team has found that patients who self-harm on TS are routinely assessed by an MHP within 24 hours because of the established practice of conducting three mental health contacts per day with all patients on TS, with the except of Sundays and holidays.

As described in Paragraph 71 above, the DQE team examined a 13% sample of all TS placements where self-injury occurred to assess whether treatment modification was clinically indicated and whether it occurred. In the DQE clinicians' judgment, 78% of reviewed SDV cases appropriately modified the patient's care after self-injury, or no such modification was necessary.

Because so few TS cases documented an adequate treatment plan to begin with (see Paragraph 52), it was unsurprising to find that treatment plans were not modified after self-injury in any cases reviewed by the DQE team. This appears to be a documentation problem rather than a change in clinical practice when compared with previous monitoring periods. It was possible for the DQE clinicians to see how treatment changed patient's treatment after SDV by reading the progress notes (e.g., referral for 18a evaluation, increase in observation status, changes to property and privileges), even as no formal treatment plan changes were documented.

111. If necessary, follow the procedures laid out in its ingestion of foreign body policy enumerated in Paragraph 112.

Finding: Partial compliance

Rationale: In the Agreement, Paragraph 111 is a subsection of Paragraph 105, so the full requirement reads: "Upon identification of an incident of Self-Injurious Behavior, MDOC will, [i]f necessary, follow the procedures laid out in its ingestion of foreign body policy enumerated in Paragraph 112."

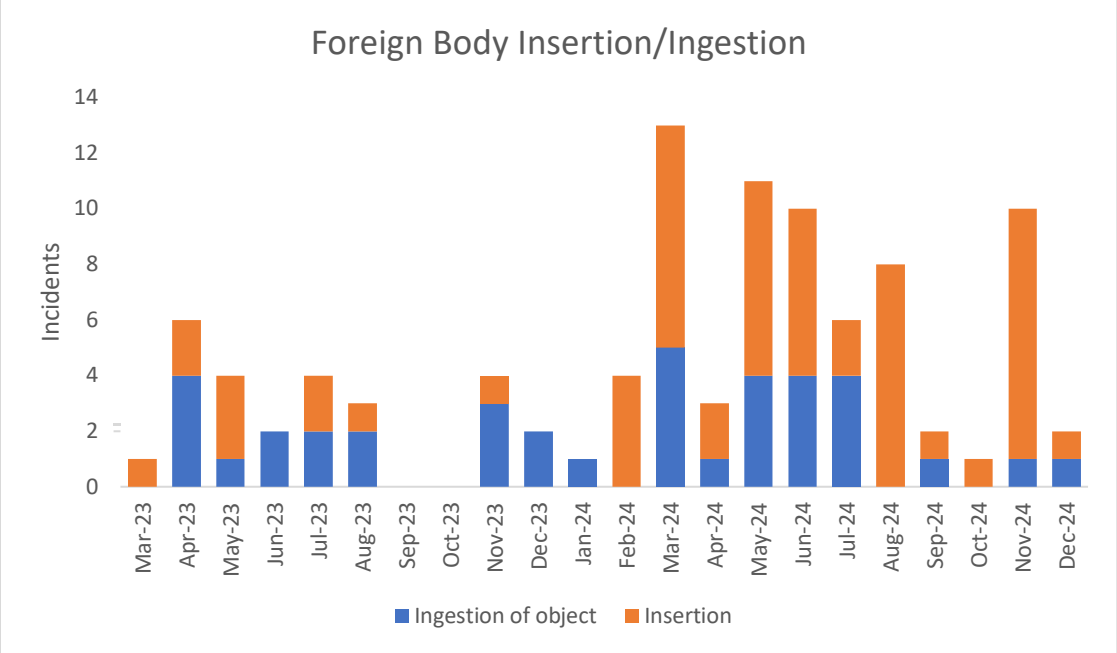
In September 2024, MDOC provided the DQE team with its policy 103 DOC 501, Institution Security Procedures, which was revised in March 2024. Section 501.09 pertains to ingestion of contraband (i.e., foreign bodies) or concealment of contraband in body cavities. To assess whether MDOC was following policy 501.09 after incidents of SDV, the DQE randomly chose 10 of the 53 incidents listed in MDOC's "Foreign Body Log" between July and December 2024. Eight of the incidents had accompanying incident reports,[101] and it was possible to tell from two of the incident reports that MDOC's general policy of having medical and mental health staff evaluate a prisoner after ingestion/insertion was followed. In both those cases, the prisoner was then placed on therapeutic supervision rather than into a "dry cell" (as authorized in policy 103 DOC 501.09). In the remaining six cases, there was insufficient information in the incident reports to determine whether MDOC was following its policy.

[101] As noted in the discussion of Paragraph 109, not all required incident reports related to SDV were completed by MDOC staff.

Overall, it appears that MDOC has a policy in place to respond to SDV by foreign body ingestion or insertion, but more is needed to demonstrate that the policy is consistently followed.

Related to the Paragraph 106 requirements, the DQE team continued to review data from the monthly Quality Assurance reports that indicate the number of foreign body ingestion and insertion incidents per month *(Figure 8)*.

Figure 8. Foreign Body Ingestion and Insertion



These data indicate that ingestion of objects and insertion of foreign bodies decreased between July and December 2024. The November 2024 spike in insertion was related to one patient, who was referred to the ISU in early December.

112. Foreign Body Ingestion: MDOC will update its policy and procedure for safely recovering internally concealed foreign substances, instruments, or other contraband to ensure facility security and prisoner safety and health. The policy will institute clear search and monitoring procedures, and clearly define the roles of Medical Providers and Qualified Mental Health Professionals. MDOC will continue to use Body Orifice Security Scanner (BOSS) chairs, body scanners, and/or hand wands to detect foreign bodies prior to putting a prisoner on Mental Health Watch.

Finding: Partial compliance

Rationale: MDOC provided its revised policy 103 DOC 501, Institution Security Procedures (dated 3/4/24), to the DQE team in September 2024. The language in this policy fulfills the first requirement of Paragraph 112, outlining a procedure for placing prisoners in a "dry cell" until contraband is recovered. The policy also outlines two roles for medical and mental health professionals: "screening" prisoners prior to placement in the dry cell and again before returning them to the BAU or general population.

Policy 103 DOC 501 does not contain any language about the use of BOSS chairs, body scanners, and/or hand wands to detect foreign bodies. However, Attachment #14 (*Therapeutic Supervision Procedures*) of MDOC's proposed revision to policy 103 DOC 650, Mental Health Services, includes the following language:

> Before placement on Therapeutic Supervision, an incarcerated individual will complete an unclothed search. The search will be followed immediately by a search in a BOSS chair in accordance with 103 DOC 506 *Search Policy*.

In turn, policy 103 DOC 506, Search Policy, and its two related documents ("Standard Operating Procedures") outline relevant practices with body scanners and BOSS chairs.[102] These procedures were revised in January 2025 and do not speak directly to therapeutic supervision. Instead, they describe in general terms when BOSS chairs and body scanners can be used to address concerns about contraband.

Putting all these policies and procedures together, the DQE could identify all the required components of Paragraph 112. However, the information is not presented clearly; one would need to review three different MDOC policies and two Standard Operating Procedure documents to understand the role of security, medical, and mental health personnel in responding to foreign body ingestion or insertion. This is not practical for busy staff working in facilities. The DQE recommends that information be added to policy 103 DOC 501, Institution Security Procedures, about the use of BOSS chairs and body scanners prior to TS placement when a prisoner is suspected of concealing contraband or has a history of doing so. Once this is completed, retraining of security staff may also be needed.

[102] The documents are titled "Standard Operating Procedure to 103 DOC 506, Search Policy: B-Scan Body Scanner" and "Standard Operating Procedure to 103 DOC 506, Search Policy: Body Orifice Security Scanner (BOSS) Chair." Both were most recently revised on 1/21/25.

INTENSIVE STABILIZATION UNIT

113. Intensive Stabilization Unit Policy and Procedure: Within 1 year of the Effective Date, MDOC will draft Intensive Stabilization Unit policies and procedures, consistent with the process in the Policies and Procedures section above.

Finding: Substantial compliance

Rationale: The third DQE report noted that MDOC had drafted ISU policies in 103 DOC 650, which were provided to the DQE on April 25, 2024. The policy language was consistent with Agreement paragraphs 113-135 except for one aspect of Paragraph 118, which states:

> Prisoners should be active participants in the interventions and in their own treatment planning, and thus may request to be considered for ISU placement. This self-identification will be considered, but MDOC's contracted healthcare provider has the ultimate authority over ISU placement.

In the revised draft of policy 103 DOC 650 shared with the DQE on September 26, 2024, the missing language from Paragraph 118 was included. Thus, it appears that the ISU policies have been now drafted in accordance with the Agreement, fulfilling the Paragraph 113 requirement.

114. Intensive Stabilization Unit: No later than eighteen (18) months of the Effective Date, MDOC will operate the Intensive Stabilization Unit (ISU).

Finding: Substantial compliance

Rationale: The ISU was officially opened on June 16, 2024, and its first patient was admitted on August 1, 2024. Since that time, 11 patients have been admitted to the program, for an average of 59 days (range 15-90 days). Since late October, the unit has consistently served four or more patients and progressed toward the highest unit census, in the most recent month, of seven patients[103] (out of the 15 total beds).

[103] The DQE team derived this information from triage meeting notes for each weekday in the period August through December 2024.

The DQE team's site visit and review of medical records indicate that the unit is fully functional.[104] There are MHPs, an activity therapist, a nurse, and two Support Persons dedicated to the program, and other disciplines contribute to treatment. Patients have multiple group and individual contacts per day, treatment team meetings occur daily on weekdays, and indoor and outdoor recreation spaces are being used. These activities all demonstrate compliance with the requirements of Paragraph 114.

115. ISU Purpose: MDOC, through its contracted healthcare vendor, will provide intensive stabilization services for prisoners unable to effectively progress with placement on Mental Health Watch or general population due to serious mental illness or marked behavioral dysregulation. ISU treatment will be for prisoners who do not meet the statutory criteria required for inpatient hospitalization but who have been on Mental Health Watch and are clinically appropriate for a higher level of care. While designed as a short-term placement, the ISU focus of treatment is to address immediate clinical needs in an intensive environment restoring safety and stabilizing symptoms while working with the prisoner to identify treatment needs to maintain in a non-ISU environment.

Finding: Substantial compliance

Rationale: The DQE reviewed the referral paperwork for all 11 patients admitted to the ISU, and it appeared that the patients were chosen because of their difficulty functioning in general population, RTU, or STP settings due to serious mental illness or personality disorder. Several of the patients had been admitted to Bridgewater State Hospital for Section 18a evaluations in the past, only to be sent back to MDOC designated as "not in need of hospitalization" or "not meeting DMH criteria for mental illness." One patient had been admitted to BSH for over 25 years prior to his ISU referral, and it made clinical sense for ISU to be a step-down upon his return to MDOC. Overall, it appears that the patients admitted to the ISU meet the definition set forth in Paragraph 115 (i.e., not meeting statutory criteria for hospitalization but still in need of a higher level of care).

Paragraph 115 also requires that the ISU focus its treatment on patients' immediate clinical needs, restore their safety and stability, and prepare them to function in a non-ISU environment. These requirements are substantively identical to Paragraph 116; please refer to the DQE's compliance assessment of Paragraph 116 below.

116. Specialized interventions are based on the prisoner's mental health needs, behavioral needs, and level of functioning. Each prisoner will be assigned to treatment and programming in accordance with their individualized treatment plan. The primary goals for ISU treatment

[104] During the DQE's site visit on October 1, 2024, the comfort rooms had not yet been outfitted with sensory or recreational items. MDOC's December 2024 status report indicates that the rooms are now functional.

include the following: stabilizing of primary symptoms necessitating referral, providing a supportive, intensive therapeutic milieu for inmates with mental health needs, and preparing each prisoner for reintegration into the general prison population or Residential Treatment Unit offering a reasonable expectation of success given current mental health needs.

Finding: Partial compliance

Rationale: MDOC's written program description for the ISU outlines a treatment structure that is consistent with the requirements of Paragraph 116. In practice, it consists of two phases – many patients begin on Phase 3, the most intensive, and Phase 4 begins to prepare for managing in other programs. Phases 1 and 2 are not components of ISU per se, but rather are therapeutic supervision if needed.

The DQE team's review of ISU medical records, as well as interviews with two ISU patients, indicates that many of the Paragraph 116 requirements are being met. During the team's site visit, it appeared that staff was creating a supportive, intensive milieu. One interviewed patient found this structure and support helpful, while the other found the amount of programming overwhelming.

The ISU treatment plans are more individualized and thoughtfully crafted than those the DQE team has reviewed for TS placements, and treatment on phases 1 and 2 is geared toward acute stabilization. On phases 3 and 4, the focus turns to addressing patients' underlying clinical problems (e.g., obsessive-compulsive symptoms or an inability to cope with institutional stressors), with the hope that patients will develop skills to help them in general population. The plans reviewed, however, did not specify the treatment and programming the patient required, so presently it is not possible to assess whether patients are assigned to that care.

To date, the last piece—skill-building for life after the ISU—has been partially successful. One patient had a second ISU admission within three months of discharge, while others returned to TS status on the day they were discharged from the ISU. Although these outcomes are not ideal, they are also to be expected when working with a patient population as challenging as those admitted to the ISU. In the DQE's opinion, the mixed outcomes do not indicate a failure of MDOC to provide appropriate treatment.

MDOC has made a good start on the ISU program. The referred patients are appropriate, and the program is designed to support the goals set out in the Agreement. The next step will be to demonstrate that the treatment team is identifying and delivering individualized care.

117. Any MDOC units that are developed to serve the same purpose as the ISU will follow the guidelines enumerated in this section.

Finding: Not assessed (by agreement of the parties)

Rationale: MDOC reported that no other units have been developed to serve the same purpose as the ISU. There is a similar program, the Intensive Treatment Unit (ITU) at Framingham, that follows a four-phase model and is the highest level of care available for female prisoners in the MDOC system. The DQE will need to discuss with the Parties whether this program serves the same purpose as the ISU and therefore should be assessed under Paragraph 117.

