SEPTEMBER 22, 2024

MASSACHUSETTS DEPARTMENT OF CORRECTION

COMPLIANCE REPORT #3

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BACKGROUND

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

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

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

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

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

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

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

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

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

PURPOSE AND FORMAT OF REPORT

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

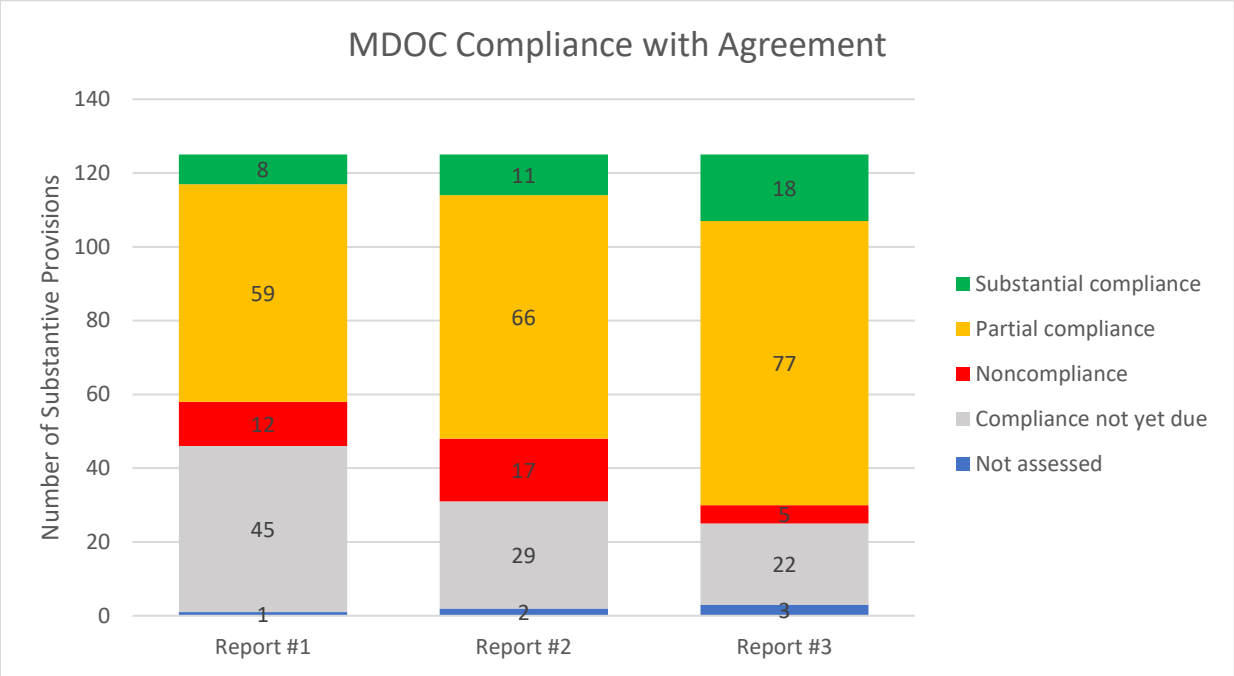
1. **Substantial compliance** indicates that MDOC has achieved material compliance with the components of the relevant provision of the Agreement.
2. **Partial compliance** indicates that MDOC has achieved material compliance with some of the components of the relevant provision of the Agreement, but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

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

EXECUTIVE SUMMARY

Approximately 21 months into MDOC's implementation of the DOJ Settlement Agreement, the system is making progress toward compliance. The seriousness with which MDOC has approached its obligations under the Agreement has not waned, even in the face of major changes such as the retirement of Commissioner Carol Mici on March 29, 2024, and the closure of MCI-Concord on June 28, 2024. The Interim Commissioner, Shawn Jenkins, has attended feedback sessions after the DQE team's site visits, and he has expressed his support for the work being done to enhance the mental healthcare of prisoners in MDOC. The Deputy Commissioner of Clinical Services & Reentry remains actively involved, as does MDOC's dedicated team of behavioral health leaders at the regional and statewide levels. These are all positive indicators of MDOC's capacity to implement the Agreement's requirements successfully over time.

During this monitoring period, MDOC improved its compliance ratings in 18 of the Agreement's 125 substantive provisions. Another 81 provisions remained unchanged or were assessed for the first time, and no provisions slid backward. Compliance with 22 provisions is not yet due, and three provisions are not being assessed by agreement of the Parties. As of June 30, 2024, the end of the data collection period for this report, MDOC had achieved substantial compliance with 19 of the substantive provisions. While this is still a small percentage of the total requirements, it demonstrates steady progress, as illustrated in the figure below.



During this monitoring period, two of the biggest projects mandated by the Agreement came due: utilizing Support Persons with prisoners in crisis and opening the Intensive Stabilization Unit (ISU). MDOC made major progress in implementing these programs:

1. ***Support Persons***: In early 2024, MDOC's contracted healthcare vendor began hiring Support Persons, whose role is to support the mental health clinicians and provide supplemental, activity-based contact with prisoners on therapeutic supervision (among others). By June 30, 2024, seven out of the eight facilities where therapeutic supervision (TS) occurs had at least one Support Person on board; only Framingham was operating without one. Although the Support Persons' roles and daily activities varied by facility, their addition to the mental health team was overwhelmingly described by patients and staff as positive. Many of the Support Persons have extensive backgrounds working in other mental health treatment settings like psychiatric hospitals and group homes, and they came into the prison system hoping to create a more therapeutic milieu. This hope is slowly being realized, with Support Persons engaging in art projects with patients, leading recreational groups, promoting patients' hygiene and activities of daily living, and delivering reminders about medication and mental health appointments. By all measures, the Support Person initiative is off to a promising start.

