SEPTEMBER 20, 2025

MASSACHUSETTS DEPARTMENT OF CORRECTION

COMPLIANCE REPORT #5

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DESIGNATED QUALIFIED EXPERT

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BACKGROUND

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

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

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

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

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

MDOC disputed the DOJ's findings and denied all Constitutional violations. Nonetheless, the parties agreed that it was in their mutual interest and the public interest to resolve the matter without litigation. After a lengthy negotiation, they entered into a Settlement Agreement dated December 20, 2022 (herein "the Agreement"), and appointed a Designated Qualified Expert (DQE) for a four-year term to assess MDOC's compliance with the Agreement. Initially, three team members were 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. A fourth team member, Dr. Vinneth Carvalho, a psychiatrist with expertise in forensic mental health systems and correctional healthcare, was added to the DQE team in March 2025.

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 fifth 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	67 77

	• 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	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 42 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

MDOC continues its steady march toward compliance with the Agreement, led by committed individuals in its Health Services Division who have implemented major changes in mental healthcare over the past two and a half years. MDOC's accomplishments between January 1 and June 30, 2025 (the end of data collection for this report), include:

- The Intensive Stabilization Unit (ISU), a 15-bed treatment unit at Old Colony Correctional Center that opened in June 2024, continues to offer patients wraparound mental health treatment as an "off-ramp" from prolonged or repeated Therapeutic Supervision (TS) placements. The ISU had 15 new admissions in the first half of 2025. The unit is functioning well, providing structured, multidisciplinary treatment and recreational activities throughout the day, Monday to Saturday. MDOC has now achieved substantial compliance with almost half (11 out of 23) of the substantive provisions related to the ISU in the Agreement. There are still growing pains around individualized treatment plans, consistency and training of security staff, and patients' access to property, but these can be remedied.

- MDOC continues to decrease the number of lengthy TS placements across the system. Between January and June 2025, the longest TS placement was 265 days—a long time, to be sure—but only three total patients across MDOC spent time on TS for longer than 30 days. Compared to the DOJ's Findings Letter in 2019, this is a remarkable 81% decrease in TS placements lasting longer than a month. The findings indicate that MDOC is doing much more of what the Agreement intended: stabilizing prisoners in crisis or transferring them to a higher level of care in a more reasonable time frame.

- Mental health staffing levels have continued to improve since VitalCore assumed MDOC's health services contract in July 2024. At that time, 68% of mental health positions were filled, whereas in May 2025, 81% of positions were filled. The biggest gains have been at MCI-Framingham and Old Colony Correctional Center (OCCC), including filling positions in the ISU.

- VitalCore has developed a more robust training program on important clinical topics, including suicide risk assessment, clinical interventions for patients on TS, behavior management plans, substance use disorders in corrections, and comprehensive mental health assessment. Given that almost 90% of MDOC's mental health professionals (MHPs) do not have an independent license and/or are early in their careers, this training program is an important step to enhance the clinical skills of its treatment providers.

- MDOC has taken steps to provide ethernet and Wi-Fi access in areas its prisons where mental health staff commonly meet with patients. Once implemented, this will allow contemporaneous access to the electronic health record and encourage better-quality risk assessments. MDOC reported that it has procured the necessary IT equipment and that installation will occur by the end of fiscal year 2025 (by June 30, 2026).

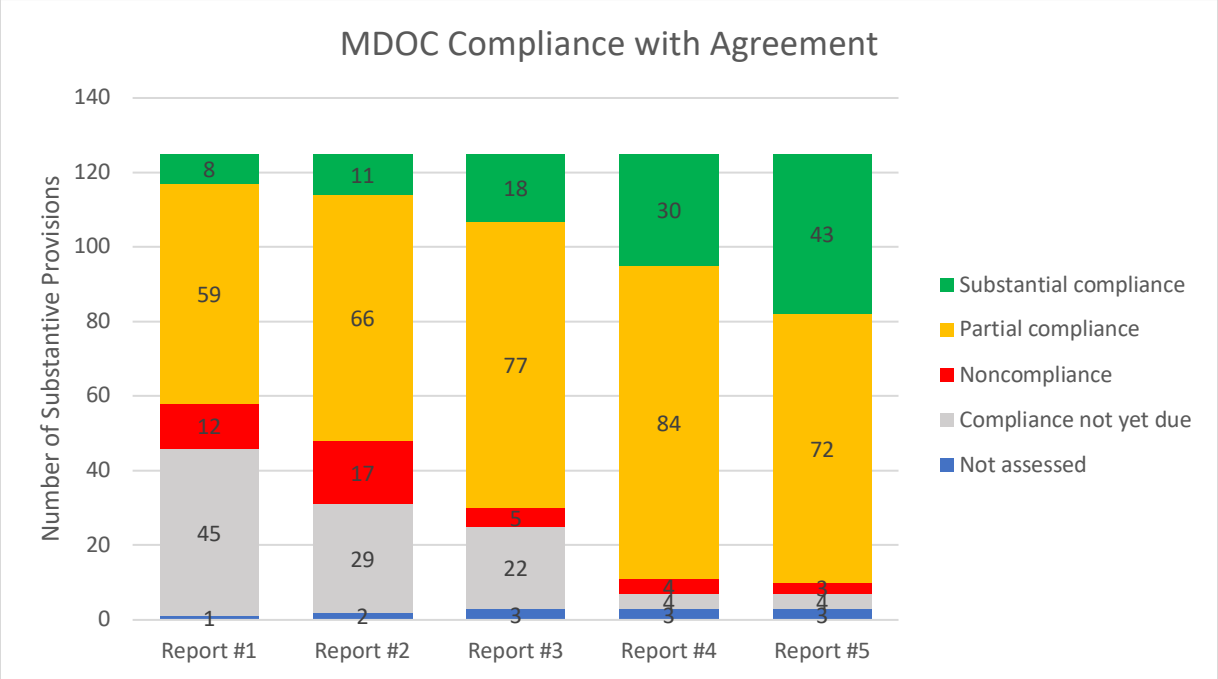
- Rates of prisoners' self-directed violence (SDV) remained substantially lower than during the DOJ investigation in 2019. In June 2025, total SDV was down 16% compared with 2019, and SDV occurring while a prisoner was on TS was down 27%. Rates of cutting while on TS decreased by 71%, attempted hanging by 36%, and insertion of foreign bodies by 38%. These gains have been sustained over the past 12 months. Much of the remaining SDV is head-banging and scratching with fingernails, which is very hard to prevent.

- Compared to when the Agreement began, prisoners on TS are more often allowed dim lighting at night, authorized clothes within two days, and provided showers more consistently, which creates a more therapeutic environment for individuals in crisis.

- MDOC is now operating peer mentorship programs in general population at both MCI-Framingham and MCI-Norfolk. Framingham's program has been functioning for over a year, while Norfolk launched in March of 2025. Should these programs remain successful, as they have been to date, MDOC plans eventually to expand peer support to prisoners on TS.

- MDOC's Morbidity/Mortality Review process is identifying important problems with the provision of mental healthcare. Although the process is still not compliant with the technical requirements of the Agreement and more work needs to be done around corrective action following suicides and serious attempts, it is encouraging that MDOC's self-auditing practices are identifying problems similar to those highlighted by the DQE team. This bodes well for sustained practice after the Agreement is formally terminated.

MDOC has now reached substantial compliance with 43 of the Agreement's 125 substantive provisions (34%), as illustrated in the figure below. During this monitoring period, MDOC improved its compliance ratings for 16 provisions. Another 101 provisions remained unchanged, and one provision slid backward. Compliance with four provisions is not yet due, and three provisions are not being assessed by agreement of the parties.



MDOC's progress over the past six months is commendable. There are, however, some important areas where progress has stalled after period of positive change earlier in the Agreement's implementation or has been progressing at a slow pace:

- MDOC was required to revise all policies by December 20, 2023, one year after the Agreement began. As of August 2025, only one MDOC policy revision was even close to being finalized and implemented, and the healthcare vendors' policy revisions had not yet begun.

- The Agreement requires that prisoners in crisis remain unrestrained (i.e., not handcuffed or shackled) during contacts with mental health staff unless "there is an imminent or immediate threat to safety of the prisoner, other prisoners, or staff." The DQE team found that prisoners are still routinely restrained for reasons other than imminent risk, with blanket policies being applied based on the location of the mental health contact or other non-individualized factors.

- Earlier in the Agreement, the DQE team had seen a modest improvement in individualized assessment and multidisciplinary treatment planning for prisoners in crisis. Except in the ISU, these practices seem to have plateaued over the past year, with clinicians often leaving blank large sections of VitalCore's documentation templates that prompt them to consider important issues such as a prisoner's diagnosis, medication compliance, and historical risk factors for self-harm.

These are some of the essential areas where the DQE team would like MDOC to focus its efforts in the next monitoring period. Others are highlighted in the *Conclusion and Next Steps* section of this report.

Souza-Baranowski Correctional Center (SBCC), where mental health services have been difficult to deliver since the Agreement began, may be headed in a better direction. In November 2024, the Superintendent from OCCC transferred to SBCC, and he has been working to expand access to mental health services. During the DQE team's April 2025 site visit, SBCC's leaders reported that they had identified additional spaces on the housing units for confidential mental health contacts and had implemented a scheduling system for these rooms. MDOC was in the process of restructuring security leadership roles for better oversight of specialized units like the Behavior Assessment Unit (BAU) and Secure Treatment Program (STP) and had designated a staff member to track problems with access to mental healthcare. In addition, plans were in motion to decrease the population of SBCC by streamlining the intake process for parole violators and allowing their quick transfer to other facilities. Although these changes were not directly related to the provision of crisis mental healthcare under the Agreement, the hope was that simplifying SBCC's mission and decreasing its population would allow staff to focus more on facilitating healthcare services. These plans are early in implementation, but there are reasons to be cautiously optimistic based on data reviewed by the DQE team during this monitoring period; self-injury at SBCC decreased by 24%, and TS placements decreased by 22%.

One other MDOC facility, MCI-Norfolk, warrants close monitoring. While nowhere near as worrisome as SBCC, data from Norfolk have been trending in the wrong direction over the past year. TS placements are increasing, as are incidents of SDV and use of force while a prisoner is on TS. Over half of the staff misconduct allegations that MDOC shared with the DQE team stem from Norfolk, and, concerningly, one patient repeatedly ingested or inserted foreign bodies including a razor blade and parts of batteries while on constant observation status. In the DQE team's review of medical records, only 13% of clinically indicated psychiatry contacts for patients on TS were completed. All these indicators point to a crisis mental health system that is not functioning well. Although the underlying reasons for this are not yet clear, it appears that Norfolk, like SBCC, underwent significant changes after the closures of MCI-Cedar Junction and MCI-Concord, placing greater strain on its mental health services.

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

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

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

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

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

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

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

ASSESSMENT METHODOLOGY

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

1. **Site Visits**

   The DQE team conducted site visits between April and June of 2025 at four of the eight MDOC facilities where TS occurs. The facilities were chosen for site visits based on performance indicators in the previous DQE monitoring periods.

   The following activities were conducted by DQE team members during the visits:

	Framingham	Norfolk	OCCC	SBCC
	6/16/25	6/17/25	4/28-4/29/25	4/15-4/16/25
Inspection of TS cells	RK		RK, SS	SS
Interview of prisoners recently/currently on TS	RK, JW	RK, JW	RK, JW, VC	RK, JW, SS
Interviews of mental health staff	JW	JW	JW, VC	RK, JW, VC
Interviews of security staff	RK	RK	RK, SS	RK, JW, SS
Observation of MHPs responding to crisis calls	JW	JW	JW, VC	JW, VC
Observation of MHPs conducting TS assessments	None to see	JW	RK, JW, VC	RK, JW, VC
Observation of MH group programming		JW	JW, VC	
Observation of other MH contacts (e.g., PCC, intake)		JW		JW, VC
Observation of MH triage meeting	RK, JW	RK, JW	RK, JW, SS, VC	JW, VC
Observation of BAU Interdisciplinary Assessment Team meeting	RK, JW			

Observation of Morning Meeting	RK, JW	RK, JW	RK, JW, VC, SS	RK, JW, VC, SS
Observation of Crisis Clinician Sign-Out	JW			RK
Observation of Support Person contacts			JW, VC	RK

During the site visits, the DQE team was given broad access to information and the facilities, as required by Paragraph 158 of the Agreement. In addition to observing the mental health clinicians at work, the team was permitted to interview prisoners, security staff, and mental health staff confidentially, without MDOC leadership or legal representatives present.[2] In total, the DQE team interviewed 32 prisoners, 18 MDOC security staff members, and 25 mental health staff members during this monitoring period. The DQE team also spoke with MDOC's behavioral health leadership about progress with the Agreement during some site visits; this information was also considered when assessing compliance.

2. Document Review

For this report, data from January 1 through June 30, 2025, across all eight facilities where TS occurred during the reporting period were reviewed, except where stated otherwise in the text. General categories of documents reviewed are listed here.

a. MDOC Status Report #5, dated June 20, 2025

b. Electronic health records

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

Facility	Approximate % of Records
Framingham	7
Gardner	5
MASAC	2
MTC	3
Norfolk	14
OCCC	24
SBCC	38
Shirley	7

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

Records were reviewed for technical compliance with the Agreement (e.g., number and timeliness of assessments by mental health staff, completion of TS Reports), 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).[3]

c. Data about crisis contacts and TS placements

1) TS Registry, a list of all prisoners placed on TS, including facility, entry and discharge dates, location of TS, and duration of TS placement
2) A sample of officers' observation logs for TS placements
3) A sample of cell inspection checklists for TS placements
4) A sample of Therapeutic Supervision Reports
5) Log and incidents reports for all restraint incidents during TS placements
6) VitalCore Notification spreadsheets (for 72 hrs, 7 days, 14 days, 14+ days on TS)
7) Minutes of Daily Therapeutic Supervision Consultation meetings
8) Daily mental health Triage Meeting notes and End of Shift reports
9) A sample of Crisis Logs documenting receipt of referrals and responses
10) Disciplinary reports reported to be associated with mental health crisis
11) Emails from MDOC responding to questions about patients, Agreement-related practice, and physical plant

d. Policies related to mental healthcare

1) Monthly letters from MDOC Clinical Operations Analyst describing the status of MDOC's policy revisions
2) Draft of MDOC policy 103 DOC 650 – Mental Health Services, revised and resubmitted to DQE on 5/16/25
3) Policy 103 CMR 430 – Inmate Discipline

e. Staffing data

1) VitalCore mental health staffing matrix from May 2025, including filled, overage, and vacant positions
2) MDOC security staffing matrix from July 5, 2025
3) Wellpath Recovery Solutions staffing matrix for MASAC, May 2025

f. Training data

1) Outline for Behavior Management Plan training (undated)
2) Crisis Intervention Training (CIT) attendance records

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

3) MDOC training records for all staff who completed CPR, suicide prevention, and Therapeutic Supervision training in TY 2025 (through June 2025)
4) Wellpath Recovery Solutions training records for all security staff at MASAC
5) VitalCore's New Employee Orientation (NEO) training records
6) Training materials and attendance logs for various VitalCore staff trainings, including for the Specialized Treatment Units (e.g., ISU, RTU)
7) "Read and sign" documentation for training on SDV protocols
8) VitalCore's "DOJ Quarterly Training Submission: Summary"

g. Intensive Stabilization Unit data

1) ISU triage meeting notes
2) Schedule of ISU activities, April through August 2025
3) Referral paperwork for all admitted ISU patients
4) A sample of Group Attendance Sheets
5) ISU staff training records
6) List of officers bid into ISU, June 2025
7) ISU Handbook dated December 13, 2024

h. Other mental health program information

1) VitalCore monthly "Mental Health Roll Up Report"
2) List of all prisoners referred to a higher level of care (Section 18(a), Section 18(a1/2), ISU, RTU, or STU)
3) Summary of all Inter-Facility Clinical Case Conferences related to TS or ISU

i. Self-injury and Use of Force data

1) Log of all SDV incidents, both on and off TS
2) Self-Directed Violence Occurrence Report (SDVOR, formerly known as SIBOR) for every incident of SDV
3) Incident reports written by security, MH, and medical staff for all SDV episodes
4) Incident reports related to two suicides and two serious suicide attempts
5) Log of Use of Force incidents that occurred while a prisoner was on TS
6) Log of foreign body ingestion/insertion
7) Incident reports and medical/MH documentation from all incidents of foreign body ingestion/insertion

j. Quality assurance materials

1) Minutes from monthly Quality Improvement Committee (QIC) meetings
2) Redacted version of "Professional Conduct Log," July 2024-July 2025
3) Monthly Quality Assurance spreadsheets in accordance with Paragraph 139

4) Morbidity/Mortality Review materials from two suicides and two serious attempts
5) Self-Directed Violence/Suicide Attempt (SDV/SATT) Review Committee Meeting minutes
6) Minutes from quarterly DOJ/MADOC Agreement Meetings

3. Stakeholder feedback

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

DETAILED FINDINGS

POLICIES AND PROCEDURES

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

Finding: Substantial compliance

Rationale: MDOC continues to consult with the DQE about policy revisions. During this monitoring period, consultation has occurred only around Policy 103 DOC 650, Mental Health Services, which has undergone further revision and review since it was approved by the DOJ on March 5, 2025. MDOC submitted a new version to the DQE on May 16, 2025. After some back-and-forth about the rationale for the proposed changes, which were relatively minor, the DQE approved the revised policy on August 12, 2025, and MDOC resubmitted it to DOJ on August 13, 2025. Although the policy has not yet been re-approved by DOJ, MDOC's pattern of consulting with the DQE about revisions has been sufficiently demonstrated.

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: We are now 20 months past the Agreement's deadline for all policies and procedures to be revised and finalized, but MDOC has not finalized even one policy,[4] leading to a noncompliance finding for Paragraph 27. The overall progress of revisions, as of the drafting of this report, is listed in *Table 1*.

Table 1. MDOC Policy Revisions

Policy	Title	Status
103 DOC 601	DOC Division of Health Services Organization	Revision sent to DQE on 9/20/23, comments sent back 1/13/24. Undergoing second revision by MDOC.
103 DOC 650	Mental Health Services	Revised again by MDOC after DOJ approval on 3/5/25. New version approved by DQE on 8/12/25, awaiting review by DOJ.
103 DOC 622	Death Procedures	Revision sent to DQE on 4/25/24, comments sent back 7/28/24.
103 DOC 501	Institution Security Procedures	Revision sent to DQE on 9/13/24, comments sent back on 1/29/25.
103 DOC 562	Code 99 Emergency Response Procedures	Revision sent to DQE on 9/13/24, comments sent back on 1/29/25.
103 DOC 216	Training and Staff Development	Undergoing first revision by MDOC.

Except for policy 103 DOC 650, Mental Health Services, no progress has been made (or at least shared with the DQE) during the past six months. Some policies, including 103 DOC 601, DOC Division of Health Services Organization, and 103 DOC 622, Death Procedures, have been under review with MDOC for over a year since the DQE last saw them. Thus, the overall status of MDOC's policy compliance with the Agreement has not changed since the DQE's fourth report:

a. The policies have been adequately revised to be consistent with paragraphs 43-74, 77-89, 92-104, 107-111, 113-137, and 140-144 of the Agreement.

b. Some Agreement provisions remain inadequately captured in the policy language, including paragraphs 38-42 (staff training), 90-91 (response to self-injury), 112 (BOSS chairs and body scanners prior to TS placement), 138-141 (quality assurance procedures), and 145-146 (morbidity/mortality reviews). Since peer support and therapy dogs are not yet part of TS, MDOC's policies do not address these aspects of the Agreement.

[4] As noted in Paragraph 26, policy 103 DOC 650 is very close to being finalized, but DOJ still must approve the most recent revision.

VitalCore's policies have not yet been provided to the DQE for review, nor have they been revised in accordance with the Agreement.[5] None of Wellpath's policies (for MASAC) have been revised. These remain significant projects to be tackled, now almost two years after all policy revisions were to have been completed.

28. No later than six months after the United States' approval of each policy and procedure, unless the public hearing process pertaining to the promulgation of regulations is implicated and/or subject to the collective bargaining process, MDOC will make any necessary modifications to all post orders, job descriptions, training materials, and performance evaluation instruments in a manner consistent with the policies and procedures. Following such modifications of post orders, job descriptions, training materials, and performance evaluation instruments, and subject to the collective bargaining process, MDOC will begin providing staff training and begin implementing the policies and procedures.

Finding: Compliance not yet due

Rationale: Nothing with this provision has changed since the DQE's last report. MDOC's policies are still being revised to align them with the Agreement, and the only policy approved the by DOJ, Policy 103 DOC 650, Mental Health Services, was revised again by MDOC, necessitating re-approval by the DOJ.[6]

Therefore, MDOC is not yet responsible for modifying post orders, job descriptions, training materials, or performance evaluation instruments. Likewise, the requirement for MDOC to train staff and implement its revised policies and procedures does not begin until after the modification of post orders, job descriptions, training materials, and performance evaluation instruments.

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

Finding: Compliance not yet due

[5] MDOC reported that VitalCore continues to follow the previous healthcare vendor's policies until it develops its own.

[6] The substantive changes proposed by MDOC are in Sections 650.09.D (treatment after serious suicide attempts or self-injury) and 650.13.D (disciplinary proceedings in the ISU).

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

It is encouraging that MDOC stated in its June 2025 Status Report that full implementation of policy 105 DOC 650, Mental Health Services, is expected by September 2026 (18 months after DOJ's approval in March 2025) despite the need for additional revisions and need for review by the DQE and DOJ.

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

Finding: Not assessed

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

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

Finding: Partial compliance

Rationale: As noted in previous DQE reports, MDOC has a procedure in place regarding annual policy reviews, which is clearly delineated in policy 103 DOC 104, Internal Regulations/Policies. Policies are assigned to their relevant MDOC leader (e.g., Deputy Commissioner of Clinical Services and Reentry) to be revised according to a monthly schedule. Each policy includes the date of its most recent annual review.

The most recent revision dates for MDOC policies related to the Agreement are listed in *Table 2.*

Table 2. Annual Revision of MDOC Policies

Policy	Title	Most Recent Revision[7]
103 DOC 601	DOC Division of Health Services Organization	1/21/25
103 DOC 650	Mental Health Services	5/14/25
103 DOC 622	Death Procedures	3/10/25
103 DOC 501	Institution Security Procedures	3/4/24
103 DOC 562	Code 99 Emergency Response Procedures	6/28/24
103 DOC 216	Training and Staff Development	4/23/25

Thus, it appears that MDOC's procedure for annual policy review is functioning, even as the policies have not yet been substantively aligned with the Agreement. The requirement to submit substantive policy changes to DOJ for approval annually has not yet taken effect because the policies are still undergoing initial revision by MDOC.

As noted in previous reports, Wellpath (for MASAC) also employs a system for annual policy review. The DQE does not yet have any information about VitalCore's process for reviewing its policies. The VitalCore and Wellpath policies must also undergo annual review by their respective agencies and, if revised, approval by DOJ before MDOC can be found in substantial compliance with Paragraph 31.

STAFFING PLAN

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

Finding: Substantial compliance

Rationale: MDOC's submission of an annual staffing plan is due in April of each year. On April 22, 2025, MDOC submitted three staffing matrices to the DQE and DOJ: VitalCore (for mental health staff at the seven prison sites), Wellpath Recovery Solutions (for all staff at MASAC), and MDOC security staff for the seven prison sites.

[7] To determine the date of revision, the DQE consulted MDOC's website for publicly available policies (216, 601, 622). For policies not available publicly (501, 562), the DQE relied upon copies provided by MDOC.

Paragraph 32 does not require the DQE's approval of the staffing plan; it only requires DOJ's approval. The DQE's concerns about the adequacy of the staffing plans are addressed in Paragraph 35. To the DQE's knowledge, DOJ has not yet approved the April 2025 staffing plans, but MDOC has met its burden to submit them.

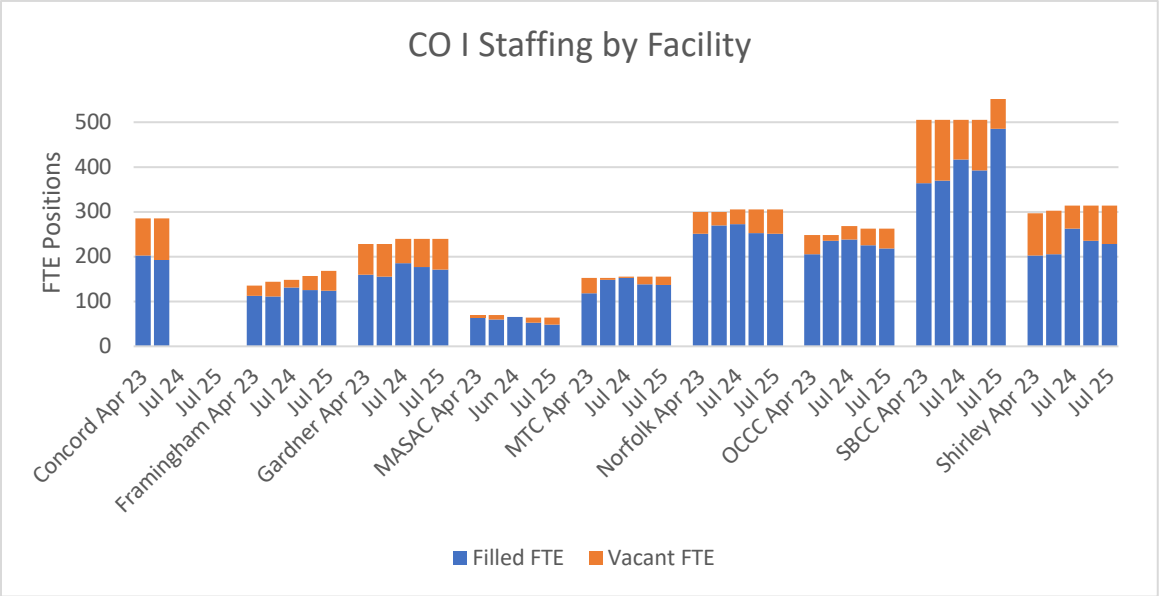
33. Security Staffing Escort: MDOC will increase security staffing as needed to ensure that there are sufficient staff to escort prisoners in mental health crisis to participate in out-of-cell activities such as recreational activities, group activities, etc., in accordance with Paragraphs 62 (Routine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

Finding: Partial compliance

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

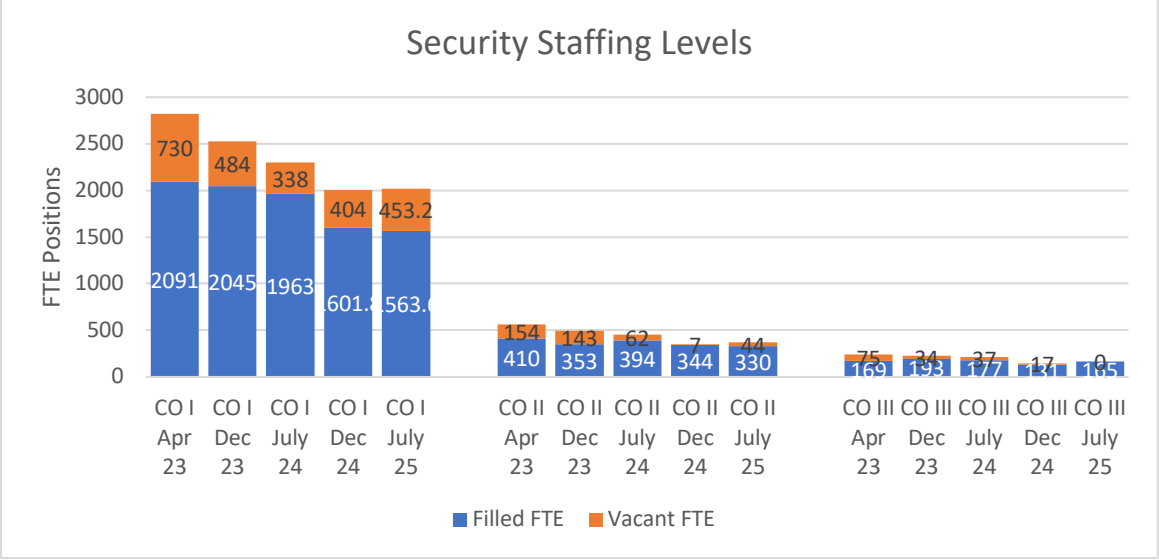
In its June 2025 Status Report, MDOC reported that it had decreased the minimum age requirement for correction officers in an effort to improve recruitment. Despite this effort, security staffing levels did not improve during this monitoring period. Based on the staffing matrix dated July 5, 2025, staffing levels for Correction Officer I positions at all facilities except SBCC declined in the previous six months, as illustrated in *Figure 1*. Although CO I staffing levels are higher than when the Agreement began in December 2022, it appears that the gains from closing Cedar Junction and Concord were eroded in the first half of 2025.

Figure 1. CO I Staffing by Facility[8]



As illustrated in *Figure 2*, the total number of officers (CO I, CO II, and CO III) declined in July 2025 when compared with December 2024. In July 2025, 81% of CO I, CO II, and CO III positions were filled, compared with 83% in December 2024 and 73% in April 2023.

Figure 2. Security Staffing Levels by Position, April 2023-July 2025[9]



[8] 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.

[9] MASAC's Residential Service Coordinators I, II, and III were included with their corresponding Correction Officer groups.

When assessing the impact of security staffing levels on mental healthcare, the DQE team relied on interviews with prisoners, staff, and MDOC leadership; review of health records; and direct observation of service provision. During the DQE team's site visits, facility leadership generally reported that staffing levels were holding steady. Although overtime continued to be mandated at most facilities, "modified operations" (i.e., closing operations temporarily in part of the facility) were not often necessary because of understaffing. This is a positive change since the Agreement's inception. However, the DQE team continued to see evidence of inadequate security staffing levels that affect the provision of mental healthcare for patients in crisis, most notably at SBCC, where current staffing levels and officers' practices in the health services unit (HSU) and behavior assessment unit (BAU) often do not allow for meaningful out-of-cell contact at the most crucial time of day for assessment and clinical decision-making (between 8 am and 11 am).

Regarding access to routine activities, exercise, and meals out of cell, the DQE team did not encounter evidence during this monitoring period that security understaffing was driving the challenges in these areas.

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

Finding: Partial compliance

Rationale: In interviews throughout the DQE team's monitoring, the great majority of correction officers and supervisors have stated that the practice of rotating responsibility for constant observation every two hours has long been established. This was reinforced by ten interviewees in this monitoring period posted to HSU, BAU, ISU, STP (which has TS cells), Framingham's ITU; STAs typically assigned constant observation; or officers who carry out that function while working overtime. Similarly, six SBCC prisoners commented on recent experiences of constant observation. Most of them estimated the rotation as being on the required schedule, while two prisoners thought officers changed every eight to twelve hours.

Documents, too, demonstrated a structure to rotate officers as required. The DQE team reviewed a sample of observation sheets from 32 TS placements with constant

observation in the monitoring period. The sample was drawn from BAU, HSU, RTU, SAU, STP, and MASAC's "Housing Unit" across seven institutions.[10] While practice is not yet in substantial compliance, 59% of sampled records essentially met the rotation goal,[11] which is substantially improved from the previous monitoring period. MASAC, MTC, and Norfolk had very strong practice, while longer coverage—as long as a whole shift—was disproportionately found at Gardner and Shirley.

In its June 2025 Status Report, MDOC described internal oversight practices—including real-time, on-unit supervision, monthly document review by site leaders, and efforts by the Quality Improvement Committee—aimed at monitoring and improving constant observation practices and documentation. MDOC has also designed a revised documentation format, with site leader input, with the goal of supporting improved future practice as well. This form will be implemented once DOJ has approved policy 103 DOC 650, Mental Health Services.

Overall, it is clear that MDOC has implemented a system for meeting this requirement, and recent improvements are much appreciated. Continuing to reduce the lengths of time on the post will be necessary to reach substantial compliance.

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

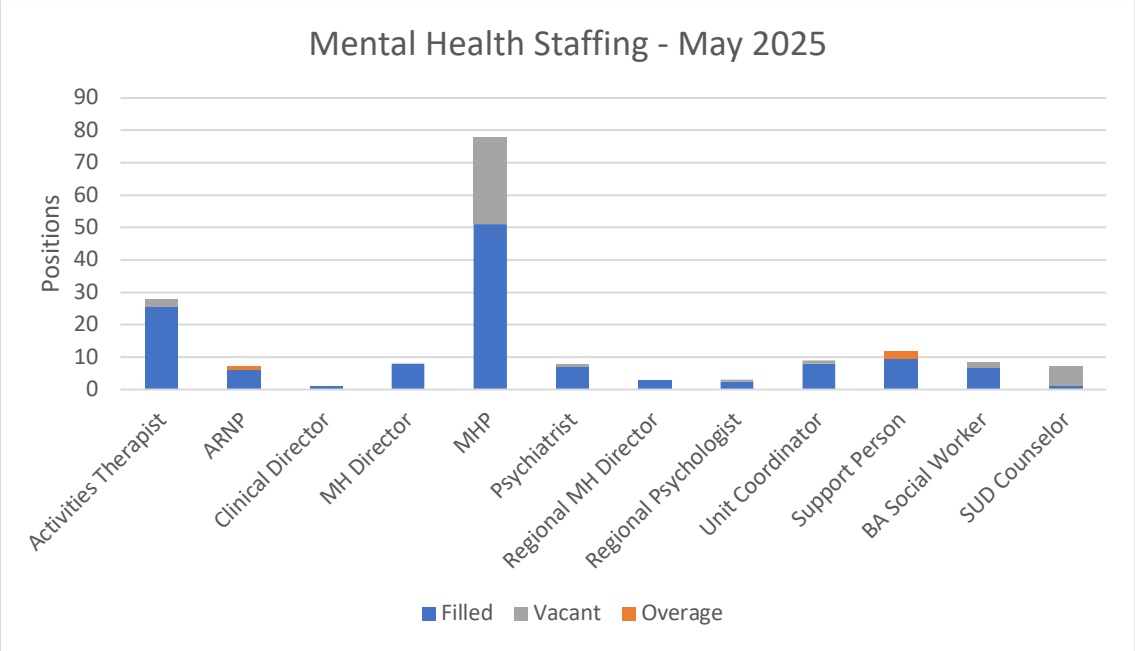
[10] In a study of several TS-related security staff requirements, the DQE team reviewed 52 records drawn from each institution providing TS, in proportion to its percentage of TS placements from January through June 2025. The sample was chosen from the TS Registry to include TS stays in BAU, HSU, ISU, ITU, RTU, STP, and MASAC's "Housing Unit." This sample was also used as the basis for analyses of the cell inspection checklist and other requirements for constant and close observation.
Within the sample, 32 records included constant observation. They represented all of the settings described above, except ISU, and all institutions except Framingham. This represents an 18% sample of the placements that had constant observation in the first half of 2025, according to the TS Registry for that period.

[11] A record was considered substantially compliant if an officer's initials indicated that they were on the post for periods of no longer than 2.5 hours. If there were longer intervals and the reviewer learned the patient went to an outside hospital, that was also treated as substantially compliant for this analysis. More discussion is needed to clarify for the future implementation expectations in that circumstance.

Rationale: Mental health staffing levels continued to improve during this monitoring period, sustaining a trend that began when VitalCore assumed MDOC's health services contract in July of 2024. There were no major changes in the VitalCore staffing matrix (i.e., the number of contracted positions), though VitalCore leadership indicated to the DQE team during the June 2025 site visits that changes will be implemented to the substance use disorder (SUD) counselor positions soon.[12] In June 2025, the total number of contracted mental health positions was 167.8 FTE, which is very similar to December 2024.[13]

In May 2025, 81% of mental health positions were filled, with the largest number of vacancies still among MHPs, as illustrated in *Figure 3.*

Figure 3. Mental health staffing by position



This vacancy rate of 19% is improved from December 2024, when the rate was 27%.[14] The staffing changes over time are depicted in *Figure 4.*

[12] Leadership indicated that these positions will become regional rather than facility-based, likely decreasing the total number of contracted positions. These changes will be reflected in the next DQE report.
[13]The following positions were included in the analysis of the VitalCore and Wellpath Recovery Solutions staffing matrices: Activity Therapist, Psychiatric APRN/CNS, Clinical Director, MH Director, Mental Health Professional, Psychiatrist, Regional MH Director, Regional Psychologist, Unit Coordinator, Support Person, BA-Level Social Worker, and SUD Counselor.
[14] 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.