118. ISU Selection: Prisoners who are assessed by MDOC's contracted healthcare provider as dysregulated and/or decompensated for whom multiple interventions have been ineffective will be referred by the contracted healthcare provider for transfer to the ISU. Duration of symptoms, utilization of Mental Health Watch and implementation of behavior management plans must be considered prior to referral. In discussion with the ISU Director, the referring treatment team will identify the goals for ISU placement and any treatment resistance or barriers thus far. Prisoners should be active participants in the interventions and in their own treatment planning, and thus may request to be considered for ISU placement. This self-identification will be considered, but MDOC's contracted healthcare provider has the ultimate authority over ISU placement.

Finding: Partial compliance

Rationale: All 11 patients admitted to the ISU meet the criteria of "dysregulated and/or decompensated" and either failing multiple interventions or needing a step-down from Bridgewater State Hospital. From the information provided by MDOC, the DQE cannot discern whether there are other patients meeting these criteria who *should* have been referred for ISU consideration but were not. The DQE team's review of the long TS placements (14+ days) indicates that only five such patients (out of 36) were admitted to the ISU, indicating that referring to the ISU from a long TS placement is more the exception than the norm. Similarly, a handful of the patients who experienced multiple TS placements during this monitoring period were referred to the ISU, while the majority were not. The DQE does not have enough information to understand what distinguished the admitted patients from the others who might have been considered.

The ISU referral form has been carefully crafted to align with the requirements of Paragraph 118. Each of the 11 referral forms reviewed by the DQE contained a section where the referring team identifies treatment goals and barriers. Each form contained an

accounting of the patient's psychiatric history, prior hospitalizations, diagnoses, and TS placements, which give the reader a meaningful indication of symptom duration and severity. None of the forms contained any information about behavior plans—whether they had been implemented or even contemplated—as required by Paragraph 118; this is consistent with MDOC's overall lack of engagement with behavior plans (see Paragraph 136).

As noted in Paragraph 113, MDOC's most recent revision of policy 103 DOC 650.12.B, states that prisoners can self-refer to the ISU, though the healthcare vendor and MDOC have the ultimate say over admissions. To date, the DQE is unaware of any patients who have requested ISU admission or what the self-referral process looks like (e.g., Would the patient initiate a sick call request? Fill out their own ISU referral form?).

Overall, MDOC appears well on its way to meeting the Paragraph 118 requirements. Next steps will include demonstrating sustained use of the ISU referral process, adding information about behavior plans to the referral form, and creating a process for patients' self-referral. In addition, although it is common to screen patients carefully before admission in the early days of a new treatment program, in the long term, the DQE hopes to see more robust use of the ISU, as there are certainly many more patients in MDOC who could benefit from that level of care.

119. ISU Treatment: Each prisoner will be assigned a stabilization clinician from the ISU treatment team.

Finding: Substantial compliance

Rationale: VitalCore has hired two MHPs and a unit director[105] who serve as the primary clinicians for ISU patients. The DQE's review of medical records and interviews with two ISU patients indicate that the patients have been assigned a primary clinician. This clinician is responsible for completing 1:1 contacts in accordance with patients' phase of ISU treatment (e.g., twice weekly on Phase 3, once weekly on Phase 4) and for revising the treatment plan as needed.

120. Upon admission to the ISU, all prisoners will be evaluated daily (Monday through Saturday) by the treatment team when in initial phases and the recommended frequency for ongoing individual contacts and group programming (if group programming is deemed clinically appropriate) will be documented in the prisoner's individualized ISU treatment plan.

[105] The unit director position is temporarily being filled by the by OCCC's Mental Health Director while VitalCore recruits a replacement.

Finding: Partial compliance

Rationale: MDOC's draft policy 103 DOC 650.C.b.i is consistent with the requirements of Paragraph 120, and MDOC's December 2024 status report indicates that a bi-annual audit process will ensure that the healthcare vendor is fulfilling its obligation.

The treatment team meets each weekday, except holidays, and their notes show that every patient is evaluated in those meetings.[106] Since mid-August, meeting participants have consistently included the unit director and usually other MHPs, a security staff representative, an activity therapist, and one or more Support Persons. Psychiatry and nursing often are present, and one or more psychologists attend an average of once a week. This is an excellent team composition, and the practice of reviewing all patients exceeds the requirement to evaluate patients on the initial phases, with the exception of doing so on Saturdays and holidays.

Paragraph 120 also requires that the frequency of individual contacts and group programming be documented in the patient's treatment plan. The DQE team's review indicates that this is not currently being done. The ISU treatment plans generally do a good job of delineating the patient's problems and progress in addressing them, but none of the reviewed treatment plans contained a specific notation about which individual or group treatments, or at what frequency, were recommended.

121. Group programming will be available in the ISU and prisoners will be referred based on their progress in treatment and individualized treatment plan. Group programming available will be maintained with rolling admission, allowing prisoners to enter the group at varying stages of treatment and based on length of stay in the ISU. Assignment to core group treatment modules is at the sole discretion of the ISU treatment team and is based on the prisoner's individualized treatment needs.

Finding: Partial compliance

Rationale: The requirements of Paragraph 121 are reflected verbatim in MDOC's policy 103 DOC 650, Mental Health Services, and group programming is certainly available in the ISU. In fact, the two patients interviewed by the DQE team in the ISU reported that their days were almost *too* full of programming, which lasted from 9 am to 7 pm, Monday through Friday. There is not yet enough data for the DQE to determine compliance with other aspects of Paragraph 121, such as whether patients are allowed to join groups on a rolling basis or the degree to which these groups are tailored to the

[106] The DQE team reviewed each day's Triage Meeting notes from August 1 through December 31, 2024

individual's needs. When the DQE team visited the ISU in September 2024, there were only two patients, and both patients had the same daily schedule of clinical and recreational groups. A sample of health records suggested that this may be continued practice.[107] Since the site visit, more patients have been admitted—11 total, and up to 7 at one time—so there may be more opportunity to assess the requirements of Paragraph 121 in the next monitoring period.

122. Out of Cell Time: The ISU will permit out of cell time and opportunities for congregate activities, commensurate with the clinical stability and phase progression of the prisoner, with the intention of reinforcing symptom and behavioral stability. Following the discontinuation of a Mental Health Watch in the ISU, ISU participants will have the following privileges/restrictions/clinical contacts:

Finding: Partial compliance

Rationale: MDOC appears headed in the right direction with Paragraph 122, but there is too little data to date to demonstrate a consistent practice. During the DQE's site visit in September 2024, the two ISU patients were observed enjoying recreational time on the covered patio, sitting in the day room, and using the showers in between structured groups. Interviews with mental health and security staff indicated that these activities are permitted on phases 3 and 4 of the ISU, along with out-of-cell meals. On phases 1 and 2, out-of-cell time is more restricted because these phases are the equivalent of constant and close observation on TS.

Paragraph 122 also requires access to certain privileges and clinical contacts "following the discontinuation of Mental Health Watch in the ISU." It is important to note that not all patients spend time on therapeutic supervision (i.e., mental health watch) in the ISU; may are admitted on "phase 3" and are never subject to the restrictions of TS. In the DQE team's review of ISU medical records, six of the 11 ISU admissions involved a patient who was placed on TS for a portion of the admission. The DQE team has interpreted the requirements of Paragraphs 123-129 to apply to a patient's ISU admission *except when on TS*, not just to the period *following* a TS placement.[108]

123. Access to all on-unit programming and activities as outlined in the individualized treatment plan, and will not restrain prisoners unless necessary;

[107] The DQE team reviewed a sample of progress notes for 4 of the 11 ISU stays.

[108] Although we acknowledge that the language of Paragraph 122 is ambiguous, any other interpretation would be bizarre. For example, if the language were construed narrowly, MDOC would be permitted to deny phone calls and visitation when a patient is admitted to the ISU on phase 3, with the requirement to grant those privileges kicking in only after the patient is "upgraded" to TS. Such an interpretation seems inconsistent with the spirit of the Agreement.

Finding: Partial compliance

Rationale: Again, MDOC appears headed in the right direction, but there is too little information to draw firm conclusions. During the DQE's site visit in September 2024, both interviewed patients stated that they were not routinely restrained during group or individual activities. Mental health staff reported the same, noting only two circumstances where a patient would be restrained in the ISU: (1) on 1:1 observation during Phase 1, and (2) if agitated and pending assessment by mental health staff.

Paragraph 123 also requires that patients have access to all on-unit activities outlined in their treatment plan. Since the ISU treatment plans do not typically specify which groups or activities a patient is recommended to attend, and because MDOC does not yet track non-clinical time out of cell, the DQE cannot yet assess whether any restrictions to these activities are occurring.

124. In addition to the requirements described in Paragraphs 120-121, individual clinical assessment by a Qualified Mental Health Professional at least one time per week;

Finding: Partial compliance

Rationale: In interviews with the DQE team, MHPs were aware of the requirement to see patients individually at least once per week in the ISU. They noted that the actual practice is more robust and dependent on a patient's phase. They said that patients are seen three times daily while on phases 1 and 2 (consistent with the requirement for three daily TS contacts), twice weekly while on phase 3, and once weekly while on phase 4. This expectation is also captured in the draft of policy 103 DOC 650 and the ISU Handbook.

The DQE team assessed health records for this requirement[109] in four of the 11 ISU stays. In nearly all cases, the patient had individual contacts with an MHP at least weekly. In one early case, an MHP contact was documented in most weeks, though it appeared that a few were missed. Of note, about 30% of the sampled contacts took place in a nonconfidential setting.

125. Contact visits and phone privileges commensurate with general population;

Finding: Partial compliance

[109] The review assessed whether contacts occurred at least weekly, not the higher standards that the program has set for staff.

Rationale: The DQE team did not ask either patient in the ISU during the September 2024 site visit about their experience with contact visits or phone privileges. Interviewed MHPs reported that patients are permitted to have video visits and that mental health staff assess patients' clinical stability before and after these visits. MHPs reported that there are no restrictions on phone calls.

The draft of policy 103 DOC 650 captures this requirement verbatim. The ISU Handbook carries it forward, though it restricts visits to *non*-contact. Other sources of data are not yet available to assess implementation of this requirement, as permissions for visits and phone calls are not routinely recorded in the health records or triage meeting notes the DQE team reviewed, and MDOC does not track or document out-of-cell activities in the ISU. However, MDOC's December 2024 status report indicates that the requirements of Paragraph 125 would likely not be met: "The ability of contact visits continues to be evaluated at the site level due to operational challenges in implementation." MDOC did not specify what those operational challenges entail.

126. MDOC will work with the Department of Public Health to satisfy the requirements necessary to obtain the Department of Public Health's approval to provide meals in the on-unit dining area. Upon approval, meals in the on-unit dining area will be provided in a group setting unless clinically contraindicated;

Finding: Partial compliance

Rationale: MDOC's draft policy 103 DOC 650.12.C.d.ix demonstrates its intent to provide meals out of cell in the ISU, and preliminary data indicate that this is occurring. Both patients interviewed by the DQE team during the September 2024 site visit reported that they have the option of eating meals in the day room, and mental health and security staff supported this assertion. Because this was early in the ISU's operation and involved experience with only two patients (there is no way to assess retrospectively from available records what happened with the other nine patients' meals), the DQE is holding off on issuing a substantial compliance finding. Nonetheless, MDOC appears to be headed in that direction, without any major barriers to a substantial compliance finding if current practices are continued (and documented).

127. Clothing and other items are allowed in-cell commensurate with general population;

Finding: Noncompliance

Rationale: MDOC's draft policies indicate that patients should have access to clothing and other in-cell items commensurate with general population, and MDOC leaders expressed an understanding that this is the standard approach. However, in interviews with the DQE team during the September 2024 site visit, both patients reported that they had access to less property than in the housing units from which they were admitted. This may have been a "glitch" for the first two admitted ISU patients, when policies and procedures were still being worked out, but there were indications that OCCC leadership was restricting access to property so that ISU patients did not get "comfortable." These patients' assertion was supported by the DQE team's review of triage meeting notes and medical records for contemporary and subsequent patients, where several progress notes indicated that some patients did not have access to family photos, personal paperwork, mail, tablets, canteen items, religious materials, and hygiene items commensurate with general population. The ISU Handbook lists art supplies, journaling materials, and equipment to play music as incentives, suggesting that may be a difference from property allowed for other prisoners as well.

Regardless of the motivation, the practice of restricting property access is inconsistent with the requirements of Paragraph 127, leading to a noncompliance finding.

128. Recreation will be provided in on-unit outdoor and indoor recreation areas;

Finding: Partial compliance

Rationale: MDOC has not yet demonstrated a sustained practice that meets Paragraph 128's requirements, but preliminary data are promising. During the September 2024 site visit, two patients were interviewed in the outdoor recreation area of the ISU, and both were clearly familiar with the space, helpfully directing the DQE where to sit so that the sun would cause less of a glare. Interviewed patients, officers, and MHPs reported that indoor and outdoor recreation is offered daily. The ISU Handbook indicates outdoor recreation is not guaranteed, however, but is dependent on active program participation and not creating incidents. With continued demonstration (and documentation) of this practice, MDOC will likely achieve substantial compliance with Paragraph 128.

129. Movement will be restricted to the ISU (other than for visits, medical appointments, or other off unit activities approved by the treatment team).

Finding: Partial compliance

Rationale: As noted in the third DQE report, the Samson unit (ISU) at OCCC appears adequate to meet most of the patients' daily needs, including meals, mental health

programming, phone calls, video visits, access to the law library, showers, outdoor recreation, and medication administration. Neither patient interviewed by the DQE team in September 2024 reported leaving the unit for other activities. It appears from the medical records that other ISU patients have left the unit for periods (e.g., for evaluation at an outside hospital), but the DQE is unaware of a method to evaluate this systematically. This will be an area of closer assessment during the next monitoring period.

130. Tracking: MDOC will track out-of-cell time offered to prisoners, as well as whether out-of-cell time is accepted or refused.

