SEPTEMBER 18, 2023

MASSACHUSETTS DEPARTMENT OF CORRECTION

COMPLIANCE REPORT #1

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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 portion 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 first 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	67 77 98 27 42(d)

	• ISU policies drafted • Status Report #2 to DQE and DOJ	113 159
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.

Of note, the DQE team was unable to assess compliance with some provisions of the Agreement with the information provided by MDOC to date. Beginning in March of 2023, the team attempted to schedule a meeting with MDOC and DOJ to discuss data sources and develop a plan to assess the provisions in question. MDOC personnel were unavailable until July 24, 2023, and the parties were not able to discuss all the provisions in question during one meeting. MDOC also did not produce a compliance report in accordance with Paragraph 159 of the Agreement, which may have alerted the DQE team to additional data sources or monitoring methods.

Thus, the DQE team cannot assess compliance in some areas. Because MDOC has the burden of demonstrating compliance with the Agreement, some of these provisions are rated noncompliant for now, and they will be reassessed during the next six-month reporting period (e.g., Paragraphs 106, 144). When the DQE team was able to gather preliminary information from the site visits to outline MDOC's practices, the provisions are rated partially compliant (e.g., Paragraphs 91, 93, 170).

EXECUTIVE SUMMARY

Since the DQE team began its work in December of 2022, MDOC has been open and forthcoming about the status of its mental healthcare system, both its successes and its ongoing challenges. MDOC is approaching its compliance obligations with the Agreement seriously, without attempting to thwart the evaluation process. Although the DQE team continues to learn,

after approximately eight months of assessing MDOC's mental health system, enough information has been gathered to assess compliance in most areas of the Agreement. This is due, in large part, to MDOC's willingness to collaborate.

There is much to admire about MDOC's provision of mental healthcare. In contrast to other correctional systems where the DQE has consulted, MDOC's healthcare professionals routinely exhibit a love for their work and commitment to serving incarcerated individuals. The mental health staff's positive attitude and dedication have not wavered despite ongoing personnel shortages and ever-changing mandates to adapt practices and meet new benchmarks. As just one example of the mental health staff's desire to expand its services and improve prisoners' mental health, MDOC partnered with the American Society for Suicide Prevention to conduct focus groups on suicide prevention with prisoners at nine facilities this year. The DQE team simply cannot express its approval strongly enough of the "can do" attitude that permeates MDOC's mental health staff and leadership.

Many areas of practice related to the Agreement are going well. To highlight just a few:

- MDOC has put in place many of the policies necessary to comply with the Agreement, such as providing three out-of-cell contacts on mental health watches and authorizing property/privileges in accordance with risk;
- Many prisoners describe their interactions with mental health clinicians in positive terms, some even using descriptors like "outstanding" and "phenomenal" to describe the mental health staff;
- The number of very long mental health watches (three months or more) has decreased substantially since the DOJ's investigation in 2019;
- Some facilities, most notably Gardner and MASAC, serve as excellent examples of successful collaboration between security and mental health staff;
- Mental health professionals (MHPs) respond to crisis calls rapidly, with most prisoners being evaluated within minutes of a call;
- Prisoners are transferred to higher levels of care very quickly once referred by MDOC, generally being admitted to outside hospitals within a day or two;
- MDOC has successfully launched a formal quality assurance program, with a Quality Improvement Committee meeting monthly since March 2023 and making sensible recommendations to improve data collection and address systemic challenges; and
- Old Colony Correctional Center (OCCC) has made significant progress on the Intensive Stabilization Unit (ISU), with the identified housing unit now emptied of prisoners and ready for renovations.

So far, when MDOC has not met the Agreement's compliance deadlines (discussed in the *Detailed Findings* section), problems seem to stem from staffing challenges and competing

obligations rather than a desire put off work or undermine the spirit of the Agreement. For example, at the time of the DQE's baseline visit to OCCC in February of 2023, MDOC had recently hired a full-time Agreement Coordinator; this individual subsequently departed the agency because her skills did not match the requirements of the role. While MDOC searches for a replacement, the Director of Behavioral Health has been serving as Agreement Coordinator, which is a substantial burden in addition to all her regular job duties. In that context, it is understandable why MDOC did not, for example, produce its required Status Report within 180 days or share any policy revisions with the DQE or DOJ.

Further complicating MDOC's compliance with the Agreement is its simultaneous involvement in several other large-scale reform projects. MDOC has eliminated its Restrictive Housing units and transformed them into Behavior Assessment Units that employ new policies and procedures—an initiative that requires as much time and effort as the Agreement, if not more. In addition, MDOC is working with Spectrum Health Systems to expand its Medication-Assisted Treatment (MAT) program for prisoners with substance use disorders. In November of 2022, the Massachusetts legislature passed a law allowing prisoners to petition for their own commitment to a psychiatric hospital under certain conditions, which has created new challenges for MDOC, the courts, and psychiatric facilities.[2] MASAC is planning a huge construction project in 2024-2025, creating new treatment spaces and over 100 new beds. Finally, MDOC ceased operations at MCI-Cedar Junction in June of 2023, requiring the gradual redeployment of hundreds of staff and prisoners to other facilities and the relocation of its intake/classification unit to Souza-Baranowski Correctional Center (SBCC). Simply put, the Agreement is just one of many big changes occurring in MDOC right now.

MDOC has not yet met its goals in many areas of the Agreement, but this is to be expected at such an early stage of implementation. About a third of the Agreement's requirements are not yet due, but for those that are, it appears that understaffing is the root cause of many of MDOC's shortcomings. MDOC's clinicians are enthusiastic, compassionate, and bright, but they are often overwhelmed just trying to keep up with daily crises. With better staffing levels and the right structures in place for collaboration and supervision, the clinicians could be doing more than just addressing the crises of the day. They could be providing proactive care to prevent crises in the first place, and they could think through biopsychosocial formulations to help explain the behavior they are seeing. Currently, there is simply no time to consult as a multidisciplinary treatment team and consider important questions such as: *What is the patient's underlying diagnosis? Why might they be engaging in maladaptive, self-injurious, or antisocial behavior to*

[2] M.G.L. c. 123, §18(a 1/2), which became effective on November 18, 2022, is colloquially known in MDOC as "Section 18a and a half." It allows prisoners or their representatives to petition a district court for transfer to a psychiatric facility if they have been on a mental health watch for 72 hours or more, or if they are at serious and imminent risk of serious self-harm.

get their needs met? What role does trauma, both inside and outside the prison system, play in the patient's presentation?

The tension between mental health and security concerns, which challenges many correctional systems, is also apparent in MDOC, especially at SBCC, the maximum-security men's facility. At SBCC and, to a lesser extent at other facilities, security practices make it difficult to provide adequate mental healthcare. Examples include frequent lockdowns and other "institutional factors" that prevent MHPs from evaluating patients; a lack of confidential, out-of-cell spaces in which to see patients; routine shackling of prisoners when leaving their cells for recreation or MHP contacts, which deters some patients from participating in these activities; and a culture of correctional officers serving as gatekeepers to mental healthcare, at times refusing to call mental health because they do not deem a situation serious enough to warrant a crisis response. It is also noteworthy that most crisis contacts and therapeutic supervision (TS) placements across MDOC are precipitated by prisoners' dissatisfaction with security matters, such as property restrictions, housing moves, disciplinary sanctions, or the conditions of confinement in the BAU. While some of this conflict is inevitable in a carceral environment, it does raise concern about austere and punitive conditions having a detrimental impact on prisoners' mental health.

Despite the system's ongoing challenges, MDOC has one other very positive attribute: its responsiveness to feedback. For example, by the time of the DQE team's second visit to OCCC in July 2023, MDOC had already responded to many of the issues raised during the baseline site visit in February 2023, including:

- Changing the primary location of therapeutic supervision (TS) placements to the health services unit (HSU) rather than the BAU – from 77% in BAU to 11% – thus creating a more therapeutic environment for TS;
- Conducting individualized assessments of general population prisoners to see if restraints are indicated when coming out of their TS cells;
- Exploring the possibility of offering out-of-cell meals for prisoners on TS, beginning such meals in the BAU in April 2023;
- Exploring how to create access to the electronic health record in the areas of the facility where clinicians are evaluating patients;
- Initiating a monthly Care and Coordination meeting between the facility's mental health and security leaders to review treatment interventions, TS placements, and progress with the Agreement;
- Creating a confidential space on the Orientation Unit for mental health staff to conduct assessments and treatment;
- Retraining clinicians about the importance of offering confidential spaces for crisis assessments and reviewing records prior to evaluating patients;

- Implementing the use of a cell inspection sheet to guide checks of TS cells for hazards before patients enter;
- Guiding security staff to improve their close watch practices and documentation, including encouraging "staggered" checks that can reduce patients' self-harm; and
- Repairing the broken video monitoring system for TS cells in the Health Services Unit.

The number and speed of these changes exceeded the DQE's expectations, and it bodes well for the future of MDOC's capacity for compliance with the Agreement.

The following table summarizes the DQE's assessment of MDOC's compliance with the Agreement. 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				X
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	a. Increase mental health staffing and hours on site, as necessary b. Mental health staff to provide 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	All staff sufficiently trained in suicide prevention a. Continue Crisis Intervention Training b. Within 6 months, revise suicide prevention training and submit to DOJ/DQE for approval c. Within 15 months of policy approval, all security staff complete 8 hours of pre-service suicide prevention training d. Within 6 months, ensure that all security staff are certified in CPR		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 a. Clothing permitted unless clinical contraindications, which are reviewed and documented three times daily (once on Sunday) b. Smock avoided unless prisoner used clothing for self-injury c. Document clinical reason that clothing is contraindicated d. Clothing returned after 48 hrs unless Director of Behavioral Health approves		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 a. Access to reading materials after 24 hrs unless contraindicated b. Access to 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 a. QMHP documents contraindications every day b. Consider alternatives to strip searches		X		
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				X
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 (Wellpath) 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 a. Conducts clinical review, administrative review, and psychological autopsy. Inform treating staff, maintain log. b. Recommends changes to correct systemic problems c. Creates written recommendations and corrective action plan d. Completes final report within 60 days		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 obligations 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 March and July of 2023 to each of the 10 MDOC facilities where TS occurred. The site visit to MCI-Shirley was cut short by a day because of a snowstorm, but otherwise the DQE team was able to accomplish the necessary objectives during the visits. The team conducted the following activities:

	Cedar Junction	Concord	Framingham	Gardner	MASAC	MTC	Norfolk	OCCC	Shirley	SBCC
	4/20/23	6/22-6/23/23	5/10-5/11/23	7/19-7/20/23	5/8-5/9/23	6/5-6/6/23	4/18-4/19/23	7/17-7/18/23	3/13/23	6/20-6/21/23
Facility tour	RK, GM[3]	RK, GM	RK, JW	RK, GM	RK	RK, JW	RK, GM	RK, GM, JW	RK, GM	RK, GM, SS, JW
Inspection of TS cells	RK, GM	RK, GM	RK, JW	RK, GM	RK	RK, JW	RK, GM	RK, GM	RK, GM	RK, GM, SS
Interview of prisoners recently on TS	RK, GM	RK, GM	RK, JW	RK, GM	RK[4]	RK, JW	RK, GM	RK, GM	RK, GM	RK, GM
Review of officers' TS watch logs	RK, GM	GM	RK	RK, GM	RK	RK	RK, GM	GM	GM	RK, GM
Interviews of mental health staff	RK, GM	RK, GM	RK, JW	RK	RK	RK, JW	RK, GM	RK, JW	RK, GM	RK, JW
Interviews of security staff	RK	RK	RK	GM	RK	RK	RK, GM	RK, GM		RK, SS
Observation of MHPs responding to crisis calls		RK	JW	RK		RK		RK, JW		JW
Observation of MHPs conducting TS assessments	None to see	RK		None to see	RK	None to see	RK	RK	None to see	JW
Observation of MH group programming			RK, JW		RK	RK		JW		
Observation of MH triage meeting	RK, GM	RK, GM	RK, JW	RK, GM	RK	RK, JW	RK, GM	RK, GM, JW	RK, GM	RK, JW, GM
Observation of BAU Interdisciplinary Assessment Team meeting		RK, GM		RK, GM		RK, JW	RK, GM	RK, GM, JW		GM, SS

During the site visits, the DQE team was given broad access to information and to the facility, 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 and

[3] RK = Reena Kapoor, GM = Ginny Morrison, JW = Julie Wright, SS = Scott Semple

[4] Because of the relatively rapid patient turnover and infrequency of TS placements at MASAC, no patients who had been placed on TS were housed at the facility at the time of our site visit. Therefore, other prisoners involved with mental health services were interviewed.

mental health staff confidentially, without MDOC leadership or legal representatives present. When interviewing security staff, an MDOC attorney stayed in the room but did not speak or interfere.[5]

In total, the DQE team interviewed 62 prisoners, 24 MDOC security staff members (primarily those holding the position of Correctional Officer I), and dozens of Wellpath staff in various roles related to mental health.[6] Because this is such a small percentage of the thousands of prisoners and staff in MDOC, the DQE has been cautious in issuing "substantial compliance" findings in areas where our assessment was largely dependent upon interviews.

2. Document Review

In addition to conducting site visits, the DQE team requested documents from MDOC on a monthly and quarterly basis, gathering hundreds of documents over the six-month review period. For the first compliance report, data from December 20, 2022, through June 30, 2023, were reviewed. Although the parties received a draft of the DQE's report on August 20, 2023, and subsequently submitted comments, they were not permitted to submit new data for consideration by the DQE team in its revisions for the final report.

MDOC provided the following documents to the DQE and DOJ teams for review, both during the site visits and in response to document requests. For the sake of brevity, general categories of documents are listed here rather than each document.

a. Electronic health records

MDOC provided the DQE team with access to Wellpath's electronic health record, the Electronic Records Management Application (ERMA), to review medical charts remotely. For the first compliance report, the team reviewed the medical records of prisoners between December 20, 2022, and June 30, 2023. In order to review a representative sample of records from the 10 facilities, records were chosen in accordance with the approximate proportion of total MDOC TS placements that occurred at each facility:

[5] The DQE team would prefer to interview MDOC staff privately because it is not clear to what extent, if any, the presence of MDOC's legal representatives influences the willingness or ability of security staff to speak candidly. MDOC has agreed to the DQE team conducting private staff interviews going forward, provided that no DOJ attorneys are included in the interviews.

[6] Interviews of Wellpath staff occurred in formal and informal settings, and they included MHPs, psychiatrists, nurse practitioners, psychologists, unit coordinators in the RTUs and STPs, facility mental health directors, and regional mental health directors. The DQE team often spoke with the clinicians during the daily triage meeting, as well as while shadowing them during TS assessments and crisis calls. The team also met with staff members individually. Because so many of the discussions occurred in large group settings or while walking in between patient encounters, the DQE team does not know the exact number of staff who were interviewed.

Facility	Approximate % of Records
Cedar Junction[7]	0
Concord	13
Framingham	8
Gardner	5
MASAC	4
MTC	3
Norfolk	7
OCCC	22
Shirley	5
SBCC	34

Records were reviewed for technical compliance with the Agreement (e.g., number and timeliness of TS 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).[8]

b. Data about crisis contacts and TS placements

1) TS Registry, a list of all prisoners placed on TS between 12/20/22 and 6/30/23, including facility, entry and discharge dates, and duration of TS placement
2) List of TS cell locations at each MDOC facility
3) Officers' watch logs for 81 TS placements distributed across 10 facilities
4) Examples of MDOC/Wellpath cell inspection checklists from various facilities
5) Log of restraints used for mental health or security purposes with prisoners on TS, March to June 2023
6) All TS Consultation/Notification forms between March and June 2023 (for 72 hrs, 7 days, 14 days, 14+ days on TS)

c. Policies related to mental healthcare

1) Letters from MDOC Director of Behavioral Health dated May 16, 2023, and July 25, 2023, describing the status of MDOC's policy revisions
2) MDOC Policies
    a. 103 DOC 650 – Mental health services

[7] Since Cedar Junction will no longer house patients, and practices during the wind-down period were atypical, the team determined that including records from this location would not benefit an accurate assessment of the compliance picture.

[8] 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.

b. 103 DOC 520 – Instruments of restraint, including attachment on Four-Point Restraints
c. 103 DOC 520 – Professional Standards Unit
d. 103 DOC 601 – Division of Health Services organization
e. 103 DOC 610 – Clinical contract personnel and the role of DOC Health Services Division
f. 103 CMR 420 – Classification
g. 103 CMR 430 – Inmate Discipline

3) Wellpath Policies
a. Wellpath 31.00 – Information on healthcare services
b. Wellpath 32.00 – Receiving screening
c. Wellpath 33.00 – Transfer screening
d. Wellpath 35.00 – Mental health initial appraisal
e. Wellpath 35.01 – Comprehensive mental health evaluation
f. Wellpath 37.01 – Referral to mental health services
g. Wellpath 37.03 – Emergency mental health assessment
h. Wellpath 37.04 – Mental health consultations with referrals to psychiatry
i. Wellpath 38.00 – Sick call
j. Wellpath 39.01 – Mental health restrictive housing assessment
k. Wellpath 42.02 – Intrasystem continuity of mental health care
l. Wellpath 53.01 – Management of self-injurious or potentially suicidal patients
m. Wellpath 53.02 – Transfer of patients on therapeutic supervision
n. Wellpath 66.00 – Therapeutic supervision
o. Wellpath 66.01 – Therapeutic restraints

d. Staffing data

1) Wellpath mental health staffing matrices dated 1/31/23, 4/18/23, and 6/30/23, including names, titles, and licensure of all staff
2) MDOC security staffing spreadsheet dated 4/15/23 (FY22 FTE Report for BU04-4.15.23), including allocated FTEs, vacancies, and staff on leave for each job class and each facility
3) Spreadsheets from each MDOC facility in June 2023 identifying security staff who are "inmate facing" and can be assigned to work with patients on TS

e. Training data

1) Presentation materials, agendas, and lesson plans for Wellpath and DOC annual employee pre-service and in-service training
a. Annual mental health training for all Wellpath clinicians on December 5, 6, and 7, 2022

b. Two-Day STU/RTU training on November 8 and 9, 2022
c. Collaborate Safety Planning slides (undated) for all Wellpath clinicians
d. MDOC Suicide Prevention & Intervention 2023
e. Suicide Prevention and Recognizing Mental Illness and Substance Related Disorders (2023)
f. Therapeutic Supervision and Duty to Protect, TY 2022
g. Overview of Correctional MH Systems in MA-DOC, April 2023
h. MA Dept of Correction Special Treatment Units: An Overview (no date, provided to DQE in June 2023)
i. Behavior Management (no date, provided to DQE in June 2023)
j. Wellpath CQI training on RTU/STU outcome measures (no date, provided to DQE in June 2023)
k. Disciplinary process and STUs (no date, provided to DQE in June 2023)
l. Wellpath Zero Suicide Training for Nurses, Part 1, September 2020 to September 2022
m. Wellpath Grand Rounds presentation materials and sign-in sheets between March and June 2023
n. Risk Management in Action small group scenarios, April 2022
o. Specific case studies for RTU/STU Training, April 2022

2) Crisis Intervention Training (CIT) records
    a. Complete slide set for 40-hr training
    b. Welcome letters and agendas for CIT trainings in 2021 and 2022
3) MDOC training records for all security staff who completed "Recognizing Mental Illness and Suicide Prevention" between 7/1/22 and 6/30/23
4) MDOC training records for all security staff who completed "Therapeutic Supervision/Duty to Protect" between 7/1/21 and 7/1/22
5) MDOC training records for all staff who completed CPR training between 9/13/22 and 6/20/23
6) MDOC monthly New Employee Orientation (NEO) training attendance records between March and July 2023
7) Wellpath attendance logs and sign-in sheets for various trainings and Grand Rounds presentations in 2022 and 2023

f. Other mental health program information

1) MDOC monthly "Mental Health Roll Up Report"
2) Mental Health program descriptions and schedules from RTUs at Framingham, OCCC, SBCC, and NCCI Gardner from the spring of 2023
3) SAU 1 and SAU 2 program descriptions from MCI-Concord
4) SAU 3 and SAU 4 program descriptions from SBCC

5) Mental health triage meeting notes (Monday through Friday) from each MDOC facility that has TS

6) End-of-shift reports from Saturday mental health clinicians at each site that has TS

7) Inmate handbooks and other materials related to mental health

8) List of all prisoners transferred to a higher level of care (Section 18, Section 18(a1/2), RTU, or STU) between 12/20/22 and 6/30/23

9) Behavior plans from 2019 to 2023 for seven prisoners in OCCC, MTC, and SBCC

10) Minutes from all Inter-Facility Clinical Case Conferences between March and June 2023

g. Self-injury and Use of Force data

1) All incidents of SDV that occurred while a prisoner was on TS from January to June 2023, plus all other SDV incidents in May-June 2023
2) All SIBOR reports between March and June 2023
3) Incident reports related to three serious suicide attempts
4) All Use of Force incidents that occurred while a prisoner was on TS between 12/20/22 and 6/30/23
5) Draft of revised SDV definitions dated June 26, 2023
6) Incident reports and medical/MH documentation from all incidents of foreign body ingestion, March to June 2023

h. Quality assurance data

1) Minutes from monthly Quality Improvement Committee (QIC) meetings between March and June 2023
2) QIC meeting recommendations from April to June 2023
3) Monthly Quality Assurance reports from March to June 2023
4) Morbidity Review dated July 14, 2023
5) Morbidity Review recommendations dated July 14, 2023
6) Self-Directed Violence/Suicide Attempt (SDV/SATT) Review Committee Meeting minutes from April 5 to June 21, 2023

i. Documents from DOJ

1) Names of prisoners whose cases were highlighted in the Findings Letter
2) Location of TS cells, 2019 vs. 2023 comparison
3) Letter from Prisoners' Legal Services to Superintendent of SBCC dated May 1, 2023

3. **Observation of MDOC/Wellpath quality assurance meetings and clinical case conferences** (all conducted via Microsoft Teams)

    1) SDV/SATT Review Committee meeting on February 15, 2023, for approximately 90 minutes
    2) Morbidity Review meetings for two suicide attempts that met the definition of a Reportable Incident specified in Paragraph 147 of the Agreement:
        - March 13, 2023, for approximately 90 minutes
        - July 14, 2023, for approximately 90 minutes
    3) Wellpath Case Conference regarding a complex patient at NCCI Gardner on July 20, 2023, for approximately 45 minutes

4. **Stakeholder feedback**

In accordance with Paragraph 153 of the Agreement, the DQE contacted stakeholders identified by DOJ and MDOC, soliciting written feedback about mental healthcare in MDOC. In total, 15 stakeholders were contacted, nine identified by DOJ and six identified by MDOC. Three substantive responses were received, which were shared with the parties along with the draft DQE report, in accordance with Paragraph 161. These responses came from the Harvard Prison Legal Assistance Project, the Committee for Public Counsel Services, and the Mental Health Legal Advisors Committee.

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: Noncompliance

Rationale: As of June 20, 2023 (six months after the Agreement's effective date), MDOC had not provided the DQE team with any evidence of policy revisions. MDOC leadership indicated that internal discussions about policy revisions were occurring and that drafts would be shared with the DQE and DOJ when ready. In a letter dated July 25, 2023, the Director of Behavioral Health indicated that the following policies were being revised:

1. 103 DOC 650 Mental Health Services
2. 103 DOC 601 DOC Division of Health Services Organization
3. 103 DOC 501 Institution Security Procedures

The same letter stated that Wellpath had no new or revised policies ready for submission to the DQE.

In the meantime, the DQE team conducted a thorough review of the Wellpath and DOC policies that had been provided to us (listed in the *Assessment Methodology* section above). On July 10, 2023, the DQE team provided MDOC and DOJ with a detailed, 79-page table reviewing MDOC and Wellpath policies related to the Agreement, suggesting changes that would bring such policies in alignment with the substantive provisions. The parties are currently reviewing this document.

The are several areas where the DQE has not yet received any relevant DOC or Wellpath policies, if they exist:

- Emergency response ("Code 99") procedures
- Searches of TS cells, including the use of a safety checklist
- Lighting for patients on TS
- Therapeutic de-escalation rooms
- Peer mentorship programs
- Therapy dogs
- Behavior plans
- Foreign body ingestion
- Quality assurance programs for Wellpath and MDOC
- Quality Improvement Committee structure and function
- Self-injurious Behavior Review Committee structure and function
- Morbidity and mortality review procedures

The DQE team will continue working with MDOC to obtain and/or develop policies over the coming months. Dozens of changes will be necessary to align MDOC and Wellpath's policies with the Agreement, so MDOC is encouraged to begin sharing their revisions as soon as possible.

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: Compliance not yet due

Rationale: This provision and its subsections are not due until December 20, 2023, one year after the Agreement's effective date. As noted above, MDOC has not yet shared any policy revisions or new policies with the DQE.

