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MASSACHUSETTS DEPARTMENT OF CORRECTION

BASELINE REPORT

REENA KAPOOR, MD

DESIGNATED QUALIFIED EXPERT

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BACKGROUND

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

In a CRIPA notice 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").

The parties appointed me for a four-year term as the Designated Qualified Expert (DQE) responsible for assessing MDOC's compliance with the Agreement. I asked three team members to assist me with this endeavor:

1. **Scott Semple:** Mr. Semple is the former Commissioner of the Connecticut Department of Correction, with over 30 years' experience as a corrections officer, administrator, and consultant. His role is to assess the security aspects of the Agreement and advise me about MDOC's compliance.

2. **Ginny Morrison:** Ms. Morrison is an attorney with over 30 years' experience investigating and monitoring correctional systems, including consent decrees and settlement agreements related to mental healthcare. Ms. Morrison's role is to conduct site visits, interview staff and incarcerated individuals, review policies and medical charts, analyze data, and assist me with drafting the compliance reports.

3. **Julie Wright, PsyD:** Dr. Wright is a psychologist with 15 years' experience as a clinician and supervisor of correctional mental health services in Connecticut, including crisis response, inpatient psychiatric treatment, and behavioral management plans. Her role is to conduct site visits, review medical records and policies, analyze data, and advise me about clinical aspects of the Agreement.

Paragraph 160 of the Agreement states that the DQE's initial task is to conduct a baseline site visit within 60 days of the Effective Date. Accordingly, the DQE team conducted a site visit of Old Colony Correctional Center (OCCC) in Bridgewater, MA, on February 6 and 7, 2023. A team from DOJ was present and operated independently of the DQE team. The DQE team chose OCCC as the site of the baseline visit because of its focus on mental health treatment and its relatively high proportion of MDOC's prisoners who experience mental health crises.

During the site visit, MDOC reported that it has made many changes to its mental healthcare policies and practices since the DOJ's investigation in 2019. Its most significant efforts have been aimed at transforming Mental Health Watch into Therapeutic Supervision (TS) and initiating a new set of policies about the care of prisoners in crisis, including:

- At least three out-of-cell contacts with mental health professionals per day while on TS, Monday through Saturday, at least one of which is conducted by the prisoner's primary care clinician (PCC)
- Crisis treatment plans for all prisoners upon entry to, and discharge from, TS
- Multidisciplinary discussions of prisoners on TS, including mental health Regional Administrators as needed
- Individualized assessments of property and clothing allowances while on TS, including access to radios and tablets when clinically appropriate
- Provision of edible utensils to all prisoners on TS
- Individualized assessments of access to outdoor exercise, showers, phone calls, and visits while on TS, resulting in increased access
- Notification of higher-level MDOC administrators when certain length-of-stay thresholds are reached on TS, including notification of the Director of Behavioral Health at 72 hours, the Assistant Deputy Commissioner at 7 days, and the Deputy Commissioner at 14 days, with the intention of considering whether a higher level of care is needed
- Increased frequency of follow-up assessments by mental health staff after discharge from TS, including within 24 hours of discharge, 3 days post-discharge, and 10 days post-discharge[2]
- Training for staff at all sites that maintain prisoners on TS
- Twice-monthly Self-Directed Violence (SDV)/Suicide Attempt Review Committee meetings to review all incidents of self-injury and suicide attempts
- Removal of all razors from medium- and maximum-security facilities
- Tracking of TS data across MDOC, including length of stay, daily census, and self-injurious behavior incidents

These policy changes represent substantial progress since the DOJ's findings letter. They demonstrate MDOC's commitment to improving their mental health services and meeting the needs of prisoners in crisis, and they provide a strong foundation upon which the DQE team begins its monitoring.

PURPOSE OF REPORT

This report is issued in compliance with paragraph 161 of the Agreement, which requires the DQE to give preliminary observations and recommendations in a Baseline Report within 90 days of the Agreement's Effective Date. The Agreement specifies that a draft of the report is due to the parties 31 days in advance of the final report deadline. Because the Agreement was finalized

[2] Paragraph 84 of the Agreement states, "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." MDOC interprets this to mean that the third follow-up visit occurs "7 days after the 3-day follow-up visit," or 10 days after discharge from TS.

just before the holiday vacation season, the parties and DQE agreed to extend the draft deadline from February 20, 2023, to March 7, 2023. The final report's deadline was also extended to April 7, 2023, to allow the parties sufficient time to comment on the draft report. Both parties submitted comments to the DQE on March 28, 2023, which were taken into consideration when writing the final report.

This Baseline Report is intended to provide initial impressions rather than a detailed report of MDOC's compliance with the Agreement. The report's preliminary conclusions are based on data received by the DQE team prior to the draft report's submission to the parties on March 5, 2023, except where indicated in the text. Subsequent DQE reports will address each substantive provision of the Agreement and provide a detailed rationale for the DQE's conclusions.

ASSESSMENT METHODOLOGY

During the site visit of OCCC on February 6 and 7, 2023, the DQE team conducted the following activities:

Activity	Date	DQE team member(s)
Facility tour	2/6/23	RK, JW, GM
Interview of Residential Treatment Unit (RTU) prisoners recently on TS	2/6/23	RK, JW
Review of medical records	2/6/23	GM
Interview of General Population and Behavioral Assessment Unit (BAU) prisoners recently on TS	2/7/23	RK, SS
Interviews of mental health staff	2/7/23	RK, JW, GM, SS
Interviews of security staff	2/7/23	RK, GM, SS
Observation of Mental Health Professionals (MHPs) responding to crisis calls	2/7/23	JW, RK
Observation of MHPs conducting TS assessments	2/7/23	JW
Observation of mental health staff's daily "triage" meeting	2/7/23	RK, JW, GM, SS
Orientation to documentation and other systems	2/6 and 2/7/23	RK, JW, GM

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, we were permitted to interview prisoners and mental health staff confidentially, without MDOC leadership or legal representatives present. When we interviewed security staff, MDOC's attorneys stayed in the room but did not speak or interfere in any way.

MDOC provided the following documents on February 3, February 14, February 15, February 23, and March 28, 2023, to the DQE and DOJ teams for review:

1. Summary of changes MDOC has made to mental healthcare since DOJ's findings letter, prepared by Mitzi Peterson, dated 1/31/23
2. Monthly "Mental Health Roll Up Report" for January 2023, which contains census data from each facility, including average daily census, average mental health caseload, number of prisoners at each "MH level" (1-5), number of prisoners with prescribed psychotropic medication, number of prisoners with a court-authorized treatment order, percentage of the caseload diagnosed as Seriously Mentally Ill. The "Roll Up Report" also contains information about mental health contacts by facility in January 2023, including initial appraisals, mental health evaluations, discharge plans, psychiatric contacts (including missed appointments and reason), MHP contacts (including missed appointments and reason), group treatment (including missed groups and reason), mental health crisis contacts, TS placements, self-injurious behavior (SIB) incidents, transfers and returns to Bridgewater State Hospital under G.L. c. 123, §18(a), hunger strikes, and Department of Mental Health (DMH) applications upon release.
3. List of all prisoners placed on TS since the Effective Date of the Agreement, 12/20/22, including facility, entry and discharge dates, and duration of TS
4. List of TS cell locations at each MDOC facility
5. MDOC Policies
    a. 103 DOC 650 – Mental Health Services (rev 6/27/22)
    b. 103 DOC 652 – Identification, treatment and correctional management of inmates with gender dysphoria (rev 1/18/22)
    c. 103 DOC 653 – Identification, treatment and correctional management of gender-nonconforming inmates (rev 10/26/22)
    d. 103 CMR 420 – Classification (rev 12/1/17)
6. Wellpath Policies
    a. Wellpath 31.00 – Information on healthcare services (rev 12/29/21)
    b. Wellpath 32.00 – Receiving screening (rev 6/30/21)
    c. Wellpath 33.00 – Transfer screening (rev 4/29/20)
    d. Wellpath 35.00 – Mental health initial appraisal (rev 10/28/20)
    e. Wellpath 35.01 – Comprehensive mental health evaluation (rev 10/28/20)
    f. Wellpath 37.01 – Referral to mental health services (rev 12/29/21)
    g. Wellpath 37.03 – Emergency mental health assessment (rev 6/30/21)
    h. Wellpath 37.04 – Mental health consultations with referrals to psychiatry (rev 6/29/22)
    i. Wellpath 38.00 – Sick call (rev 12/29/21)
    j. Wellpath 39.01 – Mental health restrictive housing assessment (rev 6/24/20)
    k. Wellpath 42.02 – Intrasystem continuity of mental health care (rev 2/23/22)