Finding: Noncompliance

Rationale: MDOC has not yet demonstrated any tracking practices consistent with Paragraph 130's requirements. According to MDOC's December 2024 status report, the Clinical Operations Analyst is working with security leadership to get a tracking system in IMS, the Inmate Management System, up and running.

131. Restraints Off-Unit: For all off-unit activities (visits, medical appointments, etc.), ISU prisoners will not be restrained unless necessary.

Finding: Noncompliance

Rationale: As with Paragraph 130, MDOC has not yet demonstrated a practice consistent with Paragraph 131's requirements, mostly because it does not yet track patients' movements or non-clinical activities. Thus, the noncompliance finding stems from a lack of information rather than an assessment that MDOC's practices defy the requirements of paragraph 131. MDOC's December 2024 status report indicates that a tracking system is in progress, and the QIC meeting minutes from June 2024 indicate that the use of restraints for off-unit transport of ISU patients will be documented in an incident report. Once implemented, these measures will help demonstrate compliance.

132. Support Persons: Support Persons will be used in the ISU consistent with Paragraph 25. Support Persons will engage in non-clinical interactions with prisoners on Mental Health Watch, will provide supplemental activities and interactions with prisoners between the three offered clinical sessions, and will document these interactions and prisoner behavior.

Finding: Partial compliance

Rationale: To assess this requirement, the DQE team reviewed health records for four of the six patients who had a TS stay during their time in ISU. In each case, the patient saw a Support Person on multiple days; most contacts or attempts were recorded as taking place in nonconfidential conditions. The Support Persons' notes captured activities consistent with those described in Paragraph 132 and briefly commented on the patient's behavior. The approach was similar to the Support Person contacts and documentation the DQE team has seen on TS in other settings, as described in Paragraph 99. With sustained practice, MDOC will reach substantial compliance on this requirement.

133. Activity Therapists: Activity therapists will be used in the ISU to provide one-on-one and group structured and unstructured interactions for ISU participants as determined by the treatment providers in the individualized treatment plan.

Finding: Partial compliance

Rationale: The DQE team's review of ISU medical records indicates that activity therapists are a routine part of treatment in the ISU, engaging in near-daily groups with patients. The connection between these groups and the patients' individualized treatment plans has yet to be demonstrated because the treatment plan template does not contain a field for MHPs to recommend specific activities or treatment modalities, and MHPs rarely documented that information.

134. Therapeutic Interventions: Therapeutic interventions or non-treatment interactions will be used by staff, including Support Persons and Activity Therapists prior to initiating a Mental Health Watch when clinically indicated.

Finding: Partial compliance

Rationale: At the time of the September 2024 site visit, only two patients were in the ISU, and neither had been on TS during their ISU admission. Therefore, no data about what clinical interventions were attempted prior to placing a patient on TS could be gathered from them.

In the DQE team's review of ISU medical records, six of the 11 ISU admissions involved TS placements. The patients did not have lengthy or frequent TS placements, as can be common elsewhere in MDOC. For all of these patients, it appeared that the circumstances precipitating TS placements arose quickly, leaving little time for intervention by activity therapists, MHPs, or support persons.

135. De-Escalation Areas: The Intensive Stabilization Unit will have a therapeutic de-escalation area for prisoners.

Finding: Partial compliance

Rationale: By the September 2024 site visit, further progress had been made on the ISU's comfort rooms (i.e., therapeutic de-escalation rooms). The rooms were outfitted with molded plastic rocking chairs, and supplies such as non-toxic chalk, weighted blankets, fidget spinners, games, and journals were being ordered. A plan for a chalk wall was in progress. If MDOC can demonstrate during the next monitoring period that these supplies have arrived (as its December 2024 status report indicates) and that the room is being utilized, a substantial compliance finding is likely.

BEHAVIORAL MANAGEMENT PLANS

136. Behavioral Management Plans: When clinically appropriate, the Qualified Mental Health Professional will create an individualized incentive-based behavioral management plan based on the following principles:
a. measurable and time-defined goals are agreed upon by the prisoner and mental health staff, with the first goal being "active participation in treatment;"
b. incentives or rewards must be individualized and must be provided to the prisoner on a prescribed schedule for achieving these goals;
c. prisoners should be encouraged to talk honestly about any self-injurious thoughts while at the same time avoiding the use of threats to manipulate staff;
d. all reports of feeling "unsafe" should be taken seriously;
e. discouraging the use of disingenuous or false statements to obtain goals other than safety-oriented goals;
f. time intervals should be considered carefully and modified based on the prisoner's clinical presentation and level of functioning such that prisoners with very poor impulse control may benefit from shorter reward periods and staff can attach greater and cumulative rewards to gradually increased time periods to encourage increased self-control and commitment to the program over time;
g. choosing the right treatment interventions must be done with the prisoner, maintaining regular contact with staff, and the prisoner should be given "homework" based on their individual level of functioning; and
h. these plans should be time limited to three to six months to look for measurable improvement and then modified to a maintenance model.

Finding: Noncompliance

Rationale: At each of the eight site visits during this monitoring period, the DQE asked the mental health director and MHPs about any active or new behavior plans; nobody identified any. During the DQE team's chart reviews, no behavior plans were evident in the medical records, including in the ISU. The DQE also reviewed the medical records of patients who had previously been identified as having an active behavior plan, and only one of the six individuals had a brief mention of such a plan in his chart ("remains on an incentive plan which is evaluated weekly, rewarding positive behaviors"). The plan itself was not in the medical record, and there was no mention of time frames or measurements for the plan, as required by Paragraph 136a.

According to MDOC's December 2024 status report:

> VitalCore has hired a third regional psychologist, filling their psychologist staffing matrix. The Mental Health Director of Training has developed training modules around Behavior Plans and clinical risk assessment to be used for the 2024 Annual Mental Health Training and the Secure Treatment Unit/Intensive Stabilization Unit Training in December.

The improvement in psychologist staffing (2.5 FTE out of 3.1 FTE in the staffing matrix are now filled), future trainings around behavior plans, and addition of behavior planning language to MDOC's policy 103 DOC 650 are encouraging. However, for the time being, the DQE must issue a noncompliance finding. For two years, MDOC has reported the healthcare vendor's intent to implement behavior plans in a systematic way, but this has not yet occurred.

QUALITY ASSURANCE

137. Quality Assurance Program: MDOC will ensure that its contracted healthcare vendor engages in a quality assurance program that is adequately maintained and identifies and corrects deficiencies with the provision of supervision and mental health care to prisoners in mental health crisis. MDOC will develop, implement, and maintain a system to ensure that trends and incidents are promptly identified and addressed as clinically indicated.

Finding: Partial compliance

Rationale: MDOC continues to require in its draft policy 103 DOC 650.20, Records and Continuous Quality Improvement, that the contracted healthcare provider engage in continuous quality improvement (CQI) activities. No information about VitalCore's CQI process has been shared with the DQE other than in MDOC's December 2024 status report:

> Oversight of the Healthcare Vendor Continuous Quality Improvement Studies is provided by the MDOC Health Services Division Regional Administrators. Questions, concerns, and suggestions, when identified, are addressed with the Healthcare Vendor and MDOC leadership as necessary.

MDOC's status report does not provide much substance from which the DQE can assess the adequacy of VitalCore's CQI process. As noted in previous DQE reports, Wellpath's CQI process never addressed the concerns about quality of care raised by the DQE team, focusing instead on "check-box" metrics such as the time frames in which patients were seen (e.g., every 30 days for MHP contacts). This led to a system where some MHPs were more focused on their statistics than on the quality of patient care. Preliminary data from the period under VitalCore raise the same concerns, with the DQE team finding in its study of crisis contacts[110] that approximately 20% of such contacts were identified as in the medical record as "proxy PCC contacts," many of which occurred cell-front, were conducted by a different clinician (not the primary care clinician), and lasted as little as one minute. This practice was most prevalent at SBCC, but it also occurred at Shirley and Norfolk.

In order for MDOC to achieve substantial compliance with Paragraph 137, the healthcare vendor's CQI program must be meaningful and adequate. By now, the DQE team's concerns about the quality of crisis mental healthcare have been stated numerous times, but they bear repeating here. They include (but are not limited to) the quality of crisis treatment plans, the ability of clinicians to recognize and respond appropriately to signs of serious mental illness, and the collaboration between MHPs and upper-level providers. To its credit, VitalCore has conducted numerous trainings with staff around these issues in recent months. Demonstrating a Quality Assurance program that captures improvements in these areas is an important next step toward compliance with Paragraph 137.

138. Quality Assurance Policies: MDOC will draft Quality Assurance policies and procedures, consistent with the process in the Policies and Procedures section above, to identify and address trends and incidents in the provision of supervision and mental health care to prisoners in mental health crisis.

Finding: Partial compliance

[110] This analysis was first described in Paragraph 47.

Rationale: The majority of MDOC's policies related to Quality Assurance are consistent with the Agreement, but previous DQE reports identified two areas where policies did not yet match: the Morbidity/Mortality Review process and the SDV/SATT Review Committee. The most recent version of policy 103 DOC 650, Mental Health Services, now includes necessary language about the SDV/SATT Review Committee's role and functioning. MDOC does not yet have morbidity/mortality review policies that align with the NCCHC's template of Clinical Review, Psychological Autopsy, and Administrative Review, as required by Paragraph 146. In its December 2024 status report, MDOC indicated that the two policies where this language is likely to be found, 103 DOC 622, Death Procedures, and 103 DOC 601, DOC Division of Health Services Organization, are still under revision.

As noted in the discussion of Paragraph 137, MDOC has not provided any information to the DQE about VitalCore's quality assurance policies. Eventually, these policies will also have to align with the Agreement.

139. Monthly Quality Assurance Reports: Within three (3) months of the Effective Date, MDOC will begin tracking and analyzing patterns and trends of reliable data concerning supervision and mental health care to prisoners in mental health crisis to assess whether measure taken by MDOC are effective and/or continue to be effective in preventing and/or minimizing harm to prisoners who are on Mental Health Watch. MDOC will review this data annually to consider whether to modify data tracked and analyzed. Any modifications will be subject to the approval of the United States, which will not be unreasonably withheld. While nothing in this Agreement precludes MDOC from considering additional or different data, the data that is to be tracked and analyzed will include the data set forth in Paragraph 139 (a) and will be reflected in monthly quality assurance reports.

a. Each monthly report will include the following relevant and reliable aggregate data, separated by prison facility:

Length of Stay Data

1. The total number of prisoners placed on Mental Health Watch during the month.
2. The total number of prisoners who spend time on Mental Health Watch during the month.
3. An attached Excel spreadsheet of all prisoners who spend time on Mental Health Watch during the month organized as follows:

i. A separate row for each Mental Health Watch stay (which could show if prisoners had multiple Mental Health Watch stays during the month)
ii. Prisoner first and last name
iii. Prisoner ID number
iv. Date of start of Mental Health Watch
v. Date of end of Mental Health Watch (leave blank if not ended)

4. The total number of prisoners whose Mental Health Watch time lasted, inclusive of consecutive Mental Health Watch time spent in a previous month (noting if there are prisoners that had multiple Mental Health Watches during the month):

i. 24 hours or less - Defined as Cohort 1

ii. 24 - 72 hours - Defined as Cohort 2

iii. 72 hours - 7 days - Defined as Cohort 3

iv. 7 days - 14 days - Defined as Cohort 4

v. Longer than 14 days - Defined as Cohort 5

Self-Injurious Behavior (SIB) Data

5. An attached Excel spreadsheet of all incidents of Self-Injurious Behavior that occurred on Mental Health Watch during the month organized as follows:

i. A separate row for each incident (which could show repeat prisoners if they had multiple incidents during the month)

ii. Prisoner first and last name

iii. Prisoner ID number

iv. Date of incident

v. Time of incident

vi. Type of incident

vii. Type of Watch – Close or Constant when Self-Injurious Behavior occurred

viii. Whether an outside hospital trip occurred as a result of the Self-Injurious Behavior

ix. Whether an outside medical hospital admission occurred as a result of the Self-Injurious Behavior

6. The total number of incidents of Self-Injurious Behavior that occurred on Mental Health Watch:

i. The overall total;

ii. Self-Injurious Behavior incident that occurred on Close Observation Watch versus Constant Observation Watch;

iii. The total broken down by type of Self-Injurious Behavior:

(1) Asphyxiation

(2) Burning

(3) Cutting

(4) Head banging

(5) Ingestion of object

(6) Ingestion of substance

(7) Insertion

(8) Jumping

(9) Non-suspended hanging

(10) Other

(11) Overdose

(12) Scratching

(13) Suspended hanging
iv. The total broken down by Cohort (defined in Paragraph 139(a)(4) above), at the time of the SIB.
Other Mental Health Watch Data
7. Uses of Force on Mental Health Watch: The number of Uses of Force on prisoners on Mental Health Watch separated by facility, whether such use was spontaneous or planned, and whether there was use of OC Spray.
8. Psychiatric hospitalization: The prisoners admitted for inpatient psychiatric level of care, or transferred to outside facility for psychiatric hospitalization
Census Data
9. Census at first of month in each Residential Treatment Unit.
10. Census at first of month in Intensive Stabilization and Observation Unit.
Staffing Data
11. Mental health staffing matrix for each facility by position, showing FTEs budgeted, filled and vacant.

Finding: Substantial compliance

Rationale: MDOC began issuing a Quality Assurance report in March 2023 and has done so monthly since that time. The most recent review of which data to track, as is required annually by Paragraph 139, occurred in March 2024, in conjunction with the DOJ and DQE. At that time, three subsections were removed from the reporting requirement in an effort to eliminate redundancy: 139.a.3, 139.a.5, and 139.a.6.iv.

Some important findings from the Quality Assurance reports between July and December 2024 include:

Number of TS Placements and Length of Stay

Between July and December 2024, there were 627 new TS placements across MDOC, which is a 13% increase over the previous six-month period (556 TS placements) and the second consecutive period of rising TS placements (see *Figure 9)*.