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: The Agreement does not specify a date by which this provision is due, but if all policies must be revised and finalized by December 20, 2023 (Paragraph 27), then the necessary modifications to post orders, job descriptions, training materials, and performance evaluation instruments would be due at the latest on June 20, 2024. If policy revisions are completed and approved prior to December 20, 2023, the DQE team will expect MDOC's accompanying document revisions to be completed within six months of that date. The only exception to this timeline is if a policy implicates MDOC's collective bargaining agreement, in which case revisions may take longer because of union negotiations.

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: Extrapolating from Paragraph 27, the deadline for all policies to be fully implemented is June 20, 2025, 18 months after the policy finalization deadline of December 20, 2023. This deadline can be extended if union negotiations or public hearings are necessary.

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: Compliance not yet due

Rationale: This provision would only be triggered when the policy revisions are completed, so no earlier than December 20, 2023.

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: MDOC leadership stated that they already review policies annually; each policy is assigned to a particular MDOC division for review at a certain time of year. The DOC policies that the DQE team has reviewed are consistent with this assertion. In addition to an "Effective Date," each policy has an "Annual Review Date" and "Responsible Division" listed at the top of the first page. Similarly, each Wellpath policy has a "Date of Issuance" and "Dates of Revision" listed at the bottom of every page. However, the Wellpath policies do not clearly indicate that they are reviewed annually.

A Partial Compliance finding is issued because, although MDOC appears to have a practice of reviewing policies annually, the DQE team has not yet seen evidence that each policy related to the Agreement has been reviewed and/or revised accordingly. The DQE team has also not seen any evidence of Wellpath's annual policy review process. MDOC will need to present information demonstrating both of these things before it 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: Partial compliance

Rationale: MDOC submitted several Wellpath staffing matrices between January and June of 2023 for review, as well as one DOC security staffing matrix dated April 15, 2023. Upon clarification with MDOC leadership, the Wellpath staffing matrix dated April 18, 2023, and DOC staffing matrix dated April 15, 2023, were intended to fulfill the Staffing Plan requirement in Paragraph 32 of the Agreement. Thus, MDOC is compliant with the requirement to submit a staffing plan within four months of the Effective Date (April 20, 2023). The DQE's concerns about the adequacy of this staffing plan are addressed in Paragraphs 33-35.

Although MDOC did submit a timely staffing plan, a Partial Compliance finding is the highest that can be issued here because the provision requires submission of *annual* staffing plans in addition to the initial one. Until those plans are submitted, the DQE cannot issue a Substantial Compliance finding.

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: Based on the MDOC security staffing matrix dated April 15, 2023, overall security staffing is hovering around 74% of full staffing levels.[9] Correction Officer I positions (CO I), who interact most directly with prisoners in mental health crisis, are slightly lower, at 70.9% overall. Correction Officers II and III, who often serve as shift supervisors, are similarly understaffed at 73% and 69%, respectively. *Figure 1* illustrates CO I staffing by facility.

[9] This figure includes positions across all MDOC facilities, not just the ones where TS occurs. In addition, it includes all security-related positions, including some that are only tangentially related to mental health or the Agreement (e.g., head cook, industrial instructors).

Figure 1. CO I Staffing by Facility

Assessing the impact of security understaffing on mental healthcare can be difficult because MDOC, like most correctional systems, mandates officers to work overtime to cover day-to-day needs, including observation of TS placements. In theory, there would be no impact of understaffing on healthcare because a smaller number of officers would still be covering the required shifts and duties. However, the DQE team found evidence during the site visits and document reviews that understaffing in MDOC may be having an impact on prisoners' therapeutic experiences on TS. Some potential examples include:

- Prisoners on TS not being offered outdoor recreation consistently
- Mental health interactions occurring cell-front rather than out of cell
- Prisoners being restrained routinely when out of cell
- Officers not calling crisis at prisoners' request
- Psychiatry assessments being rescheduled because officers were busy handling other crises
- Frequent lockdowns that stop all activity throughout the facility, including mental health contacts

These problems are undoubtedly multifactorial and include challenges with officer training and institutional culture in addition to staffing levels, but understaffing is very likely a contributing factor.

[10] 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.

The DQE reviewed only one security staffing matrix, from April 2023, so cannot say with certainty whether security staffing has changed substantially since the Agreement's inception. However, MDOC's June 2023 Quality Improvement Committee meeting minutes indicate that overall staffing had only increased by 1% in the previous quarter. Despite the overall lack of change in MDOC's security staffing levels, the ceasure of operations at Cedar Junction in June 2023 did have a positive impact on some facilities' staffing, as officers were reassigned throughout MDOC. For example, between the DQE's February and July site visits, OCCC's superintendent reported that the facility reduced its vacant officer positions from 78 to 41, which allowed them to mandate officers to work overtime once or twice a week instead of every shift.

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: As one means of assessing security staff practices when conducting constant and close observation, the DQE team reviewed a sample of officers' watch sheets from 81 therapeutic supervisions drawn from all institutions that conduct them. After reviewing the corresponding Therapeutic Supervision Reports, the team found that 34 placements in the sample had had a period of constant observation. The watch sheets appeared to show that officers consistently rotated this responsibility every two hours, or more often, in 76% of the sample.[11] Souza-Baranowski, Framingham, and Concord all met the requirement fully in these records.

The DQE team also interviewed officers who have conducted observations in 2023. Among them, 13 officers or supervisors, drawn from seven institutions, asserted that rotating on this time schedule is routine practice and they provided confirmatory detail. Some offered that this change has made the responsibility much more manageable. MDOC has made a solid start on implementing this requirement.

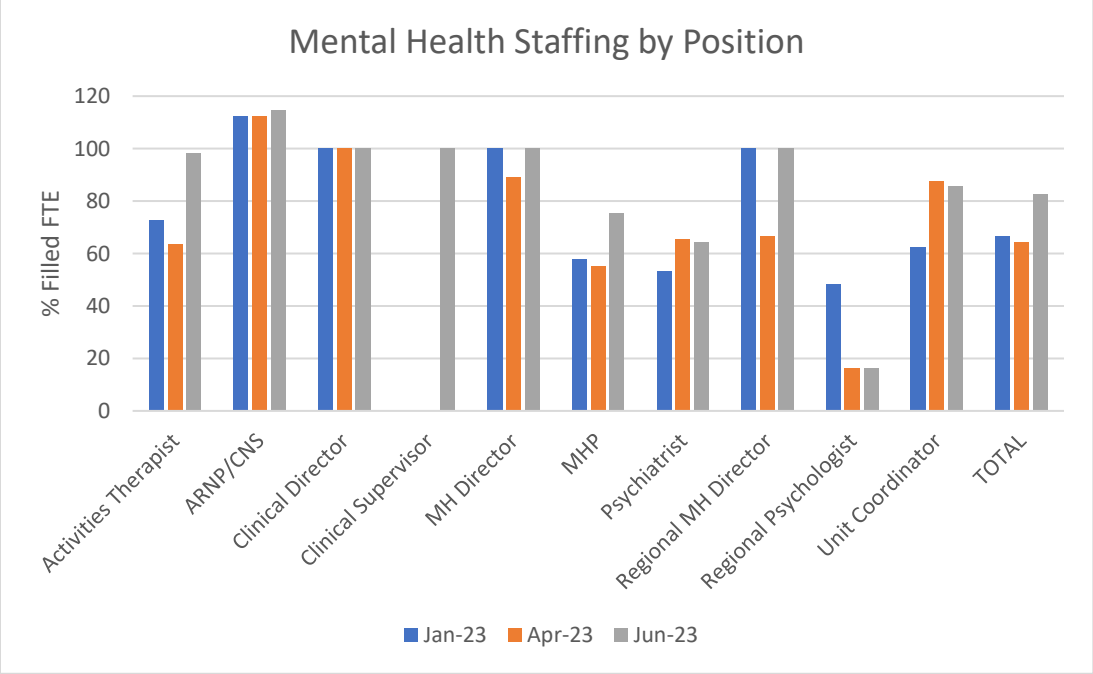
[11] This primarily was determined by observing the officers' initials and handwriting on the watch sheets. In a small number of cases (5), practice was considered to meet the requirement where a new officer usually assumed the duties at least every two hours, but there were rare exceptions exceeding that time limit by less than one hour.

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: Noncompliance

Rationale: Wellpath's staffing matrix has remained unchanged since the Agreement began; it allocates 133.95 FTE across the mental health positions in nine disciplines.[12] In June 2023, 18% of these positions remained unfilled, though this represents a substantial improvement from January 2023, when 33% of positions were unfilled. The greatest shortages remain with MHPs, psychiatrists, and psychologists – all critical members of a multidisciplinary mental health treatment team. *Figure 2* illustrates mental health staffing across MDOC.

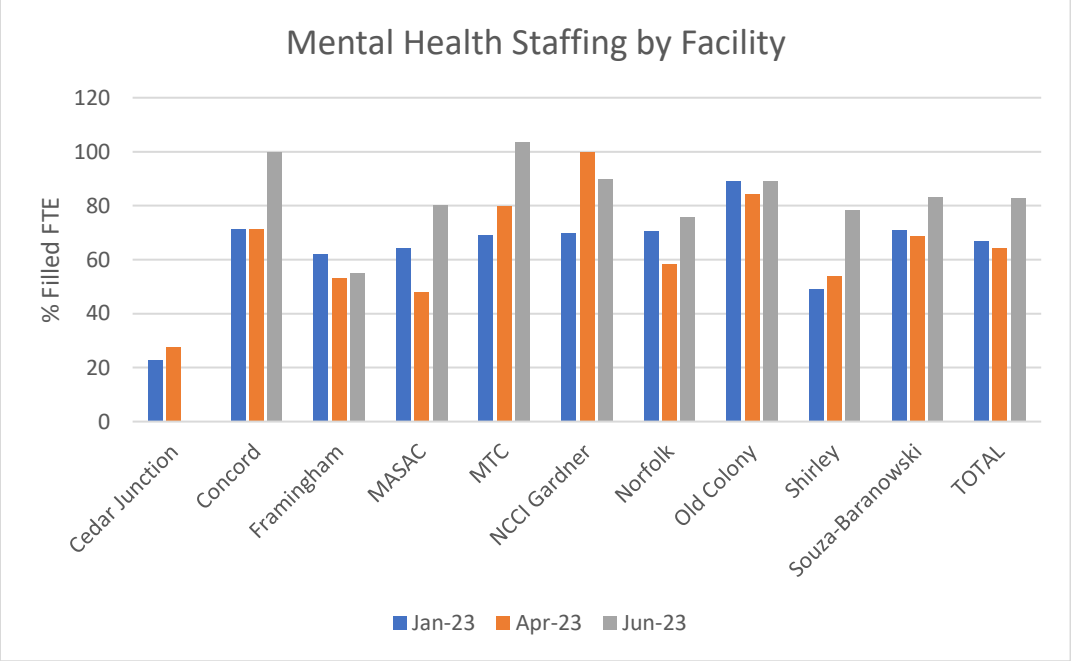
Figure 2. Mental Health Staffing by Position



[12] The staffing matrix dated 6/30/23 still includes Cedar Junction's positions, which I removed from my analysis so as not to report skewed vacancy rates (all of Cedar Junction's positions were listed on the matrix as vacant).

Staffing patterns changed little between January and April of 2023, but they substantially improved in June (see *Figure 3).* This is due largely to hiring new graduates from master's degree programs in social work and mental health counseling, some of whom had worked as interns in MDOC during their training and became full-time employees upon graduation.

Figure 3. Mental Health Staffing by Facility



Framingham appears to be struggling the most, with under 60% of mental health positions filled, but there are also bright spots in the system. In June of 2023, Concord and MTC's mental health positions were 100% filled, and Gardner was not far behind. If MDOC can retain the employees who were recently hired, the prospects for obtaining Substantial compliance with this provision in the future are greatly improved.

With MDOC still so far away from full staffing levels, it is impossible to know whether the staffing matrix itself needs revision (i.e., whether there are enough allotted positions to meet the system's needs). However, it is likely that MDOC needs more doctoral-level mental health professionals. According to the staffing matrix dated June 30, 2023, Wellpath currently has allotted 13.95 FTE psychiatrists/ARNPs to care for 2,503 prisoners on the mental health caseload.[13] This means that MDOC allocates one psychiatrist/ARNP for every 179 patients on the caseload. This ratio falls below the American Psychiatric Association's staffing guideline of 1:150 for "outpatients" in general population, which does not take into account the higher patient-to-physician

[13] Per the June 2023 MH Roll-Up Report

ratios necessary in specialized settings like the RTU or STPs. Similarly, Wellpath employs just half a full-time psychologist (0.5 FTE) for the entire system of nearly 6,000 prisoners. The staffing plan allots 3.1 FTE for Regional Psychologists, which may still be low, but the adequacy of this staffing level cannot be assessed until Wellpath reaches it.

Currently, inadequate mental health staffing is impacting clinical care in several ways. Some examples include:

- No truly multidisciplinary treatment planning (involving nursing, psychiatry, psychology, social work, and recreational therapy) for patients outside the RTU setting, including those on therapeutic supervision
- An inability to consider treatment needs beyond the prisoner's immediate crisis, such as asking *why* a patient has limited distress tolerance skills or habitually engages in self-injury
- A reliance on offering "packets" to prisoners (e.g., word searches, worksheets, coloring books) rather than engaging in individualized diagnosis, formulation, and treatment planning
- Missed TS contacts and frequent cellside contacts due in part to the crisis clinicians' lack of time or involvement in other duties
- Poor continuity of care, with multiple primary clinician (PCC) reassignments due to staff turnover and TS evaluations conducted by multiple different individuals each day due to understaffing

In the Baseline Report, the DQE raised concerns that many of Wellpath's MHPs do not have a license to practice independently in any clinical discipline. According to the staffing matrix dated June 30, 2023, just 24.2% (12.55 of 51.7 FTE) of MHPs have a license to practice independently. All others – over three quarters of MHPs – require supervision by a licensed professional (LMHC or LICSW), which typically means they are less than two years out of school.[14] However, a lack of licensure is not necessarily a problem if adequate supervision is in place. During the site visits, the unlicensed MHPs reported having individual supervision with a licensed person in their discipline (LICSW or LMHC), though often this person works at a different Wellpath facility than the MHP. In addition, unlicensed MHPs reported having informal supervision from their site's mental health director, and they overall felt supported in their work. This layered supervision structure is a good foundation for what the DQE hopes will eventually

[14] Becoming independently licensed as a social worker in MA requires at least 3,500 hours of supervised practice and 100 face-to-face hours of individual supervision, which amounts to approximately two years of full-time practice. Similarly, becoming an LMHC requires 3,360 hours of supervised clinical practice over no less than two years.

become a multidisciplinary treatment team model of care, once MDOC is able to hire sufficient clinical staff and put structures in place to foster cross-discipline collaboration.

Although there is no magic answer to MDOC's staffing challenges, the DQE urges MDOC and Wellpath to consider all avenues to recruit and retain more staff, including doctoral-level professionals. Such avenues could include increasing compensation, providing retention bonuses, enhancing retirement benefits, paying overtime to clinical staff, working with professional job recruiters, and partnering with academic institutions and medical centers to create trainee rotations. Without adequate staff, compliance with the Agreement's requirements will be nearly impossible.

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: Compliance not yet due

Rationale: The Agreement does not specify when the ISU's staffing plan should be completed, but the DQE anticipates it will be completed at least six months prior to the ISU's scheduled opening date of June 20, 2024. MDOC reported that it has submitted a staffing proposal for the ISU to Wellpath and that Wellpath is currently reviewing it. The DQE has not yet seen the staffing plan.

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

Finding: Compliance not yet due

Rationale: This provision will not be due until July 1, 2024, the start of the fiscal year after the initial staffing plan was due to the DQE and DOJ. As noted above, there is significant work to be done on staffing.

TRAINING

38. Training: MDOC, in conjunction with the contracted health care provider, will provide pre-service and annual in-service training, using competency-based adult learning techniques, to security and mental health staff on new policies, mental health care, suicide prevention, and de-escalation techniques.

Finding: Partial compliance

Rationale: The DQE has reviewed the pre-service and annual in-service training materials provided by MDOC, which do include training on suicide prevention, mental healthcare, and de-escalation techniques (see details in Paragraph 42 below). The requirement for MDOC to provide pre-service and annual in-service training on new policies cannot yet be assessed because no new policies have been finalized since the Agreement's effective date. MDOC did provide evidence of retraining its staff on the policy change from Mental Health Watch to Therapeutic Supervision, so the DQE is optimistic that MDOC will follow a similar model for future policy revisions and eventually obtain compliance with this provision.

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 policies have been revised or created since the Agreement's effective date, so MDOC is not yet required to incorporate them into its annual training plan. The deadline for final policy approval is December 20, 2023, so we anticipate the training incorporation deadline to be June 20, 2024. See Paragraph 42b for the DQE's recommended revisions to the current MDOC and Wellpath trainings.

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-

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 Wellpath or MDOC trainings for the DQE to verify yet. Since the policy finalization deadline is December 20, 2023, all trainings should be revised and implemented by December 20, 2024.

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: Partial compliance

Rationale: The DQE has not attended any of MDOC or Wellpath's training sessions, but based on a review of the training materials, the instructors' qualifications and course content appear to meet the "current evidence-based" standard articulated in this paragraph. MDOC leadership reported that they are looking into the availability of videos depicting individuals with lived experience or their family members. Thus, they are well on their way to compliance with this provision.

42. Suicide Prevention Training[15]: 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 is difficult to assess as a whole because subsections 42a-d address such different aspects of training and mandate compliance on different schedules. If rating these subsections individually, the DQE would conclude:

[15] Each subsection of this paragraph measures different things and requires compliance in different time frames, so I have broken this out into four different compliance ratings.

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

MDOC's 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.

Three of the 24 correction officers interviewed by the DQE team indicated that they are certified in CIT, completing a 40-hour initial course and an annual recertification. Several other officers recalled that the training was offered, even if they had not chosen to complete it. The DQE's review of CIT materials provided by MDOC indicates that the training was most recently given in December 2022. Three sessions were also held in September, October, and November 2021. The DQE reviewed the training materials for the 40-hour course, which are consistent with the nationally recognized and evidence-based program for law enforcement personnel, yet appropriately tailored to Massachusetts and to the correctional environment. Subsection 42a does not require that all staff undergo this training, just that MDOC continues to offer it. Thus, this subsection is rated Substantial Compliance even in the absence of receiving MDOC's training completion logs.

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

The DQE team reviewed training materials for multiple Wellpath and MDOC trainings, including Crisis Intervention Training (CIT). MDOC's trainings related to mental health encompass much more than just suicide prevention; they cover an impressive range of topics for both clinicians and security personnel, including an overview of mental health services in MDOC, specialized treatment units, trauma-informed care, de-escalation techniques, collaborative safety planning, and others. It appears that MDOC revised many of its training materials, including its suicide prevention trainings, in the spring of 2023, within six months of the Agreement's effective date. MDOC leadership indicated that they continue to revise other training materials to ensure that they comport with the Agreement.

The DQE assessed the specific requirements of subsection 42b in seven MDOC and Wellpath trainings that are closely related to the Agreement's focus on suicide prevention and therapeutic supervision. *Table 1* summarizes the DQE's findings:

Table 1. Wellpath/MDOC Trainings Related to Suicide Prevention

	Wellpath annual MH training[16]	Wellpath Zero Suicide Training for Nurses, Parts 1 & 2	RTU/STU training	MDOC Suicide Prevention & Intervention	Suicide Prevention and Recognizing MI/SUD	Therapeutic Supervision and Duty to Protect[17]	Crisis Intervention Training (CIT)
Audience							
	Wellpath clinicians	Wellpath nurses	All MDOC security and clinical staff in RTU/STU	All MDOC employees who care for prisoners	All MDOC employees	Security staff who observe TS, admin-istrators, supervisors	Voluntary MDOC staff
Timing							
	Annual	how often?	Pre-Service, Annual In-Service	Annual In-Service	Pre-Service	Site-specific dates during Training Year 2022	Annual

[16] MDOC only provided the agenda for this training, not the slides themselves, so it's possible that they contain more detailed information about suicide prevention such as warning signs, risk factors, etc. From the agenda, it appears that this training is much broader than suicide prevention, covering the criteria for 18(a) petitions, sex offender treatment, working with female offenders, and self-care.

[17] In an email, MDOC's Director of Staff Development indicated that the TS "read and sign" was integrated into the Suicide Prevention/Recognizing Mental Illness training in July of 2022. The materials provided to the DQE team are from the standalone TS training in Training Year 2022 (calendar year 2021-2022). The DQE looked for evidence of the TS training being integrated into the 2023 Suicide Prevention/Recognizing Mental Illness training but did not find such evidence. In its response to the draft DQE Report, MDOC clarified that the TS trainings are now conducted at individual facilities. The DQE team will gather more information in the next review period.

Duration							
	8 hours	3 hours	16 hrs	2 hours	8 hours	1 hour	40 hours
Content							
42.b.1 Suicide prevention policies	X	X	X	X	X	X	
42.b.2 Facility environment		X	X	X	X	X	X
42.b.3 Predisposing factors		X		X	X		X
42.b.4 High-risk periods		X		X	X		X
42.b.5 Warning signs		X		X	X		X
42.b.6 Observing prisoners on TS		X				X	
42.b.7 De-escalation techniques		X	X	X		X	X
42.b.8 Case studies	X	X	X			X	X
42.b.9 Scenario-based trainings		X	X		X	X	X

In general, these are well-designed trainings that contain information relevant to their intended audiences, with specific lesson plans and often with pre- and post-training quizzes to assess comprehension. These aspects are consistent with current principles for adult learning. The DQE appreciates that MDOC's trainings for security personnel include specific information about suicides in MDOC (e.g., statistics about location, age, race, gender, methods). Another positive is that the trainings include data about how many suicide attempts were saved by staff intervention and how suicide affects communities and bystanders, including correctional staff. The topics are covered at a depth that non-clinicians can readily absorb and appreciate. A good distinction is made between suicide attempts and non-suicidal self-directed violence (SDV).

Looking to the future, a few content areas warrant revision or expansion based on the issues encountered during the DQE's site visits:

1) **Policies related to Crisis Calls.** The TS training materials adequately cover officers' obligations while monitoring prisoners on TS, but the DQE team found during our

interviews that there were variable interpretations of how crisis calls – the interaction with prisoners *before* being placed on TS – were to be handled. In particular, officers were not sure what they should and should not be asking prisoners about the nature of their request to see mental health, and they were not certain whether the prisoner had to be monitored 1:1 while waiting for mental health assessment if they declined to disclose details about their request.

2) **Confidentiality between security and mental health staff.** Given how many conflicting viewpoints the DQE team heard from staff and prisoners about the boundaries between security and clinical staff when sharing information about mental health and suicide risk, MDOC may consider adding some specific training on this point (if not already covered in officers' "Professional Boundaries" annual in-service training). Case studies about when it would or would not be appropriate to disclose information to security staff could be included, as could specific instruction about how security staff are to maintain confidentiality when they learn of protected health information.

3) **Substance intoxication and withdrawal.** MDOC continues to see frequent episodes of substance misuse, especially synthetic cannabinoids ("K2") and prescription opiates. Substance intoxication and withdrawal are significant risk factors for violence and self-harm, and the DQE would recommend these topics be expanded in the annual in-service training for suicide prevention. Perhaps Spectrum Healthcare could be incorporated into these training revisions, given their expertise in substance use disorders.

4) **Psychosis and SDV.** In light of the incident at Gardner where a prisoner jumped from his sink in response to hearing voices, Wellpath might also consider expanding its training for clinicians on the relationship between psychosis and self-harm. Command auditory hallucinations are briefly mentioned as a clinical risk factor in the existing training materials, but a case example of how delusions or hallucinations can lead to significant self-injury (even if not explicitly trying to commit suicide) would be helpful.

5) **Individualized treatment planning and documentation.** As noted later in this report, MDOC's crisis treatment plans and mental health watch discontinuation plans often lack an appropriately individualized focus. Training for clinicians on how to write succinct but meaningful treatment plans is needed. Examples of such documentation are given in Paragraphs 52 and 83.

With these relatively minor changes to MDOC's training plan, it can achieve full compliance with this subsection.

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 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.

This provision will be due no later than March 20, 2025 (15 months after the final approval of policies, which is due on December 20, 2023). The DQE's understanding is that all officers currently complete an 8-hour pre-service training on suicide prevention. MDOC provided a report of DOC training showing that 87 employees completed the pre-service New Employee Orientation (NEO) training between 7/1/22 and 6/30/23. The same training report shows that an additional 3,182 officers completed MDOC's annual 2-hour in-service training on suicide prevention and recognizing mental illness between July 2022 and June 2023. There is no way to tell from the report what proportion of the staff population identified in this paragraph ("all correction officers who work in intake, Mental Health Units, and restrictive housing units") this represents. Similarly, the DQE received sign-in sheets from Wellpath's annual mental health training, but there is no way to determine from this information what proportion of the total mental health staff attended. The DQE team will work with MDOC to clarify those details in future reporting periods.

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").