2. ***Intensive Stabilization Unit (ISU):*** Since the Agreement began in December 2022, MDOC has been diligently preparing for the opening of the ISU, a 15-bed program at Old Colony Correctional Center (OCCC) that is designed to fill a therapeutic gap between TS

placement and psychiatric hospitalization. On July 15, 2024, when the DQE and DOJ teams visited OCCC, the ISU was on the cusp of accepting patients, and on August 1, 2024, MDOC reported that the first patient had been admitted. The housing unit where the ISU is located has been fully renovated to include cells for 15 patients (six of which are suicide-resistant), as well as ample programming, recreational, and office space. New staff have been hired, both security and mental health, though not all of the approximately 45 staff needed are yet in place. Policies and handbooks for the unit have been developed. Overall, MDOC was ready to begin operating the ISU in accordance with the Agreement, just slightly behind schedule. Given the scope of change needed to implement such a complex level of care, MDOC's progress is commendable, even as it receives noncompliance ratings for most of the Agreement requirements related to the ISU because the unit was not yet operating on June 30, 2024, the end of the data collection period for this report.

In addition to these big projects, MDOC has made incremental improvements in the quality of day-to-day mental healthcare. When the Agreement began, the DQE team commented on the lack of meaningful case formulation and treatment planning in MDOC, and MDOC's behavioral health leadership made a concerted effort to educate staff in these areas. In the DQE team's review of 100 TS placements between January and June of 2024, more charts contained treatment goals and objectives that were tailored to the patient's clinical presentation than during previous review periods. Similarly, more patients on TS were referred for psychiatric evaluation when clinically appropriate. During the DQE team's site visits, clinicians were more consistently reviewing important historical data from the electronic health record prior to conducting crisis risk assessments, though at some institutions (e.g., OCCC, Souza-Baranowski Correctional Center) this remained difficult because of time constraints and lack of access to computers in the areas where patients are typically seen. In mental health triage meetings, multidisciplinary participation improved, fostering collaborative discussions about patients and creating hope that a truly multidisciplinary approach to mental healthcare in MDOC is possible.

MDOC has also enhanced its procedures to review TS cases that last longer than three days, discussing these cases each weekday with the behavioral health leadership and considering whether a higher level of care is warranted. This process may be having its desired effect, as evidenced by the reduction in the number of long (>14 days and >1 month) and very long (>3 months and >6 months) TS placements over the course of the Agreement. MDOC's progress in this area is very encouraging. Combined with the steady stream of psychiatric hospitalizations under M.G.L. c. 123 §18(a) (i.e., referrals initiated by MDOC staff) and the increased hospitalizations under §18(a1/2) (i.e., referrals initiated by incarcerated people or their advocates), it appears that TS is beginning to serve its intended purpose as a short-term placement for stabilization or until transfer to a higher level of care.

These are all positive indications of systemic change, though challenges certainly remain in MDOC. Understaffing and high staff turnover are among the biggest concerns. The closure of two facilities, MCI-Cedar Junction and MCI-Concord, has improved security staffing levels at the remaining facilities, but this has not helped the shortage of mental health staff. Over the past year, we have seen a pattern of MDOC hiring new graduates of social work and mental health counseling master's degree programs who start working in the summer, but within a year, many of them have left MDOC for other opportunities. Overall, mental health staffing was no better in June 2024 than it was in January 2023, hovering around 68% of the total necessary staff according to the healthcare vendor's staffing matrix. Key mental health staffing positions remained critically low: mental health professionals (MHPs) at 68%, psychiatrists at 54%, and psychologists at 51%. Among the facilities, OCCC and Souza-Baranowski Correctional Center (SBCC) were worst off, operating with approximately 55% of necessary mental health staff in June 2024. This is particularly concerning because these two facilities account for over half of all TS placements and crisis mental health contacts in MDOC. Backlogs of mental health contacts were prevalent at both facilities during the DQE's site visits.

Another factor that may account for the reduced mental health staffing levels in June 2024 is MDOC's decision to change its contracted healthcare vendor from Wellpath to VitalCore Health Strategies on July 1, 2024.[2] This decision was announced on May 10, 2024, after an extensive search in collaboration with ForHealth Consulting at UMass Chan Medical School. During the DQE's site visits, it was apparent that many mental health staff members were apprehensive about the change. Some staff decided to leave MDOC rather than make the transition, further contributing to system-wide understaffing.

At SBCC, which consistently stands out as the MDOC facility most plagued by systemic problems, the mental health staff appears unable to accomplish its mandates without changes to current staffing levels and stringent security protocols. For example, despite the behavioral health leadership's heightened emphasis on conducting proper risk assessments, the DQE team continued to observe clinicians making decisions about suicidal prisoners based on inadequate information—often a quick, superficial conversation without reviewing important historical information. Facility-wide lockdowns that disrupt care happen several times a week. Prisoners can only see mental health staff during their recreation periods (which are sometimes reduced due to security understaffing), and mental health clinicians jockey with other staff to use the few spaces suitable for treatment on the housing units. The result is a system where a quick, cell-front check-in is often passing for adequate treatment of a patient in crisis. The clinicians remain largely unable to recognize or treat signs of serious mental illness such as psychosis, which may stem in part from limited opportunities to collaborate with doctoral-level mental health professionals. The clinicians continue to rely heavily on pre-assembled "packets" of printed

[2] This change does not apply to the Massachusetts Alcohol and Substance Abuse Center (MASAC), which transitioned to Wellpath Recovery Solutions on July 1, 2024, rather than to VitalCore.

materials that are sent to prisoners through the institutional mail. As one prisoner interviewed by the DQE team stated poignantly: "I said I was going to hurt myself, and [the mental health staff] said, 'Do you want some puzzles?'"

If this pattern persists, SBCC will continue to weigh down a system that is otherwise making gradual progress toward compliance with the Agreement. Sustained attention and guidance by MDOC's leadership—as they have provided and remain committed to providing—is needed to change what appears to be a problematic culture of security outweighing all other considerations, including healthcare. This is no easy task, and there are no easy answers about the proper balance of security and treatment in a maximum-security environment. However, unless things at SBCC change, the health and wellbeing of prisoners and staff will remain at risk.