Figure 9. Average Monthly TS Placements

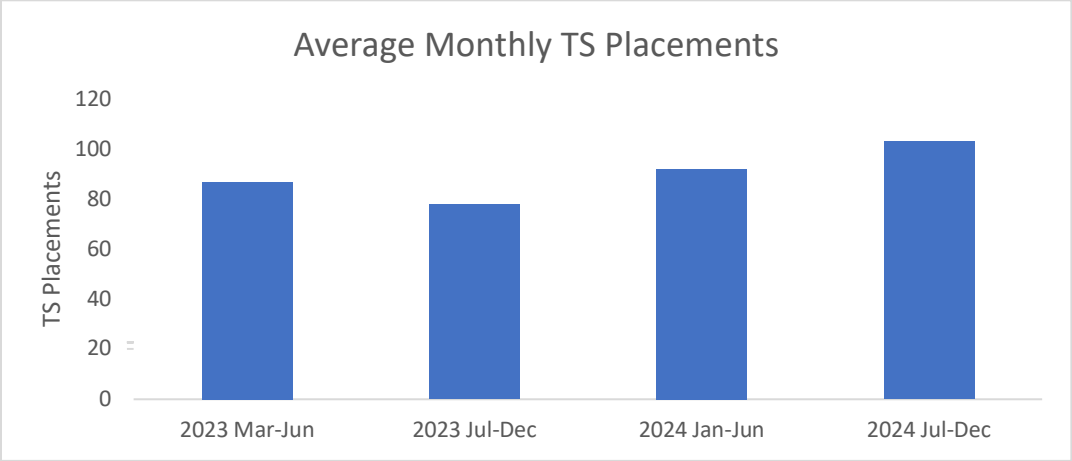
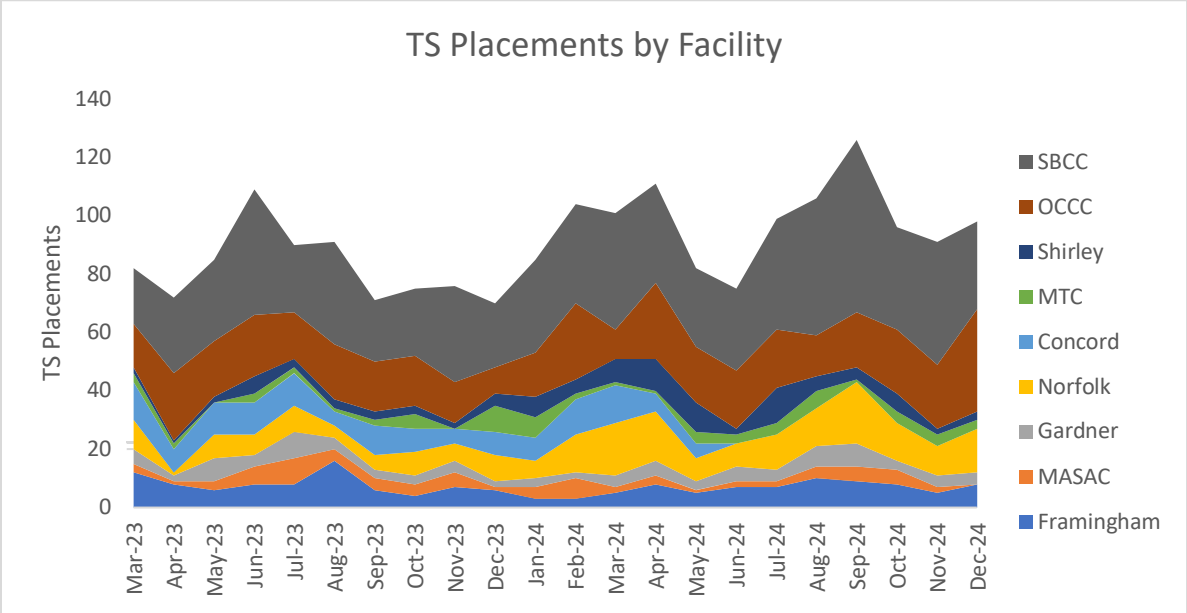


Figure 10 illustrates that the majority of TS placements continue to occur at OCCC and SBCC, which now account for 62% of the total statewide placements. This percentage has risen since the first half of 2024, when these institutions accounted for 55% of the total. Of note, Norfolk has also had a significant increase in TS placements over the course of the Agreement, now accounting for 13% of the total. Anecdotally, there has been a change in the population of Norfolk since Cedar Junction and Concord closed, with staff noting that less stable, lower functioning prisoners are housed there when compared with a few years ago. Similarly, SBCC's status as an intake facility since the closure of Cedar Junction may partly explain its rise in TS placements, as newly admitted prisoners are sometimes less stable than those who have acclimated to the carceral system.

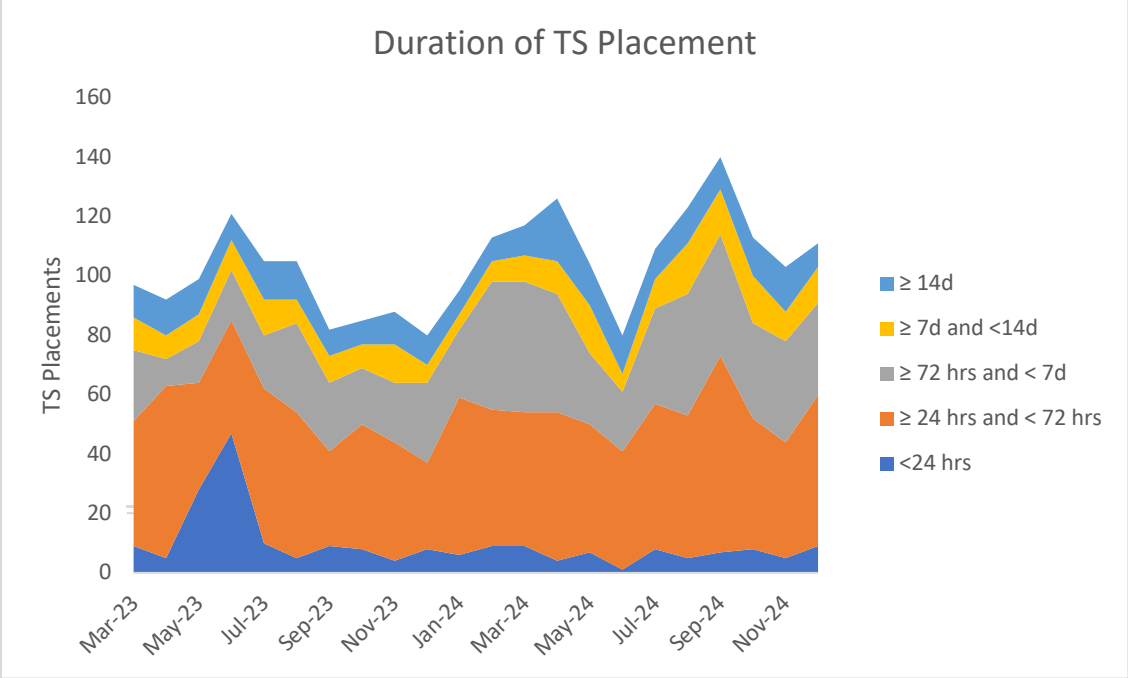
Figure 10. TS Placements by Facility, March 2023-December 2024



Between July and December 2024, the mean length of stay on TS was 4.5 days[111], which is not a significant change from the previous six-month period (4.3 days).

When examining the duration of TS placements, MDOC divides them into five cohorts: <24 hours, 24-72 hours, 72 hours to 7 days, 7 to 14 days, and greater than 14 days. As *Figure 11* illustrates, most TS placements are relatively brief, lasting less than 72 hours.

Figure 11. Duration of TS Placement



The DQE team continued its practice of analyzing whether the overall number of long TS placements has changed since the DOJ's 2019 Findings Letter. When comparing the 2019 data to present day, one must take into account the substantial decrease in MDOC's total population during that time, from approximately 8,700 prisoners in 2019 to approximately 5,800 in Dec 2024. *Table 5* highlights the DQE team's findings.

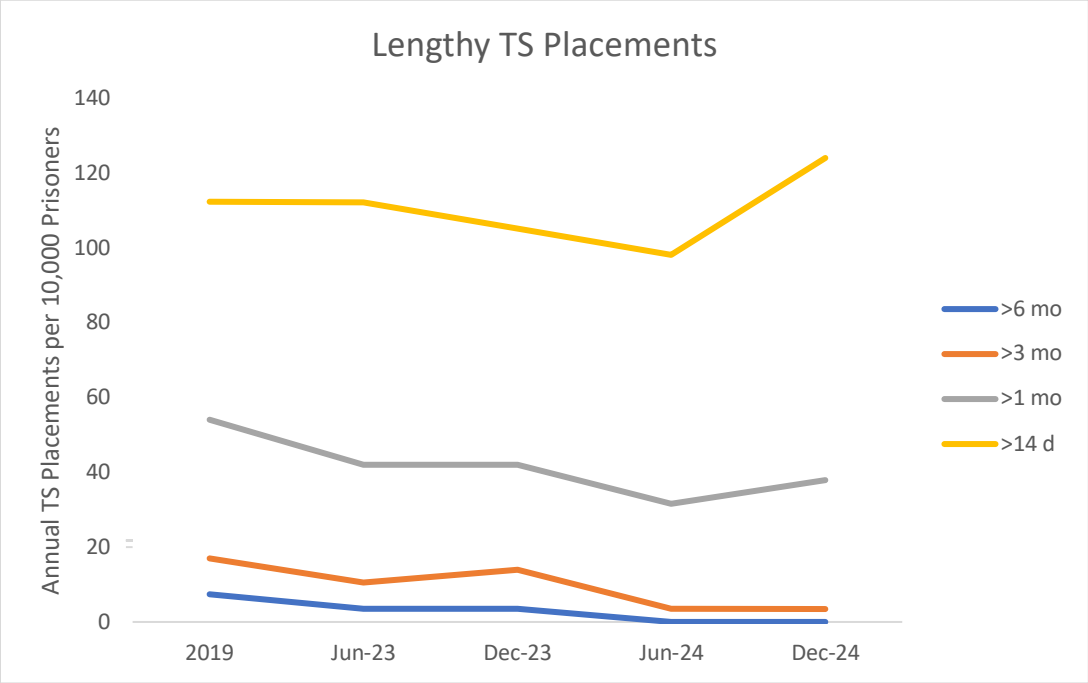
[111] Compiled and calculated from the 627 cases listed in the December 2024 TS Registries (MASAC + Prison Sites).

Table 5. Lengthy TS Placements, 2019 vs. July-Dec 2024

TS duration	Total placements in 13 months	Annual placements per 10,000 prisoners[112]	July-Dec 2024	Annual placements per 10,000 prisoners[113]	
>6 mo	7	7.4	0	0	
>3 mo	16	17.0	1	3.4	
>1 mo	51	54.1	11	37.9	
>14 days	106	112.5	36	124.1	

MDOC has sustained its gains with the longest TS placements (>1 month, >3 months, and >6 months). However, as illustrated in *Figure 11*, the rate of TS placements > 14 days increased during this monitoring period, now exceeding the rates in 2019.

Figure 12. Lengthy TS Placements



Finally, the DQE examined the location where TS placements occur within each facility. Between July and December 2024, the TS registry indicates that 48% of TS placements

[112] Calculated based on 8,700 total prisoners, as noted in the DOJ Findings Letter.
[113] Calculated based on approximately 5,800 total prisoners in MDOC in December 2024.

occurred in the Health Services Unit, as noted in *Table 6*. This represents a continuation of the trend toward conducting TS outside of designated health service units. In December 2023, 74% of TS placements occurred in the HSU, and in June 2024 it was 65%.

As noted in the third DQE report, much of this change can be attributed to OCCC, where only 20% of TS placements occurred in the HSU between July and December 2024. This is a concerning trend, as OCCC has completely reverted to the practices advised against in the DQE's first report, conflating punishment (i.e., placement in the BAU) with treatment for a mental health crisis (i.e., therapeutic supervision).

Table 6. Location of TS Placement within Facility

Unit	Facilities Using Unit for TS	# of TS placements	% of TS placements
Health Services Unit	Framingham, Gardner, Norfolk, OCCC[114], Shirley, SBCC	302	48.2%
Behavior Assessment Unit	SBCC[115], Norfolk, MTC, Shirley, OCCC	239	38.2%
Secure Treatment Unit	SBCC	25	4.0%
Secure Adjustment Unit	SBCC	12	1.9%
Residential Treatment Unit	SBCC	2	0.3%
Intensive Stabilization Unit	OCCC	7	1.1%
Intensive Treatment Unit	Framingham	20	3.2%
Booking	Framingham	1	0.2%
Housing Unit	MASAC	18	2.9%
TOTAL		**626**	**100%**

The trend toward use of the BAU for TS continues, rising sharply from 26% in the first half of 2024 to 38% in the second half. These statistics likely under-count the number of BAU placements since the TS log only lists one location, and patients frequently move from HSU to BAU at SBCC and OCCC. There is no clear reason for the increased use of BAU as a TS placement, but it possibly has to do with facility closures, which have put more strain on existing resources, especially the scarce HSU beds. Another contributing

[114] MDOC's TS Registry lists only one location per TS placement. At some institutions, particularly OCCC and SBCC, prisoners are sometimes moved from HSU to BAU for a portion of their TS placement due to space concerns and medical patients' need for HSU beds, which would not be captured in these data.
[115] A few cases from SBCC were marked "DDU" or "RHU." These were included in the BAU total, as MDOC no longer operates DDU or RHU units.

factor could be MDOC's inspection of TS cells in the summer of 2024, which resulted in many no longer being certified as suicide resistant and temporarily shifting the location of TS placements.

The trend toward increased BAU use for TS is important because prisoners' privileges, restraints, and access to property while on TS in the BAU tend to be restricted beyond what is authorized by mental health, which violates the requirements of Paragraph 56 and its subsections (Paragraphs 57-61).[116] The DQE has raised concerns about these restrictive practices in the past, but they appear to have continued during this reporting period.

Self-Injurious Behavior

This issue is discussed in Paragraph 143, in relation to the SDV-SATT Review Committee.