In interviews, all officers who were asked confirmed their requirement for annual CPR training, and MDOC provided a spreadsheet showing that thousands of security staff completed CPR training between September 2022 and June 2023. The DQE team will work with MDOC to determine how the staff identified on the training spreadsheet compare with the total MDOC security staff.[18]

[18] In preliminary discussions with MDOC's leadership, identifying staff who are not up to date on trainings can be difficult because the staffing matrix must first be cross-referenced with the training logs. When staff have been identified who have not completed training, one must then check whether they have left the agency or are out on extended leave before concluding that they are delinquent on a training requirement. None of this is an automated process.

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 and Wellpath's policies clearly state that, if a prisoner is thought to be at imminent risk of harm to self or others, staff members must inform mental health staff immediately and place the prisoner under constant observation until assessed by mental health.[19] In interviews with staff and prisoners during the site visits, the DQE team heard consistent reports that prisoners who state they are suicidal or engage in self-injury are observed 1:1 until mental health staff arrive. The DQE team reviewed multiple Incident Reports related to self-harm, which were largely silent on the matter, documenting the initiation of 1:1 observation after mental health staff evaluated the patient but rarely commenting on the prisoner's observation status prior to mental health's arrival.

Accounts of whether security staff called mental health *immediately* varied by facility and sometimes by housing unit. At OCCC, prisoners reported that officers call crisis ("Medic 5") upon request, while at Concord and SBCC, prisoners reported that security staff often delay calling or refuse to do so. There also seemed to be significant confusion about whether it is appropriate for an officer to ask a prisoner why they are requesting to speak with mental health. Some officers believed they should always inquire about the nature of the prisoner's problem so they could inform mental health staff of the situation, while others thought that they should not make such inquiries to protect prisoners' confidentiality. Similarly, some prisoners felt comfortable telling an officer why they were requesting mental health services, while others were deeply concerned about officers knowing such personal information. To address this confusion, MDOC might consider adding content to its annual in-service training about the confidentiality of healthcare information and how to handle circumstances where a prisoner requests a crisis call but does not want to disclose why.

Because delays in reporting self-injurious behavior were a central concern in the DOJ Findings Letter, the DQE team would like to collect data more systematically before issuing a substantial compliance finding for this provision. The team will work with

[19] See policies 103 DOC 650.08, Wellpath 37.03, and Wellpath 53.01.

MDOC in the coming months to develop a practice for doing so. For example, a sample of videos from SDV incidents may be reviewed and compared with staff's documentation of response time in the Incident Reports.

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: To date, the DQE team has not been made aware of documents that can provide proof of practice on this requirement. Among the team's onsite interviews, ten correctional officers or supervisors, across six institutions, offered that they find MHPs very quickly responsive to crisis calls. Several said the response is immediate, and the longest estimate was only 20 minutes. Only at MASAC did one Residential Services Coordinator (MASAC's version of a correctional officer) report that "some [MHPs] took longer than they should to respond." Five interviewed patients shared the view that MHP response occurs within minutes; another three patients estimated much longer times – from 1.5 to 5 hours – that would not be consistent with the requirement.

More information will need to be developed, but with consistent views in a large majority of interviewees, this is promising for a substantial compliance finding in the short- or medium-term.

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: Wellpath's current practice appears to comport with this requirement. An MHP is on site at each MDOC facility where TS occurs between 8 am and 9 pm, Monday through Saturday. On Sundays, a clinician is on site from 8 am to 4 pm. Outside of those hours, Wellpath has an independently licensed MHP on call by phone. If a crisis occurs during non-business hours, an on-site nurse will respond and assess the patient, then call the on-call MHP to determine what intervention is appropriate.

During the DQE's review of TS placements, several individuals were placed on TS during the overnight hours using this process. In each of these cases, the individual was evaluated by an on-site MHP the next business day. It is not clear, however, that crisis calls that did NOT result in TS placement are routinely followed up by mental health the next business day. The DQE team will need to assess these details in the next six-month reporting period. If such a practice does occur, MDOC is likely to be found in Substantial Compliance with this provision soon.

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: Partial compliance

Rationale: The DQE team spoke with 19 patients, across seven institutions, about this topic. About 80% of them affirmed they had not been disciplined for saying they were in mental health crisis. A few prisoners at Gardner, OCCC, and Shirley said that officers do threaten to write such tickets, and mental health staff and administrators confirmed that disciplinary reports are occasionally issued for misusing crisis services. MDOC's current practice is to allow only mental health staff to "sign off" on these disciplinary reports; it is not clear whether this practice is formalized in policy, as policy 103 CMR 430, Inmate Discipline, does not explicitly address the matter. It states, in relevant part:

> Disciplinary reports solely for self-injurious behavior are prohibited. Disciplinary reports for behavior directly and wholly related to self-injurious behavior, such as destruction of state property, are also prohibited. Likewise, disciplinary reports for reporting to the Department or contract staff feelings or intentions of self-injury or suicide are prohibited.

The DQE team aimed to verify the five potential disciplinary cases that came to our attention through prisoner interviews or onsite observation. After the team's review of two disciplinary reports, issuing a Misuse of Crisis ticket seemed reasonable under the circumstances described in the documentation. In another instance, the ticket was not issued for calling a mental health crisis, but for destroying a tablet.[20] The others could not be substantiated.

The DQE team did learn of two cases where a security officer or a nurse had pursued a Misuse of Crisis ticket without the input or approval of an MHP or in opposition to an

[20] The patient reportedly intended to use the pieces for self-harm.

MHP's recommendation. The DQE team observed the regional mental health administrator coordinating with security leaders to have these cases dismissed when they came to light, and written confirmation of the dismissal was later provided.

While a systematic review of disciplinary reports around crisis calls will be useful, the information gathered to date indicates that MDOC has taken many steps toward compliance with this provision.

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: Noncompliance

Rationale: The DQE team does not yet have any information about MDOC's internal audit process related to crisis calls, so we cannot say at this juncture whether MDOC "ensure[s], through an audit process," that MHPs' crisis assessments include all the areas delineated in 46a-f.

To perform an independent review of crisis assessments, the DQE team assessed 50 MHP Crisis Assessment notes in May and June 2023. The team found that MHPs consistently documented the information required by subsections 48a-c and 48e-f, but the information in subsection 48d was missing in all 46 cases (92%) where the crisis contact did not result in TS placement. Although it may seem nit-picky to focus on one subsection when all others are adequately documented, subsection 48d pertains to the prisoner's history of self-harm and suicidal ideation—a crucial part of any clinical risk assessment. Neglecting to review this information when deciding whether a prisoner needs to be placed on TS is a significant problem.

Although clinicians' documentation need improvement, the bigger problem is the crisis assessment itself. During the DQE team's site visits, we observed MHPs conducting very cursory crisis assessments, and they did not uniformly obtain critical information from the medical record that would inform their risk assessment. The crisis assessments we observed at OCCC and SBCC were generally brief, sometimes as short as 3 minutes. Crisis assessments being done for the purpose of BAU screening were particularly superficial, often consisting of an MHP asking the patient in a non-confidential setting, "You don't want to hurt yourself, right?" This practice created little opportunity for the patient to disclose how they were really feeling, and it did not constitute a clinically adequate risk assessment.

The DQE team also observed that crisis assessments were conducted in non-confidential settings at some facilities, including OCCC and SBCC. Although MDOC retrained its staff and created more confidential spaces for crisis assessments at OCCC after the DQE team pointed out the problem in February 2023, it seemed that security staff were still resistant to facilitating out-of-cell crisis evaluations in July 2023. For example, when a patient being evaluated in the Newman's area of OCCC requested an out-of-cell assessment, the security officer called his supervisor, who then declined to move the prisoner to a confidential location in the Health Services Unit, stating that the clinician could evaluate the patient cellside. The clinician contacted the Mental Health Director, who arrived quickly and intervened. Ultimately, the clinician was able to meet with the patient in a confidential location. OCCC clinicians reported to the DQE team that the situation we observed occurred commonly, and they appeared to have resigned themselves to halfheartedly asking the patients about out-of-cell contacts, knowing that most assessments would take place cellside at the discretion of the officer.

Substantial work must be done to improve the quality of crisis contacts before MDOC can be found in compliance with this provision. The DQE team hopes that MDOC's recently improved staffing levels will help the situation by allowing more time for thorough assessment and opportunities for inexperienced MHPs to collaborate with more seasoned and skilled clinicians.

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: Noncompliance

Rationale: In a detailed review of MHPs' responses to 50 crisis calls across 10 MDOC facilities in May and June 2023, a psychiatrist or nurse practitioner was consulted in only

three cases (6%). In 41 of the 50 cases (82%), the DQE did not see a clear indication for referral to psychiatry, as the crisis calls were precipitated by institutional stressors or grief, and the situation was handled by the MHP. However, in the remaining six cases (12%), the prisoner was not referred to psychiatry despite a clear indication to do so. The circumstances in these cases included:

- A patient with a diagnosis of schizophrenia was referred for crisis evaluation by security due to bizarre behavior. The MHP did not check medication compliance or refer to psychiatry.
- An officer in the BAU referred a patient because of his bizarre writings. The MHP noted possible delusions but did not check medication compliance or refer to psychiatry.
- A patient in RTU called crisis because he was upset about not being seen by psychiatry and his medications not being adjusted. The MHP did not refer to psychiatry, and the patient was not seen by psychiatry for another two months.
- A patient made overtly paranoid/delusional statements during the crisis contact. The MHP did not check medication compliance or refer to psychiatry.
- A crisis contact was precipitated by a patient's thoughts of harming others. The patient appeared fidgety, reported thoughts of harming others "to burn energy," and noted a history of ADHD and taking (non-stimulant) medications in past. The patient was not referred to psychiatry for medication evaluation or diagnostic clarification.
- A patient exhibited odd behavior during a crisis contact and was suspected of using K2. The MHP noted noncompliance with psychiatric medications but did not refer to psychiatry. The MHP initiated TS placement, but the patient was not seen by psychiatry for another two weeks, well after discharge from TS.

Overall, two thirds of cases (6 out of 9) that should have been referred to psychiatry were not. Thus, it appears that MHPs are missing important cues for referral to psychiatry, or at the very least, not documenting their thought process about why a referral is not warranted. MDOC will need to show improvement in this area to be found in compliance with this provision.

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, 46 cases included a crisis progress note in the DAP format. In all these cases, the crisis assessment did not result in

a TS placement. In the four cases where a TS was initiated as a result of the crisis contact, the MHPs' practice was to complete a Crisis Treatment Plan in lieu of the crisis progress note. The Crisis Treatment Plan template is not in the DAP format, but it prompts clinicians to enter the same information. (In fact, it is a more comprehensive note template). Thus, although all 50 cases the DQE reviewed did not contain a DAP-formatted progress note, the clinically relevant information was sufficiently documented, so a substantial compliance finding is being issued. The DQE's concerns about the thoroughness of crisis evaluations are addressed in Paragraph 47; the rating in Paragraph 49 takes into account only the presence of a properly formatted note in the medical record.

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: Partial compliance

Rationale: The DQE defines "clinically appropriate" in this context to mean that the MHP conducted a suicide risk assessment in accordance with generally accepted standards of care and then exercised reasonable professional judgment in determining which level of TS to recommend (close or constant supervision). If the DQE were assessing this provision based on medical documentation alone, a finding of substantial compliance may have been issued. In a review of 50 TS placements, there was only one case where the DQE questioned the MHP's judgment about the level of TS placement or the need for it altogether. In all other cases, it seemed that the MHP was making a reasonable decision based on the patient's documented risk factors, symptoms, and degree of cooperation with the assessment.

However, as noted in Paragraph 47, the DQE team found during the site visits that MHPs' suicide risk assessment practices varied widely and were inadequate at some facilities. Clinicians at MASAC did an excellent job, stressing the importance of reviewing the medical record prior to assessing suicide risk and describing their team's philosophy about patient care as, "Never go in blind, and always do your homework." In contrast, MHPs at OCCC and SBCC routinely assessed patients during crisis calls without contemporaneous access to their medical record, which contains much of the historical data needed to assess suicide risk. The MHPs sometimes looked up the information after the fact, when writing a clinical note about the patient encounter, but this was after the decision about TS placement and level of supervision had already been made. It seemed that time constraints and lack of access to the medical record on the housing units were the biggest drivers of MHPs' cursory risk assessments.

Given that over half of MDOC's TS placements occur at OCCC and SBCC, the DQE team would need to see improvement at these facilities before issuing a substantial compliance finding for Paragraph 50. With MDOC's improved staffing levels in recent months, the DQE hopes to see a consistent practice of MHPs reviewing the medical record and conducting more thorough risk assessments prior to making decisions about TS placements.

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: Partial compliance

Rationale: Wellpath's 66.00, Therapeutic Supervision, clearly prohibits the use of TS for punishment, stating, "TS shall not be used as a punishment or for the convenience of staff, but shall be used only when less restrictive means are not effective or clinically appropriate." MDOC's policy, 103 DOC 650.08, Emergency Mental Health Services, addresses many aspects of TS but does not explicitly state that TS shall not be used for punishment or convenience. The policy will require revision to come into compliance with Paragraph 51.

In interviews with mental health staff and prisoners, the DQE team did not find any cases where TS was being used as a punishment. There were cases where a prisoner did not participate meaningfully in a risk assessment and the MHP erred on the side of caution by initiating a TS placement, but this seemed clinically reasonable. Of note, there was a practice called "Security Watch" used with prisoners on the mental health caseload at some institutions (e.g., MASAC) that seemed to share many characteristics of TS and may warrant further clarification to distinguish it from punishment as described in the Agreement. If Security Watch practices are clarified and the Emergency Mental Health Services policy is revised, a substantial compliance finding could be issued.

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: Noncompliance

Rationale: To assess the presence of initial Crisis Treatment Plans, and many other Agreement requirements, the DQE team reviewed records from 101 TS placements, which represents 19% of MDOC's placements from December 20, 2022, through June 30, 2023.[21] The sample was drawn from nine institutions that conducted TS in proportion to their percentages of the systemwide total.[22] This sample heavily favored placements lasting three days or more and drew from each of the above-referenced months.

In this sample, 93% had a Crisis Treatment Plan in the record.[23] At least 11% were documented as being completed in nonconfidential settings.

MDOC's treatment plan template contains information on each of the topic areas outlined in subheadings 52a-k, but it is often not clear where the clinicians are getting the information that is entered into the template. As described in Paragraphs 47 and 50, crisis assessments are fairly cursory. In the DQE's review of 50 crisis contacts from across the facilities, the average duration of a crisis contact was 13 minutes, and over half the contacts were 10 minutes or less. In that brief time, it is simply not possible to assess the 45 historical, clinical, and situational risk factors and 10 protective factors that the treatment plan template prompts MHPs to review, while also building rapport and engaging with the patient around the presenting problem. In the DQE team's experience during the site visits, MHPs inconsistently asked risk-related questions during their crisis assessments, and they inconsistently gathered collateral information from the health record prior to creating a patient's crisis treatment plan.

[21] According to the spreadsheet provided by MDOC with the file name JUNE 2023 TS REGISTRY.xlsx
Also a note to the reader: This records sample provided the foundation for the analysis of many requirements in this report. The total number of records will vary, however, in different analyses for several reasons. The total may be larger where the DQE team added records because of information learned in patient interviews, incident reports, or other sources. The total may be smaller, for example, because some records lack information on a given requirement, or the requirement is not applicable to some of the sampled patients' situations.
[22] Please see the table on page 17 of this report
[23] One of these was completed significantly later than contemplated by this requirement.

In addition to concerns about the accuracy of historical information entered into the crisis treatment plans, the DQE had concerns about the quality of documented risk assessments. The DQE team reviewed 50 crisis treatment plans from across the facilities. Fourteen of these plans (28%) contained no real discussion of the patient's risk, simply cutting and pasting text about the patient's presenting problem into the Risk Assessment section without adding any further information or making only a conclusory statement like "patient will be placed on 15' watch per MH triage meeting." This practice was most prevalent at OCCC, SBCC, Norfolk, and Concord, though not universal. Each facility contained some good and some bad examples of risk assessments.

MDOC's crisis treatment plans are insufficiently tailored to the patients' individualized circumstances. A wide variety of factors lead prisoners to TS, though the most common reasons are suicidal ideation in the context of dissatisfaction with housing conditions, emotional dysregulation after receiving a disciplinary report and/or being placed in the BAU, and bizarre or suicidal behaviors detected by security staff. The DQE understands how challenging it can be to write a treatment plan for a patient who, for example, threatens suicide if not given their preferred housing location. However, a review of 50 treatment plans indicates that MHPs make almost no attempt to create an individualized plan. Regardless of the patient's presenting problem, every crisis treatment plan contained some combination of the following five objectives:

- Engage with daily mental health contacts
- Refrain from self-injury (sometimes "maintain safety" or "maintain behavioral control")
- Identify positive coping skills (sometimes specifying a particular number of skills that the patient should identify, "2-4" or "3-5")
- Remain medication compliant
- Identify triggers for self-harm

These objectives are recycled in nearly every treatment plan, even when they make no sense with the patient's presentation. For example, in one case, a patient was placed on TS two weeks apart, once for bizarre behavior and once after being found with a ligature. The "Measurable Objectives" and "Strategies to Reduce Risk" sections in the second TS treatment plan were entirely cut and pasted from the first despite the very different clinical circumstances. In another example, a patient was entirely mute during the MHP's crisis assessment, and he was placed on TS for further assessment. The crisis treatment plan makes no mention of diagnostic clarification as a goal of TS, instead stating that the objectives were to "engage with mental health" and "identify positive coping skills." In a third example, a patient was placed on TS because of altered mental status, and he admitted to misusing prescribed and non-prescribed medications. The

treatment plan does not mention substance abuse as a possible problem to be addressed, instead referring to boilerplate language about refraining from self-injurious behavior and cooperating with TS assessments.

Substantial improvements in the quality of treatment planning, including involving more treatment providers than just the crisis clinician (e.g., psychiatrist, ARNP, activities therapist), will be necessary for MDOC to be found in compliance with this provision. The DQE does not wish to place a further burden on MDOC's clinicians by requiring more exhaustive documentation; the treatment plans must simply be tailored to the patients' individual needs. Some good examples of individualized (but brief) treatment objectives from medical records at Concord and OCCC:

- "Identify plans to grieve" for a patient who requested TS after his sibling's death
- "Address security issues and move toward accepting assigned DOC housing" for a patient who threatened suicide if placed in the SAU
- "Decrease irritability and delusional thoughts" for a patient with a psychotic disorder who had stopped taking his medications

If other patients' plans follow this lead, MDOC will be on a path toward eventual compliance with Paragraph 52.

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: Partial compliance

Rationale: The wording of Paragraph 53 is so close to that of Paragraph 50 that the DQE cannot distinguish a meaningful difference between them. Thus, the partial compliance finding from Paragraph 50 is simply repeated here. Going forward, the DOJ has agreed to repeat Paragraph 50's compliance finding in this section, acknowledging significant overlap between the two provisions.

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.

Finding: Partial compliance

Rationale: MDOC maintains therapeutic supervision cells in its Health Services Units, Behavior Assessment Units, and on housing units of specialized programs in some institutions. MDOC reports it has worked with a highly respected expert on suicide prevention in incarcerated settings and has modified its therapeutic supervision cells to meet his specifications. The DQE team reviewed these cells during site visits and agrees that they are well-designed for suicide resistance.

In terms of sight lines, all TS cells had a plexi-glass window and waist-level food port through which an officer could look into the cell, as well as a video camera in a corner of the cell near the ceiling. The size and placement of the window varied between units and institutions. Some had very large windows, while some others, particularly in some Behavior Assessment Units, had narrow, high windows requiring an officer to stand or sit on a barstool-height chair to see inside. This posed a challenge for officers conducting 1:1 watches at some institutions. In one such setting, the DQE team verified that there had been no therapeutic supervisions since the Agreement went into effect, but the Superintendent asserted that all therapeutic supervisions on that unit would be conducted as constant observations to compensate for the visibility limitations. Further assessment by the DQE team is needed to determine whether limited cell visibility has an impact on therapeutic supervision, such as making it difficult to detect self-injury (as was the case during the DOJ's 2019 investigation). Further assessment is also necessary to understand how video monitoring is integrated into officers' observation of prisoners on therapeutic supervision, if at all.

MDOC leaders represented that, if a therapeutic supervision must take place in a cell that is not suicide-resistant, then constant observation is required. The DQE team has not yet received information from MDOC to clarify which of its TS placements were conducted in non-suicide resistant cells, but MDOC is developing a process to alert the DQE team to these cases going forward. The DQE team will continue to monitor this issue as it receives additional information.

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: During site visits, the majority of institutions reported using a cell checklist, and six of them provided their forms. MDOC administration reported having distributed a checklist for universal use in April 2023.

Implementation is a work in progress. Of the staff who commented on this responsibility during interviews, half were aware of the checklist.[24] Early in the monitoring period, the DQE sometimes found only one completed checklist in a sample at locations where the administration thought the forms had been adopted. Promisingly, at the end of the monitoring period, this requirement was fully met in a 10-placement sample at OCCC.[25] In April 2023, MDOC's Quality Improvement Committee identified the need to audit officers' TS documentation about the use of cell inspection checklists, so the DQE anticipates continued improvement as these audits are implemented.

Given the foregoing, it was premature to assess supervisors' use of the checklist after patients' self-directed violence.

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: Partial compliance

Rationale: All MDOC institutions where therapeutic supervision occurs employ a similar practice of discussing patients' progress on TS, the level of watch indicated (close or constant), and changes to their property/privilege access during the daily Mental Health Triage meeting, Monday through Friday. A representative from the security staff is also present during the portion of this meeting where patients on TS are discussed. The assigned "crisis clinician" presents their assessment of each TS patient, and the group then collectively decides, based on the patient's clinical status, whether to advance privileges, allow additional property, change the watch level, or discontinue the watch.

[24] This topic was discussed in interviews with 12 correctional officers or sergeants posted in a Health Services Unit or Behavior Assessment Unit and who had been identified to the DQE team as having conducted close or constant observation of prisoners in therapeutic supervision in 2023.

[25] The DQE team selected a sample of 10 therapeutic supervisions chosen primarily for length of stay, diversity of location of placement, and for an equal distribution over April through June 2023. OCCC administration provided, for each sampled placement, folders containing a cell checklist, printouts of routine activities offered, completed watch sheets, and instructions to officers.

Once decisions have been made, the patient's Therapeutic Supervision Report is updated and printed. The afternoon's crisis clinician communicates the changes to the officers and other staff assigned to the patient's TS placement, and a copy of the revised Therapeutic Supervision report is posted next to the patient's cell door.

During the site visits, the DQE team observed at least one triage meeting at each facility. The team observed clinical discussions about patients on TS during each facility's meeting (if there were currently patients on TS), and it appeared that the group's decisions about property and privileges were being made based on the patient's clinical status, in accordance with the Paragraph 56 requirements. The DQE team did not observe property/privilege discussions that were specifically tied to a prisoner's length of stay on TS or "whether the specific [privilege] has the potential to help or harm them," but the staff's practice was consistent with the overall intent of Paragraph 56.

The DQE team gathered the opinions of nearly all mental health staff at Concord, Gardner, and Norfolk during their Triage Meetings. Some described great collaboration with security staff on the decisions specified in Paragraph 56, and all believed that officers honor mental health staff's authority to make the final decision. Security leaders at several institutions reinforced this idea. Staff reported that any differences of opinion are resolved at their level and that they had had no need to go up the chains of command. This is a helpful part of the compliance picture, and the DQE team will develop information at other institutions in future monitoring. During the initial monitoring period, the DQE team heard anecdotal reports of security staff overriding the mental health staff's decisions at some institutions, but no systematic review of these reports across facilities was conducted.

In the DQE team's review of records related to 107 TS placements, described fully in the Paragraph 52 discussion, documentation of MHPs' decision-making around property/privileges was brief, typically just stating that, "per MH triage meeting," certain changes would be made. As will be detailed in paragraphs 57 through 65, while the DQE team has not yet explored staff's reasoning for their decisions, staff have been making either individualized decisions or what may be routine decisions that result in authorized showers, phone calls, and visits immediately, and many patients quickly being in clothing, receiving reading material and tablets, and being approved for recreation. With the minority that are exceptions, the reasons not to grant the property or activity often are not documented or seem at odds with other information in the records, so it may be that those decisions may not be based upon the patients' clinical acuity and whether the property or activity has the potential to hurt or help them. The DQE team observed in more than 100 health records that each of these decisions is recorded routinely on a Therapeutic Supervision Report, which is shared by mental health and security staff.

Decisions about lighting and meals are made on a group basis grounded in practical, not clinical, concerns. Restraint practice varies widely and, while sometimes the decision is made collaboratively concerning each individual patient, it is not clear that the criteria specified in Paragraph 56 are among those discussed. The DQE team observed that lighting, meals, and restraints decisions are not recorded on Therapeutic Supervision Reports.