Figure 4. Mental Health Staffing, Jan 2023 to May 2025

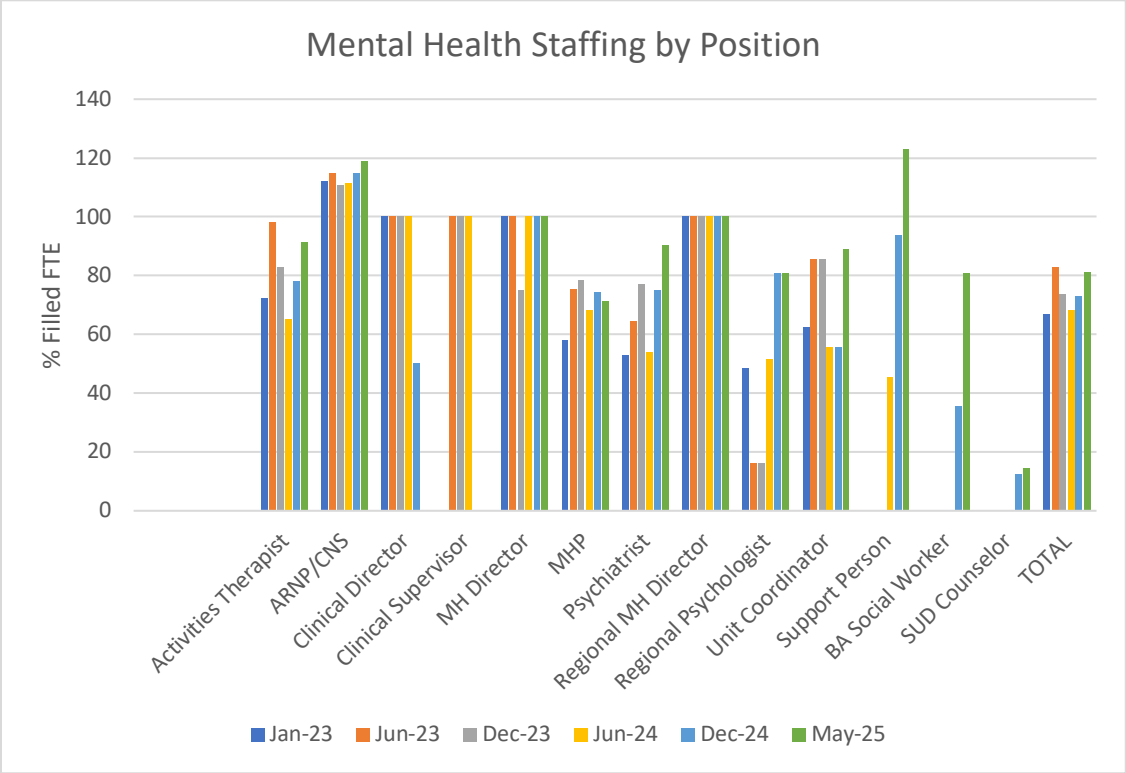
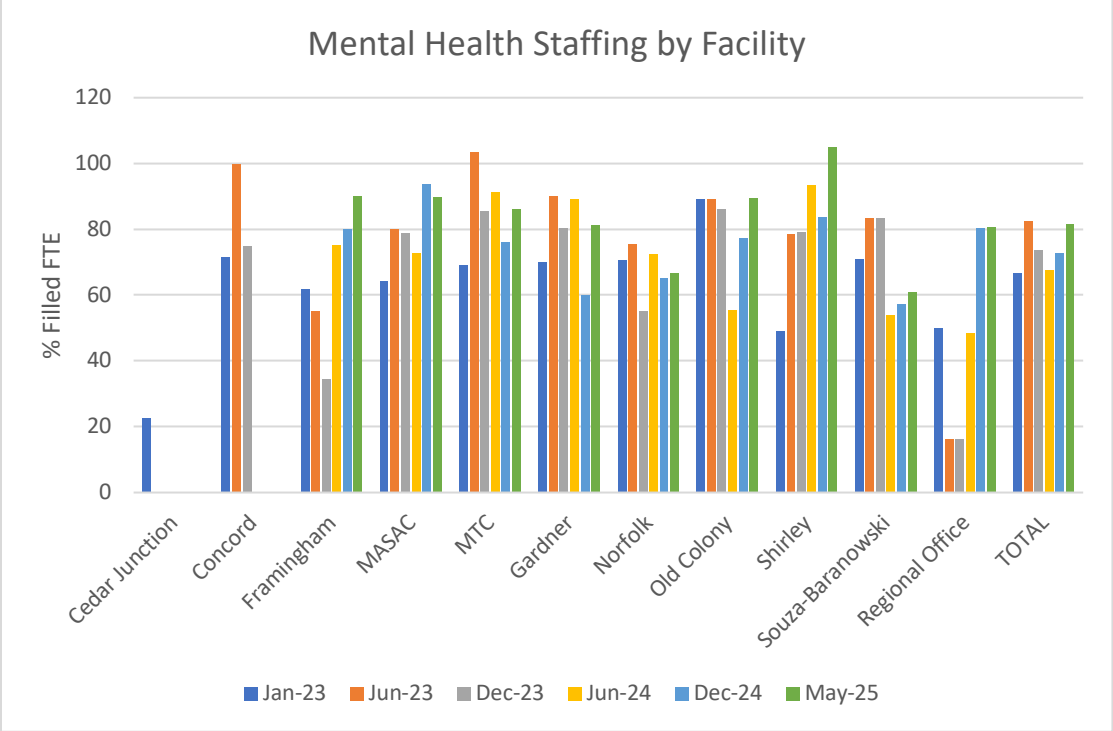


Figure 5 illustrates mental health staffing levels by facility. Among the facilities, SBCC remained worst off, operating with approximately 61% of necessary mental health staff in May 2025, including only 40% of MHP positions (7.95 out of 20 FTE). This represents a decline from December 2024, when 47% of MHP positions were filled, and it has occurred despite VitalCore's effort to improve recruitment at SBCC and OCCC by instituting a higher salary for MHPs at those facilities.

On a positive note, staffing levels at OCCC, Framingham, Shirley, and MASAC remain strong, with >90% of mental health positions filled.

Figure 5. Mental Health Staffing by Facility[15]



Since the Agreement began, the DQE team has reported concerns about the dearth of doctoral-level mental health professionals in the MDOC system; this concern has not been alleviated despite the overall positive trend in staffing numbers. Between VitalCore (for the seven prison sites) and Wellpath (for MASAC), the contracted number of psychiatrists and nurse practitioners is unchanged, with a total of 7.8 FTE psychiatrists and 6.1 FTE nurse practitioners to serve MDOC's approximately 2,700 prisoners on the mental health caseload. This does not meet the physician-to-patient ratio recommended by the American Psychiatric Association for carceral settings,[16] which led the DQE team to recommend in the last report that the number of contracted psychiatrists/APRNs be increased, especially at OCCC, SBCC, and Norfolk.

VitalCore responded to the DQE team's feedback about psychiatry understaffing, reporting during the June 2025 site visits that an additional part-time APRN had been hired to provide coverage at Framingham, Norfolk, and Shirley. This is a start, though mostly not targeted at the right facilities[17] and not nearly enough of an increase to solve the problem. As noted in Paragraphs 71 and 110, a substantial proportion of clinically

[15] On this chart, the "Regional Office" site includes only MDOC's Regional Psychologist positions (3.1 FTE total).
[16] The ratio recommended in the APA's *Psychiatric Services in Correctional Facilities, Third Edition* (2016) is 1:150 for "outpatients" in general population. Higher ratios are recommended for specialized settings like the RTU, STP, HSU, and ISU.
[17] In June 2025, VitalCore leadership reported that the nurse practitioner would spend 0.2 FTE, or one day a week, at Norfolk.

indicated psychiatry contacts for TS patients are not occurring, and these problems are worst at Norfolk, SBCC, and OCCC.

Another ongoing challenge is that MDOC continues to employ a high proportion of MHPs who are not independently licensed. In the DQE's review of the May 2025 VitalCore staffing matrix, just 6 MHPs, comprising 4.95 out of 63.75 FTE, were independently licensed, meaning that over 90% of MHPs are not independently licensed. At Framingham, Shirley, and Norfolk, the Mental Health Director is the only independently licensed MHP at the facility. Although the non-independently licensed clinicians do have formal weekly supervision as part of working toward licensure, the supervisor is often located off site. This makes for a challenging treatment environment at the facility, where each decision about patients on TS must be "triaged" with the mental health director, placing strain on limited staff resources and contributing to the sense of always operating in "crisis mode."

As noted in previous DQE reports, understaffing and inexperience of mental health clinicians negatively impact MDOC's ability to provide meaningful therapeutic intervention. Although VitalCore has enhanced its staff training in recent months, problematic practices such as conducting cell-front "proxy PCC contacts" with a staff member other than the assigned clinician persist. Although the reasons for this practice are multifactorial, it is likely driven by understaffing at some facilities.

Staff turnover is another important factor that affects the quality of mental healthcare across MDOC. The DQE team did not formally assess turnover during this monitoring period, but during the site visits, it appeared that mental health staff retention had improved modestly.

Overall, more work must be done on mental health staffing, but the improvements under VitalCore since July 2024 are a positive development.

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

Deputy Commissioner of Prisons or Designee as deemed necessary, will be responsible for rendering the final decision.

Finding: Partial compliance

Rationale: Documents and on-site discussions demonstrate that the ISU's supervising clinician (i.e., unit coordinator) is an independently licensed QMHP and that all unit mental health staff report to her. The ISU's staffing plan, as of the April 2025 OCCC site visit, is outlined in *Table 3:*

Table 3. ISU Staffing Plan

Position	Contract FTE	Filled FTE
Mental Health/Medical		
Psychiatrist	0.5	0.5
Activity Therapist	2.4	2.4
Mental Health Professional	4	3
Support Person	3.6	3.6
Unit Coordinator	1	1
Nurse	4.2	3.6
Administrative Assistant	0.5	0
Security		
CO I	16	16
CO II	2	2
CO III	4	4

The only change to this staffing plan since December 2024 is an increase in the number of contracted activity therapists from 1.4 FTE to 2.4 FTE. Key ISU positions have now been filled, including the unit coordinator, psychiatrist, and Support Persons.[18]

Because the ISU census remains fairly low—the highest census so far has been 8 patients—the MHPs assigned to the unit have been able to handle the workload despite not being at full staffing levels. From the DQE team's interviews and review of medical records, it appears that all mental health staff aside from the MHPs split their time between the ISU and other responsibilities at OCCC,[19] so the staffing matrix likely overestimates the time they spend in the ISU. Nonetheless, the current staffing levels appear adequate to meet the current number of patients' needs.

[18] The unit coordinator was in New Employee Orientation during the site visit on April 28, 2025, and began working at the facility in early May. Until that time, OCCC's Assistant Mental Health Director served as the unit coordinator.
[19] MDOC reported that a full-time ISU coordinator was hired on May 12, 2025. This staff member would not split their time between ISU and other responsibilities at OCCC.

Similarly, security staffing levels appear adequate to meet patients' needs, at least with the currently low census. On the first and second shifts, there are four officers and one lieutenant assigned to the ISU, and on third shift, there are three officers and one lieutenant or sergeant. There were no indications from the DQE team's interviews with staff or patients, or in review of medical records, that insufficient officer staffing was hampering treatment efforts in the ISU.[20]

The ISU's multidisciplinary team gathers for a daily triage meeting in which all major decisions about a patient's care are made. On the days of the DQE site visit in April 2025, the treatment team consisted of the acting unit coordinator, activity therapist, psychiatric nurse practitioner, nurse, Support Person, and one correction officer, meeting the requirements of Paragraph 36. Similarly, in a review of six months of triage meeting notes, meeting participants usually included the unit director, one or more MHPs, a security staff representative, a nurse, activity therapists, and Support Persons. In this monitoring period, psychiatry was represented in more than half of the meetings, and a psychologist participated in about 25%. Because the supervising clinician led these meetings, it is reasonable to infer that she is making determinations about treatment decisions, as required by Paragraph 36, although meeting minutes reflected these rarely.[21] Additionally, the ISU Handbook, provided to patients, indicates that the supervising clinician is to review and approve all treatment plans.[22]

Paragraph 36 also requires that the ISU's supervising clinician make decisions about the conditions appropriate for each patient (e.g., clothing, property, showers). Although the draft policy 103 DOC 650 and the ISU Handbook speak to some aspects of the patients' allowed property and privileges,[23] neither document specifies who makes those decisions. Those documents, interviews with mental health staff and patients, and other communications with MDOC confirm that property decisions are made for the unit as a whole or by ISU program phase. During the DQE team site visit in April 2025, interviewees stated that security leadership is currently making those decisions. As one prisoner noted, "Mental health wasn't in charge of anything except the content of their classes." This practice does not align with the Agreement's requirement that the ISU's supervising clinician make individualized decisions about property and privileges.

[20] See Paragraph 40 for a discussion of insufficient ISU officer training—a separate issue from staffing levels.
[21] Six months of minutes showed single instances of plans for a behavior management plan, seeking an involuntary medication order, changing the extent of staff's support to foster a patient's independence, and a handful of referrals to psychiatry or psychology.
[22] ISU Handbook dated December 13, 2024
[23] See Paragraph 127 for further discussion of property decisions.

Staff interviews indicate that disagreements about conditions decisions are handled by the same method used throughout OCCC. Please see Paragraph 56 for further discussion.

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

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

Finding: Partial compliance

Rationale: This requirement went into effect on July 1, 2024, the start of the fiscal year after the initial staffing plan was due to the DQE and DOJ (April 20, 2023). As noted above, MDOC improved its mental health staffing levels during this monitoring period, but security staffing is slightly worse. Both groups are far from full staffing levels, warranting a partial compliance finding overall.

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: Substantial compliance

Rationale: MDOC provided documentation of its pre-service and annual in-service trainings during this monitoring period to the DQE team, including "Recognizing Mental Illness and Suicide Prevention," which meets the Paragraph 38 requirement for de-escalation, mental healthcare, and suicide prevention. Interviewed staff members have consistently reported that training completion is required annually, and recent hires confirmed that mental health topics had been part of their pre-service training. After five monitoring periods of review, the DQE team is satisfied that required training occurs regularly. The DQE has reviewed the training materials in previous monitoring periods and concluded that they meet the Paragraph 38 requirement to use competency-based adult learning techniques.

MDOC also provides "Specialized Treatment Unit" training for officers posted to units such as the RTU, STP, and ISU. Throughout monitoring, officers in specialized units have told the DQE team they attend this training repeatedly. Soon after the ISU began

operating in August 2024, the initial ISU officers said most on the post had also received this training. Records indicate that the "Specialized Treatment Unit" training currently includes training on ISU policies and procedures and was most recently offered on June 10, 2024; June 24, 2024; December 12, 2024; and May 29, 2025. The DQE team has reviewed the training materials, which cover topics including behavior management plans, building effective teams, officer resiliency, correctional mental health services, and outcomes data of STUs. Two officers who completed the training described it to the DQE team as a "fantastic" two-day event, as have others in past monitoring. Although an insufficient proportion of current security staff members in the ISU have completed the training,[24] MDOC has provided ample evidence that it is being provided.

To address deficits in clinical skills that the DQE team has pointed out, as well as to train staff on new policies and procedures in accordance with Paragraph 38, VitalCore has implemented an enhanced training program for its mental health staff. During this monitoring period, VitalCore provided evidence of trainings including:

- New employee Orientation: Training on substance use disorders in corrections was added to existing trainings on suicide risk assessment, clinical boundaries, practices for clinical documentation, and sex offender treatment.
- Discipline- or role-based trainings:
    - *Mental health directors:* Clinical interventions to consider with Therapeutic Supervision, new documentation templates in the electronic health record, behavior management plans, criteria for opening and closing mental health cases (monthly)
    - *Ancillary mental health staff:* Training on QPR (Question Persuade Refer) for suicide prevention, conducting chart reviews, and professional boundaries (monthly beginning in February 2025)
    - *Support Persons:* group meeting with an independently licensed MHP to discuss case scenarios and relevant topics (weekly)
    - *Unlicensed MHPs and licensed MHPs New to DOC:* monthly, regional group supervision meetings to discuss clinical challenges
- Annual in-service training (most recently in December 2024):
    - Comprehensive mental health assessments
    - Behavior management plans
    - Staff wellness
    - Suicide risk assessment: Prevention and intervention
- Site-based trainings:

[24] See Paragraph 40 for further discussion of training completion.

- Various sex offender trainings at MTC (e.g., case conceptualization, psycholegal documentation, personality disorder, countertransference)
- Work-life balance at MTC
- Suicide Prevention at all sites (same training as for DOC staff)
- Criteria for Opening and Closing MH Cases OCCC, SBCC, Norfolk, Shirley
- Clinical Interventions for Patients on Therapeutic Supervision at all sites
- Importance of the Therapeutic Relationship, Managing Transference/Countertransference with Patients, Purpose of Crisis Assessment at SBCC
- Treatment Planning at Gardner

Although the DQE team has not seen major shifts in clinical practice as a result of these trainings,[25] their provision is an important step in the right direction. The DQE team is pleased with the enhanced focus on clinical skills that VitalCore has undertaken.

Overall, it appears that MDOC's obligation to provide pre-service and annual in-service training is being met. Completion of these trainings by required staff is addressed in Paragraphs 40 and 42c.

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

Finding: Compliance not yet due

Rationale: No new policies or policy revisions have been finalized since the Agreement began, so MDOC is not yet required to incorporate them into its annual training plan. In reality, it has already incorporated the Therapeutic Supervision policies into its annual training plan, and it has also offered ISU-specific trainings to some staff.

Paragraph 39 also requires that MDOC consider the DQE's recommendations about its training plan. At this time, the DQE team makes just one recommendation: that all officers bid into the ISU undergo ISU training immediately.[26]

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

[25] See Paragraphs 52, 72, and 73 for further discussion of this issue.
[26] See Paragraph 40 for an explanation of this recommendation.

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: Policy 103 DOC 650, Mental Health Services, was approved by DOJ on March 5, 2025, but since MDOC made further revisions after that date, re-approval by DOJ is necessary. Compliance with Paragraph 40's training requirements will be due 12 months from the date of DOJ's re-approval.

Although the Paragraph 40 requirements are not yet due, one issue arose during this monitoring period that is worthy of comment. Security and mental health staff must take a coordinated approach to creating a therapeutic milieu in the ISU; that is essential to the model. Officers initially posted to ISU reported that nearly all had received unit-specific training, and mental health staff praised the collaboration that resulted. In November 2024, there was a "job pick," and an entirely new cadre of officers now staffs the unit. With this new group, there were inconsistent reports of completing MDOC's training on ISU policies and procedures.

Accordingly, the DQE team requested ISU training completion records from MDOC's Division of Staff Development in July 2025. When the ISU training records were cross-referenced with the list of officers bid into the ISU as their primary post, it became apparent that fewer than 25% of bid officers had completed the ISU training. This is a substantial gap in MDOC's training program; correcting it as soon as possible is essential to the success of the unit.

In addition, during the DQE team's site visits, officers and security leadership reported that the ISU is often staffed with "STA" officers—roving staff who cover duties wherever needed—who are unlikely to have completed ISU training. This has the potential to substantially affect the unit's climate, and the DQE team urges MDOC to avoid this practice as much as possible.

41. Training on mental health care, suicide prevention, and de-escalation techniques will be provided by trainers using current evidence-based standards on these issues, and will include, if

available, video(s) depicting individuals speaking about their own experiences or experiences of their family members who have been on Mental Health Watch.

Finding: Substantial compliance

Rationale: There are no new findings to report here. MDOC continues to instruct staff on mental healthcare, suicide prevention, and de-escalation techniques in two main trainings: "Recognizing Mental Illness and Suicide Prevention" and "Therapeutic Supervision." The DQE and DOJ have reviewed and approved the 8-hour pre-service and 2-hour in-service suicide prevention trainings, as well as a 2-hour in-service Therapeutic Supervision training. Since September 2024, the Therapeutic Supervision training has included a video of incarcerated people discussing their experiences with mental health. Taken together, these facts warrant a continued substantial compliance finding.

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: Substantial compliance

Rationale: Since the DQE's first report, subsections 42a-d have been assessed individually because they address different aspects of training and mandate compliance on different schedules. Over time, MDOC has gradually demonstrated compliance with all the Paragraph 42 subsections:

42a (Crisis Intervention Training): substantial compliance
42b (Revise suicide prevention training): substantial compliance
42c (Pre-service and in-service training): compliance not yet due, but MDOC is already meeting the threshold for substantial compliance
42d (CPR training): substantial compliance

While it is difficult to conclude that all MDOC staff now "demonstrate the adequate knowledge, skills, and ability to respond to the needs of prisoners at risk of suicide" merely by verifying that the trainings required in subsections 42a-d are occurring, the DQE team has chosen to address those knowledge and skill gaps in the provisions where they are contributing to deficiencies in service provision (e.g., MHPs' limited skill in assessing suicide risk is addressed in Paragraph 47 rather than here).

MDOC's recent progress in each subsection of Paragraph 42 is discussed below.

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

MDOC's June 2025 Status Report indicates:

> 8-hour Crisis Intervention Training (CIT) refresher courses were completed on March 19, 2025, March 20, 2025, April 16, 2025, and April 17, 2025. The last 40-hour Crisis Intervention Training commenced in December 2024. There is no date planned as of June 20, 2025, for the next Crisis Intervention Training. As of June 20, 2025, there have been a total of 340 staff trained in CIT by the MDOC team, with 256 active individuals.

A comparison between the December 2024 and June 2025 Status Reports indicates that 77 additional staff members were trained in CIT in the first half of 2025. MDOC provided sign-in sheets from the CIT 40-hour training on December 16-20, 2024, as well as 8-hour the refresher trainings on January 23, February 19, March 20, and April 16, 2025. These logs are consistent with MDOC's report of CIT training in its June 2025 Status Report.

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

b. Within six months of the Effective Date, MDOC will review and revise its current suicide prevention training curriculum, which will be submitted to the United States for review, comment, and the United States' approval in accordance with Paragraph 27 and include the following additional topics:

1. suicide intervention strategies, policies and procedures;
2. analysis of facility environments and why they may contribute to suicidal behavior;
3. potential predisposing factors to suicide;
4. high-risk suicide periods;
5. warning signs and symptoms of suicidal behavior (including the suicide screening instrument and the medical intake tool);

6. observing prisoners on Mental Health Watch (prior to the Mental Health Crisis Assessment/Evaluation (Initial) (see Paragraph 47)) and, if applicable, step-down unit status;
7. de-escalation techniques;
8. case studies of recent suicides and serious suicide attempts;
9. scenario-based trainings regarding the proper response to a suicide attempt, and lessons learned from past interventions; and

There are no new findings here. The DOJ approved MDOC's "Suicide Prevention & Intervention" training materials on October 16, 2024, in accordance with the Paragraph 42b requirements. No substantive changes have been made to the training since then.

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.

Since no policies have been finalized, compliance with this provision is not yet due. However, MDOC has provided voluminous data about training completion to the DQE for over two years. Since the July 2024 healthcare vendor transition, training records have been compiled from three different agencies: MDOC (for security staff at the prison sites), VitalCore (for mental health staff at the prison sites), and Wellpath (for all staff at MASAC). Each agency uses different methods to keep track of training completion, which makes it difficult to arrive at an overall compliance determination. However, based on data submission and staff interviews over multiple monitoring periods, MDOC appears to be meeting the requirements of Paragraph 42c. During this monitoring period, MDOC demonstrated:

- *Pre-service training:*
    - Newly hired security staff have completed 8 hours of pre-service suicide prevention training as part of the Officers' Academy;
    - Newly hired VitalCore staff have completed 8 hours of pre-service suicide prevention training as part of VitalCore's NEO;
    - Newly hired MASAC staff have completed 8 hours of pre-service suicide prevention training as part of Wellpath's NEO;

- *Annual in-service training*[27]*:*
    - In Training Year ("TY") 2025, 87% of security staff who were required to complete annual in-service suicide prevention training[28] did so (1,758 of 2,011 staff at the seven prison sites where TS occurs). This is similar to the TY24 rate of 90%, demonstrating sustained good practice around suicide prevention training.
    - 87% of MASAC's staff (85 of 98 staff) were up to date on suicide prevention training as of June 1, 2025, which is also similar to the TY24 rate.
    - VitalCore offered online suicide prevention trainings to non-mental health staff (e.g., nurses, administrative assistants, records clerks) on January 31, March 4, April 4, and May 9, 2025. 151 staff members completed the trainings.
    - VitalCore's mental health staff completed in-person suicide prevention training during their annual in-service training in December 2024.

  Although the Paragraph 42c requirements are not yet due, given the good demonstration of suicide prevention training completion over two training years, MDOC is likely meeting the threshold for substantial compliance.

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

CPR certification is required for security staff approximately every two years.[29] MDOC provided CPR certification records to the DQE for review, which indicate that 1,779 of 2,011 staff (88%) at the seven sites where TS occurs maintained an active CPR certification as of June 13, 2025. This demonstrates continued excellent practice in CPR certification for MDOC security staff; the completion rate in TY24 was 93%.

Wellpath provided evidence of the MASAC security staff's CPR certification. These data indicate that 97 out of 98 security staff members had a current CPR certification as of May 2025 (99%). This also demonstrates excellent practice with CPR certification.

[27] MDOC's training logs do not account for staff turnover, so if there were a significant influx or exodus of staff during a training year, the actual completion rates may be higher or lower than those listed here.
[28] MDOC's June 2025 Status Report defines this group as "everyone who has contact with prisoners," which is a broader group that the Paragraph 42c requirement of security staff working in specific units or roles.
[29] Completion of CPR training is required in every other Training Year, so the actual dates might be more or less than two years apart. For example, if an officer completed CPR training in August of 2022, they would be required to recertify between July 1, 2024, and June 30, 2025.

THERAPEUTIC RESPONSE TO PRISONERS IN MENTAL HEALTH CRISIS

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

Finding: Partial compliance

Rationale: MDOC's policies clearly reflect this requirement, and officers, mental health staff, and leadership appeared well aware of these expectations when interviewed during each monitoring period. However, there have also been reports each time of substantial gaps in this policy's implementation. For the current report, the DQE team interviewed security staff across all TS settings and other types of housing, mental health staff, and prisoners. In addition, the team reviewed a log of allegations against staff.[30]

Crisis calls are concentrated in BAU, STP, SAU, and RTU settings, with officers' estimates of frequency ranging from two to three times per week to multiple times per day. Officers in Framingham's BAU, OCCC's ISU, and all facilities' HSUs and general population units reported that crisis calls happen rarely on their units.

Over time, mental health and security staff have spoken of officers and other types of staff referring a prisoner to mental health staff on an emergent basis because of their own concerns about the prisoner. As in the past, officers affirmed during this monitoring period that they also inform mental health staff when a prisoner requests an emergent contact ("calls crisis"). Among patients, however, only one-third—those in OCCC's RTU and general population and one patient at Norfolk—thought their crisis calls were always conveyed. A large majority, across all visited men's institutions and including all SBCC programs, thought officers inconsistently notified mental health of the prisoners' requests. In three cases, patients said they then cut themselves or observed others attempt hanging when they believed mental health staff had not been called on their behalf. The DQE team also encountered a constant observation sheet that recorded a patient "calling crisis" for two hours before mental health staff were called.[31]

[30] Interviews included 15 security staff, 11 mental health staff, and 19 prisoners, though in most cases, interviewees spoke about some aspects of Paragraph 43 and not others. MDOC refers to the document as the Professional Conduct log. It is managed by the Clinical Operations Analyst, who compiles data from staff's confidential incident reports, tracks and records investigation outcomes, and shares the log with the DQE team on request.

[31] MDOC looked into this event at the DQE team's request and has described plans to prevent this from recurring.

A majority of the accusations documented in MDOC's "Professional Conduct Log"—64 percent—center on not passing along, or delaying notice of, crisis calls.[32] While those complaints came from five institutions, they were primarily concentrated at Norfolk. It is unknown whether this reflects a higher rate of potentially problematic conduct or a higher rate of MHP reporting.

Some OCCC mental health staff expressed continued concerns that they receive little information from referring officers when they are notified of a crisis call, hindering their ability to review the patient's history and to assess them comprehensively. Information reportedly flowed more effectively for Norfolk and SBCC MHPs.

Staff and prisoners have noted consistently that, when a prisoner calls crisis, it is common for officers to screen the request by asking whether the prisoner intends to hurt themselves or someone else. Whether security staff then hold the prisoner under constant observation often depends on the answer to that question. To ensure that officers' actions are consistent with the Agreement, it will be important to provide them definitions of a crisis call and guidance on when constant observation until mental health assessment is required and when it is optional.

While some good practices are evident, many sources suggest that immediate notice to MHPs and maintaining constant observation is inconsistent at best. Being able to demonstrate these practices more consistently, and/or creating a system that reliably distinguishes between emergent and urgent referrals, as discussed in Paragraph 44, will be necessary to achieve substantial compliance.

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

Finding: Partial compliance

Rationale: Assessing this requirement is complicated by the significant number of prisoners who "call crisis" while also giving indications that the request concerns a more general need for mental health support or an issue related to institutional operations. Security and mental health staff have attempted different methods to manage under these circumstances.

[32] After controlling for multiple reports of the same event, there were 44 allegations of officer misconduct. Among those, 28 concerned officers conveying crisis calls to mental health staff. These numbers differ from those found in an analysis of Paragraph 93 requirements; the analysis here includes allegations made in 2024 where the investigation and resolution occurred in 2025.

As described in Paragraph 43, all types of staff and prisoners say it is common for officers to ask the prisoners whether they feel they will hurt themselves or others, and it has appeared that officers' subsequent actions, potentially including the speed with which they convey that request to mental health staff, can depend on the prisoner's answer. In the DQE's fourth report, the DQE recommended that MDOC clarify policy and practice around requesting urgent and emergent evaluation of prisoners by the mental health staff, and VitalCore took a first step in that direction during this monitoring period.

Reportedly, VitalCore informally instructed MHPs that the designated "crisis clinician" and the Mental Health Director, or another independently licensed clinician, should confer about the information security staff conveyed and decide whether a request is emergent or urgent. If there was guidance about criteria to apply or how much information is needed before reclassifying a crisis call as urgent rather than emergent, it was not shared with the DQE team. The determination of response level is then to be recorded on the "Crisis Log"[33] and it dictates the time that the crisis clinician has to complete the assessment.

When reviewing a sample of crisis logs for this monitoring period,[34] it was clear that this guidance had changed the mental health staff's practice concerning crisis calls substantially. Crisis calls were reclassified as urgent at a much higher rate than in the past, and many more crisis calls showed a response time longer than one hour. Recording methods suggested that institutions took quite different approaches. At present, the logs raise more questions about timely response than they answer, so they do not add reliably to the DQE team's analysis.

The DQE team's interviews gave a stronger sense that MHPs usually respond timely, while also presenting notable exceptions. All 11 officers, across all visited institutions, estimated that MHPs see crisis-referred patients within 40 minutes, and most said responses occurred much sooner. One mentioned that the time to contact could exceed an hour for patients who say it is not an emergency. OCCC patients, and some at SBCC, agreed that response times are very short and well within the requirement.

Five SBCC patients, however, said they have experienced waits of one to three hours, or days, or no response at all. Cross-referencing their self-reports to the sampled crisis logs provided limited information, with one or two examples each of the log confirming the

[33] This log is maintained at each facility and contains crisis calls, TS contacts, TS follow-ups, and "sick slips" (written patient requests to be seen) and sometimes other types of contacts.

[34] Each institution responsible for TS provided its crisis logs for the second week of each month in the period January through June 2025.

claim for a call designated as emergent, affirming a longer response time for a non-emergency request, or documenting shorter response times than the patient reported, while others did not appear in the sample. Thus, it was not feasible to determine any patterns of whether there were extended crisis response times, whether they were due to the time it took to notify mental health staff or to the response time, or whether response times were a product of reasonably deciding the request was non-emergent. However, with more than one-third of interviewed patients describing wait times that exceed the requirement, and with this recurring through multiple monitoring periods, one cannot reject the claims out of hand.

Much of MDOC's practice has been strong on these requirements. It remains important that MDOC and/or VitalCore work with the DQE team to ensure that the system of categorizing referrals initially labeled as crisis calls is operating in alignment with Paragraph 44. The DQE team's goal is not for staff to spend more time logging crisis calls, but rather for MDOC/VitalCore to explain the criteria and guidance given to staff about how to differentiate urgent from emergent requests.

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

Finding: Partial compliance

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

In its June 2025 Status Report, MDOC stated that trainings for nursing and mental health staff about crisis assessments have been undertaken by VitalCore's Director of Training during this monitoring period. In addition to reviewing the training materials, the DQE team saw evidence of VitalCore's efforts in the electronic health record, with a new note template for nurses' BAU screenings (form 1901) appearing in the records beginning in mid-June 2025. This template prompts nurses to review the patient's history of self-

injury and consider other important risk issues when conducting BAU screenings. It is too soon to say whether the new documentation template will improve practice, but its implementation is a positive development.

To assess MDOC's system for overnight crisis assessments, the DQE reviewed June 2025 triage notes from all eight facilities where TS occurs, trying to find cases where an MHP conducted a follow-up visit after an overnight or Sunday crisis call.[35] Eleven such cases were identified, across six facilities. Of these cases, 91% of the health records contained a progress note about the crisis contact written by a nurse. 64% of the nurses' notes indicated that the on-call MHP had been consulted, as required by Paragraph 45 and MDOC's policies.[36] A mental health clinician followed up within 24 hours in 100% of cases, but almost half of these contacts (45%) occurred cell-front or in other non-confidential settings. SBCC accounted for most of these cell-front contacts, with some lasting as little as two minutes.

Another source of data about overnight crisis contacts is the DQE team's study of 96 TS contacts, [37] where almost a quarter of the TS placements were initiated by a nurse at night or on a Sunday, in consultation with the on-call MHP. In all cases, the patient was seen by an MHP the next day by virtue of MDOC's well-established protocol for seeing TS patients three times daily.[38] This sample included one instance where the on-call MHP

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[35] This methodology would not capture overnight nursing assessments that were *not* referred to mental health for follow-up or where that follow-up did not occur. The DQE team is unaware of a method to identify those cases, but lack of mental health follow-up has not arisen as a significant problem through interviews with patients or staff across five monitoring periods.

[36] The four cases where MHP consultation was not apparent, three were BAU screenings. As noted in previous DQE reports, the parties disagree about whether these screenings should be included as crisis contacts for the purpose of the Agreement. In the fourth case, no nursing note was present in the health record, so it is not possible to determine whether the on-call MHP was consulted.

[37] The DQE team studied a sample of 96 TS placements to assess different aspects of the Agreement. To construct the study sample, the team drew upon the spreadsheets referred to as the TS Registry, which MDOC provides monthly to demonstrate all TS placements. Cases were selected from all eight institutions where TS occurred from January through June 2025, in proportion to their percentages of the systemwide total. The sample was chosen to capture stays in all housing areas where TS takes place (HSU, BAU, STU, ITU, ISU, RTU, SAU, and MASAC's "Housing Unit") and drew from each month in the period. The selection favored stays of four days or longer to be able to observe patterns of practice and requirements that go into effect as of the third day.

This sample was used to assess several Agreement requirements in this report. In some instances, conclusions may have been reached based on fewer than 96 TS placements because the requirement only occurs in the circumstances of a smaller number of patients. For some requirements, additional cases were selected to reach an adequate sample size for the question being examined. Not all method variations will be captured in this report, but descriptions are available on request.

[38] The DQE team is not aware of any data source that identifies all evaluations handled through the on-call system, so it is not possible to systematically select a sample or to determine whether this sample size is sufficient to be representative. However, this 23-record set is substantial enough to draw some conclusions and its percentage of the overall sample is nearly identical to that of the studies undertaken for the DQE's second and third reports, which could suggest the frequency with which on-call evaluations take place.

did not place the prisoner on TS after discussing the case with the nurse, but another MHP did see the patient the following day.

Across five monitoring periods, the DQE team has seen that the practice of MHPs following up with patients after overnight crisis calls is well established across MDOC. All MHPs who were asked by the DQE team knew of the requirement to see patients on the next business day after an off-hours crisis contact, the triage meeting minutes indicate that it is occurring, and the DQE team witnessed discussions of such contacts during the daily triage meetings. Nurses' documentation of their consultations with on-call MHPs continues to be less consistent. It is not clear whether this is a documentation problem or a practice problem, and the DQE team will try to clarify that point in the next monitoring period.

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

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

Finding: Substantial compliance

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

During the current monitoring period, the DQE team learned about and sought to review five potential disciplinary cases for misuse of crisis. In four cases available for review, auxiliary behavior in the incident was charged (for example, damaging a door lock), but there were no charges brought for misuse of crisis. The case resolutions seemed appropriate, including one where all charges were dismissed. It was not possible to review the other case because it reportedly remains pending after five months. All of the other 12 interviewed patients did not name any instances of being disciplined for requesting a crisis contact.

Nine officers interviewed by the DQE team affirmed that they do not write disciplinary reports for misuse of crisis, with one indicating it is within mental health staff's

discretion. The majority of MHP interviewees also said such reports are not written or that they had not seen any. Four of the MHPs recounted single examples or said they had heard the practice occurs rarely; another pointed to charges such as refusing housing in the context of crisis calls and was concerned that these charges are sometimes brought as a substitute when officers know misuse of crisis charges are disfavored.

As noted in previous reports, the DQE continues to recommend that MDOC's current practices around issuing misuse of crisis disciplinary reports be formalized in policy. This deficit is addressed in the *Policy* section rather than here. MDOC remains in substantial compliance.

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

Finding: Partial compliance

Rationale: MDOC reported that its Health Services Division conducts audits of health records; the DQE team has not seen the audit results and cannot determine whether the process meets the Paragraph 47 requirements. In the June 2025 Status Report, MDOC mentioned a new VitalCore quality assurance program that is slated to begin in July 2025, which will identify gaps in practice and documentation around crisis assessments. Together with VitalCore's efforts to train mental health staff about risk assessment and management, this is a positive step toward improving the quality of crisis mental healthcare.

To perform an independent audit of crisis contacts, the DQE team reviewed a sample of 50 MHP crisis assessment notes.[39] During this monitoring period, VitalCore implemented a new note template (BH-7.0) that prompts clinicians to comment on the factors outlined in Paragraph 47a-f. As a result, the MHPs' notes more consistently documented their review of most elements required by Paragraph 47. However, the notes almost never indicated that clinicians had reviewed a patient's history of suicidal behavior/ideation at all, let alone from two sources (IMS, electronic health record) or in the level of detail required by subsection 47d. The absence of this documentation is consistent with the DQE team's observations of crisis contacts during the site visits, when clinicians inconsistently reviewed patients' records prior to evaluating them or making decisions about their risk. In addition, as noted in the fourth DQE report, historical information prior to July 1, 2024, is very difficult to access because of the healthcare vendor transition at that time; clinicians must either access Wellpath's electronic health record, ERMA, or sift through hundreds of pages uploaded from the old record into the new one. Practically, this was not occurring, and MHPs continued to make crisis assessments based on inadequate information.[40]

To their credit, MDOC and VitalCore are working to implement a recommendation that the DQE team made as early as February 2023: that clinicians have access to the electronic health record in the spaces where they typically evaluate patients (rather than just in their offices). During the April and June 2025 site visits, the DQE team saw evidence that ethernet and Wi-Fi will be available in some housing units at SBCC, OCCC, Framingham, and Norfolk. MDOC stated that the project is likely to be completed in fiscal year 2025 (i.e., before June 30, 2026).

Once implemented, access to the electronic health record may improve the thoroughness of crisis assessments, but it will not solve the problem of cell-front assessments. In the DQE team's study, 30% of crisis contacts were conducted cell-front, and 70% were conducted in a confidential space. The cell-front crisis assessments occurred mostly at OCCC and SBCC, but also occasionally at MTC, Norfolk, and Shirley. Clinicians inconsistently recorded the reason for cell-front contact, but at least a third were documented as "per security" without any explanation for the individualized reasons for security staff's directive. These data were consistent with the DQE team's observations and interviews with mental health staff during site visits. Especially in the BAU at SBCC

[39] This is a different sample from the study of TS placements described in Paragraph 45. Here, the reviewer randomly selected 50 crisis contacts from the eight institutions' triage meeting minutes between January and June 2025, in approximate proportion to the TS placements across MDOC. 96% of the studied contacts did not result in placement on TS.

[40] For a poignant example, see MDOC's mortality review of the suicide that occurred at SBCC on April 10, 2025. This patient did not have a comprehensive mental health evaluation in his health record at all, but subsequent crisis assessments commented on his risk as if the clinicians had reviewed relevant historical information from the comprehensive evaluation.

and the "New Man's" area at OCCC, crisis contacts continued to occur in non-confidential settings.[41]

Overall, the problem of inadequate crisis risk assessments persists, but it is encouraging that MDOC is taking meaningful steps to improve practice through staff training and recruitment, as well as a plan for increased access to the electronic health record.