Use of Force

In accordance with Paragraph 139.a.iii.7, MDOC reports data on uses of force that occur while a prisoner is on TS. MDOC's data indicate that force was used 23 times with prisoners on TS between July and December 2024, which is a substantial decrease from the previous six-month period (39 uses). As noted in the DQE's earlier reports, these data do not include incidents where force was used to gain the prisoner's compliance during the incident precipitating the TS placement, so they likely underestimate the use of force in relation to the TS process.

As illustrated in *Figure 13*, over half of the use of force incidents occurred at SBCC. Use of force across MDOC declined over the past six months, but SBCC's numbers continue to rise, raising concerns about the climate at that institution.

[116] Paragraph 56 states, in relevant part: "The conditions (clothing, showers, lighting, property, privileges, activities, exercise, restraints, and meals) of Mental Health Watch for prisoners in mental health crisis will be based upon their clinical acuity, whether the specific condition has the potential to hurt or help them, and on how long they have been on Mental Health Watch." The unit in which the TS occurs is not listed as a consideration.

Figure 13. Use of Force While on TS

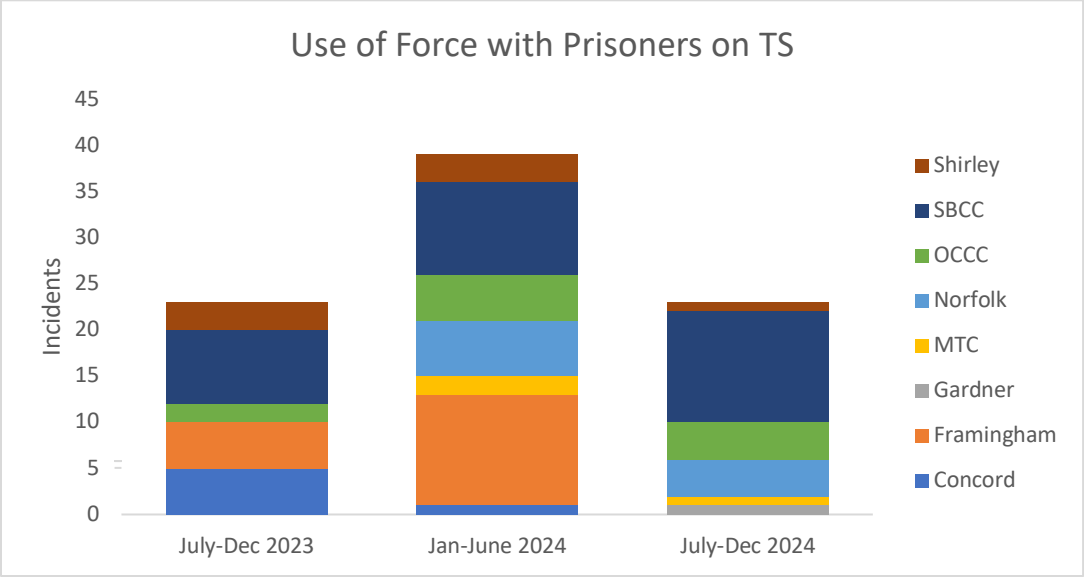
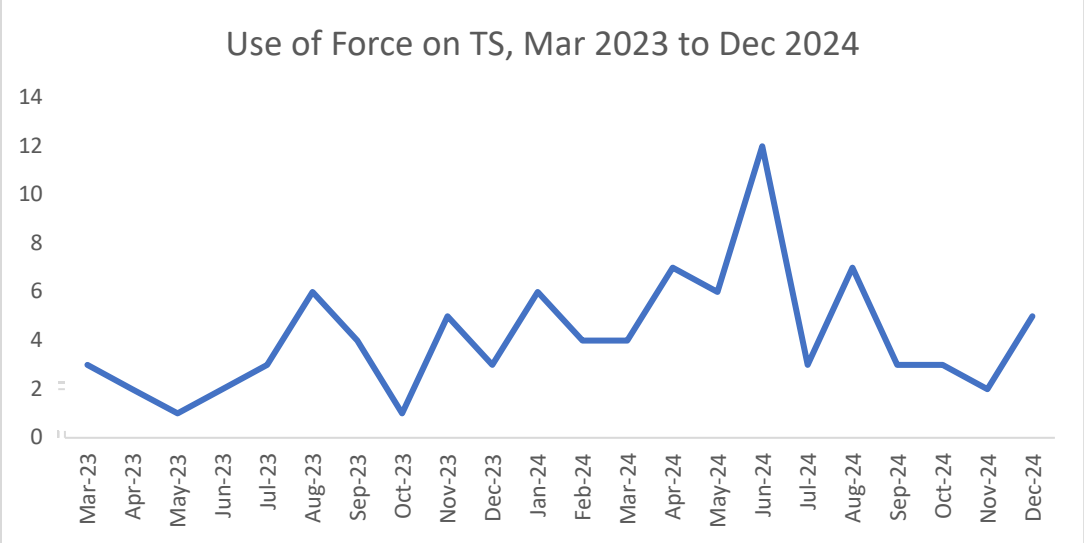


Figure 14 illustrates that, after a peak in June 2024, use of force incidents on TS decreased in the second half of 2024. This is a positive development

Figure 14. Use of Force on TS, March 2023-December 2024



Psychiatric Hospitalizations

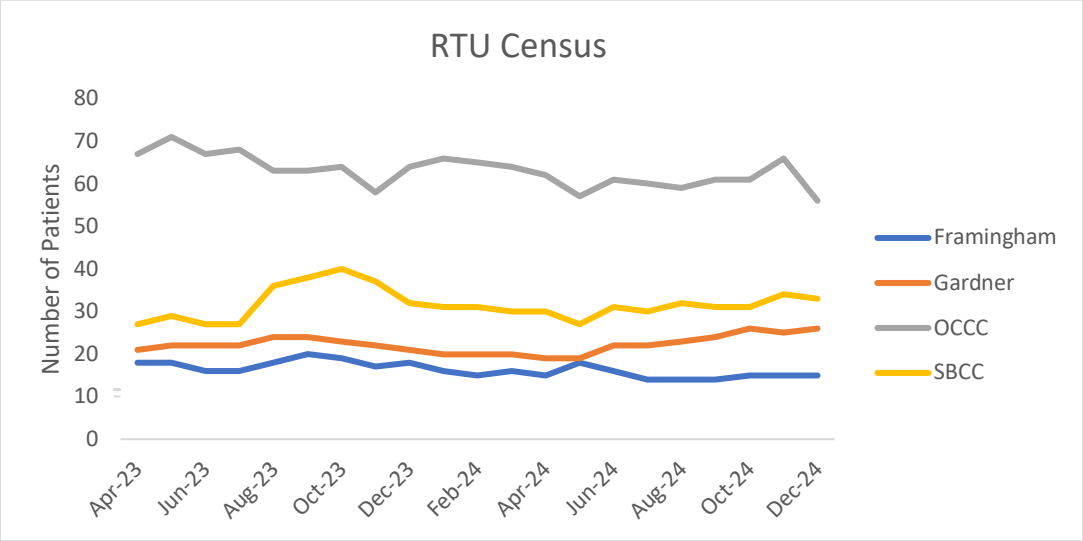
This issue is discussed in detail in Paragraph 77.

RTU Census

There have been no recent changes in the number of RTU beds. MDOC continues to designate a total of 226 RTU beds across four units: 42 at Framingham, 34 at Gardner, 86

at OCCC, and 64 at SBCC. As illustrated in *Figure 15*, the typical census of these units is much lower than capacity, with only about 60% of the beds filled. This has been consistent since the Agreement began.

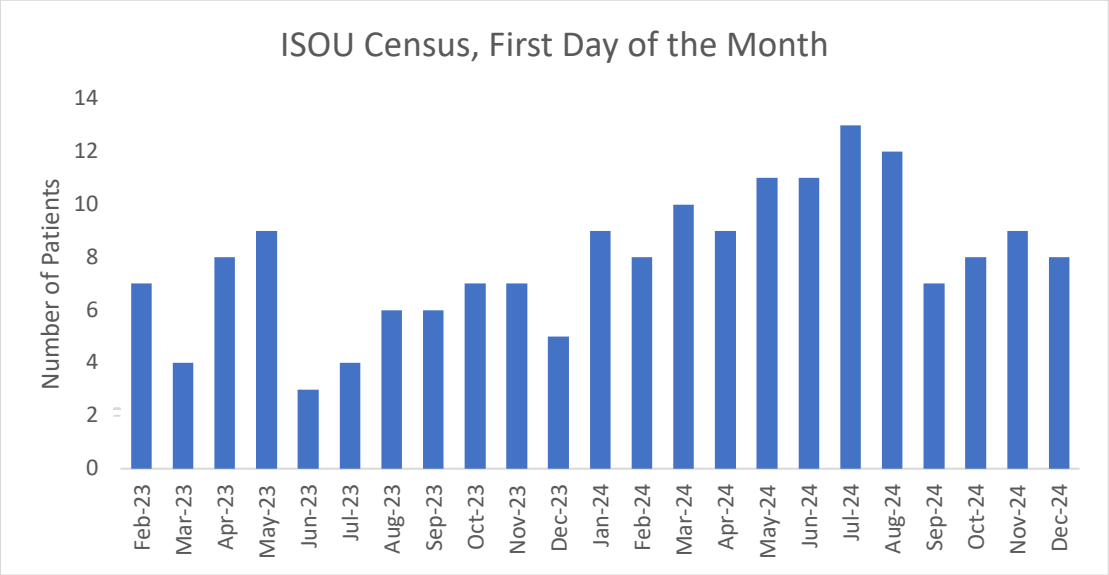
Figure 15. RTU Census, April 2023-December 2024



ISOU Census

The Intensive Stabilization and Observation Unit (ISOU) is the Bridgewater State Hospital unit at OCCC where prisoners are evaluated pursuant to a Section 18(a) or Section 18(a1/2) commitment. The unit's capacity is 50 prisoners. After an upward trend in 2023 and the first half of 2024, the census declined between July and December 2024, as illustrated in *Figure 16*.

Figure 16. ISOU Census



As noted in previous DQE reports, the ISOU remains mostly empty, with less than 20% of its available beds filled on any given day, indicating a mismatch between MDOC's identified patients in crisis (as evidenced by rising TS placements) and the court's criteria for admission to a psychiatric hospital. This is exactly the therapeutic gap that the ISU is intended to fill.

Mental Health Staffing

This issue is discussed in detail in relation to Paragraph 35.

140. Other Mental Health Watch Data Subject to Review by the DQE
a. During any site visits conducted by the DQE, the DQE may conduct reviews of inmates' medical and mental health records, as requested in advance, supplemented with interviews of prisoners, to gather information on the following topics:
1. Clinical contacts on Mental Health Watch
i. visits between prisoner and Qualified Mental Health Professional that occurred out of cell per day,
ii. time spent by prisoner with Qualified Mental Health Professional per day,
2. Property and Privileges approved while on Mental Health Watch
i. clothing,
ii. media unrelated to mental health,
iii. exercise and recreation,
iv. other out of cell activities.

Finding: Substantial compliance

Rationale: MDOC's only obligation under Paragraph 140 is to allow the DQE's assessment of the delineated areas and to provide information as requested. MDOC has remained entirely cooperative with the DQE team, both during site visits and outside of those times. As in previous reporting periods, MDOC's Clinical Operations Analyst has been an exemplary liaison to the DQE team, responding to dozens of requests for clarification and additional data, especially in the weeks before the draft DQE report is due. MDOC's timely submission of monthly data, neatly organized into folders and submitted in user-friendly electronic formats, is another strength worth mentioning here. During this monitoring period, MDOC also facilitated the entire DQE team's access and training on VitalCore's electronic health record, which was also greatly appreciated.

141. Quality Improvement Committee: Within three months of the Effective Date, MDOC will begin to develop and implement a Quality Improvement Committee that will:
a. review and analyze the data collected pursuant to Paragraph 139(a);
b. identify trends and interventions;

c. make recommendations for further investigation of identified trends and for corrective actions, including system changes; and,
d. monitor implementation of approved recommendations and corrective actions.
e. Based on these monthly assessments, MDOC will recommend and implement changes to policies and procedures as needed.
f. All monthly reports will be provided to the DQE and the United States, along with a list of any recommendations and corrective actions identified by the Quality Improvement Committee.

Finding: Substantial compliance

Rationale: The Quality Improvement Committee (QIC) continued to meet monthly during this monitoring period: on July 25, August 29, September 26, October 31, November 26, and December 27, 2024. Minutes indicate that MDOC and VitalCore leaders attended the QIC meetings and collaborated in making recommendations for improvement. The data gathered pursuant to Paragraph 139(a) are routinely reviewed and analyzed in the QIC meetings. Action items, person(s) responsible, and deadlines are tracked in the minutes. Overall, the meetings appear to meet the requirements delineated in Paragraph 141a-e and have not changed significantly since the healthcare vendor transition.

Meeting minutes from July to December 2024 indicate that the QIC continued to track several areas relevant to the Agreement monthly:

- Completion of incident reports related to SDV
- Trends in SDV on TS
- Trends in use of force on TS
- Confidential incident reports regarding staff misconduct
- Status of the Peer Support Program
- Status of the Therapy Dog project
- Status of TS trainings

In addition to these standing agenda items, the QIC discussed other ad hoc items related to the Agreement:

- How to demonstrate MHP discussions of Support Person contacts during shift transitions
- How to document restraint use for off-unit activities in ISU
- Status of officers' TS "observation check sheet"
- Admission delays for female prisoners waiting for DMH hospital beds

- Trends in 18a1/2 requests and admissions

Although the committee's functioning overall is sufficient to warrant a substantial compliance finding, the DQE urges MDOC to add two more standing agenda items to the meeting to ensure their timely completion:

- The status of TS cells' suicide resistance
- Developing a log for prisoners' TS privileges and out-of-cell time

Both of these projects could benefit from monthly review and MDOC leaders' prioritizing their completion.

142. Self-Injurious Behavior (SIB) Review Committee: MDOC will continue to operate a Self-Injurious Behavior Review Committee that will meet twice per month, be led by a member of mental health clinical staff, and include mental health staff, MDOC Health Services Division staff, and related clinical disciplines as appropriate.