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;
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: To assess this requirement, the DQE team reviewed records from 107 TS placements,[26] which represents 20% of MDOC's placements from December 20, 2022, through June 30, 2023.[27] The sample was drawn from each of the ten institutions that

[26] This set of records is different from the sample that was reviewed for more treatment-related requirements, which was described in the Paragraph 52 analysis. Here, too, the total number of records reviewed may fluctuate slightly on different requirements primarily because of additions to the core sample or removal of cases irrelevant to that specific requirement.

[27] According to the spreadsheet provided by MDOC with the file name JUNE 2023 TS REGISTRY.xlsx
Also a note to the reader: This records sample provided the foundation for the analysis of many requirements in this report. The total number of records will vary, however, in different analyses for several reasons. The total may be larger where the DQE team added records because of information learned in patient interviews, incident reports, or other sources. The total may be smaller, for example, because some records lack information on a given requirement.

conducted TS in approximate proportion to its percentage of the systemwide total and drew from each of the above-referenced months. The team reviewed the Therapeutic Supervision Reports from each day of a placement, along with Crisis Treatment Plans and/or progress notes in cases where clothing was not initially authorized.

The DQE team's assessment also integrates information from 33 patients, from eight of these institutions, who had been on TS during the monitoring period; the reviewer sometimes supplemented this with a review of relevant Therapeutic Supervision Reports. The assessment also considered a handful of comments from mental health staff and materials MDOC provides monthly to demonstrate all notifications made to Wellpath and MDOC superiors in satisfaction of Agreement Paragraphs 57, 78, 79, and 80.

The largest proportion of the sampled patients were authorized to remain in clothing from the outset, and fully 74% were in clothing by approximately the 24-hour point.[28] This practice was strongest at Concord, MTC, and OCCC.

These cases were less successful in demonstrating that clothing was removed only for the purposes stated in the Agreement -- that the patient has demonstrated they would likely use the clothing in a self-destructive manner or that there were other contraindications. Only 11 decisions to use a smock involved a patient declaring an intent to use clothing for self-harm or a recent history of doing so. Most often, no rationale was recorded or a generalized statement – "not currently approved due to risk" -- was employed. This type of decision making was observed in almost all institutions to some extent and was a pattern at SBCC.

In terms of reassessing whether clothing contraindications remain, there is not currently a demonstration that this occurs three times per day.[29] One Therapeutic Supervision Report per day is by far the norm. There *can* be two or three Therapeutic Supervision Reports in the record, and Mental Health Watch contact notes sometimes capture clothing decisions, a mention of continuing property and activities unchanged, or a reference to the Triage Meeting reviewing these decisions, but it was very rare for three decisions to be documented in any format during a day. As noted above, the Agreement also calls for Director notifications and approval of decisions to continue smock use beyond 48 hours. It appears this is in the early stages of implementation; monthly materials provided to the

[28] The study recorded property and routine activity decisions by the day, not by the hour. 74% of the sampled placements were authorized clothing on the date of placement or the following day; it is possible that some of those decisions exceeded the 24-hour point by up to a few hours.

As to whether and how long a patient was in a smock, no patterns related to the location of the therapeutic supervision (BAU, ITU, HSU, or STU) were evident.

[29] As noted in the Baseline Report, the DQE questions whether thrice-daily clothing assessments are necessary as a routine practice. However, the parties agreed to this requirement, so the DQE team assessed it.

DQE contained notifications for less than one-quarter of the sampled cases for which a notice would be expected, and those were not up to standards for timeliness, content, and/or approvals.

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: To assess shower approval practices, the DQE team drew on a sample of Therapeutic Supervision Reports similar to that described in Paragraph 52, along with a few additional such reports and notations in security watch sheets, for a total of 116 placements' documents. The analysis also integrated comments offered by two correctional officers and 17 patients who had been on therapeutic supervision during the monitoring period.

This sample demonstrated excellent compliance regarding authorizing showers. MHPs approved showers on the first day for the vast majority of sampled placements, and 98% had showers authorized within the 72-hour threshold noted in this requirement. There were only three exceptions and, although it appears the patients were never approved for a shower, they were released from therapeutic supervision within the first 72 hours.

As to offering showers, the picture was difficult to discern. In interviews, 30 patients[30] gave views that varied widely. In about half of the facilities, patients mostly said they were offered showers, but there was little agreement about the frequency. In the other half of institutions, about equal numbers asserted that they were or were not offered showers, and again frequency estimates differed. Some who said they were never allowed to shower were in therapeutic supervision only a day or two, but some had longer lengths of stay.

Some facility administrators, or supervisors or officers posted in Health Services or Behavior Assessment units, described the frequency with which they expect showers to be offered. Documentation does not yet provide consistent proof of practice. Some

[30] Patients from all but one institution responded to this question.

security personnel indicated that officers who conduct close or constant supervision also record on watch sheets when a patient is taking a shower.[31] Others described a system of capturing offers and acceptances or refusals, which are then entered in the online information system called IMS; this system reportedly has been in use in Behavior Assessment Units long-term and was expanded relatively recently for use in Health Services Units. The DQE team reviewed watch sheets for 25 placements and IMS documentation for 10 placements. Those sources showed a very low rate of showers and/or offered showers, often less than patients had estimated. This suggests to the DQE team that the recording methods are not yet fully in use.

MDOC is on a good path toward compliance with this requirement, and the DQE looks forward to the support that will be offered by documentation once recording is more established.

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: Noncompliance

Rationale: To assess this requirement, the DQE team observed the lighting controls in most units that house patients on therapeutic supervision; discussed the controls with administrators or security staff in the units; and gathered information from 20 patients who had therapeutic supervision placements in 2023, an MHP, and 13 officers who have been responsible for close or constant supervision this year in one or more of the relevant housing units, or their supervisors. [32] It is the DQE team's understanding that only Framingham and Norfolk have the type of lighting that can be dimmed. There, officers and patients generally confirmed that lighting is dimmed at night in their experience.[33]

In the other facilities, nearly all patients reported that the lights remained on full throughout the night,[34] and officers and mental health staff confirmed this as their understanding of expected procedure. It appears that both physical plant and procedure changes will be necessary to meet this requirement at most institutions.

[31] It is not clear that this would capture situations when a shower has been offered but refused.
[32] Interviewees from all but one institution gave information on this question. Most patients had been housed in a Health Services Unit, and a few had been placed in a Behavior Assessment Unit or Intensive Treatment Unit. Officers had experience in one or more of those units.
[33] At Norfolk, most said this, although two patients said the lights were on without specifying whether full or dimmed. At Framingham, interviewees said lights were dimmed or off.
[34] Two patients said lights were turned off entirely.

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 chart review previously described in relation to Paragraph 52, there were instances of patients being granted other types of property, though this occurred much less often than authorization for clothing, reading material, and tablets. Typically, this took the form of health-related material, such as glasses and hearing aids, and there were examples of patients being allowed their legal paperwork. It was not feasible to conduct a full analysis during this monitoring period.

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: The DQE team's assessment indicated that MHPs had strong practice authorizing books and other reading material for patients on therapeutic supervision. The reviewer employed the Therapeutic Supervision Report sample described above and integrated the 15 interviews in which patients commented on access to reading material.[35] Each patient's chart had Therapeutic Supervision Reports,[36] signifying that determinations had been made for that patient. The DQE team also observed at each

[35] Taken together, there were at least 130 placements reviewed. Among those, at least 118 placements exceeded one day and were subject to this requirement. There were patients at six institutions who commented on the requirement. Some of those patients had multiple placements in 2023, but each person's views were treated as one unit of analysis. Where they mentioned reading material without referencing a timeframe in which it was received, the analysis treated this as timely. The DQE team did not assess access to writing material during this monitoring round.
[36] If reading material is approved, it is listed on this document under Other Property Allowed. This is also the case with tablets and other items of physical property. If it is not named there, the patient is not permitted to have the item.

institution that it is routine to discuss each TS patient in weekday Triage Meetings and whether to authorize different types of property for him or her. The DQE team has reviewed Triage Meeting minutes from each institution in each month of the period March through June 2023, and the minutes capture decisions about property, some out of cell activities, and watch level. These practices suggest that determinations are individualized and, even if they have become routinized, the numbers below indicate that staff err on the side of permitting reading material.

In the DQE's review, only 10% of the placements exceeding 24 hours did not have approval for reading material. A similar, slightly smaller percentage authorized reading material later, between Day 3 and 6 in all such cases. Reasons for any contraindication underlying those decisions generally were not indicated in progress notes. Thus, it appears that more than 80% of relevant placements were approved on the Agreement's timeline to have reading material. In terms of access, the interviewed patients generally confirmed that they did actually have books unless they did not want them. Patients and security staff referred to a cart of books in ways that suggested it is a routine resource and, fairly often, progress notes or MHP interviews referenced providing the patients with packets of written mental health material. More will be needed to confirm these initial findings, but this is a strong start to demonstrating good practice on this requirement. Many institutions did well on this requirement, with SBCC, MTC, MASAC, and Gardner showing the best practice.

Practice concerning tablets was even better.[37] In the DQE's review sample, there were six placements that exceeded 14 days.[38] All but one were approved for a tablet in the first week, well ahead of time specified in this requirement. The one exception was a patient in this status for well over three months; he was not approved for a tablet, and the reasons were not clearly specified in progress notes. If this practice is sustained in the coming monitoring round, MDOC could earn a substantial compliance rating concerning tablets.

Additionally, MHPs went above and beyond this requirement, approving tablets in 69 placements in the sample that were much shorter than 14 days, with the majority authorized within the first two days. This practice was evident at seven of the institutions.

62. Routine Activities: Throughout the prisoner's time on Mental Health Watch, a Qualified Mental Health Professional will make and document individualized determinations regarding

[37] For this analysis, the reviewer examined the 107 records from the study first described in relation to Agreement paragraph 52 and drew upon interviews of 25 patients across eight of the institutions that conduct therapeutic supervision. As with the analysis of reading material decisions, an interviewee was treated as one unit of analysis regardless of the number of his/her placements in 2023.

[38] The TS Registries provided by MDOC show 25 placements exceeding 14 days in 2023, so this represents a 24% sample. The sampled placements ranged from 19 to 109 days and took place across four institutions.

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: Partial compliance

Rationale: MHPs almost universally authorize visitation and telephone calls for patients on therapeutic supervision, according to the DQE team's review of 111 records from the Therapeutic Supervision Report sample described above. Each patient's chart had Therapeutic Supervision Reports,[39] signifying that determinations had been made for that patient. Only three placements were not allowed either of these activities, and two others were permitted phone calls but not visits. This was confined to three institutions, and nearly all of these exceptional placements ended within two days. The reasons for not permitting these activities were not reflected in the progress notes or Therapeutic Supervision Reports.

A number of institutions structure their daily therapeutic supervision contacts to include one with an activity therapist. The DQE team interviewed most mental health staff, and at least seven security staff or supervisors, at each institution, and the team did not learn of any barriers to, or concerns about, allowing activity therapist contact. Given this 95% rate of endorsement of phone calls and visits, and the similar nature of the other routine activities given as examples in the Agreement, the DQE team is confident that other routine activities would be permitted as well.

In terms of participation, the DQE team observed portable phones at most institutions, which are brought to the patients to use while in their cells, and the team believes these phones are in use in all institutions that conduct therapeutic supervision. The team also observed individual visiting rooms, divided by Plexiglas, accessible to at least some units housing therapeutic supervision patents, and staff informed the team about the routine use of Zoom for family visits, attorney visits, and court appearances. The team noted occasional references in security's watch sheets, or MHP progress notes, to a patient having participated in such a visit. A handful of interviewed patients and correctional officers confirmed access to phone on demand and/or visits.

The DQE encourages MDOC to record the reasons on the rare occasions that an MHP considers one or more routine activities contraindicated. With that, and if the current

[39] There are fields on this form to mark Yes or No for phone calls and visits.

practices are sustained in the coming monitoring round, the DQE anticipates that MDOC could be found in substantial compliance with the Paragraph 62 requirements.

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.

Finding: Partial compliance

Rationale: To assess recreation approval practices, the DQE team drew on a sample of Therapeutic Supervision Reports previously described in conjunction with Paragraph 52, along with progress notes when additional information was needed. Within the sample, 65 placements lasted long enough for outdoor recreation to be required.[40] For nine facilities, practice was excellent, with MHPs authorizing recreation in 92% of the relevant placements.[41] In the handful of cases where recreation was not authorized, however, the reasons were not clearly recorded as they should be. Additionally, a sizeable

[40] This represents a 46% sample of all therapeutic supervisions that lasted longer than three days in the monitoring period, according to the spreadsheet titled June 2023 TS REGISTRY.xlsx

[41] MASAC is included in this aggregate although June 2023 TS REGISTRY.xlsx shows that facility has had no therapeutic supervisions longer than 72 hours since the Agreement went into effect.

number of shorter-term placements were authorized for recreation even though the Agreement does not strictly require it.

Practice differed at SBCC, where 19% of therapeutic supervisions longer than three days were authorized to have recreation. Staff routinely employed the general phrase "due to risk"; reasons that recreation would be contraindicated for the individual's mental health were not explicit in the records. In a few instances, recreation was authorized later than is required – one of them at Day 99 – again without the reasons clearly delineated.

Because SBCC has the largest number of therapeutic supervisions, its practices greatly affect systemwide compliance. While the other nine institutions timely authorized recreation in 92% of their placements, once SBCC's decisions are added to the total, the systemwide compliance rate of recreation authorization becomes 63%.

As to providing recreation once it is authorized, the DQE team saw the recreation areas designated for each unit that houses therapeutic supervisions. Additionally, 17 security staff, supervisors, or administrators spoke about recreation[42], as did 33 patients. Several staff described offering recreation, with some providing detail that indicates a system is routinely in use in their units. Several officers did not recall a therapeutic supervision patient going to recreation; it was not immediately clear whether this reflected an absence of authorization or offering, or was due to patient refusals – which some officers and patients said was common.

There was a diversity of opinion among interviewed patients. Half of the patients said they are offered recreation routinely. Among the others, some believed they were offered this activity rarely, or significantly later than the three-day point, or not at all.[43] Some believed it was institutional policy that no one on constant supervision is permitted recreation. If true, this would not be consistent with the Agreement. There were not clear patterns by institution, housing unit, or month that might explain the differences in perception or experience.

Documentation does not yet provide consistent proof of practice. Some security personnel indicated that officers who conduct close or constant supervision record on watch sheets when a patient is out at recreation.[44] Others described a system of capturing offers and acceptances or refusals, which are then entered in IMS; this system reportedly

[42] Interviewees were drawn from eight institutions and were posted in Health Services Units, Behavior Assessment Units, an Intensive Treatment Unit, or the Secure Treatment Unit, or had worked on therapeutic supervisions in those units as floaters or on overtime.
[43] Among the 33 interviewees, 13 said they were not offered recreation, but June 2023 TS REGISTRY.xlsx shows that their placements lasted a day or two and thus MDOC was not required to offer recreation. That group is excluded from this analysis.
[44] It is not clear that this would capture situations when recreation has been offered but refused.

has been in use in Behavior Assessment Units long-term and was expanded relatively recently for use in Health Services Units. The DQE team reviewed watch sheets for 25 placements and IMS documentation for 10 placements. Those sources showed a very low rate of recreation and/or offered recreation, suggesting that the recording methods are not yet fully in use.

During this monitoring period, the DQE team did not examine practices concerning officer supervision of patients at recreation or strip searches related to recreation.

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: Noncompliance

Rationale: Although MDOC's Therapeutic Supervision training materials from 2022 indicate that restraint decisions should be individualized, the actual practice appears to vary widely. A number of practices are inconsistent with the Paragraph 64 requirements. To assess this topic, the DQE team spoke with members of the administration, or others in security staff's chain of command, at most audited institutions; eight correctional officers who had conducted therapeutic supervision in 2023; five Mental Health Directors or groups of MHPs; and 26 patients who had been on therapeutic supervision in 2023. The reviewers also integrated a handful of comments found in Triage Meeting minutes and progress notes.

A majority of administrators or security supervisors stated their expectation that staff are to make individualized decisions about restraints and decide jointly with mental health staff, although many administrators also endorsed the idea that everyone on Behavior Assessment Unit status must be handcuffed during escort, mental health contact, or both. In practice, only Framingham appears likely to be employing the approach of individualized and joint decision-making, based on information the DQE team gathered from security staff and patients. On the other pole, Norfolk security and mental health staff, and patients, universally perceive that all therapeutic supervision patients are restrained whenever they are out of cell. Between those two poles, there appear to be many variations in practice.

Several institutions appear to restrain all patients who are Behavior Assessment Unit status. One set of officers believes all patients on constant watch must be restrained. At

another institution, it appears that all patients on intake status may be restrained during mental health contacts, although they are not in their housing unit. Elsewhere, staff report that all patients are restrained for crisis assessments. Some locations keep patients handcuffed behind their backs throughout a mental health contact even though the patients are already secured to a "restart chair" or physically separated from the MHP in a "split cell." Some security staff or supervisors said they restrain patients unless mental health staff request otherwise, while their mental health counterparts said they were unaware they could make such a request. In other institutions, however, both types of staff described collaborating on these decisions for many types of patients, noting it is routine to discuss this as the contact is set to begin, so they can factor in the patient's current frame of mind and most recent actions, rather than making a day-long decision that would be recorded on a Therapeutic Supervision Report or elsewhere.

At a few institutions, patients' experience reflected this kind of individual treatment. In most facilities, interviewed patients all believed that they are always restrained when coming out of a therapeutic supervision cell.[45] This could mean that those particular patients commonly pose an imminent safety risk, or the frequency of this perception may suggest that restraint is happening more by default than the requirement contemplates.

All of this leaves open a number of questions for institutions to look into. The DQE team will also continue to gather information for a more complete picture. Given the current uncertainties and variations, examining the MHP requirement to document restraint-related contraindications would be premature.

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: To date, the DQE team has only learned that OCCC is offering meals out of cell to patients on TS who are housed in the Behavior Assessment Unit. The OCCC administration described its consideration of making that change in its Health Services Unit as well; leaders noted that this would require siting meals in a place that would hinder movement or taking one of only two offices offline, which is not feasible given the frequency with which those offices are used for patient care. In addition, MDOC leaders

[45] This was the perception of patients whose therapeutic supervisions were in a Health Services Unit as well as those that had been in a Behavior Assessment Unit.

stated that the Massachusetts Department of Public Health (DPH) would not allow communal meals to occur in the Health Services Unit at OCCC.

The DQE team will continue to gather more information about the potential for out of cell meals at the other institutions, which do not currently offer them. Although the DQE understands that meals out of cell may not ultimately occur at any of these institutions, depending on physical plant limitations and DPH regulations, a response from each facility about barriers to implementation is necessary before finding MDOC in compliance with this provision.

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: There is no objective way to assess a system's commitment to providing constitutionally adequate mental healthcare, but the DQE has no reason to suspect otherwise of MDOC. In its comments on the draft DQE Report, the DOJ agreed that this provision does not need to be assessed going forward.

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: Compliance not yet due

Rationale: Although MDOC is not required to implement this provision until December 20, 2023, in conversations with mental health staff at all locations conducting TS, the requirement of three contacts per day is well understood, and all staff currently aim to accomplish it. Leaders have put in place a structure to facilitate this, with an MHP designated each day with primary responsibility for crisis calls and TS contacts and a second mental health shift, stretching into the evening, during which the MHP is to conduct TS contacts as well.

Sampled health records indicate that three contacts are the norm but that this is not being completed as often as necessary. In a review of 105 health records first described in relation to Paragraph 52 above:

- only 15 showed all the required contacts[46]
- for the other placements, 24% of the contacts were *not* completed

For most institutions, the dominant reason for the shortfall is a difference in MDOC and DOJ's understanding of the Agreement's expectation for TS contacts on Sundays and holidays. MDOC and Wellpath have implemented a plan based on the belief that, on Sundays and holidays, only one contact is required for patients on constant supervision and no contacts are required for patients on close supervision. The language of Paragraph 67 does not contain this limitation, and DOJ attorneys understand the requirement to be three contacts each day, including Sundays and holidays. The DQE team must assess based on the literal language of the Agreement, though the team remains open to discussing modification of this or any other requirement in the future.

The picture at OCCC and SBCC was different. They, too, missed contacts on Sundays, but there was also a meaningful subset of TS contacts missed because of time constraints on mental health staff. Additionally, at SBCC:

- institutional factors prevented contacts in 26% of the placements, and
- the mental health staff has a practice, at Triage Meetings, of designating three daily contacts as "contraindicated" for some patients. In the medical field generally, contraindication is typically understood to mean harmful to a patient's health. There were no descriptions of how a contact would harm the patient's mental health in the records reviewed.[47]

The DQE team also interviewed 26 patients, across seven institutions, who commented about the frequency of contact during their TS placements this year. Only a small minority of them volunteered that they were seen three times daily; the rest described a number of different practices. Several explanations appear possible,[48] but it raises a question to explore.

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[46] Reviewers checked and recorded each mental health contact or attempt, including crisis treatment plans, MHP progress notes, psychiatry progress notes, and discontinuation treatment plans. Each of these sources was counted as a contact whether it was completed or the patient refused.

[47] The DQE understands that this may be a problem with documentation rather than the clinical decision-making in some cases. During the site visits, clinicians discussed at least one case where the frequency of TS contacts was thought to exacerbate self-harming behaviors in a patient with a severe personality disorder, which seemed clinically appropriate to the DQE.

[48] Only 15% of these patients said they were seen three times daily. Among the predictable reasons for this perception are difficulty remembering, downplaying, or speaking in general rather than precise terms, as well as the

The frequency with which mental health contacts occur out of cell is also a concern. The DQE team did review many progress notes referencing patients refusing contact or declining to come out of cell for contact. Thus, it appears that this documentation does take place routinely, although noting the patient's reasons was rare. Out of cell contacts are discussed in detail in the Paragraph 72 analysis below.

Either the content of progress notes in the DQE team chart review, or the timestamp of the health care record entry,[49] illustrate that contacts are made or attempted at different times of day. There was no information in the reviewed health care records or Triage Meeting minutes about additional attempts, or different engagement methods, for patients who refuse contacts.

With each of the issues raised in this analysis, it is likely there are multiple causes. There may also be explanations that reduce the scope of the issues. Potential paths forward will depend on MDOC and Wellpath developing a more specific understanding of the causes and what is practical to ask of staff in response. The DQE encourages DOC and Wellpath to examine these questions internally and/or with the DQE team.

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: Noncompliance

Rationale: The DQE team observed Triage Meetings at each institution where TS occurs, and MDOC provided Triage Meeting minutes for the period of March through June 2023 for the DQE team's review. Staff at the observed meetings occasionally discussed patients' refusals to meet or come out of cell, [50] and progress notes indicate that patients often refused. Interventions to address the behavior were not a focus of Triage Meetings, nor was it apparent that clinicians had reviewed the minutes of prior meetings. Overall,

possibility that some or all such patients are reporting the situation accurately. It may also be that some patients are not considering cellside check-ins – which appear common in the health records -- to be mental health contacts, and this affects patients' perception of how often they were seen.

[49] The timestamp is not definitive, as there are a number of progress notes where the content makes clear that the note is being entered at a time later than the actual contact. Nevertheless, the fact that notes are timestamped at different points in the day helps to demonstrate practice on this requirement.

[50] In a few meetings, no patients were on therapeutic supervision at the time. Additionally, the DQE team does not know whether treatment refusals were an issue for the particular patients who *were* discussed.

the components of Paragraph 68's documentation requirements were not present in the Triage Meeting minutes reviewed by the DQE team.

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: Partial compliance

Rationale: Conversations with a wide range of correctional officers, their supervisors, mental health staff, and facility and MDOC administration indicate that daily updates to therapeutic supervision conditions, recorded in the form of Therapeutic Supervision Reports, is well established practice. MHPs reported that they consider TS conditions as part of the first patient contact of the day and discuss during Triage Meetings whether to make changes. Correctional officers regularly demonstrated to the DQE team that the Therapeutic Supervision Reports are posted on the patient's door, and the officers said they rely on this information for daily activities.

In the DQE team's review first described in relation to Paragraph 52 above, daily Therapeutic Supervision Reports were found for 87% of the placements. In the other placements, those reports were present, but there were single-day gaps or occasionally more than one.[51] The most common pattern was the absence of a report on the first day – perhaps when placement is directed by an on-call professional – but there were others for which a reason was not immediately apparent. All of these placements had at least one progress note per day, which satisfies the second provision of Paragraph 69.

If practice is sustained through the coming monitoring period, MDOC is on track to reach substantial compliance for Paragraph 69.

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

[51] This describes what is found in the Wellpath electronic health record ("ERMA"). MDOC administration has informed the DQE team that the Therapeutic Supervision Reports are stored both in ERMA and in IMS, the Information Management System commonly used by security staff. The DQE team does not have access to IMS, and it is possible that some or all of what appear to be missing reports are in IMS and the gap is only a glitch in copies being uploaded to ERMA.