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

Finding: Partial compliance

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

Over multiple monitoring periods, the DQE clinicians have opined that MHPs were missing cases where referral to psychiatry was clinically indicated, and this opinion has not changed during the current monitoring period. In the DQE team's study of 50 crisis contacts, first described in Paragraph 47, MHPs referred patients for psychiatric evaluation in 4% of cases. In each case where psychiatric evaluation was sought, the contact happened on the same day it was requested. There were no indications in the progress notes of more informal consultation between MHPs and psychiatry (i.e., a case discussion rather than referral for evaluation), but it is possible that such consultations occurred and were not documented (e.g., during the daily triage meetings).

In reviewing the 50 cases independently, the DQE clinicians found six other cases (12% of the total sample) where a psychiatric consultation was indicated but did not occur. The indications for consultation in these cases included reporting medication side effects or noncompliance, exhibiting signs of psychosis, specifically asking to see a psychiatrist, or reporting taking medications prior to arrival in MDOC but not currently receiving them.[42] The pattern of under-consultation with psychiatry has persisted since the Agreement began, but MDOC continues to train staff in this area and increase psychiatry staffing levels, so there is hope of eventually improving practice.

[41] MTC was not visited during this monitoring period, but its booking area also does not offer adequate confidentiality.

[42] This patient was a new admission to Framingham from the community and had not had an initial psychiatric assessment. In this instance, referral for either an urgent psychiatric evaluation or a "bridge" medication order should have been pursued, but neither were.

As for consultation with a clinical supervisor during crisis assessments, the DQE team has observed this well-established practice over five monitoring periods. MHPs' progress notes often contain the phrase "triaged with [site mental health director]" in the assessment/plan section, and during the site visits, MHPs were observed discussing cases in person or on the phone with the site-specific or regional mental health director in real time. Crisis calls were also discussed with the entire mental health team during the daily triage meeting, as observed by the DQE team and documented in the triage meeting minutes.

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

Finding: Substantial compliance

Rationale: In the DQE team's review of 50 crisis calls, 49 cases included a progress note (BH-7.0) in the DAP format (98%). In the one case where TS was initiated as a result of the crisis contact, the MHP documented the contact on a different form, the "Behavioral Health Therapeutic Supervision Contact Note" (BH-5.0), which contains all the essential elements of a DAP note. In the DQE team's examination of health records in 96 TS placements,[43] MHPs completed an appropriately formatted note for all placements.

A substantial compliance finding continues to be warranted for Paragraph 49, which requires only a properly formatted note in the medical record. The DQE's concerns about the substance and confidentiality of crisis evaluations are addressed in Paragraphs 47 and 52.

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

Finding: Substantial compliance

Rationale: Based on interviews of more than 60 mental health staff and 210 prisoners, observation of decision-making, and reviews of more than 550 health records and other documentation over five monitoring periods, the DQE team is confident that MDOC and its healthcare vendors have a culture that conservatively places prisoners on TS where there is perceived risk or uncertainty about risk.

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

As part of the analysis of this requirement, the DQE team reviewed 96 TS placements. In this sample, the MHP determined that the prisoner was at risk of self-harm in 79 cases,[44] and in each instance, the MHP did place the prisoner on TS. This is consistent with the practice observed in all previous DQE team chart reviews on this topic. While this method necessarily captures only cases that *were* placed, it provides some support for there being sustained, compliant practice. Similarly, in the DQE team's study of 50 crisis contacts,[45] all cases where an MHP identified acute risk of suicide or self-harm were then placed on TS. This demonstration is sufficient for a continued finding of substantial compliance.

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

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

Finding: Substantial compliance

Rationale: In previous monitoring periods, the DQE team established that MDOC's policies[46] prohibit the use of TS as punishment. Interviewed prisoners and staff continued to report that practice is consistent with this policy; none reported that TS was initiated for a reason other than a patient's health and safety.

Paragraph 51 also requires that TS is used only when less restrictive means are not effective or clinically appropriate. In the DQE's review of 250 crisis assessments across five monitoring periods, there have been no indications of over-use of TS. In fact, a remarkably small percentage of crisis contacts result in TS placement—just 11 out of 250 crisis contacts in the DQE's samples (4%). This is likely because crisis contacts continue to stem primarily from institutional stressors, especially at high-volume sites like SBCC

[44] See Paragraph 45 for a description of the study and its methods. The other placements were based on concerns about psychosis or harm to others.
[45] See Paragraph 47 for a description of the study.
[46] The relevant policy, 103 DOC 650, Mental Health Services, is still in draft form, but the DQE has confirmed that it prohibits using TS for punishment. The DQE team has previously recommended that MDOC memorialize its current system of allowing only mental health staff to pursue "misuse of crisis" tickets in policy; it is not clear whether this recommendation will be implemented.

and OCCC, and the patients are calmed after a brief encounter with mental health staff. The DQE team has had no concerns about TS being used punitively and has continued to observe staff in triage meetings, and at other times, recommending interventions such as more frequent mental health check-ins, referral to RTU or ISU, or Support Person contacts as alternatives to TS. Overall, the DQE team remains satisfied that, when TS is used, it is the least restrictive option based on clinical risk, warranting a continued finding of substantial compliance.

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

Finding: Partial compliance

Rationale: As in previous monitoring periods, the DQE team reviewed TS treatment plans to assess their completeness and clinical appropriateness. Despite VitalCore's retraining of staff and the revised template for TS contacts that was implemented in approximately March 2025, clinicians' documentation of treatment plans continued to be spotty. In the DQE team's review of 96 TS placements,[47] so many records left the "treatment plan" section of the initial TS contact note blank that it was impractical to quantitatively assess the detailed requirements of 52a-j. This practice was most prominent at SBCC.

The best of the TS treatment plans identified a patient's specific problems and a plan to work on them. For example, for a patient who was overwhelmed and fearful of peer conflicts on his housing unit, the MHP identified the following goals: "Utilize a 15' TS to

[47] See Paragraph 45 for a description of this study's methods. The review for these treatment plan requirements involves a subset of that sample.

ensure no conflicts with peers, and to provide a quiet, monitored space to enable patient to remain at a high enough level of functioning to participate in his safety planning." On the other end of the spectrum, treatment plans left the "assessment" and "problems" sections of the note blank and merely checked boxes indicating that the patient would be seen the next day, giving no indication of individualized planning. Overall, the new progress note template appeared to have improved documentation of initial treatment plans from the previous monitoring period, when such documentation was nearly universally absent, but more work is needed to reach substantial compliance, especially at SBCC.

Paragraph 52 also requires that patients on TS be referred to psychiatry when clinically indicated (52k). To assess this, the DQE clinicians reviewed 88 TS patients' medical records.[48] In assessing whether such contact was indicated, the DQE clinicians used the following criteria[49]:

- Self-injury that led to outside hospital evaluation (precipitating TS placement or while on TS)
- Medication noncompliance or evidence of medication misuse/diversion
- TS lasting >7 days
- More than one TS admission within 7 days
- New admission to MDOC with confirmed medications in the community[50]
- Diagnostic uncertainty after assessment by MHP
- Bizarre symptoms or out-of-character behavior
- Display or self-report of psychotic symptoms (e.g., hallucinations), even if suspected of feigning or exaggeration
- Prolonged hunger strike (to assess whether serious mental illness is contributing to the individual's food refusal)

Using these criteria, the DQE clinicians found that psychiatry referral was indicated in 90% of the sampled TS placements. Of the cases where referral was indicated, patients were seen by a psychiatrist or nurse practitioner in 58% of cases.[51] This rate is a marginal improvement over the previous monitoring period (54%) and similar to those that came before it. Practice was strongest at Framingham and Gardner, where 80% of clinically

[48] This is a subset of the TS study first described in Paragraph 45.
[49] These criteria are based on the DQE clinicians' best professional judgment and experience working in correctional settings.
[50] This applies mostly at Framingham and MASAC, where patients are sometimes admitted from the community rather than from other correctional facilities. If a patient is new to the system, has never seen a psychiatrist in MDOC, and is ill enough to warrant TS, their psychiatric evaluation should be expedited.
[51] The reviewers gave credit for psychiatry referral if the patient was referred at any time during the TS placement, not just as a result of the MHP's initial assessment and treatment plan.

indicated psychiatry contacts occurred, and worst at Norfolk, where just 13% of such contacts occurred.

Overall, it appears that crisis treatment planning is largely unchanged, underscoring the need for VitalCore's enhanced focus on training. A continued finding of partial compliance is warranted.

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

Finding: Substantial compliance

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

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

Finding: Substantial compliance

Rationale: Before Agreement implementation began, MDOC invested in designating cells for TS and modifying them for suicide resistance based on expert advice. Each facility providing TS has such cells, and the DQE team has found over time that the culture of using them is well established. Officers or supervisors interviewed during each monitoring period, including eight recently, have said there were a sufficient number of designated cells for the demand in their units; a few units reported having periodic overflow, but the officers were confident they were able to place patients in suicide-resistant cells on other units and did not have to use non-designated cells. Eleven mental health staff affirmed these points as well. The exceptions are SBCC's SAU and STP, where there are identified cells, but they are not suicide resistant.

As to sight lines, the DQE team has interviewed officers across five monitoring periods about their observation practices, and the team has observed the door design, the position of any officers providing constant observation, and the resulting sight lines in 18 units providing TS. In most facilities, this includes an HSU and a BAU, and some facilities also conduct TS in some specialized units (primarily ISU, ITU, RTU, SAU, and STP).

Some doors have been modified, in part to improve safety and visibility, since the Agreement went into effect.

On the whole, the DQE team finds that sight lines are reasonable for observing prisoners on TS.[52] A few cells, particularly in the ISU and ITU, have portions of the cell that are not easy to view, and officers had mixed opinions about whether cameras or changing positions addressed that sufficiently. It was also noted that the placement of built-in furniture in the ITU facilitates prisoners covering the cameras.

In 2024, MDOC determined that some of the designated cells at each relevant institution no longer met their standards for suicide resistance. MDOC initiated repairs and modifications, and during site visits and in status reports, MDOC updated the DQE team on the numbers of suicide-resistant cells and the progress of pending modifications. From the beginning of monitoring, interviewed officers and leaders commonly volunteered that any TS in a non-suicide resistant cell is monitored under constant observation, and they routinely reaffirmed that this has been the practice while the modifications have been underway. The DQE team also examined the security observation sheets for a sample of TS stays in non-suicide resistant cells.[53] It appeared that constant observation took place in 82% of those cases; the others were unclear.[54] This study provides further support that constant observation is the norm when non-suicide resistant cells must be used.

The DQE team finds that there is strong practice on Paragraph 54 requirements, and, on balance, it is sufficient for substantial compliance.

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

[52] For more detail, see previous DQE reports.

[53] The DQE team reviewed a convenience sample of records from 22 TS stays that likely took place in non-suicide resistant cells. These were drawn from Gardner, MTC, Norfolk, and SBCC's SAU and STP units. Norfolk's cases were selected from the period before its cells were re-certified as suicide resistant. The DQE team is not aware of a method to identify all uses of non-suicide resistant cells, so this sample may or may not be of sufficient size and balance to be representative, but it does provide some illustration of practice.

[54] Where the signatures on the security observation sheets changed approximately every two hours, this suggested the rotation that is expected when security staff conduct constant observation. Where an officer's signatures appeared to extend for a much longer time, it was unclear whether close observation was taking place instead, or whether constant observation *was* occurring but there was difficulty fulfilling the requirement to rotate officers.

Rationale: MDOC has developed an excellent cell safety checklist. It is well designed to guide staff to think about physical plant risks particular to TS patients, as well as checking on some other Agreement requirements such as lighting dimmers. Implementation of the checklist was less clear during this monitoring period.

Views about the checklist's use were wide-ranging among a few officers. Two confirmed using the checklist routinely, while others pointed to different criteria, different practices, or said cells are not checked before TS placement "unless something is amiss." At 50% of the documents reviewed, the compliance rate in the DQE team's analysis[55] was very similar to that found at the end of 2024. OCCC demonstrated the strongest, most consistent practices. Difficulties were concentrated at Norfolk, Shirley, and SBCC, although SBCC's demonstration was improved from the last time this requirement was monitored.

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

While there are some good components in place, unevenness in officers' understanding over time suggests that the practice of inspecting cells using a checklist, and documenting it, has not been standardized. The presence of checklists in materials provided to the DQE team has been improving incrementally, especially at SBCC, but the rate is still low. It seems that the most useful next step toward substantial compliance would be for MDOC to try to identify whether these results reflect issues of understanding and practice, or of managing the subsequent paper trail.

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

Finding: Substantial compliance

[55] See Paragraph 34 for a description of the sample selection and analysis methods. Cell inspection checklists were typically part of the packets provided to the DQE team.

Rationale: As detailed in previous DQE reports, MDOC has a well-established, well-functioning system to make decisions about TS patients' clothing; showers; lighting; property; privileges; activities; exercise; and, to some extent, restraints. The DQE team has observed triage meeting participants consistently discussing and deciding on these issues. Discussions often center on whether the patient has had a period of behavioral stability during the TS stay, is engaging with mental health staff, and/or is expressing intent for self-harm. Sometimes staff comment that the patient uses a particular item to cope, so it should be permitted. Similar discussions sometimes take place with mental health supervisors at other times in the workday; the DQE team observed these while shadowing MHPs and in progress notes.

In documentation, much of this reasoning was commonly captured in progress notes, triage meeting minutes, and Daily Consultation meeting notes. The decisions are consistently communicated to mental health and security staff on "TS Reports." All of these practices were sustained in the DQE team's observations and document reviews during this monitoring period.[56]

In recent site visits, three officers and 11 mental health staff commented on whether there are disagreements about property or privileges and how these are resolved. At Framingham, staff described a culture of collaboration where they could generally discuss concerns directly, and MHPs perceived officers as open to explanations, with only occasional cases being escalated and handled by first-level supervisors. At the other visited institutions, staff gave the impression of more frequent and stronger disagreements. At all visited sites, MHPs said officers sometimes do not provide property that had been authorized, and one SBCC officer understood it to be policy to withhold a controversial item until it is discussed at a weekly unit meeting.

Staff described different forms of resolution, ranging from MHPs having the final say, to direct conversation among line staff involved, to talks between Mental Health Directors and unit supervisors or Captains. Both OCCC and SBCC staff said there were times when the decision was escalated to a Deputy Superintendent or Superintendent. The decision at SBCC reportedly was made jointly with the Mental Health Director. OCCC's Superintendent ultimately made several final decisions about ISU property; the DQE

[56] To analyze practices for many of the requirements of Paragraphs 57 through 65, the DQE team selected a sample of 58 TS stays drawn from each of the eight TS institutions corresponding to their proportion of total TS stays. There were stays from each month in the period January through June 2025 and from nearly every TS setting. The sample included some cases from the study described in Paragraph 34 and some from the study described in Paragraph 45. For some property or privilege questions, other cases were substituted if necessary to answer the question posed.

The analysis employed the TS Reports from each of the sampled stays. These were either present in the electronic health record or provided by MDOC from its IMS system. In some cases, the reviewer cross-referenced this information with progress notes when necessary to clarify a question.

team was not informed whether these were made in consultation with the Deputy Commissioner of Clinical Services and Reentry, Deputy Commissioner of Prisons, or their designees.

While there are concerns about whether the bases for decisions about exercise and restraints, and the resolutions of escalated disagreements, are aligned with this Paragraph, the DQE will maintain a substantial compliance finding for now.

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: Through each monitoring period, including the present one, the DQE team has reached its findings on this paragraph after observing triage meetings and MHPs conducting TS contacts; interviewing MHPs, clinical leaders, and patients; and reviewing TS Reports. The current analysis reviewed records for 58 TS placements.[57] There was noted improvement in this monitoring period.

24- and 48-hour benchmarks: In the DQE team's analysis, 66% of the patients were authorized to be in clothes within a day, and 88% had clothes returned within two days. There were occasional reports, in MHP interviews and in progress notes, of delays in providing clothes after they were authorized.

[57] See Paragraph 56 for a description of the sample selection

Demonstrated clothing-related risk: When clothing was found clinically contraindicated in this sample, progress notes indicated that only 45% of those patients had demonstrated they would use clothing in a self-destructive manner. The DQE considers this to mean the patient made a specific threat to hang or strangle themselves; had a recent hanging or strangulation attempt, possession of a ligature, or other attempts or threats of self-harm using cloth; or had a history of one of those.[58] The compliance rate on this provision has fluctuated widely among monitoring periods, so it appears this approach has not become routine. The majority of patients were placed on smock status as an apparently conservative approach to patients with other self-harming behaviors, such as head-banging or insertion, or for self-harm threats.

Eleven mental health staff spoke about clothing decisions during site visits. All agreed that decisions are individualized, and several emphasized using smocks sparingly and seeking the least restrictive, safe option. Some described methods of providing added safety while testing out the patient's ability to manage in clothes. A few security staff also described decisions about clothing as varying by patient.

Twenty-two patients described their clothing-related TS experiences. Only 18% said they usually or always start a TS stay in clothing. A similar-sized group said some TS stays began with clothes, while others issued a smock initially, which supports the idea that decisions are tailored to the patient and circumstance. Many described it as being common to start in a smock and transition to clothes in a short time, consistent with the documents the DQE team reviewed. SBCC interviewees offered several types of experiences but were by far the largest group to say they are usually or always in a smock, including when aggression precipitated the TS and not self-harm.

Notice and consultation, daily documentation: Almost all patients who remained on smock status beyond two days were at SBCC.[59] Most had clothes returned in three to five days, although two were in smocks for the entire stay. There is a well-established system for notice and consultation concerning several Agreement provisions, including Paragraph 57.[60] For the seven relevant patients in this sample, most were captured in a timely notice to MDOC's Director of Behavioral Health and VitalCore's Director of Clinical Programs and presented at the leadership's Daily Consultation meeting, but two

[58] To seek this information, the DQE team reviewed the progress note initiating the TS placement. If additional information was needed to demonstrate clothing-related risk, the reviewer examined nursing and hospital transfer notes shortly preceding the TS and MDOC's SDV log for 2025.

[59] Norfolk and OCCC each had a single TS in the sample where the patient remained in a smock until the third or fourth day.

[60] See Paragraph 78 for a description of that system. For this Paragraph 57 analysis, the DQE team reviewed the notice spreadsheets and Daily Consultation notes for Days 2 through 4 for each of the seven patients in the sample who were on smock status on their Day 3.

were not. Of note, the meeting notes capture clinical information about these patients but do not usually reflect discussion directly about clothing status. Progress notes captured the reasons daily in a minority of these TS placements.[61]

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

MDOC remains in partial compliance with Paragraph 57. It is important that the key purpose of this requirement—that TS patients be able to wear clothes within two days—was improved to a high level, and the DQE team is hopeful that this can be sustained. Each of the other elements of this paragraph, particularly examining whether the patient's risk rises from having clothes or is unrelated, requires progress before the DQE can consider substantial compliance.

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: Practice remains the same in this monitoring period as in the last. The DQE team has found that MHPs consistently decide daily whether to authorize showers and document these decisions in progress notes and TS Reports. In the current monitoring period, the DQE team's property and privileges study found that, in every sampled case, the prisoner was approved for showers well within the required time frame.[62] A large majority of nine interviewed mental health staff said showers are always authorized, with two appropriately noting an exception if the patient were actively self-harming or in restraints.

[61] Daily notes that included reasons were present in 3 of the 7 sampled cases whose smock status remained after the second day.
[62] See Paragraph 56 for a description of the study and overall methodology.

This paragraph also requires demonstrating that TS patients are offered showers and that those are provided unless the patients decline. A handful of security staff specified the shower schedule during interviews; a similar number did not work on the shift responsible for showers but confirmed in general that they are offered routinely. One OCCC MHP offered an understanding that sometimes showers are not provided despite being authorized, and one at SBCC believed that showers are always offered. At least 83% of patients interviewed about this issue confirmed they were offered showers—they generally described the schedule—or were not on TS long enough for the requirement to apply. Three interviewed patients appeared to say they were not offered showers consistently or at all.[63]

Often, these high rates for authorizing showers and patients confirming that showers were offered, and the fact that these have been sustained for at least one year, would be sufficient for substantial compliance. Paragraph 58, however, specifies that there must be documentation of the offering and provision of showers, so this remains an outstanding issue. MDOC has informed the DQE team that it has designed the method for documenting the offer of showers and other activities, but implementation depends on first issuing the revised mental health policy, 103 DOC 650, which is pending.

MDOC will be in substantial compliance once the documentation system is consistently in use, assuming current practice regarding showers is also sustained.

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: There was great improvement, particularly at SBCC, in MHPs authorizing the use of dim lighting. The DQE team's study of property and privileges found these permissions in 97% of sampled cases,[64] and nine interviewed MHPs confirmed that they consistently authorize dim lighting.

With methods detailed in previous reports, the DQE team has verified that 15 TS settings, or 83% of TS settings reviewed, have the ability to dim lights in TS cells.[65] Two

[63] Their placements were long enough for the requirement to apply.
[64] See Paragraph 56 for a description of the study methods
[65] At MTC's most recent site visit, in 2024, staff reported that two of four TS cells have capacity for dimming. While theoretically this could leave some patients without that option, TS Registry logs show MTC had three TS patients simultaneously for only one day in the last year, so this facility is included in the 13 with sufficient dimming capacity. Dimmer installation in Shirley's two TS settings was confirmed in an MDOC email since the last DQE team visit to that institution.

interviewed officers said they work late night shifts and confirmed that dimmers are used, and some staff from other shifts believed that to be the case. A similar number said they would do so on request, seemingly putting the onus on patients, and one thought dimming was not permitted for prisoners on constant observation.

Nearly all the interviewed mental health staff believed the dimmers are used or had heard no issues about it from patients, though an MHP and a supervisor at SBCC were unsure or understood that officers sometimes do not implement that requirement. Among 18 interviewed patients, only 13% confirmed that lights are dimmed routinely. Others believed it varied depending on which officers were on shift or whether the patient was on close or constant observation, or that the lights were always fully on. Some patients at SBCC said they asked for lower lighting and officers responded that it was never allowed on TS. While perceptions and memories are not always accurate, this level of reported variation suggests implementation issues.

In its June 2025 Status Report, MDOC described a planned documentation method, which is expected after pending mental health policy revisions go into effect.

All this indicates progress but also that the use of low lighting is not institutionalized. It appears that clarifying policy for STAs and posted officers would be beneficial. More consistent use of dim lighting will be necessary for substantial compliance.

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

Finding: Partial compliance

Rationale: This requirement is handled under the same processes described in Paragraph 56, and this paragraph is understood to refer to property *other than* reading and writing material and tablets, which are addressed in Paragraph 61.

After reaching a significant level a year ago, authorizing property other than reading and writing material and tablets has greatly reduced in type and frequency. In the DQE team's analysis of property and privileges decisions,[66] MHPs authorized additional property in 43% of the sample, a low rate sustained for two monitoring periods now. Where there had been a growing pattern of diversifying items that could be helpful to patients' mental

[66] See Paragraph 56 for a description of the study methods.

health, in this review, the allowances were almost exclusively headphones and medical property, if applicable. Occasionally, eyeglasses were permitted, and there were single examples of permissions for religious items and legal paperwork. The uniformity of the choices does not suggest individualized decision-making.

In interviews with the DQE team, a handful of MHPs spoke about authorizing this type of property, and most cited headphones, medical property, and glasses, consistent with the documents the DQE team reviewed. Two OCCC clinicians referred to also providing religious items, with one saying they authorize additional property often. Nearly every prisoner who commented said they did not have any additional property, though one remembered having glasses and another said she had food and pictures.

These practices do not satisfy Paragraph 60's requirements.

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

Finding: Partial compliance

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

In the DQE team's study first described in Paragraph 56, reading material was allowed timely in 91% of the sample—an improvement since the Agreement went into effect that has been sustained at this level for 1.5 years.

A handful of MHPs and security staff, along with a majority of interviewed patients, affirmed that patients are usually or always permitted to have books. Almost half of patients, across three of the four visited facilities, said they could only access books sometimes or were never permitted to do so. The reason this report differs from other

information sources is unknown, but it has persisted at this level for 1.5 years, which suggests a potential access issue despite the books being authorized.

Writing materials were permitted less often, with timely authorizations at 66%. Only OCCC had very strong practice. This overall rate has further to go, but it continues to make steady, incremental gains during each monitoring period. Fewer interviewees spoke about writing materials. Most MHPs who commented said they do authorize such materials, while those at SBCC described it as appropriate later in a TS stay or not indicated for patients who self-harm. On the other hand, most SBCC patients said they *did* have writing material, but patients elsewhere said they did not.

As to tablets, the DQE team selected additional TS cases to review 10 patients with lengths of stay in which tablets would be required.[67] There, 70% of patients were approved to have tablets consistent with Paragraph 61, and another was authorized on the 23rd day. No patients at Shirley in the sample were not approved to have tablets. Additionally, in the larger property and privileges data set, MHPs continued to allow tablets and headphones for a majority of patients well before it would have been required.

Input from interviewed staff about tablets was similar to their thoughts about writing material. A majority of interviewed patients said they have had tablets during TS. Where patients said they had not had access, their lengths of stay were less than the 14 days at which tablets become required.[68]

In terms of documentation, whether considering reading material, writing material, or tablets, mental health staff almost never documented daily the individual reasons the item was contraindicated.[69]

To reach substantial compliance, improvement is needed for permissions for writing material, tablets for longer stays at Shirley, and particularly for thinking about and documenting contraindications for any of these items when disallowed. It appears there may be barriers to providing allowed books as well.

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

[67] This sample size represents 40% of the stays exceeding 14 days during January through June 2025. Stays of this length took place at five institutions; cases were selected from each of those facilities in roughly proportionate fashion. The cases were drawn from BAU, HSU, ISU, AND ITU.

[68] After site visits, the DQE team identified interviewees' lengths of stay for the preceding year on MDOC's log of all TS placements.

[69] Taking authorizations for reading and writing material and tablets together, there were 28 times when the Agreement would have required staff to document the reasons for contraindication daily; this occurred three times.

whether it is clinically appropriate for the prisoner to participate in routine activities (e.g., visitation, telephone calls, activity therapist visits, chaplain rounds). Absent Exigent Circumstances, the prisoner will be allowed to participate in the routine activities deemed clinically appropriate by the Qualified Mental Health Professional. If a prisoner is not approved for a particular activity, due to clinical contraindication, during a day, a Qualified Mental Health Professional will document individual reasons why that particular activity is contraindicated.

Finding: Substantial compliance

Rationale: The DQE team previously found this requirement to be in substantial compliance based on chart reviews; MHP, patient, and security staff interviews; and observation of practice during site visits. In the current monitoring period, the DQE team continued to observe property and privileges decision-making in triage meetings. In addition, the team analyzed TS Reports and progress notes and found that 100% of sampled records authorized the patient to have phone calls, visits, activity therapy, and religious rounds.[70]

A handful of interviewed officers affirmed that patients could access phone calls while on TS, as did 79% of patients who commented on this point. Those who disagreed were all on TS at SBCC.

Conversely, a similar percentage of patients thought they were *not* allowed to have visits, and three other patients reported being denied a visit despite MHPs having authorized them, according to progress notes or interviews. These could signal an access problem, particularly because the patients' beliefs have persisted at a high rate through several monitoring periods. MDOC may wish to examine whether there are barriers to implementing visits for patients on TS.

No other routine activities were specified in the reviewed documents, but the DQE team has observed MHPs' good practice of discussing whether patients were stable enough to participate in court hearings, legal visits, and off-site medical appointments, especially during long-term TS stays.

On balance, the DQE team finds that MDOC remains in substantial compliance.

[70] See Paragraph 56 for a description of the study and overall methodology. It was necessary to review the corresponding progress notes for the sample for recommendations on activity therapy and religious rounds as those are not captured on TS Reports. Practice for the one MASAC patient was not discernible as it appears recommendations are not captured in ERMA apart from the TS Reports.

Two patients were not allowed activity therapy temporarily while they were found to be out of behavioral control, but permissions were granted on other days.

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: The DQE team relied on TS Reports, staff and patient interviews, and the June 2025 Status Report to assess the Paragraph 63 requirements.

Approvals: In the DQE team's property and privileges study, TS Reports showed 68% of patients approved for recreation by the three-day benchmark.[71] A few patients were authorized within a few additional days, up to Day 8. Most institutions did well on approving recreation timely, and noncompliant cases were concentrated at SBCC, Shirley, and MTC.

[71] The DQE team studied privileges and property for 58 TS placements; see Paragraph 56 for a description of the study and overall methodology. To assess recreation authorization within that sample, the reviewer included TS stays that exceeded three days, as well as three-day stays where recreation was already allowed, and did not include cases where the patient was discharged on the morning of the fourth day.

This totaled 53 TS stays, which is a 32% sample of all stays exceeding three days in the monitoring period. Where progress notes and TS Reports conflicted, the reviewer relied on the TS Reports. The cases considered compliant included one where the patient was *not* approved for recreation but was at an outside hospital for nearly his entire TS, so meeting the requirement would be impossible.

At SBCC, only 26% of cases were compliant, and nearly all of those were approved right at the deadline. Contraindication reasons were universally recorded as "due to risk," regardless of the patient's circumstance and without reference to what risk recreation might pose for that patient's mental health. The same compliance rate and recording practices were evident in the preceding monitoring period as well. Taken together, this suggests a uniform practice of not considering recreation before 72 hours at the earliest and a default approach that recreation is contraindicated for everyone, not the required individualized decision-making.

Among 10 mental health staff interviewees, the Framingham MHPs reflected a culture strongly oriented toward recreation. Others' comments centered on concerns about patients being in smocks—by contrast, Framingham staff described authorizing clothes exclusively for yard time successfully—and risk of self-harm or aggression. Their views about SDV contraindicating recreation varied by degree, from seeing this type of contraindication as rare, to limiting yard time only if suicidal or homicidal ideation is active, to an expectation of behavioral control, to a categorical contraindication if there was any recent SDV.

Providing recreation: In terms of offering and providing recreation, the DQE team interviewed seven officers with relevant experience. Nearly all said recreation is routinely or usually offered, though Norfolk officers noted they have seen BAU TS patients go to the yard but not HSU TS patients.

Among the 13 interviewed patients subject to this requirement,[72] all Framingham and OCCC patients said they were able to go to recreation, while all Norfolk and SBCC patients said they were not. One of the SBCC patients noted recreation was offered during a TS in BAU but not when he was housed in HSU. It is also worth noting that the DQE team previously learned from staff and patients about issues in providing recreation at facilities that were not visited during this monitoring period.

Documenting offers: It is not presently possible to assess documentation of recreation offers, acceptances, and refusals. MDOC indicates that it has designed a system for this but that policy 103 DOC 650, Mental Health Services, must be issued before this documentation system can be implemented.

Monitoring use, strip searches: In previous monitoring periods, security staff spoke of routinely posting an officer outside whenever any prisoner is in the recreation yard, and

[72] These are patients who had had at least one TS in 2024-2025 and, where a patient said they had not been offered recreation, the DQE team verified on the TS Registry that at least one of that patient's lengths of stay exceeded three days.

the DQE team observed that in operation. A few officers reaffirmed that protocol during this period's site visits.

Others commented on search practices related to recreation. Framingham and Norfolk officers said it is routine only to pat search prisoners going to and from the yard, though Norfolk reportedly strip searches prisoners participating in indoor recreation. An OCCC officer spoke of strip searching all BAU status patients for recreation, while SBCC staff said it is done for everyone, and a prisoner in each of these locations confirmed those statements. The DQE team did not learn of any individualized decision-making.

MDOC remains in partial compliance. The most helpful next steps in moving toward substantial compliance are implementing the planned documentation system—to help sort out the different perceptions of practice—as well as MHPs thinking through the risks and benefits of recreation for an individual and documenting that analysis, particularly at SBCC and Shirley.

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 TS training materials and policies clearly intend for restraint decisions involving prisoners on TS to be individualized and based on risk of harm to self or others. In its June 2025 Status Report, MDOC reported that officers have been trained in anticipation of rolling out the new mental health policy. In practice, it does not appear that prisoners in mental health crisis are only restrained if there is an imminent or immediate threat to safety, as required by Paragraph 64.

The TS progress note template prompts MHPs to document daily whether restraints are contraindicated for the patient and why. However, the DQE team's document reviews[73] make clear that what is being asked of MHPs is not well understood.

[73] See Paragraph 56 for a description of the study of 58 TS stays. For this requirement, the reviewer examined both TS Reports and progress notes. Where a TS Report appeared to say restraints were contraindicated for a patient, the DQE team reviewed progress notes for that stay to identify the reasons recorded.

There are patterns of some MHPs documenting that the patient *does* or *does not need to be* restrained, which is a different issue from whether restraints are contraindicated. . Some MHPs mark "no" on these forms when they appear to mean "no need to restrain," while others appear to mean "no contraindication." Where progress notes use the language of contraindication, no reasons are recorded.[74]

There is also a trend at some institutions of MHPs forgoing giving input, instead documenting that restraints are, or are not, contraindicated "per security protocols." Several SBCC MHPs expressed an understanding that they are expected to always document that there is no contradiction to restraints, and 100% of the studied SBCC records were consistent with that understanding. All sampled records did the same at Gardner, and there were examples at other institutions as well. One Shirley record suggested it may be policy to restrain everyone on the first day of TS; if so, that approach should be revisited, as it is contrary to the Agreement.

As to security staff decision-making,[75] positive practices include some officers collaborating with MHPs on restraints at the time of contact, particularly at Norfolk. At Framingham, MHPs said general population prisoners are only restrained when they are chronically assaultive, and officers said they have discretion not to restrain BAU patients. The DQE team observed Framingham staff and leaders discussing at the morning meeting whether to remove certain prisoners' restraints status, and MHPs confirmed that this discussion is routine.

On the other hand, blanket restraint policies continue, contrary to the Agreement. In some institutions, all prisoners are restrained during escort to the crisis assessment.[76] Some facilities restrain all constant observation patients when they are out of cell. Policy continues to require restraints for all BAU status prisoners.

There were other examples of decisions made on a basis other than imminent or immediate threat to safety. Some staff said decisions depended on the culture of a unit.[77] In most of SBCC's TS settings, a prisoner might be restrained to a restart chair or at tables, or they might be unrestrained in a visiting room or "therapeutic module." It appeared that decision was based on space available rather than any safety concerns.

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[74] While some make use of the data field meant for recording a reason, the entries repeat "contraindicated" or "not clinically indicated" but do not offer a reason.

[75] The findings that follow are based on interviews with 12 security staff, 11 mental health staff, and 15 prisoners, as well as interviews in previous monitoring periods.

[76] One incident report reflected a seemingly extreme application of this protocol. A patient identified suicidal ideation during an MHP session; the session was stopped so that the patient could be handcuffed and taken to a crisis clinician.

[77] This includes, but is not limited, to BAUs.

Other restraint practices are disincentives to participating in mental health treatment and have no apparent safety benefit. Several facilities keep prisoners restrained routinely in "split cells" despite the patient not being able to reach anyone else. SBCC MHPs and patients noted a continued practice of cuffing patients behind their backs while also securing them to restart chairs.

Only 25% of interviewed patients, across four visited institutions, said they were not restrained for crisis assessments and TS contacts,[78] which also suggests the decisions were not individualized.

The restraint practices observed by the DQE team during this monitoring period are essentially unchanged from the previous two periods, despite MDOC leadership's assertion that staff have been trained on individualized decision-making. Individualized restraint decisions are shown as an agenda item for MDOC's Quarterly DOJ Implementation meetings, but the minutes do not capture any reflection about overcoming challenges, nor do they indicate any forward movement with policy or practice change.[79]

MDOC remains in partial compliance with Paragraph 64. To reconcile some of the different practices and move toward substantial compliance, the DQE team encourages VitalCore and MDOC to use the TS Report to convey a clinical opinion on whether the prisoner *does or does not need to be* restrained that day. That could also be recorded in the progress note check box and, if there is *also* a contraindication, that can be recorded, with reasons, in the related notes field. It will be important for MDOC and VitalCore to provide definitions and guidance to mental health and security staff on restraints decision-making.

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

[78] VitalCore has revised one contact form to prompt MHPs to record whether the patient was restrained during a contact. It provides limited information to date but can be another potential information source in future

[79] As shown in the four most recent sets of minutes provided to the DQE, Quarterly DOJ/MADOC Agreement Site Meeting minutes dated June 23, 2025, March 10, 2025, December 9, 2024, and September 9, 2024

Rationale: For the past year, MDOC has asserted that meals cannot be served in health service units because of its sanitation and food service regulations.[80] The DQE team accepted this limitation but requested further exploration of out-of-cell meals in the other areas of MDOC facilities where TS occurs (e.g., BAU, housing units, RTU, STP, ITU). In its June 2025 Status Report, MDOC provided the following update:

> In June 2025, all institutions where TS occurs were surveyed to determine the feasibility of out of cell meals for those on TS. Below are their responses.
>
> [Framingham] - In the HSU and ITU, indoor program space is being used to have meals out of cell.
> [Shirley] - The suicide resistant cells in the HSU were just re-certified. Security will be reviewing options for using the day room if meals out of cell are approved by mental health.
> [Gardner] - There are no areas in the HSU for this to be feasible.
> SBCC- There is insufficient space for out of cell meals in all locations where TS occurs.
> MTC – MTC does not have the space in the BAU.
> [Norfolk] - There is currently a computer in the space that could be used. There has been a request to remove the computer, and once that is completed meals can be accommodated out of cell.
> OCCC - HSU and BAU do not have sufficient space for out of cell meals. ISU is able to accommodate out of cell meals.
> MASAC - MASAC has identified a space for meals and offers them out of cell as appropriate.

The DQE team appreciates the tenacity of MDOC leadership in exploring options for out-of-cell meals in every TS location at every facility. The June 2025 Status Report indicates good progress, with three sites, MASAC, Framingham, and the ISU at OCCC, reporting that they have begun out-of-cell meals when clinically appropriate. Norfolk and Shirley appear optimistic about the prospect of out-of-cell meals soon, while SBCC, MTC, Gardner, and some areas of OCCC continue to report that it is not feasible due to space limitations.

[80] 105 CMR 590.000: Minimum Sanitation Standards for Food Establishments State Sanitary Code Article X, and 105 CMR 451.200, Food Storage, Preparation, and Service

In the next monitoring period, the DQE team will explore with facility leadership the rationale for their conclusions, as at first glance, some are inconsistent with the team's observations during site visits.[81]

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

Finding: Not assessed

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

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

Finding: Partial compliance

Rationale: As detailed in previous DQE reports, MDOC and its vendors have a well-established system to provide three contacts per day to TS patients, except for Sundays and holidays, when there is a single contact for patients on constant observation status. The DQE team drew on staff interviews, onsite observations of contacts and meetings, and review of health records and other documents to reach these findings, which have been highly consistent over time. While this satisfies a substantial amount of Paragraph 67's requirements, MDOC and DOJ disagree about whether this provision allows reduced contact on weekends and holidays.