Finding: Partial compliance

Rationale: MDOC continues to conduct an SDV/SATT Review Committee meeting twice monthly via Teams. Because MASAC is now run by a different healthcare vendor than the seven prison sites covered under the Agreement, the meetings have been separated into "Prison Sites" and "MASAC." The meeting dates during this monitoring period are listed in *Table 7.*

Table 7. SDV/SATT Committee Meetings

Prison Sites	MASAC
July 10 and 24, 2024	July 25, 2024
August 7 and 21, 2024	
September 4 and 18, 2024	September 4 and 24, 2024
October 2, 16, and 30, 2024	October 18 and 29, 2024
November 20, 2024	November 22, 2024
December 4 and 18, 2024	

The prison sites met the requirement for twice monthly meetings.[117] MASAC did not do as well, skipping its SDV/SATT meetings in early July and early November for unclear

[117] Technically, MDOC did not meet the requirement to conduct two SDV/SATT meetings in November 2024, but since three October meets were held, including one on October 30, the DQE does not find this lapse to be significant.

reasons.[118] Fortunately, the number of SDV incidents at MASAC is small, and the incidents of SDV that occurred during the gap periods were reviewed at the next SDV/SATT meeting. However, since the Agreement mandates two monthly meetings, the DQE cannot issue a substantial compliance finding for the current monitoring period. It is important to note that MDOC's track record with this requirement is historically strong, so the DQE is optimistic about MASAC's ability to get back on track.

The DQE reviewed minutes of all meetings listed in *Table 7*. The meetings were led by VitalCore at the prison sites and by Wellpath Recovery Solutions at MASAC. At the prison sites, attendees included the VitalCore Site Mental Health Directors from each facility, VitalCore Regional Mental Health Directors, VitalCore Regional Psychologist, VitalCore statewide leadership (Psychiatric Medical Director, Program Mental Health Director, Assistant Program Mental Health Director), leadership from MDOC's Health Services Division (Director of Behavioral Health, Clinical Operations Analyst, Mental Health Regional Administrators), and the VitalCore CQI Specialist.

At MASAC, the meetings were much smaller. They were led by Wellpath and attended by clinical staff (Facility Administrator, Clinical Director, Mental Health Director) and DOC Health Services leadership (Director of Behavioral Health, Clinical Operations Analyst, and Mental Health Regional Administrator).

Overall, this structure is unchanged from prior to the healthcare vendor transition and meets the requirements of Paragraph 142. Once MASAC demonstrates its return to twice monthly meetings, a substantial compliance finding is likely.

143. The Self-Injurious Behavior Review Committee will review and discuss the Quality Improvement Committee's data regarding Self-Injurious Behavior, conduct an in-depth analysis of the prisoners who have engaged in the most Self-Injurious Behavior over the past month, and conduct timely and adequate multi-disciplinary reviews for all instances of Self-Injurious Behavior that require an outside hospital trip.

Finding: Partial compliance

Rationale: As noted in Paragraph 142, SDV/SATT Review Committee meetings usually occur twice a month for up to 90 minutes, and each SDV incident over the preceding two weeks is discussed in detail by a multi-disciplinary group, not just those incidents that require an outside hospital trip. Based on the meeting minutes, MDOC does pay attention to breaches in protocol that could have contributed to the SDV, such as

[118] There were no December 2024 meetings because no SDV occurred at MASAC during the periods that would have been reviewed.

prisoners having access to dangerous items while on TS. When such problems are identified, they are flagged for follow-up by the Mental Health Regional Administrator and the facility.

The third DQE Report noted that MDOC was not compliant with Paragraph 143 because the SDV/SATT meeting minutes did not consistently document the committee's review of SDV data from the monthly Quality Assurance reports. The minutes from the prison sites' SDV/SATT meetings now clearly indicate that the data were reviewed, usually during the first meeting of the month. The minutes from MASAC's meetings contain no notation that the data were reviewed.

Paragraph 143 also requires that the SDV/SATT Committee conduct an "in-depth analysis of prisoners who have engaged in the most Self-Injurious Behavior over the past month." From the minutes, it appears that there is no distinct part of the SDV/SATT meeting that highlights these individuals; they undergo the same review and analysis as every other incident of SDV. However, the QIC meeting includes a review of SDV data, and minutes from those meetings indicate that the "outlier" patients (i.e., those who engage in so many episodes of SDV that they skew the overall monthly statistics) are discussed. The QIC meeting minutes do not contain anything that could be construed as an "in-depth analysis" of the patients—for example, discussing what drives the behavior or what strategies have been tried to curb it. However, it is important to note that membership of the SDV/SATT, QIC, and Daily TS Consultation meetings overlaps considerably, so the attendees are likely familiar with patients who repeatedly engage in SDV from discussing them in multiple settings. Although this system may not meet the exact requirements of the Agreement, it seems to fulfill the intent that MDOC's behavioral health leaders review high-risk and high-treatment-utilizing patients regularly.

MDOC's tracking of SDV data indicates that SDV incidents decreased substantially since the first half of 2024, with 300 total incidents (compared with 461 between January and June 2024). The change in rates of SDV over time are illustrated in *Figure 17.* After a major spike in the first half of 2024, SDV rates are once again below 2019 levels, both on and off TS. This is a positive development, indicating that the spike in early 2024 may have been an outlier rather than a trend.

Figure 17. SDV Rates Over Time

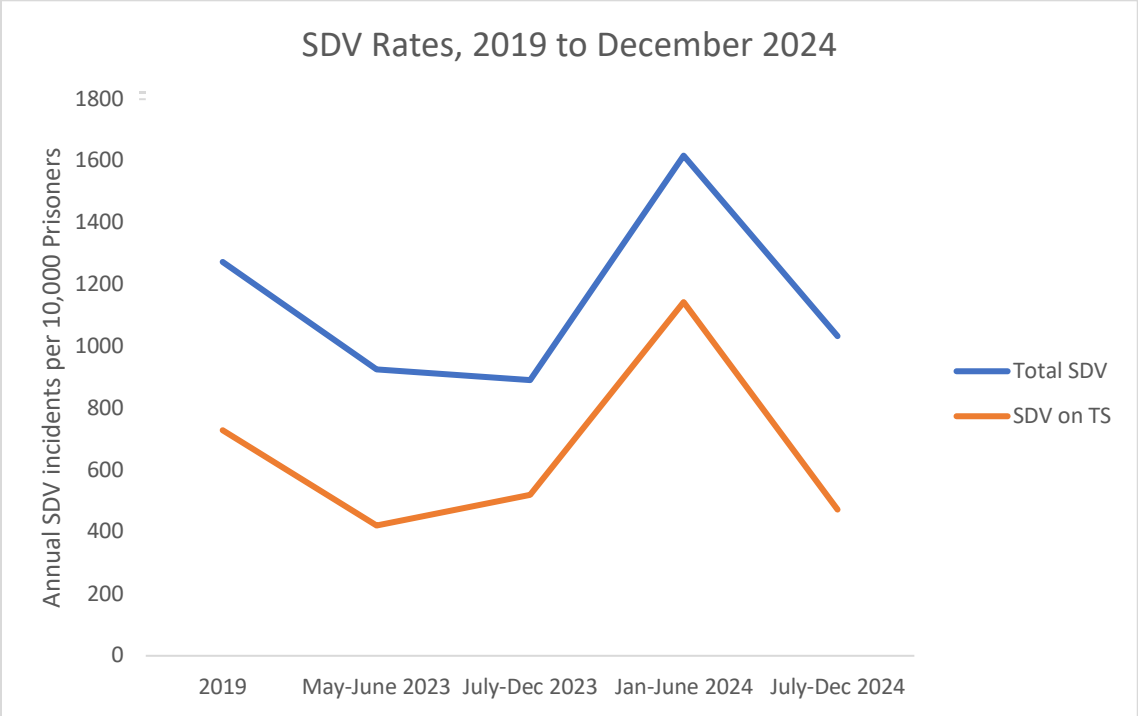


Table 8 shows the percent change in SDV rates between 2019 and the latter half of 2024.

Table 8. Rates of SDV, 2019 vs. July-Dec 2024

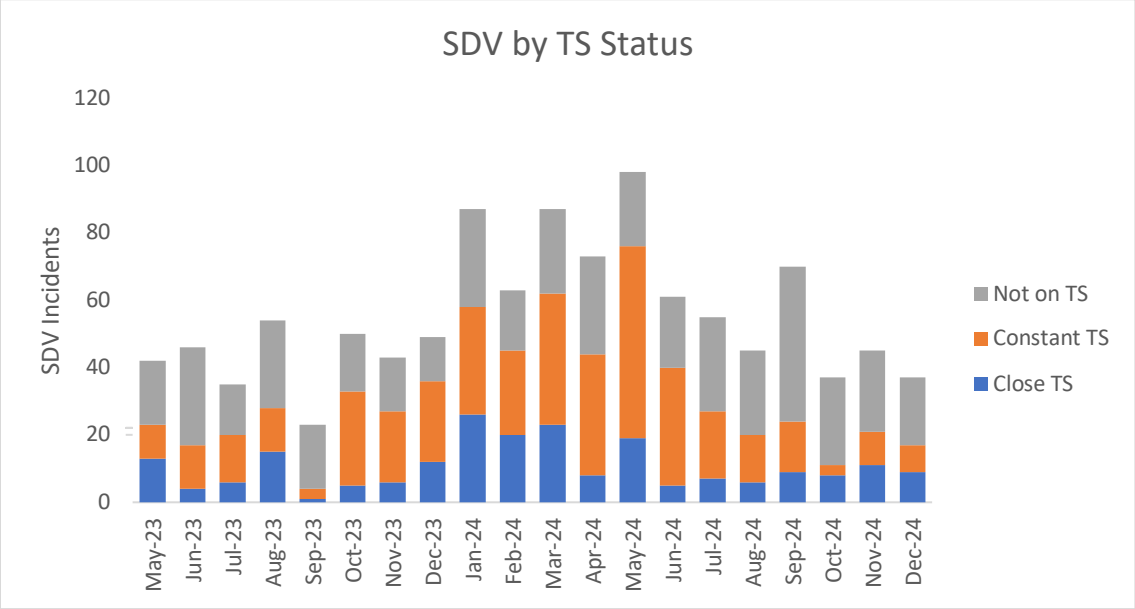
	2019		December 2024		
	SDV incidents in 13 months	Annual incidents per 10,000 prisoners[119]	SDV incidents in July-Dec 2024	Annual incidents per 10,000 prisoners [120]	**% Change since 2019**
Total SDV	1200	1273	300	1034	**-18.8%**
SDV while on TS	688	730	137	472	**-35.3%**
Cutting while on TS	217	230	19	66	**-71.5%**
Hanging while on TS	77	82	11	38	**-53.5%**

[119] Calculated based on 8,700 total prisoners, as noted in the DOJ Findings Letter.
[120] Calculated based on approximately 5,800 total prisoners in MDOC in December 2024

Insertion of foreign bodies while on TS	85	90	22	76	
Ingestion of foreign bodies while on TS	34	36	7	24	
Asphyxiation while on TS	17	18	2	7	

Figure 18 shows that, between July and December 2024, 137 of the 300 SDV incidents in MDOC occurred while a prisoner was on TS (45.7%). This is a substantial decrease from the previous six-month period, when 70.7% of the SDV incidents occurred on TS. The decrease is likely explained by three outlier patients, who were not as actively self-injurious or were at outside hospitals during the latter half of 2024.

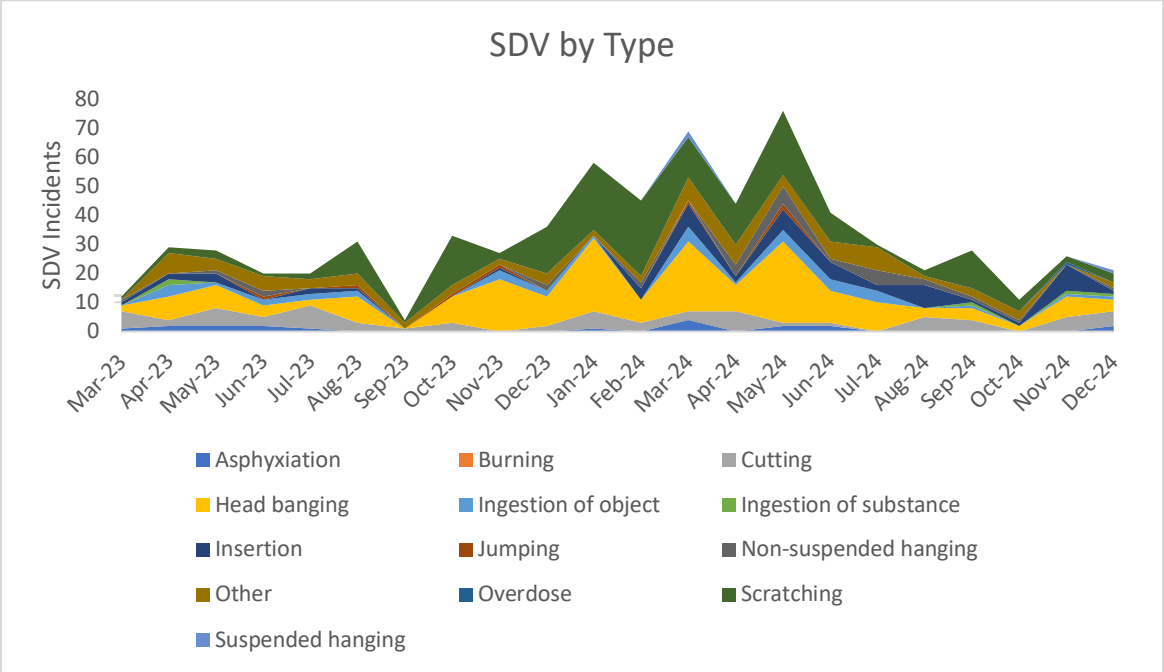
Figure 18. SDV by TS Status, May 2023-December 2024



