MARCH 24, 2024

MASSACHUSETTS DEPARTMENT OF CORRECTION

COMPLIANCE REPORT #2

REENA KAPOOR, MD
DESIGNATED QUALIFIED EXPERT

TABLE OF CONTENTS

BACKGROUND

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

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

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

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

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

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

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

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

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

PURPOSE AND FORMAT OF REPORT

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

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

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

EXECUTIVE SUMMARY

During this reporting period, MDOC has remained cooperative with the DQE team and has actively worked toward compliance with the Agreement. Site visit have gone smoothly, with the DQE team given full access to information and facilities. Leaders from MDOC's security, legal, and health services divisions have continued to attend the site visits and/or exit interviews, asking relevant questions and planning next steps. In between visits, enormous amounts of data have been provided to the DQE team in a timely manner. Overall, it has been a pleasure to work with MDOC on assessing its compliance with the Agreement.

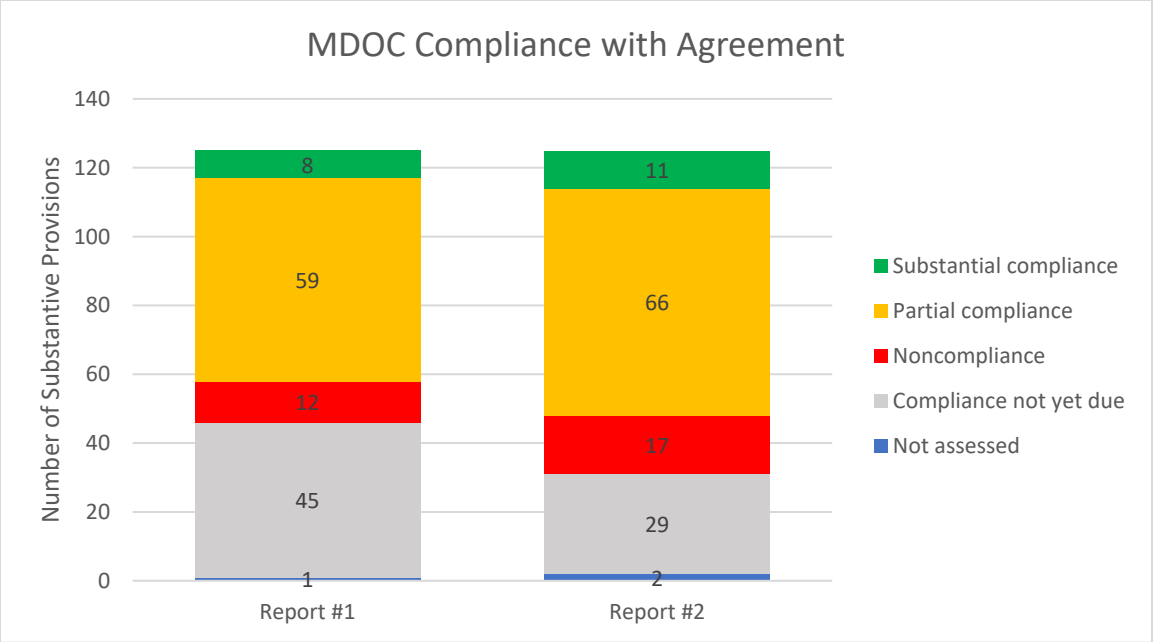
MDOC has made incremental progress toward Agreement compliance over the past six months. Since the DQE's first report was issued in September 2023, MDOC has:

- Hired an excellent, full-time Clinical Operations Analyst with experience in both clinical care and data analysis to serve as the Agreement Coordinator;
- Completed an analysis of Wellpath's staff recruitment and retention strategies, increasing compensation and improving communication with potential staff recruits and new employees;
- Modestly improved mental health staffing levels in key positions such as mental health professionals (MHPs) and psychiatrists;
- Implemented several new review meetings in accordance with the Agreement:
    - quarterly DOJ Implementation meetings to assess progress with the Agreement and gather feedback from the facilities

    - monthly or twice-monthly "Care and Coordination" meetings between mental health, medical, and security leadership at facilities where therapeutic supervision (TS) occurs
    - daily TS Notification/Consultation meetings with Wellpath and MDOC leadership to review cases with long lengths of stay on TS
    - as-needed meetings between MDOC clinical and operational leadership and facility leadership to review self-directed violence (SDV) incidents and implement corrective actions
- Posted positions for Support Persons, with Wellpath actively reviewing candidates for all facilities where TS occurs[2];
- Installed door sweeps and light dimmer switches in the TS cells of many facilities;
- Set an expectation that security staff will complete cell safety checklists prior to placing prisoners on TS;
- Revised two of MDOC's major mental health policies and submitted them to the DQE for review;
- Revised staff training materials on Therapeutic Supervision and Suicide Prevention & Intervention;
- Submitted a timely compliance report to the DQE and DOJ, documenting the status of every Agreement provision; and
- Continued to make physical plant changes necessary to open the Intensive Stabilization Unit (ISU) in June 2024.

A detailed Compliance Table is included at the end of this Executive Summary. In brief, MDOC improved its compliance ratings in 11 of the Agreement's 125 substantive provisions during this monitoring period. Another 84 substantive provisions remained unchanged or were assessed for the first time, and no provisions slid backward. Compliance with 29 provisions is not yet due, and two provisions are not being assessed by agreement of the Parties.

[2] This reflects the status of Support Persons in February 2024, when the DQE's report was drafted. In its response to the draft report, MDOC reported that it has made further progress in this area, hiring full-time and per diem Support Persons at every facility required under the Agreement as of March 14, 2024.



Although progress has not always gone according to the Agreement's timeline, one can see an overall positive trend. The majority of noncompliance findings stem from two areas where MDOC has fallen behind the Agreement's schedule: policy revision (including review and approval by the DQE and DOJ) and the implementation of Support Persons to assist with the care of prisoners on TS. In most other areas, MDOC continues to make gradual progress toward compliance. Even in areas where a partial compliance finding was issued in both monitoring periods, the DQE can see significant improvements.

The body of this report focuses on technical compliance with the Agreement, but two "big picture" issues are worth mentioning up front so they do not get lost in a sea of data and compliance findings:

Quality of mental health evaluation and treatment

MDOC's clinicians remain eager and compassionate, with an obvious desire to improve the lives of incarcerated individuals. Many prisoners described their interactions with the mental health staff in positive terms, feeling as if the staff genuinely care about them, and the DQE team observed strong collegiality among clinicians during the site visits. Nonetheless, mental health assessments and treatment remain inadequate at many institutions. During the first reporting period, the DQE team framed this inadequacy as a function of understaffing. More recently, it has seemed that problems with the quality of care are multifactorial, stemming from (1) inadequate staffing (leading to rushed assessments and therapeutic contacts), (2) limited experience of MHPs (leading to poor recognition of mental health symptoms and a narrow therapeutic repertoire), and (3)

systems of care that are organized around crisis response rather than proactive treatment. Based on the DQE team's site visits and review of over 200 medical records, it appears that MDOC's clinicians inconsistently review important historical information about self-injury, diagnoses, and medication compliance when making decisions about the care of prisoners in crisis.[3] Clinicians typically do not formulate cases in terms of diagnosis or treatment planning, focusing instead on the daily decisions about property and privileges that are required by Paragraphs 56 through 63 of the Agreement. This pattern was most pronounced at Souza-Baranowski Correctional Center (SBCC), the maximum-security men's facility, but it occurred to some extent throughout the MDOC system. To its credit, MDOC is aware of these issues and is already taking steps to enhance training and supervision for its mental health workforce.

Coordination of security and mental health functions

Security matters in MDOC both drive the demand for mental health services and sometimes interfere with the smooth delivery of those services. Most commonly, prisoners request crisis mental health services because of conflict with correctional officers, frustration with disciplinary or classification processes, or dissatisfaction with housing conditions. In MDOC's system, mental health clinicians typically respond to these situations by telling prisoners that they do not get involved in security matters. While this approach stems from a desire to maintain boundaries, it can often be counterproductive. For example, several of MDOC's longest TS placements are caused by a stalemate between a prisoner and security staff, with the former threatening self-harm if their demands for specific housing and job placements are not met and the latter stating (often with good reason) why those demands will not be met. Mental health staff are caught in the middle, dutifully conducting three check-ins per day with the prisoner while on TS but essentially being powerless to resolve the underlying conflict. Greater collaboration between mental health and security is needed, and, again, MDOC is already taking steps toward this end.

SBCC continues to stand out as the institution where security overshadows all other considerations, making it almost impossible to provide adequate mental healthcare. Lockdowns occur on a near-daily basis, causing patient care to be halted for minutes to hours at a time. Patients can only be seen by mental health staff during recreation periods, forcing the patients to choose between socializing, fresh air, and mental health treatment. Mental health professionals compete for limited office space with many other staff members, so they are frequently unable to see patients confidentially and must instead talk to them through the cell door with an officer standing nearby. Security practices such as shackling prisoners' arms behind their backs (during transport or during

[3] Please see the discussion of Paragraph 52 for further details.

the entire clinical contact) continue to deter prisoners from requesting or utilizing mental health services. All of these practices pose significant barriers to providing meaningful mental healthcare. Some other MDOC facilities face similar challenges around office space, lockdowns, and restraint practices, but none are as heightened as in the maximum-security environment of SBCC.

To be sure, these challenges are not unique to MDOC; issues with the quality of healthcare and the balance of security and mental health concerns are pervasive in carceral settings. MDOC's leadership seems committed to improving their system of care, and the DQE team remains hopeful that MDOC will continue on a positive trajectory toward eventual compliance with the Agreement.

Two major changes are anticipated in the next monitoring period: (1) the opening of the Intensive Stabilization Unit (ISU), which is intended to care for prisoners who have had repeated or lengthy TS placements but do not meet criteria for inpatient hospitalization, and (2) the closure of MCI-Concord, which was announced on February 16, 2024. MDOC has already begun preparing for both changes. For the opening of the ISU, MDOC is in the process of developing security and mental health staffing plans, as well as completing physical plant renovations. MDOC's leadership is considering how best to implement a treatment program for very challenging patients, drawing upon lessons learned from other specialized programs like the Behavior Management Unit (BMU), Secure Treatment Program (STP), and Secure Adjustment Unit (SAU). A long road lies ahead to ensure the ISU's smooth operation and ability to fill the gap that currently exists between Therapeutic Supervision placements and hospital-based psychiatric care.

The following table illustrates MDOC's current compliance with the Agreement. Ratings marked in green are ones where MDOC improved during this monitoring period. The next section, *Detailed Findings*, describes the basis for each compliance rating.

		Substantial Compliance	Partial Compliance	Non-Compliance	Compliance Not Yet Due
Policies and Procedures					
26	Within 6 months, consult with DQE to draft/revise policies and procedures		X		
27	Within one year, finalize all policies and procedures after approval by DOJ			X	
28	Within 6 months of finalizing policies, modify all post orders, job descriptions, training materials, performance evaluation instruments				X
29	Fully implement all policies within 18 months of DOJ approval				X
30	Follow public hearing process if any policy changes implicate MA public regulations				
31	Review policies annually and revise as necessary		X		

Staffing Plan					
32	Within 4 months, submit staffing plan to DQE and DOJ, and annually thereafter		X		
33	Increase security staffing to ensure out-of-cell activities for prisoners in crisis		X		
34	Rotate security staff on Constant Observation watches every 2 hours		X		
35	Increase mental health staffing and hours on site to ensure meaningful therapeutic interventions		X		
36	Staffing of ISU – supervising clinician, multidisciplinary team, make individual decisions about property/privileges			X	
37	Staff prisons within one fiscal year of each staffing plan				X
Training					
38	Provide pre-service and annual in-service training on new policies, mental healthcare, suicide prevention, de-escalation techniques		X		
39	Within 6 months of policy's final approval, incorporate Agreement requirements and DQE recommendations into training				X
40	Within 12 months of DOJ policy approval, all security and mental health/medical staff trained				X
41	Training uses evidence-based techniques and incorporates videos of prisoners/family		X		
42	Ensure that all staff are sufficiently trained in suicide prevention. Offer CIT, pre-servie and annual in-service suicide prevention training, CPR certification.		X		
Therapeutic Response to Prisoners in Mental Health Crisis					
43	Staff informs mental health immediately about concerns of suicide/self-injury, holds prisoner on Constant Observation until assessed		X		
44	QMHP responds within 1 hour during coverage hours		X		
45	During non-business hours, staff notify on-call QMHP, prisoner evaluated next business day		X		
46	Prisoners not disciplined for mental health crisis		X		
47	Initial mental health crisis evaluation includes required elements 47a-47f		X		
48	QMHP consults with psychiatrist/ARNP and clinical supervisor during initial assessment, as indicated			X	
49	Document initial assessment in progress note using DAP format	X			
50	If QMHP determines prisoner at risk of suicide/self-harm, will be placed on appropriate level of watch		X		
51	Mental health watch not used as punishment or for convenience of staff		X		
52	Crisis treatment plan includes required elements 52a-52k			X	
53	QMHP determines appropriate level of watch (close or constant)		X		
54	Prisoner placed in suicide-resistant cell or on constant observation if cell not suicide-resistant		X		
55	Implement cell safety checklist, supervisor reviews checklist if prisoner engages in self-injury		X		
56	Mental health watch conditions based on clinical acuity, disagreements referred to MH Director and Superintendent		X		
57	Individualized clothing determinations		X		

58	Shower after 72 hrs on watch unless contraindications documented, security documents when showers offered		X		
59	Lighting reduced during sleeping hours		**X**		
60	QMHP makes individualized, least restrictive property determinations		X		
61	QMHP makes individualized privilege determinations, provides access to reading materials after 24 hrs and tablet after 14 days unless contraindicated		X		
62	Individualized determinations about visits, phone, chaplain, activity therapist		X		
63	Outdoor recreation after 72 hrs on watch, security documents when offered. QMHP documents contraindications every day. 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 conducts reviews in required format/time frames		X		
147	Notify DOJ and DQE and of all suicides and serious attempts within 24 hrs		X		
Other					
159	Within 180 days, provide bi-annual compliance report to DQE and DOJ. Subsequent report due one month prior to DQE's draft report.		**X**		
169	Within 30 days, designate Agreement Coordinator	X			
170	Within 6 months, conduct quarterly meetings with staff to gather feedback re: implementation of Agreement		X		

ASSESSMENT METHODOLOGY

To accomplish the 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 November 2023 and January 2024 at each of the nine MDOC facilities where TS occurs.[4] The following activities were included in the site visits:

[4] MCI Cedar Junction ceased operations in June 2023, so there are now only nine facilities where TS occurs.

	Concord	Framingham	Gardner	MASAC	MTC	Norfolk	OCCC	Shirley	SBCC
	12/5-12/6/23	12/4/23	11/9/23	1/12/24	1/11/24	12/7/23	1/9-1/10/24	11/6/23	11/7-11/8/23
Inspection of TS cells	GM	RK	RK, GM	RK	RK, JW	GM	GM	RK, GM	GM
Interview of prisoners recently/currently on TS	RK, GM	RK, JW	RK, GM	RK	RK, JW	RK, GM	RK, GM, SS	GM	GM
Review of officers' TS watch logs			GM	RK	RK	GM	GM	RK, GM	GM
Interviews of mental health staff	RK	JW	RK	RK	RK, JW	RK	RK, JW	RK	RK, JW
Interviews of security staff	GM	RK	GM	RK	RK	GM	GM, SS	RK, GM	GM
Observation of MHPs responding to crisis calls	RK	JW	None to see	None to see	None to see	RK	RK, JW		RK, JW
Observation of MHPs conducting TS assessments	RK	JW	None to see	None to see	None to see	None to see	RK, JW	RK	RK, JW
Observation of MH group programming									RK, JW
Observation of 1:1 MH contacts				RK	JW		JW		
Observation of MH triage meeting	RK	RK, JW	RK	RK	RK	RK	RK, JW, SS	RK	RK, JW
Observation of BAU Interdisciplinary Assessment Team meeting	GM	RK, JW		(N/A)				RK, GM	RK, GM
Observation of Morning Meeting	RK, GM	RK, JW	RK, GM	RK	RK, JW	RK, GM	RK, JW, GM, SS	RK, GM	RK, GM, JW
Observation of Care Coordination Meeting									RK, GM, JW
Observation of MDT meeting in SAU	RK								RK, JW
Observation of staff training					RK, JW				

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, security staff, and mental health staff confidentially, without MDOC leadership or legal representatives present.[5] In total, the DQE team interviewed 56 prisoners, 38 MDOC security staff members, and approximately two dozen Wellpath staff members[6] in various roles related to mental health during this reporting period.

2. Document Review

For this report, data from July 1, 2023, through December 31, 2023, across all nine facilities where TS occurs were reviewed, except where stated otherwise in the text. General categories of documents are listed here rather than each document.

a. MDOC status reports about Agreement compliance

1) Sent to DQE/DOJ on September 1, 2023
2) Sent to DQE/DOJ on December 20, 2023

b. Electronic health records

In order to review a representative sample of records from the nine facilities, records were chosen in accordance with the approximate proportion of total MDOC TS placements that occurred at each facility:

Facility	Approximate % of Records
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

[5] MDOC agreed during the second round of site visits to allow security staff to be interviewed privately by the DQE team, provided that no DOJ attorneys are included in the interviews.
[6] The DQE team interviewed 18 MHPs, one psychiatrist, and one nurse practitioner formally. Additionally, informal discussions with MHPs were conducted while observing their daily practice.

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).[7]

c. Data about crisis contacts and TS placements

1) TS Registry, a list of all prisoners placed on TS, including facility, entry and discharge dates, location of TS, and duration of TS placement
2) A sample of "crisis logs" from each facility
3) Officers' watch logs for 30 TS placements
4) Cell inspection checklists for 46 TS placements
5) Log of mental health restraints
6) Wellpath TS Consultation/Notification forms (for 72 hrs, 7 days, 14 days, 14+ days on TS)
7) Minutes of daily TS Notification meetings
8) Daily mental health Triage Meeting notes

d. Policies related to mental healthcare

1) Monthly letters from MDOC Clinical Operations Analyst describing the status of MDOC's policy revisions
2) Draft revisions of MDOC policies
    a. 103 DOC 650 – Mental health services
    b. 103 DOC 601 – Division of Health Services organization
3) Wellpath policy 6.00 – Continuous Quality Improvement Program
4) MDOC Policy 103 DOC 622 – Death Procedures

e. Staffing data

1) Wellpath mental health staffing matrix from December 2023, including filled, overage, and vacant positions
2) Spreadsheet showing licensure of mental health staff by MDOC facility, undated, provided to DQE team on March 14, 2024
3) MDOC security staffing spreadsheet dated December 23, 2023

f. Training data

1) PowerPoint presentations and lesson plans for revised DOC annual employee in-service training
    a. "Recognizing Mental Illness and Suicide Prevention," revised June 2023
    b. "Therapeutic Supervision," revised July 31, 2023

[7] 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.

2) Draft of Therapeutic Supervision poster
3) Draft of TS "Read and Sign"
4) Crisis Intervention Training (CIT) attendance records for training held from July 17 to 21, 2023
5) MDOC training records for all staff who completed "Recognizing Mental Illness and Suicide Prevention" in Training Year (TY) 2023 and 2024
6) MDOC training records for all staff who completed "Therapeutic Supervision" in TY 2023 and 2024
7) MDOC training records for all staff who completed CPR training in TY 2023 and 2024
8) MDOC pre-service training records from November-December 2023

g. Other mental health program information

1) MDOC monthly "Mental Health Roll Up Report"
2) Mental health triage meeting notes (Monday through Friday) from each MDOC facility that has TS
3) End-of-shift reports from Saturday mental health clinicians at each site that has TS
4) List of all prisoners transferred to a higher level of care (Section 18(a), Section 18(a1/2), RTU, or STU)
5) Behavior plans from 2019 to 2023 for six prisoners at OCCC and Concord
6) Summary of all Inter-Facility Clinical Case Conferences

h. Self-injury and Use of Force data

1) Log of all SDV incidents, both on and off TS
2) All SIBOR reports
3) Incident reports written by security, MH, and medical staff for all SDV episodes
4) Incident reports related to two serious suicide attempts and one completed suicide
5) Log of Use of Force incidents that occurred while a prisoner was on TS
6) Incident reports and medical/MH documentation from all incidents of foreign body ingestion

i. Quality assurance materials

1) Minutes from monthly Quality Improvement Committee (QIC) meetings
2) Redacted version of QIC's "Professional Conduct Log" that tracks staff misconduct allegations and investigations
3) Monthly Quality Assurance reports (Excel spreadsheets)
4) Morbidity/Mortality Review materials:

i. Memo dated August 29, 2023, containing clinical information related to the suicide attempt on August 2, 2023
ii. Morbidity Review Recommendations letter dated February 2, 2024, regarding the suicide attempt on December 28, 2023
iii. Performance Improvement Mortality Review letter dated March 4, 2024, related to the completed suicide on November 17, 2023

5) Self-Directed Violence/Suicide Attempt (SDV/SATT) Review Committee Meeting minutes
6) Minutes from facility follow-up meetings about SDV/SATT
7) Minutes from quarterly DOJ/MADOC Agreement Site Meeting, June and September 2023
8) Minutes from monthly Wellpath's Policy, Procedure, and Forms Committee meeting

3. **Observation of seven MDOC/Wellpath Daily TS Notification/Consultation meetings between November 2023 and February 2024** (conducted via Microsoft Teams)

4. **Stakeholder feedback**

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

DETAILED FINDINGS

POLICIES AND PROCEDURES

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

Finding: Partial compliance

Rationale: Many of MDOC's key procedures related to mental healthcare are outlined in 103 DOC 650, Mental Health Services. A revised version of this policy was submitted to the DQE for review on September 20, 2023, along with revisions to 103 DOC 601, DOC Division of Health Services Organization. The DQE team compared the proposed

revisions to the substantive provisions of the Agreement in detail and reached the following conclusions:

a. The policies have been adequately revised to be consistent with paragraphs 43-53, 57-62, 64-65, 67-72, 77-85, and 108-110 of the Agreement.

b. Most provisions of the Agreement related to Support Persons and the Intensive Stabilization Unit (Paragraphs 98-104 and 113-135) have not yet been included in policy, presumably because MDOC is still finalizing the details of these new positions and programs.

c. Some Agreement provisions have been inadequately captured in the revised policy language, including paragraphs 54, 56, 63, 73, 86, 88, 90, 91, 92, 95, 107, 111-112, 142-144, and 145-146. The DQE team recommended further review by MDOC before the policies are finalized.

The DQE provided MDOC with feedback about the revised policies in December 2023 and January 2024. MDOC is currently working on a second revision.

To date, the DQE team has not seen any policy language related to cell checklists (Paragraph 55), the therapeutic de-escalation room at MCI-Shirley (74), peer programs (75), therapy dogs (76), investigation of staff suspected of violating policies related to TS (93), correctional officers' observation of prisoners on TS (96), use of door sweeps on TS cells (97), procedures for responding to self-injury (105-106), or behavioral management plans (136). It is possible that these elements of the Agreement are captured in MDOC or Wellpath policies that have not yet been shared with the DQE.

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: Noncompliance

Rationale: As noted in Paragraph 26, MDOC has begun the policy revision process, but it is a long way from completion. Two revised MDOC policies have been submitted to the DQE, and a third (103 DOC 501, Institution Security Procedures) is reportedly underway. No Wellpath policy revisions have yet begun, and no revised policies (Wellpath or MDOC) have yet been finalized. Thus, a noncompliance finding is being issued.

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: As noted above, no revised policies have yet been finalized, so MDOC is operating behind schedule in this area. The Agreement does not specify a date by which Paragraph 28 is due, but if all policies were to 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. 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: Not assessed

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

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

Finding: Partial compliance

Rationale: As noted above, MDOC's policies related to the Agreement are still undergoing an initial review, and Wellpath's policy review has not yet begun. MDOC already has a procedure in place regarding annual policy reviews, which involves assigning policies to their relevant MDOC division (e.g., Health Services Division) to be revised according to a yearly schedule. In its December 2023 Status Report, MDOC clarified that Wellpath follows a similar procedure:

> Wellpath Policy 5.00 outlines the guidelines for reviewing policies annually. Minutes of the Policy Review Committee meetings are kept by Wellpath and can be provided to the DQE team. Wellpath Policy Manual includes an index identifying all Wellpath policies being revised and dates of revisions. The dates of revision are also included at the bottom of each policy. Additionally, Senior Wellpath Leadership and the Assistant Deputy Commissioner of Clinical Services are required to review and sign the most up to date policy version yearly.

The DQE reviewed minutes from Wellpath's Policy, Procedure, and Forms Committee between July and December 2023. These minutes indicate that several policies related to the Agreement were reviewed during the August 30, 2023, meeting, including Suicide Prevention and Training (53.00), Mental Health Consultation with Referrals to Psych (37.04), and Therapeutic Supervision (66.00). On November 29, 2023, Mental Health Record Documentation (60.02) was reviewed. On December 27, 2023, Referral to Mental Health Services (37.01) was reviewed.

Given that the framework for annual policy review is already in place, the DQE does not anticipate major challenges in meeting the requirements of Paragraph 31 once the initial MDOC and Wellpath policy revisions have been completed.

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[8]

Rationale: MDOC continued to submit monthly Wellpath staffing matrices to the DQE during this reporting period, and a security staffing matrix was submitted in December 2023. Although MDOC is compliant with Paragraph 23's requirement to submit a staffing plan within four months of the Agreement's Effective Date (April 20, 2023), a Substantial Compliance finding cannot be issued until an annual staffing plan has been submitted in April 2024.

As noted in Paragraph 35, it is difficult to say whether MDOC's security and mental health staffing plans are adequate to meet the needs of prisoners in crisis because current staffing levels are currently so far below allocated levels. It is possible that, even if fully staffed, the plans would still be inadequate, but this cannot be assessed until MDOC gets much closer to 100% staffing levels.

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 December 23, 2023, overall security staffing was at approximately 80% of full staffing levels, which is

[8] Partial Compliance is the highest possible rating at this time because the provision requires submission of annual staffing plans, which are not yet due.

increased from 74% in April of 2023.[9] Correction Officer I positions (CO I), who interact most directly with prisoners in mental health crisis, are at 79% of full staffing levels. Correction Officers II and III, who often serve as shift supervisors, are at 81% and 84%, respectively. Although all these numbers look better than in April 2023, the increased higher percentage of filled FTEs appears to come from a reduction in the allocated number of CO I and CO II positions, not an increase in the number filled, as illustrated in *Figure 1*.[10] The filled FTE percentage for CO I and CO II positions is higher in December than in April 2023, but the total number of filled positions actually decreased. In contrast, CO III positions achieved their higher fill percentage by increasing the filled positions rather than by cutting the allotment.