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

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

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

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

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

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

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

ASSESSMENT METHODOLOGY

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

1. Site Visits

The DQE team conducted site visits between April and July of 2024 at eight MDOC facilities where TS occurs.[3] The following activities were included in the site visits:

	Framingham	Gardner	MASAC	MTC	Norfolk	OCCC	Shirley	SBCC
	5/28/24	7/17/24	5/30/24	5/29/24	7/16/24	7/15/24	4/3/24	4/1-4/2/24
Inspection of TS cells			RK	RK	RK, GM	RK	RK, GM	GM, SS
Interview of prisoners recently/currently on TS	RK, JW	GM	RK	RK	GM	RK, GM, SS	RK, GM	GM, SS, RK
Review of officers' TS watch logs			RK					
Interviews of mental health staff	RK, JW	RK	RK	RK, JW	RK	RK, JW	RK	RK, JW
Interviews of security staff	RK	GM	RK	RK	GM	GM, SS	GM	GM, SS

[3] MCI-Concord ceased operations in June 2024. The DQE was informed of this plan in February 2024 and decided not to conduct a site visit at Concord, but data from the facility were included in the team's document reviews.
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Observation of MHPs responding to crisis calls	JW			JW		JW	RK	RK, JW
Observation of MHPs conducting TS assessments	JW	None to see	RK	JW	RK	RK, JW	RK	JW
Observation of MH group programming					RK			JW
Observation of 1:1 MH contacts								JW
Observation of MH triage meeting	RK, JW		RK	RK, JW	RK	RK, JW	RK	RK, JW
Observation of BAU Interdisciplinary Assessment Team meeting		RK					RK, GM	RK, GM, SS, JW
Observation of Morning Meeting	RK, JW	RK			RK, GM		RK, GM	RK, GM, JW, SS
Observation of Care Coordination Meeting		RK						
Observation of Support Person supervision					RK			JW

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.[4] In total, the DQE team formally interviewed 41 prisoners, 24 MDOC security staff members, and 14 mental health staff members during this monitoring period. The DQE team also spoke with MDOC's behavioral health leadership about progress with the Agreement during some site visits; this information was also considered when assessing compliance.

MDOC graciously allowed forensic psychiatry fellows from the Yale University School of Medicine to join the site visits at SBCC and OCCC during this monitoring period, demonstrating its commitment to transparency and support for the education of mental health professionals.

2. Document Review

For this report, data from January 1, 2024, through June 30, 2024, across all nine facilities where TS occurred during the reporting period were reviewed, except where

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

stated otherwise in the text. General categories of documents are listed here rather than each document.

a. MDOC status report about Agreement compliance dated June 20, 2024

b. Electronic health records

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

Facility	Approximate % of Records
Concord	9
Framingham	5
Gardner	3
MASAC	4
MTC	3
Norfolk	13
OCCC	20
Shirley	8
SBCC	35

Records were reviewed for technical compliance with the Agreement (e.g., number and timeliness of TS assessments by mental health staff, completion of property/privilege forms), for appropriateness of clinical interventions (e.g., matching treatment to the patient's documented diagnoses and symptoms), and for adequacy of documentation (e.g., quality of treatment plans and progress notes).[5]

c. Data about crisis contacts and TS placements

1) TS Registry, a list of all prisoners placed on TS, including facility, entry and discharge dates, location of TS, and duration of TS placement
2) A sample of "crisis logs" from each facility in May 2024
3) A sample of officers' watch logs for TS placements
4) A sample of cell inspection checklists for TS placements
5) Log of all restraints that occurred during TS placements
6) Wellpath TS Consultation/Notification forms (for 72 hrs, 7 days, 14 days, 14+ days on TS)
7) Minutes of Daily Therapeutic Supervision Consultation meetings
8) Daily TS spreadsheet (maintained along with TS consultation meeting notes)

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

9) Daily mental health Triage Meeting notes and End of Shift reports

d. Policies related to mental healthcare

1) Monthly letters from MDOC Clinical Operations Analyst describing the status of MDOC's policy revisions
2) Minutes of Wellpath's monthly Policy, Procedures, and Forms committee meetings
3) Draft revisions of MDOC policies
    a. 103 DOC 650 – Mental health services (second revision)
    b. 103 DOC 622 – Death Procedures
4) Policy 103 DOC 216 – Training and Staff Development
5) Policy 103 DOC 104 – Internal Regulations
6) Policy 103 DOC 520 – Instruments of Restraint

e. Staffing data

1) Wellpath mental health staffing matrix from June 2024, including filled, overage, and vacant positions
2) Wellpath staffing matrix from April 2024, which includes the licensure of all mental health staff
3) MDOC security staffing matrix from July 27, 2024
4) ISU staffing matrix (undated, but provided to the DQE on June 25, 2024)

f. Training data

1) PowerPoint presentation and lesson plans for DOC annual employee in-service training, "Recognizing Mental Illness and Suicide Prevention," revised March 2024
2) Draft of TS "Splash Page"
3) Crisis Intervention Training (CIT) attendance records
4) MDOC training records for all staff who completed CPR, suicide prevention, and Therapeutic Supervision training in TY 2024
5) Wellpath training records for all security staff at MASAC, including CPR training
6) Wellpath's New Employee Orientation (NEO) training records
7) Agendas and attendance logs from Wellpath's weekly Support Person supervision group, April-May 2024
8) PowerPoint presentation and participation certificates for Wellpath Grand Rounds presentations
9) Attendance logs of site-specific Wellpath and MDOC trainings, including about Therapeutic Supervision and the DOJ Agreement