    l. Wellpath 53.02 – Transfer of patients on therapeutic supervision (rev 11/23/21)
    m. Wellpath 66.00 – Therapeutic supervision (rev 11/23/21)

7. Wellpath Staffing plans
    a. Mental health organizational charts for each MDOC facility
    b. Wellpath mental health staffing matrices:
        i. Dated 12/31/22 *(Wellpath Mental Health Matrix 12.31.2022.xlsx)*
        ii. Dated 1/31/23 *(Wellpath Mental Health Matrix 1.31.2023.xlsx)*
        iii. Dated 2/10/23 *(Wellpath Mental Health Matrix 2.10.2023.xlsx)*
        iv. Revised Wellpath mental health staffing matrix dated 1/31/23 *(MADOC_MH_FTE_01.31.2023.xlsx)*[3]
8. Staff training materials
    a. Agenda for annual training for all Wellpath clinicians on December 5, 6, and 7, 2022
    b. Agenda for Two-Day STU/RTU training on November 8 and 9, 2022 (all security and clinicians in RTU, Behavioral Management Unit (BMU), Secure Treatment Program/Unit (STP/STU), or Intensive Treatment Unit (ITU)
    c. Collaborate Safety Planning slides (undated) for all Wellpath clinicians
    d. MDOC Suicide Prevention & Intervention 2021-2022 slides
    e. MDOC New Employee Orientation slides: Suicide Prevention and Recognizing Mental Illness and Substance Related Disorders (2021)
    f. Therapeutic Supervision slides, Spring 2021
9. Mental Health program descriptions and schedules
    a. Document listing examples of therapeutic programs available for prisoners on Therapeutic Supervision (undated)
    b. Framingham RTU brochure and weekly group schedules for Winter 2022 and Spring 2023
    c. Gardner (NCCI) RTU welcome packet and group schedule for Winter 2023
    d. Old Colony RTU program manual and group schedule for January 16 to March 24, 2023
    e. Souza-Baranowski Correctional Center (SBCC) RTU group summaries and inmate assignments for Cycle 59 (1/30/23)
    f. Cedar Junction BMU orientation manual 2022 and description of groups
    g. STP inmate handbook, group descriptions, and Cycle 56 group schedule
10. Examples of MDOC/Wellpath forms and templates related to TS:
    a. Crisis call progress note
    b. Crisis treatment plan for mental health watch

[3] On March 28, 2023, MDOC provided revised Wellpath staffing data along with its comments on the DQE draft report. While the DQE team generally does not incorporate new demonstrations of practice during the comment period, this document helped clarify the DQE team's understanding of information already in our possession, so its analysis was included in the report.

c. Discontinuation from mental health watch
d. Mental health watch progress note
e. Group participation note
f. Therapeutic supervision report (listing allowed property, privileges, etc.)
g. Mental health status update
h. Crisis supervision log
i. Cell inspection checklists from MCI-Shirley and Souza-Baranowski Correctional Center

11. List of all prisoners housed in specialized mental health units since 12/20/22 (BMU, ITU, RTU, STP)
12. All incidents of SDV from January 1, 2023, to February 10, 2023, including prisoner name, facility, date and time, type of SDV, setting (RTU, BAU, etc.), person discovering SDV, assessment of planfulness/impulsivity, medical response, mental health response, whether the event was a suicide attempt, and whether the event was classified as a Critical Clinical Event by Wellpath
13. Use of Force data:
    a. All Use of Force incidents between 12/20/22 and 2/10/23, including prisoner name, facility, date and time, reason, housing type, TS before or after, staff and prisoner injuries *(2023-2-21 UOF on TS Report.pdf)*
    b. Revised Use of Force on TS report between 12/20/22 and 2/10/23 *(UOF data.xls)*[4]
14. Wellpath logs of crisis calls and sick call requests from each MDOC facility that has TS
    a. Cedar Junction 12/22/22 to 2/12/23
    b. Concord 12/22/22 to 2/11/23
    c. Framingham 12/22/22 to 2/10/23
    d. Massachusetts Alcohol and Substance Abuse Center (MASAC) 12/22/22 to 2/1/23
    e. Massachusetts Treatment Center (MTC) 12/22/22 to 2/10/23
    f. North Central Correctional Institution (NCCI) 12/22/22 to 2/10/23
    g. Norfolk 12/22/22 to 2/10/23
    h. OCCC 12/22/22 to 2/10/23
    i. SBCC 12/1/22 to 2/10/23
    j. Shirley 12/22/22 to 2/10/23
15. Mental health triage meeting notes (Monday through Friday) from each MDOC facility that has TS, approximately 12/22/22 to 2/10/23
16. List of all prisoners transferred to a higher level of care (Bridgewater State Hospital or DMH facility) since 12/20/22

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[4] MDOC provided revised Use of Force data to the DQE team on March 28, 2023. Again, although information received by the DQE team after the draft report's completion will generally not be included in the final DQE report, in this case, the new data clarified data already in our possession.

17. Inmate handbooks and other materials related to mental health: Framingham, Gardner, MTC Civil, MTC Inmate, Norfolk Critical Stabilization Unit, Norfolk, OCCC, SBCC, SBCC New Commitments, SBCC RTU, SBCC STP, Orientation to Mental Health Services
18. Quality assurance documents
    a. Wellpath Emerald Sites continuous quality improvement (CQI) calendar for 2023
    b. Wellpath Non-Emerald Sites CQI calendar for 2023
    c. Wellpath CQI meeting sign-in sheets
        i. Gardner 11/22/22
        ii. Norfolk 12/7/22
        iii. OCCC 9/26/22 and 1/31/23
        iv. SBCC 9/28/22 and 11/28/22
        v. Shirley 8/8/22 and 11/18/22

In addition, the DQE team observed a Wellpath/MDOC Self-Directed Violence Review Committee meeting conducted via Microsoft Teams on February 15, 2023, for approximately 90 minutes.

The DQE team's activities during the site visit, observation of the SDV meeting, and review of the documents listed above form the basis for the opinions offered in this report.