In the DQE team's chart review in this monitoring period,[82] 85% of the required TS contacts were documented. Where contacts were missed, 89% were on a Sunday or a

[81] For example, OCCC reported that the BAU has insufficient space, but the DQE team has observed that it has a fairly large day room with tables. Similarly, MTC reported insufficient space in the BAU, but it has a large room that is used for individual and group therapy throughout the day.

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

holiday. Records showed no indication that institutional factors or MHPs' workload prevented any significant number of contacts, with only 2% of expected contacts being missed for these reasons or where the reasons were unknown. In prisoner interviews across all visited institutions, 73% confirmed being seen three times per day. The DQE team considers this practice to be strong.

On the other hand, nonconfidential contacts continue to occur with higher frequency than when this was first measured early in Agreement implementation.[83] In the current study, confidential contact rates were best at Norfolk at 57%. Only 26% were confidential at SBCC; in the most extreme cases, seven patients had only one confidential contact or none at all during their TS stay.

A large majority of non-confidential contacts were recorded as patient-driven. Nearly all patients (89 of 96 studied) were shown as declining to come out of cell or not engaging sometimes, but almost half of the patients reportedly did so for more than half of the contacts offered to them. There was little to no indication in the progress notes or prisoner interviews that they refused because of barriers posed by staff or procedures.[84]

Evidence of follow-up attempts to meet with a prisoner who refuses contacts has been very limited to date. Progress notes and their timestamps illustrate that contacts naturally occur at different times of day. The DQE team has observed, and staff interviews confirm, that MHPs have limited ability to direct contact times for the purpose of reducing refusals, as suggested by the requirement, given the high rate of activities on the units and the multiple departments sharing interview spaces.

Progress notes suggested that the rate of nonconfidential contacts caused by institutional factors and MHP workload has continued to improve.[85] Almost no instances were recorded as occurring because of demands on MHPs. The sample showed 9% of all contacts completed in nonconfidential conditions because of security requirements or other institutional factors; these appeared disproportionately at Framingham, Shirley, and SBCC.

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[83] In the current study, at least 62% of contacts were nonconfidential. Where no location was indicated, the contact was counted as being in a confidential space. This was a fairly small percentage of the overall contacts, but it could increase the percentage a small amount if some of these contacts occurred in non-private settings.

[84] In the health records, patients often offered personal reasons such as feeling tired; "detoxing"; having had enough contact that day; or a perception that they would miss another desired contact or activity. It was also common for records not to contain a patient's reason. Only three patients at Framingham and Gardner were shown as refusing because of objections to restraints, and a similar number preferred to speak with their own Primary Care Clinician or objected because MHPs said they could only spend 5 or 10 minutes.

[85] Given the number of cell-front contacts that did not record a reason, the percentages in this paragraph are not definitive, but signs are promising.

There are newer documentation practices aimed at capturing contact locations and reasons with more specificity; these are in use at SBCC and an initial look suggests that institutional factors pose a much higher barrier than progress notes have indicated to date. Similarly, it is noteworthy that a number of SBCC progress notes and triage meeting minutes showed that HSU officers did not permit out of cell contacts in the mornings, and MHP interviewees confirmed this issue occurs routinely. MDOC's June Status Report described a VitalCore plan to strengthen MHPs' ability to report and seek help in resolving patient access issues in the moment, which will be an excellent addition in the future.

Interviewees sometimes saw things differently. Officers at visited institutions generally named multiple spaces that can be used for confidential contacts. Some thought the contact location is at patients' discretion; some noted that cell-front contacts can be necessary when confidential spaces are full; and some commented that, despite spaces often being full, patients typically are seen out of cell once or twice a day.

Among 18 mental health staff who commented on space and confidentiality, each named one or more confidential spaces meant for TS contacts. Some pointed to issues posed by emergencies, space competition, low officer staffing, and officer culture. At Norfolk, one MHP thought these obstacles were infrequent enough that the MHP could always return later rather than holding a nonconfidential contact; one person at OCCC held a similar view, while another felt these issues led to cell-front contacts a few times per week.

As in previous monitoring periods, some SBCC MHPs reported that HSU officers consistently require all contacts to be cell-front in the mornings. They also noted that the only confidential space available for HSU TS contacts is also used for crisis contacts with general population prisoners, so the room is frequently occupied when needed for TS contacts. Interviewed security staff in the HSU reported that current staffing levels do not allow for out-of-cell contacts, especially in the mornings, because officers are busy facilitating medical tasks and responding to emergencies. None of the interviewed staff offered potential solutions to this problem, and all seemed to have accepted cell-front contacts as the norm, at least in the HSU.

Twenty prisoners commented on the location and confidentiality of TS contacts. Nearly all at Norfolk and OCCC thought patient choice determines the location or that contacts are usually in a private space; only two SBCC patients had this experience. Rather, at SBCC, patients described contacts as usually or always being at cell-front, as did single prisoners at Framingham and Norfolk. Several of these SBCC patients offered their

understanding that this was because of room availability, other institutional factors, or because mental health staff are pressed for time.

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

Finding: Partial compliance

Rationale: In the DQE team's observation of triage meetings, it has been apparent that the staff do discuss the reasons for patients' refusal of contacts, at least some of the time. It was common for the assigned "crisis clinician" of the day—the MHP tasked with conducting the first TS contacts—to report in detail about the patients they had seen that morning, whether the patients engaged, and how they responded to the clinician's interventions. Supervisors often suggested strategies to approach the contact refusal, such as returning in the afternoon (when the patient is more likely to be awake/alert), offering a Support Person or activity therapist contact, allowing time to recover after an episode of drug/alcohol intoxication, having a different clinician approach the patient, or trying to meet the patient while on recreation time.

Although the DQE has observed that triage meetings demonstrate reasonable practice, Paragraph 68 requires specific documentation in the triage meeting minutes. Documentation rates are low but show some progress over prior monitoring periods.

To assess this, the DQE team identified, within the DQE team's largest health records study,[86] the patients who had more than *de minimis* refusals to engage in TS contacts. They were present at five institutions and particularly concentrated at Framingham and SBCC. For the 12 identified patients,[87] the DQE team reviewed triage meeting minutes and progress notes as alternative sources of documentation.

For 75% of these patients, minutes show that they were refusing, although usually far fewer refusals were identified in the minutes than in the health records. Minutes also began to record reasons; they were successful in this for 25% of these patients.[88] Progress

[86] See Paragraph 45 for a description of the study and overall methodology.
[87] These figures can not be compared to previous studies as the reviewer narrowed some definitions to more closely adhere to the language of the Agreement. These 12 patients refused one-third or more of their TS contacts.
[88] This includes entries that noted staff attempted to elicit reasons but received no answer.

notes made much greater strides forward on recording reasons, but neither source captured additional efforts or interventions to be tried by mental health staff.[89]

Reaching substantial compliance would require recording more consistently in triage minutes which patients have been refusing which contacts and the kinds of responses the DQE has observed being discussed in those meetings.

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

Finding: Substantial compliance

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

Since the DQE's second report, MDOC has been found to be in substantial compliance with Paragraph 69. However, during the fourth monitoring period, immediately after the change in healthcare vendors and electronic health record systems, support for this practice was not as consistent.

In the current monitoring period, the DQE team studied the TS Reports associated with 93 TS placements.[90] With the TS Reports required Monday through Saturday, the analysis found that 92% of the placements met the requirement, with the remaining cases missing a single day during the TS stay. For patients on constant observation on a Sunday, TS Reports were present in 88% of sampled cases.[91]

[89] Some staff have been recording, either in progress notes or triage minutes, what they did when they attempted the contact. That is a bit different from the team strategizing about alternatives to try in the future.

[90] The sample consists of a subset of the study described in Paragraph 34 and a subset of the study described in Paragraph 45.

[91] In the sample, there were 25 such cases. The DQE team understands that there is no tracking system that would be able to identify this particular population, and it is not practical to determine its size. However, in the DQE team's previous reviews, it appeared such cases were rare. Thus, the team believes that this sample gives a reasonable impression of MDOC's practice on this element of Paragraph 69.

For both the Monday through Saturday requirement and the Sunday requirement, MDOC was given the opportunity to supply the missing documents and confirmed that these were not in their systems.

Health records continued to show at least one progress note per day by an MHP[92] or by a nurse if an on-call professional initiated the placement after hours, which is common documentation practice in mental health settings and consistent with the intent of the Agreement.

The DQE team continues to consider this requirement to be in substantial compliance.

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: Clinicians continue to document their TS contacts on progress notes in VitalCore's electronic health record that are specific to that purpose (form BH-5.0). The note template contains the required elements: data, assessment, and plan.

In the DQE team's study of TS placements,[93] notes were written at least once per day, as required by Paragraph 70, and usually three times per day, in alignment with MDOC's TS protocols. Clinicians documented their interventions (e.g., "provided feedback about the importance of medications," "discussed the therapeutic materials," "informed client that property was approved") and the patient's response (e.g., "was minimally receptive," "expressed frustration," or "was agreeable"). Some clinicians checked a box, "without change," in response to a prompt about the patient's response to intervention.

The quality and format of assessments varied by clinician, institution, and time of day (e.g., first TS contacts often had a more thorough assessment and plan than the second or third TS contacts). At best, the assessments contained a brief mental status examination and conclusory statement about risk, such as "appears to be at moderate risk" or "18a is not clinically indicated at this time." Many notes left the "assessment" section blank, but it was possible to discern from other parts of the note what the clinician intended as an assessment or plan. A substantial minority of notes contained nothing that could be reasonably construed as an assessment.

Plans typically were conveyed through a series of check-boxes and brief statements like "patient to maintain on 15' TS with no changes to property" and "patient to be seen per

[92] This refers to at least one note per day Monday through Saturday, and one note on Sundays if the patient was on constant observation status.
[93] See Paragraph 45 for details.

TS and PCC protocols." Clinicians were prompted to consider whether a higher level of care was indicated, and boxes to this effect were checked.

Overall, the TS notes conveyed enough information to satisfy the requirements of Paragraph 70, though their completeness will be monitored closely in the next monitoring period because of the growing trend of leaving the "assessment" section of the note template blank. In addition, the substantial compliance finding for Paragraph 70 refers only to the completion of a property formatted progress note. The DQE team's concerns about the substantive quality of interventions behind MHPs' documentation are addressed in Paragraph 52 (crisis treatment plans), Paragraph 72 (meaningful, out-of-cell interventions), and Paragraph 73 (individualized interventions).

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

Finding: Substantial compliance

Rationale: To assess this requirement, the DQE team examined 27% of the TS placements where a patient engaged in SDV.[94] In this study, MHPs appropriately modified the patient's care after self-injury, or no such modification was necessary, in 89% of cases, according to the DQE's clinical judgment. This is similar to the previous two monitoring periods, when 78% and 90% of such SDV cases, respectively, were handled as clinically indicated.

It was unusual for MHPs to formally revise the treatment plan document after SDV,[95] but the DQE clinicians could see how patients' treatment was modified by reviewing successive progress notes in the electronic health record. Treatment modifications included referrals to psychiatry, sending the patient for a Section 12 evaluation, emergency medication administration and four-point restraints, "upgrading" the patient's TS status to 1:1, referring to an outside hospital for acute medical care, and helping patients work through the institutional stressor(s) that led to SDV. In the small number of

[94] This review draws on the study first described in Paragraph 45. Eighteen TS placements in the study involved a patient harming themselves. The DQE team also examined the VCHS SDV Database spreadsheets and, after controlling for multiple incidents in the same TS placement, determined that SDV occurred in 69 TS placements. Thus, the 18 stays in the study constitute 27% of the 69 relevant stays.

Reviewers also compared the spreadsheets titled VCHS SDV Database and TS Registry for all months in the monitoring period to determine whether the DQE team's chart review was sufficiently representative on this issue. The set of 69 placements in which self-harm occurred is 13% of the 522 placements in the monitoring period systemwide. The cases identified in the DQE team's chart review constituted 19% of the chart review. With the frequency in each data set occurring at similar rates (with the DQE team study having somewhat more information available), the DQE team sample should fairly represent the systemwide practices.

[95] See Paragraph 110 for further discussion of treatment plan revisions in response to SDV.

cases where it was not clear that patients were re-assessed or that treatment was modified after SDV, it appeared that the SDV occurred during the overnight shifts or on weekends. MHPs assessing the patient on the next business day made no mention of the SDV incident in their progress notes, raising questions about whether the information was communicated to the daytime mental health staff by nurses or on-call MHPs.

Another concerning pattern involved patients whose self-injury was handled as a security matter, with the facility's Superintendent ordering waist chains, handcuffs, leg shackles, and/or "kuzi mitts" to be applied. Again, these events seemed to happen most often overnight, when no mental health staff were on site to assess the patient or help manage the situation. In some of these cases, the patients saw psychiatry the next morning and were evaluated for 18a referral to Bridgewater State Hospital—a reasonable plan of action. In other cases, it seemed that the SDV incident and restraint use did not trigger any kind of heightened response from mental health; in one case at Norfolk, the patient did not see a psychiatrist for over two months after he was head-banging while on TS and restrained by security staff. In a similar case at SBCC, a patient jumped head-first off the sink in his cell and was restrained by security, but he was not seen by psychiatry until two months later.[96]

Although these incidents were concerning, they were rare enough that a substantial compliance finding is still warranted.

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. MDOC has made gains in this area since the Agreement began, with the DQE team observing more substantive, confidential, and therapeutic interactions between clinicians and patients on TS during the site visits.

Across MDOC, individual contacts remain the norm; only Framingham and the ISU provide group therapy for patients on TS. This is because at many sites (e.g., Gardner, MASAC, MTC, Shirley), it is rare for there to be more than one patient on TS at the same time, while at other sites (e.g., OCCC, SBCC), no group programming space has been identified.

[96] See Paragraphs 52 and 85 for further discussion of patients not seeing psychiatrists while on TS.

In the DQE team's study of 96 TS placements, first discussed in Paragraph 45, contacts often continue to appear brief and to more heavily rely on check-ins, delivery of materials without discussion, and assessment—sometimes limited, as described in Paragraph 47—more often than counseling. However, documentation of MHPs' TS contacts improved substantially from the last monitoring period because of the revised TS note template (BH-5.0) in VitalCore's electronic health record.

The DQE team study also revealed that at least 62% of the patients' contacts with mental health occurred in a non-confidential setting (cell-front), raising concerns about the meaningfulness of the therapeutic interventions. Three-quarters of the non-confidential contacts were noted to be at the patient's request, with 9% due to security or institutional factors. The remainder were at the MHP's clinical discretion or did not explain the reason.

In addition to the non-confidential contacts, 15% of contacts that should have occurred under the criteria articulated in Paragraph 67 were not completed.[97] This leaves just 32% of contacts required under Paragraph 67 occurring in a confidential, out-of-cell space during this monitoring period.[98]

The situation at SBCC remains challenging, with 74% of TS contacts conducted cell-front in the DQE team's study, but some positive steps have been taken with the aim of facilitating MHPs' out-of-cell patient contacts. During the April 2025 site visit, SBCC's security leadership reported to the DQE team that they were on the cusp of implementing a system for clinicians to reserve confidential meeting spaces on the housing units in advance. They also reported plans to hire more unit managers (to direct traffic and troubleshoot problems on busy housing units) and to expand meeting spaces in some of the specialty units (e.g., BAU). VitalCore leaders reported that they are working to address access to care issues in the moment, assigning a staff person to track and troubleshoot these incidents and providing training to MHPs. In addition, during the site visit, the DQE and DOJ teams worked with the Deputy Superintendent to identify an additional space near the HSU that could be used for out-of-cell contacts. These are all important steps toward providing more meaningful therapy to patients on TS.

[97] This deficiency rate includes three contacts on Sundays and holidays, which are required under Paragraph 67 of the Agreement but are not currently part of MDOC's TS protocols. Without including the missed Sunday/holidays contacts, only 2% of required TS contacts in the study were not completed.
[98] In the study, there were 1,557 TS contacts that should have occurred. 236 were missed, and 815 were cell-front, leaving 506 contacts completed confidentially.

Overall, significant improvement in this area is needed before MDOC can be considered substantially compliant, but it is encouraging that both MDOC and VitalCore are taking steps to enhance current practice.

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

Finding: Partial compliance

Rationale: Paragraph 73 focuses on individualization of treatment decisions and documentation of those decisions in the health record. During the DQE team's interviews with MHPs and clinical leadership, it remained clear that they intend to provide individualized, out-of-cell therapeutic activities for prisoners on TS three times daily. In practice, logistical barriers sometimes get in the way: security staff are unavailable or unwilling to bring prisoners out of cell, confidential meeting space is in use by others, or clinicians are so busy that they only have time for cell-front check-ins.

In the DQE team's review of 96 TS placements, MHPs' individualized decision-making was difficult to discern from progress notes in the health record. As noted in Paragraph 52 in relation to initial treatment plans, the subsequent TS progress notes often left crucial sections blank, including the sections for assessment, problems, goals, and interventions. Through a series of check-boxes, the notes reliably commented on the time frame for follow-up (next day or same day), the type of TS (constant or 15-minute observation), and the patient's allowed property and privileges. Beyond that, evidence of individualized treatment was rarely present.

As noted in previous DQE reports, the problem is two-fold: (1) MHPs do not document their therapeutic interventions and the rationale for them well, and (2) MHPs have a limited skill set from which they can choose individualized interventions for patients. To their credit, MDOC and VitalCore have invested substantial time and energy into training mental health clinicians on individualized treatment planning during this monitoring period, creating a training called "Clinical Interventions to Consider with Patients on Therapeutic Supervision" that has been presented at the sites where TS occurs. VitalCore has also revised its TS progress note template (BH-5.0) to prompt clinicians to document their specific therapeutic interventions. Although the DQE team has not yet seen a substantial improvement in the quality of individualized treatment—or at least the documentation of it—it is common for people to need practice, guidance, and sometimes further training before new knowledge is internalized. The DQE team much appreciates

the leadership's emphasis on enhancing clinicians' skills and it may eventually pay dividends.

Paragraph 73 also requires the documentation of all out-of-cell time on TS, which is not yet being done in MDOC. Out-of-cell time for MHP and Support Person contacts is generally documented in the progress notes, but for all other out-of-cell time—showers, recreation, visits, etc.—there is no current documentation system. As noted elsewhere in this report, MDOC is working to implement this.

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

Finding: Substantial compliance

Rationale: The therapeutic de-escalation room in the HSU at Shirley has existed since the Agreement began. The DQE team did not visit Shirley during this monitoring period, but MDOC's June 2025 Status Report indicates that the room continues to function in the facility's HSU. On April 23, 2025, all of Shirley's TS cells in the HSU were recertified as suicide resistant, and the TS registry indicates that more TS placements have occurred in the HSU since then (though the majority are still in the BAU). Thus, it appears that the therapeutic de-escalation room is available to at least some of Shirley's patients on TS.

Two de-escalation rooms have been developed in the ISU. MDOC has been working to outfit the rooms with appropriate items, and during the April 2025 site visit, the rooms contained rocking chairs and a chalk wall. Three patients interviewed in the ISU reported that they are allowed to use the room, though none of them had done so because (1) they were afraid of being locked in the room by security staff, (2) the room does not offer enough space to pace, (3) the room does not offer activities or comfort items they desired, or (4) they had not "gotten to the point [of needing de-escalation]."

Overall, although utilization of the de-escalation rooms could be improved by making them more inviting to patients, especially in the ISU,[99] MDOC is meeting the Paragraph 74 requirement to maintain the rooms.

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

Finding: Substantial compliance

[99] This issue is discussed further in Paragraph 135.

Rationale: No peers have been involved with the care of TS patients since the Agreement began, but peer activities around MDOC continue to grow. MDOC and VitalCore leaders have reported that, once the peer programs for general population prisoners at Framingham and Norfolk have demonstrated success, their expansion to include TS patients is likely. Since Paragraph 75 only mandates MDOC to "consider" utilizing a peer program for TS patients, a substantial compliance finding is now warranted, although the DQE would obviously like to see implementation of such a program rather than mere consideration of one.

Peer support programs for general population prisoners at Framingham and Norfolk are now fully operational. During the June 2025 site visit at Framingham, MDOC leadership reported that "peer support is now part of the fabric of the facility." Eleven incarcerated women had been trained as peers, and these women participated in monthly trainings with MHPs to "keep their skills up." The peer mentors had designated drop-in hours and a space to meet with their clients. The eventual plan is for them to routinely visit the HSU, ITU (where most TS patients are housed), and BAU.

At Norfolk, the formal peer support program launched on March 17, 2025. Fifteen incarcerated men, all self-nominated or peer-nominated, completed an eight-week training series led by MHPs, including topics such as boundaries, suicide prevention, and cultural competency. The peers have designated spaces and times for prisoners in general population to access them. Monthly supervision is provided by MHPs. The eventual plan is for them to work with patients on TS and for Norfolk's program to serve as a model for expansion to the other men's facilities.

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

Finding: Partial compliance

Rationale: During the previous monitoring period, therapy dogs remained an active area of discussion. MDOC's June 2025 Status Report provides an update, stating, "MDOC has considered utilizing therapy dogs and at this time it is not feasible for implementation." The report provides no explanation of the rationale, but it states that the topic has been discussed in the QIC meetings.

The DQE's review of QIC meeting minutes between January and May 2025 found only one mention of therapy dogs. On March 27, 2025: "Therapy dogs: ADC Fisher says this is currently in our hands now." It is not clear what happened after that time or why/when MDOC concluded that therapy dogs on mental health units are not feasible. Although

Paragraph 76 requires only that MDOC "consider" utilizing therapy dogs, the DQE must see a rationale for MDOC's conclusions before a substantial compliance finding can be reached. Given that dozens of puppies are trained by prisoners in MDOC facilities to be therapy dogs in the community, it is not readily apparent why dogs cannot work with mental health patients within the prisons.

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

Finding: Substantial compliance

Rationale: In over two and a half years of monitoring, MDOC has demonstrated a consistent pattern of expediently transferring patients to psychiatric hospitals once the need for a hospital level of care has been identified. This practice has not changed during the current monitoring period. In addition, now that the ISU is operating, MDOC has demonstrated expedient transfers to that setting. Delays seem to persist for transfers to the STP, but on balance, a substantial compliance finding remains appropriate.

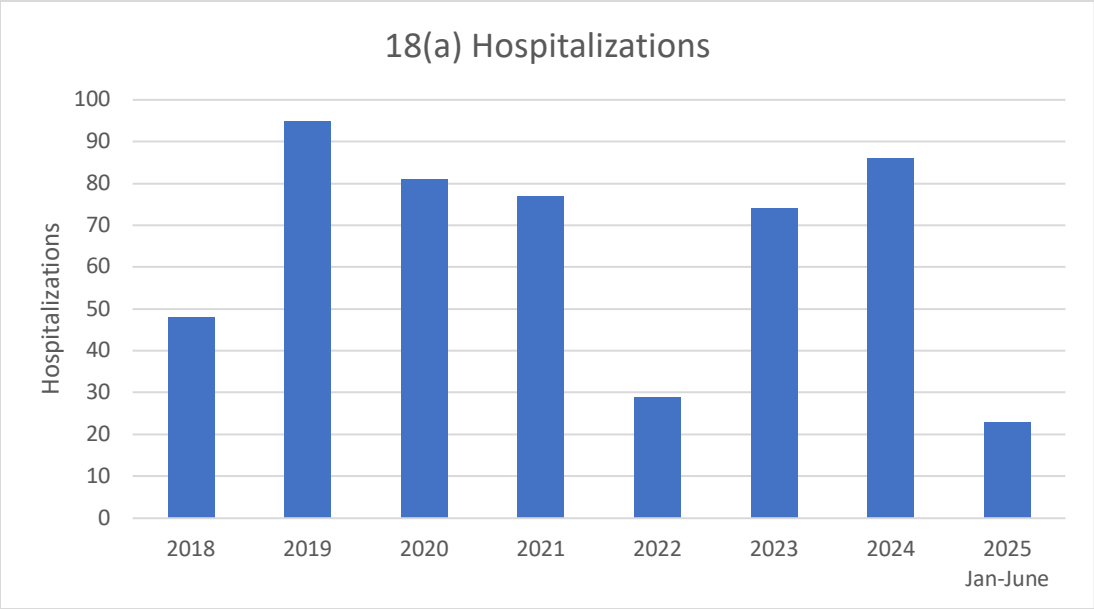
Outside hospital transfers under Section 18(a)

Data from MDOC's log of transfers to higher levels of care indicate that, between January and June 2025, 23 patients were transferred to an outside hospital under Section 18(a). Six of the seven prison sites (excluding MTC) transferred at least one patient, but most transfers were initiated by staff at OCCC (56%) and SBCC (26%).[100] Upon commitment by the court, 22 patients (96%) were admitted to the ISOU at Bridgewater State Hospital, the only option available for male patients. The one female patient committed under Section 18(a) was transferred to Solomon Carter Fuller Hospital. All the male patients were transferred on the day they were committed by the court, but the female patient experienced a delay of 6 days because of DMH bed availability. Overall, these data demonstrate excellent practice in transferring patients once the need for hospitalization has been identified, though the issue with DMH bed availability for female patients persists.

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

Figure 6 illustrates the number of 18(a) hospitalizations between 2018 and 2024.[101]

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



So far, MDOC is on track to transfer fewer patients in 2025 than in any recent year except 2022. It is not clear what accounts for this finding, but it is possible that the ISU's implementation has alleviated some of the need for outside hospitalization. This issue warrants further assessment.

Outside hospital transfers under Section 18(a1/2)

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

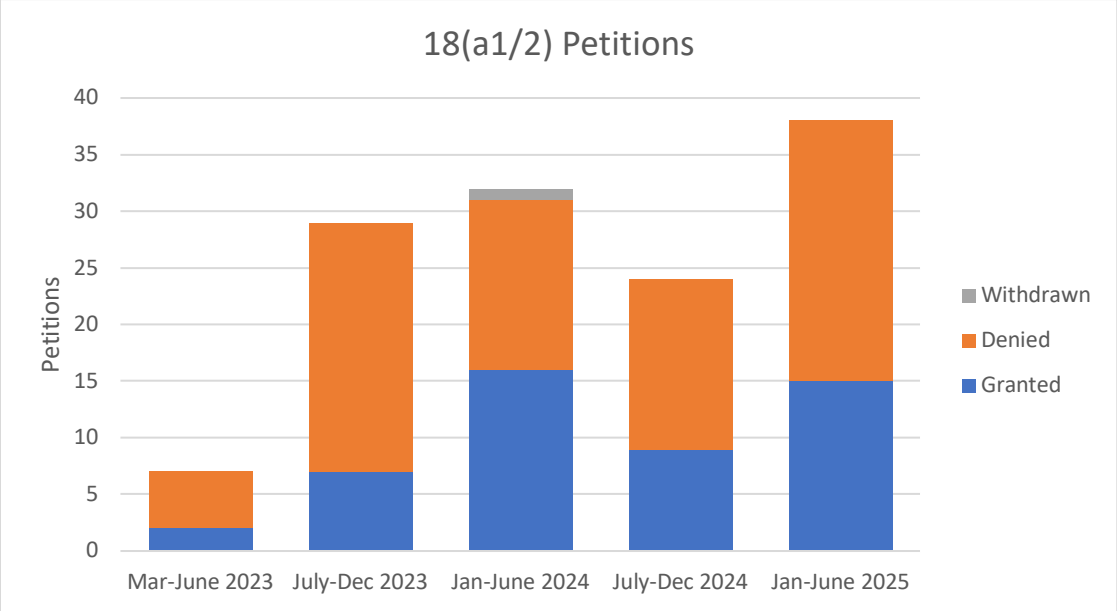
MDOC's data indicate that the law's use increased dramatically in the first half of 2025, as illustrated in *Figure 7*. Between January and June, 38 prisoners petitioned the courts under Section 18(a1/2), and 15 of these petitions (39%) were granted. Norfolk initiated the most petitions (39%), followed by SBCC (21%). For male patients, transfer occurred on the day of the court approval, while female patients waited an average of 8 days

[101] Data were compiled from MDOC's suicide prevention training presentation, which includes data from 2018-2023, as well as MDOC's "Higher Level of Care Log."

(range 4-14 days), again due to DMH bed availability. In all 15 cases that were approved by the courts, patients were returned to MDOC within 30 days of hospital admission, usually after just a few days.

Since MDOC began tracking data about Section 18(a1/2) petitions in March 2023, not a single one of the 50 patients admitted to BSH or a DMH facility has been assessed as needing hospitalization beyond the brief assessment period. Thus, it appears that Section 18(a1/2) is not an effective method for prisoners to receive longer-term hospital-based psychiatric care. The 18(a1/2) avenue is particularly fruitless for prisoners at SBCC, where 97% of the petitions submitted since March 2023 have been denied by the courts, and the one patient admitted to Bridgewater returned to MDOC within 4 days.

Figure 7. 18(a1/2) Petitions, March 2023-June 2025



Outside hospital transfers under Section 12

When MASAC determines that patients need a higher level of psychiatric care, they are transported to a local hospital's emergency department for evaluation, where they may then be committed under M.G.L.c. 123 Section 12. Data from MASAC's TS Registry indicate that patients were sent to the hospital for Section 12 evaluation in 33% of TS cases between January and June 2025.

Outside hospital transfers under Section 15(b) or 16(a)

Patients are transferred to outside hospitals for competency to stand trial evaluation and restoration under M.G.L.c. 123, Sections 15(b) and 16(a), respectively. The number of transfers continued to increase in 2025, from 6 cases (Jan-June 2024) to 24 cases (July-Dec 2024) to 28 cases (Jan-June 2025). All patients were female. The increase in 15(b)

and 16(a) commitments was accompanied by a delay in transfers because of DMH bed availability. The average wait time between January and June 2025 was 10.7 days (range 1-23 days), and the situation worsened in March, with the average wait time since then reaching 17 days.

Secure Treatment Program and Behavior Management Unit transfers

Between January and June 2025, four patients were referred to the Secure Treatment Program (STP) at SBCC, and no patients were referred to the Behavior Management Unit (BMU) because it is not operational. Only two of these patients were actually admitted to the STP; one remained at Gardner almost six months after referral, while the other remained in the SAU at SBCC. During previous monitoring periods, MHPs told the DQE team about significant wait times for STP admission, and MDOC confirmed that this remains the case, indicating that challenges with access to the program remain. This area requires closer monitoring by the DQE team in the next monitoring period.

Intensive Stabilization Unit transfers

Fifteen patients were referred to the ISU between January and June 2025, and all were accepted into the program. Eleven of these patients were on TS at the time of ISU referral (73%), indicating that the ISU is being used as a pathway out of TS, as intended by the Agreement. MDOC's data indicate that, once ISU placement was approved, transfers happened quickly, in 1.9 days on average (range 0-7 days).

Residential Treatment Unit transfers

The Residential Treatment Units (RTUs) continued to operate at OCCC, Gardner, SBCC, and Framingham during this monitoring period, with no change in bed capacity. In June 2025, the RTUs were about 55% full, as described in Paragraph 139. MDOC's data indicate that 19 patients were referred to the RTU in the first half of 2025, and all were accepted into the program. Nearly all were internal transfers, though two patients from Shirley were transferred to the RTUs at OCCC and Gardner. The time from referral to transfer remained variable, with some patients admitted to the RTU before the formal referral was completed, while others waited up to 10 days.

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: Sixty-eight percent of TS placements in the monitoring period ended by the close of the third day, a rate similar to that found in previous monitoring periods. For TS stays exceeding three days, the DQE team examined progress notes to determine whether a higher level of care was considered and documented shortly thereafter. The reviewer selected 51 TS health records, which represents 31% of the relevant placements in the monitoring period.[102] If there was no mention of consultation in the health record, the reviewer also read notes of "Daily Consultation" meetings for any such mention. Two patients were referred to a higher level of care either through staff decisions at this stage or this notice-and-consultation practice.

Progress notes provide a check box labeled "18A/Higher Level of Care Discussion." In 88% of the sample, this box was checked, and in a minority of cases, there was some description of staff's thinking. This analysis relies on MDOC and VitalCore representing that checking the box reflects that consideration of a higher level of care occurred. To the extent that progress notes documented any rationale for decision-making, the most common phrase was "due to needs being met at the institution level," which does not offer much explanation (e.g., what needs, and how are they being met?).

As to the notice and consultation requirements of Paragraph 78, there is a well-established system, detailed in previous DQE reports, in which VitalCore distributes to MDOC and VitalCore leaders a spreadsheet listing patients who have reached benchmarks laid out in Paragraphs 57 and 78 through 80. Each weekday, except holidays, the spreadsheet is provided, and several of those leaders participate in a "Daily Consultation" meeting to discuss the listed patients with the mental health leaders at the sites housing them.

In the current monitoring period, the DQE team analyzed the spreadsheets and meeting minutes for the sample described above. Notice was provided to MDOC's Director of Behavioral Health (and others) in 98% of the sample. The parties and the DQE team have decided, for a trial period, to consider the consultation requirement to be met by consulting either with VitalCore's Program Mental Health Director[103] or a skilled and knowledgeable designee. Under this definition, consultation took place in 86% of the

[102] The sample for Paragraphs 78 through 80 overlapped with the sample described in Paragraph 45 but differs in significant ways. All cases had TS stays of four days or longer during January through June 2025. They were drawn from each institution that provides TS, keeping in mind their proportions of the stays *longer than three days* (which differs from their proportion of all TS). MASAC was an exception, as it did not have any TS stays subject to these requirements (all concluded by the morning of the fourth day). Cases were drawn from nearly all types of housing that provide TS. Some cases, beyond those in the data set for Paragraph 45, were substituted in order to have a sufficient sample meeting all these criteria.

[103] VitalCore employs different job titles than are reflected in this Agreement, but the Agreement's titles will be used in this report for simplicity's sake.

sample. In the remaining cases, the patients were listed in the notice spreadsheet, but there is no record of them being discussed in the Daily Consultation meeting.[104]

MDOC remains partially compliant with the requirements of Paragraph 78, but practice appears strong. The DQE team and the parties will apply this more flexible requirement interpretation for six months. If notice and consultation continue to function similarly, MDOC can be found in substantial compliance.

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

Finding: Partial compliance

Rationale: The DQE team has confirmed over time that the personnel specified in this requirement consult in the Daily Consultation meeting, described in Paragraph 78, each weekday except holidays. To assess fidelity to that system during this monitoring period, the DQE team analyzed records for 20 TS placements, which represents 54% of placements longer than seven days.[105] Applying the criteria described in Paragraph 78, documents showed consultation in 75% of the sampled TS stays. In the remaining cases, the patient was listed in the notice spreadsheet, but no related discussion appeared in the Daily Consultation notes.

The DQE team employed the same sample to assess documentation of local decision-making at the seven-day benchmark. Two patients in the sample were referred to a higher level of care at or near that time. For others, the analysis found that a patient was considered for a higher level of care if the relevant box was checked in the progress notes or if consideration was expressly captured in other progress note sections or Daily Consultation notes, and 95% of the sample met those criteria. Where staff thought that a higher level of care was not indicated, however, only 27% recorded specific reasons.

[104] The reviewer examined the spreadsheets and meeting notes from Day 2 of the patient's TS through two business days after the patient's Day 3. Paragraph 78 does not specify *when* the notice and consultation must take place, so the DQE team considered these actions timely if they occurred by the second business day after a patient's Day 3.
[105] See Paragraph 78 for the selection methods, definitions, and criteria applied.

MDOC remains partially compliant with these requirements. To reach substantial compliance, it will be key to guide MHPs to think about and record specific reasons if a patient does not need a higher level of care. A bit more consistency in capturing all relevant patients in the Daily Consultation will also be needed. As with Paragraph 78, the parties and DQE team will monitor whether treating designee participation as compliant has any impact on practice at the end of six months.

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

Finding: Partial compliance

Rationale: The DQE team examined health records, notification spreadsheets, and Daily Consultation notes for 40% of the TS placements with a length of stay exceeding 14 days.[106]

- In half of the sampled cases, the patient was referred to a higher level of care at or near the 14-day benchmark.

- Where staff thought a higher level of care was not indicated, they did not record individual reasons in any case. There were either no comments or an identical boilerplate conclusion that was not linked to any individualized facts.

VitalCore's Program Mental Health Director, MDOC's Director of Behavioral Health, MDOC's Assistant Deputy Commissioner of Clinical Services, and MDOC's Deputy Commissioner of Re-entry and Clinical Services, or their designees, do routinely meet on weekdays, except holidays, with facility mental health leaders to discuss these patients. Modifying the standard to accommodate those practices, they consulted at the 14-day

[106] See Paragraph 78 for the selection methods, definitions, and criteria applied..

benchmark in 63% of the sample and were only able to maintain that practice every weekday for one patient.[107]

As noted in Paragraph 52, completion of formal treatment plans for TS patients is currently inconsistent, but changes in interventions *were* apparent in the progress notes for nearly every patient in this sample. This is a substantial improvement over previous monitoring periods. With improved documentation of individualized decision-making and the reasons a higher level of care is not indicated, MDOC can achieve substantial compliance with the Paragraph 80 requirements.

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

Finding: Substantial compliance

Rationale: MDOC policy 103 DOC 650.08, *Emergency Mental Health Services*, contains language about stepping down patients from constant to close observation before discharge from TS, and the DOJ has approved this language.[108] No information about VitalCore's TS policies has been shared with the DQE team, but this deficit is addressed in the *Policy* section rather than here.

MDOC's implementation of a step-down procedure for TS patients remains strong. MDOC repaired most of the TS cells that it had previously found not to be suicide resistant, and this helped demonstrate a routine step-down process from constant observation to 15-minute observation. In the DQE team's largest study of TS placements,[109] 40 patients experienced 1:1 observation for part of their TS stay, and 85% were stepped down to 15-minute checks prior to discharge from TS. The remaining 15% were transferred to Bridgewater State Hospital or a Department of Mental Health facility. These findings were consistent with the DQE team's observations across multiple monitoring periods, where clinicians routinely stepped patients down during TS stays. Overall, MDOC demonstrated that strong practice has resumed after the temporary disruption caused by TS cells needing repair in the previous monitoring period.

As noted in Paragraph 84, the expectation of post-discharge follow-up contacts is also well established across MDOC. Here, too, practice was strong in the DQE team's study. Of the TS placements reviewed, 80 patients were available for post-TS follow-up

[107] Where the requirement was not met, it was because fewer than the core group met on some days, or a weekday meeting apparently was not held as there were no notes

[108] Although policy 103 DOC 650 must be re-approved because MDOC made changes after DOJ approved the policy on March 5, 2025, the language in subsection 650.08 was not affected.