10) Minutes from Wellpath's Intern and Trainee Meeting on April 5, 2024 (discusses the status of trying to begin a nurse practitioner training program)
11) Wellpath's "Zero Suicide" toolkit
12) PowerPoint slides and attendance record from Wellpath's training "Providing Off Site On-Call Services" on January 22, 2024

g. Other mental health program information

1) MDOC monthly "Mental Health Roll Up Report"
2) List of all prisoners transferred to a higher level of care (Section 18(a), Section 18(a1/2), RTU, or STU)
3) Summary of all Inter-Facility Clinical Case Conferences
4) Email communication from Clinical Operations Analyst stating that no new behavior plans had been created between January and June 2024

h. Self-injury and Use of Force data

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

i. Quality assurance materials

1) Minutes from monthly Quality Improvement Committee (QIC) meetings
2) Redacted version of QIC's "Professional Conduct Log" that tracks staff misconduct allegations and investigations
3) Monthly Quality Assurance reports (Excel spreadsheets)
4) Morbidity/Mortality Review materials from four serious suicide attempts
5) Self-Directed Violence/Suicide Attempt (SDV/SATT) Review Committee Meeting minutes
6) Minutes from facility follow-up meetings about SDV/SATT
7) Minutes from quarterly DOJ/MADOC Agreement Site Meetings
8) Agenda and minutes from Wellpath's Clinical Operations meeting on March 25, 2024
9) Sign in sheets from Wellpath's monthly Mental Health Directors' meeting

3. **Observation of four MDOC/Wellpath Daily TS Notification/Consultation meetings, May-August 2024** (conducted via Microsoft Teams)

4. **Stakeholder feedback**

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

DETAILED FINDINGS

POLICIES AND PROCEDURES

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

Finding: Substantial compliance

Rationale: MDOC is now fully involved in the process of consulting with the DQE about policy revisions. Policy 103 DOC 650, Mental Health Services, has been revised and submitted to the DQE for review twice: first on September 20, 2023, and again on April 25, 2024. Two other policies have been submitted to the DQE: 103 DOC 601, DOC Division of Health Services Organization (submitted September 23, 2023), and 103 DOC 622, Death Procedures (submitted April 25, 2024). The DQE team provided feedback to about these policies to MDOC in January 2024 and July 2024, respectively. They are currently undergoing further revision.

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

a. The policies have been adequately revised to be consistent with paragraphs 43-45, 47-69, 71-73, 77-89, 92-93, 95-99, 107-110, 113-117, and 120-135 of the Agreement. This represents significant progress since the last DQE report.

b. The ISU policies have been drafted in accordance with Agreement paragraphs 113-135 except for relatively minor revisions needed to align with paragraphs 118 and 119. This is also significant progress since the last DQE report.

c. Some Agreement provisions are not yet adequately captured in the revised policy language, including paragraphs 38-42 (staff training), 46 (misuse of crisis tickets), 70 (TS documentation), 74 (therapeutic de-escalation room at MCI-Shirley), 75 (peer support), 76 (therapy dogs), 90-91 (response to self-injury), 94 (staff training on TS procedures), 100-106 (Support Persons), 111-112 (foreign bodies), 136 (behavior management plans), 137-141 (Quality Assurance procedures), 142-144 (Self-Injurious Behavior committee), and 145-146 (morbidity/mortality reviews).

MDOC's leadership reported that some of the provisions not yet captured in the policies reviewed by the DQE team would be included in revisions to policies 103 DOC 501, Institutional Security Procedures, and 103 DOC 562, Code 99 Emergency Procedures. The DQE team was provided these policies on September 13, 2024, and they will be reviewed in the next monitoring period. Another policy, 103 DOC 216, Training and Staff Development, may also need revision, as it addresses staff training on mental health, suicide prevention, de-escalation techniques, and cardiopulmonary resuscitation (CPR) that is mandated by the Agreement. Policies on the role of Support Persons and DOC's Quality Improvement process need to be written; the plan is for them to be included in future revisions of existing MDOC policies (e.g., DOC 650 or DOC 601).

Prior to the end of Wellpath's contract with MDOC, it had not yet revised any policies to be in accordance with the Agreement. MDOC has not provided any VitalCore policies to the DQE team; this should occur during the next monitoring period. MDOC's leadership reported that their general approach to the policy revisions is to finalize the DOC policies first and then use them as a template for the contracted healthcare vendor's policies, which seems reasonable.

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

Finding: Partial compliance

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

Table 1. MDOC Policy Revisions

Policy	Status
103 DOC 601	Revision sent to DQE on 9/20/23, comments sent back 1/13/24. Undergoing second revision by MDOC.
103 DOC 650	Second revision sent to DQE on 4/25/24, comments sent back 7/28/24.
103 DOC 622	Revision sent to DQE on 4/25/24, comments sent back 7/28/24.
103 DOC 501	Undergoing first revision by MDOC
103 DOC 562	Undergoing first revision by MDOC
103 DOC 216	Revision has not yet started

The pace of revision has been slower than the timeline mandated by Paragraph 27, which states that all policies should have been revised by December 20, 2023. To be fair, the DQE team is responsible for some of the delay. In addition, the change from Wellpath to VitalCore has slowed progress, as all of the contracted healthcare vendor's relevant policies must be gathered and shared with the DQE again. Nonetheless, MDOC must hasten the pace of policy revision if there is any hope of moving from partial to substantial compliance with Paragraph 27.

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

Finding: Compliance not yet due

Rationale: MDOC's policies are still undergoing revision to align them with the Agreement, and none have been submitted to the DOJ for review, comment, or approval. Therefore, MDOC is not yet responsible for modifying post orders, job descriptions, training materials, and performance evaluation instruments. Likewise, the requirement for MDOC to train staff and implement its revised policies and procedures does not begin until after the modification of post orders, job descriptions, training materials, and performance evaluation instruments.

29. Unless otherwise agreed to by the Parties, subject to the collective bargaining process and/or because of the public hearing process that could be implicated and affect the timelines in this Agreement, all new or revised policies and procedures that were changed or created to align

with this Agreement will be fully implemented (including completing all staff training) within 18 months of the United States' approval of the policy or procedure.