COMPLIANCE TIMELINE

The Agreement will terminate in four years of the Effective Date, or earlier, if MDOC and DOJ agree that MDOC has attained substantial compliance with all provisions of the Agreement and maintained that compliance for a period of one year. Interim compliance deadlines are specified for some provisions 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 • Status Report #2 to DQE and DOJ	67 77 98 27 42(d) 113 159
Within 16 months (Apr 20, 2024)	• Staffing plan #2 to DQE and DOJ	32
Within 18 months (June 20, 2024)	• Intensive Stabilization Unit operates • Training plan for all new/revised policies is developed • Status Report #3 to DQE and DOJ	114 39 159
Within one fiscal year of Staffing Plan #1 (June 30, 2024)	• Staffing completed in accordance with Staffing Plan #1	37
Within 24 months (Dec 20, 2024)	• All staff trained through annual in-service on new policies • Status Report #4 to DQE and DOJ	40 159
Within 27 months (March 20, 2025)	• Security staff complete pre-service suicide prevention training	42(c)
Within 28 months (April 20, 2025)	• Staffing plan #3 to DQE and DOJ	32
Within 30 months (June 20, 2025)	• Status Report #5 to DQE and DOJ	159
Within one fiscal year of Staffing Plan #2 (June 30, 2025)	• Staffing completed in accordance with Staffing Plan #2	37
Within 3 years (Dec 20, 2025)	• Implement all provisions fully • Status Report #6 to DQE and DOJ	176 159
Within 40 months (Apr 20, 2026)	• Staffing plan #4 to DQE and DOJ	32
Within 36 months (June 20, 2025)	• Status Report #7 to DQE and DOJ	159
Within one fiscal year of Staffing Plan #3 (June 30, 2026)	• Staffing completed in accordance with Staffing Plan #3	37

Within 4 years (Dec 20, 2026)	• Substantial compliance with all provisions maintained for one year • Status Report #8 to DQE and DOJ	177 159
Annual reviews (timing TBD)	• Review policies and submit revisions to DOJ for approval • Review TS data analysis/tracking plan and submit revisions to DOJ	31 139

SUBSTANTIVE PROVISIONS

As noted above, because this is a Baseline Report, the DQE team is not making detailed findings of compliance with each provision of the Agreement. Instead, we provide initial impressions and recommendations based on the site visit and document review.

POLICIES AND PROCEDURES

MDOC is not required to bring its policies and procedures in full alignment with the Agreement until one year after the Effective Date, or December of 2023. It is not even required to consult with the DQE about the policy revisions until six months after the Effective Date, or June of 2023. The DQE team has not yet completed a thorough review of policies. To date, I have only reviewed the policies specifically related to TS: Wellpath 66.00 (Therapeutic Supervision) and 103 DOC 650.08 (Emergency Mental Health Services). Upon initial review, it appears that these policies comply with many substantive provisions of the Agreement, including:

- Access to mental health professionals for prisoners in crisis
- Individualized assessments of property and privileges while on TS
- Three out-of-cell therapeutic contacts per day while on TS
- Notification of the Program Mental Health Director, MDOC Mental Health Regional Administrator, and MDOC Director of Behavioral Health after 3 days on TS
- Constant or close (staggered at intervals no greater than every 15 minutes) supervision, with completion of observation check sheets
- Out-of-cell meetings with MHPs rather than cell-front contacts
- Completion of a crisis treatment plan in the medical record
- Treatment team discussions prior to discharge from TS
- Follow-up MHP contacts after discharge from TS: within 24 hours, within 72 hours, and within 7 days

Some of the Agreement's requirements related to TS have not yet been included in the policies. For example, although MDOC is currently developing a system-wide cell safety checklist, policy 103 DOC 650.08 does not include requirements for completion of TS cell safety checks or for individualized assessments of restraints when prisoners are exiting TS cells. In another example,

MDOC and Wellpath policies (650.08 and 66.00, respectively) still state that decisions about removing clothing from prisoners on TS will be "commensurate with the level of suicide risk," as determined by an MHP. In contrast, the Agreement requires that safety gowns only be issued when the prisoner "has demonstrated that they will use clothing in a self-destructive manner" and that clothing can be withheld for longer than 48 hours only upon notification of the MDOC Director of Behavioral Health and with the approval of Wellpath's Director of Clinical Programs. (Of note, "Director of Clinical Programs" is not a title listed in Wellpath's staffing matrix; MDOC interprets it to mean the Program Mental Health Director in this context). Similarly, policy 103 DOC 650.08 states that "inmates will have shower access commensurate with their security risk," while the Agreement requires an MHP to document clinical contraindications if a prisoner is not granted shower access after 72 hours on TS. In a fourth example, Wellpath policy 66.00 requires consideration of a higher level of care after 96 hours on TS, while the Agreement specifies that this must occur after 72 hours.

Although my overall impression is that MDOC is well on its way to compliance with the Policies and Procedures section of the Agreement, we found several other examples where current policy language did not exactly match the Agreement's requirements. These areas will be discussed with MDOC leadership in the coming months, and a thorough review of policies will be completed in the First DQE Report.

STAFFING PLAN

The Staffing Plan is not due until four months after the Effective Date, but Wellpath's staffing matrix as of January 31, 2023, was provided to the DQE for review.[5] Even at this early stage of the DQE's monitoring, staffing levels are clearly concerning. *Table 1* illustrates the mental health staffing plan and vacancies at each of the ten MDOC facilities where TS occurs.[6]

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[5] MDOC provided several different staffing plans to the DQE for review. On February 23, 2023, Wellpath staffing matrices for 12/31/22, 1/31/23, and 2/10/23 were provided, and the DQE team included an analysis of the 2/10/23 staffing plan in a draft report to the parties. Upon review of the DQE's draft report, on March 28, 2023, MDOC provided a revised staffing matrix for 1/31/23, stating that the previous matrices had erroneously included clerical positions and Health Services Administrators who are not considered part of the mental health staff. At this early stage of monitoring, it is not clear to the DQE team which Wellpath and MDOC positions are related to the Agreement, so we have analyzed the data according to MDOC's guidance. Should it become clear in the future that additional positions are relevant to the Agreement, we will include these positions in assessments of staffing levels.

[6] The following positions were included in this analysis: Activities Therapist, Advanced Registered Nurse Practitioner (ARNP)/Clinical Nurse Specialist (CNS), Clinical Director, Clinical Supervisor, Mental Health Director, Mental Health Professional, Psychiatrist, Regional Mental Health Director, and Unit Coordinator.