Rationale: In the DQE team's chart review of 101 TS placements described in Paragraph 52 above, clinicians consistently documented their attempted interventions and plan. When a patient engaged with the clinician, the notes generally did a good job of documenting the intervention – "writer spoke with patient about her mother being her biggest support" – and the patient's response – "client was receptive to support throughout the contact." When a patient did not engage, the clinician documented what they tried to do and how the patient responded: "Client was observed to be lying in bed covered by security blanket…. Writer prompted [client] to engage in risk assessment, to which [client] refused." The progress notes were not long, but given that they were written three times a day, they seemed sufficiently detailed for the next clinician to understand the patient's trajectory and to create a longitudinal history of the patient's progress on TS. Documentation did not vary significantly between facilities; all clinicians had a similar style of describing their discussion with the patient and whether the patient was "receptive" or not. In cases where the patient did not engage, many clinicians demonstrated good practice by documenting information from collateral sources, such as medication compliance records and officers' reports of meal completion, hygiene, and recreational activity.

Clinicians' documentation about the patient's plan on TS was also sparse, generally consisting only of a note that the patient was discussed in the triage meeting (or 1:1 with the site or regional mental health director) and whether the TS placement would be continued at the current level, upgraded, downgraded, or discontinued. Occasionally, the plan would include a notation about increased property or privileges being granted. Although not extensive, given the demands on clinicians' time and the frequency of contacts, the DQE team found the documentation to be sufficient for its clinical purpose.

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: Interviewed officers generally perceived that patient self-harm is rare during therapeutic supervision. Indeed, officers who conduct these watches at four institutions said they had not seen any such incidents occur in 2023. In a sample of 57 patients interviewed, four volunteered that they had injured themselves while on therapeutic supervision this year.[52]

[52] The DQE team verified these reports, and gained further information, by identifying the patient's therapeutic supervision dates on the spreadsheet titled June 2023 TS REGISTRY.xlsx and reviewing the electronic health records for those dates.

As one window into this requirement, the DQE team examined the self-injuries documented during the TS placements that made up the chart review first described in Paragraph 52 above. This was supplemented by the health records for some self-injuries that came to light during patient interviews, observing Triage Meetings, and an external information source.[53] In total, the DQE team analyzed 29 self-harm events drawn from eight institutions, representing 38% of MDOC's reported SDV incidents for patients on TS between March and June 2023.[54] One-third of the reviewed incidents occurred while the patient was on constant observation.

While some patients hurt themselves using only their own bodies, and there was a very low incidence of inserting or swallowing objects, about 10% of the sampled placements saw patients initiating hanging or cutting themselves, which TS aims to prevent. Most troubling were three events, which took place at OCCC and SBCC, where patients ingested between 30 and 80 pills they were able to hoard or buy.

In response to patient self-harm, health records indicated that staff commonly would reduce allowable property and increase security supervision, but it appeared interventions were reassessed in only one-third of these incidents. In better cases, staff created a plan for how the patient could progress, introduced new topics into counseling, and/or referred the patient to Bridgewater State Hospital. There were also single instances of responses such as deciding to see the patient less, putting the patient in restraints without medical supervision, discontinuing medication, or changing the patient's mental health code without any other action.

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: Although MDOC clinicians clearly interact with patients on TS regularly, there are several practices that raise questions about whether patients are receiving meaningful therapeutic interventions. The DQE team's chart review showed that the majority of TS contacts, approximately 60%, occur cellside or in another nonconfidential setting. Most of these are recorded as being the patient's preference or the patient not engaging. It is noteworthy that, when the DQE team observed MHP contacts, the

[53] The DQE received an unsolicited email from a prisoner's family member, which prompted a review of that prisoner's records.
[54] Based on the SDV logs, 77 total incidents of SDV occurred while patients were on TS during this period.

question of whether to meet out of cell tended to be framed in ways that discouraged coming out; only Framingham MHPs impressed the DQE team as consistently extending a genuine invitation. As detailed elsewhere in this report, it is not evident in documents that mental health staff employ strategies in situations of chronic refusals. In addition to patient-driven nonconfidential contacts, a significant subset of cellside contacts resulted from institutional factors, MHP time constraints, and other reasons initiated by staff. It is also possible that the prospect of being restrained deterred prisoners from accepting out-of-cell contacts; the DQE team observed individuals at several facilities placed in handcuffs behind their backs for extended periods while interacting with mental health professionals.

Although the DQE team certainly witnessed examples of meaningful, therapeutic interactions between patients and MHPs during the site visits, the team's chart review found that little time was spent on therapeutic interventions in a significant minority of cases:

- In 18% of sampled TS placements, *all* contacts were cellside
- In 132 patient days, the total time spent with the patient was less than 30 minutes for the entire day
- In a few cases, the contact time was less than 45 minutes *total* for up to a week[55]

As detailed elsewhere in this report, the content of sessions can be a concern. Some progress notes reflected work helping the patient process facts and emotions, develop skills, and/or feel essential support. Fairly often, however, notes appeared to show MHPs applying a small set of the same practices to most patients, which could have the feel of skimming the surface and sometimes omitted addressing the precipitating factors for the placement. In another example, in progress notes and conversation with staff, it appears common to provide a packet of information and exercises for the patient to use on his or her own, but it seems the therapist does not guide processing of that material to help the patient recognize insights or apply skills to their current circumstances. If so, these are missed opportunities. Additionally, the DQE team observed group therapy being available at Framingham, but no other institution offered it to patients on TS, according to the DQE team's chart review. While some institutions do not have enough concurrent therapeutic supervisions to make a group, several do, and nothing in the documents suggested that staff had considered whether it would be suitable and beneficial to some patients.

[55] One patient was seen for 44 minutes total in 7 days. One patient was seen for 34 minutes total in 6 days. One patient was seen for 22 minutes total in 5 days.

Additional patients had a similar pattern but a somewhat larger total time. One had one 30-minute session, but the rest of his contact time totaled 39 minutes for six days. Another had one 20-minute session, but the rest of his contact time totaled 34 minutes for 5 days.

Overall, the quality of therapeutic interventions with TS patients across MDOC was mixed, with examples of good and poor care. The DQE's impression is that understaffing of MHPs contributes significantly to the problem, as clinicians often do not have time to coax a patient into engaging out of cell, to return later in the day to see if a refusing patient has changed their mind, to conduct group programming, or to convince security that an out-of-cell contact is necessary. Understaffing also has created a system with poor continuity of care for TS (i.e., the patient will often be seen by different clinicians during every shift of a TS placement), which can make it difficult to build rapport, engage patients in true therapy, and measure progress. Finally, the lack of a multidisciplinary approach to TS placements may also be contributing to the limited quality of therapeutic interactions, as less experienced MHPs may have few opportunities to see patients together with other members of the treatment team, leaving them with a limited skill repertoire. 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: To date, it does not appear that MHPs consistently take an individualized approach to developing out-of-cell activities for patients on TS. MDOC's leaders have designed a structure to ensure that three contacts take place per day; the structure expects an assessment contact, a counseling contact, and an activity contact. Based on the DQE team's chart review and conversations with MDOC and Wellpath leadership and mental health staff systemwide, it appears that staff adhere strictly to this structure without variation.[56] Staff commonly speak about handing out pre-assembled information and activity packets on set topics for patients to work through on their own. It is unclear whether the MHP and activities therapist for a patient coordinate on the content of their sessions, but there was no evidence of that in progress notes or Triage Meetings that the DQE team observed.

In the approximately 60% of sampled contacts that occurred cellside, most took place for five minutes or less, so there was little opportunity for individualization. Progress notes for out of cell contacts dominantly focused on a few key approaches; there were instances

[56] With the exception of Souza-Baranowski where, as described in the Paragraph 67 analysis, staff jointly decide that some patients should have one contact per day.

in the sample where staff appeared not to work with the patient on the presenting issues – such as grief or newly coming out as transgender – and there was little indication that approaches were adjusted during longer term placements.

Overall, the DQE's chart review was inconsistent with the description of individualized programming on TS that was provided by MDOC's leadership, which included:

- Anger Management
- Behavior Chain Analysis
- Communication Skills
- Current Events
- Dual Diagnosis
- Developing future orientation
- Developing goals
- Discussion of health and wellness
- Sleep hygiene
- Psychoeducation around major mental illness
- Stress management
- Narrative therapy

Some chart notes captured discussions of sleep hygiene or stress management, but there was little evidence of clinicians engaging patients around anger management, behavior chain analysis, current events, narrative therapy, or the other treatment modalities described by the leadership.

In terms of documentation, staff do take care to record the content and duration of contacts, including administrative notes when a contact was due but circumstances prevented it. While the DQE team is not aware of a method to systematically identify contacts that occurred but were not documented, none came to the team's attention, and the consistency of existing documentation suggests that staff are doing well on this aspect of the requirement.

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: During the DQE team's site visit to MCI Shirley, the team observed group therapy taking place in the therapeutic de-escalation room, and the facility's Mental Health Director described other uses to which the room is put. The DQE understands

from MDOC administration that a therapeutic de-escalation room is also part of the plan for the ISU, for which construction was slated to begin in July 2023. Thus, MDOC is making progress toward substantial compliance.

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

Finding: Partial compliance

Rationale: The MDOC administration informed the DQE that there has been discussion of this potential practice and that more discussion is planned. It is encouraging that some institutions already utilize peer support in other programs – for example, in Health Services Units for patients who benefit from support in carrying out activities of daily living – which can provide a framework on which to build. In the DQE team's interviews at Framingham, peer mentors indicated an eagerness to be more involved with prisoners on TS, as this activity provided them with an enhanced sense of worth and pride in supporting members of their community.

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

Finding: Partial compliance

Rationale: The MDOC administration informed the DQE that there has been discussion of this potential practice and that more discussion is planned. It is encouraging that some institutions already have programs in which prisoners train support dogs for external beneficiaries, such as veterans and individuals with disabilities, which can provide a framework on which to build.

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: Compliance not yet due

Rationale: Mental health staff and supervisors at multiple institutions told the DQE team that they do not experience barriers in access to state psychiatric hospitals and that patients transfer quickly once referred. The results of the DQE team's chart review were consistent with that report. In the general review of TS placements that was *not* targeted to locate potential referrals, there were 12 referrals to Bridgewater State Hospital or another outside psychiatric hospital generated across seven MDOC facilities. Each of the patients appeared to transfer the day of, or day after, the referral. The need was recognized very early in the TS placement for about half of these patients; for the other half, the referrals seemed to take into account the patient's length of stay, appropriately considering the need around the seventh day of the therapeutic supervision or as the fourteenth day was approaching.

Additional information about hospital transfers was gathered from the site visits and data provided by MDOC. Framingham mental health staff informed the DQE team that three of their patients were at the Worcester Recovery Center and Hospital or Solomon Carter Fuller Hospital at the time of the site visit, and MASAC staff gave detail about four patients whom they had transferred to outside psychiatric hospitals in 2023. MDOC provided an additional 16 sets of Section 18(a) petitions and orders from the period of March through June 2023. Logs and the electronic health record indicate that all referrals were approved and that these patients, too, transferred on the same or next day.

MDOC's records indicate that seven prisoners petitioned the courts for transfer to a psychiatric hospital between March and June 2023 under G.L. c. 123, Section 18(a1/2). Five of the petitions were denied by the court, and two were granted. Both these patients were admitted to Bridgewater State Hospital and discharged within two weeks because Bridgewater staff did not think that they had DMH-qualifying diagnoses or that hospitalization was warranted. Thus, it appears that patients' independent attempts at obtaining treatment in a psychiatric hospital rather than prison were largely unsuccessful in the first few months after the law's implementation.

MDOC provided documents and logs to the DQE showing 10 referrals to Residential Treatment Units between March and June 2023. All of them were approved. Times to placement ranged from the same day to two months.[57]

It appears most difficult to meet the need for the Secure Treatment Program. While all other specialized programs appear to have comfortable margins of open beds, the Secure Treatment Program had only one vacancy during the DQE team's site visit, and a mental health administrator described an ongoing need to prioritize among referrals because

[57] MDOC's Quality Assurance Reports during this period indicate that no RTUs were full, so it is not clear what accounts for the long lead time before transfer in some cases.

there is always a waiting list. MDOC provided logs that show 10 referrals were made between March and June 2023. All referrals were approved, but it appears that:

- Only half of these patients have been placed
- For them, times from referral to placement ranged from five weeks to three months
- For those awaiting placement, as of the end of June:
    - they continued to wait after six weeks to four months
    - two people appear to have been redirected to other housing at SBCC and may no longer be on a path to a Secure Treatment Program
    - one man was released from custody after six weeks without receiving Secure Treatment Unit programming

The Behavior Management Unit, which had been located at Cedar Junction, was temporarily closed as operations there ceased. SBCC staff projected that the program would open at their site in August 2023, and a regional mental health administrator anticipated that the new unit could accommodate all patients on this summer's waiting list. MDOC is working toward the launch of an Intensive Stabilization Unit.

In all the cases above, mental health staff thought that a higher level of care was clinically indicated, and all were approved. No instances came to the DQE team's attention where staff determined that a higher level of care was appropriate but that the patient was not approved. While compliance is not yet due under the Agreement, the facts above illustrate promising progress toward the goals of Paragraph 77.

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: Within the chart review first described in connection with Paragraph 52, the DQE team selected the 62 placements initiated between the end of February and the end of June 2023 whose length was four days or more.[58] Reviewers searched for those cases within the notification materials that MDOC provided monthly. If more information was

[58] Reviewers excluded cases that exceeded 72 hours but the third day fell on a Sunday and the patient was discharged from therapeutic supervision on Monday morning. The review time period was selected because MDOC began providing documentation to support its practice on Paragraph 78 requirements beginning with March 1, 2023.

needed, the DQE team checked progress notes and Triage Meeting minutes for the days a notification would be required and for adjacent days.

These materials indicate that notifications have begun, but they need to be made more consistently. In the sample, fewer than half of the contacts were documented timely and a handful were made a day, or a few days, later. While some consultations with a Wellpath regional mental health administrator were described in progress notes, most of the DQE team's assessment relies on the materials provided monthly to demonstrate practice on Paragraph 78. Those materials are addressed to the regional administrator; there is no express demonstration of notice being given to MDOC's Director of Behavioral Health, although she informed the DQE team that she receives a copy. The notification document gives good detail about the patient's condition, actions MHPs have taken, and general thoughts about next steps. The document has a space for Wellpath's administrator to add treatment thoughts, but that field was blank in every document in the sample. The DQE team did not receive demonstration that a discussion took place or that any change in interventions resulted. That leaves a question about whether what is occurring is *notice* rather than *consultation*.

While there is still room for improvement, a somewhat higher percentage of sampled placements showed that a higher level of care had been considered; here, 56% met the requirement, and another handful showed the documentation one or a few days later.[59] Most of this documentation was in the health care record, though some was absent there and captured in the notification to Wellpath and MDOC administrators. One patient in the sample was referred to Bridgewater State Hospital.

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: Noncompliance

[59] Because this requirement was likely to be found in progress notes and was not as dependent on the notifications sent monthly, this finding is based on a larger sample -- 72 placements drawn from the entire monitoring period. Reviewers continued to check notifications, if available, and Triage Meeting minutes if the information was not present in progress notes.

Rationale: This analysis draws on the same samples and methods described in relation to Paragraph 78 above, and some of the concerns are the same. On the one hand, the rate of notices documented is much higher; this was evident on notification forms or progress notes in 75% of the 20 sampled placements whose length was more than seven days. On the other hand, these forms also appear to be notices alone, and none of the documentation references consultation and planning with the two administrators named in Paragraph 79, nor does it capture the content of any discussions that may have occurred. Absent this information, the DQE cannot find that these consultations are taking place.

The fact of having considered a higher level of care was recorded in 63% of the 24 sampled placements. The majority of these notes or notifications, however, did not describe the reasons that a referral was not clinically indicated, and a few were communicated later than expected under this requirement. As with Paragraph 78, much of the documentation was outside the health record. To staff's credit, two women were referred and transferred to Worcester Recovery Center and Hospital and Solomon Carter Fuller Mental Health Center, respectively, and one man was placed in an RTU setting.

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: MDOC data shows there have been 30 placements in the monitoring period lasting 14 days or longer and that these cases were concentrated at four institutions. This constitutes 6% of the therapeutic supervisions.

The DQE team assessed a 20% sample,[60] reviewing documents that MDOC provided to demonstrate its practices on Paragraph 78 through 80 requirements, along with records of Inter-Facility Clinical Case Conferences.

[60] The reviewer selected cases on the log from three of the four relevant institutions. It was not possible to review the fourth institution, OCCC, because notification documents have been provided from March 2023 forward and

On Day 14, a bit over half of the sample had notices.[61] As with the analysis of Paragraph 79 requirements, the provided documents show there is communication, but they do not indicate whether the three officials named in Paragraph 80 received this information and whether any consultation occurred. Those notices indicated mental health staff's consideration of a higher level of care, though there was mixed practice in whether the reasoning was described or a cursory statement was made. It did not appear that interventions and treatment plans were re-evaluated at that time.

After Day 14, there was a range of practices. The same notices were employed, and there were Inter-Facility Clinical Case Conferences for some of the patients. In some cases, the notices were submitted daily except for weekends and holidays; in others, submission was frequent but much more uneven. Here, too, the documents did not indicate consultation or the involvement of all the required officials.

In terms of higher level of care, one patient had been referred to RTU before Day 14, and two others had lawyers pursuing a patient-initiated placement at Bridgewater State Hospital under Section 18(a1/2), although mental health staff did not always agree that was warranted. Another patient was ultimately referred to the Secure Treatment Program but not until more than six months on TS. Where staff thought a higher level of care was not clinically indicated, the reasons were sometimes described, but more often a conclusion alone was stated.

As to adjusting treatment, Inter-Facility Case Conference documents did not reflect any treatment recommendations and, with two exceptions, each patient's post-14 day notices continued to repeat the original language about his interventions. This was the case for one patient for months but, encouragingly, once staff began implementing a series of different approaches, there were signs of success during his most recent six weeks on TS.

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

OCCC had only one potentially relevant placement in that period. That patient was discharged on the morning of the 14th day and, while the records did not contain a notification for him, the reviewer believes that is reasonable under the circumstances.

[61] Within the sample, there was one very lengthy admission. Its Day 14 occurred before the Agreement went into effect so was not included in this part of the analysis. For obligations on this placement after Day 14, the reviewer examined notices from the first date provided, March 1, 2023.

Rationale: MDOC has developed a policy, 103 DOC 650.08, Emergency Mental Health Services, and Wellpath has developed policy 66.00, Therapeutic Supervision. Each contains identical language for stepping down patients from constant to close observation before discharge. They discuss, in different levels of detail, how discharge decisions are to be made and documented, with the MDOC document capturing most aspects of Paragraph 82. The Wellpath policy requires post-discharge follow-up contacts consistent with the parties' current understanding of Paragraph 84 of the Agreement.

As to implementation, the DQE team looked to its chart review previously described. That sample contained 39 patients whose placements included time on a constant watch; almost all were stepped down to close watch for at least one day before discharge, which the DQE team considers a reasonable time consistent with Wellpath's and MDOC's policies.[62] The post-discharge follow-up contacts are also widely implemented. As will be detailed in the analysis of Paragraph 84 requirements, these practices are well-executed in most facilities and clearly have been established in all of them. While improvements are needed at two institutions, that can be monitored under Paragraph 84. Implementation is sufficient to satisfy the requirements of Paragraph 81.

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 understands the overall intent of Paragraph 82 to be that patients on TS are discharged from that status promptly after an out-of-cell assessment by an MHP and a discussion with supervisors and upper-level providers. In general, the DQE observed this process occurring during the site visits, though some concerns about the documentation emerged during the team's chart review.

[62] The only exceptions were one patient who was not stepped down, one where this information cannot be discerned from the health record, and seven patients who transferred directly to a psychiatric hospital.

MDOC has designed a form for MHPs to perform a suicide risk assessment when considering therapeutic supervision discharge. It is in routine use, with only a handful not found in the DQE team chart review previously described.[63] Where self-injury was thought to be a risk during the TS placement, the documents generally describe the patients being at lower risk of imminent self-injury at the time of discharge. While the DQE team did not undertake a systematic study of the forms' content, the reviewers noted that information on the discontinuation form often differed substantially from the progress notes, which risks missing issues that require attention in ongoing treatment. Similarly, at least a few forms were complete, but the basis for the risk assessment was unclear, as the MHPs had recorded almost no substantive contact during the TS placement due to the patients not engaging. Consultation with a psychiatrist or psychiatric nurse practitioner was not recorded on the forms; it is not currently known whether such a consultation was not clinically indicated in all 101 placements. The location of the discharge assessment contact was not usually recorded in the sampled documents, but when a cellside contact was noted, it was recorded as the patient's preference in each case.

In addition to MHPs completing a suicide risk assessment form, they also consult with the mental health team about potential discharges. The DQE team observed Triage Meetings during site visits of each relevant institution. The site Mental Health Director participated in each, and a psychiatrist or nurse practitioner attended at most. The DQE team reviewed Triage Meeting minutes from each facility that conducts therapeutic supervisions; minutes do not always indicate the role or discipline of attendees, but psychiatric staff is clearly shown as present at least some of the time. The minutes always capture that discharge decisions were made, and the DQE team observed that everyone present has the opportunity to weigh in on all decisions made during these meetings. Therapeutic Supervision reports documenting termination of the placement frequently are issued at midday, which predictably coincides with the end of a Triage Meeting. Triage Meetings occur on weekdays, and the DQE team did not encounter discharges that took place on weekends; it was common to see Monday morning discharges, suggesting the patient was held until the Triage Meeting could consider the decision. While more certainty is needed on the required personnel's participation, from these facts, the DQE feels confident that discharge decisions are made after consultation with the mental health team.

[63] Of the records reviewed, seven were not applicable to this question because the patient transferred to Bridgewater State Hospital or another outside psychiatric hospital. Among the 101-placement sample, only 4 did not have a completed Discontinuation from Mental Health Watch form in the electronic health record.

The DQE team reviewed Monthly Quality Assurance Reports and Quality Improvement Committee documents, and minutes show the committee considering length of stay at an individual level and in aggregate. The committee is in its initial months of operation, and discussions appeared to center on trends and methods to capture meaningful data, foundational components toward future audits.

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: As described in relation to Paragraph 82 above, MHPs do consistently employ the Discontinuation from Mental Health Watch form. In the DQE team's assessment of TS placements, previously described, MHPs consistently completed the form's section for brief mental status updates. They also recorded the patient's risk factors and an overall assessment of risk (checking a box for low, medium, or high), but the form does not provide a field where clinicians would connect those risk factors to a discharge plan. In the "Plan and Recommendations for Continued Care" section of the form, MHPs consistently indicated the type of housing or program to which the patient would be discharged; the form presents this information as a statement of fact and does not indicate any rationale for the choice. MHPs then checked boxes for follow-up plans, choosing between finite actions such as placement on the mental health caseload, referral to an inpatient hospital or medical provider, or instructing the patient on mental health access. The forms did not contain descriptions of the issues that the mental health staff and patient would focus upon, goals, outcomes, or interventions planned for upcoming contacts, as would be typical for a plan of care. As will be discussed in the analysis of Paragraph 84 requirements, it was also rare for this information to be captured elsewhere.

Paragraph 83's requirement for a "safety plan that addresses risk factors unique to [the patient]" need not add a large burden to MHPs' workload. As with initial crisis treatment plans, the goal with discontinuation plans is to tailor them to the individual patient, not necessarily to make them longer or more detailed. Some hypothetical examples of documentation that the DQE believes would satisfy this requirement:

- A patient was placed on TS because he was upset about being transferred to a new facility and had difficulty adjusting to general population. The discharge plan could be something like: "Patient will return to general population and inquire

about job opportunities on his housing unit. He met his new PCC while on TS, and this PCC will perform the required TS follow-up checks at Day 0, 3, and 7 so he begins building stable relationships at the new facility. Patient knows he can access crisis MH services in addition to the scheduled contacts if he has difficulty adjusting."

- A patient was placed on TS because of repeated self-injury. After a lengthy TS placement, he was transferred to the STP. A plan of care could be something like: "Patient remains at chronic risk of self-injury due to his borderline personality disorder diagnosis, but at this time he appears future-oriented and interested in the STP. He has met with his assigned PCC and attended an STP group to help with the transition. Per security, patient's cell has been searched and is free of hazards, but this will need to be monitored closely."
- A patient was placed on TS due to bizarre behavior, and he was suspected of mixing prescribed stimulant medications with illicit substances. A follow-up plan could be something like: "Patient has not exhibited psychotic symptoms or bizarre behaviors in 48 hours, so he will be discharged back to his housing unit. Psychiatry reviewed dangers of stimulant meds with him, and he agreed not to take them in the future. Spectrum was informed of medication misuse. Patient will follow up with psychiatry in 1-2 weeks for mental status check, in addition to MHP follow-up at days 0, 3, and 7."