Finding: Compliance not yet due

Rationale: MDOC's policies are still undergoing revision to align them with the Agreement, and none have been submitted to the DOJ for review, comment, or approval. Therefore, the 18-month clock for full implementation of the policies has not yet begun. This deadline can be extended if union negotiations or public hearings are necessary after the DOJ has approved a policy.

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

Finding: Not assessed

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

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

Finding: Partial compliance

Rationale: MDOC's policies are still undergoing initial revision to align them with the Agreement, and none have been submitted to the DOJ for review, comment, or approval. MDOC already has a procedure in place regarding annual policy reviews, which is clearly delineated in policy 103 DOC 104, Internal Regulations/Policies, and involves assigning policies to their relevant MDOC leader (e.g., Deputy Commissioner of Clinical Services and Reentry) to be revised according to a monthly schedule. Wellpath employs a similar process, reviewing policies in the monthly meetings of their Policy, Procedures, and Forms Committee. Each MDOC and Wellpath policy notes the date of its creation and of its most recent revision.

Given that the framework for MDOC's annual policy review is already in place, the DQE does not anticipate major challenges in meeting the requirements of Paragraph 31 once the initial revisions have been completed. Nothing is yet known about VitalCore's policies or review procedures, but these policies must also align with the Agreement and undergo annual review for MDOC to be substantially compliant with Paragraph 31.

STAFFING PLAN

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

Finding: Substantial compliance

Rationale: MDOC continued to submit monthly Wellpath staffing matrices to the DQE and DOJ during this reporting period, and a security staffing matrix was submitted on April 22, 2024.[6] Paragraph 32 does not require the DQE's approval of the staffing plan; it only requires that MDOC submit a plan. Thus, MDOC has fulfilled its obligation under Paragraph 32, and the staffing plan is now awaiting the DOJ's approval.

The DQE's reservations about the adequacy of MDOC's mental health staffing plan are addressed in Paragraph 35. The substantial compliance finding here refers only to the timely submission of mental health and security staffing plans in April 2023 and April 2024.

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).

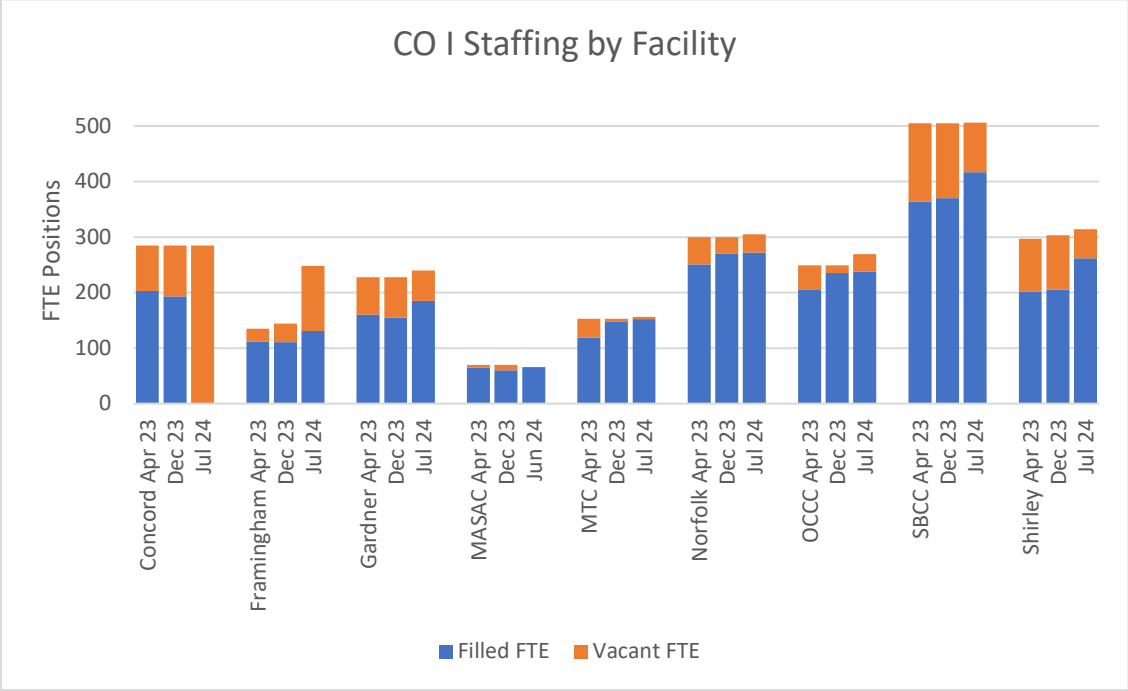
Finding: Partial compliance

[6] This is the first business day after the deadline of April 20, 2024, so it is considered timely.

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

Based on the MDOC security staffing matrix dated July 27, 2024, CO I staffing levels have improved at many facilities because of the closure of Concord in June 2024, as illustrated in *Figure 1*. The Concord staff have been redeployed mostly to Gardner, SBCC, and Shirley, where vacancy rates had been highest.

Figure 1. CO I Staffing by Facility[7]