***Table 1.* Mental Health Staffing Levels by Facility**

	Allotted FTE	Filled FTE	Overage FTE	Vacant FTE	**% Filled FTE**
Cedar Junction[7]	9.35	2.1	0	7.25	**22.4**
Concord	7.55	5.4	0	2.15	**71.5**
Framingham	11.8	7.3	0	4.5	**61.9**
MASAC	24.8	15.9	0	8.9	**64.1**
MTC	5.7	3.95	0.6	2.35	**69.3**
NCCI/Gardner	10	7	0	3	**70.0**
Norfolk	8.2	5.8	0	2.4	**70.7**
Old Colony	20.55	18.3	1.05	3.3	**89.0**
Shirley	8.15	4	0.4	4.55	**49.1**
Souza-Baranowski	24.75	17.55	0	7.2	**70.9**
TOTAL	**130.85**	**87.3**	**2.05**	**45.6**	**66.7**

Table 2 illustrates staffing levels as of January 31, 2023, for mental health staff who provide care related to the Agreement, as identified by MDOC:

***Table 2.* Mental Health Staffing Levels by Position**

	Allotted FTE	Filled FTE	Overage FTE	Vacant FTE	**% Filled FTE**
Activities Therapist	20	14.65	0	5.35	**73.2**
ARNP/CNS	6.6	7.4	1.05	0.25	**112.1**
Clinical Director	1	1	0		**100.0**
Clinical Supervisor	1	0	0	1	**0**
MH Director	9	9	1	1	**100.0**
MHP	74.15	42.95	0	31.2	**57.9**
Psychiatrist	8.1	4.3	0	3.8	**53.1**
Regional MH Director	3	3	0	0	**100.0**
Unit Coordinator	8	5	0	3	**62.5**
TOTAL	**130.85**	**87.3**	**2.05**	**45.6**	**66.7**

During the OCCC site visit, MDOC and Wellpath acknowledged that staffing is suboptimal for nearly all positions, including correctional officers. They explained that the COVID-19

[7] According to MDOC leadership, Cedar Junction is slated for closure in 2023.

pandemic exacerbated the staffing challenges already facing MDOC, as many mental health professionals are now able to work from home (via telehealth) and do not wish to travel to a correctional facility. This, and other factors, have resulted in particularly acute shortages of psychiatrists and MHPs, as *Table 2* illustrates. Staffing levels for MHPs and psychiatrists are currently below 60%. While the Agreement does not require MDOC to have filled its positions by this time, it certainly faces an uphill climb to do so.

During the exit interview at OCCC, I shared my initial impression that MDOC has a remarkable lack of doctoral-level mental health professionals (i.e., psychologists and psychiatrists) among its ranks. Based on the January 31, 2023, staffing matrices, MDOC currently has only 4.3 FTE psychiatrists and two psychologists to care for over 5,200 prisoners at the ten facilities where TS occurs, approximately 2,400 of whom have an open mental health case and almost 2,000 of whom have a serious mental illness (SMI). This staffing level would leave each FTE psychiatrist responsible for over 550 active patients, which is simply unworkable in any context. The presence of nurse practitioners, who can perform many of the same functions as a psychiatrist, improves the staffing level somewhat. Combining the 7.55 FTE nurse practitioners and 4.3 FTE psychiatrists significantly reduces the average caseload for providers with prescriptive authority, but the overall staffing level still seems low for a system as large and complex as MDOC.

An additional concern is that many of Wellpath's MHPs are unlicensed or do not have a license to practice independently.[8] According to the February 10, 2023, staffing matrices, of the 36.95 FTE mental health professionals whose licensure is known[9], 52.5% (19.4 FTE) have no license, and an additional 16.2% (6 FTE) have a social work license (LCSW or LSWA[10]) that requires supervision by a licensed independent social worker (LICSW). Only 31.2% (11.55 FTE) are filled by individuals with a license to practice independently (LICSW or LMHC). Most MDOC sites have a Mental Health Director who does have an independent license. However, at Framingham, because of the Mental Health Director vacancy, it appears that no mental health staff member on site has an independent license.[11] Future DQE site visits will include an assessment of how the supervision of unlicensed MHPs works in practice.

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[8] For this analysis, the staffing matrix dated February 10, 2023, provided to the DQE on February 23, 2023, was used because the updated spreadsheet provided on March 28, 2023, did not contain any licensure data.

[9] Three MHPs at MASAC have "N/A" listed under licensure. These individuals were excluded from the analysis because it was not clear whether they are licensed or unlicensed.

[10] Only one MHP at Old Colony Correctional Center was identified as an LSWA, which may be an error on the spreadsheet, as MDOC stated that an LSWA would not meet the required educational background/credentials to be hired as an MHP.

[11] Framingham does have independently licensed practitioners working as "as-needed" ("PRN") or per diem MHPs, but since they have no set schedule or percentage of time regularly worked, those individuals were not included in the calculations above. MDOC reported that the Health Services Administrator (HSA) at Framingham is an LICSW who formerly served as the site's Mental Health Director and who still performs some functions of that role, but MDOC also indicated that HSAs are not to be included in mental health staff numbers.

No information regarding security staffing levels were provided to the DQE for review, though administrators noted that there are security staffing shortages system-wide and that hiring has been difficult. These areas will be explored further in the First DQE Report. During the OCCC site visit, it appeared that security staffing in the BAU, where the majority of TS placements occur, was adequate to meet the prisoners' needs for out-of-cell activities such as showers, recreation, 1:1 sessions with mental health, and phone calls.

TRAINING

The Agreement mandates MDOC and Wellpath to provide pre-service and annual in-service training to all security and mental health staff on suicide prevention, mental healthcare, de-escalation techniques, TS monitoring methods, CPR, and new policies. MDOC appears to be offering some of these trainings already. The DQE team reviewed PowerPoint slides and agendas for several staff trainings:

a. ***Annual Mental Health Training*** intended for all Wellpath clinicians held on December 5, 6, and 7, 2022. This 8-hour training includes modules on suicide prevention, considerations for 18(a) (civil commitment) petitions, working with female offenders, sex offender treatment, diagnostics, managing problematic behavior, and self-care.

b. ***RTU/STU Training*** intended for all security staff and clinicians assigned to RTU/STU, held on November 8 and 9, 2022. This two-day (16 hour) training is offered pre-service and as an annual in-service refresher. It includes an overview of mental health services in MDOC, an overview of the RTU model, and training modules on unit operations, correctional stress, de-escalation, building effective teams, disciplinary board, STU/RTU outcome data, trauma-informed care, suicide prevention and intervention, behavior management, and debriefing.

c. ***Collaborative Safety Planning***, held in November 2022 and meant to be offered to all Wellpath clinicians in an ongoing manner. This training addresses crisis management skills, suicide risk assessment, and collaborative safety planning with prisoners, such as identifying self-injury warning signs, reasons to live, coping strategies, and social supports.

d. ***MDOC Suicide Prevention & Intervention 2021-2022***. This training is an annual requirement for all MDOC employees who have care and custody of inmates. The training presents basic facts about suicide in correctional settings, statistics from MDOC, warning signs and risk factors, MDOC suicide prevention policies, and techniques for intervention with suicidal prisoners.

e. ***Suicide Prevention and Recognizing Mental Illness and Substance Related Disorders 2021.*** This training is designed to be provided to all new MDOC employees as part of their pre-service orientation. It includes statistics about suicide in MDOC, instruction on suicide risk assessment, and emergency response guidelines. In addition, the training includes basic information about mental illnesses such as schizophrenia, mood disorders, personality disorders, substance use disorders, and cognitive disorders.

f. ***Therapeutic Supervision***, developed in the spring of 2021 and reportedly given to all security staff who observe TS, all administrators and supervisors, and MDOC executive staff. This training reviews MDOC's change in policy and practice from Mental Health Watch to Therapeutic Supervision. It includes instruction on the indications for TS, goals of TS, role of the mental health team, role of security, assessments of property and privileges, communication skills, restraints, and case examples. It does not appear to contain any content about assessing TS discontinuation or providing follow-up care because MDOC did not think the information would be relevant to security staff.

In addition to these trainings, security staff reported during the OCCC visit that they are offered the opportunity to participate in Crisis Intervention Training (CIT), a 40-hour, evidence-based program that began as a model for police response to individuals with mental illness and has since been adapted for correctional workforces. The DQE team was provided with MDOC's CIT training materials to review on March 28, 2023, and will assess these materials in subsequent reports.