Head-banging and scratching still accounted for the greatest proportion of SDV, as illustrated in *Figure 19,* but the relative increase in insertion of objects and cutting is concerning. This may indicate a lapse in search procedures prior to placing patients on TS (searches of the cell and/or of the patient).[121]

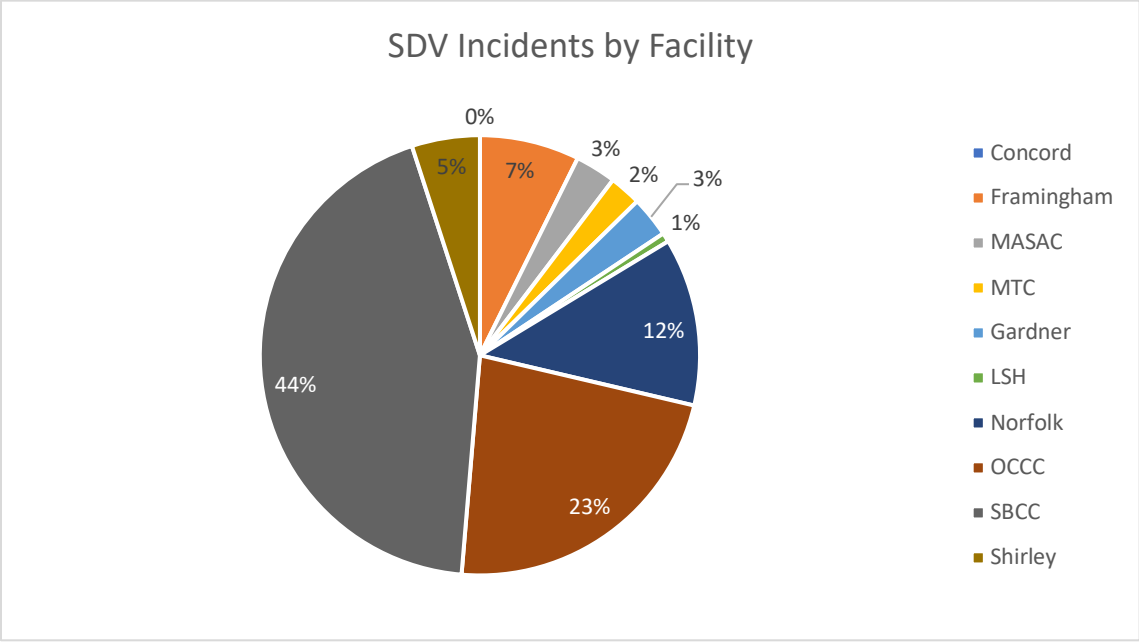
[121] See Paragraph 144 for further discussion of this issue.

Figure 19. Type of SDV while on TS, March 2023-December 2024



The total incidents of self-injury (not just those that occurred on TS) were divided across MDOC facilities as illustrated in *Figure 20.* SBCC now accounts for an astounding 44% of all SDV incidents in MDOC, up from 27% in the first half of 2024. Norfolk's share of SDV incidents continues to rise, and Framingham's decreased substantially, likely because one outlier patient was hospitalized outside of MDOC for a few months.

Figure 20. SDV Incidents by Facility, July-December 2024



144. The minutes of these reviews will be provided to all treating staff and senior MDOC staff. MDOC will take action to correct any systemic problems identified during these reviews.

Finding: Partial compliance

Rationale: In its December 2024 status report, MDOC reported, "Healthcare Vendors have identified intent to share their SDV meeting minutes via e-mail with their treating staff." In reviewing the triage meeting notes from all eight facilities in December 2024, only OCCC's minutes contained a notation that the SDV data were reviewed. MDOC does routinely share the SDV/SATT Meeting minutes with senior MDOC staff, as required by Paragraph 144, by virtue of reviewing the previous meeting's minutes at the start of each SDV/SATT meeting.

The other mandate of Paragraph 144, taking corrective action around systemic problems identified during the SDV/SATT meetings, is a work in progress. MDOC has a system in place for the Regional Mental Health Administrator to follow up with a facility's leadership when a problem is identified during the SDV/SATT meetings, and meeting minutes indicate that these facility-based discussions are occurring. For example, in August 2024, after patients at SBCC had climbed up the basketball hoop and threatened self-injury (more than once), SBCC replaced the existing basketball hoops with a different style of hoop/net.

On the other hand, patients having access to contraband items on TS remained a problem throughout this monitoring period despite MDOC's behavioral health leadership making the facility's security leadership aware of the issues. Minutes from the SDV/SATT meetings indicate that patients at SBCC used plastic utensils, pieces of metal, or hoarded medications to injure themselves while on TS on July 10, August 5, August 6, September 24, October 19, November 2, November 5, November 6 (two different patients), November 13, and November 25, 2024. Norfolk had similar challenges with contraband access on TS, with patients using contraband items to injure themselves on September 2, November 8, November 28, December 9, and December 10, 2024. Although motivated patients can often find ways to self-injure despite staff's efforts to keep them safe, there is no indication of what action MDOC took for example, to retrain security or kitchen staff about prohibiting access to plastic utensils while patients are on TS. Demonstration of this type of corrective action will be necessary for MDOC to achieve substantial compliance with the requirements of Paragraph 144.

145. Morbidity-Mortality Reviews: MDOC will conduct timely and adequate multidisciplinary morbidity-mortality reviews for all prisoner deaths by suicide and all serious suicide attempts (i.e., suicide attempts requiring medical hospital admission).

Finding: Partial compliance

Rationale: Five serious suicide attempts occurred between July and December 2024, and MDOC conducted morbidity reviews as indicated in *Table 10.*

Table 9. MDOC Morbidity Reviews, July-December 2024

Incident Date	Morbidity Review Meeting Date	Days Elapsed
July 28, 2024	August 23, 2024	26
July 31, 2024	August 23, 2024	23
August 7, 2024	September 6, 2024	30
August 17, 2024	September 27, 2024	41
August 29, 2024	October 3, 2024	31[122]

Looking back on two years of data, MDOC has had 13 serious suicide attempts and one completed suicide (as of December 31, 2024). Of these 14 incidents, a morbidity or mortality review was completed within 30 days for 10 cases (71%).

Since the Agreement's inception, two documents related to MDOC's morbidity review process have been shared with the DQE following each serious suicide attempt or death by suicide: (1) a memo titled "Scheduled Morbidity Review" containing a clinical case summary written by an MDOC regional mental health administrator in advance of the review committee's meeting, and (2) a memo containing the meeting attendance and the review committee's recommendations.

Although it was initially difficult for the DQE to assess the adequacy of MDOC's morbidity and mortality reviews from these documents, in more recent cases, it has been easier to see how the committee's recommendations stemmed from the case circumstances. As a result, the DQE has growing confidence in the adequacy of MDOC's review process.

For the five incidents occurring between July and December 2024, the Morbidity Review Committee made the recommendations contained in *Table 10.*

[122] MDOC was notified by Vitalcore on September 3, 2024, that the incident on August 29 was a suicide attempt. The mortality review was therefore 31 days after MDOC learned of the suicide attempt.

Table 10. Morbidity Review Committee Recommendations

Incident Date	Morbidity Review Recommendations
July 28, 2024	1) Superintendent will send a memo to Shift Commanders to remind them to: a) Ensure an Incident Report confirming an incarcerated individual has been assessed by both medical and mental health for the Behavior Assessment Unit (BAU) is submitted by the end of their shift. b) Speak directly with the charge nurse about the housing plan for an incarcerated individual to determine if a BAU medical/mental health assessment is needed. 2) Superintendent will ensure the Shift Commanders receive training on the expectation of reviewing reports and what actionable items require follow-up. An attestation of training will be completed to confirm training was held.
July 31, 2024	Superintendent will send a memo to Shift Commanders to remind them to: a) Ensure an Incident Report confirming an incarcerated individual has been assessed by both medical and mental health for the Behavior Assessment Unit (BAU) is submitted by the end of their shift. b) Speak directly with the charge nurse about the housing plan for an incarcerated individual to determine if a BAU medical/mental health assessment is needed. c) Ensure an incarcerated individual is on 1:1 observation status if in crisis and awaiting assessment from mental health.
August 7, 2024	When a qualified mental health professional (QMHP) needs to leave an incarcerated individual (II) to triage a clinical contact and is considering whether to initiate therapeutic supervision, the QMHP shall advise a correctional officer that the II is on “at risk status” and to maintain constant visual observation of the II until otherwise instructed by a QMHP. .
August 17, 2024	The contracted healthcare vendor shall review with all qualified mental health professionals the requirement that therapeutic supervision follow-up contacts occur after the incarcerated individual has transitioned to their housing unit from the unit where their therapeutic supervision (TS) was held. When the

	incarcerated individual resides in the unit wherein the TS was held, the TS follow-up shall occur after the incarcerated individual has returned to their housing cell. When an incarcerated individual attempts suicide and a precipitant appears to be housing-related stressors or concerns, the discontinuation plan will include a documented housing plan and document the discussion with DOC staff regarding the housing plan for the incarcerated individual.
August 29, 2024	The Assistant Statewide Mental Health Director for VitalCore reported that the Mental Health Director of Training has provided site-level training regarding documentation, including risk assessment formulation and documenting the rationale for clinical decision-making. Additionally, a portion of the annual mental health training for all qualified mental health professionals will be dedicated to reviewing risk assessment formulation and comprehensively documenting clinical decision-making regarding suicide risk assessment. The Department applauds these efforts and recommends the vendor consider adding, if it has not already done so, including suicidality as a direct target of treatment planning when clinically indicated. The discussion surrounding these issues recognized the importance of supporting newer clinicians in developing these skills.

From reading the case histories alongside the committee's recommendations, the DQE can see that significant deviations from established policy or protocol occurred in each of these suicide attempts—both security and mental health—and it is encouraging that MDOC has recommended corrective action. It is noteworthy that many of the problems the Morbidity Review Committee found in these cases are similar to those documented by the DQE team over the past two years. For example, the committee's review of the suicide attempt that occurred at SBCC on August 29, 2024, takes issue with the superficiality, brevity, and nonconfidentiality of mental health contacts and risk assessments, stating:

> Overall, from January 22, 2024, until his suicide attempt, [the patient] had 8 PCC contacts for a total of 89 minutes. [He] was evaluated by self-referred crisis referral six times between January 22, 2024 and August 29, 2024. During most of these contacts, [the patient] was evaluated in a nonconfidential setting and discussed his concerns related to housing and classification. In total, these

contacts lasted twenty-two (22) minutes. Given the likely connection between [the patient]'s suicide risk and his concerns related to housing and the breadth of risk and protective factors one needs to assess in developing an appropriate risk formulation, these contacts lasting an average of three minutes and forty seconds each were insufficient to do so.

If MDOC can improve its timeliness of reviews, continue to make meaningful recommendations for systemic change (as it has done throughout this monitoring period), and demonstrate adequate follow-through on these recommendations, substantial compliance with the requirements of Paragraph 145 can be achieved.

146. The Morbidity and Mortality Review Committee will include one or more members of MDOC Health Services Division staff, the medical department, the mental health department, and related clinical disciplines as appropriate. The Morbidity and Mortality Review Committee will:

a. ensure the following are completed, consistent with National Commission of Correctional Health Care standards, for all prisoner deaths by suicide and serious suicide attempts:

1. a clinical mortality/morbidity review (an assessment of the clinical care provided and the circumstances leading up to the death or serious suicide attempt) is conducted within 30 days;
2. an administrative review (an assessment of the correctional and emergency response actions surrounding a prisoner's death or serious suicide attempt) is conducted in conjunction with correctional staff;
3. a psychological autopsy (a written reconstruction of an individual's life with an emphasis on factors that led up to and may have contributed to the death or serious suicide attempt) is performed on all deaths by suicide or serious suicide attempts within 30 days;
4. treating staff are informed of the recommendations formulated in all reviews;
5. a log is maintained that includes:
    i. prisoner name or identification number;
    ii. age at time of death or serious suicide attempt;
    iii. date of death or serious suicide attempt;
    iv. date of clinical mortality review;
    v. date of administrative review;
    vi. cause of death (e.g., hanging, respiratory failure) or type of serious suicide attempt (e.g., hanging, overdose);
    vii. manner of death, if applicable (e.g., natural, suicide, homicide, accident);
    viii. date recommendations formulated in review(s) shared with staff; and
    ix. date of psychological autopsy, if applicable.

b. recommend changes to medical, mental health and security policies and procedures and ensure MDOC takes action to address systemic problems if identified during the reviews;

c. develop a written plan, with a timetable, for corrective actions; and

d. ensure a final mortality review report is completed within 60 days of a suicide or serious

Finding: Partial compliance

Rationale: As noted in previous DQE reports, MDOC has a process in place to review completed suicides and serious suicide attempts, but this process does not meet all the requirements of Paragraph 146. Nothing has changed in the most recent monitoring period. In order to achieve substantial compliance, MDOC must improve its current review procedure by:

1. Ensuring that all three parts of the NCCHC's schema for morbidity/mortality reviews are completed within 30 days of the sentinel event: Administrative Review, Clinical Review, and Psychological Autopsy.
2. Completing a written corrective action plan, with a timetable and persons responsible for carrying it out.
3. Demonstrating that changes recommended by the committee have actually occurred.
4. Completing a final mortality review report within 60 days of the sentinel event (typically this is done after the review meeting).
5. Providing documentation to the DQE that the committee's recommendations have been shared with the facility's staff.
6. Providing documentation to the DQE of the log kept by MDOC consistent with Paragraph 146.a.5.

147. Reportable incidents: Within 24 hours, MDOC will notify the United States and the DQE of suicides and all serious suicide attempts (i.e., suicide attempts requiring medical hospital admission). The notification will include the following information:
a. Incident report, name, housing unit location, brief summary or description, mental health classification, security classification, date of birth, date of incarceration, and date of incident.

Finding: Partial compliance

Rationale: Five reportable incidents occurred between July 1 and December 31, 2024. The DQE was notified within 24 hours of the serious suicide attempt in three of the five cases, as noted in *Table 11*.