In conversations during site visits, mental health staff told the DQE team that they do not share discharge plans with security staff out of concern for patient confidentiality but that the plans are available to appropriate mental health staff (e.g., RTU or STP clinicians) through the electronic health record. This separation between security and mental health staff is likely a good practice for most patients, though there may be cases where closer communication with security is necessary for a successful discharge plan. For example, if a patient has active symptoms of SMI, a discussion about cellmate choice or a single cell may be warranted. MHPs' decision-making about communication with security staff should be incorporated into discharge plans as clinically indicated.

With these changes in discharge planning and documentation, MDOC can come into compliance with the requirements of Paragraph 83.

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: The expectation for MHPs to complete three follow-up contacts after TS discontinuation is clearly established. Mental health staff at each visited institution were clearly familiar with it. It is common knowledge that these are one of the responsibilities when one is assigned as the crisis clinician for the day, and Triage Meeting minutes[64] typically list the patients for whom a contact is due that day. There is an electronic Mental Status Update form to facilitate gathering necessary information, and the DQE team observed that completed forms are routinely found in the health records of patients who have been on therapeutic supervision. MDOC and DOJ have agreed informally to some flexibility on the timeframes for these contacts with an understanding that three contacts be completed by the tenth day after discharge.

The DQE team assessed practice employing the chart review first described in conjunction with Paragraph 52 above, with 94 sampled placements being subject to this requirement.[65] The team's assessment reviewed the frequency and timing of the required contacts.[66] In most institutions, the practice was excellent. For seven facilities, the follow-up contacts were completed and timely in 96% of their placements in aggregate.

Practice differed, however, at SBCC and Shirley. There, a small handful of follow-ups were missed. Additionally, there was a practice, on a large scale, of seeing the patient while he was still in the Health Services Unit and/or just a few minutes after discharge from TS. This cannot serve to assess how the patient is adjusting to being off therapeutic supervision and thus cannot reasonably be considered a follow-up contact that satisfies Paragraph 84. Given these concerns, only 38% of placements had compliant follow up at Shirley and SBCC.

If one were to aggregate the performance of the whole system, the compliance rate in the DQE team's assessment is 68%.

[64] The DQE team reviewed minutes from each institution from the period March through June 2023.
[65] The requirement was not applicable to another some placements because the patients transferred to an outside hospital or Bridgewater State Hospital or were released from custody.
[66] A contact was counted if it was completed or the patient refused. If a patient was readmitted to therapeutic supervision, the requirement for that patient was considered satisfied if the contacts due up to that point were completed. While the most typical pattern was for the MHP to see the patient later on the day of discharge, the next day, and the seventh day after discharge, the reviewer counted as compliant any contacts within 10 days after discharge with a significant exception that will be discussed in the main text.

There was also a concern about the contacts taking place in nonconfidential settings and how that may affect the truthfulness of patients' reports about their adjustment. Systemwide, 40% of follow-up contacts took place at officers' desks in housing units, dayrooms, or in the recreation yard. The majority are recorded as being at the patient's request, or the patient was "agreeable" to this arrangement, though nearly half did not record a reason the contact was nonconfidential. These practices were particularly concerning at Concord and SBCC; at the latter, 75% of sampled follow up contacts were nonconfidential.

On the other hand, MHPs did sometimes follow the patients more closely than required. In about 20% of the sampled placements, the patient had additional contacts during the initial ten-day period. Among the patients the DQE team interviewed, eight commented on various aspects of follow-up. While they confirmed generally that follow-up occurs, there was not sufficient information to draw additional conclusions.

Among those placements where a post-discharge treatment plan review would be required,[67] health records indicated that few received it. In nine cases, a timely review and update was clear; in seven more, the MHP checked a box indicating the review occurred and no update was needed, though that decision could be concerning, as will be described below. Another nine treatment plan reviews were completed later, between 1.5 and 4 weeks after discharge. Where updates occurred, it was not clearly documented whether an "upper level provider" was involved. The remainder, 70% of sampled placements, had no indication of a post-discharge treatment plan review.

There were a number of cases where the absence of a treatment plan update was concerning. These included patients:

- presenting with new symptoms and behaviors such as
    - "catatonia," not processing information, urinating on the floor, and involuntary movement (all are one patient's experience)
    - delusions, psychosis, and/or mania
    - substantial self-harm known for the first time
- presenting with new stressors such as grief, new PREA reports, and first coming out as transgender or with sexuality concerns
- demonstrating patterns of behavior such as three TS placements in a month and habitually not engaging with treatment providers
- restarting medication after a period of nonadherence

[67] After removing those cases where the patient was released from custody, transferred to Bridgewater State Hospital or another outside psychiatric hospital, or was readmitted to therapeutic supervision with seven days, the number of sampled records relevant to this requirement was 83.

With each of those patients, staff either:

- updated treatment plans but did not include some or all of the new key problems;
- checked form boxes indicating an intention to add new interventions, but that did not occur subsequently;
- inaccurately checked form boxes indicating that a review had taken place when that patient had no treatment plan that could have been reviewed;
- chose not to update; or
- there was no demonstrated review.

In seven cases, the therapeutic supervision occurred soon after the patient's arrival in MDOC and the patient had no treatment plan at all, either post-discharge or months later, at the time of the DQE team's analysis.

Thus, MHP follow-up contacts are excellent at most institutions, with just two facilities needing improvement. Much more is required to reach substantial compliance with post-discharge treatment plan reviews and updates.

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 relied upon a review of 101 therapeutic supervision placements, which was heavily weighted toward patients placed from 3 to 22 days. In this sample, a psychiatrist or nurse practitioner only met with the patient in 43% of the placements. There was no indication of contacts with other types of upper-level providers as defined in the Agreement.

In a minority of cases where no psychiatrist contact occurred, the DQE did not see a clear clinical indication for a referral, but in most, there was an obvious rationale for referral such as:

- Medication noncompliance noted by the MHP
- Recent misuse of prescribed medications
- New-onset psychotic symptoms
- Medical complaints and/or chronic pain precipitating suicidal ideation

- Lack of diagnostic clarity

There were also instances where an MHP noted that a patient should see psychiatry, but the contact never occurred during the TS placement. It is not always clear from the records why the appointment did not take place, but there were some instances where security staff did not allow the contact or were busy with other duties. Similarly, there were instances of extended time to be seen after an issue was identified or a patient was nonresponsive to mental health staff. Should any of these examples prove to be a pattern over time, this would raise the DQE team's level of concern.

Only MASAC had a high rate of psychiatric contacts. Concord, Shirley, and SBCC appear to have the furthest to go to reach substantial compliance. Overall, it seems that psychiatry should be involved earlier in the TS placements and in a greater share of the TS placements. In many cases we reviewed, when psychiatry did finally assess the patient, they provided a much-needed diagnostic assessment and formulation that informed the treatment plan going forward.

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: Partial compliance

Rationale: MDOC has a practice of reassessing patients upon return from hospitalization pursuant to Section 18(a), though the Wellpath and DOC policies addressing hospital transfers do not explicitly mandate the consideration of placement on TS. This assessment occurs in addition to the routine communication that happens between BSH and MDOC clinicians during the patient's hospitalization and the interfacility case conference (IFCC) mandated by policy 103 DOC 650.08, Emergency Health Services. The DQE witnessed several verbal and written communication between BSH and MDOC about mutual patients during the site visits, which is consistent with good clinical practice.

In practice, both an MHP and a psychiatrist typically assess a patient upon return from an outside hospital. MDOC and Wellpath have designed a form to guide assessment of such patients. The form calls for an express decision about whether a patient returning from a hospital should be placed in therapeutic supervision. MDOC logs reflect 16 transfers to Bridgewater State Hospital and other outside hospitals in recent months. The DQE team reviewed health records for 38% of that population. Staff at all six sampled institutions completed the form in all cases and made a decision whether to readmit the patient to therapeutic supervision.

Additionally, in two of the DQE team's patient interviews, the men mentioned they had been treated at Bridgewater this year, and they confirmed that MDOC mental health staff met with them upon return. If this practice is sustained, and if MDOC amends its policies to include a requirement for TS assessment upon return from hospitalization, MDOC is well positioned for a finding of substantial compliance on this requirement in the next DQE report.

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: Compliance not yet due

Rationale: Although this paragraph does not specify a date by which the policies should be established, the overall deadline for final policies is December 20, 2023, so the DQE understands that deadline to apply here as well. MDOC does already have policies for close and constant observation on TS, but the policies are still undergoing a careful review to assess whether they are entirely compliant with the Agreement.

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

Rationale: Conversations with a wide range of correctional officers, their supervisors, mental health staff, and facility and MDOC administration indicated it is well established

practice to determine the level of observation as a key part of daily updates to therapeutic supervision conditions. Typically, MHPs say, they consider those conditions as part of the first patient contact of the day and discuss during Triage Meetings whether to make changes. Patients who are on 1:1 observation are assessed by an MHP every day, including Sundays and holidays, but those who are on close observation are only assessed Monday through Saturday.

The DQE team observed these discussions in Triage Meetings and reviewed Triage Meeting minutes from each institution. Level of observation decisions were recorded routinely there. The decisions also appeared in progress notes and in Therapeutic Supervision Reports.

In the DQE team's Therapeutic Supervision Report review, previously described, there were numerous examples of an MHP changing the level of observation day to day, or within a day, in response to a patient's self-injury or a change in his sense that he could keep himself safe. The DQE team also saw examples in officers' watch sheets of a change in level of observation.

Daily Therapeutic Supervision Reports were found for 87% of the reviewed placements. In the other placements, those reports were present, but there were single-day gaps, or occasionally more than one.[68] The most common pattern was the absence of a report on the first day – perhaps when placement is directed by an on-call professional – but the level of observation determination could sometimes be found in nursing notes in that event.

Despite these gaps in documentation, the consistency of information from all these sources gives the DQE team confidence that MHPs are deciding the level of observation based on the patient's risk of self-injury and communicating it to security staff.

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

Finding: Partial compliance

[68] This describes what is found in the electronic health record ("ERMA"). It is possible that some or all of what appear to be missing reports are in the information system IMS and the gap is only a glitch in copies being uploaded to ERMA.

This review did check the day of the week for those gaps to ensure there were Therapeutic Supervision Reports on Sundays for patients on constant observation, and records of patients on close observation were counted as complete if they did not have this form on Sundays.

Rationale: Wellpath policy 66.00, Therapeutic Supervision, contains explicit language prohibiting the use of TS for disciplinary purposes: "TS shall not be used as a punishment or for the convenience of the staff…." The corresponding section of DOC policy 650.08, Emergency Mental Health Services, does not contain any language about using TS for punishment, stating instead, "The determination of the level of supervision shall not be dictated by the availability of bed space or staff." The DQE recommends that language be added to 103 DOC 650.08 to prohibit the use of TS for disciplinary purposes.

Among the DQE team's interviews, 13 patients, across seven institutions, commented on this topic. Each affirmed that they did not believe they had ever been placed on therapeutic supervision as punishment. If this practice is sustained, and if MDOC makes the minor adjustment to its policy as recommended, a substantial compliance finding is likely in the next DQE report.

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: During the DQE team's interviews of security staff, seven correctional officers across six institutions reported slight variations of the same procedure for handling self-injury that occurs while a prisoner is on TS. The officers reported that, first, they would speak to the prisoner and ask them to stop the behavior. If the prisoner did not cooperate, the officer would notify their sergeant or shift commander, who then would notify mental health and medical staff. Ultimately, if no staff were successful in deescalating the situation, a decision would be made by a supervisor about whether to use force and enter the cell to stop the self-injurious behavior.

The relative consistency of officers' responses was encouraging, but the DQE team did not find an MDOC policy that clearly outlines how to notify security, medical, and mental health staff about self-injury. The closest policy to touch upon the subject is 103 DOC 650, Attachment 14, Therapeutic Supervision Procedures, which contains a notification procedure for prisoners who have ingested or inserted foreign bodies:

> IV. Procedure for inmates on Therapeutic Supervision and ingestion/Insertion of Drugs or Foreign Bodies: A. Notifications 1. Once on Therapeutic Supervision, **if an inmate is observed ingesting contraband or inserting a foreign object into their body, the officer assigned to the Supervision shall contact the Shift Commander immediately and the Shift Commander shall ensure that**

medical staff respond to the area. Appropriate medical protocols shall be adhered to. The officer witnessing such ingestion or insertion shall submit an IMS incident report prior to the end of their shift. 2. If the officer assigned to the therapeutic supervision witnesses an inserted foreign object being passed, or if the inmate is observed to have an implement or weapon and is causing self-harm, the Shift Commander shall be notified immediately to determine the appropriate number of staff.

The existing policy seems reasonable, but it does not address all forms of self-injury (e.g., cutting, head-banging, asphyxiation), and it does not specify that mental health staff should be notified in additional to medical staff. Thus, the DQE team recommends that MDOC revise its policy to clarify the notification process to all disciplines and all types of self-injury. This will require fairly small changes to existing policies, so the DQE team is confident that MDOC will come into compliance with this provision.

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: The DQE team does not have enough information to assess this provision yet. As outlined in Paragraph 90, DOC policies specify procedures to notify supervisors in the security chain of command, but they do not state that mental health and medical professionals must be immediately notified. Based on interviews of seven correction officers, it does appear that both medical and mental health professionals are notified by the sergeant about self-injury, but the DQE team has not systematically assessed this, nor has DOC provided any data to demonstrate it. Given the concerns raised in the DOJ's Findings Letter about officers remaining inactive while prisoners injured themselves in mental health watch cells, the DQE may wish to review video footage in certain cases rather than rely on staff's documentation alone.

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 practice is for the officer to write an Incident Report in IMS and for the mental health clinician to write a progress

note in the electronic health record. Thus, it appears that the basic structures are in place to obtain compliance with this provision. However, as noted in Paragraph 109, the DQE's assessment revealed that only about 70% of incidents documented in the SDV log between March and June 2023 were accompanied by an officer's Incident Report. MDOC's Quality Improvement Committee identified the need to train officers about completing incident reports for all episodes of SDV, as it had found that some were missing when collecting data for the DQE. Improvement in the documentation of SDV incidents will put MDOC on a path toward compliance with this provision.

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: MDOC does have a policy that mandates investigations of staff misconduct, 103 DOC 522, Professional Standards Unit. The policy states, in relevant part: "The PSU shall investigate allegations of staff misconduct and violations of policy and procedure that may result in administrative review and possible discipline against staff, vendors and/or contract staff."

To date, the DQE team has not been provided with any evidence of MDOC investigating or disciplining staff for behavior related to TS. From discussions with MDOC administration, the DQE understands that, if such behavior were to occur, a confidential incident report would be written by the party observing it, and the conduct would be investigated by the facility Superintendent's special investigator. During the site visits, the DQE team heard several accounts from prisoners and staff that, even when unprofessional conduct is reported, nothing comes of the investigation, and the staff member remains in their position. These reports, while anecdotal, do raise enough concern about the adequacy of the investigation process that the DQE team would like to review data about the number of such reports made across MDOC and the outcome of each investigation.

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: MDOC's Director of Staff Development indicated in an email that the Therapeutic Supervision training was a standalone, annual in-service training until July 2022, and he provided a report indicating that 1,758 MDOC employees completed the training between July 1, 2021, and June 30, 2022. He indicated that the TS training was subsequently combined with the two-hour Suicide Prevention/Recognizing Mental Illness training and provided documentation that 3,178 employees completed that training between July 1, 2022, and June 30, 2023. The DQE does not know what proportion of the correctional officers who observe prisoners on Mental Health Watch this number represents.

Paragraph 94 also requires MDOC to post the current TS policy in visible places on every unit where TS takes place. During the facility site visits, the DQE team did not see a policy posted in the officers' bubble or similar location in the housing units where TS occurs. In some locations, officers or supervisors said they were not aware of any such policy. One exception was at NCCI Gardner, where the officers in the HSU kept a folder that included both formal and informal information for officers conducting TS watches. Both HSU and BAU officers were also able to demonstrate quickly finding the TS policy online. DOJ has raised questions about whether such methods are sufficient to meet the requirement's goal of having the policy highly visible; this issue will be explored during the next monitoring period.

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: Without prompting, interviewed officers and leaders highlighted this as a feature essential to conducting constant observation, so there is certainly an understanding of this expectation. During facility tours, staff would commonly show the DQE team where an officer would be posted in order to maintain line of sight. Because of the DOJ's concerns during the 2019 investigation about officers falling asleep or otherwise being inattentive to prisoners during constant watches, the DQE team will need to gather additional information before issuing a substantial compliance finding. During

the next monitoring period, the DQE will work with the parties to consider methods that could identify, or rule out, any lapses in implementation. Such methods could include reviewing staff disciplinary reports and/or videos of TS placements, but further exploration with MDOC is needed.

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 MDOC has set these expectations – both documentation and what to look for – with officers who conduct close observations. As one measure, the DQE team examined the forms on which officers are required to record the checks they have made. The team reviewed forms for 81 placements drawn from all ten institutions that conducted therapeutic supervision.

Sampled forms recorded contacts every 15 minutes,[69] or missed a contact only very rarely, in 78% of the placements. Some staff have adopted the practice, recommended by suicide prevention specialists, of varying the timing of the contacts by a few minutes ("staggering") so they are less predictable to a patient planning to self-injure. Staggered contacts are not yet widespread, but MDOC began to emphasize it during the monitoring round. Practice is strongest at Concord, and there was substantial improvement at OCCC by later in the monitoring period.

In the other 22% of the sample, there were gaps in documentation of contacts from 45 minutes to 2 hours, or substantially longer gaps that may reflect either a practice issue or an issue during gathering and transmitting the documents. Some methods of recording, in the sample as a whole, also raised possible accuracy concerns. For example, on a few watch logs, 15' checks attributed to several different officers were all written in the same handwriting, suggesting that the log had not been completed in real time.

The content of officers' entries on the watch logs was often very limited, sometimes to the degree of not demonstrating that the officer has checked for signs of life. Minor adjustments to add brief information, already called for in the form, could go a long way to demonstrating that officers are conducting checks consistent with the requirements of Paragraph 96.

[69] Or equally consistent use of "staggered" contacts

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 therapeutic supervision cells and whether it hinders or could ease transmission of contraband that could be used for self-harm. The team observed:

- There are door sweeps or similar construction protecting the cells in SBCC's RTU cells designated for therapeutic supervision and in Gardner's and OCCC's Behavior Assessment Units.

- There are gaps at the bottom of the doors, which could benefit from door sweeps or a similar remedy, in the Gardner, Norfolk, OCCC, Shirley Health Services Units, Shirley Behavior Assessment Unit, and MASAC Intake Wing. The Gardner and OCCC administrations noted that this issue was on their lists of maintenance projects.

The DQE team will continue to develop information on this requirement. The team is optimistic about MDOC's potential for compliance with this provision. In fact, on August 4, 2023, MDOC provided photos from MCI Framingham showing the installation of new door sweeps.

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: Compliance not yet due

Rationale: This provision is not due until December 20, 2023. To date, no Support Persons have been hired, but MDOC administration reported that they have created a job description that is currently being reviewed.by administrators.

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: Compliance not yet due

Rationale: This provision will come into effect once the Support Persons have begun working with prisoners on TS.

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: Compliance not yet due

Rationale: This provision will be due sometime after December 20, 2023. To my knowledge, the exact training they will receive has not yet been determined.

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: Compliance not yet due

Rationale: This provision will apply only after the Support Persons have been hired.

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: Compliance not yet due

Rationale: This provision will apply only after the Support Persons have been hired.

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: Compliance not yet due

Rationale: This provision will apply only after the Support Persons have been hired.

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: Compliance not yet due

Rationale: This provision will apply only after the Support Persons have been hired.

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: Compliance not yet due

Rationale: There does not seem to be anything substantive to assess in this paragraph other than MDOC's policy update. To the DQE's knowledge, MDOC has not yet completed any policy revisions about Therapeutic Supervision, but compliance is not due until December 20, 2023.

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: Noncompliance

Rationale: MDOC has not yet shared its Code 99 policy with the DQE, so the team cannot assess whether it is being followed. The DQE understands from discussions with MDOC administration that this policy is not public, so it may require additional review before being released to the DQE.

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: As discussed elsewhere in this report, MDOC offers Crisis Intervention Training, and trainees say they are required to refresh their knowledge annually; this is one method to support the actions required by Paragraph 107. At least two officers interviewed by the DQE were trained members of their facility's crisis intervention team. The DQE team encountered examples, in multiple sources, of officers or supervisors deescalating a self-harm event and bringing it to an end without using force. Four such events surfaced in progress notes and incident reports at Concord, Gardner, and MASAC. Two prisoners, at Cedar Junction and Concord, said that security staff had convinced them to relinquish ligatures. At least one interviewed officer at each of SBCC, OCCC, and Concord noted that they had talked a patient into ending a self-harm event, with Concord Health Services Unit officers describing it as a large part of the job and estimating that this method is effective "90%" of the time. Some other officers and administrators endorsed this practice, and several of the above sources indicated that medical and mental health staff were notified of these incidents.

In some interviews with prisoners and mental health staff, the DQE team heard of officers behaving in a manner that encouraged rather than deescalated self-injurious behavior; prisoners reported that officers sometimes told them to harm themselves or expressed indifference to self-injury. However, it was not clear from the interviews how long ago these incidents happened or how widespread the staff's behavior might be. The DQE team would like to gather more information before coming to conclusions about officers' responses to non-life-threatening self-injury. Given the DOJ's findings in 2019 about officers ignoring or escalating prisoners' cutting behaviors, this is an area that warrants considerable scrutiny. The DQE team will continue to work with MDOC to devise a method for systematic review of the Paragraph 107 requirements.

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

Finding: Partial compliance

Rationale: MDOC provided the SIBOR for each episode of SDV that occurred while a prisoner was on TS for the DQE team to review. Between March and June 2023, all 125 incidents of SDV listed on the SDV Registry were accompanied by a SIBOR (46 in June, 42 in May, 27 in April, 10 in March). However, in April, there were SIBORs for 7 cases that were not listed on the SDV Registry, meaning that a total of 34 SDV incidents occurred while on TS in that month rather than 27.

The DQE team spot-checked 50 cases for SIBOR completion within 24 hours of the SDV incidents. *Table 2* illustrates the results.

Table 2. SDV Incidents with Timely SIBORs

	Total SDV incidents[70]	# of cases audited	SIBORs completed on day of SDV or following day	% completed on time
March 2023	10	10	8	80
April 2023	34	15	9	60
May 2023[71]	42	15	9	60
June 2023	46	10	10	100
TOTAL	**132**	**50**	**36**	**72**

Of the 14 cases where a SIBOR was not completed within 24 hours, the delays ranged from 1 day to 11 days. SBCC and OCCC had the most difficulty completing SIBORs within 24 hours, which is correlated with the relatively high volume of SDV at those institutions.

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: The DQE's review of Incident Reports related to SDV that occurred while a patient was on TS indicated that the reports, when present, contain a reasonably detailed description of the patient's self-injurious behavior. However, less than 70% of the SDV incidents recorded in MDOC's log between March and June 2023 had an accompanying Incident Report. Results of the DQE's audit of Incident Reports for SDV are contained in *Table 3.*

[70] For March and April, MDOC only provided data about SDV incidents that occurred while on TS, in accordance with the Agreement. In May, at the DQE's request, they began reporting all SDV incidents. Thus, March and April statistics should not be compared with May and June.

[71] In a third case in May, the SIBOR was completed approximately one month after the SDV incident, but this was unavoidable because the prisoner did not disclose the incident until much later. The SIBOR was completed on the same day the prisoner reported the behavior and was considered timely in the DQE's analysis.

Table 3. SDV Incidents with Completed Incident Reports

	# of SDV incidents on TS	# of SDV incidents w/ accompanying IRs[72]	% of expected Incident Reports
March 2023	10	8	80
April 2023	34	20	59
May 2023	23	16	69
June 2023	17	14	82
TOTAL	**84**	**58**	**69**

MDOC's Quality Improvement Committee meeting minutes indicate that MDOC is already aware of the missing Incident Reports and is creating a plan for retraining officers on the importance of completing this documentation for every instance of SDV. Thus, the DQE team is optimistic about improvements in this area over time.

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 reviewed 30 cases in which SDV occurred while a prisoner was on TS between March and June 2023.[73] This assessment indicated that patients were routinely assessed by an MHP within 24 hours of SDV because of the staff's practice of seeing patients on TS three times daily. In no cases did an MHP complete a formal treatment plan update after the SDV episode, but in some charts, it was apparent from the progress notes that the MHP had adjusted treatment going forward. Documented interventions included increasing the level of supervision (constant rather than close), removing clothing or other property used in the SDV incident, discussing coping skills and triggers for self-harm in sessions with the patient, and referring the patient for an 18a evaluation by the psychiatrist.

At least one case documented the use of security restraints (metal cuffs behind the back) as an intervention to prevent further SDV, which is concerning to the DQE. No conclusions can be drawn from a single event, but the DQE learned during site visits and discussions with MDOC leadership that security restraints (as opposed to mental health restraints) are routinely employed to manage SDV. This assertion is supported by MDOC's data indicating that not a single instance of mental health restraint has occurred

[72] MDOC provided a large PDF containing multiple Incident Reports for each month. To verify completion of an IR for each SDV incident, the PDFs were searched for the prisoner's last name and date of incident. If present, the person completing the IR was noted, and "full credit" was given only if that person were a staff member observing the SDV behavior, not if the only IR was written by a nurse or MHP responding to the Code 99.