The DQE team has not yet observed any of the MDOC or Wellpath trainings in practice, but based upon a review of the provided materials, my overall impression is that they are thoughtfully designed and already include most of the content areas specified in Paragraph 42 of the Agreement:

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 and, if applicable, step-down unit status;
7. de-escalation techniques; and
8. case studies of recent suicides and serious suicide attempts; scenario-based trainings regarding the proper response to a suicide attempt, and lessons learned from past interventions.

Future DQE assessments will focus on (1) evaluating how the trainings are implemented in practice, (2) verifying all staff's participation at the frequency required by the Agreement, and (3) fine-tuning the educational materials. For example, the *New Employee Orientation* materials still refer to Mental Health Watch rather than Therapeutic Supervision, and the *Therapeutic Supervision* training does not include any instruction on how to assess readiness for discharge or to create follow-up plans for prisoners. These are relatively minor changes, and I am confident that MDOC and Wellpath can make them within the 6-month period stipulated by the Agreement. In addition, the training materials do not include videos or other materials depicting incarcerated or formerly incarcerated individuals speaking about their experiences on Therapeutic Supervision, as the Agreement suggests should be included. MDOC reported that it is already exploring how best to accomplish this and will discuss ideas with the DQE team in the coming months.

As new policies are created and approved by the DQE and DOJ, the Agreement requires MDOC to (1) incorporate revised training materials into its annual training plan within six months of the policies' approval, and (2) train all staff on the new policies within 12 months of their approval. To date, no policies have been revised since the Agreement's Effective Date, so this provision has not been assessed. Similarly, CPR training verification is not due until six months after the Agreement's Effective Date, or June of 2023, so this provision has not yet been assessed.

THERAPEUTIC RESPONSE TO PRISONERS IN MENTAL HEALTH CRISIS

This is the largest section of the Agreement, and its thorough assessment will take time. To date, the DQE team has only evaluated the relevant mental health and security practices at one facility, Old Colony Correctional Center, during the day shift on weekdays. Remote access to Wellpath's electronic health record, ERMA, is still being arranged, so the DQE team has only reviewed a handful of records while on site. Thus, any impressions shared at this time are based on a limited assessment and refer only to OCCC (except where indicated in the text).

Although the comments below describe challenges with the mental health services at OCCC, it is important to acknowledge that many of the prisoners interviewed by the DQE team described having very positive experiences with the facility's mental health staff. They stated that the mental health staff were "fantastic" and "doing a phenomenal job," particularly in the RTU settings. Overall, the prisoners described feeling like the mental health staff makes the best of its limited resources. Similarly, the DQE team appreciated during the site visit the creative, industrious, and compassionate attitude of OCCC's mental health staff. It was clear that the staff care about the prisoners and are committed to providing the highest quality care, albeit often in the face of significant systemic challenges.

Mental Health Crisis Calls/Referrals:

At OCCC, it was clear that prisoners have on-demand access to mental health staff during business hours on the weekdays by asking a security officer to "call crisis." According to the prisoners we interviewed, the mental health staff usually respond to these calls within minutes. Until the MHP arrives, an officer reportedly watches the prisoner continuously, sometimes in a location outside of their assigned housing unit. For example, at OCCC, there is no space for confidential mental health evaluations in the orientation unit, so prisoners are placed in the "Newman's" area to wait for an MHP (which was also not confidential, so it is not clear what advantage it has over the housing unit). We did not observe any instances where prisoners are disciplined for asking for crisis services. To the contrary, it appeared that OCCC's philosophy is that the mental health staff will respond to any prisoner's request as urgent, regardless of whether it is an actual crisis such as a suicide attempt or suicidal ideation. Most of the crisis calls we observed during the OCCC visit were for matters such as dissatisfaction with housing or access to healthcare services (e.g., wanting to move up an evaluation in Spectrum's Medication Assisted Treatment program for opioid use disorders).

I do not yet have a clear understanding of how calls during non-business hours are handled. At OCCC, an MHP is on site until 9 pm, Monday to Friday, and until 4 pm on Saturdays. Outside of those times, MDOC reports that an independently licensed Wellpath clinician is on call by phone after hours. If a prisoner is in crisis at night, or on Sundays or holidays, they are assessed by an on-site nurse, who then discusses the case with the on-call MHP. If TS is indicated, the prisoner is placed in a TS cell with property/privileges determined by the on-call MHP, and they are assessed the following day by an on-site MHP.

An analysis of daily mental health contact logs, which document the facility's crisis requests and the staff's responses, indicates that MHPs responded to more than 958 crisis calls across the MDOC system between December 22, 2022, and February 10, 2023. Only a small number of crisis calls result in placement on TS. The great majority of prisoners were found not to need TS, and 11% resulted in TS placement.[12]

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[12] This analysis draws upon logs titled Mental Health Referral Log/Sick Call Request (or similar titles, depending on the institution) from 10 institutions (Cedar Junction, Concord, Framingham, Massachusetts Alcohol and Substance Abuse Center (MASAC), Massachusetts Treatment Center (MTC), North Central Correctional Institution, Norfolk, Old Colony, Souza-Baranowski, and Shirley). Most provided logs for the period December 22, 2022, through February 10, 2023, a seven-week period. If an institution provided data for a longer period, the DQE team did not review additional days so as to preserve as much uniformity as possible. Some institutions provided data for a somewhat shorter period. Most or all did not have logs for Sundays and holidays, presumably because mental health professionals are not onsite. Cedar Junction provided a log concerning BMU prisoners, but it does not appear to include other prisoners, if there are any. For these reasons, the numbers in the analysis may be under-inclusive. The DQE team also drew on the spreadsheet with the electronic file name *TS Registry 12.20.22 ONWARD.xlsx*.

The TS placement rate was fairly consistent across institutions. The prisons with smaller mental health populations generally had a somewhat higher rate of placement from screenings, although MTC placed none and Norfolk placed 7% on TS. There appeared to be large numbers of self-referrals and referrals from security staff, along with a smattering from other sources; the rate of placement did not vary much by referral source. Souza-Baranowski had by far the highest demand for these screenings.

Mental Health Crisis Assessments:

Wellpath's Crisis Call Progress Note template is simply the shell of a typical clinical progress note, so the DQE team cannot comment on its quality until we have reviewed how MHPs are completing the crisis notes. However, the crisis assessments we observed during the OCCC site visit raise questions about whether MDOC is meeting the requirements of Paragraph 47 of the Agreement, which mandates that clinicians assess:

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.

At OCCC, it appeared that crisis assessments commonly were made without important and available information because of difficulties in communication between mental health and security staff and because of limited access to the electronic health record in patient-care areas. The DQE team observed some crisis assessments being conducted in non-confidential settings,

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The logs capture a variety of types of contacts, and there is some variation in how staff approach recording. The DQE team employed the following assumptions. The referral source "DOC" was taken to mean custody staff. The reviewer counted as a Therapeutic Supervision screening any entry appearing on the TS Registry (with only a few exceptions that appeared to be errors, according to the other logs), and any referral log entry labeled as "crisis" being the reason for the contact, "emergent" being the level of priority, or a contact resulting in a Therapeutic Supervision placement (initiate TS, or 15', or 1:1, or words to this effect). The analysis does *not* include contacts labeled "crisis" or "emergent" if the prisoner was clearly already in Therapeutic Supervision. If actual practice differs from any of these assumptions, the analysis numbers may be over- or under-inclusive.

such as cell-front in a hallway where other prisoners were waiting for appointments. Even when conducted in private settings, the MHPs' assessments were brief, asking questions about prisoners' current thoughts/plans to engage in self-harm or harm to someone else, whether they felt safe, and whether they felt that they needed TS. Some evaluations included a review of the prisoner's coping skills. Clinicians did not ask about the areas specified in the Agreement, nor did they have access at the time of the assessment to medical records that may have contained important historical data that could inform a risk assessment. These practices raised questions about the efficacy of the MHPs' crisis assessments and about their fidelity to the Agreement, which will be explored during future DQE site visits.