Figure 1. Security Staffing Levels

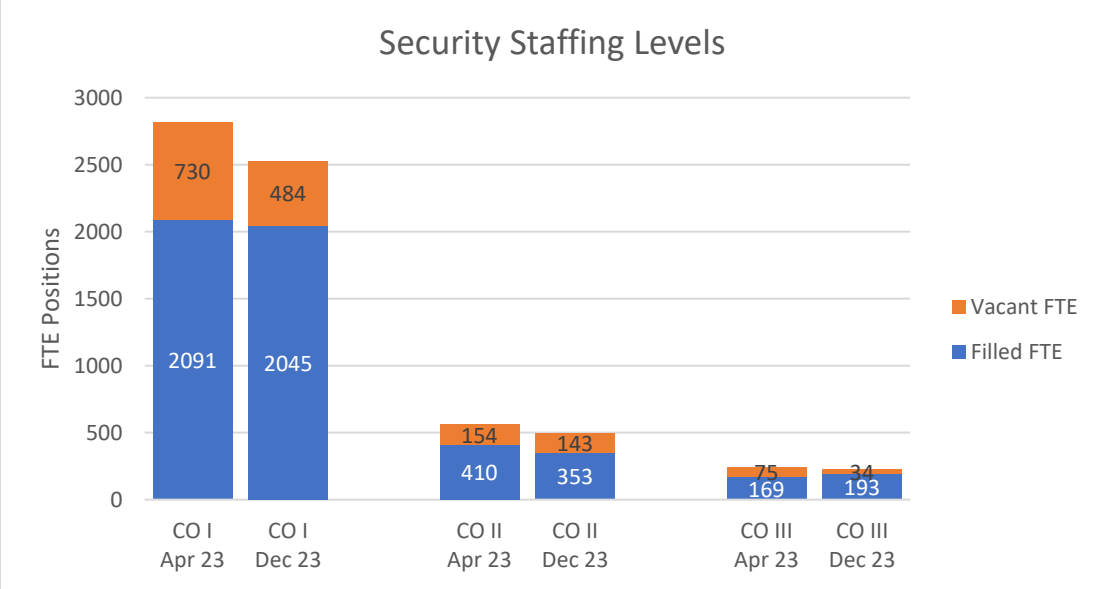
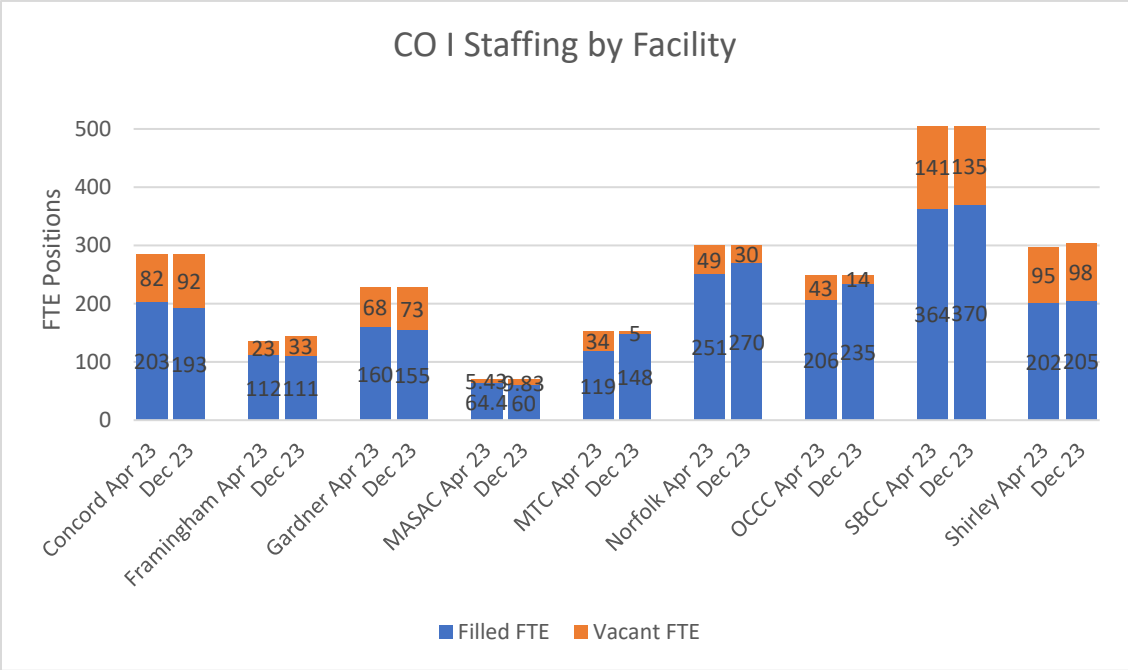


Figure 2 illustrates CO I staffing levels by facility in April 2023 vs. December 2023. CO I staffing levels at OCCC, MTC, and Norfolk increased during this period, which was mostly related to the redeployment of officers from Cedar Junction when it ceased operations in June 2023. CO I staffing levels at other facilities remained relatively stable. Shirley, Concord, and Gardner have staffing levels below 70%, with SBCC not far behind at 73%.

[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).

[10] It appears that the reduction in allocated positions stems mostly from the cessation of operations at MCI Cedar Junction, which accounted for 434 total positions in April 2023. Staff who previously filled security positions at Cedar Junction were transferred to unfilled positions at other institutions.

Figure 2. CO I Staffing by Facility[11]



Overall, the DQE sees improvement in security staffing levels only at the facilities that benefited from Cedar Junction ceasing its operations: OCCC, MTC, and Norfolk. This is despite MDOC's reported attempts at recruitment. In its December 2023 Status Report, MDOC noted that Correction Officer training academy classes graduated on May 19, November 17, and December 1, 2023. It is possible that the benefit from the November and December 2023 graduating classes will be reflected in the 2024 staffing levels. It is also possible that MCI-Concord's planned closure in 2024 will help alleviate understaffing by redeploying security staff to other institutions.

As noted in the first DQE report, 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. MDOC noted in its December 2023 Status Report, "Administrations at all sites have prioritized security staffing to ensure that access to routine activities for those incarcerated individuals on therapeutic supervision are not impacted by security staffing levels." This sentiment was expressed by officers during the DQE's interviews, who noted that an "eyeball watch" will always be staffed, even if the officer must be pulled from other another post. This emphasis by MDOC's leadership on the needs of prisoners on therapeutic supervision is necessary and much appreciated by the DQE team.

[11] 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.

Nonetheless, the impact of security understaffing on Therapeutic Supervision remains a problem at many MDOC facilities. Examples include:

- A small percentage of missed mental health contacts because of "institutional factors"
- Low morale among correctional officers because of frequently mandated overtime shifts, leading to lower tolerance of prisoners' problematic behavior
- Insufficient correctional officers to facilitate out-of-cell contacts with clinicians
- Correctional officers assigned to constant observation of prisoners on TS for longer than two hours at a time
- Prisoners on TS not being provided with property that mental health staff have approved
- Prisoners being restrained routinely when out of cell
- Officers not calling crisis at prisoners' request

As noted in the DQE's first report, these problems are undoubtedly multifactorial and include challenges with officer training and institutional culture in addition to staffing levels, but understaffing is a contributing factor.

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: MDOC continues to work toward implementing this requirement. Security leaders and correctional officers mentioned that this has been an area of focus in 2023. Ten interviewed officers discussed the now-established routine of rotating officers who are assigned to constant observation duties every two hours. The interviewed officers were posted in both types of commonly utilized therapeutic supervision settings (BAU and HSU) at five institutions.

The DQE team reviewed MDOC's "TS Registry", as well as Therapeutic Supervision Reports in facility files and in the electronic health record, to identify TS stays that included constant observation. The team reviewed a sample of officers' watch sheets for

those stays drawn from all institutions that conduct them.[12] It was clear that the intention was to rotate an officer's responsibility at the required interval, and the goal was largely met. However, just over half of the sample had times when signatures on the watch sheets indicated that an officer watched the prisoner for 2.5 to 3.5 hours. In a few instances, it appeared the officer was at that duty for 6 to 7 hours. The DQE team is not yet aware of a method to determine whether these instances fell under the exceptions permitted by Paragraph 34 (e.g., jeopardizing safety and security, unanticipated event, temporary reduction in security staffing).

Interviewed prisoners generally thought that the intervals between officer rotations were longer than the Agreement expects. Three prisoners estimated that observing officers changed every two hours or less, but an equal number thought the intervals were double that. Almost half the prisoners believed an officer remained in place for entire eight-hour shifts.[13]

While more will be needed for substantial compliance, MDOC has clearly invested in implementing this requirement.

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

Finding: Partial Compliance

Rationale: Since the First DQE Report, Wellpath's staffing matrix has been amended to include the Support Person positions, which account for 10.8 FTE across the nine sites.[14] The staffing matrix otherwise remained unchanged, with 135.4 FTE across 11 mental health-related job titles.[15] In December 2023, 26.2% of these positions remained

[12] The DQE team selected 25 therapeutic supervisions from facility files during site visits and from the TS Registry maintained by MDOC and provided to the DQE monthly. The cases spanned July through December 2023.
[13] Ten patients offered their opinions based on having been on constant observation at five institutions.
[14] The positions at Cedar Junction remain on the Wellpath staffing matrix, but they were not included in the DQE's current analysis.
[15] Activities therapist, ARNP/CNS, Clinical Director, Clinical Supervisor, MH Director, Mental Health Professional, Psychiatrist, Regional MH Director, Regional Psychologist, Unit Coordinator, and Support Person.

unfilled, though this number is skewed by the Support Person positions, which were 100% vacant. Excluding those positions, the vacancy rate was 19.2%, a slight increase from the 18% vacancy rate in June 2023 and an overall sustained improvement since January 2023, when the vacancy rate was 33.3%.[16]

The greatest shortages remain with MHPs, psychiatrists, and psychologists. However, as *Figure 3* illustrates, MHP and psychiatrist vacancies have steadily decreased since January 2023, which is a positive trend. Psychologist hiring remains a significant problem, as the one part-time regional psychologist who works in MDOC is unable to keep up with the demand for consultations.[17] There is some hope on the horizon, as MDOC reported in January 2024 that a new regional psychologist would be starting soon.

Figure 3. Mental Health Staffing by Position

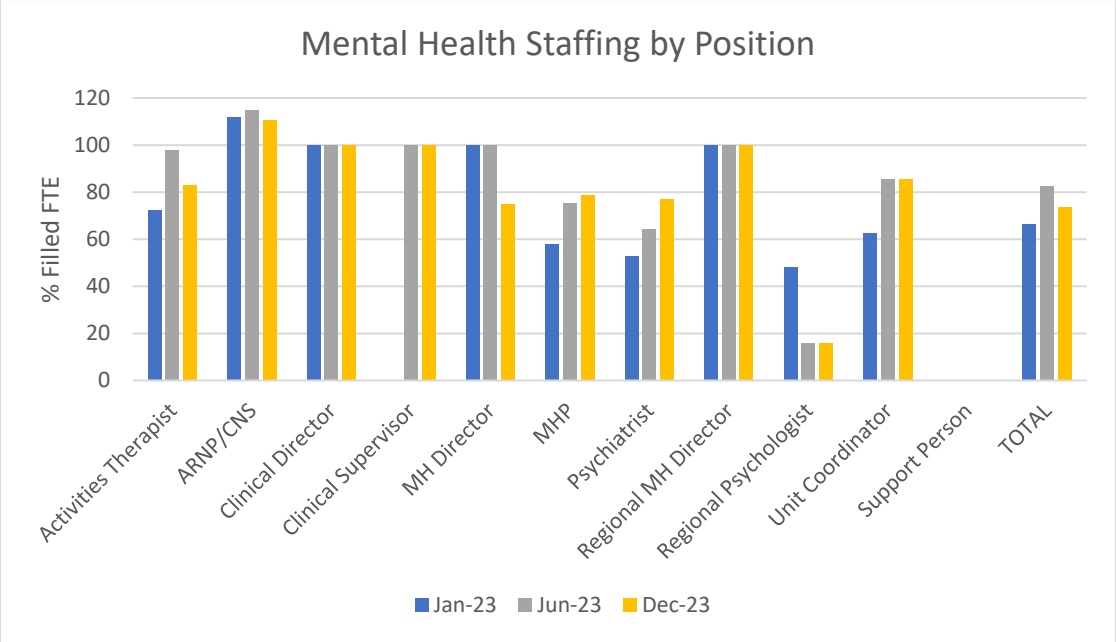


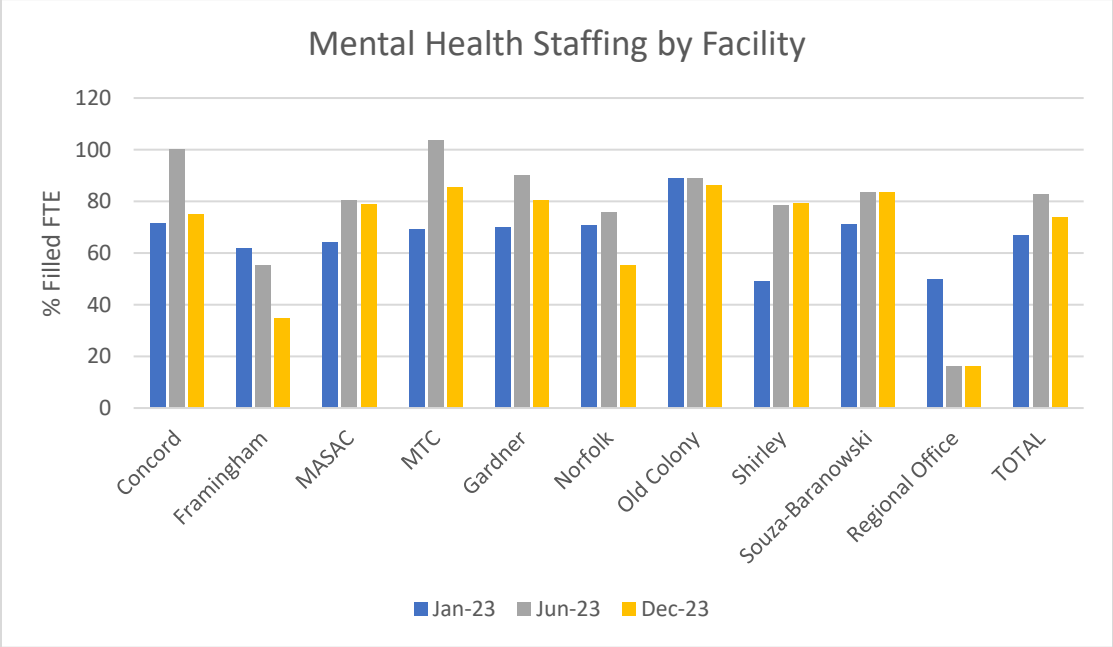
Figure 4 illustrates staffing levels by facility. When excluding the unfilled Support Person positions, staffing levels at most facilities remained relatively stable during this reporting period. Framingham continued its worrisome downward trend, with only 34.5% of its positions filled (4.5 out of 13). It is not clear what accounts for this low staffing level. MTC's mental health staffing levels have improved, but the DQE team

[16] The reported vacancy rates do not include temporary vacancies such as a staff member being on medical or administrative leave, nor do they include per diem employees. The DQE team learned during site visits that, in practice, vacancy rates are often higher than those listed on the staffing matrix, and per diem employees help to provide coverage.

[17] MTC employs psychologists who are assigned to the Sex Offender Treatment Program. They do not participate in the routine assessment or treatment of prisoners on therapeutic supervision, so they are not included in the DQE's staffing analysis.

learned during the site visits that the Sex Offender Treatment program is still significantly understaffed, with just 59% of the allocated positions filled. At Norfolk, staff noted that the recent decrease in MHP staffing levels occurred around the same time that a new responsibility to see patients at nearby Pondville Correctional Center was added (because of Cedar Junction's cessation of operations), leading to high caseloads and backlogs of mental health contacts.

Figure 4. Mental Health Staffing by Facility[18]



Overall, it appeared during the site visits that most facilities were experiencing lower turnover and better staffing levels, which contributed to higher staff morale. By December 2023, MDOC had retained most of the staffing gains achieved during the summer 2023 hiring push, when it recruited new graduates from social work and counseling programs. This positive change likely stemmed from MDOC and Wellpath's increased efforts to recruit and retain mental health staff, including:

- Increasing salaries in 2023 for many positions, including MHPs and psychiatrists
- Reducing response times by mental health leadership when a potential recruit expresses interest in a position;
- Holding recruiting calls between senior leadership and the recruiting team, as well as meetings every two weeks to review progress with recruitment;
- Sending a recruiter and seasoned mental health leader to school and agency career fairs to engage with students and candidates;

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

- Establishing new academic affiliations with the Columbia School of Social Work, Boston University School of Social Work, Roger Williams University master's program in counseling/psychology, UMASS, Southern New Hampshire University, Salem State School of Social Work, and Lesley University;
- Creating a Sex Offender Treatment (SOT) Certification curriculum at MTC and salary differential for staff who complete the training, aiding with recruitment and retention of those with specialized skills;
- Conducting 30-, 60-, and 90-day post-hiring check-ins with staff in key disciplines to assess employee adjustment and needs;
- Buying out locum tenens contracts for psychiatrists who express interest in providing long-term service in MDOC facilities; and
- Continuing to explore opportunities for remote work, student loan subsidies, and leadership training.

Although MDOC is still far from full staffing levels, the upward trend and concerted efforts by Wellpath to improve recruitment and retention are positive signs.

As noted in the First DQE Report, the DQE team remains concerned about the dearth of doctoral-level mental health professionals in the MDOC system, as well as the high proportion of MHPs who are unlicensed.[19] Wellpath's strategy of recruiting new graduates of master's degree programs results in an inexperienced mental health workforce, which often translates to a limited clinical skill set and overreliance on distributing "packets" of worksheets and puzzles rather than providing diagnostic assessments and individualized treatment. Psychiatrists and ARNPs, even when present, tend to see patients infrequently and to play a secondary role in the care of prisoners in crisis. Although better than a year ago, psychiatry understaffing is still a concern, with OCCC (the main mental health treatment facility) having a psychiatrist available just one day per week at the time of the DQE team's January 2024 site visit. Not all psychiatry/ARNP hours are on site, with several facilities using telepsychiatry services as the primary modality for psychiatric treatment.

During the DQE's site visits, evidence of inexperience and understaffing's impact on patient care remained apparent, even as MHPs' caseloads at most institutions were more manageable. The impacts of understaffing included:

- Limited multidisciplinary treatment planning (involving nursing, psychiatry, psychology, social work, and recreational therapy) at most facilities, including for those on TS;

[19] MDOC reported in March 2024 that 41% of its MHPs are licensed, in addition to the site managers who are independently licensed.

- High levels of staff turnover, hindering relationship-building and collaboration between security and mental health staff;
- Poor continuity of care, with prisoners in crisis seeing multiple different clinicians, even within a single day;
- A pervasive practice of MHPs using brief crisis evaluations as "proxy PCC contacts" to fulfill their technical obligation to see patients monthly while not actually providing a therapeutic contact with the assigned clinician;
- Backlogs for psychiatric assessments and for assignment to a mental health clinician at some facilities;
- Missed TS contacts or cellside contacts due in part to the crisis clinicians' lack of time or involvement in other duties; and

The opening of the ISU in June 2024 may further strain MDOC's already scarce resources. Thus, staffing levels and their impact on patient care will continue to be monitored closely.

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: Noncompliance

Rationale: The Agreement does not specify when the ISU's staffing plan should be completed, but one would expect it to be completed several months in advance of the unit's June 2024 opening date. As of March 24, 2024, no plan has been provided to the DQE for review. During the OCCC site visit in January 2024, it appeared that a draft of the staffing plan was being circulated among MDOC and Wellpath leadership over email, so some progress is being made. Although the DQE has confidence that MDOC will finalize a staffing plan in the near future, a noncompliance finding is being issued for Paragraph 36 because of the absence of information provided to the DQE team.

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 being done to improve mental health staffing levels across MDOC; efforts to enhance recruitment of security staff are less clear. It seems unlikely that MDOC will achieve compliance with Paragraph 37 in the next six months, but the system does continue to improve staffing levels in key positions like psychiatrists and MHPs, as noted in Paragraph 35.

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: MDOC continues to provide pre-service and annual in-service training on mental healthcare, suicide prevention, and de-escalation techniques, as described in the DQE's first report. Although no policy revisions have been finalized since the Agreement's effective date, MDOC has started revising its pre-service and annual in-service trainings in accordance with the Agreement. The DQE reviewed the lesson plans and PowerPoint presentations for two key trainings, "Therapeutic Supervision" and "Suicide Prevention & Intervention," and provided feedback to MDOC in late January 2024 about areas where the language appeared inconsistent with the Agreement. Thus, MDOC's training revisions are in progress, and it is anticipated that Wellpath's training revisions will follow. The DQE remains optimistic about the system's capacity to achieve substantial compliance with Paragraph 38.

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. Revised trainings on Therapeutic Supervision have already begun, as noted in Paragraph 38.

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

Finding: Compliance not yet due

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

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

Finding: Partial compliance

Rationale: As noted in the DQE's first report, MDOC's trainings already include instruction on mental healthcare, suicide prevention, and de-escalation techniques, and they are provided using current evidence-based standards. MDOC leadership reported that they are looking into the availability of training materials depicting individuals with lived experience or their family members. According to the December QIC meeting minutes, options being investigated include an incarcerated person who previously spoke at the Suicide Prevention Walk, social media videos, memoirs, and websites that tell the stories of suicide survivors.

42. Suicide Prevention Training: MDOC will ensure, by providing sufficient training, that all security staff demonstrate the adequate knowledge, skill, and ability to respond to the needs of

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

Finding: Partial compliance

Rationale: This provision remains difficult to assess as a whole because subsections 42a-d address such different aspects of training and mandate compliance on different schedules. If rating these subsections individually, the DQE would conclude:

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.

Regarding CIT, MDOC's December 2023 Status Report indicates the following:

> Crisis Intervention Trainings (CIT) were conducted on 7/17/23- 7/23/23 and 8-hour refresher courses were completed on 7/19/23, 9/11/23, 9/12/23, 9/18/23, and 9/19/23, 12/4/23, 12/6/23, 12/11/23, and 12/12/23. The next 40-hour CIT training is scheduled for January 22-26, 2024. As of 12/2023, there have been a total of 275 people trained in CIT by the MDOC team.

MDOC provided sign-in logs for the full CIT training conducted on July 17-21, 2023, for the DQE team to review. 36 individuals with a range of titles (CO I, CO II, CO III, CPO A/B, Wellpath) completed the five-day training at that time. The Agreement does not create specific benchmarks for MDOC to meet regarding CIT training, so the current scheme meets the threshold for substantial compliance with Paragraph 42a.

b. Within six months of the Effective Date, MDOC will review and revise its current suicide prevention training curriculum, which will be submitted to the United States for

review, comment, and the United States' approval in accordance with Paragraph 27 and include the following additional topics:

1. suicide intervention strategies, policies and procedures;
2. analysis of facility environments and why they may contribute to suicidal behavior;
3. potential predisposing factors to suicide;
4. high-risk suicide periods;
5. warning signs and symptoms of suicidal behavior (including the suicide screening instrument and the medical intake tool);
6. observing prisoners on Mental Health Watch (prior to the Mental Health Crisis Assessment/Evaluation (Initial) (see Paragraph 47)) and, if applicable, step-down unit status;
7. de-escalation techniques;
8. case studies of recent suicides and serious suicide attempts;
9. scenario-based trainings regarding the proper response to a suicide attempt, and lessons learned from past interventions; and

MDOC submitted its revised "Suicide Prevention & Intervention" curriculum to the DQE for review in September 2023, slightly behind the 6-month time frame specified in Paragraph 42b. In addition to updating statistics about suicides in MDOC and making the PowerPoint slides more visually interesting, the trainers added new content including:

- Protective factors
- De-escalation skills
- Active listening skills
- Emergency response to suicide attempts, including security, medical, and mental health staff responsibilities
- Case examples of morbidity and mortality reviews related to recent suicides and attempts
- Scenario-based training and examples of effective staff intervention
- Case examples of staff at MDOC institutions successfully intervening in cases of SDV
- List of all relevant DOC suicide prevention policies

The DQE concluded that the revised curriculum meets all the criteria delineated in 42.b.1 through 42.b.6. Minor feedback and suggestions about the training's content were provided to MDOC in late January 2024.

Of note, the DQE's assessments related to Paragraphs 43, 45, 47, 50, 52, and 107 describe areas in which MDOC's training of mental health and security staff related to

the care of prisoners in crisis could be improved. For example, correctional officers currently employ different observation protocols when a prisoner requested a crisis call but does *not* state that they would harm themselves or others; some observe the prisoner 1:1, while others do not. Similarly, correctional officers are unsure whether they have discretion to employ de-escalation techniques rather than immediately initiating Code 99 procedures in cases of non-life-threatening self-harm. Some mental health staff have significant difficulty performing adequate risk assessments and creating individualized treatment plans. At night and on weekends, the on-call MHP is consulted regarding some crisis assessments, but not in all BAU assessments. All these areas are important for MDOC to highlight and clarify in future trainings. In fact, it has already begun to do so, with the DQE team learning of facility-based trainings on treatment planning occurring at MTC and OCCC in recent months.

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 was due on December 20, 2023). In practice, MDOC and Wellpath already require all staff to complete eight hours of pre-service training on suicide prevention, and annual in-service training for all correctional officers already includes two hours of suicide prevention training. MDOC submitted its 2023 training logs to the DQE for review, but it is not yet clear how to interpret them in light of the Paragraph 42c requirements. No Wellpath training logs were submitted to the DQE during this reporting period. The DQE will work with MDOC's Director of Staff Development to develop a system for MDOC to demonstrate its compliance with Paragraph 42c prior to the March 2025 deadline.

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").

MDOC's CPR certification log for Training Year 2024[20] is difficult to interpret, but it appears to indicate that 3,179 staff were required to undergo CPR training between July

[20] MDOC's training years span from July 1 to June 30. For example, Training Year 2024 is from July 1, 2023, through June 30, 2024.

2022 and November 2023. Of those, 270 staff did not complete the training, leading to an overall completion rate of 91.5%. The DQE will need to verify that all security staff are included in the training log provided and that the document is being interpreted correctly. In addition, MDOC will need to provide evidence that MASAC's Residential Service Coordinators, who function similarly to correctional officers in other facilities, have completed CPR training. Once these steps have been taken, the DQE is optimistic that MDOC can achieve substantial compliance with the requirements of Paragraph 42d.