[73] This was also one of the requirements assessed in the DQE team study of 101 charts, detailed in Paragraph 52.

in the system since the Agreement's effective date, despite dozens of SDV episodes occurring in that time. It appears that, across MDOC facilities, security staff not only manage the acutely dangerous situation (e.g., entering the cell and removing the noose or razor from the patient), but then also determine whether restraints are necessary, what type, and for how long. There is no evidence that mental health restraints are ever considered, which may stem from the sparse availability of psychiatrists at most facilities. If true, the practice of routinely using security restraints to manage SDV would be inconsistent with both MDOC's own policies[74] and with external guidelines from the National Commission on Correctional Healthcare[75] and American Psychiatric Association,[76] which recommend the use of therapeutic restraints ordered by a physician rather than security restraints. The DQE recommends that MDOC's Quality Improvement Committee conduct a review of restraint practices and guidelines and consider retraining its staff about how to handle SDV, whether it occurs while on TS or not.

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

Finding: Compliance not yet due

Rationale: Since MDOC's policy update in Paragraph 112 is not due until December 20, 2023, it follows that Paragraph 111's requirement to follow the policy is also not yet due. When the time comes for assessment, the DQE team will need MDOC's guidance about what data exist to demonstrate its practices around foreign body ingestion. To date, the team has reviewed policy 103 DOC 650, Attachment 14, Section IV, regarding foreign body ingestion/insertion for prisoners on Therapeutic Supervision, as well as data from the monthly Quality Assurance reports that indicate the number of foreign body ingestion and insertion incidents per month *(Table 4).*

[74] 103 DOC 650, Attachment 14, Therapeutic Supervision Procedures: "An inmate who is actively engaging in self-injurious behavior may be placed into mental health restraints as outlined in 103 DOC 650. Alternatively, if mental health restraints are not deemed to be appropriate, Mental Health staff in conjunction with security staff may determine that the inmate may be placed into one or more restraint devices as outlined in 103 DOC 507 Security Equipment. Any determination for restraints is to be made as an individualized determination for each inmate on therapeutic supervision."

[75] See NCCHC Mental Health Standards 2015, MH-I-01: Restraint and Seclusion. In relevant part, "Mental health staff order clinical restraints and clinical seclusion only for patients exhibiting behavior dangerous to self or others as a result of mental illness."

[76] See American Psychiatric Association's "Psychiatric Services in Correctional Facilities," 2019. Seclusion and Restraint, page 66.

Table 4. Foreign Body Ingestion and Insertion

Month	Ingestion of Object	Insertion of Object
March 2023	0	1
April 2023	4	2
May 2023	1	3
June 2023	2	0
TOTAL	**7**	**6**

The DQE team has not yet reviewed 103 DOC 501, MDOC's policy on foreign body ingestion.

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: Compliance not yet due

Rationale: MDOC's policy on foreign body ingestions,103 DOC 501, has not yet been provided to the DQE for review. No specific time frame for updating this policy is stated in Paragraph 112, so the DQE understands the deadline to be the same as for all other policies: December 20, 2023. From the May 2023 QIC Meeting minutes, it appears that MDOC has already begun discussing how best to clarify the roles of mental health, medical, and security staff in managing foreign body ingestions, which is a positive step toward compliance with this provision.

INTENSIVE STABILIZATION UNIT

None of the requirements in Paragraphs 113-135 are due at this time. They are listed here only for reference, followed by a brief description of the current status of ISU planning.

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.

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

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.

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 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.

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

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.

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

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.

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.

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:

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

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;

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

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;

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

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

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

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

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

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.

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.

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.

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

Findings for Paragraphs 113-135: Compliance not yet due

Rationale: Although planning for the ISU is well under way, MDOC is not required to provide formal plans to the DQE until December 20, 2023, and the unit is not required to open until June 20, 2024. During the DQE team's second visit to OCCC in July 2023, the facility's leadership reported that the housing unit where the ISU will be located has been emptied of prisoners and is awaiting the completion of renovations. MDOC intends for all 15 cells in the ISU to be suicide-resistant, so some physical plant changes are necessary before patients can move into the unit. Because of shortages in labor and construction materials, MDOC could not yet identify a projected completion date for the renovations.

Of note, after reviewing the cases of several prisoners whom MDOC has repeatedly referred to Bridgewater State Hospital, the DQE has a better sense of why the ISU is being developed. It seems that, as a rule, Bridgewater clinicians who assess MDOC patients pursuant to Section 18(a) do not consider borderline personality disorder to be a DMH-qualifying diagnosis, no matter how severe the symptoms. Even when MDOC makes a clinically reasonable decision to refer a patient to Bridgewater's higher level of care, the patient is returned within 30 days along with a declaration that they can be managed in a prison setting. The fact that the patient continues to self-injure in a prison

setting and improves in the hospital setting makes no difference to the 18a evaluators; they often view this as evidence of manipulation for secondary gain. Thus, the door to a hospital level of care is essentially closed for patients with severe personality disorders, despite Bridgewater's beds being only 10-20% full on any given day.[77]

Between Bridgewater and MDOC facilities, the treatment system currently has a gap in its ability to treat patients with personality disorders and repeated self-injury. Building the ISU is a reasonable next step in attempting to care for these challenging patients. The DQE has not yet seen a referral list for the ISU, but it seems likely that a significant portion of the unit's population will be patients who are ineligible for services in psychiatric hospitals because of their diagnoses.

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: Partial compliance

[77] See details about Bridgewater's Intensive Stabilization and Observation Unit (ISOU) census in the Paragraph 139 discussion.

Rationale: MDOC utilizes behavior plans to incentivize pro-social behavior for a small number of prisoners who have engaged in repeated self-injury. Based on materials provided to the DQE in June 2023, Wellpath recently trained its clinicians in Behavior Management, including instruction on how to develop and implement behavior plans. The training materials indicate that Wellpath leadership is familiar with important principles of behavior planning, such as identifying the function of a problematic behavior, incentivizing progress with varying rewards over time, maintaining consistency of implementation among staff members, and monitoring staff countertransference.

To assess MDOC's behavior plans in practice, the mental health clinician members of the DQE team reviewed seven behavior plans from MTC, SBCC, and the RTU at OCCC, which were dated between May 2019 and May 2023. The plans were all different in their format and incentives, suggesting that each facility creates the plans independently, without a template from Wellpath. This is not necessarily a bad thing, as behavior plans should be individualized to the patient and to the treatment context. However, some of the plans lacked key elements such as:

- the function of the problematic behavior
- specific interventions/strategies to diminish or eliminate the behavior
- who is responsible for monitoring the behaviors
- how adherence or nonadherence will be determined
- variation of incentives over time

In one recent case at SBCC, the behavior plan was not particularly detailed, but it appears to have been successful. Records indicate that the plan was created in June 2023, just after the patient returned from Bridgewater State Hospital with the conclusion that he did not have "a bona fide major mental illness" by the 18a evaluator (because his diagnoses are borderline personality disorder and antisocial personality disorder). SBCC admitted the patient to a Secure Treatment Program, where he was placed on a behavior plan. His first set of expectations and incentives was for two weeks. The plan was reviewed after two weeks, and the patient was allowed to choose one extra therapeutic group (his chosen incentive) to attend per week. Two weeks later, the patient continued to progress, and he was transferred from the STP to the RTU, a less restrictive setting. To date, he is doing well, and his behavior plan was discontinued in the RTU after discussing it with him. This case represents exactly the type of individualized planning that Paragraph 136 is intended to support, and MDOC has done a nice job with it, especially in the face of Bridgewater essentially rejecting the patient and saying that he "can be managed in a penal setting." Although the patient's illness is chronic, and future episodes of SDV are

to be expected, MDOC has meaningfully employed a behavior plan to address the patient's problems.

The other behavior plans the DQE team reviewed have been less successful. The team was provided with another prisoner's (undated) plan at SBCC that was designed to incentivize good hygiene practices, but in reviewing three years of progress notes and treatment plans, the DQE could not find any evidence that the plan was implemented. A third plan at SBCC, from April 2022, contains an elaborate set of incentives for a patient housed in the RHU, but it is not clear from the follow-up notes what happened to the plan. One supervisor's note from April 2022 refers to things going well, but the primary clinician's notes never mention the plan. A supervisor's treatment plan review from September 2022 briefly refers to an incentive plan and the client being "receptive to incentives earned," but then there was no further discussion and no treatment plan updates since then.

At OCCC, the three behavior plans the DQE team reviewed were all for RTU patients. The first was from May 2023 for a patient who had difficulty feeling safe in general population and had repeated, lengthy TS placements. By utilizing financial incentives for staying in GP, which allow him to purchase music downloads (his preferred incentive), he has been off TS for over two months. In a second case, the Incentive Plan has no date, and a copy of it could not be located in the medical record. However, progress notes refer to the plan being developed in November 2020, just after the patient's return from Bridgewater after an 18(a) evaluation. Treatment plan reviews every three months since January 2021 refer to the fact that the patient is still on an incentive plan that "rewards positive behaviors," but there is no discussion about whether such a plan is still necessary after nearly three years. Finally, the third case from OCCC dates back to June 2019, when a four-phase behavior plan was implemented after the patient's return from Bridgewater. Treatment plan reviews since September and December 2019 say that the patient has been earning incentives based on his plan, including a job. However, by March 2020, the behavior plan is no longer mentioned in the treatment plan or progress notes, without any explanation for why it was stopped (or even whether it was).

Overall, MDOC is on the right track with behavior plans, and the more recent examples from 2023 demonstrate the type of individualized and time-limited incentives required by Paragraph 136. With consistent application of these principles across the facilities, MDOC will be compliant with this provision. The DQE urges MDOC to consider staffing the ISU with a psychologist who can lead the treatment team's efforts to create and implement behavior plans for individuals with personality disorders and patterns of repeated self-injury. MDOC may also wish to consider a Behavior Plan template that addresses the specific subsections of 136a-h so that clinicians are prompted to think

through each highlighted areas (e.g., time intervals, homework, disincentives for false statements).

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: The DQE does not have much information about Wellpath's quality assurance program other than that it employs a CQI Program Manager and CQI Mental Health Coordinator who focus on collecting and analyzing mental health data. In addition to documents about Wellpath's quarterly "CQI screens," the DQE team was provided with sign-in sheets from quarterly CQI meetings at OCCC, SBCC, Shirley, Gardner, and Norfolk from various dates in 2022. MDOC leadership stated that these facility-specific quality assurance meetings have continued even after MDOC's system-wide QIC meeting began in March 2023. The DQE will need to gather additional information about the various quality improvement meetings in the next reporting period.

Thus far, the DQE is not aware of any Wellpath quality assurance practices that would address the DQE team's concerns about the quality of MHPs' diagnostic assessments, risk assessments, and treatment interventions that are described elsewhere in this report. Addressing these concerns will require auditing more than just the presence and timeliness of chart notes, as the DQE team found many instances of clinicians writing a note simply to say that they could not see the patient because of insufficient time or competing demands. A metric to measure quality rather than quantity or timeliness will need to be devised.

The DQE reviewed PowerPoint slides from a training that Wellpath's CQI team provided on the use of data to track patient-specific outcomes in the RTU and STU programs. The proposed data tracking was very impressive, allowing MDOC to see whether the specialized treatment programs are having an impact on outcomes such as crisis calls, self-injury, outside hospital trips, and TS placements. It also allows MDOC to track program-wide outcomes such as referrals and acceptance rates, average length of stay, SDV events, and reintegration into less restrictive placements. The DQE looks forward to reviewing these data when they are available.

Another positive aspect of Wellpath's quality assurance program is that it collaborates with MDOC for several joint activities, including:

- Monthly SDV-SATT Review Committee meetings
- Monthly Quality Improvement Committee meetings
- Inter-Facility Case Conferences
- Morbidity and Mortality Review meetings and corrective action plans

Given the close relationship between MDOC Behavioral Health staff and Wellpath's staff, the DQE appreciates their practice of engaging in quality assurance meetings jointly. This is a good practice to continue, fostering a collaborative approach to system-wide problem solving and quality improvement.

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: Compliance not yet due

Rationale: No specific time frame for drafting these policies is outlined in the Agreement, so the DQE understands it to be the same as all other policies: finalize by December 20, 2023. MDOC began its Quality Improvement Committee and monthly Quality Assurance Reports in March 2023, but administrators reported that they have not yet finalized the policies related to these practices.

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.

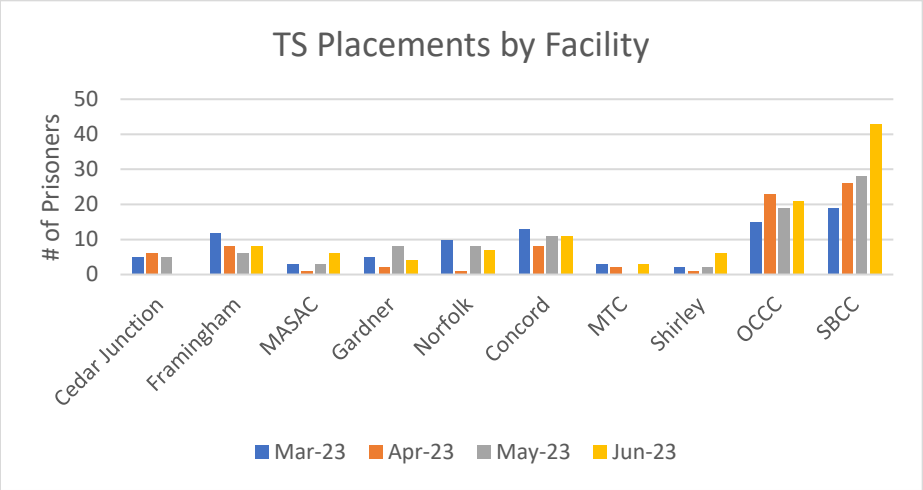
Finding: Substantial compliance

Rationale: MDOC began issuing this report in March 2023 and has done so monthly since that time. All 11 subsections of this paragraph are addressed in each monthly report. The DQE highlights some important findings from the Quality Assurance reports between March and June 2023:

Number of TS Placements and Length of Stay

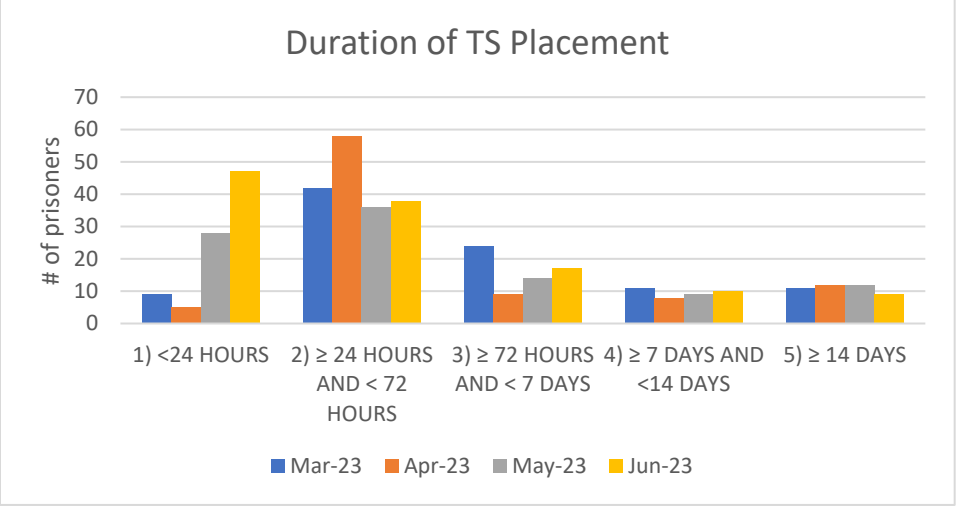
Figure 4 illustrates that the majority of TS placements occur at OCCC and SBCC, with a steady increase at SBCC over the months between March and June 2023. MDOC noted that this change coincides with SBCC becoming the system's intake facility rather than Cedar Junction. TS placement rates at all other facilities remained fairly stable.

Figure 4. TS Placements by Facility



When examining the duration of TS placements, the placements are divided into five cohorts: <24 hours, 24-72 hours, 72 hours to 7 days, 7 to 14 days, and greater than 14 days. As *Figure 5* illustrates, most TS placements are relatively brief, lasting less than 72 hours. For unclear reasons, the number of very brief placements – under 24 hours – grew substantially between April and June 2023. Excluding three outlier cases from SBCC with lengths of stay greater than 100 days, the mean length of stay on TS was 4.1 days, with a median of 2 days and range of 0-44 days.

Figure 5. Duration of TS Placement



[78]

The DQE team also analyzed whether the overall number of long TS placements has changed since the DOJ's 2019 Findings Letter. When comparing the 2019 data to

[78] The DQE changed the MDOC's line graph to a bar graph so it is easier to interpret, but the data comes from the June 2023 Quality Assurance Report.

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 5,700 in mid-2023. Overall, the DQE found that the rate of TS placements of 14 days or more remained stable, but the longest TS placements (>3 months and >6 months) declined substantially. *Table 5* highlights these results.

Table 5. Lengthy TS Placements, 2019 vs. 2023

	2019		2023		
TS duration	Total placements in 13 months	Annual placements per 10,000 prisoners[79]	First 6 months of 2023	Annual placements per 10,000 prisoners[80]	**% Change since 2019**
>6 mo	7	7.4	1	3.5	**-52.7%**
>3 mo	16	17.0	3	10.5	**-38.2%**
>1 mo	51	54.1	12	42.1	**-9.9%**
≥ 14 days	106	112.5	32	112.2	**-0.2%**

The numbers alone do not tell the whole story, but the substantial decrease in 3-month and 6-month TS placements likely indicates that MDOC is considering prisoners' transfer to higher levels of care earlier in the TS process.

Given the DOJ's concern about long lengths of stay on TS in its 2019 Findings Letter, the DQE reviewed the three longest TS placements in 2023, those lasting 90 days or more. All three cases occurred at SBCC, and all three patients had primary diagnoses of borderline personality disorder. One patient was eventually transferred to the STP while still on a TS and successfully transitioned off that status in the STP. Another was taken off TS but still housed in the HSU, where he could continue receiving intensive monitoring and treatment. The third patient's TS ended when he successfully petitioned for transfer to BSH under Section 18(a1/2), though he was returned to SBCC less than two weeks later because BSH opined that he did not have a DMH-qualifying mental illness. All three of these cases are very complex, and MDOC has tried multiple different settings – RTU, TS placements, STPs, 18(a) petitions – in the past, without any "magic bullet" to solve the patients' problems. It is possible that the ISU's opening will provide another alternative for patients like this, who do not thrive in prison settings but have

[79] Calculated based on 8,700 total prisoners, as noted in the DOJ Findings Letter.
[80] Calculated based on approximately 5,700 total prisoners in MDOC in June 2023

been rejected by psychiatric hospitals as not meeting the Section 18(a) commitment criteria.

Finally, the DQE examined the location where TS placements occur within each facility. This question was raised in the Baseline DQE Report because of OCCC's tendency at that time to place prisoners in the BAU rather than the HSU; the latter was considered a more therapeutic setting. Looking at TS placements across the entire MDOC system between January and June 2023, the DQE team found that over two thirds of TS placements occurred in the Health Services Unit, a positive finding that is highlighted in *Table 6*.

Table 6. Location of TS Placement within Facility

Unit	Facilities Using Unit for TS	# of TS placements	% of TS placements
Health Services Unit	Concord, Framingham, Gardner, Norfolk, OCCC, Shirley, OCCC	343	68.1%
Behavior Assessment Unit	SBCC, Norfolk, MTC, Shirley, OCCC	74	14.7%
Disciplinary Detention Unit	Cedar Junction	20	4.0%
Secure Treatment Unit	SBCC, Cedar Junction	37	7.4%
Intensive Treatment Unit	Framingham	12	2.4%
Housing Unit	MASAC, OCCC[81]	17	3.4%
TOTAL		**503**	**100%**

Self-Injurious Behavior

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

[81] Of the 17 cases, 16 were at MASAC. Only one case at OCCC in January 2023 occurred in a housing unit, and facility leadership stated that they now only use the HSU and BAU for TS placements. The TS registry data clearly indicates a shift toward using the HSU rather than the BAU for TS placements between March and June 2023.

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 eight times with prisoners on TS between March and June 2023. Three incidents occurred at SBCC (involving three different prisoners on three different days), two at Cedar Junction (both on the same prisoner, one day apart), two at Gardner (both on the same prisoner, one day apart), and one at Concord. All eight incidents are described as a spontaneous use of force, and four involved the use of OC spray.

Although compliant with the Agreement's reporting requirement, these data do not quite capture the extent that force is being used with prisoners in MDOC, as they do not include incidents where force was used to gain the prisoner's compliance during the incident precipitating the TS placement. They also do not capture incidents that occur in units with high concentrations of SMI prisoners such as the BMU, STP, or SAU. For example, during the DQE team's site visit of SBCC in June 2023, an officer informed us that force was used to perform "26 cell extractions in one day" in the SAU the previous week, a report that was confirmed by several prisoners. Reports like this raise the DQE's level of concern about the use of force with SMI prisoners broadly, while also acknowledging that the Agreement does not mandate disclosure of the information except when it occurs on TS.

Psychiatric Hospitalizations

MDOC's records indicate that 21 patients were transferred to psychiatric hospitals under Section 18(a) between March and June 2023. Two additional patients were transferred to BSH under Section 18(a1/2), and one under Section 15(b).

RTU Census

Table 7 illustrates that the RTU census has been fairly stable across all institutions, and none of the RTUs are operating at capacity. Gardner is the closest, with 22 of 24 beds filled in June 2023, with SBCC and Framingham operating at about one third of their total capacity.

Table 7. RTU Census and Capacity

Facility	Capacity	Mar-23	Apr-23	May-23	Jun-23
Framingham	42	18	18	16	16
Gardner	24	21	22	22	22
OCCC	98	67	71	67	68
SBCC	64	27	29	27	27

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, but its average census in 2023 was 6 prisoners. At first glance, it appears that these beds are being severely under-utilized, but one must also take into account that MDOC does not control admission to Bridgewater. This is under the purview of the courts, and patients must meet criteria for admission under Section 18(a) or 18(a1/2).

Mental Health Staffing

This issue is discussed in detail 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: This paragraph is not so much a directive to MDOC as it is to the DQE. If MDOC is required to do anything, it is simply to allow the DQE's assessment of the delineated areas and to provide information as requested. To date, MDOC has been

entirely cooperative with the data gathering process, both during site visits and outside of those times.

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: Partial compliance

Rationale: MDOC began its monthly Quality Improvement Committee in March 2023. Minutes from this meeting indicate that MDOC and Wellpath leadership attend this meeting and collaborate in making recommendations for improvement. The DQE has reviewed the minutes from four such meetings, March to June 2023. The meetings appear to meet the requirements delineated in Paragraph 141.

Some areas that MDOC has identified for improvement and/or further investigation in the first four meetings of the QIC:

- Clarifying the definitions of different types of SDV so that data is tracked consistently across facilities
- Tracking the type of instrument used when a prisoner cuts themselves so that security can see whether items from the cell are being used
- Tracking not just the RTU/STU census, but also their total capacity, to get a better sense of fill rates and/or wait lists
- Improving the process of notifying the DQE and DOJ about serious suicide attempts
- Developing a process to audit officers' use of cell safety checklists and offering of out-of-cell activities to prisoners on TS
- The need to train officers to complete incident reports in all cases of SDV, as some were found to be missing

- The need to review MDOC's annual in-service training in light of the Agreement, ensuring that all requirements are covered

It also appears that the QIC meeting reviews issues raised by the DQE during the previous month's site visits, and potential solutions are discussed. In one example, the DQE inquired about the process of confidential incident reports about staff members' alleged unprofessional conduct, and the Deputy Commissioner of Reentry agreed to provide examples of such incident reports to be included in the DQE's monthly information packet. In another example, the Committee discussed how to minimize human error in reporting data to the DQE, and a process for automating data collection is being considered.

Overall, the DQE is very pleased with the roll out of MDOC's QIC meeting. The DQE team's suggestion in the Baseline DQE Report to formalize the corrective action planning process has been adopted, and each QIC meeting contains action items, responsible parties, and time frames for completion. The status of each action item is reviewed at the following month's meeting.

With sustained monthly QIC meetings and demonstration of corrective action implementation as required by subsections 141d and 141e, MDOC will achieve full compliance with this provision.

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: Substantial compliance

Rationale: MDOC conducts an SDV/SATT Review Committee meeting twice monthly via Teams for two hours. The meeting is led by a member of MDOC's Health Services Division, typically the Director of Behavioral Health or a Mental Health Regional Administrator. Other attendees include the Wellpath Mental Health Directors from each MDOC facility, the Wellpath statewide leadership (Psychiatric Medical Director, Program Mental Health Director, Assistant Program Mental Health Director), and the Wellpath CQI Mental Health Coordinator. The DQE attended the meeting on one occasion. Each facility site presented its SDV incidents during the reporting period, and a discussion about systemic changes and/or follow-up for the individual patient ensued. Overall, the meeting appeared to meet the requirements of Paragraph 142.