[109] See Paragraph 45 for a description of the study and its methods.

contacts (the remainder were transferred to a higher level of care, released from custody, or readmitted to TS). All contacts were made timely for this group with the exception of eight made while the patient was still in TS housing and/or just a few minutes after TS discharge.

Thus, once VitalCore's policies have been revised in accordance with Paragraph 81, MDOC should once again achieve substantial compliance with the requirements.

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

Finding: Partial compliance

Rationale: As detailed in previous DQE reports, it is routine practice for MHPs to conduct a mental health assessment using a suicide risk assessment format and to discuss potential discharge with the mental health team during daily triage meetings. Meeting minutes show that the site's Mental Health Director almost always participates and that psychiatry often does.[110]

In the DQE team's review of TS placements,[111] 95% contained a detailed progress note, with a section for suicide risk assessment, on the day of the patient's discharge. The risk assessment section was completed in the records reviewed, along with a brief mental status exam, a notation that the patient was briefed on next steps, and sometimes a collaborative safety plan. Of note, at least 20% of the cases[112] showed this all took place

[110] In the triage minutes reviewed for discharge information in the DQE team's study, for example, psychiatry was listed as present in 84% of 75 records examined.
[111] The study, first described in Paragraph 45, examined 96 TS placements. Among them, between 70 and 88 cases were examined for information on the different elements of the Paragraph 82 requirements. Typically, the reasons a record would not be included would be that the TS ended not with discharge but with transfer to a higher level of care, continued TS at another facility, or release from custody.
[112] As the lengths of contacts were often not recorded, there is potential for this number to be higher.

in five minutes or less, raising questions about the adequacy of the risk assessment and discharge planning process.

Confidential contacts prior to discharge improved to 69%, according to the progress notes. This is far higher than the privacy rate for TS contacts overall. There was even greater improvement at SBCC; nearly all discharge contacts were cell-front through March 2025, while nearly all were recorded as being in confidential settings from April forward. The chart review did not separately examine the recording of rationales for cell-front contacts at this stage, but reasons were present for 94% of them in the study overall (e.g., patient declined or was "agreeable" to meeting cell-front, security protocols, institutional factors).

When TS placements arose from risk of self-harm, the rate of MHPs documenting that the patient presented a lower risk at discharge continued to decline to 41%.[113] Typically, however, progress notes did contain facts and observations reflecting improvement, and one could reasonably infer the MHP thought there was lower risk.

In all site visits across five monitoring periods, the DQE team has observed MDOC's standard practice of discussing patients on TS as the first agenda item in the daily triage meeting, and this includes a group decision about whether to continue the patients on TS. Those decisions are routinely captured in meeting minutes, which the DQE team has reviewed in each monitoring period. Interviewed MHPs have also described the practice of conferring with a supervisor if the potential for discharge arises after the triage meeting has been held or on the weekend. The DQE team has encountered this decision-making captured in progress notes and in End of Shift Reports.

The DQE team reviewed a subset of its chart review for progress notes concerning discharge and cross-referenced those cases with triage meeting minutes on the dates of discharge. In 79% of the sample, the patient's discharge was clearly discussed in the triage meeting or in a separate consultation with the site's Mental Health Director.[114] Cases that appeared noncompliant typically involved deciding in coordination with mid-level supervisors (e.g., RTU or STP coordinator) rather than the director and were found almost exclusively at SBCC.

The DQE team also analyzed whether consulting with an upper-level provider was indicated for these patients and whether that took place. Within the chart reviews, DQE clinicians determined that an upper-level provider consult was indicated for 18

[113] In the sample, 71 TS placements were initiated for risk of self-harm; 29 of those TS stays documented the required finding. The other examined placements arose from concerns about harm to others or potential psychosis.
[114] Consultations with the site Mental Health Directors, or anyone to whom they report, were considered compliant.

patients.[115] For 72% of those patients, there was a progress note referring to a conversation between the MHP and a psychiatrist or nurse practitioner within a day before discharge, or a psychiatrist or nurse practitioner was present at the triage meeting in which a discharge decision was documented,.[116]

Paragraph 82 also requires that MDOC conduct audits to ensure that MHPs' are making appropriate discharge decisions. MDOC's June 2025 Status Report points to audits it conducts of various practices arising out of this Agreement, but quality improvement information provided to the DQE has not reflected audits to date of whether patients are discharged as early as possible from TS.

To reach substantial compliance, it would be advisable to concentrate on continuing to improve suicide risk assessments and confidential contacts and to expand the role of psychiatry and psychologists in the team's care of TS patients. Ultimately, the Agreement requires audits to demonstrate a quality-of-care issue—that discharges take place as early as possible—but TS lengths of stay have improved substantially throughout Agreement implementation, and signs are promising for this requirement.

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: MHPs have stated over time that, in complex cases or when a patient is transferring to another facility, they may have a case conference or informal discussion with the receiving mental health team to prepare for the patient's arrival. More commonly, clinicians who will be assuming care of the patient after TS are present during the facility's daily triage meetings, so they have often been following the patient's progress. MHPs can also communicate through End of Shift Reports" and triage meeting notes, which are accessible to all MHPs at the facility. Thus, there are multiple avenues for mental health clinicians to communicate about patients' discharge plans with each other. The DQE team has observed dozens of triage meetings and read hundreds of the documents noted above. In that experience, it was most common for the plan to consist of

[115] See Paragraphs 52 and 85 for descriptions of the criteria

[116] In the other cases, no psychiatry was present at the triage meeting or the meeting decision was to maintain the patient on TS but was changed later in the day without apparent involvement of psychiatry. Where the triage decision contemplated discharge later in the day if certain conditions were met, that was counted as compliant.

the number of sessions planned for the patient—the three follow-ups required by the Agreement and, in some cases, additional MHP or Support Person sessions. It was relatively rare for a treatment approach or goals for those sessions to be included.

Updates to the electronic health record format and MHP training are paying dividends in discharge planning documentation. Within the DQE team's review of TS placements first described in Paragraph 45, there were 81 patients requiring a discharge plan.[117] Records demonstrated a brief mental status examination for all but one patient. The creation of safety plans improved substantially; they were present in 36% of the sample. A number of other files noted that safety plans had been generated, but it appears they had not been uploaded into the health record. Framingham and MASAC routinely made choices for housing based on clinical need. Follow-up specified the number of expected sessions, but not the treatment focus, and sometimes a referral to another profession, such as psychiatry. While practice has further to go, these compliance rates are by far the highest since the Agreement went into effect.

As in previous monitoring periods, when asked how they communicate discharge plans to appropriate security staff, MHPs told the DQE there is not a routine practice of sharing the content of discharge plans out of concern for patient confidentiality. All indications are that mental health and security staff make notifications about the discharge, as per policy, but typically no communication occurs about how mental health staff and the receiving unit's security staff will support the prisoner's mental health needs.

The DQE team appreciates the steps that VitalCore, MDOC, and MHPs have taken to improve these practices and looks forward to further progress on each of the elements of this requirement.

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

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

Rationale: As detailed in previous DQE reports, the system for providing three follow-up contacts after discharge from TS is well-established; this was determined through observing triage meetings and MHPs providing the contacts, interviewing staff and patients, and reviewing meeting minutes and electronic health records. Employing those same methods, the DQE team confirmed that the system has been sustained. In its Status Report, MDOC also reported that VitalCore has conducted additional staff training concerning several elements of Paragraph 84.

In the DQE team's chart review, first described in Paragraph 45, 80 patients required MHP follow-up after discharge.[118] Progress notes showed that all contacts were consistently made within required time frames, with the exception of eight made while the patient was still in TS housing and/or just a few minutes after TS discharge.[119]

It remains a concern that the rate of confidential TS follow-up contacts is worse than when Agreement implementation began.[120] Progress notes show nonconfidential contacts taking place at officers' desks in housing units; in dayrooms; in recreation yards; and cell-front, where there are also difficulties hearing and visually assessing the patients when they are speaking. Ten interviewed MHPs[121] described specific private spaces as the locations for follow-ups. Most did not comment on whether they also saw patients in nonconfidential conditions, though one noted patients sometimes prefer that, and two OCCC clinicians said they postpone and return if the private space is in use.

In the chart sample, 53% of contacts took place in confidential conditions. The large majority of nonprivate contacts were recorded as being at the patient's request or that the patient was "agreeable" to this. Progress notes showed the rate of nonconfidential contacts for staff-generated or institutional reasons continuing to improve, at 15% of all contacts.[122]

Patients who commented on follow-ups were almost exclusively at SBCC. There, few remembered three contacts; most thought there were fewer follow-ups or did not specify an amount. The majority said all contacts were nonconfidential, while others described a

[118] The total differs from the total patients requiring a discharge plan (Paragraph 83) because of a patient who was readmitted to TS the same day. As to the other 16 patients in the chart review, before follow up could begin, they transferred to a higher level of care, left MDOC, or were immediately readmitted to TS.
[119] If a patient had some follow up contacts and then left the facility or was readmitted to TS, the record was treated as compliant if the MHPs had completed the number of contacts required as of the date those events rendered further follow up impossible.
[120] In the analysis for the DQE's first report, 60% of the reviewed contacts were confidential. In the current chart review, 53% of contacts were confidential. In the interim, there has been fluctuation, some of which was in a positive direction, but the rate never improved upon the beginning of Agreement implementation.
[121] These included MHPs from each of the institutions visited during the monitoring period.
[122] As described in Paragraph 67, newer methods of recording the location of contacts suggest this rate is higher.

combination of cell-front contacts and private ones subject to the type of housing unit, space availability, or patient choice.

As for treatment plan reviews and updates, only 18% of the relevant records[123] contained an indication that the treatment plan had been reviewed. While this is improved over what records showed in the fourth monitoring period, it is far lower than in other monitoring periods.

Overall, MHPs are successful in consistently completing follow-up contacts. To reach substantial compliance, more contacts should be confidential, and treatment plans must be reviewed and updated if that is clinically indicated.

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: As noted in Paragraph 52, the DQE team analyzed a sample of TS placements and determined that psychiatry consultation was clinically indicated in 90% of cases. With such a high rate of psychiatric contact recommended *generally* on TS, it remained difficult to separate out the issue of upper-level provider contact *prior to discharge* to assess Paragraph 85. Nonetheless, in a sample of 70 TS placements,[124] the DQE clinicians reviewed the course of care and determined that upper-level provider contact before discharge was clinically indicated in 18 cases (26%).

The DQE clinicians considered upper-level provider contact necessary prior to discharge in cases where:

- Patients had not had an initial psychiatric evaluation since their entry into MDOC *(i.e., new admissions to the system who were placed on TS and should have been prioritized for evaluation by psychiatry)*

[123] In the same sample, described in Paragraph 45, 62 stays were subject to the requirement to review and potentially update treatment plans. For the remaining patients in the sample, before the seven-day deadline for treatment plan review, they were readmitted to TS, transferred to a higher level of care, or left MDOC custody.
This number of stays differs from the number of placements requiring the three follow-up contacts. This difference occurs when the change in circumstance takes place after the first one or two contacts were due (making the patient subject to the follow-up contact requirement) but before seven days when the treatment plan requirement would be applicable.
[124] This is a subset of the sample described in Paragraph 45.

- Cases where TS was being discontinued while a patient was still actively threatening harm to self or others (*as an added check on an MHP's judgment about risk)*
- Before discharge to a setting in which the patient had previously engaged in self-injury *(again, as an added check on an MHP's judgment about risk).*

In the DQE team's sample, an interview with an upper-level provider was indicated primarily for patients who had never been evaluated by MDOC psychiatry. There were also patients who should have been seen because of their long TS length of stay, because a higher level of care was being considered, or because of expressing paranoia and suicidal ideation with a plan on the day of discharge.

Where upper-level provider contact was indicated, 61% of the patients were seen by a psychiatrist or nurse practitioner. There was no evidence of patient contact with a psychologist prior to discharge, or at all, in the DQE team's study. Practice was strongest at SBCC and OCCC, where 75% of clinically indicated psychiatry contacts occurred, and the rate was lowest at Norfolk, where just 25% of such contacts took place.

This warrants a finding of partial compliance. The DQE team urges MDOC to work toward establishing a culture of involving psychiatrists and psychologists in TS placements generally (e.g., for diagnostic clarity or second opinions in high-risk cases), including prior to discharge.

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

Finding: Substantial compliance

Rationale: In previous monitoring periods, the DQE team determined that this practice is in substantial compliance. In the current monitoring period, the team reviewed a 59% sample of the health records of patients who had been placed at Bridgewater State Hospital or a Department of Mental Health facility and had returned to MDOC.[125] In

[125] The study drew from the spreadsheets titled Higher Level of Care 2025.xlsx and Higher Level of Care 2024.xlsx, which MDOC provides monthly to demonstrate all referrals to higher levels of care. There were 27 patients shown

every case, MHPs completed the form and decided whether to readmit the patient to therapeutic supervision. Unfortunately, only half of the contacts were confidential. Health records continue to show that MDOC exceeds the Paragraph 86 requirements by having these patients meet with a psychiatrist as well as an MHP.

MDOC is encouraged to increase the confidentiality of these contacts with patients likely to be reviewing private information about their hospitalizations. Nevertheless, the DQE will continue to find MDOC in substantial compliance with this requirement.

SUPERVISION FOR PRISONERS IN MENTAL HEALTH CRISIS

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

Finding: Partial compliance

Rationale: MDOC's policy 650.08.B, which addresses therapeutic supervision, was approved by the DOJ in March 2025. This is an important milestone, but full compliance with Paragraph 87 requires the healthcare vendors' policies to be revised as well. To date, no information about VitalCore policies has been provided to the DQE or DOJ, and no Wellpath policies (for MASAC) have been revised.

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: As noted in previous DQE reports, it is well established practice for MHPs to determine a patient's level of observation as a key part of daily updates to TS conditions. This determination is based in part on the patient's risk of self-injury, as required by Paragraph 88, though other clinical factors are also appropriately considered. During the DQE team's site visits, MHPs were observed assessing the patient's risk as part of the first TS contact of the day and discussing potential changes to the level of observation,

having returned to MDOC in 2025. The sample includes cases from each month from January through July 2025 and from each of the five institutions to which the patients returned in approximate proportion to their percentage of total 18(a) returns.

property, and privileges during the daily triage meetings. Documents demonstrate that the same types of assessments take place on weekends with an MHP meeting the patient and conferring with a supervisor. Notes about the patient's level of observation were recorded in the triage meeting minutes, End of Shift Reports, the patient's progress notes, and TS Reports. As required by Paragraph 88, patients who are on 1:1 observation are assessed by an MHP every day, including Sundays, and those who are on close observation are assessed Monday through Saturday.

As an additional information source about daily determination of level of observation, the DQE team reviewed a sample of TS Reports, where those determinations routinely are documented, for 93 TS stays.[126] In that study, 92% of the stays had daily TS Reports Monday through Saturday, and for the 22 patients on constant observation on a Sunday, 88% had a TS Report. Where there were exceptions, the records were missing a single day.

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

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

Finding: Partial compliance

Rationale: MDOC's policy 103 DOC 650.08, *Emergency Mental Health Services*, was approved by the DOJ in March 2025. The revised policy clearly prohibits the use of TS for punishment or staff convenience. No VitalCore policies have been provided to the DQE for review,[127] and no Wellpath policies (for MASAC) have been revised. If the healthcare vendors adopt language consistent with Paragraph 89, a substantial compliance finding can be achieved.

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

[126] The sample overlaps with the sample first described in Paragraph 45. Some TS stays were substituted as some TS Reports were available in the electronic health record and others were provided as part of custody observation packets. The sample maintains the facilities' approximate proportions of the total TS placements. Where it appeared that an expected TS Report was missing, MDOC was given the opportunity to provide it separately.

[127] MDOC reported that VitalCore is following the previous healthcare vendor's policies until its own are developed

Finding: Partial compliance

Rationale: There has been no progress with this provision during the monitoring period. MDOC's policies about the response to self-injurious behavior that occurs on TS are contained in three policies (103 DOC 650.8 (*Therapeutic Supervision* in Mental Health Services), 103 DOC 562 (Emergency Response Guidelines), and 103 DOC 501 (Institution Security Procedures). All three policies remain under revision by MDOC, with policy 103 DOC 650 closest to being finalized and implemented. Policy 103 DOC 562, Code 99 Emergency Response Guidelines, has the furthest to go, as the current version does not contain any language stating that MHPs should be notified in the event of self-injury and does not delineate the responsibilities of the mental health team under these circumstances.

VitalCore's relevant policies have not yet been shared with the DQE team. To achieve compliance with this provision, VitalCore and Wellpath (for MASAC) must also establish policies and procedures to notify medical, mental health, and security staff in response to SDV that occurs on TS.

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

Finding: Partial compliance

Rationale: The DQE team's review of health records and incident reports related to SDV that occurs on TS indicates that security and medical staff are typically notified about self-injury immediately, but mental health staff are often not notified until after the acute incident is over. As noted in previous DQE reports, self-injury in MDOC is most often handled as a security matter, with implements like shackles (i.e., metal wrist or leg restraints) and pepper spray being used in response to behavior such as tying a noose around one's neck. However, there were examples during this monitoring period of MHPs and/or nurses consulting with a psychiatrist about a prisoner's self-injury or threats to self-harm, which resulted in the psychiatrist ordering as-needed, oral medication in an effort to avoid restraints or a use of force. While not yet frequent or numerous enough to constitute a trend, these incidents of therapeutic intervention as an alternative to immediate security intervention are encouraging.

The DQE team continued its practice of reviewing each incident of restraint use that occurred while a patient was on TS (in an effort to understand how the protocols for responding to self-injury work in practice). There were nine such incidents between

January and June 2025 at four facilities: OCCC, SBCC, Shirley, and Norfolk. Five incidents involved "security restraints" ordered by the Superintendent, while four involved therapeutic "mental health" restraints ordered by a physician. Despite VitalCore's statewide chief psychiatrist explaining the protocols and thought process around ordering mental health restraints to the DQE team in October 2024,[128] it was impossible to discern why some SDV incidents during this monitoring period were handled with security rather than mental health restraints. The clinical circumstances of the two groups appeared indistinguishable (e.g., same diagnoses, modes and duration of self-injury, motivation for self-harm). The chosen path seemed more related to historical practice at the facility and/or the ready availability of a psychiatrist: all four incidents of mental health restraints occurred during the day shift on weekdays, while four out of five security restraints occurred during the overnight shift. All the cases at SBCC and Norfolk utilized security restraints, while all those at OCCC and Shirley utilized mental health restraints.

Although it is important not to draw sweeping conclusions from a small number of cases, the DQE team has now reviewed the use of restraints with patients on TS for over two years,[129] and the findings are mixed. As time goes on, it is encouraging to see more cases of SDV being handled by psychiatrists rather than security staff, but there are still a concerning number of cases where shackles, pepper spray, and other harsh practices are used in response to SDV, especially at SBCC.

The DQE continues to urge MDOC to use more therapeutic measures in response to SDV and to review its policies in relation to published guidelines by the NCCHC and American Psychiatric Association. To meet the requirements of Paragraph 91, MDOC must demonstrate more consistent notification of MHPs in response to self-injury than is currently occurring.

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

Finding: Partial compliance

[128] He explained that VitalCore's psychiatrists would only order mental health restraints when a patient's SDV *stems from serious mental illness*. Because so many of MDOC's SDV incidents involve prisoners trying to achieve a specific objective (e.g., obtain a single cell or transfer to a different housing location), in VitalCore's understanding, most incidents would not be appropriate for the use of mental health restraints and should instead be handled according to security protocols.

[129] MDOC began tracking these cases in March 2023.

Rationale: When an incident of self-injury occurs, MDOC's expectation is that all involved staff will write an incident report in the Inmate Management System (IMS) and that mental health and medical staff will write a progress note in the health record as clinically indicated. These protocols meet or exceed the requirements of Paragraph 92. In previous monitoring periods, the DQE team also established that the notes' content meets the requirements of Paragraph 92, documenting a prisoner's statements and behaviors related to self-harm.

To achieve substantial compliance with the Paragraph 92, MDOC must demonstrate consistent completion of incident reports for all episodes of self-injury. This remains a work in progress, according to the minutes of MDOC's Quality Improvement Committee (QIC) meetings. Between January and May 2025, monthly completion rates for incident reports ranged from 38% to 73%, depending on the month and the staff discipline (security, medical, or mental health). Although these rates are not yet substantially compliant, they are improved from the previous monitoring period.

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: The DQE team interviewed 13 prisoners, across all visited institutions, who reported having recent experience with constant observation. Just under half said that officers remained awake when observing them, while a slight majority reported observing an officer fall asleep on duty once or multiple times. The patients identifying this issue were most concentrated at SBCC, and a Norfolk MHP said they had heard the same from patients. Fewer patients commented on other potential misconduct during observation, but most said that officers otherwise fulfilled their responsibilities to monitor prisoners continuously and did not leave the post unattended or become unreasonably distracted.[130] Two interviewees, from Framingham and OCCC, felt that officers provoked or mocked them while on TS. More interviewed patients and MHPs raised concerns about officer behavior more broadly, but not specific to TS.

MDOC's policy 103 DOC 522, Professional Standards Unit, mandates investigations of all staff misconduct, including that which occurs in relation to TS. The DQE team reviewed a redacted version of the "Professional Conduct Log," a document compiled by

[130] The exceptions were two patients who thought officers sometimes leave the post or become inattentive.

the Clinical Operations Analyst from staff-generated confidential incident reports and from other issues that come to the attention of top MDOC leadership. This log does not include complaints generated from prisoner grievances or Staff Access hours, so it gives an incomplete picture of alleged misconduct, but it is one of the only sources of data available to the DQE team to assess the Paragraph 93 requirements.

There were allegations of 34 new incidents of staff misconduct related to crisis/TS added to the log in the first half of 2025.[131] As in the DQE's last report, a disproportionate number of these allegations stem from Norfolk (55%). The remaining allegations are from Framingham (24%), SBCC (9%), OCCC (9%), and Gardner (3%).

The large majority of allegations, 86%, involved an officer delaying or refusing to call crisis on behalf of a prisoner, spanning five institutions. The remaining allegations involved encouraging prisoners' self-injury while on TS, physical assault of a prisoner, and destroying a prisoner's property while he was out of his cell on TS. The most disturbing allegation was at SBCC, where several prisoners reported that an individual who died by suicide in the BAU had been screaming and asking for crisis mental health services for over two hours before his death. According to MDOC's log, the investigation of staff who allegedly ignored these requests is ongoing.

Another disturbing incident during this monitoring period occurred in the ISU, where officers' use of force resulted in serious injuries to the patient, requiring surgery, and this has been under review by MDOC for over seven months. This incident does not appear in the Professional Conduct Log, presumably because it came to light by means other than a staff-generated confidential incident report.

Overall, while MDOC seems to have a process in place for investigating allegations of professional misconduct, the Professional Conduct Log raises more questions for the DQE team than it answers. The investigation and resolution of most allegations are summarized with a brief phrase like "no further action warranted" or "no misconduct." Those entries do not indicate what actions were taken or why this conclusion was reached. A simple entry, such as this existing log entry, would be much more effective:

> "SSI conducted an interview with the II who was unable to provide additional information, other than reporting it was 'months ago.' No further action."

[131] There are 41 total incidents on the log that allegedly occurred in the first half of 2025. The four allegations excluded from the DQE's analysis were related to a prisoner's mental health but not clearly to crisis/TS services. Additionally, three incidents were reported more than once, so each set of complaints is treated as one incident for this analysis.

Only one of the 101 allegations documented in the Professional Conduct Log since July 2024 appears to have resulted in staff discipline, though several are still under investigation.

These practices are sufficient for a partial compliance finding, but to reach substantial compliance, MDOC will need to demonstrate the methodology and rationale behind its conclusions.

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: As noted in the previous report, from the DQE's perspective, the requirement for officers to complete a "read-and-sign" document is no longer active because MDOC has been offering live trainings about Therapeutic Supervision since the fall of 2023. Currently, MDOC is required to demonstrate two things: (1) that correction officers who observe TS prisoners have completed the training, and (2) that the current policy is posted in visible places on every unit where TS occurs.

During this monitoring period, MDOC provided records of staff training in Training Year 25, which show that 1,759 of 2,011 staff members (87%)[132] at the seven prison sites where TS occurs completed the TS training. MASAC's records indicate that 99% of security staff completed the TS training, though 16% did so prior to the Agreement's inception, when policy and practice may have been different. The training records did not specify the staff members' job class, so it is not possible to say with certainty that staff who "observe prisoners on mental health watch" (the requirement of Paragraph 94) have the same completion rate as the full group. However, MDOC's overall demonstration of excellent completion of TS training across two training years at the

[132] The numbers and percentage may vary from this as it appears they do not take staff turnover into account.

prison sites is sufficient to satisfy the DQE. Some staff at MASAC may need refresher training.

The TS poster has now been finalized, and MDOC reported in its June 2025 Status Report that it is being posted in areas that conduct TS. MDOC has begun providing photo documentation of those postings. The next round of DQE site visits will provide an opportunity to verify that each of the 18 areas in the eight facilities where TS occurs has a poster displayed.

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: During site visits, the DQE team has always observed numerous officers in position for constant observation, and officer interviewees have always described maintaining an uninterrupted view as their primary duty when assigned to that role. Nearly all interviewed prisoners with recent experience on constant observation said that officers fulfilled their responsibilities to monitor them continuously, though there were two who alleged that officers sometimes leave the post or become inattentive. A larger exception came from those noting times when they believed officers fell asleep (see Paragraph 93).

Officers' TS observation sheets tended to support that officers are carrying out this responsibility as required. The DQE team's study of 32 constant observations[133] found that officers routinely captured their observations while on that post. About 25% of the constant observation packets showed lengthy recording gaps. This could suggest that the task was intermittently not being performed, but the timing—often the length of one rotation on the post or a whole shift—point toward a greater likelihood of issues in document transmission rather than observation practice.

In general, the content of constant observation sheets was more informative than sheets documenting close observation and had more indicia of reliability. While a small percentage, it is troubling that 16% of these forms raised questions about the veracity of recording, such as pre-filled or potentially post-filled entries and multiple people completing sheets as though they were on the same post for an hour or more.

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

In terms of the visibility available to these officers, the DQE team continued to observe the sight lines for cells in different units used for TS and has tested the seating arrangements and visibility in some locations. While there are some limitations, on the whole, the DQE team finds that sight lines are reasonable for observing prisoners on constant observation.[134]

Measures to reach substantial compliance would address Paragraph 95, as well as other Agreement paragraphs. An internal review of claims that officers fall asleep on post seems needed, given that they have persisted since at least 2020, as well as a review of constant observation entries that seem unlikely, would also be beneficial. Such reviews could either produce new information that demonstrates strong practice or identify and remedy issues that are preventing substantial compliance.

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

Finding: Partial compliance

Rationale: The DQE team understands from interviews that the responsibilities outlined in Paragraph 96 have been included in formal training and on-the-job training since before the Agreement began. As one measure of implementation, the DQE team examined the forms on which officers are required to record the checks they have made. The team reviewed forms for 52 TS placements drawn from all institutions that conducted TS.[135] The presence of complete records appears improved from the last few monitoring periods but remains below the performance observed at the beginning of Agreement implementation.

In the current study, 71% of sampled TS placements recorded contacts every 15 minutes—or a similar interval if contacts were "staggered"—or missed contacts only very rarely.[136] Among noncompliant records, the absence of recorded contact ranged from 45 minutes to a full shift.[137] Performance was particularly strong at Framingham, Norfolk, and OCCC, while SBCC has the furthest to go. The practice of staggering contacts (making them at unpredictable intervals) as a means to prevent and quickly identify patients' self-injury appears to have been largely abandoned. Only OCCC was

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

mostly successful in staggering contacts, according to observation sheets, and Framingham did so sometimes.

The majority of the records reasonably captured prisoners' activity, and sometimes mood, and some were very informative. In almost 40% of the cases, however, there remained recording practices that raise questions about the adequacy of the observation and truthfulness. These included apparently pre-filled sheets; identical two-word entries for long stretches from 9 to 40 hours; and content that seems improbable. These concerning practices were seen almost exclusively at SBCC and OCCC.

In its June 2025 Status Report, MDOC reported a number of mechanisms in place for oversight of these responsibilities. During a shift, unit officers in charge are responsible for checking the in-progress sheets. Site managers reportedly also review the observation sheets.

All elements of this requirement would need improvement to reach substantial compliance.

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

Finding: Partial compliance

Rationale: During institutional tours, the DQE team observed door construction for TS cells and whether it hinders or facilitates transmission of contraband that could be used for self-harm. MDOC has continued to make progress. Of the 18 units that house patients on TS, the DQE team has verified, either in person or with photographs, that 15 have installed effective door sweeps or have door construction sufficient to prevent harm without them.

MTC is continuing to seek solutions after installation of two door sweep models were problematic for the doors' functioning. In the HSUs at OCCC and SBCC, there remain either gaps at the bottom of some doors or the use of brush-like material that is flexible, so contraband can be pushed through it. These units house a large percentage of MDOC's TS patients, and a substantial amount of SDV occurs there, so the absence of solid door sweeps carries potentially greater risk. MDOC is very close to reaching substantial compliance with this requirement.

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

Finding: Substantial compliance

Rationale: The staffing matrices from VitalCore and Wellpath Recovery Solutions indicate that, in May 2025, each of the eight MDOC sites where TS occurs employed at least one full-time Support Person, Monday through Friday. Framingham was the only site with full staffing of Support Persons (1.2 FTE), but others, including Norfolk and SBCC, utilized per diem Support Persons to cover some Saturday shifts. Thus, MDOC's obligation to ensure that the healthcare vendor retains Support Persons at the facilities where TS occurs remains fulfilled. Concerns about unfilled weekend Support Person positions are addressed in Paragraph 102 below.

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

Finding: Partial compliance

Rationale: As noted in the previous DQE report, Support Persons have been integrated into the mental health teams at all facilities subject to the Agreement. It remains true, however, that they are not interacting with patients on TS consistently at all facilities, although that practice seems to be increasing.

The DQE team interviewed three Support Persons and six MHPs or supervisors about Support Persons' roles and contributions, and the team observed their interactions during triage meetings. Staff described Support Persons' current responsibilities and ongoing processes to refine how they can best complement the services that MHPs and Activity Therapists provide. Interviewees said Support Persons tend to have routine activities, and additions or changes are sometimes made during triage meetings, by a supervisor, or by MHPs requesting additional support for patients they have identified.

Among the 95 TS placements that the DQE team examined for this report,[138] Support Persons interacted with as many as 44 of the patients,[139] often on multiple days during the stay. At OCCC and Framingham, it was common for a patient to see these staff members nearly every day. MASAC and Norfolk increased their rates of patients connecting with this support, and Gardner began to do so in the later months of the monitoring period. These combined to demonstrate a significant improvement over the previous period's analysis.

Sampled health records showed that SBCC, Shirley, and MTC did not use their Support Persons in the TS setting, although the DQE team was told this was being initiated at SBCC in April 2025.

The high rate of cell-front contacts between Support Persons and TS patients is concerning. At Framingham, all completed contacts appeared to be out of cell, but at Norfolk and in OCCC's BAU, there were indications that security staff frequently required cell-front contacts. Systemwide, in the DQE team's sample, only 20% of completed Support Person TS contacts took place out of cell.

Support Persons continued to document their TS contacts in role-specific progress notes, as required by Paragraph 99. These notes were evident in the records reviewed by the DQE team and generally consisted of two to three sentences documenting that an interaction was attempted or completed, the type of activity, and a brief description of the prisoner's behavior.

In addition to interacting with patients on TS at some facilities, Support Persons offered services in the ISU, BAU, RTU, SAU, and general population. Data confirm that the large majority of Support Persons' time at all facilities was spent outside TS, both in the current and previous monitoring periods.[140] Support Persons described leading groups—giving art, music, games, comic books, healthy living (hygiene, coping, spirituality), and goals as examples—and distinguished their groups from those led by Activity Therapists and MHPs, saying the latter tend to be more educational while Support Persons' groups tend to focus on more everyday topics. At OCCC, a Support Person said they also join groups led by others, helping with logistics and giving a patient an opportunity to decompress when group becomes too much for him.

[138] The sample substantially overlaps with that described in Paragraph 45. A few records were substituted for greater appropriateness for this particular question.
[139] This number of charts contained at least one Support Person Contact note during a TS in the monitoring period. Most were clearly created by a Support Person; with a few (four), it was not clear whether the note covered a Support Person's activity or that of an activity therapist or staff member with a BSW degree.
[140] The data are provided monthly in a document referred to as the Monthly Mental Health Roll-Up. The DQE team analyzed these documents for January through May 2025. The conclusion that much more time is devoted outside TS is consistent with these data from July through December 2024.

Support Persons also reported distributing materials (psychoeducational worksheets, word searches, and puzzles) and, at OCCC, conducting BAU rounds. At Framingham, a Support Person said they see all TS patients, and all interviewees said they provide individual support to patients when requested by mental health staff or supervisors. In these contacts, they might have discussions or engage in games or puzzles.

Overall, MDOC continues to move toward compliance with the Paragraph 99 requirements. More consistent offers of support to TS patients and improving access to out-of-cell space when necessary will be important to fulfilling these obligations.
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100. A Support Person will receive 40 hours of training pre-service training prior to engaging with prisoners on Mental Health Watch, which will include training about how to appropriately interact with, and document interactions with, prisoners on Mental Health Watch. Support Persons will also receive Crisis Intervention Training.

Finding: Partial compliance

Rationale: As in previous monitoring periods, interviewed Support Persons reported completing two weeks of New Employee Orientation (NEO) with MDOC and the healthcare vendor prior to beginning work in the facilities. NEO records from January to June 2025 are consistent with this report, documenting eight hours of Suicide Prevention and Mental Health training during the MDOC week and additional mental health topics during the healthcare vendor's week. The three Support Persons hired by VitalCore during this monitoring period completed NEO, according to attendance logs provided to the DQE.

The DQE team interviewed three Support Persons at three institutions during this monitoring period. All reported that they learned how to interact with patients from previous work experiences (e.g., at other programs for people with mental illness) and/or by shadowing MHPs. Similarly, all reported using the electronic health record to document their contacts, having learned how to use it during NEO and in their first weeks at the facilities. Interviewed Support Persons at Framingham and OCCC reported routinely interacting with patients on TS and documenting those contacts, while the Support Person at SBCC did not interact with TS patients and, therefore, did not report having experience with such documentation.

Paragraph 100's final requirement is that Support Persons receive CIT training, and two interviewed Support Persons reported that they had been offered the training recently. A review of CIT training records provided by MDOC revealed that one Support Person (at

Framingham) completed the full CIT training in December 2024; none participated in the "refresher" trainings offered in 2025.

Overall, MDOC has continued its positive trajectory regarding Support Person training. Pre-service training remains in place, and CIT training has begun. With sustained practice and more Support Persons' completion of CIT training, MDOC is likely to achieve compliance with the Paragraph 100 requirements.

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

Finding: Substantial compliance

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

All interviewed Support Persons reported frequently consulting with MHPs throughout the day about their work with patients, and all identified the site Mental Health Director as their main supervisor. Interviewed Mental Health Directors and MHPs reported the same. Support Persons' work schedules align with MHPs' schedules, so they always have access to supervisors. In addition, Support Persons attend statewide, weekly group supervision meetings on Teams with an MHP. Although Support Persons' reports of the meeting's helpfulness varied, all understood that it was mandatory and reported attending regularly.

Overall, it appears that the structures necessary for on-site supervision of Support Persons by MHPs are in place. Over three monitoring periods, the vast majority of Support Person contacts have been positive and clinically appropriate, and supervision has been adequate. This is sufficient for a continued substantial compliance finding.

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

Finding: Partial compliance

Rationale: As noted in previous DQE reports, each MDOC site where TS occurs is allotted 1.2 FTE Support Persons, which adds up to the time required by Paragraph 102: 6 days per week, 8 hours per day (Monday through Saturday). The ISU has an additional 3.4 FTE Support Persons allotted to it. In total, there are 13.2 FTE Support Person positions across MDOC.

As of May 2025, 11.8 out of 13.2 FTE had been filled. All the full-time positions were filled, while only one of the part-time (0.2 FTE) positions was filled. Although the Saturday positions remain difficult to fill because of the less desirable weekend shift and limited weekly hours, MDOC has overall made progress with staffing the Support Person positions. As noted in previous DQE reports, their shifts align with the times when most self-injury occurs. If MDOC can get closer to full staffing of the part-time positions, it can achieve substantial compliance with the Paragraph 102 requirements.

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

Finding: Partial compliance

Rationale: The main shift transition where TS contacts could be discussed occurs at approximately 1 p.m. on weekdays; the morning "crisis clinician" hands off the two-way radio and responsibility for responding to crises to an MHP who works from 1 pm to 9 pm. Through interviews and observation of MHPs' practices across two monitoring periods, it appears that Support Persons' contacts are discussed inconsistently during these shift transitions. As noted in relation to Paragraph 99, the DQE team's review of medical records indicates that Support Persons at SBCC, Shirley, and MTC are not seeing patients on TS, so their shift transitions do not include a discussion of Support Person contacts. Observation of Framingham's practices during this monitoring period indicated that Support Person contacts are not discussed, even though the Support Person typically sees TS patients daily. Interviewed Support Persons and MHPs reported that information about Support Person contacts with TS patients is more commonly exchanged during the daily triage meetings, in emails, or in End of Shift Reports.

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

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

Finding: Partial compliance

Rationale: In the DQE's study of 95 TS placements,[141] 44 patients had documented Support Person contacts (46%), and many had multiple such contacts during the TS. There is no way to know whether any additional, undocumented contacts occurred. However, three Support Persons interviewed by the DQE team across three institutions knew of their need to document all contacts and reported doing so in the electronic health record. Given the consistency of data obtained from chart reviews and interviews across two monitoring periods, the DQE finds that MDOC is meeting the documentation requirements of Paragraph 104.

As noted in the fourth DQE report, Support Persons' documentation is not reviewed in the triage meetings at any MDOC facilities, but such a practice would be inconsistent with the way that most mental health team meetings operate (in the DQE clinicians' experience). During the current monitoring period, DOJ agreed to consider compliant the practice of Support Persons' contacts being reviewed *verbally* during triage meetings. By this revised metric, MDOC's practice appears strong at some facilities, while more is needed at others. During site visits, the DQE team observed clinical teams routinely discussing Support Persons' contacts during triage meetings, though only a minority of these contacts involved patients on TS. The DQE team also reviewed the June 2025 triage meeting minutes from all facilities where TS occurs. Notes from OCCC and Framingham indicate that Support Persons' contacts with TS patients were discussed daily, while those at the other six sites did not indicate any discussion of such contacts. The infrequency of TS placements at Gardner, Shirley, MASAC, and MTC may explain why no discussion of Support Persons' TS contacts occurred at those sites, but that hypothesis would not explain the deficits at SBCC or Norfolk.