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.[21]

In prisoner interviews across seven institutions, nearly half said that officers consistently call mental health or escort them to see mental health when they report being in crisis. Other interviewed prisoners commented that whether an officer calls promptly (or at all) strongly depends on the individual officer, or the prisoner cited a single event or officer where the response was problematic.[22] Some MHPs expressed similar concerns, based on their own observations or patient reports, about officers refusing to call, delaying, or resisting, sometimes to the extent that MHPs see patients as hesitant to ask for the help they need.[23] According to prisoner and staff interviews, security staff at Gardner, Shirley, and Framingham were generally noted to call mental health promptly, while officers on specific units at Concord, Norfolk, OCCC, and SBCC were noted to delay calling or encourage prisoners to manage their problems independently. Most such complaints were limited to specialized housing units such as the BAU and SAU.

[21] See policies 103 DOC 650.08, Wellpath 37.03, and Wellpath 53.01.
[22] 23 patients offered these opinions based on personal experience calling crisis.
[23] These thoughts were expressed by 9 MHPs at three institutions.

The DQE team interviewed officers and supervisors in areas that house prisoners on therapeutic supervision, mostly in Health Services Units and Behavior Assessment Units.[24] A large majority of interviewees said they call mental health staff immediately and maintain continuous observation of the prisoner until an MHP arrives. A significant minority described making a distinction between prisoners who said they wanted to harm themselves/others and those who said this was not the case but urgently wanted to speak with an MHP. Those officers said that, for the latter group of prisoners, they would call mental health but would not remain continuously with the prisoner until the MHP's arrival.[25] While this practice has the potential to slide into gatekeeping of crisis services, the DQE could see such a system being implemented appropriately with careful guidance to staff. As long as security staff call mental health immediately and keep continuous watch for all prisoners who indicate risk of harm or do not answer the officer's questions, there could be merit to allowing greater prisoner comfort and privacy in less emergent cases where a prisoner simply wants to speak with mental health.

Paragraph 43 is silent on the matter of restraining prisoners while they are waiting for a crisis clinician to arrive, during transport to the mental health evaluation area, or during the evaluation itself, but this question arose repeatedly during the DQE team's site visits. Practice currently varies by institution, ranging from Norfolk's model of allowing prisoners to remain unrestrained during transport and assessment, to SBCC's model of handcuffing prisoners behind their backs during both transport and assessment. The DQE acknowledges that this is a gray area under the Agreement but looks to Paragraph 64 for guidance. That provision mandates individualized decision-making around restraints for out-of-cell activities while a prisoner is on therapeutic supervision, and the principle seems to apply to crisis assessments as well. However, this is a complicated area requiring further discussion with MDOC and DOJ before firm recommendations can be made.

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

[24] There were 27 officers who commented on some or all components of this requirement. Of note, several observed that calling crisis is relatively rare once the prisoner is on therapeutic supervision.
[25] This practice was described at four institutions.

Rationale: Among the DQE team's onsite interviews, 22 correctional officers or supervisors and 17 prisoners[26] commented on MHPs' response times for crisis calls. These interviewees were drawn from eight of the institutions that provide therapeutic supervision. Staff and prisoners perceived response times to be quick, and they often estimated the typical time to contact as being only five to 10 minutes. Nearly all estimated the longest response times as a half-hour or less, well within the requirements of Paragraph 44. Only one prisoner thought that one response time was longer than an hour. This strong performance is consistent with staff and prisoner views in the first monitoring period and is based on a larger sample.

The DQE team also sought to substantiate MHP timeliness by analyzing a 13% sample of documents that MDOC terms "crisis logs."[27] While the logs call for recording the time the request was received and the time of response, it was rare for these both to be captured.[28] Thus, this source cannot serve to support proof of practice at this time. If MDOC can record response times on its crisis logs more consistently, and if prisoner/staff interviews continue to indicate short response times, the DQE anticipates a substantial compliance finding for Paragraph 44 in the short- to 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: An MHP is on site at each MDOC facility where TS occurs between 8 am and 9 pm, Monday through Friday. On Saturdays, a clinician is on site from 8 am to 4 pm, and on Sundays, a clinician is on site only in the event of a 1:1 TS placement. Outside of

[26] Some other interviewed prisoners were already meeting with an MHP when the potential need for therapeutic supervision surfaced. A handful of others called crisis during on-call hours, and so the time to initial response could not be estimated.

[27] The DQE team employed a random selection method by requesting the logs for three specified days per month for July through December 2023. If a facility did not have any crisis calls on a date requested, staff were asked to substitute the next day that did record one or more crisis calls. Assuming approximately 24 workdays in a month, with MHPs covering Mondays through Saturdays, a three-day per month sample represents about 13% of the total. The reviewer examined these records from all MDOC institutions that provide therapeutic supervision. While the logs capture several types of contacts, this analysis included only those labeled as a crisis contact or an emergent referral by staff.

[28] Of the 334 relevant entries, 74 recorded both times.

those hours, Wellpath has an independently licensed MHP on call by phone. If a crisis occurs during non-business hours, MDOC's typical practice is for an on-site nurse (registered nurse or licensed practical nurse) to assess the patient, then call the on-call MHP to determine what intervention is appropriate. The next business day, an MHP conducts a follow-up visit with the patient.

The DQE is unaware of a method to assess this practice systematically, as the facilities' crisis logs and Triage Meeting minutes do not consistently identify cases in which an overnight assessment is followed up by an on-site MHP the next business day. The DQE team did find 20 such cases from eight facilities when reviewing the Triage Meeting minutes for other purposes. Of those 20 cases, 16 (80%) involved overnight BAU clearance assessments, and the remaining involved overnight crisis calls. A review of the electronic health record made it clear that the mental health staff's practice is to conduct follow-up assessments on the next business day, regardless of the reason for the overnight assessment. In 17 of the 20 cases (85%), a timely follow-up note was completed, indicating good practice in this area.

Documentation of the overnight assessment itself was less consistent, with only 7 of 20 notes (35%) indicating that the nurse consulted with the on-call MHP. This may be due, in part, to the current BAU Assessment note template instructing evaluators to consult with the on-call MHP in cases where a prisoner answers one of the risk screening questions in the affirmative, not in *all* cases. It is possible that MDOC's planned policy revisions will correct this discrepancy between the Agreement and current practice. In fact, the DQE reviewed draft language for policy 103 DOC 650.08, Emergency Mental Health Services, that appears identical to Paragraph 45 of the Agreement.

MDOC may wish to further clarify with staff that the requirement for consultation with an on-call MHP during nights and weekends includes BAU assessments. With that change, MDOC will be well on its way to compliance with the requirements of Paragraph 45.

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: As discussed in the first DQE report, policy 103 CMR 430, Inmate Discipline, prohibits discipline for reporting "feelings or intentions of self-injury or suicide." MDOC's proposed revision to policy 103 DOC 650.08.A.1, Referral for Emergency Mental Health Services, adds language that is identical to the Agreement:

If an incarcerated individual requests to speak to mental health staff because the incarcerated individual believes they are in mental health crisis, that incarcerated individual will not be disciplined for that request.

This proposed change further clarifies MDOC's prohibition on discipline for requesting crisis services, which is an important step toward compliance with Paragraph 46. However, neither policy (103 CMR 430 or 103 DOC 650.08) seems to capture MDOC's current practice, which permits discipline related to crisis calls in cases where mental health staff recommend that crisis services have been misused. This narrow exception to the general prohibition on discipline related to crisis calls seems reasonable. The DQE recommends that it be formalized in policy.

The DQE team interviewed prisoners, correctional officers and supervisors, and MHPs across seven institutions regarding this practice. In 26 recent interviews, 92% of prisoners said they had not been disciplined for requesting a crisis contact since the Agreement went into effect,[29] with some noting that this was a change from the past and others commenting that they had never heard of this practice. Three prisoners believed that others may have received such discipline.

In speaking with 16 officers or supervisors and five MHPs, all the officers said they had not personally written a disciplinary report for misuse of crisis in 2023, though a minority thought it might be happening elsewhere. Most interviewees, across professional disciplines, asserted that such cases are very rare and are only allowed if initiated by mental health staff, and that cases from officers are not being allowed to proceed.

The DQE team learned about four disciplinary cases for misuse of crisis during the first monitoring period[30] and three cases in the current period. Consistent with the first round of monitoring, in each instance in the current round, documents show that the cases (none of which were initiated by an MHP) were dismissed, or the existence of a disciplinary report could not be substantiated. Thus, it appears that MDOC has a consistent practice of avoiding discipline related to the use of crisis mental health services. With sustained demonstration of this practice, and with finalizing the necessary policy revisions, MDOC can achieve substantial compliance with this provision.

[29] The other two prisoners each said they had been written disciplinary cases; one could not be substantiated, and MDOC provided documentation that the other was administratively closed.
[30] See the DQE's Compliance Report #1 for a detailed discussion.

47. Mental Health Crisis Assessment/Evaluation (Initial): MDOC will ensure through an audit process that, after the crisis call, the Qualified Mental Health Professional's evaluation will include, but not be limited to, a documented assessment of the following:

a. Prisoner's mental status;

b. Prisoner's self-report and reports of others regarding Self-Injurious Behavior;

c. Current suicidal risk, ideation, plans, lethality of plan, recent stressors, family history, factors that contributed to any recent suicidal behavior and mitigating changes, if any, in those factors, goals of behavior;

d. History, according to electronic medical records and Inmate Management System, of suicidal behavior/ideation - how often, when, method used or contemplated, why, consequences of prior attempts/gestures;

e. Prisoner's report of his/her potential/intent for Self-Injurious Behavior; and

f. Prisoner's capacity to seek mental health help if needed and expressed willingness to do so.

Finding: Partial compliance

Rationale: As noted in Paragraph 137, Wellpath has declined to provide its CQI meeting minutes to the DQE. Therefore, DQE team does not yet have any information about MDOC's internal audit process related to crisis calls and cannot say whether MDOC "ensure[s], through an audit process" that MHPs' crisis assessments include all the areas delineated in 47a-f.

The DQE team reviewed a sample of 53 MHP Crisis Assessment notes to perform an independent audit.[31] One area improved since the first reporting period: 81% of crisis evaluations between July and December 2023 occurred in a confidential space, compared with 66% between May and June 2023. This is good progress, likely resulting from MDOC's concerted effort to emphasize with staff the importance of conducting crisis assessments confidentially. Some difficulty with securing confidential spaces remained apparent during the DQE team's site visits. At SBCC, mental health staff reported seeing only about half of their clients out-of-cell; the remaining contacts occurred at the cell door with an officer standing directly behind, which obviously hindered open and meaningful communication between clinician and client. Staff at OCCC reported an improvement in confidential assessment and treatment since the first reporting period, with greater access to confidential spaces and less frequent resistance by security staff to facilitating out-of-cell contacts. Staff at Gardner and MTC continued to report conditions

[31] This is a different sample from the study of 100 TS Placements described in Paragraph 50. The current study reviewed 53 randomly chosen crisis assessments from across nine institutions, of which 94% did not result in placement on Therapeutic Supervision.

that hindered crisis assessments, including conducting assessments in areas where staff and prisoners frequently stand nearby and peer inside the evaluation room.

The quality of crisis assessments remained variable, with most contacts being brief and superficial. As noted in the DQE's first report, the biggest problem is that MHPs inconsistently review patients' diagnoses and histories of self-harm before making assessments about safety and risk. Only three of the 53 crisis contacts reviewed (6%) contained any notation in the medical record that the MHP had reviewed relevant historical information prior to the assessment. This does not appear to be solely a problem with documentation. During the DQE team's site visits, practices varied by clinician and by facility, with the most consistent problems apparent at OCCC and SBCC. MHPs at SBCC and OCCC did not have consistent access to the medical record when responding to crisis calls, limiting their access to key information.[32] MHPs at OCCC reported that their attempts to gather collateral information are sometimes unsuccessful because correctional officers decline to provide even the name of the prisoner requesting the crisis contact. The DQE team observed MHPs basing their risk assessments on superficial questions like "Are you going to be safe?" and "You're not at risk to yourself or others?" During the Concord site visit, the DQE witnessed the crisis clinician being paged for a BAU risk assessment during the daily triage meeting. The requesting officer identified the prisoner only by his race, not his name, making it impossible for the clinician to review information from the medical record prior to conducting the assessment. Five minutes later, the clinician returned to the triage meeting, having reportedly completed a risk assessment.

In contrast, the DQE also observed crisis assessments where the clinician had clearly reviewed the medical record prior to seeing the patient and spoke easily about relevant risk factors. Overall, it appeared that crisis assessments still vary significantly, with many that are far from the mark of appropriate clinical care. A partial compliance finding is being issued in recognition of the marginal improvements with confidentiality and reviewing medical records during this monitoring period, but substantial work must be done before MDOC can be found in compliance with Paragraph 47.

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

[32] At SBCC, staff could consult the medical record when evaluating patients in the "restart chair" outside the HSU because of its proximity to the mental health offices, but this was not the case for crisis calls in the BAU or in other specialized housing units.

Rationale: No improvements in this area have occurred since the DQE's first report. In the DQE team's review of records from 53 crisis calls between July and December 2023, just one case was referred to a psychiatrist or ARNP for follow-up (2%). In 43 cases (81%), the DQE did not see a clear indication for psychiatric referral, but in the remaining nine cases (18%), there were obvious reasons to do so including new-onset bizarre behavior, complaints of side effects from medications or questions about why a dose was changed, an increase in symptoms without a clear precipitating stressor, or a specific request to see a psychiatric provider. Overall, 9 out of 10 cases that should have been referred to psychiatry for follow-up were not, which is similar to the DQE's findings in the first reporting period.

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 53 crisis calls, 51 cases included a crisis progress note in the DAP format (96%). In the two 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, which contains the same information as a DAP note (and more). A substantial compliance is warranted for Paragraph 49, which requires only a properly formatted note in the medical record. The DQE's concerns about the thoroughness of crisis evaluations are addressed in Paragraph 47.

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

Finding: Partial compliance

Rationale: For a number of Agreement requirements, the DQE team studied 100 therapeutic supervisions from the monitoring period.[33] In this sample, the MHP determined that the prisoner was at risk of self-harm in 73 cases.[34] In each case, the MHP did place the prisoner on therapeutic supervision. While this method necessarily captures

[33] From the TS Registry provided by MDOC, the team selected 100 stays, which represents a 21% sample of the 475 stays from July through December 2023. The sample was drawn from the nine institutions that conducted therapeutic supervision in proportion to their percentages of the systemwide total. The sample was chosen to capture stays in all housing areas where therapeutic supervision takes place (HSU, BAU, STU, ITU, and RTU), drew from each of the above-referenced months, and favored placements of three days or longer.

[34] The other placements were based on concerns about psychosis or harm to others.

only cases that *were* placed, it provides some support that this practice is in use. The DQE team also sampled crisis logs, documents that capture contacts in which prisoners are assessed for whether therapeutic supervision is warranted.[35] In the contacts responding to a prisoner saying they are in crisis or a staff referral labeled as emergent, 95% did not result in therapeutic supervision placement,[36] but entries also indicate that the assessing MHP determined that there was *not* a risk of immediate self-harm in those cases.

Additionally, the DQE team interviewed 17 MHPs, 35 officers, and 47 prisoners about TS placements. None offered any examples of an MHP believing there was a risk of self-harm but not placing the person on therapeutic supervision.

This requirement also anticipates an assessment of whether prisoners were placed on clinically appropriate levels of therapeutic supervision. As in the first report, 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 higher compliance finding may have been issued. 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 in many cases. 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.

Time constraints and lack of access to the medical record on the housing units contributed to MHPs' cursory risk assessments, though during the current monitoring period, the DQE team also had concerns about the skill level of some MHPs. As noted in the Staffing section of this report, most of MDOC's MHPs are inexperienced, having recently completed a master's degree in counseling or social work and not yet possessing a license to practice independently. In some cases where the DQE team shadowed these clinicians responding to crisis calls, their interactions with patients seemed transactional rather than inquisitive, with the MHP approaching the encounter as "What can I do for you today?" rather than assessing the patient's historical, clinical, and situational risk factors. This pattern was most pronounced at OCCC and SBCC. Because these two

[35] The selection method for this sampling is described above in conjunction with Paragraph 44.
[36] In this sample, there were 334 contacts initiated on this basis; 16 resulted in placement on therapeutic supervision.

facilities account for over half of MDOC's TS placements, the DQE team would need to see improvement at these facilities before issuing a substantial compliance finding for Paragraph 50.

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: In more than 200 chart reviews during the first and second monitoring periods, the DQE team has not encountered any indicia that the TS placements were for any reason other than the prisoner's request or the prisoner's well-being. The same is true of the placements that prisoners described during recent interviews, with 16 prisoners, across six institutions, commenting directly on this point.

Wellpath's policy 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." The draft revision of MDOC's policy, 103 DOC 650.08, Emergency Mental Health Services, adds language identical to Paragraph 51, making clear that TS cannot be used for punishment or the convenience of staff. If this policy language is finalized and if MDOC continues to demonstrate good practice in this area, the DQE anticipates a finding of substantial compliance in the near future.

During this reporting period, the DQE team learned of practices that share many characteristics with TS but are not "official" TS placements. For example, at Framingham, prisoners are housed in the HSU on a status called "[Intensive Treatment Unit] Phase 3," which seems to be used either for patients with acute psychiatric symptoms but who do not appear to be at risk for self-harm, or as a step-down from TS before returning to a regular housing unit. Prisoners on Phase 3 status continue to have 15-minute observation by an officer and are permitted the same property and privileges as other patients housed in the HSU. In another example at MASAC, prisoners are placed on "Security Watches" in the same location where TS occurs (C-dorm), but seemingly for different reasons (e.g., to separate two patients after a fight or to allow someone space to calm down). OCCC also has "Security Watches," and on at least one occasion this occurred simultaneously with a Therapeutic Supervision placement, resulting in security leadership denying the prisoner clothing that the mental health staff had approved him to have. The DQE team will continue to monitor these practices to

ensure that they are not being used as punishment or as a workaround to avoid the intensive staff resources required by therapeutic supervision.

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: As in the DQE's first report, crisis treatment plans were completed in the vast majority of TS placements. In a review of medical records for 57 TS placements chosen from nine institutions in proportion to the total TS placements,[37] 54 records (95%) contained a completed Crisis Treatment Plan form. The DQE team's interviews with MHPs confirmed that the expectation for treatment plans to be completed upon initiation of TS is well established throughout MDOC. Treatment plans generally contained all the elements of subsections 52a through 52j, but only 13% of plans indicated that a prisoner's medication compliance had been reviewed (52k). In over half of cases, a psychiatry referral was indicated but not completed.

The DQE's first report detailed significant problems with the quality of MDOC's crisis treatment plans, especially the poor documentation of risk assessments and the lack of individualized treatment planning. Not much has changed in this regard over the past six months. Although the Crisis Treatment Plan does not document how much time was spent assessing the prisoner, during the DQE team's site visits, crisis assessments remained brief. A chart review of 53 crisis assessments indicated that over half of such assessments were 10 minutes or less, with a range of 2 to 45 minutes. In interviews and

[37] These 57 cases are a subset of the 100 TS placements first described in relation to Paragraph 50.

observation of MHPs' practice during the DQE team's site visits, clinicians typically spoke to the patient briefly, "triaged" the case with the mental health director, decided whether to initiate TS, and later read the chart to find the historical information about risk factors necessary to complete the Treatment Plan template. This practice led to timely and complete Crisis Treatment Plan documentation in most cases, but without the substantively proper evaluation to back it up.

In the DQE's study of 54 completed TS treatment plans, 50% contained a poor-quality risk assessment where the MHP simply stated the outcome of the assessment (i.e., that the patient would be placed on a 15-minute therapeutic supervision) or cut and pasted the "Precipitating Events" section of the note into the risk assessment. In one case, the clinician entered historical risk factors into the crisis treatment plan from a Comprehensive Mental Health Evaluation done in 1994, without any indication of updating the information since that time. In another case, the clinician seemingly made no effort to update risk factors since the prisoner's mental health case was closed in 2019. In a third case, where the prisoner's swallowing of a battery and cleaning fluid precipitated his TS placement, the clinician wrote in the risk assessment, ""While [client] struggles with consistency he appears willing to work on maintaining himself. [Client] denied intent and speaks of his release date regularly." It was not clear what this had do with ingesting dangerous foreign bodies.

When compared with the first reporting period, the DQE did observe more variety in the treatment goals and risk management strategies identified in TS treatment plans, which may be a result of Wellpath and MDOC's efforts to emphasize the importance of individualized treatment planning with staff. However, the relationship between treatment strategies and the patient's clinical status remained tenuous in many treatment plans. For example, a prisoner was placed on TS for over 90 days, spanning three placements. Throughout that time, the prisoner remained a closed mental health case, with no identified diagnosis and strong suspicion of malingering, while "treatment plans" were dutifully being completed about developing coping skills and discussing "MH related issues." The incongruity between writing treatment plans and not identifying an individual as needing treatment remained unaddressed. In another example, a prisoner was placed on TS four times for different reason over the span of three months. The treatment objectives and risk reduction strategies in all four treatment plans were identical, clearly cut and pasted from one note to the next.

The problem with TS treatment plans is not just poor documentation; it appears more fundamental. During the DQE team's observation of mental health triage meetings, discussions about diagnoses were rare, and discussions about treatment on TS tended to focus on the daily decisions about what status (15-minute vs. constant) and property the

prisoner would be given. 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 Paragraph 52. To its credit, MDOC has begun holding informal, facility-based trainings for clinicians at some facilities, such as OCCC and MTC, to improve clinicians' skills around treatment planning and documentation.

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

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

Finding: Partial compliance

Rationale: MDOC maintains therapeutic supervision cells in its Health Services Units, Behavior Assessment Units, and housing units of specialized programs at some institutions. To the DQE's knowledge, no TS cells have been added or removed since the Agreement's signing. The only recent changes in practice have occurred at Framingham and OCCC. At Framingham, TS now occurs in the HSU rather than in the Smith building in an effort to separate BAU prisoners from those on a therapeutic supervision. At OCCC, both the HSU and BAU are used for TS placements, but the HSU is now preferred because of its more therapeutic milieu.

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 DQE team did not encounter any cases in its study of 100 TS placements or in interviews with prisoners and staff where poor sight lines clearly contributed to an individual's self-injury. There were occasional reports of officers being inattentive to prisoners on TS or of prisoners covering the cell door and/or camera to

avoid detection, but these reports were infrequent enough that they did not help identify trends related to problematic cells or units.

During the same study of 100 TS placements, the DQE team did not encounter any cases where TS had clearly occurred in a non-suicide resistant cell, but a few officers reported during the site visits that this occasionally occurs when simultaneous TS placements exceed the capacity of designated cells. Those officers confirmed what MDOC leadership asserted: that prisoners would be on Constant Observation status for the duration of placement in a non-suicide-resistant cell.

Overall, preliminary information indicates good practice in relation to Paragraph 54. The DQE will work with MDOC to develop a strategy for demonstration of 1:1 observation during TS placements that occur in non-suicide-resistant cells.

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: MDOC administration provided a form it had designed for use as a cell inspection checklist, and leaders reported that they distributed it for universal use in April 2023. Implementation remains a work in progress. More interviewed officers or supervisors were aware of the responsibility to use the checklist than those who spoke with the DQE team during the first monitoring period. When describing their routine for inspecting and preparing a cell for a placement, 78% of security staff mentioned using the checklist, and many detailed some good methods for checking for contraband and other means a patient might use for self-harm.[38]

The DQE team reviewed a sample of 46 therapeutic supervisions for their use of the cell inspection sheet. The team selected cases from facility files and asked MDOC to provide cell observation packets for TS placements the team identified from the MDOC "TS Registry." The cases were drawn from eight institutions and spanned July through December 2023. In the sample, just over half had cell inspection sheets completed at the time a prisoner was placed on therapeutic supervision. Forms were present in another

[38] Staff interviews included 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 experience with therapeutic supervision in 2023. Among them, 18 staff from eight institutions commented on cell inspection.

handful of placements but did not appear consistent with MDOC expectations.[39] There were no checklists in 28% of the sample.

Given the foregoing, it was premature to assess supervisors' use of the checklist after prisoners' 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: Based on staff and leadership interviews and document review, it appears hat MDOC has set an expectation of individualized decision-making for property, privileges, and activities for therapeutic supervision patients. To assess implementation, the DQE studied records of those decisions for 100 TS placements during the monitoring period.[40] The DQE's opinions are also grounded in part on observing multiple Triage Meetings in which staff at each relevant facility employ a similar practice of discussing patients' progress on TS, the level of watch indicated (close or constant), and property or privileges. Mental health staff and a security staff representative discuss and collectively decide, based on the patient's clinical status and risk factors, whether to advance privileges, allow additional property, change the watch level, or discontinue the watch.

The DQE team has observed clinical discussions in multiple Triage Meetings at each of these institutions, and it appeared that the group's decisions about property and privileges were being made primarily based on the patient's clinical status. The DQE team did not observe property and privilege discussions that were specifically tied to a prisoner's

[39] Forms were sometimes provided for dates other than the identified TS dates, in a format that did not facilitate cell reviews in detail comparable to the MDOC form, and/or with indicia that the contents were not accurate.

[40] The sample drew from each of nine institutions in proportion to its percentage of therapeutic supervisions from July through December 2023. The cases were selected partially from the sample described in Paragrapht 50 and partially from facility files that include Therapeutic Supervision Reports. This sample served as the basis for analyses for requirements 57 through 65. Additional materials and modifications needed to answer questions posed in those requirements will be described in those respective sections of this report.

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 observed that decisions about lighting, meals, restraints, and activities other than phone use and visits are not recorded on Therapeutic Supervision Reports. Leadership interviews indicate that decisions about lighting and meals are made on a group basis grounded in practical, not clinical, concerns. Restraint practice varies widely.[41] The DQE team has not heard restraints decisions discussed in Triage Meetings. Rather, mental health and security staff members say that restraint use is partly a matter of policy – for example, all prisoners on Behavior Assessment Unit status must be restrained during movement. Where there is discretion, the individual security officer or supervisor decides, sometimes in consultation with the individual MHP. It is not clear that the criteria specified in Paragraph 56 are among those discussed.

Different staff, both mental health and security, have expressed different opinions about how well this system operates to make effective decisions about property, privileges, and activities. Some mental health staff indicated concern about some officers overriding mental health property and privilege decisions. Some security staff worry about whether decisions to permit certain property are sufficiently safe. While there is some discontent, the majority said they believe it is officers' obligation to defer to mental health staff's authority to make the final decision and that differences of opinion are resolved at their level or at the first supervisory level, and they had no need to go further up the chains of command.[42]

Security leaders at several institutions reinforced these ideas and stated that they are available to address these concerns if needed. MDOC leadership agreed to monitor whether disputes on these decisions were escalating. They noted that Deputy Commissioners review site meeting minutes and communications from Superintendents, and, if the Deputy Commissioners learned of such conflicts, they would reach out to Superintendents to attempt to resolve them. MDOC leaders say they have asked the sites to record any such difficulties in Care Coordination meeting minutes. As of mid-February 2024, MDOC leaders said that these methods had not yet brought serious disagreements to their attention.