Table 11. Notification of Reportable Incidents

Date of incident	Date of DQE/DOJ notification	Days to notification
July 28, 2024	July 29, 2024	1
July 31, 2024	August 3, 2024	4
August 7, 2024	August 8, 2024	1
August 29, 2024	September 3, 2024	5
December 23, 2024	December 23, 2024	0

In the two cases where notification did not occur within 24 hours of the self-injury, the DQE reviewed records to determine when the patient returned to MDOC from an outside hospital and therefore could have been interviewed by mental health professionals about whether there was suicidal intent behind the self-injury. For the incident on July 31, 2024, it appears that the healthcare vendor notified MDOC of the suicide attempt on August 1, but it took an additional two days to notify the DQE and DOJ. For the incident on August 29, 2024, the patient was at an outside hospital until September 2. The following morning, after mental health staff evaluated him, they informed MDOC leadership of the suicide attempt, and the DQE was notified within a few hours.

Interpreting the Paragraph 147 requirements generously and acknowledging that the language ("within 24 hours") does not specify whether it means within 24 hours of the medical admission or 24 hours of determining that an episode was a suicide attempt, MDOC's notification was timely in four of the five cases. For the incident on July 31, 2024, there is no clear reason for the delayed notification. Once again, a partial compliance finding seems most appropriate.

Also, although these incidents are not reportable under the terms of Paragraph 147, the DQE learned of episodes of non-suicidal self-injury that were serious enough to require hospital admission between July and December 2024:

- September 2024: a patient in the ISU ingested staples and paperclips, necessitating a five-day hospitalization
- September 2024: a patient at SBCC swallowed two razor blades and ran head-first into a wall, necessitating a three-day hospitalization
- October 2024: a patient at OCCC inserted the stem of his eyeglasses into his abdomen, requiring surgery and a six-day hospital admission
- November 2024: a patient at Norfolk inserted pieces of glass and metal into body orifices on two occasions, each time requiring hospitalization and invasive procedures to remove the items

These episodes of self-injury are obviously concerning, even if they did not meet the technical definition of a suicide attempt that triggers DQE/DOJ notification.

OTHER

159. MDOC will provide to the DQE and the United States a confidential, bi-annual Status Report detailing progress at MDOC, until the Agreement is terminated, the first of which will be submitted within 180 days of the Effective Date. Status Reports will make specific reference to the Agreement's substantive provisions being implemented. The Status Reports will include action steps, responsible persons, due dates, current status, description of (as appropriate) where pertinent information is located (e.g., DAP note, meeting minutes, Mental Health Watch sheet, etc.), DQE recommendations, and date complete. Subsequent Status Reports will be submitted one month before the DQE's draft report. MDOC, however, retains the discretion to achieve compliance with the Agreement by any legal means available to it and may choose to utilize methods other than those identified or recommended in any reports.

Finding: Substantial compliance

Rationale: By agreement of the parties, MDOC's bi-annual status reports are due on June 20 and December 20 of each year. MDOC submitted its most recent status report on December 20, 2024. Since June 2024, the format of the status report has contained all the elements required by Paragraph 159, including action steps, responsible persons for each provision, due dates, current status, description of where pertinent information is located, DQE recommendations, and date completed. While the document contains a "current status" section that is sufficient for substantial compliance, the DQE once again encourages MDOC to provide evidence or data to support its conclusions. For each section, a statement is needed about the extent to which MDOC is compliant, along with the reasons for those conclusions (e.g., what documents were checked, who were the sources of the information (types of staff or professional roles, not names), was there an audit, etc.).

169. Within 30 days of the Effective Date, MDOC will designate an Agreement Coordinator to coordinate compliance with this Agreement and to serve as a point of contact for the Parties and the DQE.

Finding: Substantial compliance

Rationale: MDOC continues to employ an excellent Clinical Operations Analyst who serves as the Agreement Coordinator. As noted in previous reports, the goal is for MDOC eventually to perform internal audits similar to those the DQE team has been

conducting, in an effort to develop self-auditing practices that will be sustained after the Agreement's formal termination.

170. Within six months of the Effective Date, MDOC will conduct regular quarterly meetings with prison staff to gather feedback from staff on events, accomplishments, and setbacks regarding implementation of this Agreement during the previous quarter.

Finding: Substantial compliance

Rationale: The DQE reviewed the minutes from MDOC's "Quarterly DOJ Implementation" meetings that occurred on September 9 and December 9, 2024. These meetings were attended by MDOC's behavioral health leadership, the Clinical Operations Analyst, and the Superintendent and Deputy Superintendent of Reentry from each facility where TS occurs.[123]

Meeting minutes indicate that some aspects of Agreement implementation were discussed, including:

- Progress with using cell safety checklists and officers' observation sheets for TS
- Reviewing the initial months of the ISU's functioning (e.g., referrals and staff collaboration)
- Plans for out-of-cell meals on TS

It is also apparent from the minutes that the Director of Behavioral Health and Clinical Operations Analyst solicited feedback from facility leaders about other implementation challenges, such as security understaffing making it difficult in the past to rotate officers every two hours for constant TS observation. Responses to these inquiries were limited, with seemingly little engagement on the part of facility leaders.

Overall, the DQE is pleased that the meetings are occurring regularly and that they are attended by leadership from each facility. The seeming lack of engagement by meeting participants may simply be a matter of documentation style, so the DQE may wish to use alternate methods, such as observing a meeting, to assess the area further in the next monitoring period. For now, MDOC's demonstration is sufficient for a continued finding of substantial compliance.

[123] In previous communication with MDOC's leadership, they reported that "prison staff" as described in Paragraph 170 was interpreted as the leadership, not the line staff, from each facility.

RECOMMENDATIONS

The following recommendations stem from the information in the *Detailed Findings* section of this report. As always, the DQE appreciates that some recommendations can be accomplished in the next six-month reporting period, while others will take much longer to implement fully.

POLICIES AND PROCEDURES

1. Continue submitting revisions of DOC policies to the DQE and DOJ. Although this is in progress, the pace is far behind that outlined in the Agreement.

2. Gather VitalCore's policies relevant to the Agreement and submit them to the DQE and DOJ for review.

3. Formalize in policy the current practice of issuing "misuse of crisis" disciplinary reports only when initiated or approved by mental health staff and in cases of blatant misuse.

4. Develop and implement policies for Support Persons that specify the tools/supplies they may utilize and activities they may engage in with prisoners on TS.

5. Clarify and consolidate policies around the use of BOSS chairs and body scanners prior to placing a prisoner on TS. These protocols currently exist but are spread across five different policy/procedure documents.

6. Clarify policy and procedures around notifying mental health staff in the event of SDV, including in Code 99 procedures.

STAFFING PLAN

7. Continue all efforts to improve mental health and security staffing levels throughout MDOC, focusing on retention of mental health staff in addition to recruitment.

8. Increase the number of contracted psychiatrists/APRNs at high-acuity and high-volume sites such as OCCC, SBCC, and Norfolk.

9. Continue recruiting and onboarding mental health staff for the ISU so that understaffing does not limit the number of patients who can be admitted or the nature of treatment provided in that setting.

10. Continue hiring Support Persons across facilities where TS occurs, especially the part-time or per diem staff needed to cover Saturday shifts.

TRAINING

11. Provide documentation of training completion in the following areas:
    - Security staff's CPR and suicide prevention training during NEO
    - VitalCore staff's annual completion of suicide prevention training, and
    - MASAC staff's completion of TS training

12. Once policies have been finalized and approved by the DOJ, incorporate training about the new policies into pre-service and in-service trainings.

13. Continue with plans to distribute Therapeutic Supervision posters to sites and post them in areas where TS occurs.

14. Continue efforts to train the healthcare vendor's clinicians, particularly those who have recently completed a degree program and are not yet independently licensed, on diagnosis, treatment planning, risk assessment, and documentation.

15. When revising pre-service and annual in-service training, enhance content in areas where the DQE team has repeatedly found confusion or variable practices across institutions, including:

    a. Contacting mental health without delay for prisoners who request crisis contacts, regardless of whether the individual expresses suicidal ideation
    b. Conducting adequate BAU risk assessments, recognizing that BAU housing is a major risk factor for suicide and self-injury even if the contacts are not traditional "crisis calls"
    c. Individualized decisions about whether to restrain a prisoner during crisis evaluations, out-of-cell contacts on TS, and related escorts
    d. Lighting protocols for prisoners on close and constant watch in TS cells
    e. Clothing being removed only if used for self-harm

THERAPEUTIC RESPONSE TO PRISONERS IN MENTAL HEALTH CRISIS

16. Continue with physical plant modifications and/or space reallocations to allow for adequate assessment and treatment of patients in crisis and/or on therapeutic supervision:
    a. Identify or create a group space for TS/ITU patients at Framingham.
    b. Consider moving Gardner's crisis assessment room to an area with more privacy from other prisoners.

c. Provide adequate treatment and assessment space at SBCC on the housing units, beginning with implementing a schedule for use of existing spaces (e.g., times of day for use by medical, mental health, Spectrum, and security staff)

17. Clarify policy and practice around requesting urgent (i.e., within the same day) and emergent (i.e., within one hour) evaluation of prisoners by the mental health staff. Currently, staff at some institutions are making these distinctions without clear guidance.

18. Minimize practices that deter prisoners from requesting crisis mental health services, including routine shackling during mental health assessments, conducting assessments in areas without adequate sight/sound confidentiality, and locking down units while a prisoner is waiting for mental health assessment. Staff at SBCC, MTC, OCCC, and Gardner continue to report challenges in conducting confidential assessments and treatment.

19. Provide contemporaneous access to the electronic health record to MHPs when conducting crisis assessments and TS therapeutic contacts. Ensure that MHPs are reviewing historical risk factors for suicide, clinical symptoms, and medication compliance in the electronic health record when conducting crisis assessments and creating TS treatment plans.

20. Ensure that clinicians are making appropriate referrals to psychiatry at the time of a prisoner's crisis assessment, while on TS, and prior to discharge from TS. If clinicians continue to struggle with recognizing clinical circumstances warranting such referrals, MDOC can consider implementing more structured protocols, such as requiring referrals after an individual engages in SDV, after a use of force, on Day 3 of TS placement if not seen earlier, or before discharge to high-risk settings like the BAU.

21. Integrate upper-level providers (psychiatry and psychology) more meaningfully into the treatment of patients on TS, including seeing patients sooner in the TS placement, helping to develop treatment plans, and assessing patients prior to discharge.

22. Continue making necessary physical plant modifications and policy changes to dim the lights in TS cells during sleeping hours.

23. Continue investigating the feasibility of therapy dogs and peer mentors working with TS patients at all facilities.

24. Implement a system to document offered and accepted recreation, showers, visits, and phone calls for prisoners on TS.

25. Ensure that TS follow-up contacts are being conducted in confidential settings and that the first follow-up contacts occur after patients return to their housing units

26. Ensure that treatment plan updates after a TS placement acknowledge that this event occurred and take it into account when revising a patient's goals and objectives.

SUPERVISION OF PRISONERS IN MENTAL HEALTH CRISIS

27. Ensure that security officers are consistently using a cell safety checklist to search TS cells and prisoners for potential hazards prior to initiating TS and, as needed, during TS.

28. Conduct individualized assessments of prisoners' risk with clothing and remove clothing only in cases where a prisoner has demonstrated that they will use clothing in a self-destructive manner.

29. Continue revising policy and practice so that individualized assessments of prisoners' need to be restrained when leaving their TS cells are conducted.

30. Continue installing door sweeps for the few remaining TS cells where significant gaps exist between the cell door and floor.

BEHAVIORAL MANAGEMENT PLANS

31. Follow through with plans to involve a psychologist in revising the behavior plan template to be consistent with the requirements of Paragraph 136.

32. Continue with plans to re-train the healthcare vendor's clinicians on behavior planning once the template has been revised.

QUALITY ASSURANCE

33. Develop an action plan to address the poor completion rates for security officers' SDV incident reports. VitalCore has added the matter as a standing agenda items at its leadership meetings, but it is not clear what is happening on the security side.

34. Add two more standing items to the meeting agenda:
    a. The status of TS cells' suicide resistance and the necessary repairs
    b. Implementing a log for prisoners' TS privileges and out-of-cell time (e.g., showers, outdoor recreation)

35. Provide information about VitalCore's CQI process to the DQE that demonstrates its efforts to address problems with the quality of mental healthcare identified throughout this report.

36. Revise the morbidity/mortality review policies to require completion of a clinical mortality/morbidity review, administrative review, and psychological autopsy within 30 days of a serious suicide attempt or death by suicide.

37. Ensure that the minutes of the SDV-SATT Review Committee meetings are reviewed with clinicians at all facilities where TS occurs.

CONCLUSION AND NEXT STEPS

In recognition of MDOC's progress in the first two years of Agreement implementation, the DQE team will modify the site visit schedule for the next monitoring period. The team will not visit MASAC, MTC, Shirley, or Gardner in the first half of 2025, focusing instead on sites with greater clinical acuity and/or need for oversight. Review of data from all eight sites where TS occurs will continue, and the DQE team will return to all eight sites in the latter half of 2025.

One other significant change with the DQE's practices will occur: the addition of a new team member, Vinneth Carvalho, MD. Dr. Carvalho has held several leadership positions in Connecticut's public mental health system, and she has over 10 years of clinical, administrative, and oversight experience in correctional settings. Dr. Carvalho will attend the spring 2025 site visits at OCCC and SBCC.

As noted in the Executive Summary, the DQE encourages MDOC to focus on substantive improvements in patient care over the next six-month monitoring period, including:

- Continuing efforts to train clinical staff about risk assessment and treatment planning
- Implementing behavior plans for patients whose behavior and symptoms could benefit from such an intervention
- In the ISU, continuing to enhance referrals, recruit the remaining mental health staff, and implement individualized care plans
- Addressing institutional factors at SBCC that hinder the provision of mental health care

Focus on a few areas of technical compliance is also needed:

- Completing necessary policy development and revision in accordance with the Agreement, including VitalCore's policies
- Revising the format of morbidity and mortality reviews to comply with the requirements of Paragraph 146

The DQE team anticipates resuming site visits of MDOC facilities in April 2025 and looks forward to seeing additional progress with Agreement implementation.