With improved demonstration of Support Person discussions during the triage meetings across all sites, MDOC can achieve substantial compliance with the Paragraph 104 requirements.

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:

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

Finding: Partial compliance

Rationale: There are no new findings here. According to MDOC's June 2025 Status Report, policy 103 DOC 562, Code 99 Emergency Response Guidelines, remains under review. As noted in the previous DQE report, the version dated June 28, 2024, does not align with some aspects of the Agreement, including (1) delineating what types of self-injury are included, (2) what factors staff should consider when determining the type of protective equipment and clothing to utilize in a Code 99 response, and (3) specifying that mental health staff should be notified in the event of SDV.

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

Finding: Partial compliance

Rationale: As noted in the fourth DQE report, the only source of data available to the DQE team regarding Code 99 activation is incident reports stemming from episodes of SDV. The DQE examined 10 such incidents during this monitoring period, including two completed suicides, two serious suicide attempts (as defined in Paragraph 145), and six other potentially life-threatening incidents chosen from the SDV log.[142] From this documentation, one can tell that Code 99 procedures were activated by an officer when observing a prisoner engaging in self-injury. It is not possible to determine whether this occurred immediately or what factors were considered when determining the type of protective equipment and clothing to use in the response.

Prisoners and staff across four institutions were asked how SDV is handled, and interviewed officers uniformly reported an obligation to call a Code 99 upon discovering life-threatening self-injury. Mental health staff generally reported that the officers were good about calling them if concerned about prisoners, including regarding self-injury. Encouragingly, fewer interviewed patients during this monitoring period reported that correction officers ignored or encouraged SDV.

[142] The reviewer chose hanging, jumping, and object ingestion incidents from the SDV log because they were most likely to be life-threatening (as opposed to head-banging, scratching or insertion of objects).

One other source of information is the "Professional Conduct Log" that MDOC's Clinical Operations Analyst keeps as a quality assurance measure. This log recorded four incidents between January and June 2025, all at Norfolk, of officers allegedly delaying their response to SDV that occurred while a prisoner was on TS. MDOC reported in its June 2025 Status Report that video footage of such alleged incidents can be reviewed by the DQE team during site visits; this will likely occur in the next monitoring period.

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: Officers at all visited sites continued to affirm that, in their experience, prisoner self-injury is rare or that they had not seen any. Of 29 prisoners interviewed, only seven said they had injured themselves in recent years. These statements are consistent with the declining rates of SDV discussed elsewhere in this and previous DQE reports.

MHPs estimated that SDV incidents occur at a higher frequency, perhaps because of their institution-wide experience. Estimates were still moderate, ranging from two times per week to once or twice per month, and Norfolk clinicians noted that a small number of patients accounted for most of the incidents at that site. MHPs and officers said that the majority of incidents used only the patient's body; they gave head-banging, biting, and scratching as examples. Staff also observed insertion, ingestion, tying an item around the neck, and cutting—some said with metal pieces or weapons—and each of these was mentioned about half as often as using one's body alone. These impressions are similar to the frequency of these actions reflected in MDOC's SDV database. One OCCC patient set himself on fire.

In the DQE team's interviews in all monitoring periods, including the present one,[143] security and mental health staff have consistently described an officer's routine response to a prisoner's in-progress self-injury as being an immediate call to a supervisor, who then calls nursing and mental health staff.[144] Several officers explicitly mentioned remaining with the prisoner until the security supervisor directs other action and some patients confirmed that.

[143] In the current monitoring period, 14 security staff and 11 mental health staff commented on point. The seven prisoners who said they had recently self-harmed also offered input.

[144] See Paragraph 43 for discussion of the timing of mental health notification

Many officers over time have said that, after they have made their calls and while waiting for supervisors and/or the response team, they personally attempt to influence the prisoner to stop self-injuring. Fewer officers raised this during recent interviews, but there were examples at several visited institutions. MHPs described some officers using verbal deescalation, putting up protections so a head-banging patient could not reach the wall, or taking an item from the patient's hand.

There were also some promising examples in a sample of incident reports,[145] where the large majority described the first officer on the scene or a responding lieutenant successfully encouraging a patient to come down from an elevated surface or to give up a ligature or piece of plastic, or the officer removing the ligature through the door. In each of these cases, it was evident that an officer remained with the prisoner until the incident concluded.

On the other hand, in that document review, there were a few cases where it appeared force was used without informal attempts at persuasion, and a few MHPs at OCCC reported having the impression that officers do not attempt to deescalate SDV situations. A few prisoner accounts raised troubling questions as well, with two men saying security staff did not take any action and that it was only upon contact with another officer that there was a response. One of them named a second incident where he was in a therapeutic module calling crisis repeatedly and officers did not notice for an extended period that he had initiated hanging.

There are mostly positive indications about promptly making key notifications and attempts at deescalation. As noted in Paragraph 91, clarification about mental health notification is still needed in the Code 99 policy. With that update and more consistent demonstration of attempts at deescalation, MDOC should be able to reach substantial compliance.

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

Finding: Partial compliance

[145] The DQE team reviewed incident reports that were included in security observation sheet packets, or otherwise provided by MDOC, which included seven incidents involving in-progress self-harm.

Rationale: The expectation to complete a SIBOR[146] within 24 hours of an SDV incident is well established among MDOC's mental health staff. As in previous monitoring periods, MDOC provided a SIBOR for each episode of SDV listed in the tracking spreadsheet as occurring while a prisoner was on TS. Between January and June 2025, all but one incident of SDV was accompanied by a completed SIBOR, which indicates excellent practice.

The DQE team reviewed 50 cases for SIBOR completion on the day of the SDV incident or the following day. Cases were chosen in approximate proportion to the percentage of SDV incidents that occurred at each facility. *Table 4* illustrates the results.

Table 4. SDV Incidents with Timely SIBORs

	% of Total SDV	# of cases audited	SIBORs completed on day of SDV or following day	% timely
Framingham	8	4	4	100
Gardner	1	1	1	100
MASAC	3	2	2	100
MTC	2	1	1	100
Norfolk	17	7	5	71
OCCC	30	15	12	80
SBCC	32	16	11	69
Shirley	7	4	3	75
TOTAL	**100**	**50**	**38**	**76**

Overall, 76% of SIBORs were completed within 24 hours of the event, which is an improvement from the previous six-month period (52%). The vast majority of SIBORs were completed within 48 hours of the SDV incident (90%), indicating that the expectation of timely SIBORs has taken hold across MDOC. With improved practice at SBCC, MDOC can achieve substantial compliance with the Paragraph 108 requirements.

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

[146] This document is now known as a Self-Directed Violence Occurrence Report (SDVOR), but the DQE reports continue to use the term SIBOR to maintain consistency with the Agreement's terminology.

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

MDOC continues to audit the completion of incident reports related to SDV, and the results are then reviewed in the monthly QIC meetings. Minutes from the QIC meetings between January and May 2025 indicate that the completion of incident reports related to SDV is improving. However, completion rates by all disciplines (mental health, medical, and security) were still below 70% as of May 2025, and some SDV incidents had no reports at all. In meeting minutes and its June 2025 Status Report, MDOC reported that it continues to remind staff about the importance of completing incident reports related to SDV, and going forward, it plans to track a sub-category of reports related to SDV that occurs while a prisoner is on TS.

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 previous monitoring periods, the DQE team has found that patients who self-harm on TS are routinely assessed by an MHP within 24 hours because of the established practice of conducting three mental health contacts per day with all patients on TS, except Sundays and holidays. This practice has not changed during the current monitoring period.

As described in Paragraph 71, 18 cases in the DQE team's study of TS placements involved a patient engaging in SDV at least once. To assess Paragraph 110's requirement for treatment plan modification, the DQE team reviewed treatment plans in the health record on the next business day following self-injury,[147] looking for any acknowledgement by the MHP that self-injury had occurred and any consideration of whether to modify the treatment plan. Seven out of the 18 cases (39%) contained such a notation. Practice was strongest at Framingham, where MHPs revised the treatment plan in 100% of TS cases where SDV occurred.

[147] In some cases, patients engaged in several SDV incidents within a span of hours, or the SDV occurred at night or on the weekend. In those cases, it would be unreasonable to expect a formal treatment plan update until the next working day, when the treatment team can assess the situation and determine the best path forward.

Overall, it appears that patients' care is being modified appropriately following SDV (as determined in Paragraph 71), but the documentation in treatment plans, as required by Paragraph 110, is lagging behind. This is sufficient for a partial compliance finding.

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

Finding: Partial compliance

Rationale: MDOC's policy on ingestion of foreign bodies is a subsection of policy 103 DOC 501, Institution Security Procedures, revised in March 2024. Section 501.09 pertains to ingestion of contraband (i.e., foreign bodies) or concealment of contraband in body cavities.

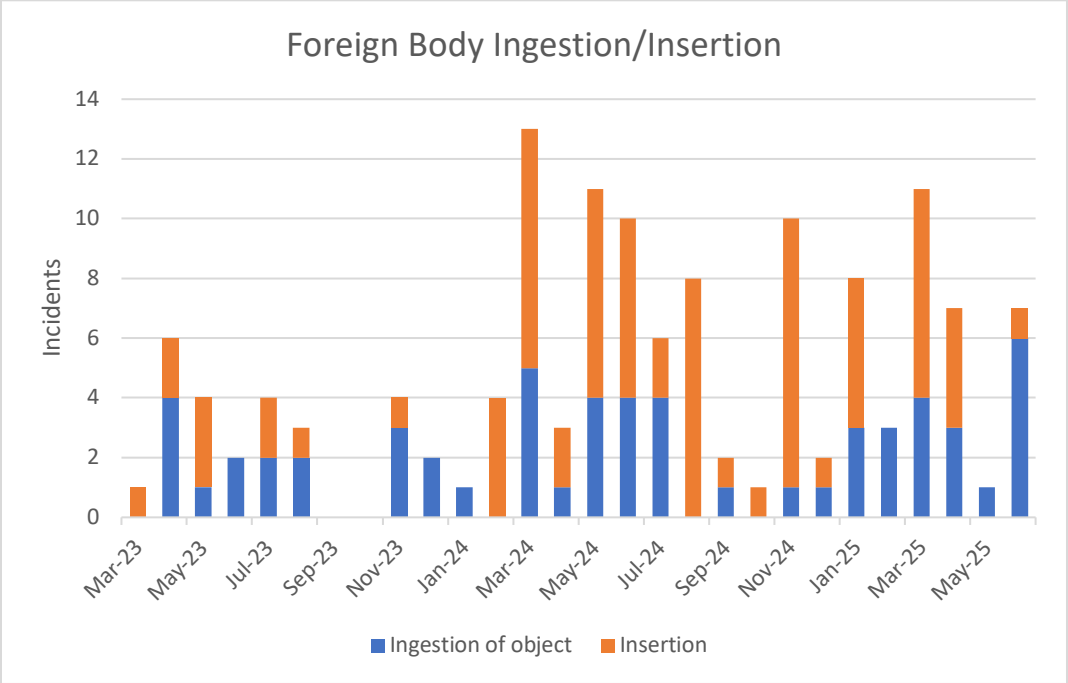
To assess whether MDOC was following policy 501.09 after incidents of SDV, the DQE randomly chose 10 of the 75 incidents listed in MDOC's "Foreign Body Log" between January and June 2025. Six of the incidents had accompanying incident reports,[148] and it was possible to tell from two of the incident reports that MDOC's general policy of placing a prisoner on constant observation before having him evaluated by medical and mental health staff was followed. In the remaining four cases, there was insufficient information in the incident reports to determine whether MDOC was following its policy.

Overall, it appears that MDOC has a policy in place to respond to SDV by foreign body ingestion or insertion, but more is needed to demonstrate that the policy is consistently followed. Improved completion of incident reports related to SDV could help with this demonstration.

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

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

Figure 8. Foreign Body Ingestion and Insertion



These data indicate that ingestion of objects increased between January and June 2025. This largely stems from the behavior of three patients at Norfolk and SBCC, all of whom were eventually admitted to the ISU or Bridgewater State Hospital.

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

Finding: Partial compliance

Rationale: A handful of MDOC policies address the Paragraph 112 requirements:

- 105 DOC 501, Institution Security Procedures (revised 3/4/24)
- Attachment 14 of 103 DOC 650, Mental Health Services (currently awaiting re-approval by DOJ)

- 103 DOC 506, Search Policy, and its two accompanying Standard Operating Procedure documents[149]

In the previous monitoring period, the DQE recommended that the policies and procedures for handling foreign body ingestions be consolidated in one place, likely policy 103 DOC 501, Institution Security Procedures, so they would be readily accessible and comprehensible to staff. There has been no progress during this monitoring period, as the draft of policy 103 DOC 501 remains under review by MDOC, according to its June 2025 Status Report.

INTENSIVE STABILIZATION UNIT

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

Finding: Substantial compliance

Rationale: There has been no change in this area since the fourth DQE report. MDOC drafted, and DOJ approved, the language in policy 103 DOC 650, Mental Health Services, regarding the operation of the ISU.

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

Finding: Substantial compliance

Rationale: The ISU was officially opened on June 16, 2024, and its first patient was admitted on August 1, 2024. Since that time, records indicate that there have been 26 admissions involving 23 different patients (one person was admitted four times, the others once each). The average length of stay has been 57 days (range 9-91 days), and the highest census has been 8 patients. During the April 2025 site visit, OCCC staff reported that there had been seven "graduates" of the program (defined as successful completion of programming for 90 days) and 10 "discharges" from the program (i.e.,

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

transfer out earlier than 90 days because of not benefitting from or disrupting the programming).[150]

The DQE team's April 2025 site visit and review of medical records indicate that the ISU remains fully functional. There are MHPs, activity therapists, a nurse, a psychiatrist and nurse practitioners, a psychologist, and Support Persons contributing to treatment. Patients have multiple group and individual contacts per day, treatment team meetings occur daily on weekdays, and indoor and outdoor recreation spaces are being used. These activities all demonstrate compliance with the requirements of Paragraph 114.

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

Finding: Substantial compliance

Rationale: The DQE reviewed the referral paperwork for the 15 patients admitted to the ISU between January and June 2025. Patients were referred from OCCC, SBCC, Norfolk, Shirley, and Bridgewater State Hospital. As in the previous monitoring period, it appeared that the patients were chosen because of their difficulty functioning in general population, RTU, or STP settings due to serious mental illness and/or personality disorder. Of the 15 patients admitted to the ISU, 11 had been on TS at the time of their referral, and the remaining patients had had multiple TS placements in the preceding weeks/months or were referred as a step-down from Bridgewater State Hospital. Overall, it appears that the patients admitted to the ISU meet the definitions set forth in Paragraph 115 (i.e., unable to effectively progress with TS, not meeting statutory criteria for hospitalization but still in need of a higher level of care).

Paragraph 115 also requires that the ISU focus its treatment on patients' immediate clinical needs, restore their safety and stability, and prepare them to function in a non-

[150] Of note, one patient was discharged after less than two weeks because of a physical fight with officers that resulted in severe injuries to the patient. The DQE team understands that the use of force review remains pending after almost seven months.

ISU environment. These requirements are substantively identical to Paragraph 116; please refer to the DQE's compliance assessment of Paragraph 116 below.

116. Specialized interventions are based on the prisoner's mental health needs, behavioral needs, and level of functioning. Each prisoner will be assigned to treatment and programming in accordance with their individualized treatment plan. The primary goals for ISU treatment include the following: stabilizing of primary symptoms necessitating referral, providing a supportive, intensive therapeutic milieu for inmates with mental health needs, and preparing each prisoner for reintegration into the general prison population or Residential Treatment Unit offering a reasonable expectation of success given current mental health needs.

Finding: Partial compliance

Rationale: MDOC's written program description for the ISU outlines a four-phase treatment structure that is consistent with the goals of Paragraph 116. In practice, the ISU program consists of two phases. Most patients begin on Phase 3, and they eventually progress to Phase 4, which begins to prepare them for their return to the home site. Phases 1 and 2 are not components of ISU per se, but rather are therapeutic supervision if needed.

During the previous monitoring period, the DQE team observed that most of the Paragraph 116 requirements were being met in the early days of the ISU, including providing a supportive, intensive milieu; stabilizing the symptoms leading to referral; and preparing patients for reintegration into their home sites. After observing unit operations and reviewing health records and other documents during the current monitoring period, it is clear that those elements are sustained.

Because so few patients had been admitted to the ISU as of the fourth DQE report, it was not yet possible to demonstrate individualized treatment planning to the extent required by Paragraph 116. To assess individualized treatment planning during this monitoring period, the DQE clinicians reviewed medical records for 5 of the 20 patients treated in ISU between January and June 2025; this represents a 25% sample.[151] This review confirmed what MDOC asserted in its June 2025 Status Report: that VitalCore had created a new form, BH-8.0, for ISU treatment plans. It was clear from the medical record that treatment plans are updated approximately once per week after a discussion with the treatment team. Patient participation in this process is evolving, with clinical leadership working on a system for patients to review and sign their treatment plans.

[151] The DQE team reviewed the electronic health records of five patients who were placed in ISU between March and June 2025 and had lengths of stay of at least five weeks. When analyzing some aspects of treatment plans, the DQE team reviewed at least eight plans per patient, or all plans if the length of stay was shorter than that.

In the DQE clinicians' opinion, the treatment plans captured the patients' presenting problems and set goals consistent with them, but the plans sometimes missed the bigger picture or left out an important aspect of treatment. For example, one patient was admitted to the ISU because of depression, weight loss, and possible medical problems, but his treatment plan did not identify medical evaluation of his symptoms as a goal. In addition, the patient was never evaluated by a psychiatrist during his ISU placement.[152] In another example, substance use was not included in several patients' treatment plans, seemingly because they were already involved in the MAT program.

The interventions section of the treatment plans was not individualized. The identical description appears under every goal, every week, for every patient reviewed. Additionally, there is a set group program provided to all patients, and treatment plans do not select which groups are suited to addressing the individual patient's mental health needs. Overall, the treatment plans in the ISU were significantly better than those completed for patients on TS, though they still reflected the clinicians' inexperience and limited interdisciplinary collaboration.

Based on the DQE team's interviews with patients and mental health staff and a review of ISU medical records, the program endeavors to prepare patients for life after the ISU. Progress notes reflect multiple discussions about patients' anxiety about leaving the ISU, especially when they would be transferring to undesired placements like SBCC or the SAU. As one would expect, patients' trajectories after discharge from the ISU were highly variable, ranging from successful reintegration into general population to admission to Bridgewater State Hospital.

Overall, MDOC continues to operate the ISU program successfully. The referred patients are appropriate, and the program is designed to support the goals set out in the Agreement. With some improvement in the quality of treatment plans and provision of individualized treatment, MDOC can achieve substantial compliance with the Paragraph 116 requirements.

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

Finding: Not assessed (by agreement of the parties)

[152] As of 7/27/25, the patient had not been discharged from the ISU, but there were no psychiatry notes in the EHR since admission three months earlier..

Rationale: No other units have been developed to serve the same purpose as the ISU. The Intensive Treatment Unit (ITU) at Framingham follows a four-phase treatment model that is similar to the ISU, but neither MDOC nor DOJ have asserted that its purpose is the same as the ISU.

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

Finding: Partial compliance

Rationale: In the previous monitoring period, the DQE's review of ISU referral paperwork confirmed that the spirit of Paragraph 118 is being met, as all referred patients could easily be described as "dysregulated and/or decompensated for whom multiple interventions have been ineffective." This remains true during the current monitoring period, based on the DQE's review of 15 referrals between January and June 2025. Each written referral commented on the patient's duration of symptoms, history of TS placements, and many other relevant factors, such as medications, diagnoses, substance use, self-injury, disciplinary history, and psychosocial history. The DQE team did not find evidence that behavior plans were considered prior to or during the ISU referral process, but MDOC reported that it has revised the form to include that information. The new form will be used once policy 103 DOC 650, Mental Health Services, has been re-approved by DOJ.

MDOC's records indicate that every patient referred to the ISU by a clinical team has been accepted into the program. Although it is possible that every referral has been appropriate, the more likely scenario is that the true screening of ISU admissions occurs "upstream" from the referral paperwork, likely in case conferences or at the Daily TS Consultation meetings. While it is difficult to know with certainty what number of patients should be referred to the ISU, the DQE team has observed, in chart reviews and interviews throughout monitoring, a number of patients who were dysregulated or decompensated over extended periods and who would be reasonable candidates for consideration. Importantly, MDOC has greatly reduced TS placements longer than 30

days, so it does appear that the ISU is being utilized as a pathway out of lengthy TS placements, one of the intentions of the Agreement.

Paragraph 118 also mandates that referring treatment teams identify ISU treatment goals and barriers in collaboration with the ISU Director. The referral paperwork does contain this information, and the ISU Director described meeting with treatment teams for a clinical case conference to discuss goals, program expectations, and the patient's willingness to participate. This process appears consistent with the Agreement's intent.

Finally, Paragraph 118 requires that prisoners be allowed to request ISU admission. As noted in the previous DQE report, MDOC's most recent revision of policy 103 DOC 650.12.B states that prisoners can request to be considered for the ISU, though the healthcare vendor and MDOC have the ultimate say over admissions. This language is consistent with Paragraph 118, but the policy has not yet been finalized or implemented. In the DQE team's interviews with four ISU patients in April 2025, two were aware that they could request ISU placement, having heard about it from their primary clinicians. The other two patients were not aware of the process and stated that they would have asked for admission, had they known.

Overall, MDOC appears well on its way to meeting the Paragraph 118 requirements. With the addition of information about behavior plans to the ISU referrals and more consistent education of prisoners about the ISU request process, MDOC can achieve substantial compliance.

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

Finding: Substantial compliance

Rationale: VitalCore has hired three MHPs and a unit director who serve as the primary clinicians for ISU patients. The DQE's review of medical records indicates that the patients have been assigned a primary clinician, as evidenced by a consistent staff member documenting 1:1 contacts, being listed as the primary clinician on treatment plans, and updating treatment plans. In the DQE team's interviews with six ISU patients over two monitoring periods, all were able to identify their assigned clinician. This is sufficient for a continued substantial compliance finding.

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: Substantial compliance

Rationale: The ISU treatment team meets each weekday for a triage meeting, except holidays and rare other exceptions, and every patient is discussed in each meeting. The DQE team has confirmed this practice through observation during site visits and an extensive review of meeting minutes.[153]

Meeting participants usually include the unit director, one or more MHPs, a security staff representative, a nurse, activity therapists, and Support Persons. In this monitoring period, psychiatry was represented in more than half of the meetings, and a psychologist participated in about 25%. This remains an excellent team composition. Minutes reflect details of patients' functioning, group participation, and other interactions. The practice of reviewing all patients exceeds the requirement to evaluate patients in the initial phases of the ISU program.

On Saturdays, there is no triage meeting to discuss the patients, but they are evaluated by different staff members during the group programming. For example, during the DQE team's site visit in April 2025, the Saturday schedule included four groups led by clinical staff members, including Current Events, Goals Group, Psychoeducation, and Games. Although these clinical contacts may not be in-depth evaluations, they extend well beyond patients in the initial phases of ISU treatment, are consistent with the DQE clinicians' experience of Saturday routines in other clinical settings (e.g., inpatient psychiatric units), and carry out the intent of this provision. Taken together with the weekday practice, the DQE finds this is sufficient for substantial compliance.

Paragraph 120 also requires that the frequency of individual contacts and group programming be documented in the patient's treatment plan. During this monitoring period, VitalCore created a new treatment plan template, BH-8.0, that prompts clinicians to enter details about the patient's plan. In the DQE team's review of five medical records of ISU patients, all sampled treatment plans indicated a standardized frequency for primary clinician and psychiatry contacts and indicated that group programming was also appropriate. The recommended frequency of groups was not included in the plans but is reflected in an activity schedule for the unit that is applied to all patients. This, too, is sufficient for a substantial compliance finding.

[153] The DQE team has reviewed the meeting minutes for every meeting from August 1, 2024, through June 30, 2025.

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

Finding: Partial compliance

Rationale: As noted in the previous DQE report, group programming is not just available in the ISU; it is abundant. Unit schedules show that groups total 5.5 hours per day during a schedule spanning 9 am to 7:30 pm on Monday through Friday and 2.75 hours on Saturday.[154]

Four interviewed ISU patients confirmed that the groups typically occur as scheduled. Three patients reported that the clinical groups are "mandatory," while the recreational groups are optional.[155] DQE clinicians observed groups taking place during each site visit in 2024 and 2025. Mental health staff maintain ISU Group Attendance sheets that also support that groups are being provided.

The DQE team reviewed a sample of these attendance sheets,[156] which listed each group on the unit schedule and recorded whether the patient attended and briefly described his participation. Cancellations were only evident on holidays and occasionally for institutional factors. Interviews, progress notes, and triage minutes suggest that patients choose each day whether to attend groups, so it does not appear that movement restrictions or other operational factors limit their access. Triage minutes routinely note when patients do not attend, and staff follow-up is reflected there and in some progress notes the DQE team encountered.

It is difficult to assess whether patients' assignment to groups is based on their individualized treatment needs, as all ISU patients are offered the same group programming each day. Staff have described that structure to the DQE team, and an analysis of group attendance records supports that group assignments are universal, with

[154] This was demonstrated during this monitoring period on the documents titled ISU Group Cycle for April 1 through May 31, 2025, June 1 through July 31, 2025, and August 4 through October 3, 2025.
[155] MDOC clarified that, although patients are encouraged to participate actively in treatment, none of the activities in the ISU are mandated.
[156] Attendance sheets were identified for two to three patients per week for each of seven weeks in May and June 2025, along with a few sheets from March, April, and July. A total of 30 patient-weeks were reviewed.

only 5% that may have varied from that model potentially as a means of meeting an individual's needs differently.[157]

Although the "every patient in every group" model may reflect a lack of individualized treatment planning in the ISU, in the DQE clinicians' observations so far, the groups have been clinically relevant to the patients' presenting problems. For example, nearly all patients referred to the ISU have struggled with self-injury and aggression, so having them all attend START NOW (an adaptation of Dialectical Behavior Therapy for the prison environment) and Anger Management groups is clinically appropriate. Similarly, because so many ISU patients have struggled with substance use, referring them all to an Acceptance and Commitment Therapy (ACT) group is reasonable. ISU clinicians engaged in excellent individualized treatment planning with one patient in the DQE team's five-chart study who had extreme difficulty interacting with others and was excused from group; his treatment goals then shifted to building up his ability to come out of cell and to manage basic hygiene, rather than requiring group participation.

Attendance records showed that all reviewed patients began attending in-progress groups promptly upon admission to the unit, usually within a day or two, regardless of the curriculum. In that sense, Paragraph 121's requirement for "rolling admission" is being met. The DQE team has not observed a change in group assignments based on patients' progress in treatment or length of stay.

All indications, from the sources above, are that group assignments are made at the sole discretion of the ISU treatment team and are not unreasonably affected by other factors. A longer assessment period is necessary to ensure that individualized treatment plans are being implemented, but MDOC appears off to a good start.

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: Substantial compliance

Rationale: Over two monitoring periods, all six patients interviewed in the ISU reported that they are permitted out-of-cell time and opportunities for congregate activities. In

[157] When comparing available group attendance sheets for May and June within the sample described above, group assignments were uniform for nearly all groups; in nine instances, a patient had an activity the others did not or was omitted from a group the others were assigned to.

addition to group programming, the patients' written schedules contain blocks of "free time" when they can partake in indoor or outdoor recreation. During the DQE team's site visits, patients were observed enjoying recreational time on the covered patio, sitting in the day room, and using the showers in between structured groups. Interviewed prisoners and staff reported no restrictions on patients' ability to move about the unit freely except when on Phases 1 and 2, the equivalent of therapeutic supervision. Such freedom of movement undoubtedly supports patients' recovery (i.e., "reinforces symptom and behavioral stability," as required by Paragraph 122).

Paragraphs 122-129 also require access to certain privileges and clinical contacts "following the discontinuation of Mental Health Watch in the ISU." As noted in the previous report, the DQE team has interpreted these requirements to apply to a patient's ISU admission *except when on TS*, not just to the period *following* a TS placement.[158] It is important to note that not all patients spend time on TS in the ISU; most are admitted on Phase 3 and are never subject to the restrictions of TS. In the DQE team's review of ISU medical records, six of the 15 ISU admissions in 2025 involved a patient who was placed on TS at least once during their admission.

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

Finding: Substantial compliance

Rationale: In interviews across two monitoring periods, patients and staff have consistently reported that prisoners are not routinely restrained during ISU treatment activities. This was consistent with the DQE team's observations during the site visits; patients moved about the unit freely except when on TS. When asked if they had ever been restrained in the ISU under any circumstances, all four patients interviewed in April 2025 replied unequivocally, "No."

A review of health records supports this report. Some forms for recording MHP contacts have a field for noting whether the patient was restrained. In the five-chart analysis described above, the DQE team found 100% of the out-of-cell individual contacts, including crisis assessments, indicated the patients were unrestrained.[159]

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

[159] The study examined a sample of 20 individual contacts for each patient, or all contacts if the total was fewer than 20.

Paragraph 123 also requires that patients have access to all on-unit activities outlined in their treatment plan. Here, too, all interviewed patients and staff reported the same thing: that patients can access groups and individual contacts as delineated on the unit schedule.[160] Four interviewed ISU patients reported that they are allowed to leave group and go to their rooms if the topic is overwhelming or dysregulating, and two reported doing so. Mental health clinicians stated that patients do sometimes get asked to leave group because they are disruptive. This is the only circumstance in which a patient might not have access to a therapeutic activity listed in their treatment plan, and the restriction would only last as long as needed to maintain patients' and staff's safety.

Overall, all available information indicates that ISU is meeting the Paragraph 123 requirement to provide access to therapeutic activities and minimize the use of restraints. This warrants a substantial compliance finding.

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: Substantial compliance

Rationale: In interviews with the DQE team, MHPs were aware of the requirement to see patients individually at least once per week in the ISU. They noted that the actual practice is more robust and dependent on a patient's phase. They said that patients are seen three times daily while on phases 1 and 2 (consistent with the requirement for three daily TS contacts), twice weekly while on Phase 3, and once weekly while on Phase 4. This expectation is also captured in the draft of policy 103 DOC 650 and the ISU Handbook. A regional psychologist reported administering structured symptoms scales at the beginning and end of the ISU program to measure a patient's progress. These contacts, as well as psychiatry contacts, occur in addition to the once- or twice-weekly MHP contacts.

Patient interviews and records confirmed that MDOC's practice meets or exceeds the Paragraph 124 requirements. All four interviewed patients said they see their primary clinician two to three times per week. In the DQE team chart review described above, nearly all files showed primary clinician contact weekly or more often. The one exception was understandable in that the patient spent nearly all of his ISU time in an outside hospital, with short periods on TS.

[160] As discussed above, group assignments are not specified in ISU treatment plans at present.

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

Finding: Partial compliance

Rationale: Four patients interviewed by the DQE team in April 2025 reported that, in general, patients are allowed to have unlimited phone calls and video visits at least once a week in the ISU. One patient noted that disciplinary reports from his home site, SBCC, had followed him to the ISU, and he was therefore on "phone sanctions," restricting him from making any calls. All these practices appear commensurate with general population.

When asked about contact visits, patients' reports were mixed: two patients stated that these were allowed but had never occurred for them, while the other two did not know because they do not have visitors. The ISU Handbook and MDOC's June 2025 Status Report both indicate that contact visits are not currently occurring. In the ISU Handbook: "All phases will have non-contact visitation." In the Status Report, "MDOC continues to work with Site Administration on how to best expand visits in the ISU to include non-contact visits." However, MDOC subsequently reported to the DQE team that visiting schedules at OCCC have been modified to accommodate contact visits for ISU patients, taking a further step toward compliance with Paragraph 125.

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: Substantial compliance

Rationale: MDOC's draft policy 103 DOC 650.12.C.d.ix demonstrates its intent to provide meals out of cell in the ISU. Although a system to track patients' out-of-cell time, including meals, in the Inmate Management System is still being developed, multiple staff and patient interviews across two monitoring periods indicate that meals in the ISU are routinely served in the unit's common area. On Phases 3 and 4 of the program, patients are permitted to eat at the communal tables or to take their trays back to their cells. On Phases 1 and 2 (the equivalent of TS), meals are served in-cell. These practices appear to meet the Paragraph 126 requirements.

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

Finding: Noncompliance

Rationale: In the previous DQE report, a noncompliance finding was issued for this provision because MDOC was routinely restricting property in the ISU beyond what is permitted in general population. This area remains a work in progress. In its June 2025 Status Report, MDOC stated:

> MDOC is working with site administration for the ISU to determine appropriate property allowances for those [prisoners] from OCCC and those transferring to OCCC for ISU placement to ensure clothing and other items are allowed commensurate with general population.

No details about the proposed solutions were provided.

The ISU Handbook allows specified clothing items and six named property items a prisoner could have, subject to mental health staff approval, along with canteen "determined by the progress with the program." With everything but clothing being subject to someone's approval, this leaves a lot of room for discretion. Taken together with the handbook stating that property "will not exceed" that list, and that anything else in the prisoner's property is to be inventoried and stored, there is a strong likelihood that ISU patients' property will be less than that allowed for general population.

In the DQE team's interviews with six current and former ISU patients in April 2025, all reported significant property restrictions in the ISU, with one even stating that he would not have agreed to join the program if he had known about the restrictions beforehand. Patients reported restrictions on clothing, hygiene items, paperwork, personal photos, and canteen orders. Their reports were no different than those conveyed to the DQE team during the September 2024 site visit, indicating there has been no change since then. This warrants a continued finding of noncompliance.

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

Finding: Substantial compliance

Rationale: The ISU Handbook[161] indicates that, during Phases 1 and 2, access to recreation is based on a patient's clinical status (similar to TS protocols), and an officer must be assigned to the recreation area when in use. On Phases 3 and 4, patients are permitted recreation throughout the unit. Recreation can be restricted as a disciplinary sanction; this is commensurate with practices in general population.

[161] Most recently revised on 12/13/24

MDOC has not yet developed a tracking system to document non-clinical activities in the ISU but interviewed patients and staff across two monitoring periods have consistently reported access to indoor and outdoor recreation. During the April 2025 site visit, patients reported that they can access recreation "all day long," except during count times and after curfew (9:30 pm), and some said it was not permitted when groups are in progress. The DQE team observed patients enjoying recreation time in the unit's day room and outdoor patio and yard during the site visits. These practices are sufficient to demonstrate substantial compliance with Paragraph 128.

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

Finding: Substantial compliance

Rationale: Interviewed patients and staff reported a practice that is broadly consistent with the Paragraph 129 requirements; patients only leave the unit for medical appointments, legal visits, and haircuts. All other needs, including meals, mental health programming, phone calls, video visits, access to the law library, showers, recreation, and medication administration, are handled on the unit. The DQE team's review of available medical records and incident reports from the ISU over two monitoring periods is consistent with data obtained from interviews, showing off-unit trips only to outside hospitals in emergencies (e.g., after self-injury). The ISU Handbook is also consistent, stating that movement will be restricted to the unit except for visits, medical appointments, or activities approved by the treatment team.

As noted in relation to Paragraph 125, off-unit visits are not currently permitted for ISU patients. This practice appears inconsistent with Paragraph 129, which expressly allows movement outside the unit for visits. However, since the DQE assessed this practice in Paragraph 125, MDOC will not be doubly penalized with a partial compliance finding here.

Overall, appreciating how difficult it is for MDOC to demonstrate an *absence* of off-unit movement, the DQE is satisfied that the Paragraph 129 requirements are being met.

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: Partial compliance

Rationale: MDOC has not yet demonstrated any tracking practices consistent with Paragraph 130's requirements, but it is working to develop them. According to MDOC's June 2025 Status Report:

> The Clinical Operations Analyst has worked with the Director of Application and Development on the changes to the Inmate Management System to put the log in place for officers to document and track out of cell time. MDOC anticipates the log will be utilized once the 103 DOC 650 policy is finalized.

As noted in Paragraph 28, policy 103 DOC 650, Mental Health Services, was recently re-approved by the DQE, so its full implementation is not far off. Thus, it appears that progress is being made toward tracking out-of-cell time, and even without this tracking, there is ample evidence that out-of-cell time is being provided to ISU patients as the Agreement intended. Given this consistent demonstration of free movement around the unit, the DQE encourages the parties to consider whether the tracking described in Paragraph 130 is still necessary.

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

Finding: Partial compliance

Rationale: MDOC has made progress toward this requirement, documenting in its draft policy 103 DOC 650.12.C.d.xii.1 that ISU prisoners will not be restrained during off-unit activities. Interviewed patients and staff in the ISU did not comment directly on the use of restraints during off-unit transports, and incident reports from this monitoring period shed little light on the matter. Thus, the DQE team does not have much information on which to base an assessment of this provision.

MDOC's June 2025 Status Report states:

> During the June 2024 QIC meeting, it was determined that if a prisoner is taken off the unit in restraints, it would be documented in an incident report. This continues to be reviewed by the site for operational effectiveness.

It is not clear why the matter continues to be reviewed more than a year after the QIC recommended a plan of action.

132. Support Persons: Support Persons will be used in the ISU consistent with Paragraph 25. Support Persons will engage in non-clinical interactions with prisoners on Mental Health Watch,

will provide supplemental activities and interactions with prisoners between the three offered clinical sessions, and will document these interactions and prisoner behavior.

Finding: Partial compliance

Rationale: Paragraph 132 requires that Support Persons interact with ISU patients only while they are on TS (Phases 1 and 2), but it appears that Support Persons routinely interact with patients during all phases of the program. All four ISU patients interviewed by the DQE team knew the Support Persons by name and reported that they are "always around" the unit. Patients identified a particularly helpful practice of the Support Persons checking in with them one-on-one if they needed to leave group due to emotional or behavioral difficulties. Over two monitoring periods, interviewed patients have expressed uniformly positive views of the Support Persons.

A Support Person interviewed by the DQE team during the April 2025 site visit reported a similarly positive experience, expressing passion and pride for the therapeutic work being done in the ISU. She reported leading the daily Goals Group, as well as several other recreational activities on the unit. She stated that four different Support Persons work in the ISU, but typically not at the same time, staggering their shifts and balancing their responsibilities outside the ISU.

The DQE team also reviewed health records for 11 TS placements in the ISU, identified from MDOC's log of TS placements. In 64% of those stays, the patient saw a Support Person, usually on multiple days; in the remaining cases, it was impractical for them to meet because the placement lasted a matter of hours on arrival or because the patient went repeatedly to a community hospital and was rarely onsite. Unfortunately, it appeared that 85% of the Support Person contacts were cell-front; these were all recorded as being the patient's preference, which is contrary to those same patients' behavior in the other ISU phases.