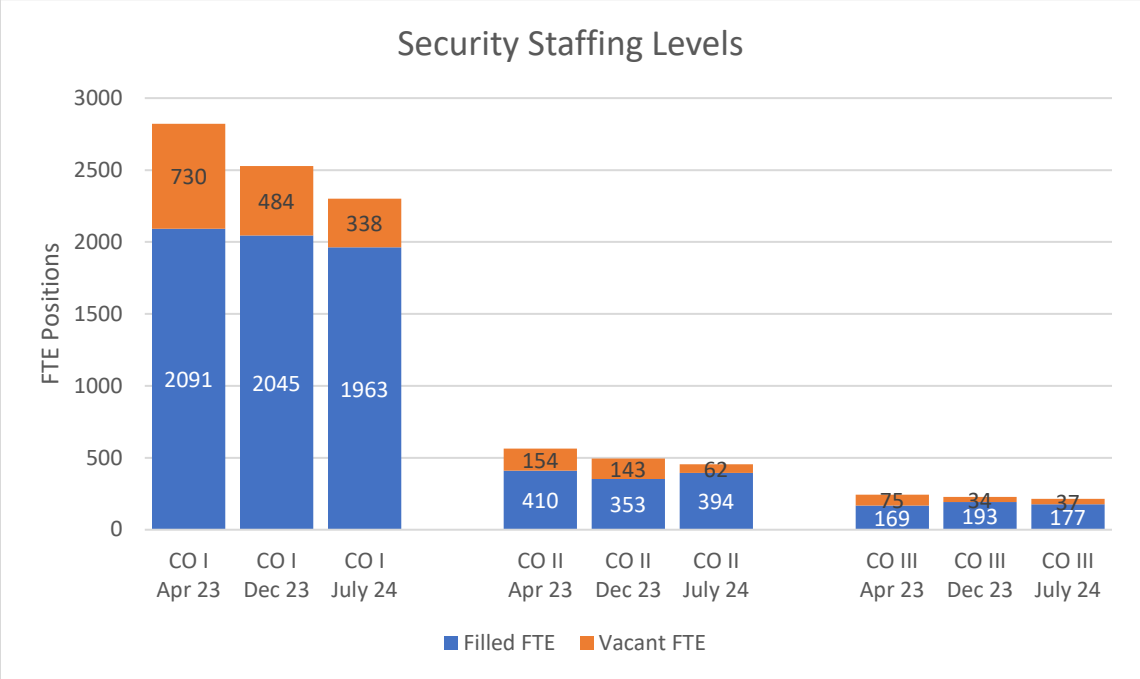


As illustrated in *Figure 2*, MDOC has achieved its improvements in staffing levels since the Agreement began by closing facilities and reallocating those staff members, not by increasing the number of officers overall. The total number of officers (CO I, CO II, and CO III) is lower in July 2024 than it was in April 2023, but those officers are now working at a smaller number of facilities, resulting in improved staffing percentages. In

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

July 2024, 85% of CO I, CO II, and CO III positions were filled, compared with 73% in April 2023, prior to the closure of Cedar Junction and Concord. MDOC stated in its June 2024 status report that new classes of officers were scheduled to graduate the training academy on July 12 and September 22, 2024, which may further improve security staffing levels.

Figure 2. Security Staffing Levels, April 2023-July 2024[8]



With the reallocation of staff from Cedar Junction and Concord, facility Superintendents reported needing to "inverse" security staff (i.e., mandate them to work overtime shifts) less often, though it still occurs regularly at some facilities. For example, at SBCC in April 2024, officers were being forced to work overtime every day, on all three shifts. Understaffing resulted in "modified operations," where the gym and recreation yard were frequently closed from 7 am to 3 pm. On some housing units, not having a "rover" officer meant that half the typical number of prisoners could come out of their cells at one time, effectively decreasing their recreation time and ability to see mental health professionals. The negative effect of understaffing and mandated overtime on morale could be felt among the officers. The facility's administration also noted the effect of recent staff assaults by prisoners, which had been publicized in the local media and further hindered both morale and recruitment efforts.

[8] MDOC's staffing matrix dated July 27, 2024, still had 285 CO I, 57 CO II, and 23 CO III positions allocated to Concord, all of which were listed as vacant. This skewed the overall vacancy rates to appear higher than they actually are, so the vacant Concord positions were removed from the analysis in *Figure 2.*

The impact of security staffing levels on TS placements—showers, recreation, and out-of-cell activities—is discussed in relation to Paragraphs 62, 63, and 65 below. Overall, poor security staffing continues to affect these activities, though there were improvements during this monitoring period.

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

Finding: Partial compliance

Rationale: MDOC continues to work toward implementing this requirement. Nine interviewed officers, from five institutions, said that when they serve as constant observation officers, they rotate the duty every two hours, and a few of them named a shorter interval. This is consistent with officer interviews during the previous monitoring period.

Documents suggested that MDOC has set a goal of rotating officers as required, but that goal is not always met. The DQE team reviewed a sample of records from 37 TS placements with constant observation in 2024; the sample was drawn from all institutions responsible for TS and from BAU and HSU settings. Just over half showed officers rotating every two hours or shortly thereafter. The other observations included some instances of an officer on the task from 2.75 to 6 hours, usually multiple times, and a handful had an officer observing for a whole shift. Additionally, documents showed that observation times could be quite lengthy when the patient was at an outside hospital. While the Agreement notes that hospital trips are an exception to a strict two-hour rotation requirement, the rules governing observation under these circumstances are not clear. Further discussion with the parties is needed to determine how to interpret this provision when an exception occurs.

Among interviewed patients with a recent experience of constant observation, the majority thought that observing officers changed every two hours, or they estimated similar lengths of time. More than 40%, though, said that officers remained on constant observation duty for their entire shifts, particularly at Shirley, Gardner, and most patients at Norfolk.

Overall, MDOC is on the path to substantial compliance with this requirement, but more is needed.