[41] See Paragraph 64 for further detail.

[42] These beliefs were shared in interviews during the first monitoring period (see Compliance Report #1 for detail) and, during the second monitoring period, by 7 MHPs and 12 custody staff and supervisors drawn from eight of the institutions managing therapeutic supervision.

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: Drawing on observations of Triage Meetings and MHPs conducting therapeutic supervision contacts; conversations with MHPs, clinical leaders, and correctional officers; and reviews of Therapeutic Supervision Reports and progress notes, the DQE team has found that decisions about clothing are largely individualized. The majority of interviewed officers perceive this to be the case.[43]

Patterns are emerging, however, that suggest situations in which the decisions to withhold clothing are made categorically out of a sense of caution. To date, this appears common in placement decisions by an on-call professional and placements where the patient is not forthcoming. This was echoed in comments from nine interviewed MHPs from four institutions, most of whom said they prefer to start a patient in a smock under these conditions and when he shows a risk of SDV by *any* method. Some officers, too, understood that prisoners on constant observation always start in a smock. In such cases, the reasoning process called for under this requirement is not evident, and MDOC will want to integrate the required reasoning into these types of decisions.

[43] Ten officers drawn from five institutions commented on clothing decisions. Six of them thought the decisions are very individualized, while the remainder thought most patients, or only those on constant observation, begin TS placements in a smock.

Among 36 interviewed prisoners, just over half said they were able to have clothes during their TS placements, while somewhat fewer said they usually start their stays in a smock and receive clothes after some days.

The DQE team also examined records from 91 TS placements, reviewing the Therapeutic Supervision Reports from each day of a placement, along with Crisis Treatment Plans and progress notes in cases where clothing was not initially authorized.[44] The review yielded these results:

- MDOC is working toward the goal of authorizing clothing within 24 hours; this was accomplished in 67% of the sample, slightly lower than the 74% rate found in the first monitoring period.

- Where clothing was withheld, 46% of cases documented that the prisoner had demonstrated that they would use clothing in a self-destructive manner.[45] This rate is essentially the same as in the first-round analysis.

- Where a prisoner remained in a smock for multiple days, only 25% of those cases documented a relevant clinical contraindication each day.

- Where prisoners were not approved for clothing after 48 hours, the reviewed records do not reflect notifications to the MDOC Director of Behavioral Health and consultation and approval by the Wellpath Director of Clinical Programs.[46]

There is not currently a demonstration that MHPs reassess clothing contraindications three times per day.[47] One Therapeutic Supervision Report per day is by far the norm, though there can be two or three such reports in the record. Progress notes sometimes capture clothing decisions, mention that property and activities will continue unchanged, or reference that decisions will be reviewed in the Triage Meeting. It was very rare for three decisions per day about clothing to be documented in any format.

---

[44] The 91 records are drawn from all institutions that provide therapeutic supervision and are a subset of the sample described in the discussion of Paragraph 56.

[45] The DQE considers "demonstrated" to mean that the patient (1) made a specific threat to hang or strangle themselves, (2) made a recent hanging or strangulation attempt, possessed a ligature, or otherwise attempted self-harm using cloth, or (3) had a history of one of those behaviors.

[46] There were 8 such cases in the sample. The progress notes do not reference contact with these leaders. MDOC also provides materials monthly to demonstrate all notifications made to Wellpath and MDOC administrators in satisfaction of Agreement Paragraphs 57, 78, 79, and 80. Those materials do not include notices for half of these cases on or shortly after the 48-hour point. Where there are notices, some do not reference clothing, and others mention clothing and a rationale, but no approval is reflected.

[47] As noted in previous reports, 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.

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: As with decisions about other property, privileges, and activities, the DQE team has observed that MHPs consistently carry out the system of daily decision-making about authorizing showers and documenting these decisions on Therapeutic Supervision Reports. This has been mentioned consistently in MHP, security staff, and leadership interviews throughout 2023 and is supported by more than 200 health record reviews drawn from all facilities providing therapeutic supervision.

To assess shower approval practices in the current monitoring period, the DQE team reviewed Therapeutic Supervision Reports for 100 stays.[48] In every case, the prisoner was approved for a shower or discharged from therapeutic supervision within 72 hours.[49] This is consistent with practice observed in a similar-sized DQE team study in the first monitoring round.

In terms of offering showers, 77% of interviewed prisoners said they were offered showers or records show they were discharged from therapeutic supervision in less than 72 hours.[50] Many of them shared supporting detail. The remaining prisoners said no showers were offered or were made available so infrequently as to be concerning.[51] Six interviewed MHPs affirmed that showers are consistently offered, and another thought that showers were made available if the patient takes the initiative to ask.

The DQE team interviewed 16 officers who said they have responsibility for providing showers; they worked in BAU and SAU units at seven of the institutions providing therapeutic supervision. Their descriptions included the first day a shower can be offered, the schedule, and the logistics of offering and providing showers. Another four officers

[48] Please see Paragraph 56 for a description of the sample selection and methodology

[49] 99 prisoners were approved for a shower; one prisoner was not authorized for a shower but discharged from therapeutic supervision in two days.

[50] 35 prisoners commented about showers.

[51] Some asserted, for example, that showers were only offered once or twice a week. The complaints were not centered at any particular facilities.

worked on a shift different from the one on which showers are typically handled, but they stated their belief that showers are offered on the same basis as with other prisoners on that unit. MDOC leaders indicate they are working on a system to document activities offered and accepted or refused by therapeutic supervision patients. Referred to as "unit logs," this system reportedly has been used in Behavior Assessment Units long term, and MDOC reports it is being extended to settings that house therapeutic supervisions. That system is not yet established sufficient to provide proof of practice.

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

Finding: Partial compliance

Rationale: MDOC made progress in installing dimmers for some of its therapeutic supervision cells. Through observation and officer interviews, the DQE team learned that it is now possible to dim lights in almost half of the 18 therapeutic supervision settings reviewed. Gardner appears to be the only facility that has dimmers in both its Health Services Unit and its Behavior Assessment Unit, but six other institutions have them in at least one relevant unit.

The DQE team interviewed 30 prisoners who commented on lighting; only one Framingham prisoner believed the lights had been dimmed at night.[52] The team also interviewed 11 officers or supervisors posted in a Health Services Unit or Behavior Assessment Unit on the 3:00-11:00pm shift, who would be more likely to control the lights.[53] The majority believed it is policy to keep the lights fully on for therapeutic supervision patients, though three said a dimmer is used either routinely or at a patient's request.

It appears that continued physical plant and procedure changes will be necessary to meet this requirement at most institutions, but MDOC is steadily moving toward this goal.

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.

[52] Nearly all other prisoners believed the lights were kept on fully, though three said the lights were on but did not recall whether it was full or a reduced setting.
[53] The team also spoke with five officers on the day shift who offered their impressions about how lighting is handled but would likely have much less experience with it.

Finding: Partial compliance

Rationale: As with property, privileges, and activities discussed under other Agreement requirements, there is a field to record decisions about "other property" on the Therapeutic Supervision Reports. The DQE team reviewed 99 health records to determine practice concerning authorizing property other than clothes, reading and writing material, and tablets.[54] MHPs authorized additional property in 48% of the sample. Most often, glasses were permitted, and medical or ADA devices – such as hearing aids, dentures, physical therapy items, and CPAP machines – were also commonly allowed. There were occasional permissions for radios and Gameboys, legal work, religious and cultural items, personal mail or photos, and extra hygiene items. The nature of the different items allowed for different patients suggests that the decisions were individualized. OCCC showed the strongest practice with nearly every prisoner authorized to have one or more of these categories of property.

In interviews, most prisoners said they did not receive any other property while on TS, though one third said they received property in general or named a single item.[55] The DQE team did not undertake an assessment of whether the approach taken by MHPs was the least restrictive possible, but in interviews, MHPs articulated a clinically reasonable framework for making property decisions. Overall, it appears that MDOC is well on its way to compliance with the requirements of Paragraph 60.

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: Drawing on observations of Triage Meetings and MHPs conducting therapeutic supervision contacts; conversations with MHPs, clinical leaders, and

[54] This is a subset of the sample described in conjunction with Paragraph 56. The reviewer examined the Therapeutic Supervision Report for each day of each TS placement in the sample.
[55] 22 prisoners offered their experience as to property.

correctional officers; and reviews of Therapeutic Supervision Reports and progress notes, the DQE team found that decisions about property are largely individualized and are captured on Therapeutic Supervision Reports.

To assess the practice of authorizing reading materials, the DQE team reviewed each day's Therapeutic Supervision Report for 100 placements and related progress notes in cases where MHPs determined the patient could not have reading or writing materials. In that study, reading materials were allowed in 86% of the stays.[56] In the remaining cases, however, mental health staff did not document individual reasons that reading materials would be contraindicated on each day that the materials were not authorized.

Writing materials were permitted less often. In the study, only 43% of the stays exceeding one day included an authorization for writing material.[57] Here too, mental health staff did not document individual reasons that writing material would be contraindicated on each day that the materials were not authorized.

OCCC authorized tablets for all prisoners in the sample, and more than half of the institutions allowed tablets well before the 14-day threshold required by Paragraph 61. In total, prisoners were allowed to have tablets in 43 of the examined stays.[58] There was only one stay exceeding 14 days, and the prisoner received timely permission for a tablet.

Prisoner interviews were consistent with the study findings; 75% said they were allowed to have books and half said they could have writing materials. All prisoners said they could have tablets except those who lived at facilities that did not yet have those devices.[59]

62. Routine Activities: Throughout the prisoner's time on Mental Health Watch, a Qualified Mental Health Professional will make and document individualized determinations regarding whether it is clinically appropriate for the prisoner to participate in routine activities (e.g., visitation, telephone calls, activity therapist visits, chaplain rounds). Absent Exigent Circumstances, the prisoner will be allowed to participate in the routine activities deemed

[56] Please see Paragraph 56 for a description of sample selection and methodology. When reviewing authorizations for reading material, those materials were not allowed in some stays where the patient also was discharged by the second day, so those cases were removed. The analysis is therefore composed of 95 stays; in 82 of them, reading materials were permitted.
[57] There were 13 stays that concluded within about one day, and they were removed from this analysis, making the sample size 87 cases. A stay was considered to meet the requirement if it authorized any type of writing material, including a crayon. In *some* of the stays that concluded in about one day, the patient *was* allowed to have a book, so the stays were retained in the study above. That is the reason for the different sample sizes in these two analyses.
[58] The study examined the full set of 99 stays.
[59] Different numbers of prisoners, across eight institutions, discussed each of these topics. 20 prisoners discussed books, 11 commented on writing materials, and 25 mentioned tablets.

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: As previously described, the DQE team has observed MHPs discussing in Triage Meetings what can be authorized for each therapeutic supervision patient. In reviews of medical charts and security observation records, the team has also observed that it is well-established routine to capture those decisions in Therapeutic Supervision Reports on most days.[60] Security officers, MHPs, and leadership regularly refer in conversation to using these reports. The DQE has made these observations in both monitoring rounds to date and at all institutions that provide therapeutic supervision.

The Therapeutic Supervision Reports require an MHP to designate whether to authorize visits and phone calls each time a report is created or updated. In the current monitoring period, the DQE team conducted a study of Therapeutic Supervision Reports for 100 stays.[61] In that sample, phone access and visits were authorized in 98% or more of the stays. Typically, they were authorized from the first day forward, though a few showed changes during the stay when the patient's condition changed. The DQE team reviewed the remaining two patients' health records, and no reason for contraindicating phone use or visits was apparent.[62] The findings of the current DQE study are consistent with a similar-sized study completed for the DQE's first report.

Interviewed officers and supervisors generally assert that MHPs have the final say as to what property, privileges, and activities a prisoner is allowed and that officers implement what is indicated on the Therapeutic Supervision Report. Prisoners were not so certain. Among the 25 who commented on allowed activities, the majority thought they were authorized for phone calls, but a significant minority thought it was not permitted. The majority thought they were not allowed to have visits. The reasons for the differences between these perceptions and the documents is unknown.

As for other activities, none are pre-defined fields on the Therapeutic Supervision Reports, and the DQE team has not seen any added to an individual's reports. A number of institutions structure their daily therapeutic supervision contacts to include one with an activity therapist. No barriers to, or concerns about, allowing contact with activity

[60] Please see Paragraph 69 for a more detail on the use of these reports.
[61] Please see Paragraph 60 for a description of the sample selection and methodology.
[62] Both stays were limited; one lasted two days and the other lasted three days.

therapists have surfaced during interviews of mental health staff, security staff, and supervisors throughout 2023.

Overall, the DQE finds that MHPs make and document individual determinations about allowing access to phone and visits and that MDOC allows contacts with activities therapists. Given prisoners' perceptions, it is uncertain whether phone use and visits are allowed in practice as often as they are in documents. It is also unclear whether staff consider prisoners' access to other types of activities. As in the first report, 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 practices are sustained in the coming monitoring round, the DQE anticipates that MDOC will 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 reviewed each day's Therapeutic Supervision Reports and related progress notes for 100 placements.[63] The observed patterns are consistent with the analysis captured in the DQE's Compliance Report #1, though there is some improvement at SBCC.

Similar to practice in the first monitoring period, in 75% of the sampled stays, prisoners were authorized to have recreation or were not authorized but were discharged from TS within three days. The difference among institutions also continued:

- Three institutions were fully compliant by authorizing all sampled prisoners for recreation within three days
- Five institutions each showed only one prisoner who was not allowed to have recreation in that timeframe
- At SBCC, 39% of the sample met the requirement. While this is a low rate, it is significantly improved from 19% in the first monitoring period.

Any mental health contraindications for exercise were not clearly recorded in the health records the DQE team reviewed.

In terms of documenting the offer of recreation, MDOC leaders indicate that they are working on a system to document activities offered and accepted or refused by prisoners, but that it is not yet established sufficient to provide proof of practice. Interviewed officers and supervisors at seven institutions[64] detailed the process they use to offer recreation and to escort and observe those who accept. Many institutions use the Behavior Assessment Unit yard for therapeutic supervision recreation, so officers in that unit and the Health Services Unit described how they coordinate, the shift responsible for managing recreation, and other logistics. Officers at six facilities uniformly said the routine is to have an officer monitor the yard continuously, regardless of whether the prisoner is on close or constant observation. The majority of officers in both of SBCC's units (HSU and BAU) believed that recreation is not permitted for therapeutic supervision patients, and an OCCC supervisor thought it is not allowed when a patient is on constant observation.

While about one-third of interviewed prisoners said that recreation was offered, the majority said it was either not offered or not provided.[65] Different prisoners within an

[63] Please see Paragraph 56 for a description of the sample selection and methodology.
[64] 18 officers commented from direct experience. Another four officers worked on shifts other than the one in which recreation is reportedly made available.
[65] 27 patients, drawn from eight institutions, commented about recreation

institution tended to report different experiences, and explanations for the differences among them, or between prisoner and officer accounts, were not evident.

Several staff members noted that, even when offered, recreation is often refused. Interviewed MHPs noted that prisoners do not want to go outside in the winter months because of the weather, while others noted that indoor recreation can be unpopular because it occurs in a room only slightly larger than the individual's TS cell. Security staff at Framingham and MTC said prisoners do accept recreation, while Concord, Gardner, and OCCC staff said that few, if any, participate. A handful of interviewed prisoners said they routinely refuse.

The DQE team did not learn of efforts to consider individualizing decisions about strip searches for recreation. The team will continue to develop information in future monitoring periods.

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

Finding: Partial compliance

Rationale: MDOC's revised Therapeutic Supervision training materials and policies clearly indicate their intention for all restraint decisions involving prisoners on TS to be individualized and based on risk of harm to self/others. During the DQE team's most recent site visits, two facilities reported that they have begun the process of individualizing decisions about restraints: Gardner and MTC. These two facilities join MASAC, which reported during both rounds of site visits that it does not routinely restrain patients during out-of-cell contacts. Thus, it appears that three MDOC facilities have begun implementing a practice of individualizing restraint decisions.

The DQE team interviewed 24 correctional officers or supervisors, 17 MHPs, and 33 prisoners, across eight institutions, about this topic.[66] Their descriptions of restraint practices varied so widely that it was impossible to determine what the typical practice at any institution was. Most commonly, interviewed officers stated that restraint decisions for prisoners on TS are based on the individual's status, such as whether they are "BAU

[66] During the MASAC site visit, the one patient at the facility who had been placed on TS suffered from cognitive deficits that rendered him unable to recall details of his time on TS.

status" or on constant observation. Other officers cited protocols about cuffing prisoners during transport to a mental health assessment and then uncuffing them once in the room. Still others stated that restraint decisions vary by the location of contact; the BAU may differ from the HSU, even if both patients have the same security and TS status. A significant minority of officers reported that they consult with MHPs about whether a prisoner needs to be restrained during the mental health contact. No officers reported using the Therapeutic Supervision Reports as a source of information about restraints.

At Gardner and MTC, interviewed MHPs and correctional officers confirmed that they recently began consulting about individual patients' restraint decisions, and officers at MASAC could not recall restraining a prisoner for a mental health contact while on TS. MHPs at Gardner noted that practices still vary by officer, with some willing to uncuff patients during mental health contacts and others refusing to do so. MHPs at Norfolk and SBCC reported that patients are shackled behind their backs during all out-of-cell TS contacts, while MHPs at OCCC reported that this is the case only in the BAU, not the HSU. MHPs at Concord, Shirley, and Framingham reported having input into restraint decisions, with security personnel asking their preference for TS contacts.

Similarly, interviewed prisoners reported a wide variety of restraint practices. Their descriptions sometimes directly contradicted the reports of staff and of other prisoners at the same institution.[67] Some prisoners reported that their arms or legs are shackled to a "restart chair" during mental health contacts, while others reported being handcuffed behind their backs. Still others stated that they were not shackled at all.

Overall, the DQE can see some progress in this area, moving from a noncompliance finding during the first monitoring period to a partial compliance finding now. Security and mental health staff at several institutions appear to be consulting about the restraint status of prisoners on TS, at least those who are not BAU status. Significant work remains to be done, particularly at the institutions where routine shackling of prisoners behind their backs during mental health contacts is the current norm.

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

[67] These varying reports could all be accurate. For example, one prisoner may have been restrained for mental health contacts while housed in the BAU or while on 1:1 observation, while another may have been unrestrained because they were on 15-minute observation in the HSU.

Rationale: To the DQE team's knowledge, this area remains unchanged from the first DQE report. MDOC stated that OCCC is offering meals out of cell to patients on TS who are housed in the Behavior Assessment Unit, but it is not feasible, nor would it be permitted by the Massachusetts Department of Public Health (DPH), to do so in the OCCC Health Services Unit. Informal conversations at some sites in this monitoring period indicate that TS meals are provided in cell, and it does not appear that those facilities have explored whether serving meals out of cell would be feasible and permitted. In its December 2023 Status Report, MDOC wrote: "As of this time, there are no facilities with DPH approved locations for meals out of cell within Health Services Units."

The DQE team will continue to gather more information on these points. Although the DQE understands that meals out of cell may not ultimately occur at any of these institutions, depending on physical plant limitations and state regulations, a response from each facility about either a change in practice or 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: Because there is no objective way to assess a system's commitment to providing constitutionally adequate mental healthcare, the parties agreed that this provision will not be assessed.

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

Finding: Compliance not yet due[68]

[68] While this report is being issued after the deadline for this requirement, the data in this analysis is from the period preceding the deadline (July through December 2023). Compliance will be assessed in the next DQE report, when practice will all have taken place after this requirement was fully in effect.

Rationale: The findings in this area are consistent with those captured in the DQE's first compliance report, with incremental progress on some measures.

A staffing structure has been in place since before the Agreement's signing to provide three contacts on weekdays; two contacts on Saturdays; and, for patients on constant observation, one contact on Sundays. During each 2023 site visit, the DQE team accompanied MHPs conducting these contacts, interviewed MHPs and clinical leaders, and observed staff meetings discussing the contacts. The DQE team reviewed Triage Meeting minutes for each month of the monitoring period from each facility providing therapeutic supervision, and they capture discussion of three contacts per day, either completed or planned. It is clear that this system is operating systemwide.

Electronic health records, however, show significant ways that practice differs from the language of this requirement. The DQE team conducted a detailed analysis of 100 therapeutic supervisions.[69] In that sample:

- Only 18% of the stays showed all contacts required by this Agreement provision; while this is a low rate, it does show some progress from the first monitoring period.
- Where contacts were not completed, the vast majority occurred on a weekend or holiday.[70] This is the system that MDOC has designed, but the Agreement language requires three contacts each day, without exceptions for Sundays.
- Mental health staff concerns or institutional factors – which can include other activities on the unit, lockdowns, security staffing levels, disruptive behavior by other prisoners, space availability, safety concerns about the patient's own behavior, and other considerations – were recorded as posing minimal barriers, preventing only 3% of all contacts.
- In total, 22% of required contacts were not completed. This is also incremental progress over the first monitoring period.

[69] Please see Paragraph 50 for a description of the selection method. For the Paragraph 67 analysis, the reviewer 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 if it was completed or if the patient refused. The number of required contacts was adjusted for time of placement, time out of the institution (for example, trips and/or admissions to community hospitals), and approximate time of discharge. The reviewer recorded any reasons a contact was not completed if indicated in the progress notes and whether the relevant date was on a weekend or holiday.

[70] Of the 380 contacts that the Agreement expects but did not take place, 324 were on a Saturday, a Sunday, or a holiday.

Health records also showed only a slight majority of contacts (52%) taking place out of cell.[71] MHPs did frequently document when the patient declined to come out of cell or refused the contact, as mandated by the Agreement. The patient's reasons were not often captured. The progress notes indicated that patient preference was the dominant reason for nonconfidential contacts[72], while institutional factors and mental health staff concerns prevented an out of cell contact in at least 10% of contacts. Others were unexplained.

Among 34 interviewed prisoners, the majority confirmed they were seen three times daily, though almost half estimated it was only once or twice per day. The majority of interviewed prisoners believe it is their choice whether to meet out of cell. Interviewed correctional officers affirmed this in more than half of the institutions; others thought it was up to MHPs to decide, that the burden to request out of cell contacts is on the prisoner, or that there is a set routine for which contacts occur in which setting.[73] Some prisoners affirmed that they often decline to come out of cell and cited a variety of reasons. Only officers at Concord, Norfolk, and SBCC raised security and institutional reasons to deny out of cell contact, particularly in those BAUs; a similar number of officers throughout the system thought those reasons do not present barriers. When interviewed staff and prisoners considered the overall frequency of out-of-cell contacts -- mostly out-of-cell, mostly cellfront, or about half and half -- about equal numbers of people favored each option, though the greatest number of prisoners thought they mostly met out of cell.

The content of progress notes and the timestamps of the health record entries[74] illustrate that contacts are made or attempted at different times of day. There was almost no information in the reviewed health care records or Triage Meeting minutes about additional attempts, or different engagement methods, for patients who refuse contacts.[75]

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.

[71] The DQE team recorded each instance where the progress note showed the contact taking place at the cell door and any reasons indicated in the note. Where no location was indicated, the contact was counted as being out of cell.
[72] MHPs attributed a cellfront contact to patient preference in 68% of the cellfront contacts completed.
[73] 34 patients, 18 officers, and 3 MHPs commented on some aspect of Paragraph 67, but different numbers of people addressed different elements.
[74] 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.
[75] Please see the discussion of Paragraph 68 for detail

Finding: Noncompliance

Rationale: In conversation with MHPs and Mental Health Directors, or observation of multidisciplinary meetings onsite or consultations online, the DQE team sometimes heard staff discuss approaches they had taken to encourage engagement by patients who had been refusing. Documents do not, as yet, provide support for these practices.

In the DQE team's study of 100 TS placements, the reviewer assessed the frequency and reasons for refusals and staff's response as described in progress notes and Triage Meeting minutes.[76] There were 58 stays that involved more than *de minimis* refusals to come out of cell or to meet at all.[77] Triage Meeting minutes note discussion of one of the cases, and progress notes include a change in practice in two cases.[78] This does not demonstrate compliance with the requirements of Paragraph 68.

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

Finding: Substantial compliance

Rationale: Conversations with correctional officers, their supervisors, mental health staff, and facility and MDOC administration indicate that daily updates to therapeutic supervision conditions are well established practice, and they are recorded and communicated to security staff at least daily on Therapeutic Supervision Reports.

MHPs consider conditions as part of therapeutic supervision contacts, and these are discussed for each patient during Triage Meetings, both of which the DQE team observed as consistent practice during site visits. The DQE team reviewed Triage Meeting minutes from every institution that provides therapeutic supervision; they record changes in the watch level and sometimes capture changes in privileges or property. Correctional officers regularly discuss relying on the Therapeutic Supervision Reports as they manage prisoners' daily activities.

[76] The DQE team recorded all refusals of contacts and refusals to come out of cell for each case in the sample and reviewed the progress notes in the same and subsequent days for mention of staff efforts to address the refusals. For each patient whose refusals were more than *de minimis,* the reviewer then read the Triage Meeting minutes for all entries related to those patients during the dates encompassing that patient's first refusal through the end of his or her stay.

[77] Often a progress note description illustrates that these are effectively the same behavior. A common example is a patient labeled as refusing to come out of cell who responds to the MHP for five minutes or less, with little or no content is discussed, so it is not practical to separate refusal to come out of cell and refusal of contact.

[78] In these three stays, a discussion or change in approach was recorded once or twice and not on an ongoing basis.

In the DQE team's review first described in relation to Paragraph 50 above, daily Therapeutic Supervision Reports on Monday through Saturday were found for 86% of the placements.[79] In the other TS stays, those reports were present, but one to two days were missing. Most commonly, gaps occurred on Saturdays, holidays, or when the patient was placed after hours by an on-call professional. Practice was similar for patients on constant observation on a Sunday. There, Therapeutic Supervision Reports were produced in 68% of the relevant placements, but in all but two cases where the documentation was missing, it was clear that they report had not been completed because the patient was at an outside hospital. All the 1:1 TS placements had at least one progress note per day. When an on-call professional initiated a placement after hours, the note was completed by an on-site nurse and not the on-call MHP. Since this is common practice in mental health settings, the parties have agreed that this is consistent with the intent of the Agreement and can be considered a compliant practice.