MDOC reported that, after receiving feedback from the DQE during the OCCC site visit's exit interview, it took preliminary steps to improve its practices. The Deputy Commissioner of Clinical Services and Reentry spoke with mental health staff to help ensure that thorough assessments are conducted in accordance with the Agreement. In addition, MDOC reported that it was exploring ways to make the electronic health record available to clinicians while they are in the housing units.

Initial TS Placement and Crisis Treatment Plan:

As noted above, according to MDOC's logs, approximately 11% of crisis calls resulted in TS placement. Between December 20, 2022, and January 31, 2023, 103 TS placements took place across MDOC. These were spread across nine MDOC facilities, with almost half occurring at SBCC and OCCC, as illustrated in *Table 3*.

Table 3. **TS Placements by Facility**

Facility	Number of TS Placements
SBCC	28
OCCC	23
Shirley	6
Concord	12
Norfolk	8
MASAC	6
Gardner	5
Framingham	9
Cedar Junction	6
TOTAL	**103**

According to MDOC administrators, at OCCC, the "official" start of TS occurs upon the completion of a crisis treatment plan and property/privilege form. No physician or psychologist's order is needed to initiate TS, to change property/privileges, or to discontinue TS. A review of the electronic health record indicates that the Crisis Treatment Plan is written by an

MHP, without any place on the form for co-signatures from multidisciplinary team members or any indication that team members participated in its development.

Upon initial review, Wellpath's crisis treatment plan format complies with the Agreement's requirement to 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.

In future reviews, the DQE team will examine the extent to which actual treatment plans fulfill these requirements. Although the treatment plan template is comprehensive, as noted above, it is not clear where the MHPs are getting the information used to complete it, as they were not asking about the specified areas during the crisis contacts we observed, and they reportedly do not review the health record before or during these contacts.

According to MDOC's policies, the prisoner's watch level (Constant or Close (every 15 minutes)) is determined by the MHP and communicated to the security officers, who are responsible for ensuring the safety of the suicide-resistant TS cell and conducting the necessary checks of the prisoner. During the OCCC site visit, communication between MHPs and security officers about property, privileges, and watch levels seemed to work smoothly. As noted above, officers did not use any type of checklist to ensure the TS cell is free of potential hazards, as is required by the Agreement. MDOC reported that they are in the process of developing a universal checklist for use at all facilities.

TS Conditions:

At OCCC, TS placements occur in two units: the Health Services Unit (HSU) and the Behavioral Assessment Unit (BAU). Although either location can be recommended by the MHP based on clinical factors, the location is ultimately chosen by security staff. MHPs reported that they

typically recommend the HSU but that security places most prisoners in the BAU. Data provided by MDOC indicate that 21 of the 33 TS placements between 12/20/22 and 2/10/23 occurred in the BAU, which was formerly known as the Restrictive Housing Unit and continues to house prisoners facing potential disciplinary sanctions in addition to those on TS. Several prisoners commented that this sends a confusing message about TS placement, as they are sent to the same physical location when expressing a need for mental health services as when getting in trouble for something. They noted that the high likelihood of being placed in the punitive BAU can serve as a disincentive to asking for TS.

Once placed in the TS cell, the prisoner's access to property and privileges is determined by an MHP, often after consultation with other mental health staff members during the daily mental health triage meeting. All prisoners interviewed by the DQE team at OCCC reported that they are provided access to clothing, showers, radios, tablets, reading materials, outdoor exercise, phone calls, and visits in accordance with the Agreement. Individualized decision-making was also apparent in health records the team reviewed, and several of these choices exceed the Agreement's requirements. Of note, although Paragraph 57 of the Agreement requires documentation and review of clothing access three times each day (Monday through Saturday), this was not done in practice, nor does it make clinical sense to me as a routine practice. Once-daily property/privilege determinations, including clothing, seem adequate to meet prisoners' needs and to use the MHPs' time wisely.

One aspect of TS at OCCC is clearly not in compliance with the Agreement: the use of restraints when out of cell. Currently, according to OCCC administrators and MHPs, all prisoners on TS in the BAU are handcuffed behind their backs when exiting their cells, and they remain in handcuffs even when placed in the "split cell" with an MHP. (Split cells are private rooms in which the prisoner and MHP are separated by a plexiglass screen; they are used for MHPs' out-of-cell contacts with TS prisoners.) MHPs do not make individualized recommendations about whether a prisoner needs to be restrained when removed from their cell, and this is not one of the categories for decision on the form for property and privilege determinations.

Mental Healthcare during TS:

The DQE team has not yet reviewed enough medical records to determine whether MDOC consistently provides three out-of-cell contacts per day (Monday through Saturday) to prisoners on TS, but based on the OCCC site visit, this does seem to be the routine practice. Souza-Baranowski logs show gaps in this, however, so the issue bears further examination. On Sundays, only those prisoners on Constant Observation are seen by an MHP; this reportedly occurs once per day. OCCC staff stated that the first out-of-cell contact is typically conducted by the first-shift Crisis Clinician, the second by the prisoner's assigned Primary Clinician, and the third by the second-shift Crisis Clinician.

All out-of-cell interactions we observed were individual MHP contacts in a split cell. There was some indication in contact logs, particularly at Souza-Baranowski, that some prisoners were not allowed to come out of their cells for contacts, sometimes for weeks. During the OCCC visit, no group programming occurred for TS prisoners.

In their response to the DQE's document request, MDOC stated that the following therapeutic programs are available to prisoners on TS:

- Anger management
- Behavior chain analysis
- Communication skills
- Current events
- Dual diagnosis
- Developing future orientation
- Developing goals
- Discussion of health and wellness
- Sleep hygiene
- Psychoeducation around major mental illness
- Stress management
- Narrative therapy

During the OCCC site visit, the DQE team did not observe these programs being utilized with TS prisoners, but it is possible they are occurring at other times and/or at other sites. The DQE team only observed the first out-of-cell contact of the day for prisoners on TS. These contacts were brief, typically between 5 and 10 minutes each, and took the form of assessment rather than therapy. They included the MHP asking the prisoner whether he thought he could come off TS; if he was having thoughts of harming himself or others; what his coping skills were; if he was taking his medications; and if he was sleeping, eating, and using recreation time. The cases were then briefly reviewed at the mental health triage meeting (1-5 minutes of discussion for each case), where a decision about ending or continuing TS was made. A revised privilege/property form was generated if there were any changes occurring, or a TS discontinuation note was completed if needed. No formal updates to the Crisis Treatment Plan were made, but staff stated that changes to the plan would be included in a progress note. The DQE team does not yet know whether the practices are similar at other institutions or whether all three out-of-cell contacts per day at OCCC are handled in a similar manner.