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

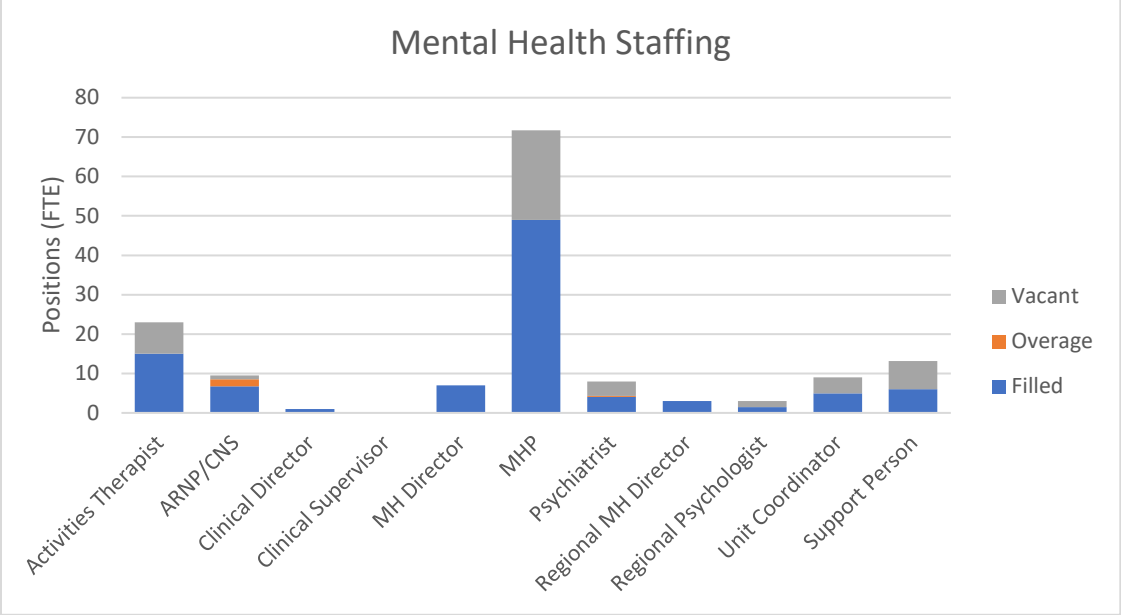
Finding: Partial Compliance

Rationale: Since the last DQE Report, the mental health staffing matrix was amended to add positions in the ISU at OCCC (16.8 FTE) and the Secure Adjustment Unit (SAU) at SBCC (3 FTE). Mental health positions totaling 8.75 FTE were eliminated in June 2024 upon the closure of MCI-Concord.[9] With these additions and subtractions, the allocated mental health positions totaled 145.75 FTE across eight facilities and the Wellpath regional office.[10]

In June 2024, 31.8% of mental health positions remained unfilled, with the largest number of vacancies among MHPs, as illustrated in *Figure 3.*

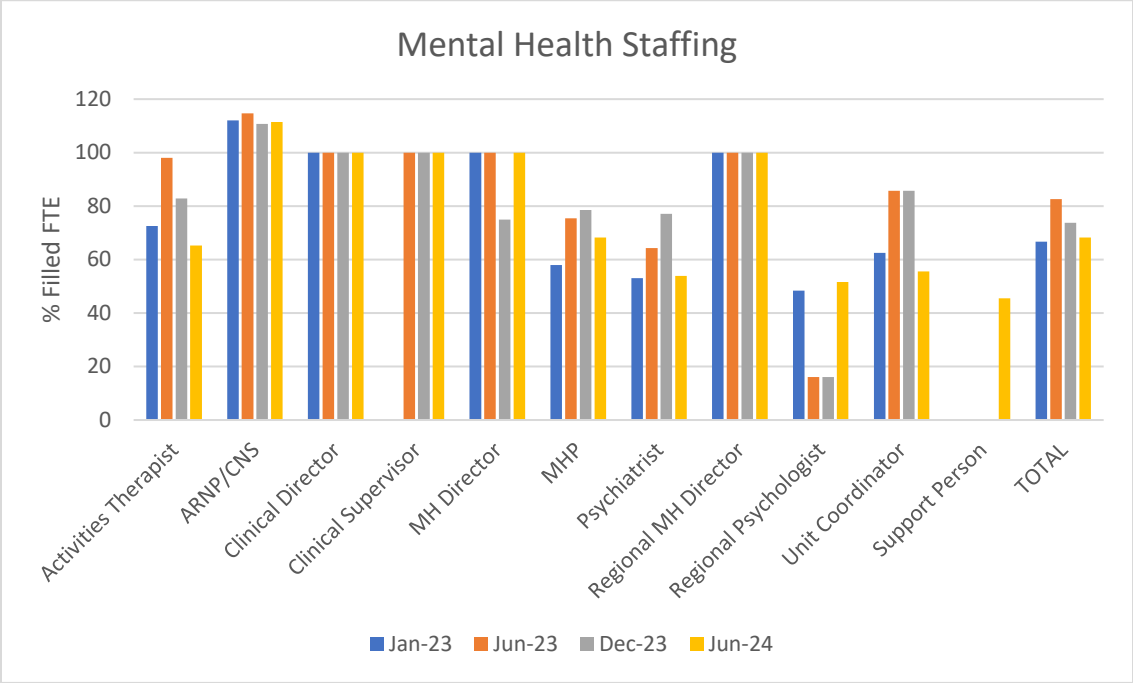
[9] The positions at MCI-Concord remained on the June 2024 Wellpath staffing matrix, but they were not included in the DQE's current analysis.
[10]Activities therapist, ARNP/CNS, Clinical Director, Clinical Supervisor, MH Director, Mental Health Professional, Psychiatrist, Regional MH Director, Regional Psychologist, Unit Coordinator, and Support Person.

Figure 3. Mental Health Staffing, June 2024



This vacancy rate of 31.8% is significantly higher than December 2023, when the rate was 19.2%.[11] The staffing changes over time are depicted in *Figure 4.*