Overall, the DQE team's monitoring found a consistent level of practice throughout 2023. MDOC is in substantial compliance with 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

Rationale: This area remains unchanged from the first reporting period. In the DQE team's chart review of 100 therapeutic supervision placements, first described in conjunction with Paragraph 50, clinicians documented attempted interventions in each case. Descriptions of these interventions and the prisoner's response were succinct, generally stating what the clinician said or did and whether the prisoner was "receptive." When a patient did not engage, the clinician documented what they tried to do and how the patient responded, such as ignoring the clinician or declining to meet out of cell. In cases where the patient did not engage, many clinicians demonstrated good practice by documenting information from collateral sources, such as medication compliance records

[79] Here, the DQE team reviewed the electronic health record for each day of each patient's stay in the sample. Results were recorded for Monday through Saturday. The reviewer determined whether the patients were on constant observation status on the Therapeutic Supervision Report, or progress note, generated latest in the day on Saturday if the stay included weekends; if so, the reviewer recorded whether there was a Therapeutic Supervision Report for Sunday.

The Therapeutic Supervision Reports are also stored in a different MDOC information system ("IMS"). Where reports were not present in the health record, MDOC was able to provide copies from the IMS system in many cases.

and officers' reports of a prisoner's behavior, sleep, meal completion, hygiene, and recreational activity.

Overall, the DQE team found the documentation of TS contacts to be sufficient for its purpose of communicating between clinicians. The DQE's concerns about the quality of risk assessments and treatment planning are captured in the discussions of Paragraphs 50, 52, and 72. The substantial compliance finding for Paragraph 70 refers only to the documentation.

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: MDOC's logs show that, in the vast majority of self-injury that occurred during therapeutic supervision, patients used only their bodies (e.g., head-banging, scratching, or jumping from a height).[80] During the monitoring period, the logs also recorded four instances of a prisoner possessing and/or using a ligature, and 16 people who were able to ingest an object or use it to cut themselves.[81] It appears promising that no overdoses were indicated.

In a DQE team's study of 100 TS placements, there were 16 stays in which patients injured themselves. This represents a 30% sample of all stays where self-harm occurred in the monitoring period.[82] The sample picked up events at six of the institutions providing therapeutic supervision.

It was only clear in two cases that MHPs reassessed the care for the patient In one case, the patient's frequent, severe head-banging resulted in a physician ordering emergency medication and four-point restraints for a short period, and in another case, MHPs decided to refer the patient to a higher level of care. In most other reviewed cases, MHPs generally removed property and sometimes increased the frequency of staff observation, but no differences in treatment approach were apparent (e.g., introducing new topics into

[80] See Figure 8 in Paragraph 143 for further detail.
[81] These figures are drawn from a DQE team review of the spreadsheets that MDOC provides showing all incidents of self-directed violence ("SDV log") from July through December 2023. It appears that 20 people engaged in 101 incidents of self-injury using their bodies alone. Also, the methods for another small group of incidents was labeled "other" without further detail.
[82] MDOC monthly provides the SDV log and a spreadsheet reflecting all therapeutic supervisions ("TS Registry"). Working with only SDV log entries of self-injuries occurring in this setting, the DQE team compared the dates on the logs to identify the number of *stays* during which self-harm took place (often the SDV log shows multiple self-injuries during a stay), which was a total of 53 from July through December 2023.

therapy, making medication changes, or considering a higher level of care such as Bridgewater State Hospital).

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

Finding: Partial compliance

Rationale: Paragraph 72 focuses on the quality of treatment provided to prisoners on TS, including meaningful, out-of-cell group and individual therapy. As described above, the expectation for MHPs to conduct three daily contacts with TS patients, Monday through Saturday, is well established throughout MDOC. In the DQE team's study of 100 TS placements, first described in Paragraph 50, 52% of mental health contacts occurred in a non-confidential setting (i.e., cellside). Another 14% of contacts that should have occurred under the criteria articulated in Paragraph 37 were not completed. This leaves just 34% of contacts required under Paragraph 67 occurring in a confidential, out-of-cell space. All recorded contacts were individual; the DQE team found no examples of group therapy occurring for prisoners on TS during the current study.[83]

MDOC cannot be blamed for failing to provide out-of-cell therapeutic interventions when a prisoner refuses to engage with MHPs or prefers to speak cellside, provided that reasonable efforts are made to facilitate and encourage out-of-cell contact. During the DQE team's site visits, it did appear that such efforts are being made at most facilities, and this impression was supported by data from the team's chart review of TS placements. In the DQE team's study, just 3% of completed TS contacts occurred cellside because of "institutional factors" or at the insistence of security staff. It is not clear to what extent security practices such as shackling prisoners' hands behind their backs during out-of-cell mental health contacts contributed to the rate of refused TS contacts.

Although the DQE team certainly witnessed examples of meaningful, therapeutic interactions between patients and MHPs during the site visits, other onsite observations and the team's chart review found that, more often than is reasonable, contacts were made under conditions where it is difficult to hear and make oneself understood, build a therapeutic alliance, elicit self-disclosure, or develop insight and skills. While brief and/or nonconfidential contacts were more widespread than the following examples

[83] At MTC, the same unit houses both BAU and TS prisoners. Wellness groups are offered in that unit, but the DQE team did not encounter cases during the chart reviews where TS prisoners participated.

indicate, they highlight how such practices can accumulate and change the nature of the care being delivered. For example:

- In 24% of sampled TS placements, three-quarters or more of a patient's contacts were cellside, including some where *all* of the contacts were cellside
- In 329 patient days, the total time spent with the patient was less than 30 minutes for the entire day
- For 14 patients, there was no contact of even 20 minutes' duration throughout the entire therapeutic supervision[84]

Similar to the DQE's first report, the quality of therapeutic interventions with TS patients across MDOC remained mixed, with examples of good and poor care. One interviewed prisoner described the negative end of the spectrum: "You just sit in the room all day except when mental health comes and asks if you want a packet." On the positive end, prisoners described feeling that TS provided them with the time and space needed to decompress from institutional or personal stressors.

The DQE's impression is that understaffing and inexperience of MHPs contribute significantly to the problem with the quality of care with therapeutic supervision. MDOC 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: Paragraph 73 focuses on individualization of treatment decisions and documentation of those decisions in the health record. During the DQE team's

[84] In reaching the conclusions above, the DQE team recorded the contact times indicated on each progress note; included psychiatry, MHP, and activity therapist notes; and credited crisis treatment plans and discharge plans as 20 minutes each.

interviews with MHPs and clinical leadership, it was clear that they intend to provide individualized, out-of-cell therapeutic activities for prisoners on TS three times daily. Generally, the first daily contact is focused on assessing a patient's risk, the second is focused on therapy, and the third is a recreational contact. This structure is loosely based on psychiatric hospitalization, where a mixture of assessment, therapy, and recreational contacts would occur throughout the day, and it seems like a reasonable framework for therapeutic supervision.

The challenge is not with the structure of TS treatment, but rather in the implementation and individualization. Many prisoners spoke of receiving pre-assembled psychoeducation and activity packets through the institutional mail, and the DQE team observed this practice during the site visits. Some mental health clinicians stated that they are not allowed to exchange paperwork directly with a prisoner because of security protocols, making it difficult to review psychoeducational materials in a therapy session or to help patients apply the information to their own circumstances. At several institutions, the TS contacts observed by the DQE team felt transactional rather than therapeutic, with sessions framed around the question "What can I do for you today?"

In the approximately 52% of sampled contacts that occurred cellside, most took place for five minutes or less, so there was little opportunity for individualization of approach. On the other hand, the DQE team also witnessed clinical contacts that were clearly therapeutic and targeted toward the patient's presenting problems. Overall, as noted in Paragraph 72, the quality of out-of-cell assessment and treatment was mixed.

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. All 100 TS placements reviewed by the DQE team contained notes that documented the duration and setting of the contacts (out-of-cell vs. cellside). 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 Paragraph 73 requirements.

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, officers, mental health staff, and prisoners reported that 1:1 contacts with mental health take place in the therapeutic de-escalation room. Although group therapy can, in theory, be conducted in that room, it

was not being used for that purpose at the time of the site visit because not enough patients were on TS simultaneously to warrant holding a group.

The DQE understands from MDOC administration that a therapeutic de-escalation room is planned for the ISU, which is scheduled to open in June 2024. Thus, MDOC is making progress toward compliance with Paragraph 74.

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

Finding: Partial compliance

Rationale: MDOC reported that it continues to consider how peers can be integrated into TS, but it has not made any firm plans. As noted in the First DQE Report, peers have already been trained and work with prisoners at some facilities. Framingham has a formal peer mentorship program that operates facility-wide, though one interviewed prisoner described the program as "dormant" recently. Norfolk utilizes peers in the Health Services Unit to help individuals with their activities of daily living, and Old Colony has trained peer mentors in the RTU to help with lower-functioning individuals with mental illness. MTC uses peer supports in its Sex Offender Treatment (SOT) program. Thus, MDOC already has a framework for peer mentorship on which to build a peer program during TS placements, should it decide to do so.

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

Finding: Partial compliance

Rationale: MDOC's leadership stated that they continue to discuss the use of therapy dogs for prisoners on TS. According to the December 2023 QIC meeting minutes, a subcontractor has expressed interest in providing therapy dogs and plans to submit a proposal to Wellpath.

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[85]

Rationale: MDOC is already well on its way to compliance with this requirement. As in the first reporting period, MDOC generally facilitated expedient transfers to psychiatric hospitals once a prisoner was identified as needing that level of care. In the DQE team's study of 100 TS placements, first described in relation to Paragraph 50, prisoners were transferred to an outside hospital in 20 cases (20%). There was no indication of transfer to a different setting of care such as the STP or BMU. MDOC's transfer log indicates that, in total, 44 individuals were transferred to a psychiatric hospital under G.L.c. Section 18(a) between July and December 2023. Only one 18(a) petition submitted by an MDOC psychiatrist was denied by the court, and the vast majority of transfers to an outside hospital occurred on the same day that the petition was submitted to the court. On four occasions, all involving female patients being transferred to Solomon Carter Fuller Mental Health Center, the transfer was delayed by one to three days due to bed availability at that facility.

During the DQE team's site visits, mental health staff members occasionally reported difficulty completing the psychiatric evaluations necessary for an 18(a) petition because of psychiatry understaffing. Wellpath responded to the psychiatrist shortage by creating a statewide on-call system for 18(a) referrals. The DQE team did not detect any delay in assessment or referral based on the materials provided by MDOC or available in the electronic health record, but this area will continue to be monitored.

MDOC's records indicate that petitions for psychiatric hospitalization under G.L. c. 123, Section 18(a1/2) have continued to grow in use since the law was first established in November 2022. Between July and December 2023, 29 petitions were submitted, of which courts granted seven. All seven individuals were returned to MDOC a few days later because hospital staff determined that further hospitalization was not warranted. Thus, it appears that patients' independent attempts at obtaining treatment in a psychiatric hospital rather than prison remained largely unsuccessful.

MDOC provided documents and logs to the DQE showing 20 referrals to Residential Treatment Units between July and December 2023. All of them were approved. The average time from referral to placement in an RTU was 13 days, with a range of 0 to 41 days.[86]

[85] Although the DQE's report was drafted after the Paragraph 77 due date of December 20, 2023, the data upon which the findings are based are from July-December 2023. Substantive compliance will be assessed during the next reporting period, based on data from January-June 2024.

[86] In two cases, the patient was placed in the RTU prior to formal approval of the referral. These cases were counted as same-day placements when calculating the average time from referral to transfer.

In contrast to the DQE's first report, referrals to the Secure Treatment Program appear to be occurring more smoothly. Six individuals were referred between July and December 2023, and they were transferred in less than a month from the time of referral. Individuals who have been referred to the Behavior Management Unit continue to wait for that unit to open at SBCC; it appears from MDOC's logs that four individuals are on the waitlist. Three individuals are housed in the STP at SBCC while waiting, and one is housed at Shirley. To the DQE's knowledge, there is no set opening date for the BMU.

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: To assess compliance with Paragraph 78, the DQE team analyzed a 16% sample of therapeutic supervisions lasting three days or longer.[87] Half of the records provided some indication of a consultation with the Program Mental Health Director. Sometimes this was included in a progress note. Equally often, there was a notification form describing the case, and the Program Mental Health Director was asked to check a box concurring with the plan or offering input. The content of the consultation, and any feedback, was not captured in the reviewed documents. MDOC's Director of Behavioral Health informed the DQE team that she receives notice of the consultations by way of a copy of this document.

In terms of the mental health staff considering a higher level of care at this point in the therapeutic supervision, progress notes and/or notification documents mentioned this in two thirds of the cases reviewed. Typically, this took the form of a conclusory statement that a higher level of care was not indicated. This compliance rate is an improvement over the 56% rate from the first monitoring period.

It was also noteworthy that practice seemed to be significantly stronger in the most recent months. Materials showed that MDOC has issued documents to help structure facility

[87] The DQE team chose a sample from the TS Registry for July through December 2023. The reviewer selected therapeutic supervisions of more than three days' duration from all relevant institutions. The sample consists of 24 records, which is a 16% sample of the 150 stays of this duration in this time period. This was a subset of the study described in relation to Paragraph 50.

The reviewer examined progress notes for those cases along with length of stay notification materials that MDOC provides monthly, daily consultation meeting minutes from November forward, and Triage Meeting minutes. The reviewer checked the materials for the days a notification would be required and adjacent days.

staff's thinking and reporting about these patients, and minutes of a daily leadership call to review TS placements capture more of the thinking underway. These are promising signs of momentum toward fulfilling the requirements of Paragraph 78.

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

Finding: Partial compliance

Rationale: This analysis draws on the samples and methods described in relation to the Paragraph 78 requirements above. The DQE team analyzed the 14 TS placements within that sample that exceeded seven days' duration, which constitutes a 22% sample of TS stays of that length during the monitoring period.

Materials only demonstrated that the consulting expectations of this requirement were met in one case. More typically, documents showed that notice was given to the Program Mental Health Director through the same method used at the three-day benchmark; feedback was evident in one of these cases. This communication was not documented, however, in half of the reviewed placements.

During the summer of 2023, MDOC initiated a daily consultation call for MDOC and Wellpath clinical leadership and facility Mental Health Directors to discuss therapeutic supervision cases of longer duration. The DQE team has observed seven of these calls from November 2023 through February 2024. Long-term cases were presented on each call, and there was discussion of current symptoms and behaviors, response to previous approaches, and some problem-solving of practical stressors affecting the patients. In the DQE team's observation of the meetings and review of some of the minutes from these meetings, the personnel named in Paragraphs 79 and 80, as well as regional clinical leaders, generally participated. Since consultation among the Site Mental Health Director, Program Mental Health Director, Director of Behavioral Health, and Assistant Deputy Commissioner of Clinical Services was captured in daily consultation call minutes in the most recent case, it is possible that they also consulted on more of the cases in the DQE team study, and it was not documented in the previous recordkeeping practices.

As to the other components of Paragraph 79, facility staff frequently documented that they considered a higher level of care; this was noted in every case with only one exception. The reasons that a referral was not clinically indicated were *not* generally made explicit. Staff's reasoning was clearly reflected in less than one-third of the sample.

Several of the compliance rates above are improved over the previous monitoring period's analysis, and a daily consultation call is an excellent mechanism for ensuring the necessary consultations. As with consideration of a higher level of care at the three-day point, it appears that practice on this requirement is headed in the right direction.

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: This analysis draws on the samples and methods described in relation to Paragraphs 78 and 79 above. The DQE team analyzed the 6 stays within that sample that exceeded 14 days' duration, which constitutes a 23% sample of stays of that length during the monitoring period. Practice at these points in time appeared similar to consultation and documentation at the seven-day benchmark.

Materials demonstrated consultation on most weekdays and with some of the required people.[88] Daily consultation call minutes, as well as meetings that the DQE team observed, suggest that practice in recent months may be closer to fulfilling the requirement than earlier documents indicate, and that the Deputy Commissioner of Re-entry and Clinical Services[89] also usually joins those consultations.

[88] On the 14th day, documents showed communication with the Program Mental Health Director in five of six cases, and she was joined by some, but not all, of the required personnel in recent minutes of meetings discussing patients in this sample. After the 14th day, notifications or daily consultation calls were documented on weekdays for two of the patients but there were no documents, or some weekdays were missed, in three other cases.

[89] This official is required by Paragraph 80 to join the consultations; participation by all other named leaders is required by both Paragraphs 79 and 80.

Staff's documentation of considering a higher level of care and the reasons they believed it was not clinically indicated was strongest with this cohort. Both of these elements were present in the documents for two-thirds of the sampled placements. These daily reports were also significantly improved, conveying more of the clinical picture than did the reports generated in the first monitoring period.

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

Finding: Substantial compliance

Rationale: No significant changes have occurred in this area since the DQE's first report. MDOC policy 103 DOC 650.08, Emergency Mental Health Services, and Wellpath policy 66.00, Therapeutic Supervision, contain identical language for stepping down patients from constant to close observation before discharge. The DQE has reviewed MDOC's proposed revisions to policy 105 DOC 650, and they are consistent with the requirements of the Agreement.

In the DQE team's study of 100 TS placements, 50 prisoners' placements included time on a constant watch. Almost all were stepped down to close (15-minute) watch for at least one day before discharge, which the DQE team considers a reasonable time consistent with Wellpath's and MDOC's policies.[90] The post-discharge follow-up contacts are also widely implemented, as detailed in the DQE's analysis of Paragraph 84. Overall, MDOC remains substantially compliant with 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.

[90] The only exceptions were one patient who was not stepped down and five patients who transferred directly to a psychiatric hospital.

Finding: Partial compliance

Rationale: In general, the DQE observed the process described in Paragraph 82 during the site visits, and several key elements were confirmed in a chart review, although the involvement of upper-level providers should have been greater in a substantial number of reviewed discharges.

The DQE team observed Triage Meetings during site visits of each institution that provides therapeutic supervision. Meeting participants discussed and decided on potential discharges; the DQE team did not learn of any discharges taking place outside of this process. The site Mental Health Director participated in each of the observed meetings, and a psychiatrist or nurse practitioner attended at most. Triage Meeting minutes also provided support for the consistent attendance of the mental health team, supervisors, and upper-level providers. Psychiatry's participation in the decision-making process around TS placements was variable, with some institutions showing good multidisciplinary discussions (e.g., Concord, Gardner) and others with psychiatry in a passive role, rarely saying anything in relation to TS decisions (e.g., SBCC, OCCC, Framingham, MTC).

In the DQE's study of 100 TS placements, there were many cases where consultation with a psychiatrist or nurse practitioner was clinically indicated upon discharge, but there was no mention in the medical record of such a consultation occurring beyond typically limited Triage Meeting participation. Such consults were only documented in 24% of the cases where it was clinically indicated. This finding is consistent with the DQE team's observations of typical practice during the site visits, when psychiatry consultations prior to discharge from TS occurred primarily in cases where an 18(a) referral was being considered.

MDOC has designed a form for MHPs to perform a suicide risk assessment upon discharge from therapeutic supervision, and it appears to be in widespread use. In the DQE team's study of 100 TS stays, the suicide risk assessment form was present in all relevant cases in the sample except one.[91] Where the patient had been placed on TS because of a risk of self-harm, the MHPs almost universally documented that the patient presented a lower risk of imminent self-injury at the time of discharge.[92] During the DQE

[91] There were 83 stays in which one would expect to find a Discontinuation of MH Watch form. The other sampled cases were not discharged in that they transferred to another institution's therapeutic supervision, transferred to an outside psychiatric hospital, or were released directly from therapeutic supervision to the streets.

[92] In the sample, 65 placements were initiated for this reason (the other placements arose from concerns about harm to others or potential psychosis); 63 of them documented the required reduced risk in the Discussion of Current Risk section of the form and/or in the sections rating Risk and Global Rating of Distress when compared to those ratings in the Crisis Treatment Plan.

team's site visits, TS discharge assessments were not observed, so the team cannot comment on whether an appropriate risk assessment is being done in practice. Given the DQE's concerns about the quality of risk assessments during initial crisis contacts, this is an area that warrants closer monitoring during the next reporting period.

The location of the discharge assessment contact was not usually recorded in the medical record, so it is not possible to assess whether these contacts are out of cell frequently enough to meet this requirement. Neither did the DQE examine the question of whether discharges are approved as early as possible. As noted elsewhere in this report, the DQE does not have any information about Wellpath's auditing process that would demonstrate its quality assurance process in this area. Minutes from MDOC's Quality Improvement Committee meetings indicate that trends related to TS length of stay are followed closely.

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 the DQE's first report and in relation to Paragraph 82 above, MHPs routinely employ the Discontinuation from Mental Health Watch form. The DQE team draws on its review of 82 such forms, described above, for the following findings. Overall, the current findings are consistent with those articulated in the first monitoring report.

MHPs universally completed the Discontinuation from Mental Health Watch form's section for brief mental status updates. They sometimes completed a separate safety plan with the patient, but that was only clearly present in 13% of the cases.[93] Similarly, MHPs recorded the patient's risk factors and an overall rating of risk (low, medium, or high), but the form does not provide a field where clinicians would connect those risk factors to a discharge plan. In a large majority of cases, MHPs marked the type of housing or program to which the patient would be discharged, though there was no indication of whether they had clinical recommendations concerning it.

[93] There were 11 such plans in the sample. The actual figure may be incrementally higher as, in four more cases, progress notes referred to a plan having been completed, but it was not visible in the electronic health record.

The Discontinuation from Mental Health Watch forms did not contain descriptions of the goals, intended 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, it was also rare for this information to be captured elsewhere in the medical record. Overall, it appeared that MHPs were completing the Discontinuation form as a means of ending the TS placement formally, without much consideration of what would happen next for the patient beyond "return to housing unit" and "follow up per TS protocols." This was consistent with the DQE team's observations during triage meetings and in conversations with the mental health staff, where discussions tended to focus on decisions about "downgrading" TS placements (from constant observation to 15-minute) or discontinuing them rather than on crafting a long-term plan of care.

The communication of discharge plans to mental health and security staff remains brief. Security staff stated in the DQE team's interviews that they typically learn of the mental health team's decision to end a TS placement from the officer who attended the daily Triage meeting, and they receive supporting paperwork from the mental health staff shortly thereafter. Information about the patient's ongoing plan of care is not routinely shared with security staff in the unit where the TS occurred or in the housing unit to which the patient is being discharged. While it is appropriate to protect the privacy of patients' mental health information in routine cases, the DQE team would like to see evidence of collaboration between mental health and security staff in complex cases or those where security-related stressors may contribute to post-discharge risk. For example, if a patient's TS placement involved statements that they would harm themselves if placed in the BAU, it would be appropriate for the mental health staff to alert security personnel in the BAU of this risk at the time of discharge from TS. In another example, if a patient has active symptoms of a serious mental illness, a discussion about triggers or warning signs to watch for, cellmate choice, or a single cell may be warranted.

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

Finding: Partial compliance

Rationale: As detailed in the DQE's Compliance Report #1, the system for providing three follow-up contacts after therapeutic supervision is well-established; this was determined through observing Triage Meetings and MHPs providing the contacts, interviewing MHPs and clinical leaders, and reviewing Triage Meeting minutes and electronic health records. Those sources also support a finding that the system continued to operate in the current monitoring period. MDOC and DOJ have agreed informally to some flexibility on the timeframes for these contacts, with an understanding that three contacts should be completed by the tenth day after discharge.

In the previous monitoring period, there were concerns about some methods of conducting follow-up contacts, some of which greatly improved in this monitoring period. In the DQE team's current 100-TS analysis,[94] 70 sampled placements were subject to the requirement for follow-up contacts.[95] The team analyzed the frequency and timing of the required contacts.[96]

Very few contacts were missed altogether. There remained a practice of seeing some patients while they were still in the Health Services Unit and/or just a few minutes after discharge from TS, which cannot be considered a follow-up contact that satisfies Paragraph 84. However, the scale of this issue was greatly reduced, with SBCC having made strong progress and MCI-Shirley appearing to have eliminated the practice. The sampled therapeutic supervisions, then, show a systemwide compliance rate of 87%. This is a significant improvement from the first monitoring period's compliance rate of 68%.

In interviews, 27 patients, drawn from eight institutions, commented on therapeutic supervision follow-up. All but one affirmed that it took place after their discharges, although their estimates ranged from one to three contacts; a significant minority described being seen more often than the requirement.

The DQE team has also had concerns about contacts conducted in nonconfidential settings and how that may affect the truthfulness of patients' reports about their adjustment. In the current sample, 49% of follow-up contacts took place at the cellfront, at officers' desks in housing units, in dayrooms, or in the recreation yard. This is a decline from the DQE's previous assessment, when 40% of contacts occurred in non-

[94] Please see Paragraph 50 for a description of the overall study and its methodology

[95] For the remaining 30 placements, before a third follow-up was due, the patients were readmitted to therapeutic supervision, transferred to an outside hospital, or released from custody.

[96] A contact was counted if it was completed or if 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.

confidential settings. The majority of non-confidential contacts were recorded as being at the patient's request, or the patient was described as "agreeable" to this arrangement. While protecting confidentiality is not expressly named in this requirement, it is a common expectation throughout the Agreement and supports good suicide prevention practice. The DQE encourages MDOC to work toward greater confidentiality for these contacts.

Among those placements where a post-discharge treatment plan review would be required,[97] a timely review and update was clear in only seven cases (10%), and it was not clearly documented whether an "upper-level provider" was involved. In 29 more cases (41%), the MHP checked a box indicating that the review occurred and that no update was needed. At best, then, the sample showed 51% compliance with this requirement. While some treatment plan reviews were present in some of the remaining records, they were dated from two to 11 weeks after discharge from TS.

Overall, the DQE team found that MHP follow-up contacts are being completed consistently across MDOC, with Shirley and SBCC improving since the first monitoring period. Confidentiality of these assessments should be prioritized in the next reporting period. Much more is required to reach substantial compliance with post-discharge treatment plan reviews and updates, which are currently completed infrequently and without any evidence of upper-level provider involvement.

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 drew on its review of 100 therapeutic supervision placements. The DQE reviewed the course of care and determined that psychiatric contact was clinically indicated in 81 of the placements for reasons such as:

- A high-risk event occurred while the patient was on TS, such as ingestion of a foreign body
- Medication noncompliance was noted by the MHP

[97] 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 within seven days, the number of sampled records relevant to this requirement was 71.

- Misuse of prescribed medications or illicit substances led to the TS placement
- The patient presented with new-onset signs of a serious mental illness
- Lack of diagnostic clarity

Of these 81 cases, a psychiatrist or psychiatric nurse practitioner met with the patient in 59% of those cases. A handful of those contacts were made far later than the patient's need became evident. There was no indication in the medical record of contacts with other types of upper-level providers as defined in the Agreement. During the site visits, the DQE did observe a regional psychologist participating in triage meeting discussions on two occasions, offering feedback about psychological testing she had performed to aid in the team's diagnostic assessment.