The Support Persons' notes in the health record captured activities consistent with those described in Paragraph 132, and they briefly commented on the patient's behavior. The documentation approach is also described in Paragraph 99.

Overall, MDOC is nearing substantial compliance on Paragraph 132. The DQE team encourages staff to consider what would make it more possible for Support Persons to meet TS patients out of cell.

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

Finding: Partial compliance

Rationale: The DQE team's interviews with patients and staff indicate that activity therapists are an integral part of treatment in the ISU, engaging in groups with patients and attending triage meetings daily. A review of the ISU weekly schedules in April and August 2025 supports this conclusion. In the most recent schedule, MDOC identified that activity therapists lead groups titled Creative Expressions, Across the Decades, Creative Writing, Current Events, Folklore, and Ancient History, which all appear to be structured.

The DQE team has insufficient information from interviews or record reviews to determine whether activity therapists provide one-on-one structured interactions; this will be assessed in the next monitoring period.

Paragraph 133 requires that patients' treatment plans indicate the nature of their interactions with activity therapists. In the DQE team's review of five ISU patients' treatment plans, this connection was not clear. The treatment plans specifically mentioned the roles of psychiatry and the primary care clinician, stating that group and individual contacts should occur and identifying the treatment goals. The plans made no mention of activity therapists or the role of recreational group/individual contacts in the patients' treatment. The activity therapists themselves did not record their contacts in the medical record, so this sheds no light on the relationship between their patient interactions and the treatment goals.[162]

Overall, it appears that activity therapists are interacting regularly and meaningfully with ISU patients, but MDOC has not yet demonstrated how these interactions relate to the patients' treatment goals. A minor adjustment in treatment plan documentation should be able to address this deficit in future monitoring periods.

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

Finding: Partial compliance

[162] Activity therapists initial the patients' group attendance logs, which are scanned and uploaded to the medical record, but they do not write clinical notes.

Rationale: In the DQE team's review of ISU medical records, six of the 15 admissions between January and June 2025 included at least one TS placement. There were a total of 14 TS placements in the ISU, five of which occurred upon admission as a precautionary measure. The remaining placements all involved self-injury (e.g., foreign body insertion/ingestion) or a patient making provocative threats of self-harm in an effort to be put on TS. In all these cases, the acute dangerousness and/or rapid escalation of patients' behavior left essentially no opportunity for staff to use therapeutic interventions or other interactions to deescalate the situation.

Because this fact pattern is similar to the DQE's assessment during the previous monitoring period, a discussion with the parties about how best to assess compliance with this provision may be necessary. The intent of Paragraph 134 is to ensure that clinicians are not reflexively placing patients on TS without trying less restrictive measures first. However, because the events precipitating TS in the ISU arise suddenly and often while patients are already engaging in multiple therapeutic activities daily, it is difficult to see what other options the clinicians have in those moments. For now, a partial compliance finding is being issued.

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

Finding: Partial compliance

Rationale: The DQE team observed the ISU's two therapeutic de-escalation rooms ("comfort rooms") during the April 2025 site visit. The rooms were outfitted with molded plastic rocking chairs and chalk walls, and MDOC leadership reported that games, journals, and fidget spinners were available for use.

Three patients interviewed by the DQE team reported that they were permitted to use the comfort rooms but had not done so because (1) they were afraid of being locked in the room by security staff, (2) the room does not offer enough space to pace, (3) the rooms did not offer activities or comfort items they desired, or (4) they had not "gotten to the point [of needing de-escalation]."

Mental health staff echoed patients' concerns that restrictive security practices are a deterrent to using the comfort rooms. In the mental health staff's understanding, patients must be locked into the comfort rooms because security staff are concerned they will pass contraband items to patients on TS (the TS cells and comfort rooms are located in the same hallway). Reading materials are not rotated periodically, so prisoners get bored with them. The mental health staff reported making a list of therapeutic supplies they

would like for the comfort room, but half the requested items were denied by security leadership. The end result is that, currently, "the comfort room is not comforting."

If MDOC can demonstrate that the therapeutic de-escalation rooms meet patients' needs for a comforting space, substantial compliance is possible. Allowing unlocked doors seems to be a crucial step, as does access to therapeutic items such as weighted blankets, music, and calming scents.

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: In its June 2025 Status Report, MDOC stated:

> VitalCore has identified that they are working closely with their corporate clinical leadership to consult and implement behavior plans across sites. Behavior Plans

training was completed with all mental health staff during their December 2024 Annual Mental Health Training.

The DQE team reviewed an outline and attendance logs from the VitalCore training provided on December 3-5, 2024. These materials indicate that approximately 60 staff, a mixture of MHPs and other types of mental health staff, participated in an introductory session on behavior plans. The training was broadly consistent with the requirements of Paragraph 136, although not in as much detail (e.g., it did not cover the duration of behavior plans or how to measure outcomes). This was an important step toward compliance with the Paragraph 136 requirements, though much work remains to be done.

During the DQE team's site visits, mental health staff were interviewed about training and implementation of behavior plans. In April 2025, five of seven interviewed staff members were aware of the behavior plan training and believed (correctly) that the regional psychologists were primarily responsible for the plans' development. A regional psychologist confirmed that MHPs had undergone training about how to refer patients for behavior plans, which had resulted in approximately 10 referrals to the psychologist. Although some referrals were appropriate, where a patient was invested in participating, others were more difficult to implement because of lack of patient buy-in. In addition, multiple mental health staff members at OCCC noted that security leadership could benefit from education about the individualized nature of behavior plans, as the mental health staff routinely encountered resistance to the idea that an incentive might be approved for one patient that was not approved for everyone in the unit or facility. This was a particular challenge in the ISU, where behavior plans had been proposed but were rejected by security leadership.

Later the same month, mental health staff at SBCC reported a similar concern about lack of security staff understanding or approval of behavior plans. For the one behavior plan that had been created by the mental health staff, the plan was not approved by security leadership and was therefore not implemented. Therefore, implementation of behavior plans at OCCC and SBCC was limited as of April 2025, despite VitalCore's efforts to train staff.

QUALITY ASSURANCE

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

Finding: Partial compliance

Rationale: MDOC continues to require in its draft policy 103 DOC 650.20, *Records and Continuous Quality Improvement*, that the contracted healthcare provider engage in continuous quality improvement (CQI) activities. In its June 2025 Status Report, MDOC gave the DQE team its first glimpse into what VitalCore's CQI process will entail:

> VitalCore has identified a CQI study in which site MH Leaders will audit 20% of the TS documentation, or a minimum of 2 patient charts per month to confirm the quality of crisis treatment plans (looking at the quality of the treatment plan goals, identifying if they are SMART format and measurable, if they are appropriate to the clinical issue/ patient profile, and if they are being reviewed as needed and daily starting at 14 days on TS). Audits will also include a review of the ability of clinicians to recognize and respond appropriately to signs/symptoms of mental illness (is the assessing clinician identifying reported/observed clinical symptoms in documentation and noting interventions to address/reduce symptoms) and whether the TS documentation reflects collaboration between MHPs and upper-level providers as indicated and upon discharge from TS. These audits will also confirm if there is documentation that the patient has met these goals at the time of TS discontinuation. Reviews will be conducted at 3 months and 6 months, with improvement plans being implemented, if indicated, at 6 months. Reviews will continue to be conducted at 9 and 12 months to determine any additional areas needing improvement, if any. The plan is for this study to being [sic] on July 1, 2025.

Once these studies have begun, MDOC will review the results during its monthly QIC meetings.

This plan is an important step toward demonstrating compliance with Paragraph 137, and, more importantly, toward developing sustainable self-auditing practices. In addition to the metrics identified in the Status Report, the DQE team urges VitalCore to track "proxy PCC contacts," especially those that occur cell-front. In the DQE's study of crisis contacts, first described in Paragraph 47, and interviews with mental health staff, this practice continues to be used at sites including SBCC, Shirley, Gardner, and Norfolk to improve those sites' monthly statistics without providing meaningful care to patients.

The DQE team looks forward to reviewing VitalCore's quality assurance data during the next round of site visits. The team will also be very interested to see the tools provided to guide the auditors' reviews. Finally, the team encourages VitalCore to consider and

provide the resources that will make it possible to meet its goal of auditing 20% of records at the institutions with high rates of TS placements (e.g., OCCC and SBCC).

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: There has been no further progress with this provision. Previous DQE reports have identified two areas where MDOC's policies did not yet align with the Agreement's requirements for quality assurance: the Morbidity/Mortality Review process and the SDV/SATT Review Committee. These processes are included in policies 103 DOC 622, Death Procedures, and 103 DOC 601, DOC Division of Health Services Organization, respectively. In its June 2025 Status Report, MDOC reported that the policies are still under revision. In addition to these two MDOC policies, VitalCore and Wellpath's CQI policies will also need to be created/revised in accordance with the Agreement before a substantial compliance finding can be issued.

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 continued to track data and issue a monthly a Quality Assurance report during this monitoring period. The annual review of which data to track was due in March 2025, two years since MDOC began tracking data in March 2023. Minutes of MDOC's Quality Improvement Committee (QIC) meetings indicate that MDOC made one small change to the way that wait times for psychiatric hospitalization were tracked, and it considered whether to eliminate tracking of 18(a1/2) and 15(b) admissions to outside hospitals. MDOC subsequently clarified to the DQE team that it will continue to track wait times for DMH beds and that is has stopped tracking (1) the day of TS on which SDV occurs, and (2) Section 18(a1/2) petition approvals and denials by site. Otherwise, the tracked data remained consistent during this monitoring period, and none of the changes directly impact Paragraph 139.

Some important findings from the Quality Assurance reports between January and June 2025 include:

Number of TS Placements and Length of Stay

Between January and June 2025, there were 522 new TS placements across MDOC, which is a 17% decrease from the previous six-month period (627 TS placements), as illustrated in *Figure 9)*.

Figure 9. Average Monthly TS Placements

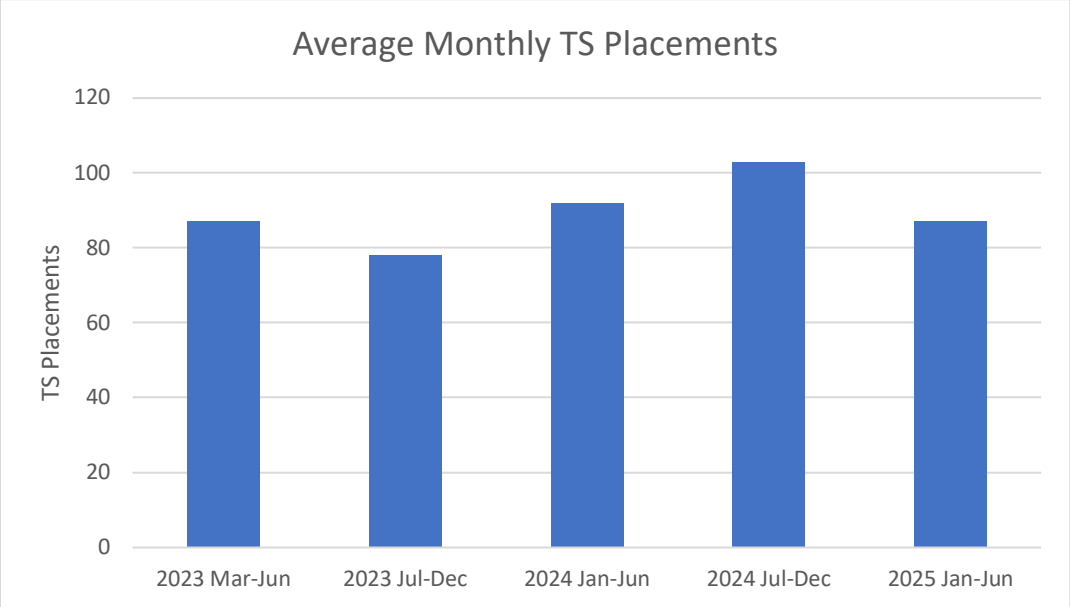
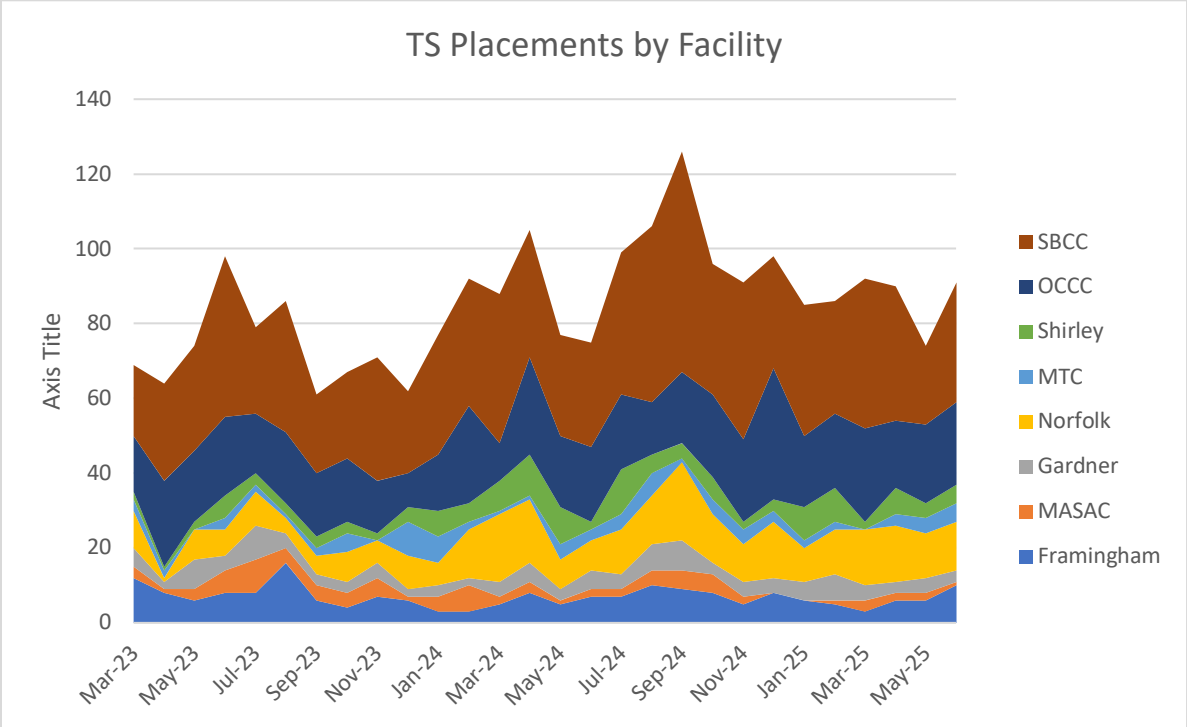


Figure 10 illustrates that the majority of TS placements continue to occur at OCCC and SBCC, which account for 61% of the total statewide placements. There were no significant changes in TS placements by facility during this monitoring period. Norfolk and SBCC have continued to see higher rates of TS placements since the closures of Cedar Junction and Concord, likely because Norfolk and SBCC are treating less-stable populations (e.g., new intakes).

Figure 10. TS Placements by Facility, March 2023-June 2025

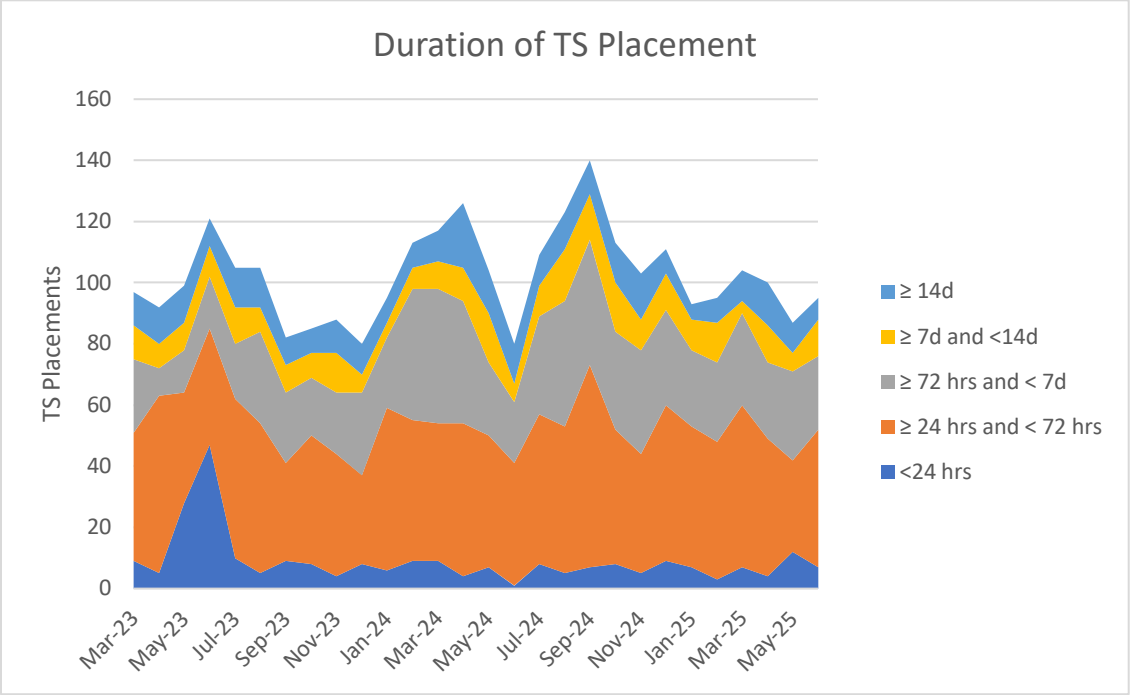


Between January and June 2025, the mean length of stay on TS was 3.7 days[163], which is decreased from the previous two monitoring periods (4.5 and 4.3 days, respectively). This is likely due to a large number of "zero day" placements (i.e., TS placements lasting less than 24 hours) at SBCC, Norfolk, and Shirley.

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

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

Figure 11. Duration of TS Placement



The DQE team continued its practice of analyzing whether the overall number of lengthy 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 5,900 in June 2025. *Table 5* highlights the DQE team's findings.

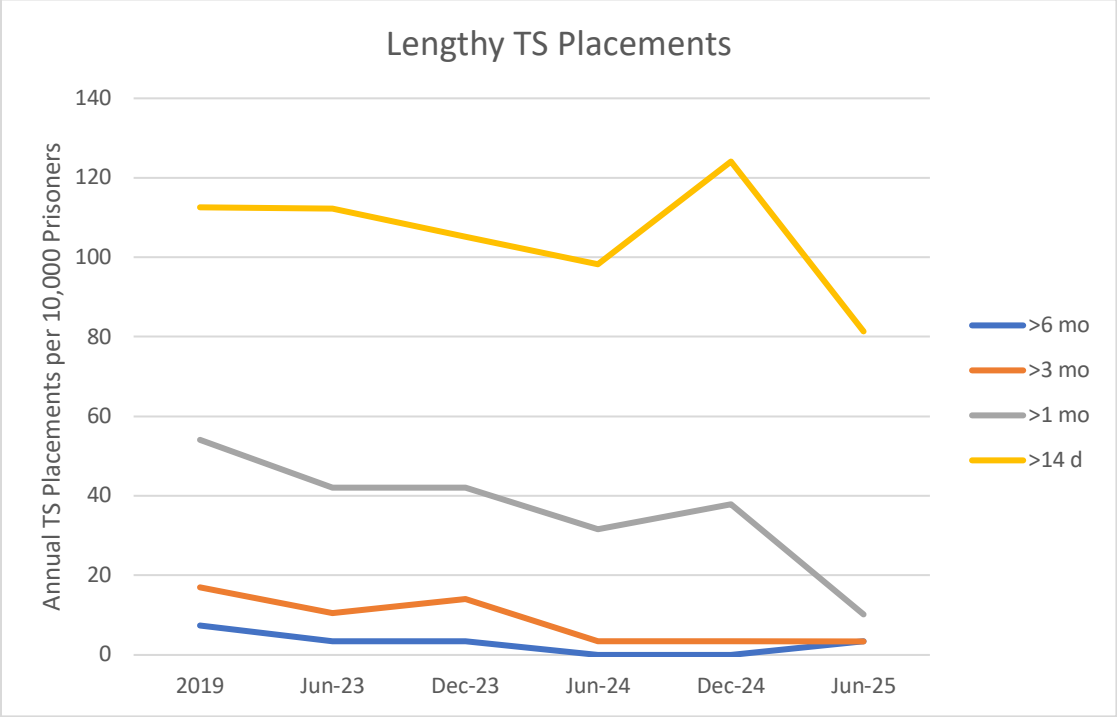
Table 5. Lengthy TS Placements, 2019 vs. Jan-June 2025

	2019		**June 2025**		
TS duration	Total placements in 13 months	Annual placements per 10,000 prisoners[164]	Placements in Jan-June 2025	Annual placements per 10,000 prisoners[165]	**% Change since 2019**
>6 mo	7	7.4	1	3.4	**-54.2%**
>3 mo	16	17.0	1	3.4	**-80.0%**
>1 mo	51	54.1	3	10.2	**-81.2%**
>14 days	106	112.5	24	81.3	**-27.2%**

[164] Calculated based on 8,700 total prisoners, as noted in the DOJ Findings Letter.
[165] Calculated based on approximately 5,900 total prisoners in MDOC in June 2025 (derived from "Monthly Mental Health Roll-up" and MASAC population data).

As illustrated in *Figure 12*, lengthy TS placements declined substantially during this monitoring period in all categories (>14 days, >1 month, >3 months, and >6 months). This is a noteworthy and positive trend. Although the longest TS stay was 278 days,[166] only four patients spent more than a month on TS—a stark contrast from the DOJ's findings letter in 2019, when 51 patients in a 13-month period spent more than a month on mental health watch.

Figure 12. Lengthy TS Placements



Finally, the DQE examined the location where TS placements occur within each facility. Between January and June 2025, the TS registry indicates that 51% of TS placements occurred in the HSU, as noted in *Table 6*. This is similar to the previous six-month period. Overall, there has been a trend toward conducting TS outside of designated health service units since the Agreement began. In December 2023, 74% of TS placements occurred in the HSU; in June 2024, 65%; December 2024, 48%; and June 2025, 51%.

[166] Of note, this was a female prisoner at Framingham for whom the ISU and STP were not options, as those programs only admit men. She had already had a three-month DMH placement and was returned to MDOC. The TS stay eventually ended with her transfer to a DMH facility under Section 18(a1/2).

Table 6. Location of TS Placement within Facility

Unit	Facilities Using Unit for TS	# of TS placements	% of TS placements
Health Services Unit	Framingham, Gardner, Norfolk, OCCC[167], Shirley, SBCC	267	51.2%
Behavior Assessment Unit	SBCC, Norfolk, MTC, Shirley, OCCC	173	33.2%
Secure Treatment Unit	SBCC	20	3.8%
Secure Adjustment Unit	SBCC	12	2.3%
Residential Treatment Unit	SBCC	3	0.6%
Intensive Stabilization Unit	OCCC	10	1.9%
Intensive Treatment Unit	Framingham	27	5.2%
Booking	Framingham	1	0.2%
Housing Unit	MASAC	9	1.7%
TOTAL		**522**	**100%**

It is encouraging that TS placements in the BAU fell from 38% in the second half of 2024 to 33% in the first half of 2025. OCCC did better, with 54% of TS placements now occurring in therapeutic locations (HSU or ISU), compared with 20% during the previous monitoring period. However, it is important to note that MDOC's statistics likely under-count the number of BAU placements since the TS log only lists one location, and patients frequently move from HSU to BAU at SBCC and OCCC.

As in previous reports, the DQE discourages the use of BAU as a TS location because it conflates treatment with punishment and because prisoners' access to property and privileges is sometimes restricted in those settings beyond what is authorized by mental health staff.

Self-Injurious Behavior

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

[167] MDOC's TS Registry lists only one location per TS placement. At some institutions, particularly OCCC and SBCC, prisoners are sometimes moved from HSU to BAU for a portion of their TS placement due to space concerns and medical patients' need for HSU beds, which would not be captured in these data.

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 15 times with prisoners on TS between January and June 2025, which is a substantial decrease from the previous six-month period (23 uses) and a continued downward trend. As noted in the DQE's earlier reports, these data do not include incidents where force was used to gain the prisoner's compliance during the incident precipitating the TS placement (because the Agreement does not require such disclosure), so they likely underestimate the use of force in relation to the TS process.

As illustrated in *Figure 13*, one-third of the use of force incidents occurred at SBCC, which is lower than the previous monitoring period. Norfolk accounts for an increasing percentage of incidents, which is concerning, while Framingham's incidents have decreased substantially, which is a positive development.

Figure 13. Use of Force While on TS

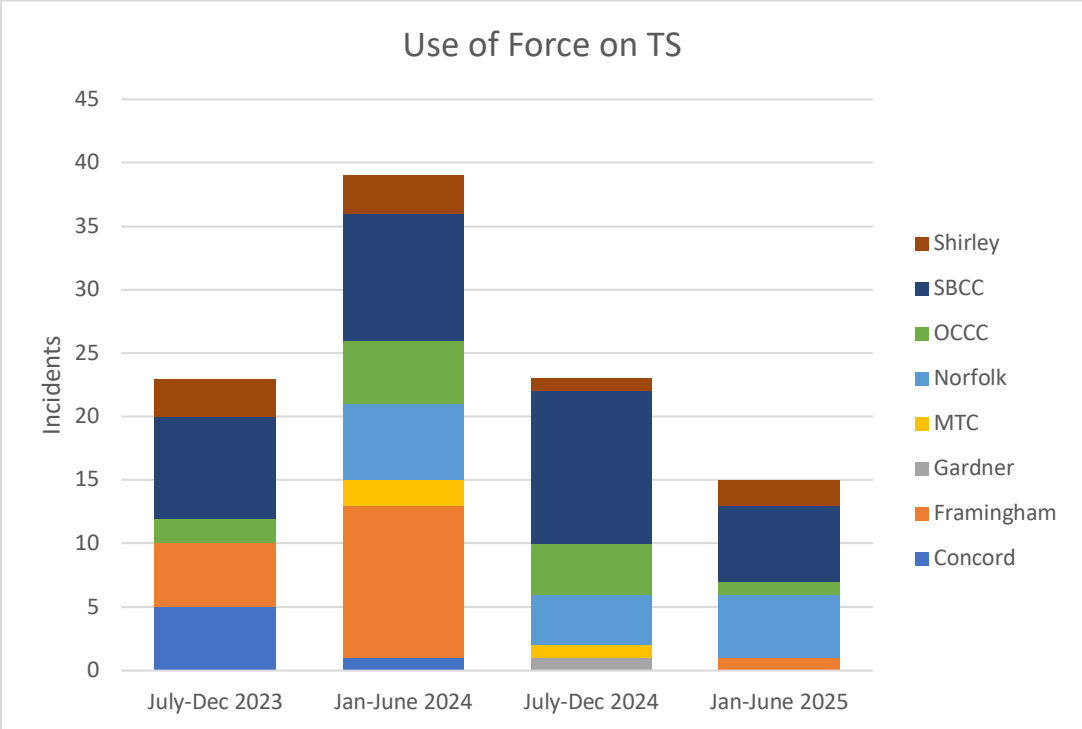
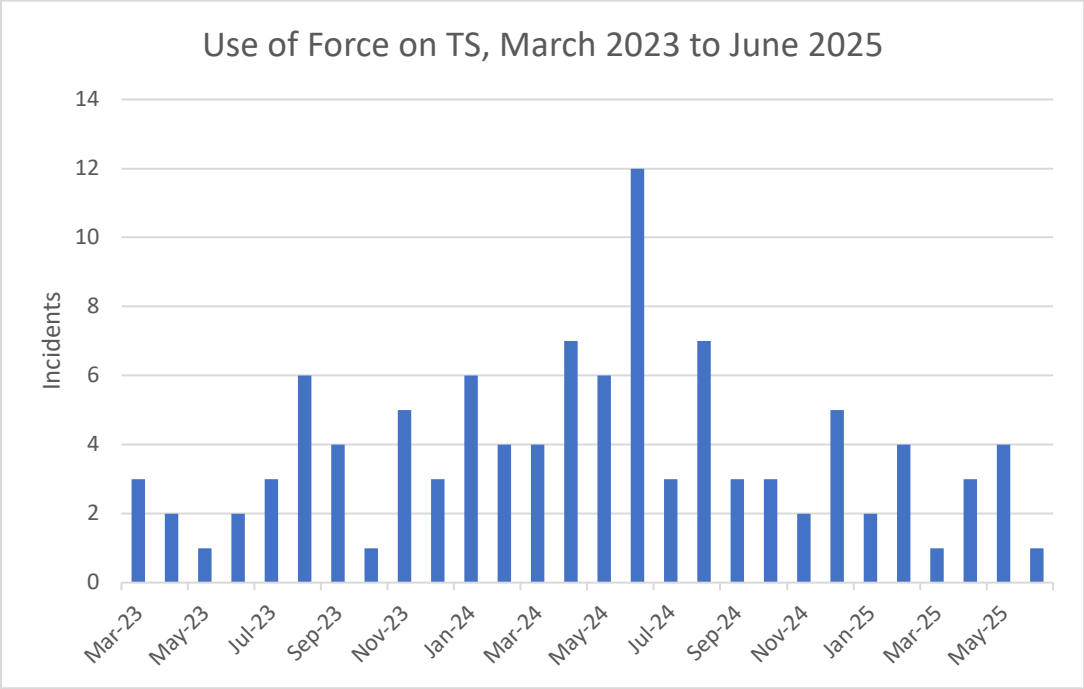


Figure 14 illustrates that, after a peak in June 2024, use of force incidents on TS have continued to decline. This is a positive development

Figure 14. Use of Force on TS, March 2023-June 2025



Psychiatric Hospitalizations

This issue is discussed in detail in Paragraph 77.

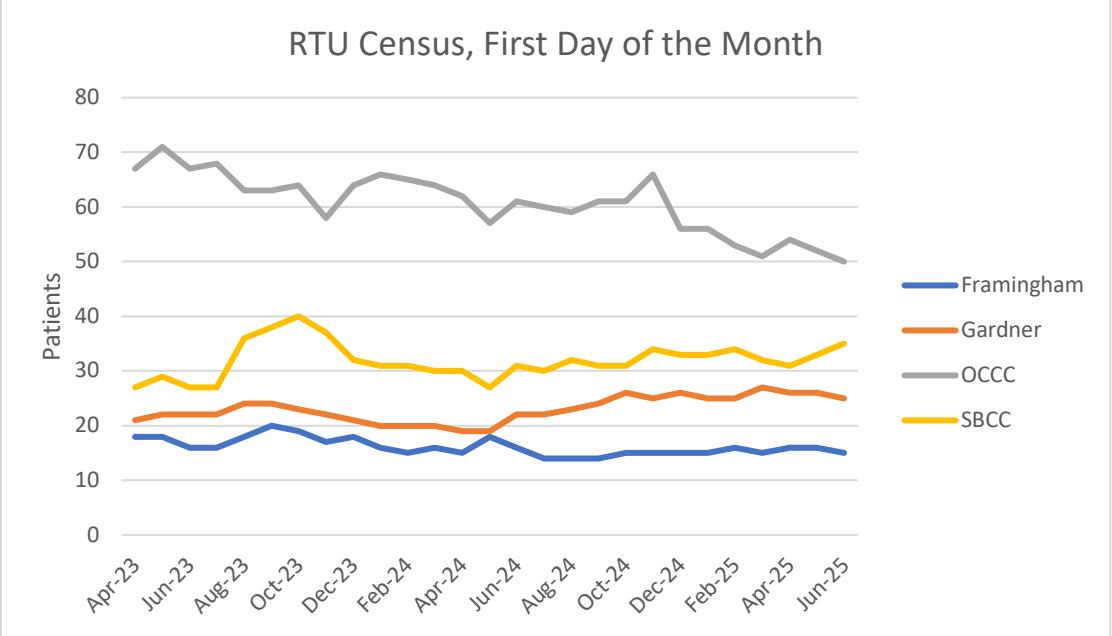
RTU Census

There have been no recent changes in the number of available RTU beds. MDOC continues to designate a total of 226 RTU beds across four units: 42 at Framingham, 34 at Gardner, 86 at OCCC, and 64 at SBCC. The typical census of these units is much lower than capacity, with only 55% of the beds filled in June 2025.

As illustrated in *Figure 15*, the RTU population of OCCC has been declining, especially since October 2024, for unclear reasons. During the OCCC site visits, the DQE team learned that "non-RTU" patients being placed in the same housing unit as the RTU.[168] This practice, along with new correction officers running the housing unit after a "job pick" in November 2024, has caused considerable turmoil among the RTU patients, who can have difficulty even with small changes in their routine.

[168] MDOC stated that the decline in the RTU population at OCCC is unrelated to the non-RTU prisoners being housed in the same unit and that non-RTU patients are not displacing those who need an RTU level of care.

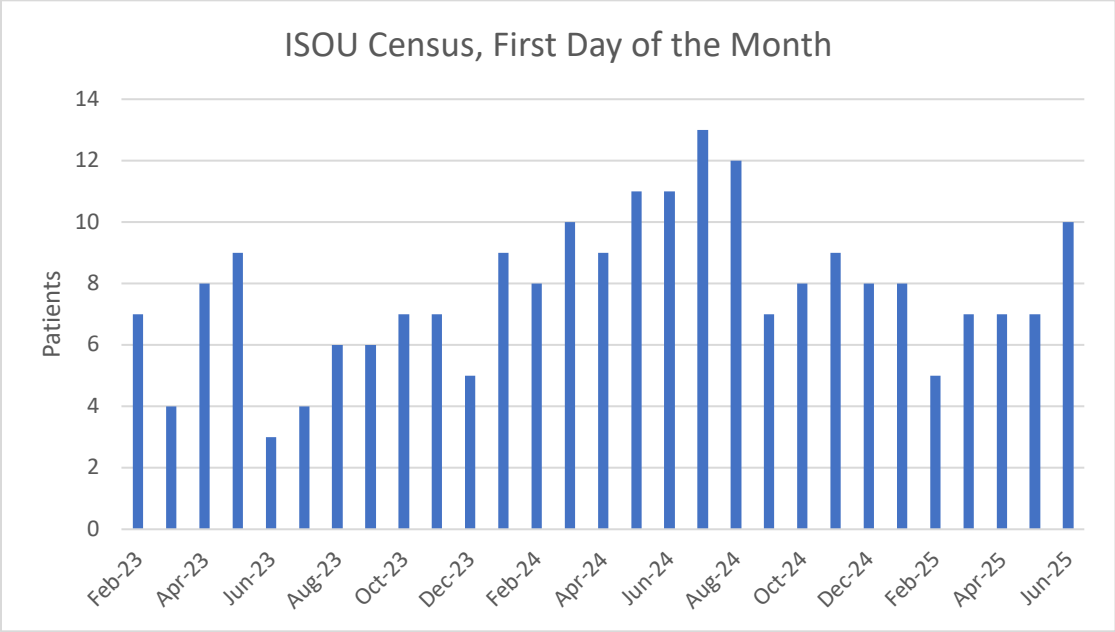
Figure 15. RTU Census, April 2023-June 2025



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 it sits mostly empty, with fewer than 20% of the beds filled on any given day, as illustrated in *Figure 16*.

Figure 16. ISOU Census



In the DQE's review of ISOU placements since the Agreement began, the vast majority of prisoners sent to BSH for evaluation have been returned within 30 days after a determination that they do not meet statutory criteria for mental illness and do not need a hospital level of care. BSH's assessments are frequently inconsistent with the DQE team's overall impression that many MDOC prisoners are ill enough to warrant a hospital level of care.

Mental Health Staffing

This issue is discussed in detail in Paragraph 35.

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

Finding: Substantial compliance

Rationale: MDOC's only obligation under Paragraph 140 is to allow the DQE's assessment of the delineated areas and to provide information as requested. MDOC has remained entirely cooperative with the DQE team, both during site visits and outside of those times. VitalCore's leadership has also been very cooperative, with the Assistant Chief Medical Officer of Behavioral Health and Director of Training attending each of the DQE's site visits during this monitoring period. These VitalCore leaders presented information at the start of each site visit, explaining how they were working to address areas of concern noted by the DQE team during previous monitoring periods.

141. Quality Improvement Committee: Within three months of the Effective Date, MDOC will begin to develop and implement a Quality Improvement Committee that will:
a. review and analyze the data collected pursuant to Paragraph 139(a);
b. identify trends and interventions;

c. make recommendations for further investigation of identified trends and for corrective actions, including system changes; and,
d. monitor implementation of approved recommendations and corrective actions.
e. Based on these monthly assessments, MDOC will recommend and implement changes to policies and procedures as needed.
f. All monthly reports will be provided to the DQE and the United States, along with a list of any recommendations and corrective actions identified by the Quality Improvement Committee.

Finding: Substantial compliance

Rationale: The Quality Improvement Committee (QIC) continued to meet monthly during this monitoring period: on January 30, February 27, March 27, April 30, May 29, and June 26, 2025. Minutes indicate that MDOC Health Services Division, VitalCore, and Wellpath Recovery Solutions leaders attended the QIC meetings and collaborated in making recommendations for improvement. The data gathered pursuant to Paragraph 139(a) were reviewed and analyzed in the QIC meetings. Action items, person(s) responsible, and deadlines were tracked in the minutes. Overall, the meetings appear to meet the requirements delineated in Paragraph 141a-e and have not changed significantly during this monitoring period.

Meeting minutes from January to June 2025 indicate that the QIC continued to track several areas relevant to the Agreement monthly:

- Completion of incident reports related to SDV
- Trends in SDV on TS
- Trends in use of force on TS
- Confidential incident reports regarding staff misconduct
- Status of the Peer Support Program
- Status of the Therapy Dog project

In addition to these standing agenda items, the QIC discussed other ad hoc items related to the Agreement:

- How to track wait times for DMH beds (for 18a, 18a1/2, and 15b transfers)
- Status of TS cells' Hayes compliance (i.e., suicide resistance)
- Trends in 18(a1/2) requests and admissions

As in previous reports, the DQE urges MDOC to add one more standing agenda item to the meeting to ensure its timely completion: developing a log for prisoners' TS privileges

and out-of-cell time. This project has been in development for almost two years without being implemented, though MDOC stated in its June 2025 Status Report that it will occur once policy 103 DOC 650 has been finalized.