TS Length of Stay Requirements:

MHPs and MDOC leadership reported that the Director of Behavioral Health and Program Mental Health Director are notified when a prisoner has been on TS for 72 hours. At seven days, another notification to the same individuals is made, and this time MDOC's Assistant Deputy Commissioner of Clinical Services is involved in the discussion of next steps. At 14 days, MDOC's Deputy Commissioner of Re-entry and Clinical Services is notified. Although the MHPs at OCCC were not aware of what the supervisors do with the information once they are notified, the MDOC leadership stated that the primary question is whether to transfer the prisoner to a higher level of care, such as Bridgewater State Hospital. All these procedures comport with the Agreement, even though MDOC is not required to comply with this provision until December of 2023.

Analysis of MDOC's TS monthly data indicates that, for TS stays that occurred between December 20, 2022, and January 31, 2023, the mean length of stay was 5.38 days, with a median of 2 days and range of 0-64 days. However, the mean was significantly affected by three outlier cases at SBCC where TS stays began in November of 2022 and had not ended by January 31, 2023. Excluding those three cases, the mean length of TS was 3.63 days, with a median of 2 days and range of 0-30 days. The DQE team will review the three outlier cases in the coming months to understand the circumstances that led to the unusually long TS placements.

Table 4 illustrates TS data broken down into the Agreement's five specified cohorts:

Table 4. **Therapeutic Supervision Length of Stay**[13]

Cohort	Length of Stay[14]	Number of Prisoners
1	24 hours or less	10
2	24 to 72 hours	62
3	72 hours to 7 days	17
4	7 to 14 days	6
5	>14 days	8
TOTAL		103

[13] Two individuals were placed on TS on 1/17/23 and remained on TS by 1/31/23. Their lengths of stay were categorized as ">14 days" because their TS stays, which extended into February, were at least 15 days long. Similarly, the three men who were placed in November and had not been discharged as of 1/31/23 are counted in this category.

[14] The data provided by MDOC in *TS Registry 12.20.22 ONWARD.xls* lists the date of admission and date of discharge, so the exact number of hours a prisoner spent on TS cannot be calculated. Thus, prisoners were placed into Cohort 1 if their date of admission and discharge were the same. They were placed into Cohort 2 if their Length of Stay (LOS) was 1-3 days, Cohort 3 if LOS was 4-7 days, Cohort 4 if 8-14 days, and Cohort 5 if 15 days or longer. Although MDOC provided some data for February 2023, these TS placements were excluded from the current analysis and will be included in the First DQE Report, when the full month's data can be reviewed.

It appears that most TS placements in MDOC are relatively short, with 70% lasting three days or less. Data from MDOC indicates that eight prisoners[15] were transferred to Bridgewater State Hospital between 12/20/22 and 2/13/23, but the dates of transfer do not appear to correlate with TS length of stay.[16] Of the 14 prisoners whose TS lengths of stay exceeded seven days, none were transferred to a higher level of care prior to 2/13/23, when MDOC's data ended.

Because the data collection period since 12/20/22 is so short, it is difficult to compare MDOC's current TS placement data with the numbers reported in the DOJ's 2020 findings letter. At that time, the DOJ reported that 106 MDOC prisoners had been held on Mental Health Watch for 14 days or longer during the 13-month period between July 2018 and August 2019. 51 of those placements were for longer than one month, 16 were for longer than three consecutive months, and seven were for longer than six consecutive months.

In the current review, the *rate* of placements exceeding 14 days is the same as in the DOJ findings letter – about 8 per month in both instances – but the longest stays are substantially improved. Overall, it does seem that TS lengths of stay are shorter than those reported in 2018-2019, indicating positive systemic change. Further analysis is necessary before drawing firm conclusions.

TS Discharge Plans and Follow-Up:

Again, the DQE team has not reviewed enough medical records to draw conclusions about MDOC's compliance with the Agreement's requirement to conduct follow-up mental health evaluations at 24 hours, 72 hours, and 7 days after discharge from TS. There was some indication of follow-up shown on referral/sick call logs. During the site visit, we observed that each prisoner on TS was discussed during the daily mental health triage meeting, which included all MHPs, a security officer, psychiatrist, Mental Health Director, and Regional Mental Health Director. A consensus decision about whether to keep the prisoner on TS or to discontinue it was made. No individualized discharge plan was discussed and, although there is a form for that purpose, in the few medical records we reviewed, that form was present but did not contain a plan of care. Neither did we see any information about the prisoner conveyed to the receiving officers on the prisoner's housing unit, and both mental health staff and security staff confirmed during interviews that such information is not typically shared. The prisoner simply returns from TS to his housing unit and is assessed by an MHP within 24 hours, per policy.

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[15] One prisoner was transferred to Bridgewater twice during this period, making 9 total referrals.

[16] For example, Prisoner AA was placed on TS from 12/23/22 to 12/24/22. *LINE ITEM 10 HIGHER LEVEL OF CARE 12.20.22.xls* indicates that his Bridgewater State Hospital transfer occurred on 1/12/23, more than two weeks after he was discharged from TS. Thus, it is not clear that the transfer was related to the TS placement.

Although I understand the MHPs' workload concerns and the privacy considerations involved in communicating with security staff on the prisoners' housing units, the total lack of communication does not seem in keeping with the Agreement, which states in Paragraph 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.

The Agreement also states that, if clinically indicated, prisoners on TS 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 or misdiagnosis. We observed no such evaluations during the OCCC site visit. A psychiatrist was present during the mental health triage meeting and presented the results of one assessment of whether a prisoner met criteria for civil commitment to a hospital under G.L. c. 123, §18(a), but he played essentially no role in the determinations being made about TS placements, diagnoses, or discharges. However, it is possible that nurse practitioners, who have more weekly hours than psychiatrists at OCCC, play a larger role in TS decisions when they are on site. It is also possible that the practices we observed during one site visit do not represent the norm at OCCC or at other facilities. Further analysis of medical records and interviews of staff will be necessary to draw conclusions.

SUPERVISION FOR PRISONERS IN MENTAL HEALTH CRISIS

During the OCCC site visit, MHPs and prisoners reported tension between mental health and security staff that may be affecting whether MHP recommendations are followed regarding location of TS and the frequency of custody observation (Close or Constant). It is noteworthy that MHPs say they consider the healthcare unit (HSU) to be a more therapeutic environment, while TS logs indicate that the majority of TS takes place in the BAU. Souza-Baranowski provided another example of security-mental health disconnects, with logs showing MHPs not allowed to meet with TS prisoners or not allowed to see them out of cell, sometimes for extended periods.

Although the DQE team has not yet conducted a system-wide assessment of the supervision provided to prisoners on TS, it was clear from the OCCC site visit that many prisoners still manage to injure themselves while on TS in a suicide-resistant cell at that institution. For example, the DQE team met a prisoner who had swallowed dozens of pills while on TS, raising significant questions about the cell search and strip search that security performed prior to his placement on TS, the medication administration procedures, and/or the monitoring and cell

searches while on TS. Although I understand that some prisoners, particularly those who are experienced with self-injury, can hide things in/on their body and in their cells in a manner that evades reasonable efforts at detection, security practices related to TS searches and monitoring warrant further evaluation by the DQE team. For example, we learned during the OCCC site visit that security officers in the HSU "bubble" could not see the video of the TS cells in real time, making it more difficult to detect self-injury. Similarly, TS watch logs indicated that security officers documented checks of TS prisoners exactly every 15 minutes, making it easy for prisoners to predict officers' behavior and avoid detection of self-injury.