Overall, the data show progress when compared with the rate of psychiatric contacts during the prior monitoring period, but more is needed. In this sample, Shirley and OCCC came closest to meeting the requirements of Paragraph 85, but all other institutions had compliance rates very similar to the systemwide rate. During the DQE's site visits, triage meetings at some institutions proactively involved psychiatrists in discussions about TS placements and the progress of patients on TS, while at other institutions it was clear that psychiatrists play a peripheral role in the decision-making process. Given the inexperience of most MHPs, involving upper-level providers in the routine care of prisoners on TS would be prudent.

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

Finding: Substantial compliance

Rationale: In its December 2023 Status Update, MDOC reported that prisoners are assessed by both an MHP and a psychiatrist/ARNP upon return from a psychiatric hospitalization pursuant to G.L.c. 123, Section 18(a). Throughout 2023, the DQE team has observed that MHPs use a form to assess patients returning from Section 18 placements that calls for an express decision about whether to initiate therapeutic

supervision. In the DQE team's study of 100 therapeutic supervisions,[98] 20 people were transferred under Section 18, and 16 of them had returned to MDOC as of the time of the study. In every case, MHPs completed the form and decided whether to readmit the patient to therapeutic supervision, and this occurred on the date of return, as indicated by an Intrasystem Transfer Reception Screening document in the electronic health record.

The DQE team also conducted a study based on the spreadsheet that MDOC maintains to track referrals to a higher level of care. Using a random selection method, the team chose a 20% sample of all 18(a) referrals initiated from July through December 2023.[99] There, too, a form indicated that an MHP had assessed the patient and determined whether they should be placed on therapeutic supervision, and it appears that these forms were also completed promptly.[100]

Taken together, these findings are based on 55% of the patients who transferred to a psychiatric hospital on 18A status and returned to MDOC during the monitoring period. As performance was equally effective in the first monitoring period, MDOC has demonstrated sustained, strong practice on this requirement throughout 2023, warranting a substantial compliance finding.

As noted in the First DQE Report, MDOC and Wellpath's policies do not appear to require consideration of TS placement upon return from 18(a) hospitalizations. A policy revision is recommended to clarify this requirement. The DQE team will take this revision into account when assessing MDOC's compliance with Paragraphs 26-27 rather than counting it toward compliance with Paragraph 86.

SUPERVISION FOR PRISONERS IN MENTAL HEALTH CRISIS

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

Finding: Partial compliance

[98] Please see Paragraph 50 for a description of the study and its overall methodology

[99] The log provided in January 2024 shows 44 referrals from July through December 2023 (45 less one duplicate entry). The reviewer selected every fifth case for a total of 9 referrals, 8 of whom had returned to MDOC at the time of the review. None of the selected cases appeared in the 100-stay study.

[100] In 6 of the 8 cases, the form was labeled with the same date as the Intrasystem Transfer Reception Screening document. In the remaining 2 cases, there was no screening document in the electronic health record, but the 18A return form was dated a few days preceding the 30th day after the patient had transferred out, which is a typical timeframe for patients on 18A status to return to MDOC.

Rationale: MDOC's policy 650.08.B addresses Therapeutic Supervision and is currently being revised in accordance with the Agreement. Wellpath's policy 66.00, Therapeutic Supervision, has not yet been revised. Once the policies have been finalized and approved by the DQE and DOJ, a substantial compliance finding is expected.

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: No significant changes have occurred in this area since the DQE's first report. It is well established practice for MHPs to determine the level of observation as a key part of daily updates to therapeutic supervision conditions. The DQE team observed MHPs considering those conditions as part of the first patient contact of the day and discussing potential changes during Triage Meetings. Notes about the patient's level of observation were recorded in the Triage Meeting minutes, the patient's progress notes, and the Therapeutic Supervision Reports. As required by Paragraph 88, patients who are on 1:1 observation are assessed by an MHP every day, including Sundays and holidays, and those who are on close observation are assessed Monday through Saturday.

During the first monitoring period, the DQE's study of TS placements found that daily Therapeutic Supervision Reports were completed in 87% of cases, and in most of the remaining cases, information about the patient's level of observation could be found in progress notes. Findings from the DQE team's most recent study of 100 TS placements were similar, with 86% of charts containing daily Therapeutic Supervision Reports between Monday and Saturday. In the cases where a patient was on 1:1 observation on a Sunday or holiday, 68% of expected Therapeutic Supervision Reports were completed. However, when the DQE team reviewed the electronic health record for the cases with missing paperwork, there were clear reasons in all but one case why the TS Report had not been completed.[101] Thus, it appears that MDOC's practice related to the requirements of Paragraph 88 remains strong.

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

[101] In four cases, the patient was at an outside hospital on Sunday. In one case, there was no clear explanation for why the Sunday progress notes and Therapeutic Supervision Reports were missing.

Finding: Partial compliance

Rationale: As noted in Paragraph 51, Wellpath's policy 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….." The draft revision of MDOC's policy, 103 DOC 650.08, Emergency Mental Health Services, adds language to further clarify this prohibition. After two monitoring periods and a review of over 200 TS placements, the DQE team has yet to encounter a case where TS was used as punishment.[102] Thus, finalizing the language in policy 103 DOC 650.08 will likely result in a substantial compliance finding for Paragraph 89.

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: No significant change has occurred in this area since the DQE's first report, when it was recommended that MDOC revise its policy to clarify the notification process to all disciplines (security, medical, and mental health) and for all types of self-injury. In its December 2023 Status Report, MDOC stated:

> In regard to provisions #90-92, the draft 103 DOC 501 policy Institution Security Procedures is currently under review and will be submitted once complete. It has been discussed regularly in monthly QIC meetings, as well as during the quarterly implementation meetings, to ensure staff are submitting incident reports any time an incarcerated individual engages in self-directed violence.

During the DQE team's review of Incident Reports related to SDV, it appeared that most officers respond to self-injury by giving a direct order to stop the behavior. If the prisoner does not comply, the shift commander is notified, and a decision is made about whether to use force. It appeared that, in all but two cases of self-injury requiring the use of force between July and December 2023, security personnel handled the matter using metal restraints and/or OC spray. In two cases, both at OCCC involving the same patient, mental health restraints and intramuscular medications were ordered by a physician to control the self-injury. This pattern of handling self-injury as a security matter rather than a mental health issue is somewhat concerning to the DQE, but further study of

[102] See Paragraph 51 for further discussion of this issue.

MDOC's practice, as well as its proposed policy revisions, is needed before drawing firm conclusions.

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: There have been no significant changes in this area since the DQE's first report. MDOC stated that it is currently revising its policy 103 DOC 501, Institution Security Procedures, which aims to clarify the notification procedures upon discovery of self-injury. In the meantime, the DQE team interviewed correctional officers and supervisors at eight institutions about current notification practices. Most officers could not recall being involved in an incident of SDV that occurred while a prisoner was on TS since the Agreement began, with several noting that such SDV was more common in the past. Generally, officers understood their obligation to notify a shift commander immediately about SDV upon discovery. Fewer interviewees mentioned immediate notification of medical or mental health staff, saying that this generally occurs after security personnel have secured the scene and stopped the prisoner's self-injury. In interviews of prisoners, only two prisoners recalled instances where an officer ignored or encouraged self-injury, and it was not clear whether these episodes occurred before or after the Agreement's signing.

Going forward, the DQE team will work with MDOC on a strategy for demonstrating compliance with Paragraph 91's requirements. Policy revision is certainly a step in the right direction. 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 relying on staff's documentation and/or interviews. MDOC's recent roll-out of body-worn cameras for correctional officers may facilitate detection of inappropriate staff behavior in this area.[103]

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

[103] See discussion of Paragraph 93, where one such allegation is already being investigated.

Rationale: When an incident of self-injury occurs, MDOC's expectation is that all involved staff with write an Incident Report in IMS, and mental health and medical staff will write a progress note in the health record as clinically indicated. Thus, it appears that the basic structures are in place to obtain compliance with this Paragraph 92. However, as noted in Paragraph 109, the DQE's assessment and MDOC's QIC meeting minutes both indicate that staff members are not completing all Incident Reports that are required by policy. MDOC reported that it is developing a strategy to encourage timely and thorough completion of these documents. It is also revising policy 103 DOC 501, Institution Security Procedures, to clarify the requirement for all staff to document self-injury.

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."

MDOC provided the following update in its December 2023 Status Report:

> The Agreement Coordinator currently has a tracking process for all staff misconduct that is reported. During the last site visits, it was identified that confidential incident reports have not been forwarded for tracking purposes. The Agreement Coordinator is currently working on a process to ensure access to confidential incident reports identifying staff misconduct. Once this tracking process is effectively in place, data around outcomes of the investigations will be provided to the DQE team.

MDOC's Agreement Coordinator shared a redacted version of the Professional Conduct Log with the DQE team. It indicates that two incidents of staff misconduct were investigated. In the first incident at Concord, the alleged conduct involved an officer making inappropriate comments to a prisoner during a strip search. The outcome of this investigation is "TBD." In the second incident, an officer at MTC was allegedly

observed on body-worn camera footage to make demeaning comments to a prisoner that encouraged self-injury. This officer was placed on "No Inmate Contact" status.

Overall, it appears that MDOC has developed a process for investigating complaints about professional misconduct, and it is in the early stages of demonstrating that process to the DQE. In the meantime, the DQE team continued to hear reports during site visits of unprofessional conduct related to prisoners with mental health concerns, though not always specifically related to TS placements. The allegations involved officers threatening prisoners who engage in self-harm with violence, encouraging self-harm, using derogatory language to describe individuals with mental health conditions, falling asleep while assigned to "eyeball" watches, and ignoring requests for mental health help.

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 annual in-service training includes a two-hour "Suicide Prevention & Intervention" training by Wellpath, as well as a two-hour "Therapeutic Supervision" training by the institutional training officer. MDOC submitted revised TS training materials to the DQE in September 2023, which were returned to MDOC with suggested edits in January 2024. These training materials will be finalized soon and will be incorporated into pre-service and annual in-service training. In the meantime, MDOC provided training logs demonstrating that 3,180 staff members are scheduled for Therapeutic Supervision training in TY2024, with 628 having completed it by November 30, 2023.

During site visits, the DQE team observed officer work areas in Health Services Units and Behavior Assessment Units and interviewed officers and supervisors in those units in seven institutions concerning the availability and visibility of therapeutic supervision policies. It appeared that the policy was not posted, and 19 interviewed staff confirmed that, saying it is standard practice to use a searchable database of policies. All expressed

ease with doing so, and several noted that no policies are posted because they could be viewed by prisoners, who should not have access. Staff at Concord, MASAC, and Norfolk said there also were hard copies of policies in a binder or folder in an established location.

MDOC submitted a draft of the TS poster that will be posted in housing units to the DQE in September 2023. Once this poster has been finalized and posted, and MDOC finalizes its revised TS training materials, the DQE anticipates a substantial compliance finding with Paragraph 94.

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: The DQE team continued to observe the sight lines for Health Services Unit and Behavior Assessment Unit cells used for therapeutic supervision at each relevant institution. Officers showed the team the types of chairs they employ when monitoring prisoners on TS, demonstrated where those chairs are placed, and described how they maintain visual contact with the prisoners, especially where cells have angles or door designs that hinder views of the entire cell at once. The DQE team tested the seating arrangements and visibility in some locations.

Officers continued to describe maintaining an uninterrupted view as their primary duty when assigned to constant observation. The DQE team asked prisoners about officers' conduct during constant observation. Among the eight prisoners who said they had been subject to this level of therapeutic supervision in 2023, they almost universally said that officers remained continuously in the post and did not engage in distractions such as phone or computer use or going to another part of the unit.[104] More prisoners thought that officers did not maintain constant observation because they fell asleep, however. Half of the group said this did not happen in their experience, while others estimated that occurred once, twice, or occasionally.

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

[104] One prisoner asserted that the officers were hardly ever in a position to watch.

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 when prisoners are on TS. The team reviewed forms for 30 placements drawn from all institutions that conducted therapeutic supervision.

Sampled forms recorded contacts every 15 minutes,[105] or missed a contact only very rarely, in just over half of the placements. MDOC leaders have been working to have staff adopt 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 prisoner planning to self-injure. It was evident in this sample that the practice is growing, to MDOC's credit.

In the other half of the reviewed forms, there were gaps in recorded contacts from one to three hours and a few that lasted much longer than that. This may reflect either that checks are not taking place as they should, or potentially issues during gathering and transmitting the documents. Some methods of recording continued to raise possible accuracy concerns. For example, on a few watch logs, times were pre-filled, or 15-minute checks attributed to several officers were all written in the same handwriting, both of which suggest that the log had not been completed in real time.[106] As other examples, multiple officers submitted forms for the same time period, and some sets contained the same, minimal entry for more than 12 hours, sometimes repeatedly during the therapeutic supervision.

The DQE team observed some improvement in the content of officers' entries on the watch logs. More than a third stood out as capturing the kind of detail that suggests close attention to signs of life and safety.

While some of the content and the practice of staggering contacts are promising signs, those model practices remain in the minority of records reviewed. On balance, extended gaps in recording, questions of accuracy, and the limited content on the majority of forms raise concerns about whether the practice of checking for signs of life in at least 15-minute intervals is happening reliably.

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

[106] At MTC, officers reported another practice involving one officer serving as the "scribe" for all 15-minute checks during the shift, regardless of which officer completed them. This may also explain why checks attributed to several officers were written in the same handwriting.

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 site visits, the DQE team observed the door construction for therapeutic supervision cells and whether it hinders or could ease transmission of contraband that could be used for self-harm. MDOC continues to modify cells, with several facilities having added door sweeps since the previous monitoring period.

Among 17 settings that house prisoners on therapeutic supervision, about half had door sweeps or other features to reduce passing contraband to the relevant cells. In some of the other settings, improvements were present on some cells, and facility leadership stated that they are planned for the other cells. At MASAC, MTC, and Shirley, it did not appear that efforts to address the gaps at the bottom of the therapeutic supervision doors had begun.

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: Noncompliance

Rationale: As of December 20, 2023, the due date for this provision, no Support Persons were working in any MDOC facilities. Wellpath advertised the positions in early December and began interviewing candidates shortly thereafter. By the time of the DQE team's site visit to MTC on January 11, 2024, MDOC reported that a full-time support person had been hired for that facility and was scheduled to begin training at the end of January. Thus, although MDOC did not meet the deadline specified in the Agreement for hiring Support Persons, it is on its way to implementing Support Persons in its facilities where TS occurs.

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: Noncompliance

Rationale: The DQE understands December 20, 2023, to be the deadline for Support Persons to be functioning in MDOC facilities as outlined in Paragraphs 99-104. As noted in Paragraph 98, MDOC is a couple of months behind the Agreement's time frame for Support Persons. No Support Persons are yet working in any capacity in MDOC, but the DQE team is optimistic that that they will be up and running well before the next DQE report.

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: Noncompliance

Rationale: The DQE understands December 20, 2023, to be the deadline for Support Persons to be operating in MDOC facilities as outlined in Paragraphs 99-104. As noted above, MDOC was in the process of hiring Support Persons during the January 2024 site visits, and it reported in March 2024 that Support Persons had been hired and trained at each required facility. The DQE team has not yet seen any evidence of this training but is optimistic about MDOC's eventual compliance with Paragraph 100.

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: Noncompliance

Rationale: Although MDOC reported in March 2024 that Support Persons have been hired and trained at all relevant facilities, no evidence of their functioning has been provided to the DQE team. It remains to be seen whether they are being overseen by the MHPs and are engaging in clinically appropriate activities for prisoners.

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: Noncompliance

Rationale: MDOC reported in its response to the DQE's draft report that Support Persons have been assigned work schedules, but no additional information about this has been provided to the DQE. Although a noncompliance finding is being issued due to the lack of information, the DQE is optimistic about MDOC's compliance with his provision within the next reporting period.

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: Noncompliance

Rationale: Support Persons just began working within MDOC facilities. The DQE has no information about how they approach the daily shift transition.

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: Noncompliance

Rationale: Support Persons just began working in MDOC facilities. The DQE team is not yet able to assesss their documentation practices.

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: Noncompliance

Rationale: Per MDOC's December 2023 Status Report, policy 103 DOC 562, Code 99 Emergency Response Guidelines, is being revised in accordance with the Agreement. The DQE has not yet been provided with the original policy or any evidence of its revision.

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: Nothing has changed since the DQE's first report. MDOC has not yet shared its Code 99 policy with the DQE, so the team cannot assess whether it is being followed.

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 during the first monitoring period, the DQE team encountered numerous examples of staff using de-escalation techniques to deter self-injury and avoid uses of force. Interviewed correctional officers, especially those posted in the housing units where TS occurs, spoke with ease about the techniques they employed to help prisoners calm down and surrender items used for self-harm. Generally, officers seemed unaware that they may have discretion to deescalate a situation rather than immediately initiate Code 99 procedures. As noted elsewhere, the DQE team has not reviewed MDOC's current Code 99 policy, so the officers may accurately be reporting current policy and practice.

In the DQE team's interviews, mental health staff members stated that they rarely witness inappropriate behavior by correctional officers, noting that many officers are very good at deescalating situations. Interviewed prisoners mostly stated that they had not engaged in self-injury in recent memory, though two recalled instances where an officer had encouraged them to self-injure or did not attempt to remove an item they were using to self-harm while on TS. A third recalled overhearing officers speaking in a derogatory manner while observing a prisoner engage in self-injury in an adjacent TS cell. Data from MDOC indicates that at least one investigation is being conducted of an officer allegedly heard on body-worn camera footage saying to a prisoner, "You are not even cutting right."

Overall, it appeared that many officers are facile with de-escalation techniques, though there may be some confusion about the circumstances in which they can employ those techniques prior to (or in lieu of) Code 99 procedures. 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 July and December 2023, all 254 incidents of SDV listed on the SDV Registry were accompanied by a completed SIBOR.[107]

The DQE team reviewed 50 cases for SIBOR completion within 24 hours of the SDV incidents. Cases were chosen in proportion to the percentage of SDV incidents that occurred at each facility between July and December 2023. *Table 1* illustrates the results.

Table 1. SDV Incidents with Timely SIBORs

	% of Total SDV	# of cases audited	SIBORs completed on day of SDV or following day	% completed on time
Concord	7	3	3	100
Framingham	27	14	14	100
Gardner	2	1	1	100
MASAC	4	2	1	50
MTC	3	2	2	100
Norfolk	2	1	1	100
OCCC	26	13	7	54
SBCC	24	12	10	83
Shirley	5	2	1	50
TOTAL	**100**	**50**	**40**	**80**

Overall, 80% of SIBORs were completed within 24 hours of the event, which is improved from 72% in the First DQE Report. Framingham showed excellent practice in timely completion of SIBORs, with OCCC having more difficulty. Of the 10 cases where a SIBOR was not completed within 24 hours, the delays ranged from 1 day to 8 days. MDOC reported that this generally occurs when a prisoner is at an outside hospital and unable to give input necessary to complete the SIBOR within 24 hours.

[107] The completed suicide at Norfolk on November 17, 2023, was not included in the SDV log and had no accompanying SIBOR, which MDOC stated is consistent with their practice for deaths.

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 completion of Incident Reports related to SDV that occurs while a prisoner is on TS remains a work in progress. The DQE reviewed all Incident Reports provided by MDOC, which were written by security, mental health, and medical staff. When present, the reports contain a reasonably detailed description of the patient's self-injurious behavior. Approximately 76% of SDV incidents listed in the SDV log had an accompanying Incident Report, which is slightly improved from 69% in the first monitoring period. However, some of the Incident Reports were not completed by the staff member witnessing the SDV; they were written by those who responded to a Code 99 or provided follow-up medical care, so actual compliance with the requirements of Paragraph 108 is lower than the findings contained in *Table 2.*

Table 2. SDV Incidents with Completed Incident Reports

	# of SDV incidents on TS	# of SDV incidents w/ accompanying IRs[108]	% of expected Incident Reports
Jul-23	18	14	77.8
Aug-23	28	18	64.3
Sep-23	4	3	75.0
Oct-23	32	27	84.4
Nov-23	25	18	72.0
Dec-23	34	27	79.4
TOTAL	**141**	**107**	**75.9**

MDOC's December 2023 Status Report indicates that they have been tracking the completion of Incident Reports related to SDV, and their audit results indicate a need for significant improvement:

> Incident report submissions across disciplines have been audited monthly and are submitted approximately 30% of the time across disciplines. It is the expectation that incident reports are submitted by each discipline for each SDV incident, when that discipline is made aware of the SDV. Discussions continue to happen

[108] 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.

with site administration around ensuring all disciplines are submitting incident reports in regard to SDV incidents.

Given MDOC's active engagement with this issue, the DQE team is optimistic about the capacity for improvement 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: In the DQE team's study of 100 TS placements first described in relation to Paragraph 50, 18 cases involved SDV that occurred while a prisoner was on TS. This assessment indicated that patients were routinely evaluated by an MHP within 24 hours of SDV because of the staff's practice of seeing patients on TS three times daily. In only one case did an MHP complete a formal treatment plan update after the SDV episode, but in a few others, it was apparent from the progress notes that the MHP had adjusted treatment going forward by increasing the level of supervision (constant rather than close), consulting psychiatry, or removing clothing or other property used in the SDV incident. Overall, it appeared that MDOC consistently meets the requirement to assess prisoners within 24 hours of SDV, but modification of the treatment plans occurs in a minority of cases.[109]

Related to this provision, the DQE remains concerned that SDV is routinely treated as a security matter, whether it occurs while on TS or not. Only two of the 254 SDV incidents that occurred between July and December 2023 resulted in an order for mental health restraints. Security restraints and OC spray were much more commonly used in response to individuals engaging in SDV, without any indication that mental health restraints were considered. As noted in the DQE's first report, this practice appears inconsistent with MDOC's own policies, as well as published guidelines by the National Commission on Correctional Health Care and American Psychiatric Association. The DQE continues to recommend that MDOC's Quality Improvement Committee conduct a review of restraint practices and guidelines.

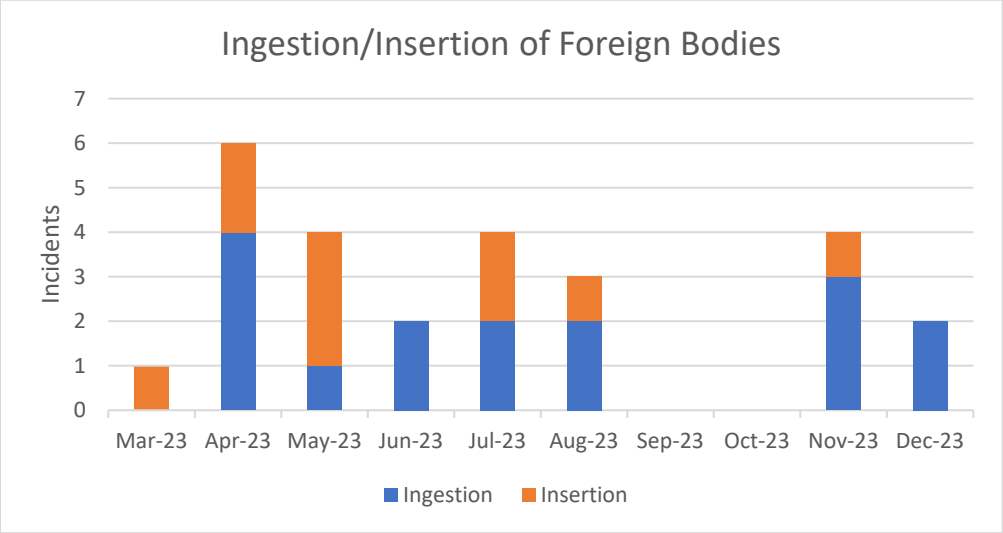
111. If necessary, follow the procedures laid out in its ingestion of foreign body policy enumerated in Paragraph 112.

[109] The DQE recognizes that not every incident of SDV requires modification of a patient's treatment. The expectation is that clinicians document their formulation of the SDV event and consideration of any necessary treatment plan modifications going forward.

Finding: Noncompliance

Rationale: This requirement is rated noncompliant because the DQE team has not been provided with the original or revised version of MDOC's foreign body policy to review. Thus, it is impossible to determine whether MDOC is following its policy. In the meantime, the DQE team reviewed data from the monthly Quality Assurance reports that indicate the number of foreign body ingestion and insertion incidents per month *(Figure 5)*.

Figure 5. Foreign Body Ingestion and Insertion



Such incidents are rare enough that it is difficult to discern trends in the short time the DQE team has been reviewing MDOC's data.

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: Noncompliance

Rationale: MDOC's policy on foreign body ingestions is contained within policy 103 DOC 501, Institution Security Procedures. This policy has not yet been provided to the DQE; MDOC reported that it is currently being revised. Because the DQE team has not

seen the original policy or any evidence of its revision, a noncompliance finding is being issued, but we are optimistic that MDOC will complete this task in the next reporting period.

Of note, Attachment #14 to MDOC's policy 103 DOC 650, Therapeutic Supervision Procedures, also contains language around foreign body ingestion. MDOC has begun the process of revising that policy overall, but the proposed changes to Attachment 14 have been minimal (only changing "inmate" to "incarcerated individual"). As written, the policy does not clearly outline notification, search, or monitoring procedures as required by Paragraph 112. It will likely require revision along with policy 103 DOC 501.

INTENSIVE STABILIZATION UNIT

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

Finding: Noncompliance

Rationale: No policies related to the ISU have yet been shared with the DQE team. From discussions with MDOC leadership, it appears that these policies are actively being developed but have not yet been finalized. For example, on the first day of the OCCC site visit in January 2024, an ISU planning meeting involving MDOC, Wellpath, and OCCC leadership occurred. A draft staffing plan for the ISU was being discussed between MDOC and Wellpath leadership around the same time. Thus, although MDOC is not compliant with Paragraph 113's required timeline for drafting ISU policies, the DQE team is confident that it will complete this task relatively soon.

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

Finding: Compliance not yet due

Rationale: The ISU is not required to operate until June 20, 2024. During the January 2024 site visit, it was clear that MDOC has made progress in renovating the housing unit where the ISU will reside. The unit will contain 15 suicide-resistant cells, a few overflow cells, two group treatment rooms, staff offices, a day room, a therapeutic de-escalation room, and an outdoor recreation area. OCCC leadership reported that they are on track for a June 2024 opening.

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

Finding: Compliance not yet due

Rationale: This provision is not required until June 20, 2024.

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.