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. Because MASAC is run by a different healthcare vendor than the seven prison sites covered under the Agreement, the meetings have been separated into "Prison Sites" and "MASAC." The meeting dates during this monitoring period are listed in *Table 7.*

Table 7. SDV/SATT Committee Meetings

Prison Sites	MASAC
January 15 and 29, 2025	Jan – (no SDV incidents)
February 5 and 19, 2025	Feb – (no SDV incidents)
March 5 and 19, 2025	March – (no SDV incidents)
April 2 and 16, 2025	April 7 and 22, 2025
May 7 and 21, 2025	May 12, 2025
June 4 and 18, 2025	June – (no SDV incidents)

The prison sites met twice monthly. MASAC scheduled meetings every two weeks, but it did not meet if there were no SDV incidents during the two-week period being reviewed.[169]

The DQE reviewed minutes of all meetings listed in *Table 7*. The meetings were led by VitalCore at the prison sites and by Wellpath Recovery Solutions at MASAC. At the prison sites, VitalCore attendees typically included the Site Mental Health Directors from each facility, unit coordinators for specialized units (e.g., RTU, SAU), Regional Mental Health Directors, Director of Training, Regional Psychologists, and statewide leadership (Psychiatric Medical Director, Program Mental Health Director, Assistant Program Mental Health Director), and CQI Specialist. Attendees from MDOC's Health Services Division typically included the Director of Behavioral Health, Clinical Operations Analyst, and Mental Health Regional Administrators.

[169] The DQE agreed that no meetings were necessary if there were no SDV incidents to review.

At MASAC, the meetings were much smaller, typically attended by just the MASAC Clinical Director, Assistant Clinical Director, and DOC's Mental Health Regional Administrator. Given the small number of SDV incidents that occur at MASAC and the closer relationship between security staff (e.g., Residential Service Coordinators) and health services staff, this attendance seems adequate to fulfill the meeting's purpose. Therefore, a substantial compliance finding is warranted.

143. The Self-Injurious Behavior Review Committee will review and discuss the Quality Improvement Committee's data regarding Self-Injurious Behavior, conduct an in-depth analysis of the prisoners who have engaged in the most Self-Injurious Behavior over the past month, and conduct timely and adequate multi-disciplinary reviews for all instances of Self-Injurious Behavior that require an outside hospital trip.

Finding: Partial compliance

Rationale: As noted in Paragraph 142, SDV/SATT Review Committee meetings usually occur twice a month for up to 90 minutes, and each SDV incident over the preceding two weeks is discussed in detail by a multi-disciplinary group, not just those incidents that require an outside hospital trip. Based on the meeting minutes, MDOC does identify breaches in protocol that could have contributed to SDV, such as prisoners having access to dangerous items while on TS. When such problems are identified, they are flagged for the Mental Health Regional Administrator to follow up with facility leadership.

Previous DQE reports noted that MDOC was not compliant with Paragraph 143 because the SDV/SATT meeting minutes did not consistently document the committee's review of SDV data from the monthly Quality Assurance reports. There has been no change in this area during the past six months. Minutes from the prison sites' SDV/SATT meetings clearly indicate that the data were reviewed and that trends were discussed, usually during the first meeting of the month. The minutes from MASAC's meetings contain no such notation, but MASAC's leadership attend the monthly QIC meetings, where the same information is reviewed. While this may not meet the technical requirement for SDV data to be reviewed *by the Self-Injurious Behavior Committee*, in the DQE's opinion, it fulfills the intent of Paragraph 143.

Paragraph 143 also requires that the SDV/SATT Committee conduct an "in-depth analysis of prisoners who have engaged in the most Self-Injurious Behavior over the past month." As noted in previous DQE reports, there is no distinct part of the SDV/SATT meeting that highlights these individuals; they undergo the same review and analysis as every other incident of SDV. In its June 2025 Status Report, MDOC noted that this will

soon be changing: “Beginning in June 2025, a deeper review and identification of those individuals who have engaged in the most Self Directed Violence for the month will be discussed during the Self Directed Violence/ Suicide Attempt meeting.”

MDOC’s tracking of SDV data indicates that 315 SDV incidents occurred between January and June 2025. The change in rates of SDV over time are illustrated in *Figure 17.* After a major spike in the first half of 2024, SDV rates are now below 2019 levels, both on and off TS, for a second consecutive monitoring period. This indicates that the spike in early 2024 may have been an outlier rather than a trend.

Figure 17. SDV Rates Over Time

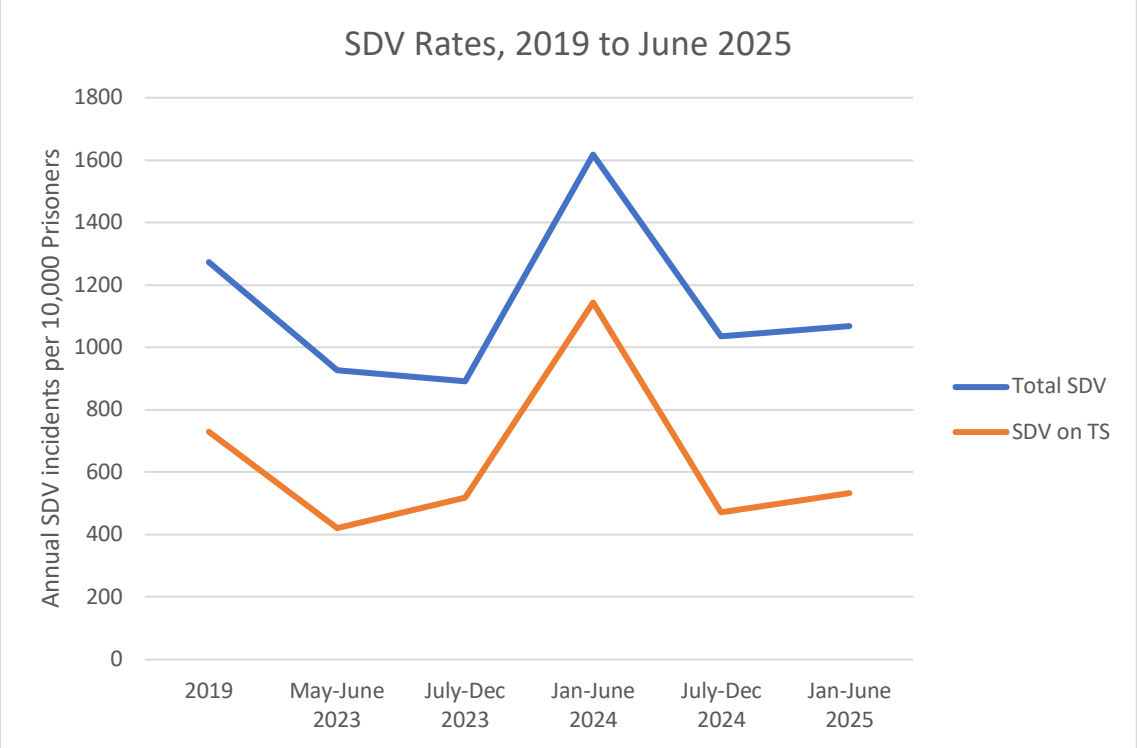


Table 8 shows the percent change in SDV rates between 2019 and the first half of 2025.

Table 8. Rates of SDV, 2019 vs. January to June 2025

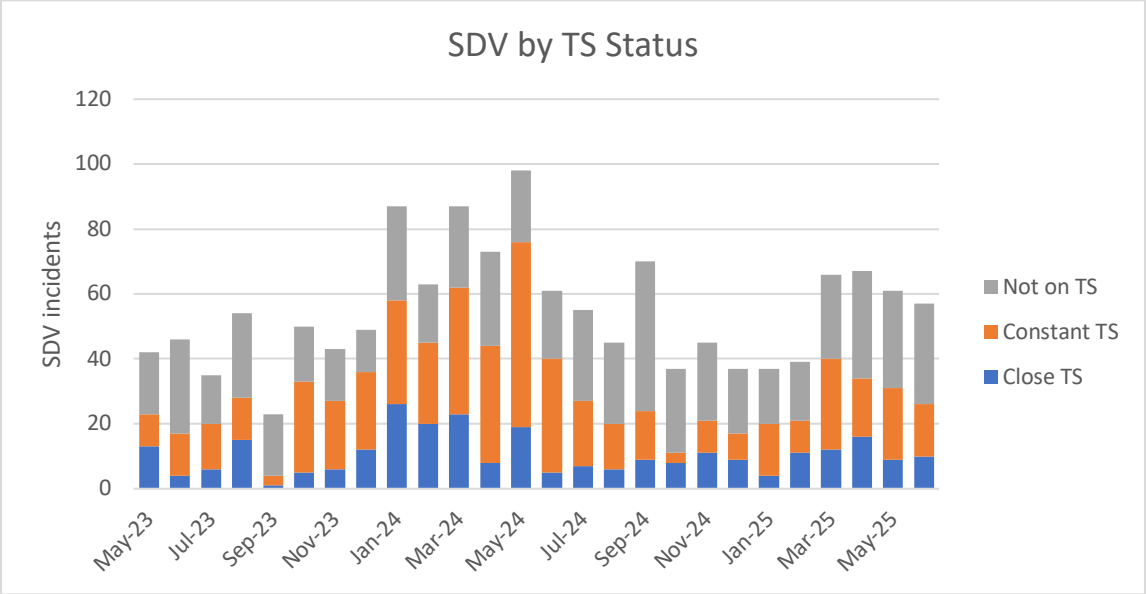
	2019		June 2025		
	SDV incidents in 13 months	Annual incidents per 10,000 prisoners[170]	SDV incidents in Jan-June 2025	Annual incidents per 10,000 prisoners [171]	**% Change since 2019**
Total SDV	1200	1273	315	1068	**-16.1%**
SDV while on TS	688	730	157	532	**-27.1%**
Cutting while on TS	217	230	20	66	**-70.6%**
Hanging while on TS	77	82	17	38	**-36.1%**
Insertion of foreign bodies while on TS	85	90	15	76	**-37.8%**
Ingestion of foreign bodies while on TS	34	36	20	24	**+87.9%**
Asphyxiation while on TS	17	18	4	7	**-24.8%**

SDV of all types decreased, except for ingestion of foreign bodies, which was 88% higher during this monitoring period than in 2019. However, it is important to note that almost all the ingestion incidents were attributable to three patients at SBCC and OCCC, which significantly skewed the overall data.

Figure 18 shows that, between January and June 2025, 157 of the 315 total SDV incidents in MDOC occurred while a prisoner was on TS (49.9%). This is similar to the previous monitoring period.

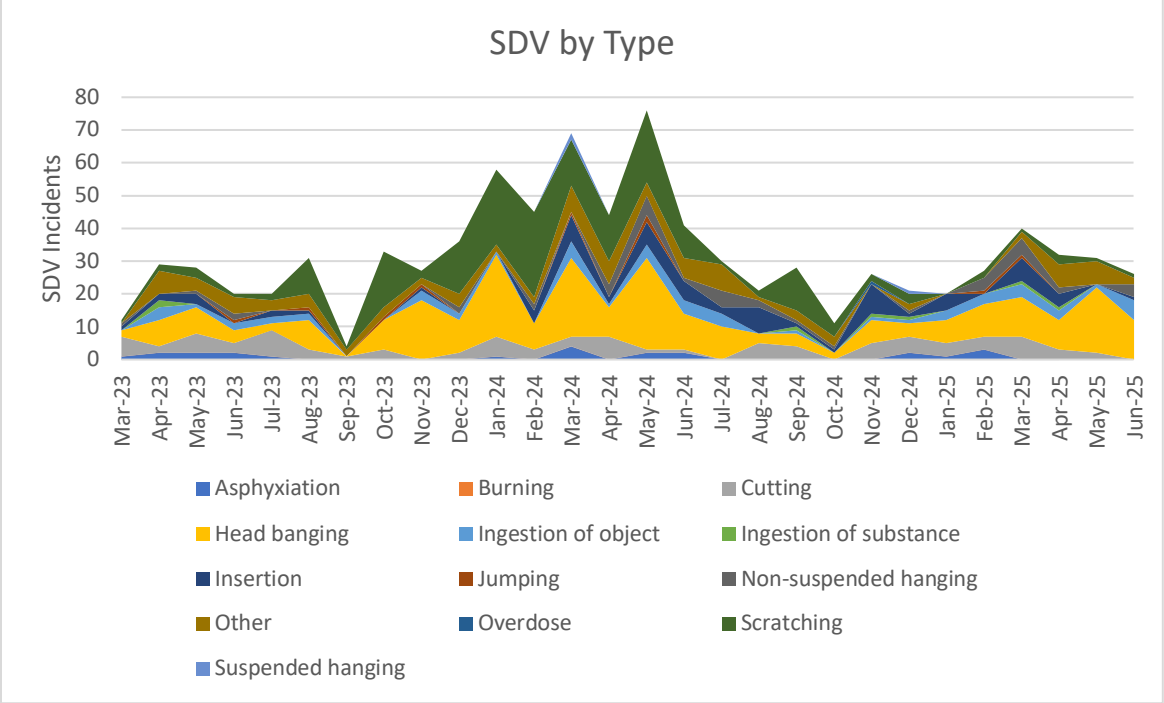
[170] Calculated based on 8,700 total prisoners, as noted in the DOJ Findings Letter.
[171] Calculated based on approximately 5,900 total prisoners in MDOC in June 2025

Figure 18. SDV by TS Status, May 2023-June 2025



Head-banging and scratching still accounted for the greatest proportion of SDV, as illustrated in *Figure 19,* but the number of SDV episodes involving insertion of objects and cutting remains concerning because it may indicate a lapse in search procedures prior to placing patients on TS (searches of the cell and/or of the patient).[172]

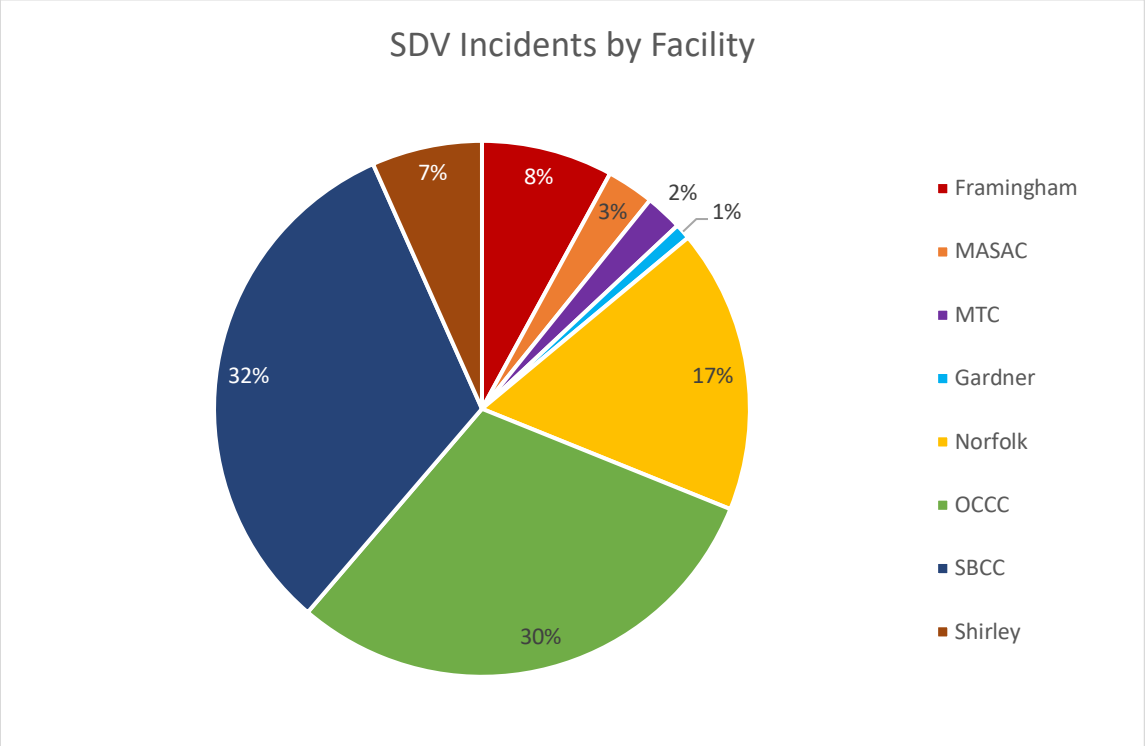
Figure 19. Type of SDV while on TS, March 2023-June 2025



[172] See Paragraph 144 for further discussion of this issue.

The total incidents of self-injury (not just those that occurred on TS) were divided across MDOC facilities as illustrated in *Figure 20.* SBCC's SDV incidents fell by 24% during this monitoring period, so the facility now only accounts for 32% of incidents across MDOC, compared with 44% in the latter half of 2024. This is a positive development. Norfolk's share of SDV incidents continues to rise, from 12% to 17% during this monitoring period. It is not clear what accounts for the steady increase over the past year, but it may be due to the repeated SDV of one patient who was highly dysregulated between January and April.

Figure 20. SDV Incidents by Facility, January-June 2025



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: MDOC's June 2025 Status Report states, "Healthcare Vendors have identified intent to share their SDV meeting minutes via e-mail with their treating staff," which is the same language used in its December 2024 update. To date, no interviewed mental health staff have reported reviewing these data via email or in triage meetings. As noted in the last DQE report, MDOC does routinely share the SDV/SATT Meeting minutes

with senior MDOC staff, as required by Paragraph 144, by virtue of reviewing the previous meeting's minutes at the start of each SDV/SATT meeting.

Paragraph 144's other mandate is to take corrective actions around systemic problems identified during the SDV/SATT meetings. Here, MDOC's practice appears to be improving. For example, during this monitoring period, there were significantly fewer instances of patients at SBCC engaging in SDV using contraband items while on TS—an area of focus during the previous monitoring period. However, there were still over a dozen such instances across other MDOC facilities between January and June 2025, using items including razor blades, pieces of tile, pieces of a mirror, plastic spoons and forks, batteries, hoarded medications, a sewing needle, and glass shards.

To spot-check MDOC's follow-up of SDV incidents, the DQE requested documentation from three problematic incidents identified in the SDV/SATT meetings. MDOC provided this documentation, showing that a half dozen meetings were held with Norfolk's leadership between February and May 2025 because of repeated incidents of foreign body insertion/ingestion on TS. These minutes demonstrate that facility leadership, including the Deputy Superintendent and Health Services Administrator, have been taking corrective actions including retraining officers on search procedures and documentation practices, implementing auditing tools, repairing broken floor tiles, and investigating staff alleged to have provided contraband to prisoners. These documents demonstrate Norfolk's ongoing efforts to reduce access to dangerous items for individuals on TS. In contrast, documentation from OCCC and SBCC's follow-up meetings was less complete, with very few action items or responsible parties identified.

Overall, MDOC has taken significant steps to demonstrate compliance with an important aspect of Paragraph 144—taking corrective action to address systemic problems that contribute to SDV. By providing SDV/SATT meeting minutes to all treating staff and improving documentation of facility follow-up at SBCC and OCCC, MDOC can achieve substantial compliance.

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: One serious suicide attempt and two completed suicides occurred between January and June 2025, and MDOC conducted timely morbidity reviews in all cases, as indicated in *Table 10.* An additional serious suicide attempt that occurred on December

23, 2024, was erroneously excluded from the fourth DQE report, so it is included in the current report. This incident also underwent timely review by MDOC's Morbidity/Mortality Review Committee.

Table 9. MDOC Morbidity Reviews, December 2024-June 2025

Incident Date	Morbidity Review Meeting Date	Days Elapsed
December 23, 2024	January 22, 2025	30
January 19, 2025	February 18, 2025	30
March 6, 2025	April 4, 2025	29
April 10, 2025	May 9, 2025	29

Since the Agreement began, MDOC has had 14 serious suicide attempts and three deaths by suicide (as of June 30, 2025). Of these 17 incidents, a morbidity or mortality review was completed within 30 days for 13 cases (76%). The trend has been positive, indicating that MDOC has solidified its practice of conducting timely morbidity and mortality reviews.

As in previous monitoring periods, it is difficult to judge the adequacy of MDOC's reviews based on the information provided to the DQE team, which usually includes only (1) a memo titled "Scheduled Morbidity Review" containing a clinical case summary written by an MDOC regional mental health administrator in advance of the review committee's meeting, and (2) a memo containing the meeting attendance and the review committee's recommendations. However, the case summary memos are quite thorough, and it is noteworthy that many of the recommendations made by MDOC's Morbidity/Mortality Review Committee during this monitoring period are consistent with those made by the DQE team since the Agreement began. For example, the DQE has raised concerns about the cursory nature of BAU risk assessments, finding that they generally last a minute or two and are more of an orientation to mental health services in the BAU than a proper risk assessment. In another example, the DQE team has pointed out the need for supervision and skills enhancement for inexperienced clinicians. In a third example, the DQE team has discouraged the practice of using brief, cell-front contacts as "proxy PCC" sessions in lieu of meaningful treatment with one's assigned clinician. Improvement in all these areas was recommended by the Morbidity/Mortality Review Committee after reviewing the suicides and serious attempts between December 2024 and June 2025, as noted in *Table 10.*

Table 10. Morbidity Review Committee Recommendations

Incident Date	Morbidity Review Recommendations
December 23, 2024	*Recommendations to VitalCore:* ○ Propose patient education materials regarding suicide warning signs and intervention strategies. Collaborate with MDOC to determine which method(s) are best for distributing these materials to incarcerated individuals.
January 19, 2025	*Recommendations to VitalCore:* ○ Retrain mental health staff about opening and closing mental health cases, including: ○ Taking history of mental health diagnosis, treatment and static/dynamic risk factors into account and documenting these ○ Ensuring multidisciplinary triage decisions about mental health clinical case status occur and are documented ○ Reviewing elements of the 103 DOC 650 required for opening and closing mental health cases
March 6, 2025	*Recommendations to VitalCore:* ○ Ensure that mental health treatment plans are reviewed promptly and revised as clinically indicated following any incident of self-directed violence. When a revision is not clinically indicated, a clear clinical rationale shall be documented in the medical record. ○ Improve the identification and documentation of suicide risk factors, with particular attention to a history of suicide among family members or close associates. ○ Address ongoing staffing shortages that impede timely mental health follow-up by a regularly assigned Qualified Mental Health Professional for individuals on the open caseload. Demonstrate how [VitalCore] is actively working to fill critical vacancies and mitigate the clinical consequences of unfilled positions. ○ Strengthen oversight and accountability mechanisms to ensure that all documentation requiring supervisory or director-level cosignature is subject to meaningful review prior to signature.
April 10, 2025	*Recommendations to VitalCore:* ○ Training Improvements ○ Provide refresher training that medical healthcare responders on scene may seek to have the

	incarcerated individual moved when safe to do so to ensure adequate space for CPR or other emergent care. ○ Ensure that annual mental health trainings should review that risk assessment for admission to BAU should include the incorporation of information from the initial mental health appraisal (IA) and comprehensive mental health evaluations (CMHE) when indicated. If not available, the clinician conducting the BAU risk assessment should conduct the initial appraisal. ○ Provide refresher training to prescribers for improved documentation of the rationale for medication continuation, discontinuation or modification. ○ Provide refresher training to all DOC and vendor healthcare staff regarding bidirectional information sharing available between SUD treatment service provider and comprehensive clinical services provider staff. ○ Documentation ○ Add line in BAU assessment having clinician attest that the initial assessment (IA) or comprehensive mental health assessment has been reviewed, and if not available, ensure an IA is completed as part of a quality BAU assessment. ○ Develop methods to ensure timely completion of the required mental health assessments. ○ Develop protocols and policy to ensure all completed hard copy forms of clinical documents are scanned into the electronic health record with timeframes delineated by vendor policy. *Recommendations to Facility Superintendent:* ○ Refer security rounds and their oversight for investigation. ○ Evaluate the ligature risks within the BAU units to determine potential risk reduction improvements.

MDOC stated that its current practice is to request a corrective action plan from its healthcare vendors following deaths by suicide, not serious attempts, which is inconsistent with the Agreement.[173] For the two deaths by suicide in *Table 10* (January

[173] In an email, the Clinical Operations Analyst reported that only completed suicides require a corrective action plan, although Paragraph 146c requires for serious attempts as well.

and April 2025), MDOC required that VitalCore and/or the facility Superintendent submit (1) a corrective action plan within approximately 45 days, and (2) documentation that the plan was completed within an additional 30 days.[174] These are important steps toward a meaningful and sustainable morbidity/mortality review process.

The DQE requested to review documentation of completed corrective action plans for the incidents in *Table 10*. Two corrective action plans were provided, and they outlined reasonable steps to be taken by VitalCore, though not within the requested time frames.[175] Limited evidence of completed corrective action was provided, but some of the actions outlined would not be due until later in 2025, so they were not delinquent. The DQE team saw that VitalCore had provided follow-up trainings for its staff on the opening and closure of mental health cases following the suicide in January 2025; this was completed at all facilities by May 2025. No evidence of MDOC security's completion of its required corrective actions related to the April 2025 suicide was provided to the DQE.

Overall, improved demonstration of corrective action after episodes of serious self-injury is needed, but MDOC and VitalCore do have a process in place for morbidity and mortality review.

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:

[174] This is the time frame specified by MDOC. In the DQE team's experience, meaningful corrective actions may take much longer than 30 days to complete.
[175] For example, VitalCore's corrective action plan for the suicide on April 10, 2025, was completed in a timely manner (within 45 days of the mortality review meeting held on May 9, 2025), but its time frame for completing the identified steps extended until October 14, 2025, two months beyond MDOC's requirement (within 30 days).

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 previous DQE reports and above, MDOC has a functioning Morbidity/Mortality committee that reviews deaths by suicide and serious suicide attempts, but its process does not meet all the requirements of Paragraph 146. During this monitoring period, MDOC took some steps toward demonstrating compliance, including providing the DQE with two of VitalCore's written corrective action plans stemming from completed suicides (requirement 146c). MDOC also shared its log of Morbidity/Mortality Reviews that meets all the requirement 146.a.5 except for the date of Psychological Autopsy.

In order to achieve substantial compliance, MDOC must improve its current Morbidity/Mortality review procedure by:

1. Ensuring that all three parts of the NCCHC's schema for morbidity/mortality reviews are completed within 30 days of the sentinel event: Administrative Review, Clinical Review, and Psychological Autopsy;
2. Developing corrective action plans for serious suicide attempts in addition to completed suicides;
3. Demonstrating that all corrective actions recommended by the committee have actually occurred;

4. Completing a final mortality review report within 60 days of the sentinel event (typically this is done after the review meeting);[176] and
5. Providing documentation to the DQE that the committee's recommendations have been shared with the facility's staff.

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: Substantial compliance

Rationale: Four reportable incidents occurred between December 23, 2024,[177] and June 30, 2025: two serious suicide attempts and two completed suicides. The DQE was notified within 24 hours of all four cases, as noted in *Table 11*.

Table 11. Notification of Reportable Incidents

Date of incident	Date of DQE/DOJ notification	Days to notification
December 23, 2024	December 23, 2024	0
January 19, 2025	January 19, 2025 (and update on January 23, 2025)	0
March 6, 2025	March 7, 2025	1
April 10, 2025	April 11, 2025	1

Over the past three monitoring periods, MDOC's timeliness of notification has improved. Since January 2024, timely notification[178] has been made in 11 of the 13 reportable incidents (85%). This is sufficient for a substantial compliance finding.

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

[176] Currently, MDOC's Health Services Division writes memos following the morbidity/mortality review meetings to the healthcare vendor and/or the relevant facility's Superintendent. These memos contain the review committee's recommendations and request completion of an action plan. It is not clear to the DQE team whether MDOC intends for these memos to serve as the final mortality review report identified in Paragraph 146d.
[177] As noted in relation to Paragraph 145, one serious suicide attempt that occurred during the previous monitoring period, on December 23, 2024, was erroneously excluded from DQE Report #4, so it is included here.
[178] Notification occurred within 24 hours of MDOC determining that the episode of self-injury was a suicide attempt, which sometimes did not occur until after the patient returned from the hospital and was interviewed by mental health staff.

submitted within 180 days of the Effective Date. Status Reports will make specific reference to the Agreement's substantive provisions being implemented. The Status Reports will include action steps, responsible persons, due dates, current status, description of (as appropriate) where pertinent information is located (e.g., DAP note, meeting minutes, Mental Health Watch sheet, etc.), DQE recommendations, and date complete. Subsequent Status Reports will be submitted one month before the DQE's draft report. MDOC, however, retains the discretion to achieve compliance with the Agreement by any legal means available to it and may choose to utilize methods other than those identified or recommended in any reports.

Finding: Substantial compliance

Rationale: By agreement of the parties, MDOC's bi-annual Status Reports are due on June 20 and December 20 of each year. MDOC submitted its most recent Status Report on June 20, 2025. The Status Report contains all the elements required by Paragraph 159, including action steps, responsible persons for each provision, due dates, a section for current status, description of where pertinent information is located, DQE recommendations, and date completed. While the document contains a "current status" section that is sufficient for substantial compliance, the document could be greatly enhanced by providing evidence or data to support MDOC's conclusions (e.g., what documents were checked, who were the sources of the information (types of staff or professional roles), was there an audit, etc.).

169. Within 30 days of the Effective Date, MDOC will designate an Agreement Coordinator to coordinate compliance with this Agreement and to serve as a point of contact for the Parties and the DQE.

Finding: Substantial compliance

Rationale: MDOC continues to employ an excellent Clinical Operations Analyst (COA) who serves as the Agreement Coordinator, and the COA has been proactively training a Mental Health Regional Administrator to fill in while she is on leave. As noted in previous reports, the goal is for MDOC eventually to perform internal audits like those the DQE team has been conducting so it can develop self-auditing practices that will be sustained after the Agreement's formal termination.

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

Finding: Substantial compliance

Rationale: The DQE reviewed the minutes from MDOC's "Quarterly DOJ Implementation" meetings that occurred on March 10 and June 23, 2025. These meetings were attended by MDOC's behavioral health leadership, the Clinical Operations Analyst, and the Superintendent and Deputy Superintendent of Reentry from each facility where TS occurs.[179]

Meeting minutes indicate that aspects of Agreement implementation were discussed, including:

- Progress with the ISU's functioning
- Data about SDV that occurs while prisoners are on TS
- Plans to document in IMS the activities of TS prisoners, as well as plans to modify officers' post orders to include this required duty
- Surveys about feasibility of out-of-cell meals on TS
- Status of individualized restraint decisions for crisis assessments
- Need for officers to convey the prisoner's name to mental health staff when calling crisis
- Status of TS posters
- Status of Hayes-compliant cell updates

It is also apparent from the minutes that the Director of Behavioral Health and Clinical Operations Analyst solicited feedback from facility leaders about other implementation challenges, such as space limitations preventing out-of-cell meals at some facilities.

Overall, the DQE remains pleased that the meetings are occurring regularly and that they are attended by leadership from each facility. MDOC's demonstration is sufficient for a continued finding of substantial compliance.

RECOMMENDATIONS

The following recommendations stem from the information in the *Detailed Findings* section of this report. As always, the DQE appreciates that some recommendations can be accomplished in the next six-month reporting period, while others will take much longer to implement fully.

[179] In previous communication with MDOC's leadership, they reported that "prison staff" as described in Paragraph 170 was interpreted as the leadership, not the line staff, from each facility.

POLICIES AND PROCEDURES

1. Prioritize the revision of MDOC policies for the next monitoring period, as several other Agreement provisions depend on completion of this task (e.g., training staff about new policies, demonstrating full implementation of policies).

2. Gather VitalCore's policies relevant to the Agreement and submit them to the DQE and DOJ immediately.

3. Define "mental health crisis" in policy as a first step toward clarifying security staff's response and the time frame in which it must occur.

4. Formalize in policy the current practice of issuing "misuse of crisis" disciplinary reports only when initiated or approved by mental health staff and in cases of blatant misuse.

5. Clarify and consolidate policies around the use of BOSS chairs and body scanners prior to placing a prisoner on TS. These protocols currently exist but are spread across five different policy/procedure documents.

6. Clarify policy and procedures around notifying mental health staff in the event of SDV, including in Code 99 procedures.

STAFFING PLAN

7. Continue all efforts to improve mental health and security staffing levels throughout MDOC, focusing on retention of mental health staff in addition to recruitment.

8. Further increase the number of contracted psychiatrists/APRNs at high-acuity and high-volume sites such as OCCC, SBCC, and Norfolk.

9. Continue hiring part-time Support Persons to cover Saturday shifts, especially at facilities where TS occurs frequently (e.g., OCCC, SBCC, Norfolk, Framingham).

TRAINING

10. Ensure that all officers who routinely work in the ISU have completed the ISU training. At a minimum, this should include all bid officers, but the training should also be offered to STAs if there are some who frequently cover the ISU.

11. Continue with plans to post Therapeutic Supervision policies in areas where TS occurs.

12. Continue the healthcare vendor's efforts to train clinicians, particularly those who have recently completed a degree program and are not yet independently licensed, on diagnosis, treatment planning, risk assessment, and documentation.

13. When revising pre-service and annual in-service training about mental health topics, enhance content in areas where the DQE team has repeatedly found confusion or variable practices across institutions, including:

    a. Contacting mental health without delay and maintaining constant observation of prisoners who request crisis contacts, regardless of whether the individual expresses suicidal ideation
    b. Conducting adequate BAU risk assessments, recognizing that BAU housing is a major risk factor for suicide and self-injury even if the contacts are not labeled as "crisis calls"
    c. Making individualized decisions about whether to restrain a prisoner during crisis evaluations, out-of-cell contacts on TS, and escort to these contacts
    d. Removing clothing from prisoners on TS only if used for self-harm

THERAPEUTIC RESPONSE TO PRISONERS IN MENTAL HEALTH CRISIS

14. Continue with physical plant modifications and/or space reallocations to allow for adequate, confidential assessment and treatment of patients in crisis and/or on therapeutic supervision:

    a. Building upon the strategies suggested by DOJ during the site visit on April 16, 2025, create additional treatment/assessment space in the HSU at SBCC. Continue with plans to create a scheduling system for confidential spaces at SBCC, including times that can be used for MHPs to see TS contacts prior to the daily triage meeting.
    b. Consider moving Gardner's crisis assessment room to an area with more privacy from other prisoners.
    c. Identify a confidential space at MTC for crisis contacts.
    d. Utilize confidential spaces at OCCC rather than the "New Man's" area for crisis assessments.

15. Clarify policy and practice around MHPs designating crisis calls as either urgent (i.e., within the same day) or emergent (i.e., within one hour). Currently, staff at different institutions are interpreting policy differently and using unclear criteria to decide the time frame in which they must respond to crisis calls.

16. 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.

17. Minimize practices that deter prisoners from requesting crisis mental health services, including routine shackling during mental health assessments, conducting assessments in areas without adequate sight/sound confidentiality, and locking down units while a prisoner is waiting for mental health assessment.

18. Train MHPs on individualized decision-making about recreation for patients on TS.

19. 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.

20. Train MHPs to consider and document specific reasons why patients are not being referred to a higher level of care, especially at the 3-day, 7-day, and 14-day benchmarks.

21. Integrate upper-level providers (psychiatry and psychology) more meaningfully into the treatment of patients on TS, including seeing patients sooner in the TS placement, helping to develop treatment plans, and assessing patients prior to discharge. If clinicians continue to struggle with recognizing clinical circumstances warranting such referrals, MDOC can consider implementing more structured criteria (e.g., after SDV that occurs on TS).

22. Continue investigating the feasibility of therapy dogs and peer mentors working with TS patients at all facilities.

23. Continue with plans to implement a system to track offered and accepted recreation, showers, visits, and phone calls for prisoners on TS.

24. Clarify the policy on dimming lighting for all officers who work in units where TS occurs, including bid officers and STAs.

25. Ensure that TS follow-up contacts are being conducted in confidential settings.

26. Ensure that treatment plan updates after a TS placement are completed and that the patient's goals and objectives are appropriately revised.

SUPERVISION OF PRISONERS IN MENTAL HEALTH CRISIS

27. Ensure that security officers are consistently using a cell safety checklist when searching TS cells and prisoners for potential hazards prior to initiating TS and, as needed, during TS.

28. Demonstrate more consistent involvement of Support Persons in the care of TS patients at Shirley, SBCC, and MTC.

29. Facilitate out-of-cell Support Person contacts with patients on TS.

30. Continue installing door sweeps for the few remaining TS cells where significant gaps exist between the cell door and floor, prioritizing the HSUs at SBCC and OCCC, where many TS patients are housed.

INTENSIVE STABILIZATION UNIT

31. Ensure that property in the ISU is commensurate with general population settings and revise the ISU handbook accordingly.

32. Develop a plan to offer contact visits for ISU patients.

33. Ensure that patients' treatment plans are individualized, with problems and goals clearly tied to specific group and individual treatments offered in the ISU.

BEHAVIORAL MANAGEMENT PLANS

34. Train security leadership and staff about the rationale behind behavior management plans and the types of individualized incentives that should be offered to patients, especially at OCCC and SBCC, where these plans are most urgently needed.

35. Continue training the healthcare vendor's clinicians on behavior planning, involving regional psychologists to develop the plans and guide staff through implementation and revision.

QUALITY ASSURANCE

1. Continue plans to develop VitalCore's CQI process and demonstrate its efforts to address problems with the quality of mental healthcare identified throughout this report.

2. Add one more standing item to the Quality Improvement Committee meeting agenda: Implementing a tracking system for prisoners' TS privileges and out-of-cell time (e.g., showers, outdoor recreation). This project has been in process for over two years without completion, and MDOC is unable to demonstrate compliance with several Agreement provisions without it.

3. Conduct an internal review of prisoners' claims that officers fall asleep during constant observation posts, as well as a review of documentation that raises questions about its veracity, such as multiple officers documenting observation of a prisoner at the same time.

4. Revise the morbidity/mortality review policies to require completion of a clinical mortality/morbidity review, administrative review, and psychological autopsy within 30 days of a serious suicide attempt or death by suicide.

5. Ensure that the healthcare vendors are completing the corrective actions recommended by the Morbidity/Mortality Review Committee in a timely manner after each suicide or serious attempt, and provide evidence to the DQE team that this occurring.

6. Ensure that the minutes of the SDV-SATT Review Committee meetings are reviewed with clinicians at all facilities where TS occurs.

CONCLUSION AND NEXT STEPS

Over the next six months, MDOC is encouraged to focus on areas of the Agreement where progress with crisis mental healthcare has stalled or is occurring at a slow rate, including:

- Addressing physical plant and operational factors that hinder MHPs' ability to conduct confidential, meaningful assessments and treatment of patients on TS, especially at SBCC;
- Better integrating psychiatrists and nurse practitioners into the care of TS patients, including increasing the number of contracted positions as needed;
- Ensuring that all security staff who work in the ISU have completed ISU training; and
- Individualizing restraint decisions for patients in crisis and on TS.

Focus on a few areas of technical compliance with the Agreement is also needed:

- Completing all policy revisions, including VitalCore and Wellpath's policies;
- Demonstrating VitalCore's CQI process to the DQE team, as well as its corrective actions after suicides and serious suicide attempts; and
- Revising the format of morbidity and mortality reviews to comply with the requirements of Paragraph 146.

The DQE team anticipates conducting the next round of site visits between October and December 2025, this time visiting all eight MDOC facilities where TS occurs.