Finally, I would note that MDOC's documentation practices make it difficult for any clinician or supervisor to get a full picture of what happens to a prisoner in crisis. The mental health clinician's response to a crisis call is documented in the Inmate Management System (IMS). If TS is initiated, the crisis treatment plan and clinicians' progress notes are kept in the electronic health record, ERMA. The property/privilege assessments are generated in IMS, and a signed version is uploaded into ERMA daily. The TS watch logs are kept by hand and stored with the facility's Deputy Superintendent; no electronic copy is saved. All this makes it confusing and difficult to keep track of whether proper procedures for prisoners on TS are being followed. For auditing purposes alone – both external and in preparation for effective internal auditing – MDOC may wish to consider a more streamlined documentation method.

The Agreement outlines the responsibilities of Support Persons, who will provide additional, non-clinical interaction with prisoners on TS. This requirement is not due until December of 2023. MDOC reported that they have been making plans for the qualifications, training, and supervision of Support Persons, but no individuals have yet been hired.

INTENSIVE STABILIZATION UNIT

No formal plans for the ISU were provided to the DQE team for review, but this is not due until one year after the Agreement's Effective Date, in December of 2023. During the initial site visit, MDOC reported that plans for the ISU are well under way, and it may be opened in advance of the Agreement's deadline in June of 2024. The ISU will be located at OCCC in a housing unit that is currently occupied. The ISU's opening will require the movement of several groups of prisoners to different OCCC housing units, but given the facility's low census, this should not be too burdensome. The housing unit will require some physical plant renovations to accommodate the ISU. MDOC continues to refine its plans for staffing levels, prisoner selection criteria, and programming for the ISU. The general idea is that the unit will house prisoners who have had lengthy or repeated TS placements and will serve as an intermediate care level between TS and the commitments at Bridgewater State Hospital under G.L. c. 123, §18(a).

BEHAVIORAL MANAGEMENT PLANS

The DQE team has not assessed MDOC's or Wellpath's behavioral management plans other than to confirm with MHPs at OCCC that they do utilize such plans on occasion. The MHPs said that they typically create the plans independently, without the input of a psychologist or psychiatrist. At OCCC, the MHPs identified three prisoners who have specific behavioral plans in their charts. During the coming months, the DQE team will assess these plans, as well as Wellpath's overall approach to behavioral management plans.

QUALITY ASSURANCE

My initial impression is that MDOC's data tracking and analysis capabilities exceed that of most correctional systems, though it is not yet clear whether they meet the exact requirements of the Agreement. MDOC already tracks monthly census data, crisis contacts, TS placements, and episodes of self-injury, as is required by the Agreement. Morbidity and mortality reviews reportedly are conducted for prisoner deaths and serious self-injury episodes. Wellpath has its own continuous quality improvement (CQI) program for both physical and mental health practices, performing monthly audits of specific areas (e.g., alcohol and benzodiazepine withdrawal, emergency services, sick call, suicide prevention). A system-wide MDOC Quality Improvement Committee was scheduled to begin meeting in March of 2023. The MDOC leadership indicated that they were on track to begin providing monthly quality assurance (QA) reports to the DQE team by the deadline of March 20, 2023. These are all important steps toward meeting the Agreement's requirements related to QA.

As additional oversight, MDOC leadership reported that it holds Self-Directed Violence (SDV) Review Committee meetings twice monthly and allowed the DQE team to attend the meeting on February 15, 2023. Representatives from each MDOC facility's mental health staff presented all their SDV cases, and the Director of Behavioral Health and Wellpath leadership provided feedback about clinical strategies to mitigate the risk of self-harm. This process plays a valuable role in reducing risk and maintaining the quality of care. Moving forward, I would like MDOC to consider developing a more formal mechanism to review critical incidents related to crisis mental healthcare and to create corrective action plans. Such a system should include a process for identifying systemic factors that contributed to an episode of self-injury, corrective action(s), staff member(s) responsible for carrying out each corrective action, a timeframe for each action to be completed, and metric(s) by which improvement will be measured.

For January 2023, MDOC's SDV report indicates that there were 30 incidents of self-injury involving 22 individuals. One individual engaged in two incidents of SDV during the month, two engaged in three incidents each, and one engaged in four incidents. The incidents were spread across MDOC facilities as noted in *Table 5*:

***Table 5.* Self-Directed Violence Episodes by Facility**

Facility	Number of SDV Incidents
Cedar Junction	5
Concord	1
MASAC	1
MTC	1
Norfolk	1
OCCC	10
SBCC	10
Shirley	1

The types of SDV that occurred in January of 2023 are noted in *Table 6*:

***Table 6.* Self-Directed Violence by Type**

Type	Number of SDV Incidents[17]
Cutting	9
Scratching	1
Head-banging	9
Non-suspended hanging	3
Asphyxiation	2
Object ingestion	4
Substance ingestion	1
Insertion	1
Other	1

MDOC's Use of Force data indicate that, from 12/20/22 to 2/10/23, force was used on four occasions with prisoners on TS, twice at Old Colony and twice at Souza-Baranowski.[18] The incidents at Old Colony both involved the use of OC spray. No staff or prisoner injuries occurred during the four use of force incidents. The DQE team does not know the specifics of these incidents, so we cannot comment on the appropriateness of the use of force.

RECOMMENDATIONS

At this early stage of the DQE's assessment, I offer only the most obvious and uncontroversial recommendations. Other issues are noted above, but they will be the subject of ongoing discussion with the parties in the coming months, as the DQE team becomes more familiar with MDOC and its complex system of mental healthcare. For now, I encourage MDOC to:

[17] Total is greater than 30 because some individuals engaged in more than one type of self-injury during a given incident.

[18] MDOC provided revised Use of Force data to the DQE team on March 28, 2023, because the original data set erroneously contained some cases where force was used prior to TS placement rather than during TS placement.

1. Continue all efforts to improve its mental health staffing levels, especially MHPs and psychiatrists.

2. Provide contemporaneous access to the electronic health record to MHPs when conducting crisis assessments and TS therapeutic contacts.

3. Ensure adequate confidentiality of all mental health assessments, including crisis contacts and TS contacts.

4. Ensure that security officers are systematically checking TS cells and prisoners for potential hazards prior to initiating TS and periodically throughout the TS placement.

5. Begin conducting individualized assessments of prisoners' need to be restrained when leaving their TS cells.

6. Continue developing a Quality Assurance program that includes a process by which corrective actions will be implemented after critical incidents.

NEXT STEPS

In March of 2023, the DQE team began conducting two-day site visits at each of the ten MDOC facilities where TS occurs: Cedar Junction, Concord, Framingham, Gardner, MASAC, MTC, Norfolk, Old Colony, Shirley, and Souza-Baranowski. These visits will continue until July of 2023 and will allow us to assess more comprehensively MDOC's practices related to crisis mental healthcare.

In addition, the DQE team anticipates working with MDOC and DOJ to create a format for monthly sharing of data related to the Agreement. To date, MDOC has been entirely cooperative with this process. They recently hired a staff person whose primary responsibility is to gather the necessary data and facilitate its provision to the DQE and DOJ teams.

The DQE team also anticipates creating a mechanism to receive periodic input from various stakeholders, including prisoners' rights advocates and parties involved in the supervision and treatment of individuals with mental illness, in accordance with Paragraph 153 of the Agreement. The DQE team looks forward to maintaining our collegial working relationships with the parties and to developing new relationships with stakeholders.