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

118. ISU Selection: Prisoners who are assessed by MDOC's contracted healthcare provider as dysregulated and/or decompensated for whom multiple interventions have been ineffective will be referred by the contracted healthcare provider for transfer to the ISU. Duration of symptoms, utilization of Mental Health Watch and implementation of behavior management plans must be considered prior to referral. In discussion with the ISU Director, the referring treatment team will identify the goals for ISU placement and any treatment resistance or barriers thus far.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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.

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

122. Out of Cell Time: The ISU will permit out of cell time and opportunities for congregate activities, commensurate with the clinical stability and phase progression of the prisoner, with the intention of reinforcing symptom and behavioral stability. Following the discontinuation of a

Mental Health Watch in the ISU, ISU participants will have the following privileges/restrictions/clinical contacts:

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024. When the DQE team toured the planned ISU space, indoor and outdoor recreation areas were included.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024. When the DQE team toured the planned ISU space, it appeared that the unit would be self-contained, with no routine need for off-unit movements.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024.

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

Finding: Compliance not yet due

Rationale: This provision is not due until June 20, 2024. When the DQE team visited the planned ISU space in January 2024, the area had enough room to create a therapeutic de-escalation area.

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

Rationale: Not much has changed in this area since the First DQE Report. MDOC continues to utilize behavior plans with a small number of patients, mostly those in RTU and Secure Treatment Unit settings. When copies of recent behavior plans were requested during the DQE team's site visits, the same examples from the first reporting period were provided, dated 2019 to 2023. During chart reviews, the DQE team found two additional examples of behavior plans from August and September 2023 at Concord. All of the behavior 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 addition, the plans were poorly integrated into the overall treatment plan. For example, a behavior plan from November 2022 at Old Colony was mentioned once in a note in December 2022, but by January 2023, it had disappeared from the treatment plan without explanation.

Wellpath reported that it is working on revising its behavior plan template and plans to retrain its staff once that task is complete. Wellpath leadership reported that a psychologist with experience in this area was hired in January 2024, so she will be involved in revising the template. As noted in the DQE's first report, including a psychologist in the ISU's treatment team will also be crucial, given that many individuals

with personality disorders and patterns of repeated self-injury will likely be treated in that environment.

QUALITY ASSURANCE

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

Finding: Partial compliance

Rationale: MDOC's policy 103 DOC 650.20, Records and Continuous Quality Improvement, requires the contracted healthcare provider to engage in continuous quality improvement (CQI) activities. Wellpath's policy 6.00, Continuous Quality Improvement Program, outlines a structure for CQI that includes holding quarterly CQI meetings, monitoring performance related to established standards, and creating performance improvement plans when indicated. Thus, it appears that the basic structure for a quality assurance program between MDOC and Wellpath is in place.

The DQE requested minutes from Wellpath's CQI meetings, but these were not provided because they are "a patient safety work product." Without any evidence of the CQI program's operations, the DQE cannot assess whether the program is adequately addressing the concerns about healthcare quality discussed in this report.

In the absence of comprehensive information about Wellpath's CQI process, the DQE team can only base its findings on data gathered during the site visits. During those visits, it was clear that Wellpath's MHPs are acutely aware of the metrics by which their charts are audited; these metrics seemed to focus on whether a note was completed within specified time frames (e.g., notes every 30 days for patients who are designated MH2, a first follow-up not within 24 hours of discharge from TS). Accordingly, clinicians engaged in a routine practice of documenting "proxy PCC contacts," which involved documenting a crisis assessment or other brief contact as a monthly therapeutic contact, even if not conducted confidentially or by the patient's actual clinician. Another workaround that the DQE team occasionally encountered involved writing a TS follow-up note just minutes after the patient was officially removed from TS, while they were

still housed in the HSU.[110] These practices are clearly done in the service of paperwork rather than patient care.

In order to move from partial to substantial compliance, the DQE will need to see evidence that Welllpath is actively trying to address the problems with healthcare quality identified in this report, including the cursory nature of mental health evaluations and risk assessment, lack of individualized treatment planning, and poor continuity of care, among others.

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

Finding: Partial compliance

Rationale: Some quality assurance policies are included in the draft revisions of policies 103 DOC 601 and 103 DOC 650 that were submitted to the DQE for review in September 2023. Section 650.20 addresses the contracted mental health provider's obligation to engage in continuous quality improvement; this language was not revised and appears consistent with the Agreement. In policy 601.05, a new section was added that describes the structure and function of MDOC's Quality Improvement Committee. In addition to specifying the committee's membership, the policy states that the QIC shall:

- review and analyze data related to the supervision and care of incarcerated individuals experiencing mental health crisis;
- identify trends that indicate the need for further investigation and/or intervention;
- make recommendations for corrective actions;
- make recommendations for policy and procedure change as indicated; and
- monitor implementation of approved recommendations, corrective actions, and policies and procedures

The new language mirrors the Agreement fully and appears to meet the requirements of Paragraph 138.

[110] See discussion in Paragraph 84, which indicates that this practice is less prevalent than in the first monitoring period but still occurs at SBCC.

Two quality improvement areas remain to be addressed in MDOC's policies: the Morbidity/Mortality Review process and the SIB Review Committee. Currently, MDOC has policies in place to conduct reviews after deaths or serious suicide attempts, but they do not appear to follow the NCCHC's template of Clinical Review, Psychological Autopsy, and Administrative Review, as required by Paragraph 146. From the DQE's review, policies 103 DOC 601 and 103 DOC 622, Death Procedures, will both need further revision to be consistent with the Agreement. Policies related to the SIB Review Committee were not found in 103 DOC 601. It is possible that the policies exist in materials not provided to the DQE, or it is possible that they have yet to be drafted.

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.

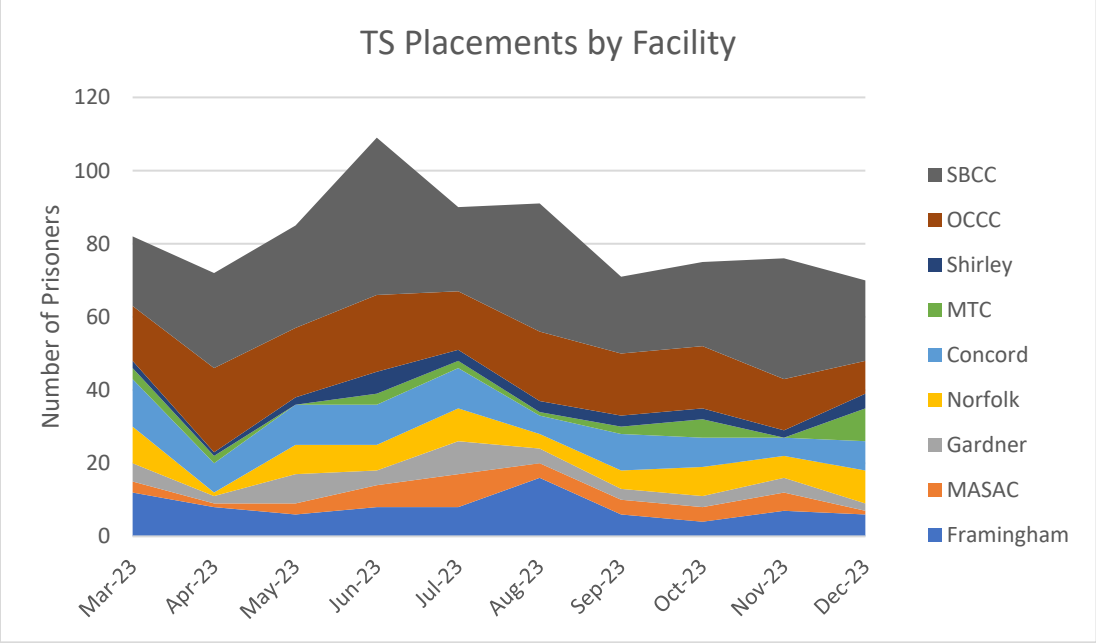
Finding: Substantial compliance

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:

Number of TS Placements and Length of Stay

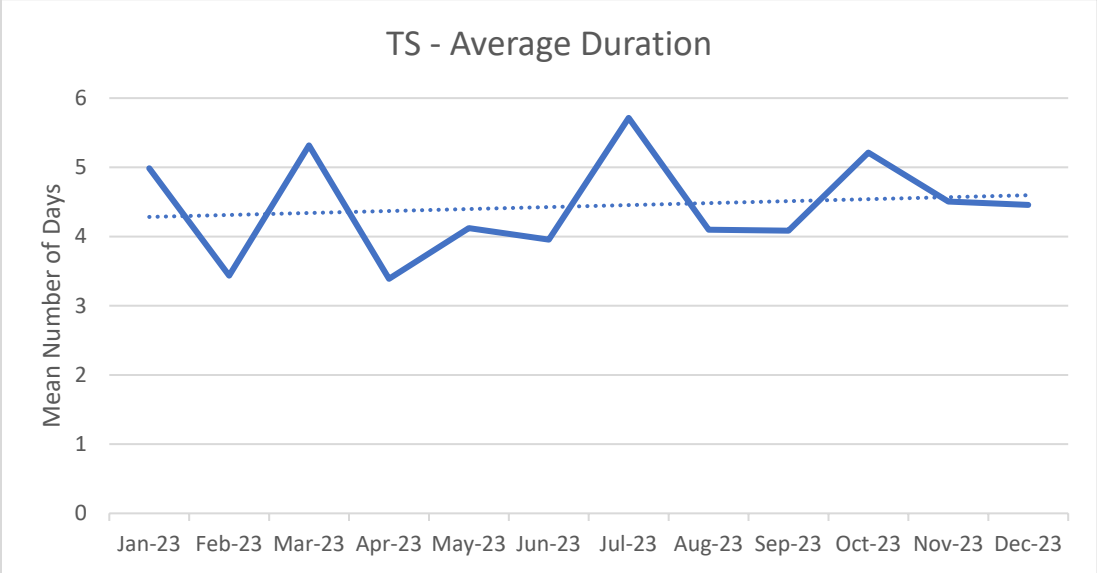
Between July and December 2023, there were 475 total TS placements across MDOC. *Figure 5* illustrates that the majority of TS placements continue to occur at OCCC and SBCC. SBCC's TS placements peaked June 2023, which may have been related to major discord in the SAU when prisoners were initially transferred from Cedar Junction. TS placements at OCCC and SBCC declined in the second half of 2023. TS placements at all other facilities remained relatively stable.

Figure 5. TS Placements by Facility



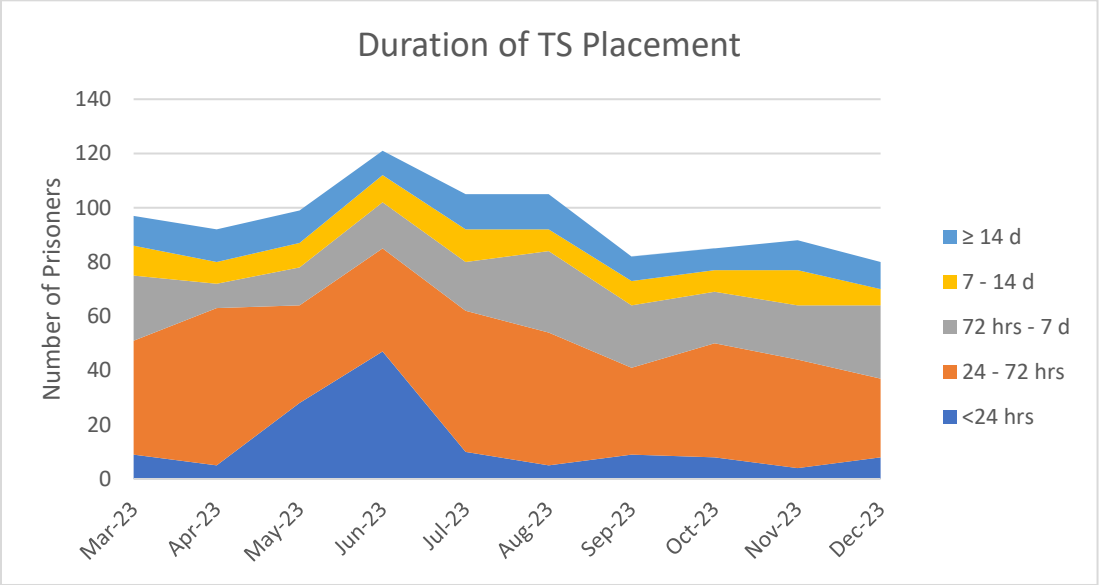
Between July and December 2023, the mean length of stay on TS was 4.7 days, with a median of 2 days and range of 0-144 days. The mean length of stay for TS increased from 4.2 in days in the first half of 2023. Overall, the trend was slightly upward in 2023, as illustrated in *Figure 6.*

Figure 6. TS Average Duration



When examining the duration of TS placements, MDOC divides them into five cohorts: <24 hours, 24-72 hours, 72 hours to 7 days, 7 to 14 days, and greater than 14 days. As *Figure 7* illustrates, most TS placements are relatively brief, lasting less than 72 hours. After a spike of very brief placements – under 24 hours – in June 2023, these placements returned to baseline. The temporary increase appears to have stemmed from the same incident in the SAU at SBCC noted above.

Figure 7. Duration of TS Placement



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 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 4* highlights these results.

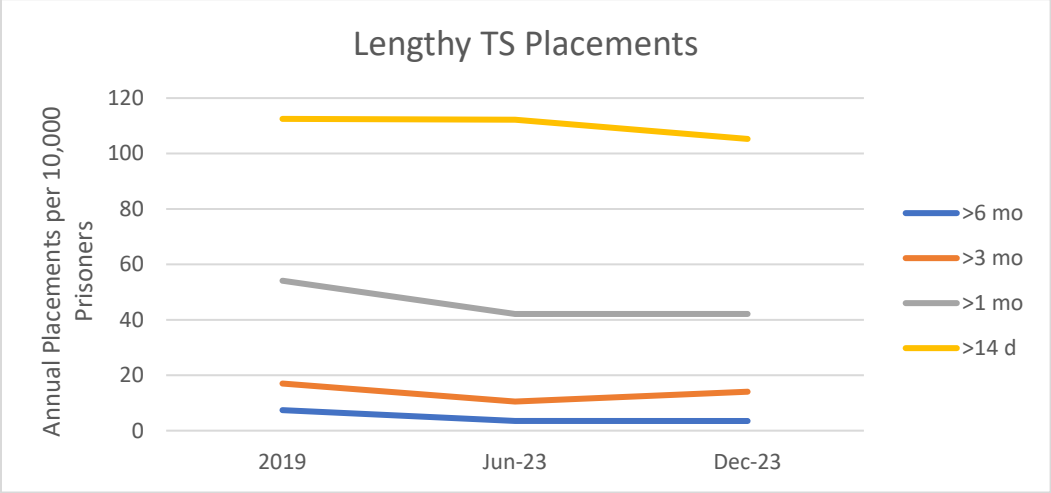
Table 4. Lengthy TS Placements, 2019 vs. July-December 2023

	2019		**Dec 2023**		
TS duration	Total placements in 13 months	Annual placements per 10,000 prisoners[111]	July-Dec 2023	Annual placements per 10,000 prisoners[112]	**% Change since 2019**
>6 mo	7	7.4	1	1	**-52.5%**
>3 mo	16	17.0	4	14.0	**-17.4%**
>1 mo	51	54.1	12	42.1	**-22.1%**
≥ 14 days	106	112.5	30	105.2	**-6.4%**

[111] Calculated based on 8,700 total prisoners, as noted in the DOJ Findings Letter.
[112] Calculated based on approximately 5,700 total prisoners in MDOC in June and December 2023

The numbers from July to December 2023 are essentially stable when compared with the first half of 2023, as illustrated in *Figure 8.*

Figure 8. Lengthy TS Placements



The prisoners with the longest lengths of stay on TS during this reporting period, 90-237 days, are well known to the DQE team by this point. All are individuals with significant personality disorders who have been referred by MDOC to a state hospital within the past year, only to be returned after a short time with a report saying that they do not need a hospital level of care. Three of the individuals have had long-standing disputes with security personnel related to their housing placement or other aspects of classification. The mental health staff is caught in the middle, dutifully conducing three clinical contact per day with the individual while waiting for the security matters to move forward. For reasons unclear to the DQE, this process can take months. It remains to be seen whether the ISU's opening will provide an alternative for patients like this.

Finally, the DQE examined the location where TS placements occur within each facility. Between July and December 2023, approximately 74% of TS placements occurred in the Health Services Unit, as noted in *Table 5*. This represents a slight increase from the first half of 2023. Although most prisoners interviewed by the DQE team reported that they preferred the HSU over other TS options, Framingham was an exception. At that facility, prisoners and staff noted that the HSU can be noisy due to prisoners with medical or alcohol/drug detox needs, offers less space for therapeutic programming, and is farther away from the mental health staff offices, all of which make it less desirable than its previous location.[113]

[113] Some prisoners were under the impression that Framingham leadership moved the location of TS to the HSU at the DOJ/DQE's direction, which was not the DQE's intention. The DQE team recommended not housing the BAU

Table 5. 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[114], Shirley, OCCC	352	73.9%
Behavior Assessment Unit	SBCC, Norfolk, MTC, Shirley, OCCC	74	15.5%
Secure Treatment Unit	SBCC	19	4.0%
Residential Treatment Unit	SBCC	2	0.4%
Housing Unit	MASAC	27	5.7%
TOTAL		**476**	**100%**

Self-Injurious Behavior

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

Use of Force

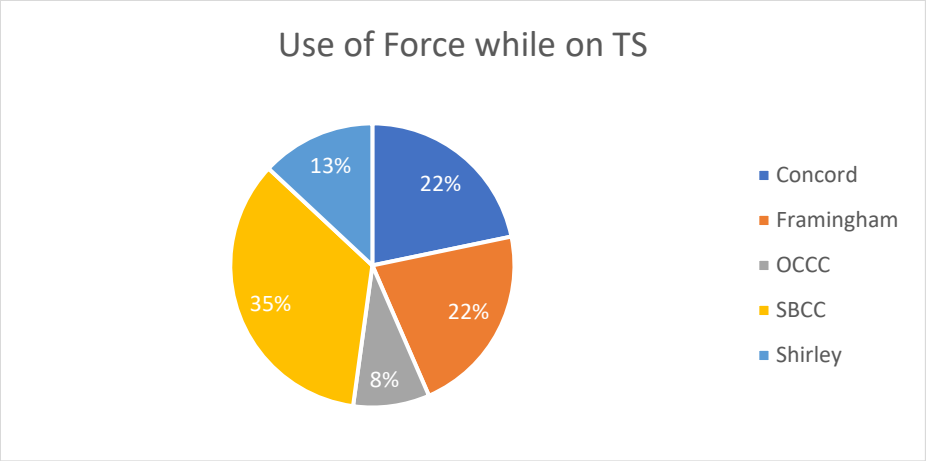
In accordance with Paragraph 139.a.iii.7, MDOC reports data on uses of force that occur while a prisoner is on TS. MDOC's data indicate that force was used 23 times with prisoners on TS between July and December 2023. As noted in the DQE's first report, these data do not include incidents where force was used to gain the prisoner's compliance during the incident precipitating the TS placement.

As illustrated in *Figure 9*, uses of force on TS occurred at five institutions between July and December 2023. The largest number of such incidents occurred at SBCC, followed by OCCC and Concord.

Figure 9. Use of Force While on TS

and TS placements in the same place to minimize the chance of prisoners conflating TS placement (for a therapeutic purpose) with disciplinary measures. The DQE remains open to alternative strategies that would enhance the therapeutic mission of TS, whether or not it occurs in the HSU.

[114] MDOC's TS Registry lists only one location per TS placement. At OCCC, prisoners are sometimes moved from HSU to BAU due to space concerns for a portion of their TS placement, which would not be captured in these data.



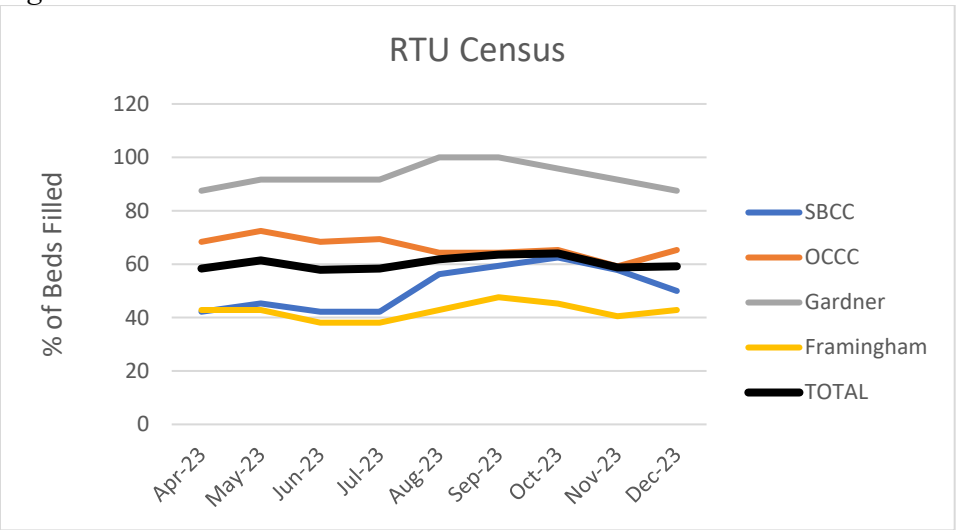
Psychiatric Hospitalizations

MDOC's records indicate that 44 patients were transferred to psychiatric hospitals under Section 18(a) between July and December 2023. Seven additional patients were transferred to BSH under Section 18(a1/2), and three under Section 15(b).

RTU Census

MDOC continues to operate a total of 228 RTU beds across four units: 42 at Framingham, 24 at Gardner, 98 at OCCC, and 64 at SBCC. *Figure 10* illustrates that, in any given month, approximately 60% of these beds were filled. Fill rates were lowest at Framingham and SBCC. It is not clear why so many RTU beds are empty. MDOC's log of referrals to higher levels of care indicates that all RTU referrals during the reporting period were approved.

Figure 10. RTU Census



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 between July and December 2023 was 6 prisoners, the same as in the first half of the year. As noted in the First DQE Report, it appears that these beds are being severely under-utilized, but one must also consider that admissions to Bridgewater are under the purview of the courts, not MDOC.

Mental Health Staffing

This issue is discussed in detail in relation to Paragraph 35.

140. Other Mental Health Watch Data Subject to Review by the DQE
a. During any site visits conducted by the DQE, the DQE may conduct reviews of inmates' medical and mental health records, as requested in advance, supplemented with interviews of prisoners, to gather information on the following topics:
1. Clinical contacts on Mental Health Watch
i. visits between prisoner and Qualified Mental Health Professional that occurred out of cell per day,
ii. time spent by prisoner with Qualified Mental Health Professional per day,
2. Property and Privileges approved while on Mental Health Watch
i. clothing,
ii. media unrelated to mental health,
iii. exercise and recreation,
iv. other out of cell activities.

Finding: Substantial compliance

Rationale: 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. MDOC has remained 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: Substantial compliance

Rationale: MDOC began its monthly Quality Improvement Committee (QIC) in March 2023, and the committee continued to meet throughout this reporting period. Meeting minutes have been provided to the DOJ and DQE monthly. Minutes indicate that MDOC and Wellpath leadership attend the QIC meeting and collaborate in making recommendations for improvement. Action items, person(s) responsible, and deadlines are tracked in the minutes. Overall, the meetings appear to meet the requirements delineated in Paragraph 141a-e.

Between July and December 2023, MDOC began tracking a few new data points:

- "Tool" used for SDV while on TS (e.g., razor, clothing, fingernails, head-banging)
- Confidential incident reports related to staff conduct during TS monitoring
- % completion of incident reports for SDV by staff cohort (security, medical, and mental health)
- 18(a1/2) petitions that are denied, not just those that are granted

The areas identified for improvement and/or further investigation in March to June 2023 were mostly completed by December 2023, including:

- Clarifying the definitions of different types of SDV so that data is tracked consistently across facilities → completed
- Studying the type of instrument used when a prisoner cuts themselves to assess whether contraband items or materials from from the cell are being used → completed
- Tracking not just the RTU/STU census, but also their total capacity, to get a better sense of fill rates and/or wait lists → ongoing
- Improving the process of notifying the DQE and DOJ about serious suicide attempts → revised process developed

- Developing a process to audit officers' use of cell safety checklists and offering of out-of-cell activities to prisoners on TS → security leadership are now auditing the cell checklists and TS watch logs, with an ongoing initiative to improve staggering of 15-minute observations
- Training officers to complete incident reports in all cases of SDV, as some were found to be missing → Tracking was implemented, re-training may not have occurred yet
- Reviewing MDOC's annual in-service training in light of the Agreement, ensuring that all requirements are covered → completed, submitted to DQE for review

Between July and December 2023, the QIC noted several new or ongoing trends related to therapeutic supervision:

- Most SDV incidents on TS are occurring by scratching and head-banging rather than through use of razors or other contraband items, indicating an improvement in security searches prior to TS placement
- Most SDV incidents occur within the first 24 hours on TS (based on a Nov 2023 review of 33 incidents), indicating the highest risk/acuity is in the initial phase of TS
- There was an increase in TS placements at SBCC and Concord related to the SAU units (July-Aug 2023)
- A large number of short TS placements (< 24 hrs) at SBCC are due to "security-related issues"
- Completion of Incident Reports related to SDV remains poor across all disciplines (medical, security, mental health)
- RTU beds at Framingham are unfilled at greater rates than at other facilities

Overall, the DQE remains pleased with the operations of MDOC's QIC meeting. Occasionally, some topics of discussion or corrective actions seem to disappear from the meeting minutes without follow-up, but these are rare events. Thus, the finding for Paragraph 141 has improved to from partial to substantial compliance during this reporting period.

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 continues to conduct an SDV/SATT Review Committee meeting twice monthly via Teams for two hours. The DQE reviewed minutes of meetings that occurred on July 5 and 19, August 3 and 16, September 6 and 20, October 4 and 18, November 1 and 22, and December 6 and 20, 2023. The SDV/SATT 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. This structure meets 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.