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 occur twice a month, and each SDV incident over the preceding two weeks is discussed in detail, not just those that require an outside hospital trip. The DQE has not attended the SDV/SATT meeting since February 2023, so it is possible that the format has changed since MDOC began issuing its monthly Quality Assurance reports in March 2023. However, based on the meeting minutes the DQE reviewed from March to June 2023, it does not appear that the SDV/SATT committee systematically reviews the SDV data from the monthly Quality Assurance reports. Instead, the QIC Committee itself reviews the SDV data.

Technically, MDOC is not fully compliant with Paragraph 143 because the SDV Committee does not review the QA reports. However, the DQE is open to considering whether discussion in both settings is really necessary, as the membership of the committees overlaps quite a bit. The main distinction between the two groups is that the Mental Health Directors from each facility are not present at the QIC meeting. Although the DQE agree that the Mental Health Directors should review relevant data from the monthly Quality Assurance Report and share it with their staff when appropriate, perhaps this could be done over email for the sake of efficiency.

The DQE team reviewed MDOC's SDV data in detail, given the DOJ's concern in the Findings Letter about the number and severity of SDV episodes that occurred while prisoners were on mental health watches. In March and April 2023, MDOC was reporting only the SDV incidents that occurred while a prisoner was on TS in its monthly Quality Assurance report. In May 2023, at the DQE's request, MDOC began reporting all SDV incidents in the report, not just those that occurred while on TS.

Table 8. SDV Incidents by Month

Month	Total SDV incidents on TS	Total SDV Incidents
March 2023	10	Not reported
April 2023	27	Not reported
May 2023	23	42
June 2023	17	46

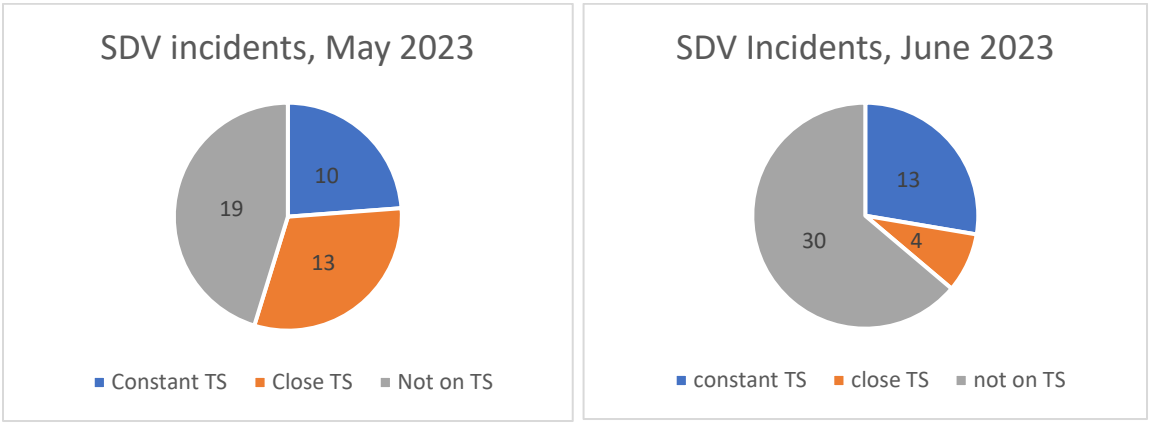
When compared with the DOJ's findings in 2019, SDV incidents decreased significantly in 2023, though the data must be interpreted with caution because of the limited SDV data reported in 2023. The change is illustrated in *Table 9.*

Table 9. SDV Incidents, 2019 vs. 2023

	2019		2023		
Category	Total SDV incidents in 13 months	Annual SDV incidents per 10,000 prisoners[82]	Total SDV incidents in May-June 2023	Annual SDV incidents per 10,000 prisoners[83]	**% Change since 2019**
Total SDV	1200	1273.2	88	926.3	**-27.2%**
SDV on TS	688	730	40	421	**-41.5%**

MDOC's data indicate that a little over half of all SDV incidents in May 2023 occurred while a prisoner was on TS. In June 2023, the ratio dropped to about a third (see *Figure 6*). However, these month-to-month variations may not have much significance because of the relatively small numbers, and further data will be needed to assess long-term trends.

Figure 6. SDV Incidents in May and June 2023

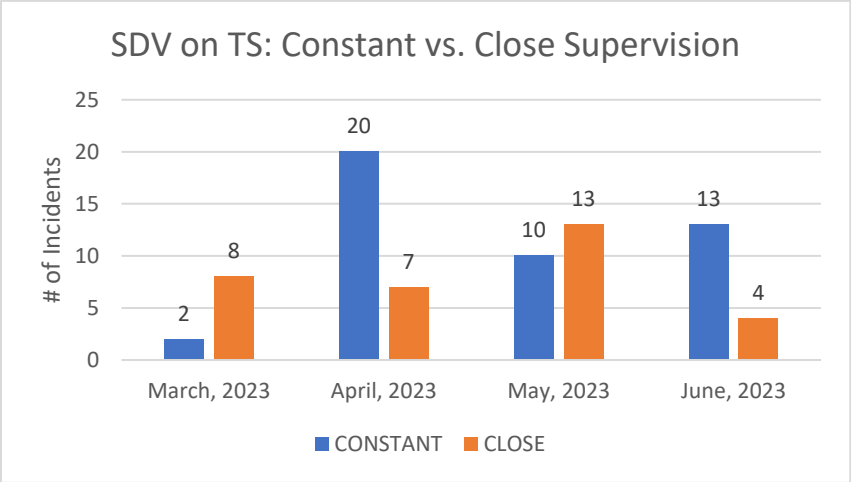


Most of the SDV incidents that occurred while a prisoner was on TS occurred under constant supervision rather than under close supervision. In June, the 13 total incidents in

[82] Calculated based on 8,700 total prisoners, as noted in the DOJ Findings Letter.
[83] Calculated based on approximately 5,700 total prisoners in MDOC in June 2023

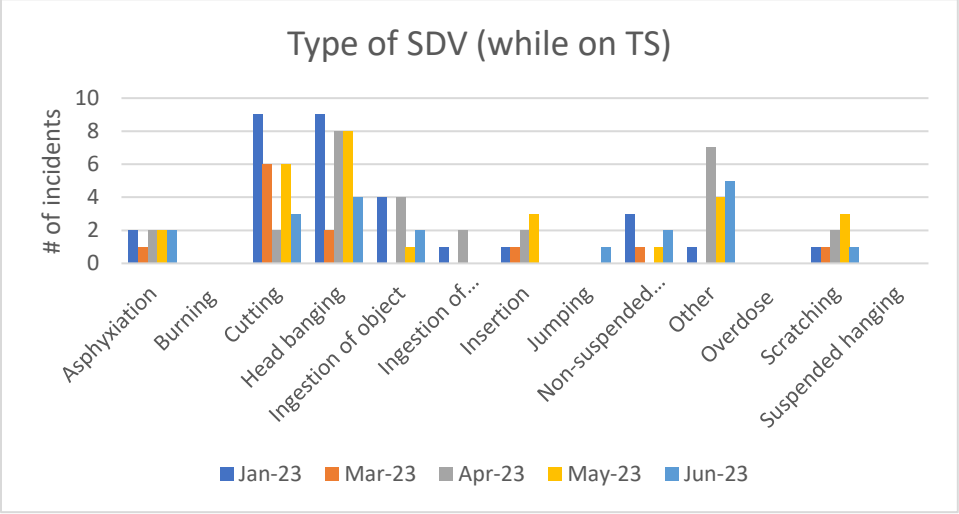
this category were attributable to 7 prisoners; many prisoners had a "spree" of self-injurious incidents while on TS, often within hours of each other.

Figure 7. SDV Incidents on TS, Constant vs. Close Supervision



Prisoners engaged in self-injury while on TS occurred using many different methods, but the most common were cutting and head-banging. The fact that cutting continues to be prevalent in patients on TS is somewhat concerning, but more data is needed to assess whether the cutting is preventable (e.g., the prisoner used something from the cell that should not have been there) or not (e.g., the prisoner used a fingernail or teeth). MDOC's Quality Improvement Committee has already identified the need to collect this information going forward.

Figure 8. Type of SDV while on TS

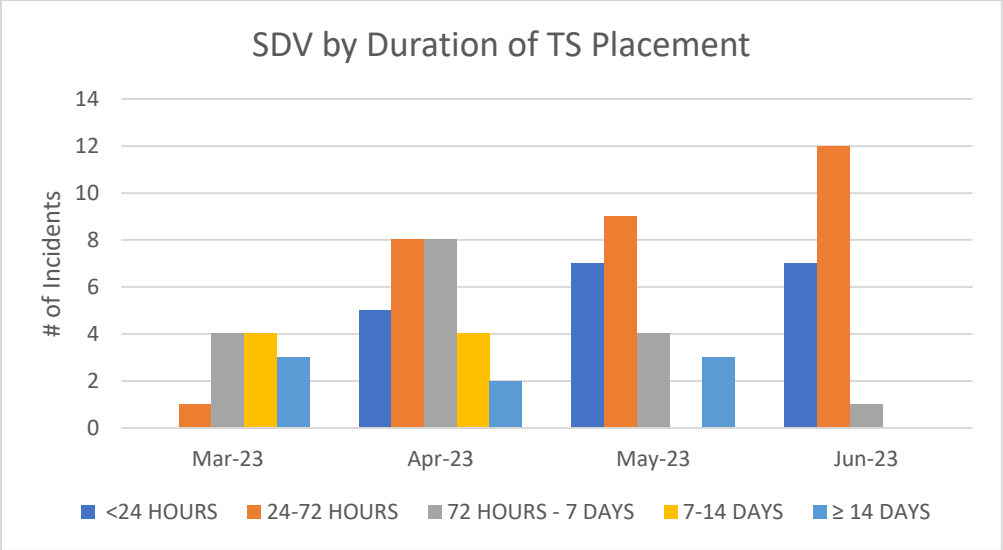


[84]

[84] The DQE is missing data from February 2023 because MDOC did not start issuing the monthly Quality Assurance Report until March 2023. Data from January is from the Baseline DQE Report.

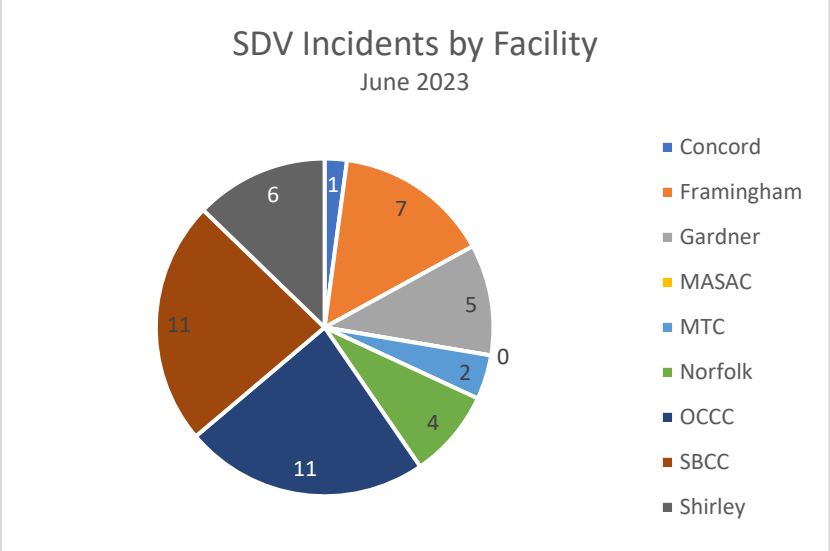
Self-injury occurred during TS placements of varying durations, but most incidents occurred during placements of 72 hours or less. This finding is noteworthy, but it is not yet clear what it means.

Figure 9. SDV by Duration of Placement



In June 2023, the total incidents of self-injury (not just those that occurred on TS) were divided across the MDOC facilities as illustrated in *Figure 10.*

Figure 10. SDV Incidents by Facility



OCCC and SBCC outpaced all facilities in the number of SDV episodes, with nearly half of MDOC's SDV incidents occurring at those two facilities. This is not surprising, given

the facilities' relatively high proportion of prisoners on the mental health caseload, but it warrants further monitoring.

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: Noncompliance

Rationale: MDOC may very well be doing this, but the DQE has not been provided with any evidence of it to date. From the April 2023 QIC meeting minutes, it appears that MDOC has begun holding SDV follow-up meetings at the facilities, but the details of this practice are not yet known.

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: Three serious suicide attempts, as defined in Paragraph 145, have occurred since the Agreement's effective date. The first occurred on December 25, 2022, at OCCC, and the morbidity review meeting was not conducted until March 13, 2023, because MDOC's Behavioral Health leadership was not notified of the event by the facility until months after it occurred. MDOC did not provide any documentation related to this event, such as a Morbidity Review report. It did, however, provide documentation of its revised protocol for notifying MDOC DHS leadership of serious suicide attempts so that notification is not delayed in the future.

The second serious suicide attempt occurred at NCCI-Gardner on June 21, 2023, and MDOC DHS leadership was notified by the facility right away. The morbidity review meeting occurred in a timely manner, with a multidisciplinary meeting held on July 13, 2023. The formal Morbidity Review report was completed on July 14, 2023, and was distributed to the facilities shortly thereafter.

The third incident occurred on August 2, 2023, and the morbidity review meeting had not yet occurred at the time of this report's draft. The DQE team will continue to monitor timeliness of the morbidity and mortality reviews, but if MDOC stays on its current path, it is likely to be compliant with the Paragraph 145 requirements in the near future.

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 suicide attempt.

Finding: Partial compliance

Rationale: MDOC has a Morbidity Review Committee, though the DQE does not know its exact membership. During the two Morbidity Review meetings attended by the DQE, attendees included the Director of Behavioral Health, Mental Health Regional Administrators, Deputy Commissioner for Clinical Services and Reentry, Assistant Deputy Commissioner for Clinical Services, Wellpath Psychiatric Medical Director, Wellpath Program Mental Health Director, Wellpath Regional Mental Health Director,

Wellpath CQI Program Manager, representatives from the facility's mental health staff (e.g., mental health director, health services administrator), and others. These individuals likely satisfy the requirements of Paragraph 146.

No deaths by suicide have occurred since the Agreement's effective date, but presumably the same group would convene for a Mortality Review if needed.

Although a morbidity review report is completed for each serious suicide attempts, the current format of this document does not contain all the items required in Paragraph 146. The documentation reviewed by the DQE was completed by MDOC's Mental Health Regional Administrator, and it thoroughly outlines the events surrounding the suicide attempt. Using the NCCHC's framework, the current documentation is best described as a clinical morbidity review, leaving MDOC without the other two requirements: an Administrative Review and a Psychological Autopsy. Going forward, MDOC should complete these two documents within 30 days of the incident and add them to the packet of information that is reviewed by the Morbidity Review Committee.

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: As noted above, a suicide attempt requiring outside hospital admission occurred on December 25, 2022, but the DQE was not notified until March 22, 2023. A second serious suicide attempt occurred on June 21, 2023, and the DQE was notified on June 28, 2023. A third incident occurred on August 2, 2023, and the DQE was notified on August 3, 2023. Thus, although two out of three DQE notifications did not occur in a timely manner during the review period, it appears that the notifications are happening sooner, with the most recent one occurring within the 24-hour window specified in Paragraph 147. In all three cases, MDOC provided the information delineated in subsection 147a. If MDOC continues on its current path, it will likely be found in Substantial Compliance with this provision soon.

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: Noncompliance

Rationale: MDOC's first Status Report was due on June 20, 2023. On July 3, 2023, the DQE inquired about the Status Report and several other items that were due within six months of the Agreement's effective date. MDOC replied that the documents were still under internal review and not ready to be shared. To date, the DQE has not received this report.

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 hired a full-time Agreement Coordinator in early 2023, but this person's employment was short-lived. Currently, the MDOC Director of Behavioral Health serves as the Agreement Coordinator. She has been doing an outstanding job keeping up with the DQE team's document requests and responding to numerous inquiries in real time. However, the DQE team believes (and MDOC would likely agree) that a full-time Agreement Coordinator would be a huge asset to the monitoring endeavor and to implementation. When such a person is hired, the DQE team would like to transfer some data gathering and analysis to MDOC in an effort to develop a sustainable practice of self-auditing. For example, now that the DQE team has developed auditing instruments for MDOC's medical records, the team can train MDOC's Agreement Coordinator to perform these audits internally, with spot-checking by the DQE for accuracy.

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: Partial compliance

Rationale: To date, MDOC has not provided any documentation to demonstrate that these meetings are occurring across the system. However, the DQE team did learn during the OCCC site visit in July 2023 that the facility has implemented a multidisciplinary (mental health and security) Care and Coordination meeting during which the progress and setbacks of compliance with the Agreement are discussed. MDOC leadership stated that similar meetings began at all facilities in June 2023 and will be conducted quarterly going forward. The DQE team will look for evidence of Care and Coordination meetings during the next round of site visits; these meetings would likely satisfy the requirements of Paragraph 170.

RECOMMENDATIONS

The following recommendations stem from the information in the *Detailed Findings* section of this report. 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. Begin submitting revisions of existing policies – both DOC and Wellpath – to the DQE and DOJ as soon as possible, as MDOC is already behind the schedule outlined in Paragraph 27.

2. Continue drafting policies for the ISU so they can be reviewed prior to the due date of December 20, 2023 and do not inadvertently contribute delay to opening the unit.

STAFFING PLAN

3. Continue all efforts to improve mental health staffing levels, especially for MHPs, psychologists, and psychiatrists. Possible strategies to explore include increasing compensation, providing retention bonuses, enhancing retirement benefits, increasing overtime pay, working with professional job recruiters, and partnering with academic institutions and medical centers to create trainee rotations.

4. Continue all efforts to improve security staffing levels by exploring the same strategies listed in recommendation #3 (except for trainee rotations, which do not apply to security staff).

5. Continue with plans to hire and implement Support Persons for patients on TS in the next six months. MDOC will also need to consider whether there are currently enough mental health staff to supervise the Support Persons.

6. Continue with staffing plans for the ISU, including a psychologist with expertise in behavioral management plans.

TRAINING

7. Working with MDOC's Director of Staff Development, develop a strategy to demonstrate to the DQE that all staff requiring training under Paragraphs 35-42 have completed it. A similar discussion should occur with Wellpath's training division regarding MASAC's staff, who undergo different trainings.

8. When revising pre-service and annual in-service training, enhance training in areas where the DQE team 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. Lighting protocols for prisoners on close and constant watch in TS cells
    c. Clothing being removed only if used for self-harm
    d. Mental health assessments occurring in confidential, out-of-cell spaces
    e. Individualized decisions about restraining prisoners when on TS

9. Consider adding content trainings for Wellpath mental health clinicians including:

    a. The relationship between SDV and psychosis
    b. The relationship between SDV and substance intoxication and withdrawal
    c. Individualized treatment planning

THERAPEUTIC RESPONSE TO PRISONERS IN MENTAL HEALTH CRISIS

10. Ensure adequate confidentiality of all mental health assessments, including crisis contacts and TS contacts. Crisis contacts at SBCC, OCCC, and MTC are of particular concern, though OCCC has already begun to address this issue.

11. 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 treatment compliance in the electronic health record when conducting crisis assessments and creating TS treatment plans.

12. Improve clinicians' documentation of individualized decision-making and treatment planning in crisis assessments and TS contacts. The documentation need not be lengthy or elaborate as long as it demonstrates the clinician's thought process in arriving at their assessment and plan.

13. Integrate psychiatry 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. One potential strategy is to have the psychiatrist conduct rounds with the MHP every morning, seeing patients together and discussing treatment plans. Another is to create criteria for psychiatry referral rather than leaving it simply "as clinically indicated." A third is for psychiatrists to write orders for TS initiation and discontinuation, which will naturally involve them in the decision-making process more fully.

14. Consider including representatives from MDOC's substance use disorder treatment program (Spectrum Health at most facilities, Acadia Health at MASAC) into the daily mental health triage meetings and the facilities' interdisciplinary assessment teams.

15. Begin making necessary physical plant modifications to dim the lights in TS cells during sleeping hours at all facilities.

16. Continue investigating the feasibility of out-of-cell meals, therapy dogs, and peer mentors for TS patients at all facilities.

17. Ensure that consultation with MDOC Behavioral Health leadership, not just notification, occurs for patients after 72 hours, 7 days, and 14 days on TS. These consultations should include consideration of a higher level of care, as well as potential treatment plan changes while on TS.

18. Improve the consistency of IMS documentation of offered and accepted recreation, showers, visits, and phone calls for prisoners on TS.

19. Improve clinicians' discharge planning and documentation on the Mental Health Watch Discontinuation Form to include individualized plans that are connected to the patient's risk factors.

SUPERVISION OF PRISONERS IN MENTAL HEALTH CRISIS

20. Ensure that security officers are using a cell safety checklist to search TS cells and prisoners for potential hazards prior to initiating TS.

21. Conduct individualized assessments of prisoners' risk with clothing and remove clothing only in cases where a prisoner has used the clothing for self-harm.

22. Conduct individualized assessments of prisoners' need to be restrained when leaving their TS cells.

23. Continue installing door sweeps for TS cells where significant gaps exist between the cell door and floor.

24. Work with the DQE to demonstrate compliance with the requirement that staff notify mental health immediately after discovering self-injury, such as reviewing video footage and Incident Reports from known episodes of SDV.

25. Work with the DQE to demonstrate that investigations of alleged staff misconduct related to the Agreement occur, as well as the outcomes of these investigations.

26. Conduct a review of how restraints are currently utilized in the management of self-injury, with an eye toward whether MDOC's policies and national guidelines are being followed for the use of therapeutic vs. security restraints.

BEHAVIORAL MANAGEMENT PLANS

27. Involve a psychologist in creating behavior plans.

28. Ensure that behavior plans involve incentives identified by the patient, realistic time frames and behavioral expectations to achieve positive reinforcement, clearly defined measures of compliance, staff members responsible for assessing compliance, and updated incentives over time.

QUALITY ASSURANCE

29. Develop a strategy to assess the quality, not just the completion, of MHPs' crisis and TS contacts. Possible factors to assess include the duration of contact, location of contact, reason for cellside contact, and attempts to reapproach patients who refuse contact.

30. Begin completing morbidity review paperwork within 30 days in the format required by Paragraph 146, including a clinical mortality/morbidity review, administrative review, and psychological autopsy.

31. Continue with plans noted in the QIC Meeting minutes to assess SDV incidents on TS involving contraband, such as sharp implements, hoarded medications, or items not permitted

on the prisoner's Therapeutic Supervision Report. The focus at this stage should not be staff accountability but, rather, identifying practices that could prevent recurrence.

CONCLUSION AND NEXT STEPS

MDOC's cooperation with the DQE to date has been exemplary, and MDOC has made substantial improvements to mental healthcare since the DOJ's investigation in 2019. Significant work remains to be done, but that is expected at this early stage of Agreement implementation. Currently, the greatest challenges lie with staffing (both security and mental health), the quality of mental health assessment, and individualized treatment planning. Fortunately, MDOC's mental health staff and leadership are dedicated, creative, and resilient, and there is every reason to believe that MDOC will achieve compliance with the Agreement over time.

The DQE team understands that every project cannot be tackled at once, so we have identified priorities for the next six months:

Improvements in Patient Care

- Emphasizing with security and mental health staff the importance of providing confidential, out-of-cell settings for assessment and treatment, both while on TS and during crisis assessments
- Encouraging and training MHPs to individualize treatment activities (and their documentation of such) to patients' needs
- Integrating psychiatry more fully into the treatment of patients on TS
- Completing necessary renovations in the planned ISU space at OCCC

Technical Compliance with the Agreement

- Hiring a full-time Agreement Coordinator
- Working with the DQE and DOJ to identify the data sources that will allow the DQE to assess compliance with every single provision of the Agreement
- Completing self-audits related to the Agreement and providing semi-annual compliance reports to the DQE and DOJ
- Reviewing and finalizing policies related to the Agreement

The DQE encourages the parties to consider streamlining or reducing requirements of the Agreement in a few areas that are highlighted earlier in this report. The DQE is wary of creating an undue emphasis on paperwork and protocol at the expense of staff morale and time spent with

patients. The DOJ has expressed similar sentiments, so a discussion about ways to minimize documentation while still meeting the substantive requirements of the Agreement would likely be welcome.

The DQE team anticipates resuming site visits of MDOC facilities in November 2023. Most of these visits will be shorter in duration than the first round, but OCCC, SBCC, and Concord will continue to be two-day site visits because of their relatively large proportion of TS placements and SDV incidents. The DQE will also continue to solicit feedback from relevant stakeholders, aiming to understand MDOC's mental health system from as many viewpoints as possible prior to completing the second compliance report in March 2024.