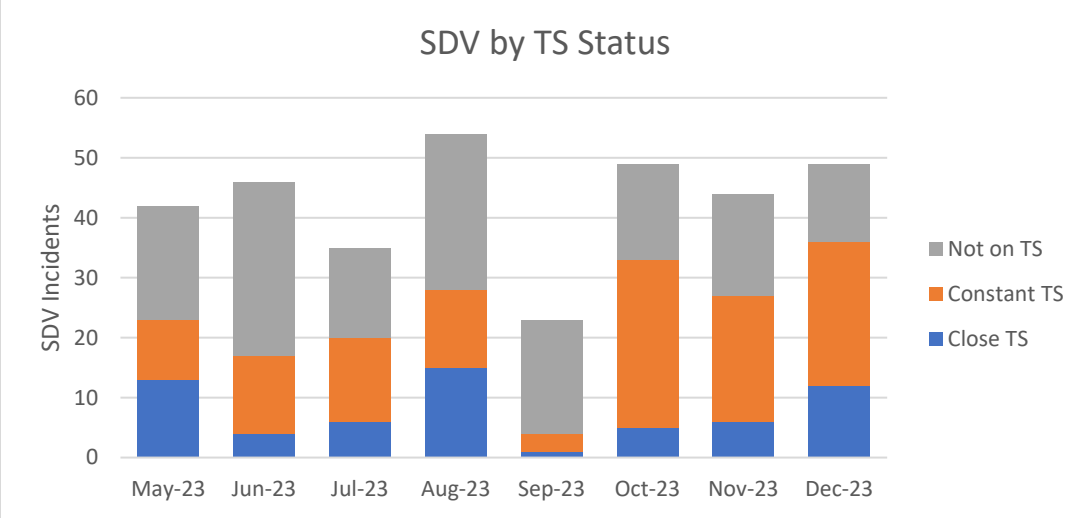
Finding: Partial compliance

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. Based on the meeting minutes, MDOC does pay attention to breaches in protocol that could have contributed to the SDV, such as prisoners having access to dangerous items while on TS and mental health staff not being notified immediately of SDV. When such problems are identified, someone from the SDV Committee follows up with the facility regarding a corrective action.

The First DQE Report noted that MDOC is technically not compliant with Paragraph 143 because the SDV/SATT committee does not systematically review the SDV data from the monthly Quality Assurance reports. In its December 2023 Status Report, MDOC wrote, "Monthly, time is set aside during the SDV meeting to review and discuss the QIC's data regarding SIB. These reviews are included in the meeting minutes." The DQE found a notation in minutes from the meeting on October 4, 2023, that SDV data would be reviewed on the first Wednesday of every month for analysis and discussion. However, there is no mention in any subsequent minutes of such a discussion occurring until January 3, 2024. If MDOC can more consistently demonstrate that SDV data is reviewed in the SDV/SATT meeting, a substantial compliance finding for Paragraph 143 is likely.

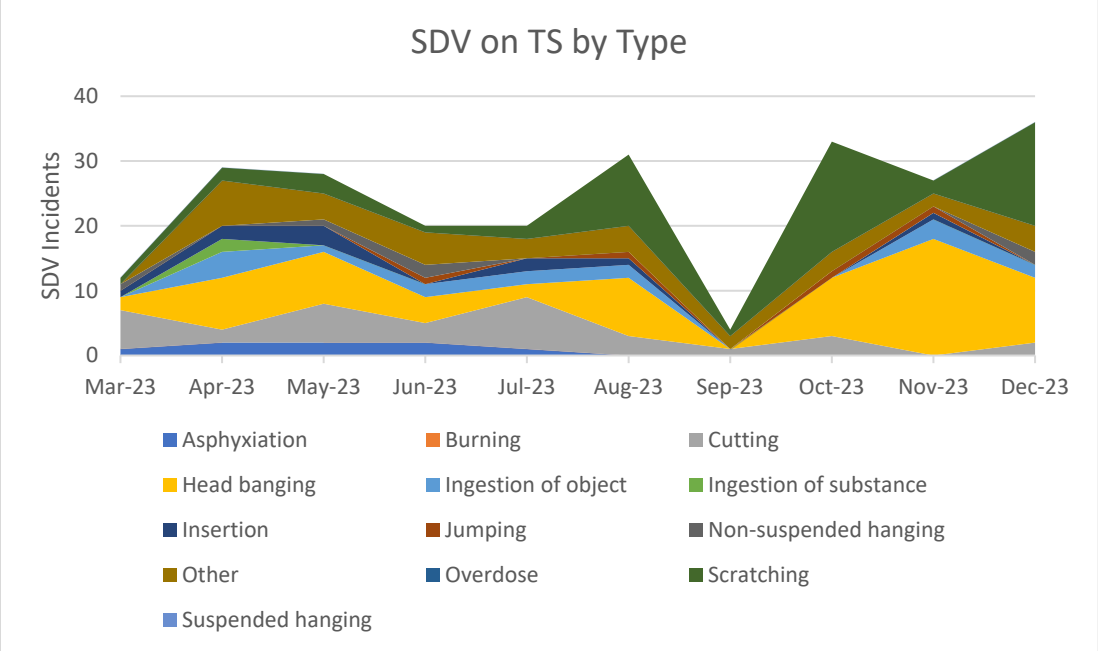
Figure 11 shows that, between July and December 2023, 151 of the 254 SDV incidents occurred while a prisoner was on TS (55.5%). Most of the SDV incidents that occurred while a prisoner was on TS occurred under constant supervision rather than under close supervision.

Figure 11. SDV by TS Status



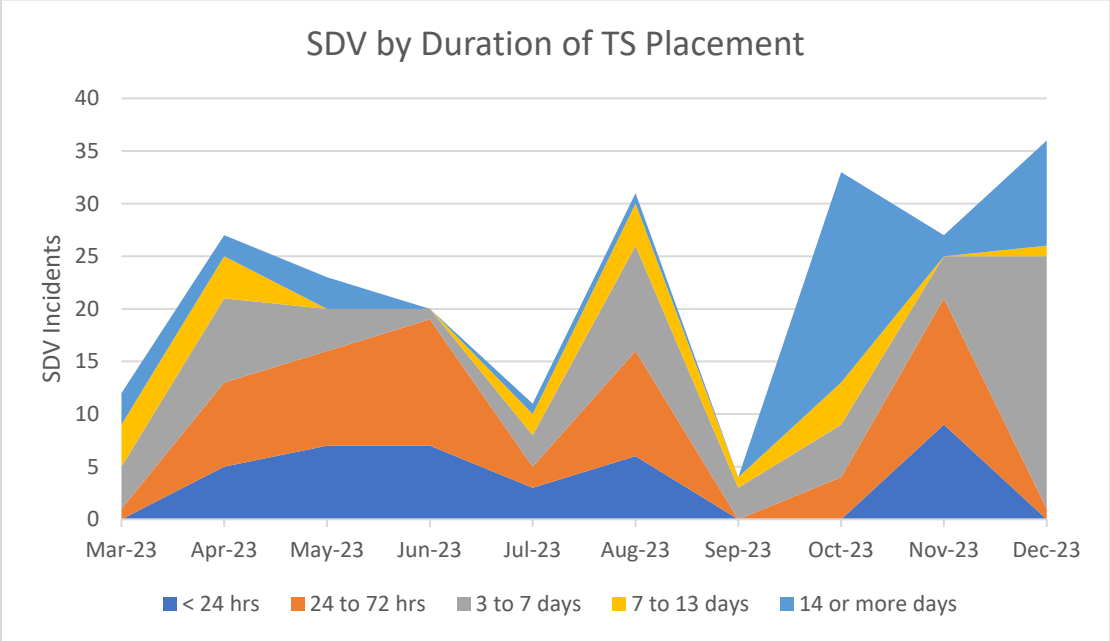
When MDOC reviewed these incidents in detail, much of the increase the self-injury between October and December 2023 was related to one individual who repeatedly engaged in head-banging and scratching, as illustrated in *Figure 12*.

Figure 12.. Type of SDV while on TS



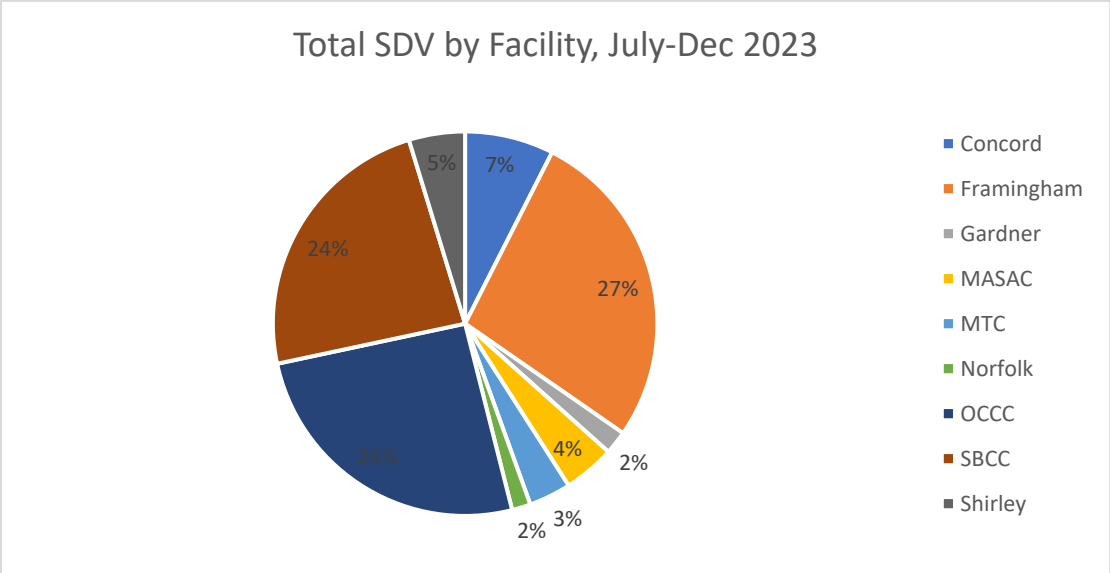
Self-injury occurred during TS placements of varying durations, and there were significant month-to-month fluctuations, as illustrated in *Figure 13*. It is difficult to say what these numbers mean, so they will continue to be monitored.

Figure 13. SDV by Duration of TS Placement



The total incidents of self-injury (not just those that occurred on TS) were divided across the MDOC facilities as illustrated in *Figure 14*.

Figure 14. SDV Incidents by Facility



As in the First DQE Report, SBCC accounted for about half of MDOC's SDV incidents from July to December 2023. During this reporting period, Framingham's SDV incidents increased substantially; most of these incidents are related to one prisoner.

When compared with the DOJ's findings in 2019, SDV incidents in the latter half of 2023 were 30% lower, and SDV incidents on TS were 28.9% lower. The change is illustrated in *Table 6.* These findings are similar to those reported in the First DQE Report, demonstrating a sustained improvement.

Table 6. SDV Incidents, 2019 vs. July-Dec 2023

	2019		**2023**		
Category	Total SDV incidents in 13 months	Annual SDV incidents per 10,000 prisoners[115]	Total SDV incidents in July-Dec 2023	Annual SDV incidents per 10,000 prisoners[116]	**% Change since 2019**
Total SDV	1200	1273.2	254	891.2	**-30.0%**
SDV on TS	688	730	148	519.3	**-28.9%**

144. The minutes of these reviews will be provided to all treating staff and senior MDOC staff. MDOC will take action to correct any systemic problems identified during these reviews.

Finding: Partial compliance

Rationale: In its December 2023 Status Report, MDOC reported that it now facilitates site meetings to address issues that have been identified during the bi-monthly SDV/SATT meetings. The DQE reviewed minutes from some of these site meetings, which were led by the MDOC Mental Health Regional Administrator and included the facility's security and health services leadership. No front-line staff were present (correctional officers or MHPs). The meetings seem to have begun in April 2023, and they continued into this reporting period. Eight such meetings involving facilities where TS occurs have been held, and they were intended to follow up on episodes of self-injury that may have involved a breach of standard protocol:

[115] Calculated based on 8,700 total prisoners, as noted in the DOJ Findings Letter.
[116] Calculated based on approximately 5,700 total prisoners in MDOC in July-December 2023

- April 12, 2023, at MTC: A prisoner on 15-minute TS observation engaged in SDV using a razor blade hidden in his mouth. The facility responded by "remind[ing]" staff of proper search protocols for those being placed on TS.
- July 10, 2023, and July 17, 2023, at MCI Concord: A prisoner on TS engaged in SDV using paint chips. The facility considered sandblasting the cells but ultimately painted over the peeling paint because concerns about asbestos.
- September 18, 2023, at MCI Framingham: A prisoner engaged in SDV while on TS using an unauthorized plastic fork. Staff were reeducated about replacing plastic utensils with edible utensils for individuals on TS.
- September 28, 2023, at MCI Concord: A prisoner engaged in SDV because he felt he was denied a shower in the BAU. In another incident, a prisoner engaged in SDV with a piece of metal. The facility clarified shower schedule with the BAU captain and confirmed that showers are offered five days per week. It also confirmed that BOSS chair was being used to search all prisoners suspected of concealing an item.
- November 28, 2023, at MCI Shirley: A prisoner in the HSU engaged in SDV using metal screws. The facility considered how the prisoner would have had access to screws, determining that they came from his locker. The facility is considering the use of soft lockers.
- December 4, 2023, at SBCC: Two incidents of SDV while on TS were reviewed. One involved a prisoner swallowing a screw, and no corrective action was identified. The other involved a prisoner engaging in SDV with staples and "pieces of noose." The facility determined that the prisoner had been searched appropriately and that the items were too small to have been detected.
- December 28, 2023, at OCCC: A prisoner engaged in SDV using plexiglass while on 15-minute TS observation. No corrective action was identified after determining that the object was too small to have been detected during a pat search and there had been no indication to initiate a foreign body watch.

This practice of conducting follow-up meetings about SDV with the facilities and identifying corrective actions is a positive step toward compliance with Paragraph 144. However, the provision requires that the SDV/SATT meeting minutes be shared with "all treating staff," which does not appear to be happening. During the DQE's site visits, none of the mental health providers interviewed could recall seeing any follow-up materials related to the SDV/SATT meetings, and the facility-based follow-up meetings to do not including treating staff other than the Mental Health Director. MDOC can achieve full compliance with Paragraph 144 by ensuring that findings from the SDV/SATT meeting are shared with all treating staff.

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: Two serious suicide attempts and one completed suicide occurred during this reporting period. The first serious attempt occurred on August 2, 2023, and the morbidity review meeting was conducted on August 29, 2023. For the completed suicide on November 17, 2023, a mortality review was held on December 15, 2023. On March 14, 2024, the DQE team was provided with a letter containing the recommendations emerging from that review, but no details about the case itself. A second serious suicide attempt occurred on December 28, 2023. On March 14, 2024, MDOC reported completion of a morbidity review on February 2, 2024, providing a brief letter with the single recommendation stemming from the review, not any details about the case itself.

Without further information about the incidents on November 17 and December 28, 2023, the DQE team cannot assess the adequacy of MDOC's morbidity-mortality review process. The DQE team's concerns about the review process utilized for the incident that occurred on August 2, 2023, are detailed in Paragraph 146. Overall, the finding for Paragraph 145 is partial compliance.

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: As noted in the First DQE Report, MDOC has a process in place to review completed suicides and serious suicide attempts, though this process does not meet all the requirements of Paragraph 146. In MDOC's relevant policies (DOC 601.05.3 and DOC 622.9), the committee is called "Quality Assurance Suicide Review Committee," which is an offshoot of the "Quality Assurance Mortality Review Committee," a group tasked with reviewing all deaths that occur within MDOC facilities or within 72 hours of being transferred to an outside hospital.

The Suicide Review Committee is led by the Assistant Deputy Commissioner of Clinical Services, and its required members include:

1. Medical Regional Administrator and Mental Health Regional Administrator of the institution involved
2. Senior Medical Consultant and Senior Mental Health Consultant
3. Superintendent of institution (or designee) where death occurred

This membership appears to meet the requirements of Paragraph 146. As noted in the first DQE report, in practice, attendance at morbidity/mortality meetings is robust, consisting of many levels of MDOC and Wellpath leadership and relevant staff from the involved facility, such as the mental health director and health services administrator.

MDOC's process for reviewing suicides is not yet consistent with the technical details of the Agreement. Based on the DQE's review of the serious suicide attempt that occurred

on August 2, 2023, MDOC produces three documents related to its morbidity/mortality reviews:

1. A memo written by the Regional Mental Health Administrator in advance of the morbidity/mortality review meeting. This contains a description of the SDV event, prisoner's functioning around this time, recent stressors, SDV history, mental health history, protective factors, and current status (e.g., deceased, hospitalized, recovered);
2. An attendance log for the morbidity/mortality review meeting; and
3. A brief memo written by the Regional Mental Health Administrator after the morbidity/mortality review meeting that summarizes the committee's recommendations for systemic changes.

To the DQE's knowledge, no changes have been made to MDOC's morbidity/mortality review policies or procedures since the Agreement's effective date. In order to be substantially compliant with Paragraph 146, MDOC must improve its current review procedure by:

1. Ensuring that all three parts of the NCCHC's schema for death review are completed within 30 days of the sentinel event: Administrative Review, Clinical Review, and Psychological Autopsy. A description of these documents can be reviewed at the NCCHC website.
2. Completing a written corrective action plan, with a timetable and persons responsible for carrying it out.
3. Completing a final mortality review report within 60 days of the sentinel event (typically this is done after the review meeting).
4. Providing documentation to the DQE that the committee's recommendations have been shared with the facility's staff.
5. Providing documentation to the DQE of the log kept by MDOC consistent with Paragraph 146.a.5.

147. Reportable incidents: Within 24 hours, MDOC will notify the United States and the DQE of suicides and all serious suicide attempts (i.e., suicide attempts requiring medical hospital admission). The notification will include the following information:
a. Incident report, name, housing unit location, brief summary or description, mental health classification, security classification, date of birth, date of incarceration, and date of incident.

Finding: Partial compliance

Rationale: As noted above, three reportable incidents occurred between July and December 2023. The DQE was notified within 24 hours in two of the three cases, leading to an overall finding of partial compliance with the Paragraph 147 requirements.

Date of incident	Date of DQE/DOJ notification	Days to notification
August 2, 2023	August 3, 2023	1
November 17, 2023	November 18, 2023	1
December 28, 2023	January 5, 2024	8

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: Partial compliance

Rationale: MDOC submitted Status Reports to the DQE and DOJ on September 3, 2023, and December 20, 2023. The first report was submitted past the deadline of June 20, 2023, and the second report was timely. The first Status Report was brief, responding in bullet points to the recommendations made in the Baseline DQE Report rather than providing updates on each substantive provision in the Agreement. The second report was more substantial, delineating the DQE's most recent compliance finding and MDOC's action steps taken for each substantive provision of the Agreement. The report did not, however, provide many details to substantiate MDOC's reports of progress. Information required by Paragraph 159 is still missing from MDOC's Status Reports, including responsible persons for each provision, due dates, current status, description of where pertinent information is located, DQE recommendations, and date completed.

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: After the first Agreement Coordinator left her position, MDOC refilled the position on September 11, 2023. The Agreement Coordinator's formal title is Clinical Operations Analyst, and she has been doing an outstanding job coordinating site visits, providing timely reports and documentation to the DQE team, and responding to requests for additional data. At some point, the DQE team would like to discuss the feasibility of MDOC's Agreement Coordinator performing some audits internally that the DQE team has been conducting, in an effort to develop self-auditing practices that will be sustained long after the Agreement's formal termination.

170. Within six months of the Effective Date, MDOC will conduct regular quarterly meetings with prison staff to gather feedback from staff on events, accomplishments, and setbacks regarding implementation of this Agreement during the previous quarter.

Finding: Partial compliance

Rationale: MDOC reported in its December 2023 Status Report that quarterly DOJ Implementation meetings were held in June, September, and December 2023. MDOC provided minutes from meetings on June 26 and September 25, 2023, for the DQE for review; it is not clear why the December meeting was not included in the materials. Attendance at the meetings included MDOC Health Services Division leadership, as well as the Superintendent from each facility involved in the Agreement and Deputy Superintendents of Reentry from most of these facilities. No Wellpath staff were present. Topics discussed include:

- Difficulty getting all officers to conduct staggered 15-minute checks on TS, identifying strategies to clarify policies and procedures
- How to initiate TS during hours when Mental Health is not on site
- How to ensure thorough completion of TS packets by officers and whether they need to be reviewed at Care & Coordination meetings

This is a very solid start toward compliance with Paragraph 170. With evidence of sustained practice, MDOC will likely achieve substantial compliance.

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. Continue submitting revisions of DOC policies to the DQE and DOJ. Begin revising Wellpath's policies in accordance with the Agreement.

2. Continue drafting policies for the ISU so that they can be reviewed by the DQE and DOJ and do not inadvertently contribute to a delayed opening of the unit.

3. Provide the Code 99 and Foreign Body Ingestion policies to the DQE so that we understand current practice and can assess Paragraphs 106 and 112.

STAFFING PLAN

4. Continue all efforts to improve mental health and security staffing levels. Explore whether the strategies that Wellpath utilized to improve staffing levels in 2023 can be applied to MDOC's security staff recruitment efforts.
5. Continue recruiting and onboarding Support Persons across facilities where TS occurs. Relatedly, MDOC will need to assess whether there are currently enough mental health staff to supervise the Support Persons.

6. Submit a staffing plan for the ISU as soon as possible. The DQE continues to recommend that the plan include a psychologist with expertise in implementing behavioral management plans.

TRAINING

7. Develop a strategy for the training divisions of MDOC and Wellpath to demonstrate that staff have completed trainings required under the Agreement:
    - Pre-service and annual in-service training on policy updates – all security and mental health staff (Paragraph 40)
    - 8 hours of pre-service training on Suicide Prevention – all security and mental health staff (Paragraph 42c)
    - 2 hours of annual in-service training on Suicide Prevention – security staff who work in Intake, Mental Health, and Restrictive Housing units (Paragraph 42c)

- CPR certification – all security staff (Paragraph 42d)

8. Continue with plans to distribute Therapeutic Supervision posters to sites and post them in areas where TS occurs.

9. Continue efforts to train Wellpath's clinicians, particularly those who have recently completed a degree program and are not yet independently licensed, on diagnosis, treatment planning, risk assessment, and documentation. All these areas are in need of improvement based on the DQE's observation of practice and review of medical charts. Such instruction can be included in annual in-service training, but it may also be suited to more frequent, small group discussions and demonstrations.

10. When revising pre-service and annual in-service training, enhance content 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. Individualized decisions about whether to restrain a prisoner during crisis evaluations and during out-of-cell contacts on TS
    c. Lighting protocols for prisoners on close and constant watch in TS cells
    d. Clothing being removed only if used for self-harm
    e. The importance of facilitating confidential, out-of-cell mental health assessments

THERAPEUTIC RESPONSE TO PRISONERS IN MENTAL HEALTH CRISIS

1. Minimize practices that deter prisoners from requesting crisis mental health services, including routine shackling during mental health assessments and conducting assessments in areas without adequate sight/sound confidentiality. Staff at SBCC, MTC, OCCC, and Gardner all identified challenges in conducting confidential assessments and treatment during this reporting period.

2. Record clinicians' response times to crisis calls more consistently.

3. Provide contemporaneous access to the electronic health record to MHPs when conducting crisis assessments and TS therapeutic contacts. Ensure that MHPs are reviewing historical risk factors for suicide, clinical symptoms, and medication compliance in the electronic health record when conducting crisis assessments and creating TS treatment plans,

4. 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.

5. Note the length of contact for crisis assessments that result in TS placement, as the current Crisis Treatment Plan template does not record this information.

6. Ensure that clinicians are making appropriate referrals to psychiatry at the time of a prisoner's crisis assessment or while on therapeutic supervision. If clinicians consistently struggle to recognize clinical circumstances warranting such referrals, MDOC can consider implementing more structured protocols, such as requiring referrals after an individual engages in SDV, after a use of force, on Day 3 of TS placement if not seen earlier, or before discharge to high-risk settings like the BAU.

7. Integrate upper-level providers (psychiatry and psychology) more meaningfully into the treatment of patients on TS, including seeing patients sooner in the TS placement, helping to develop treatment plans, and assessing patients prior to discharge.

8. Clarify the protocols for after-hours crisis assessments with nursing and mental health staff, as nurses are not consistently consulting with on-call MHPs when conducting BAU risk assessments.

9. Improve coordination of healthcare by 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.

10. Continue making necessary physical plant modifications and policy changes to dim the lights in TS cells during sleeping hours.

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

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

13. Consider revising the Mental Health Watch Discontinuation Form to capture elements monitored under the Agreement, including the duration of contact, location of contact, and consultation with upper-level providers. Further emphasis on individualized discharge plans that are connected to the patient's risk factors is also needed.

SUPERVISION OF PRISONERS IN MENTAL HEALTH CRISIS

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

15. Conduct individualized assessments of prisoners' risk with clothing and remove clothing only in cases where a prisoner has demonstrated that they will use clothing in a self-destructive manner.

16. Continue revising policy and practice so that individualized assessments of prisoners' need to be restrained when leaving their TS cells are conducted.

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

18. Develop a strategy to demonstrate compliance with the requirement that staff notify mental health immediately upon discovering self-injury.

19. Develop a strategy to demonstrate that investigations of alleged staff misconduct related to the Agreement occur, as well as the outcomes of these investigations.

20. 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

21. Continue with Wellpath's plan to involve a psychologist in revising its behavior plan template and in creating patient-specific behavior plans going forward.

22. Continue with plans to re-train Wellpath clinicians on behavior planning once the template has been revised.

QUALITY ASSURANCE

23. Provide information about Wellpath's CQI process to the DQE that demonstrates its efforts to address problems with the quality of mental healthcare identified throughout this report.

24. Revise policy and procures so that morbidity/mortality review paperwork is completed within 30 days in the format required by Paragraph 146, including a clinical mortality/morbidity review, administrative review, and psychological autopsy.

CONCLUSION AND NEXT STEPS

MDOC's cooperation with the DQE remains exemplary, and the system has made incremental progress with Agreement compliance during the past six months. Currently, the greatest challenges lie with staffing (both security and mental health), the quality of mental health assessment and treatment planning, and the coordination of security and mental health functions. These are significant hurdles to overcome, but the DQE remains optimistic that MDOC will eventually achieve compliance with the Agreement.

For the next six-month monitoring period, the DQE team has identified a few key priorities:

Improvements in Patient Care

- Opening the Intensive Stabilization Unit at OCCC in June 2024
- Implementing the role of Support Persons for individuals on Therapeutic Supervision
- Conducting an analysis of security staff recruitment practices similar to that done by Wellpath for mental health staff in 2023
- Ensuring that mental health assessments and treatment occur in settings with adequate confidentiality
- Integrating psychiatry and psychology more fully into the treatment of patients in crisis, including in clarifying diagnoses, assessing and managing risk, and planning short- and long-term treatment

Technical Compliance with the Agreement

- Reviewing and finalizing policies related to the Agreement
- Enhancing the semi-annual Status Reports to include all the elements required by Paragraph 159

The DQE team anticipates resuming site visits of MDOC facilities in April 2024. SBCC will be a focus because of its significant difficulty providing mental healthcare in accordance with the Agreement. The ISU at OCCC is scheduled to open in June 2024, and a site visit is planned for July 2024 to see the initial stages of implementation.