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



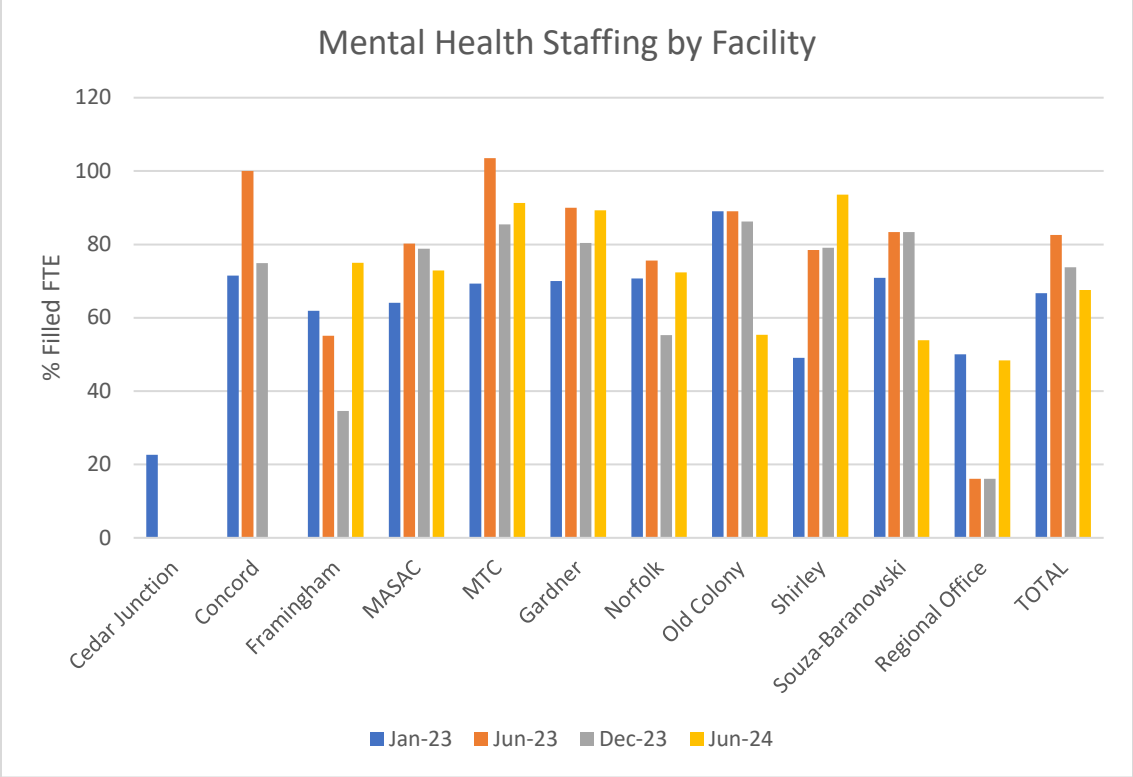
[11] The reported vacancy rates do not include temporary vacancies such as a staff member being on medical or administrative leave, nor do they include per diem employees. The DQE team learned during site visits that, in practice, vacancy rates are often higher than those listed on the staffing matrix,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

The reasons for the poor staffing levels in June 2024 are not entirely clear, but the DQE team has observed a pattern of Wellpath hiring new graduates of social work and mental health counseling master's degree programs, many of whom completed internship rotations in MDOC. These staff start working in the summer, but within a year, many of them have left MDOC for other opportunities. Thus, Wellpath's staffing levels may look better in the fall and winter than they do in the spring and early summer. MDOC's decision to change healthcare vendors from Wellpath to VitalCore could also have contributed to the high vacancy rate in June 2024. During the DQE team's site visits in May and July 2024, it was clear that many staff were apprehensive about the transition. Because of this, some staff had chosen to explore career opportunities outside of MDOC rather than sign on with the new vendor. The vendor transition added to an already difficult recruitment landscape for mental health professionals of all disciplines, who are in short supply nationwide.

Overall, MDOC's mental health staffing was barely better in June 2024 than it was in January 2023, hovering around 68% of the total necessary staff according to its staffing matrix. Key mental health staffing positions remained critically low: mental health professionals at 68%, psychiatrists at 54%, and psychologists at 51%.

Figure 5 illustrates mental health staffing levels by facility. Among the facilities, OCCC and Souza-Baranowski Correctional Center (SBCC) were worst off, operating with approximately 55% of necessary mental health staff in June 2024. This is particularly concerning because these two facilities account for over half of all TS placements and crisis mental health contacts in MDOC. On a positive note, staffing levels at Framingham and Norfolk improved significantly from December 2023, and levels at Shirley, Gardner, and MTC remained relatively strong.

Figure 5. Mental Health Staffing by Facility[12]



As noted in the previous DQE Reports, the DQE team remains concerned about the dearth of doctoral-level mental health professionals in the MDOC system. This situation has only worsened since the Agreement's inception. In June 2024, there were only 4.1 FTE psychiatrists and 6.7 nurse practitioners working in the MDOC system, which includes approximately 5,700 total prisoners, 45% of whom are on the mental health caseload and 33% of whom are prescribed psychiatric medication. This equates to approximately 240 patients per psychiatrist/ARNP, which far exceeds the patient-to-physician ratios recommended by the American Psychiatric Association for carceral settings.[13] In addition, there are only 1.5 FTE psychologists for the entire MDOC system despite its high proportion of prisoners with behavioral disturbances.

MDOC continues to employ a high proportion of MHPs who are unlicensed. In April 2024, 19.55 FTE out of the total 53.4 FTE filled MHP positions had an independent license (LICSW or LMHC)—36.7% of the MHP workforce. All others required supervision from licensed professionals, and most of the unlicensed staff were less than two years out of school. Overall, Wellpath's strategy of recruiting new graduates of

[12] On this chart, the "Regional Office" site includes only MDOC's Regional Psychologist positions (3.1 FTE total). .
[13] The ratio recommended in the APA's *Psychiatric Services in Correctional Facilities, Third Edition* (2016) is 150:1 for "outpatients" in general population. Higher ratios are recommended for specialized settings like the RTU, STP, and ISU.

master's degree programs, combined with a paucity of doctoral-level professionals to supervise and collaborate, resulted in an inexperienced mental health workforce. The deeply caring and well-intended MHPs simply did not yet have the experience to recognize symptoms or major mental illness or to offer more than "packets" of worksheets and puzzles to occupy prisoners' time.

The impacts of understaffing and inexperience continue to include:

- Limited multidisciplinary treatment planning (involving nursing, psychiatry, psychology, social work, and recreational therapy) at most facilities, including for those on TS;
- High levels of staff turnover, hindering relationship-building and collaboration between security and mental health staff and rapport-building with patients;
- Poor continuity of care, with prisoners in crisis seeing multiple different clinicians within a single day;
- Backlogs for assignment to a primary mental health clinician (PCC), with some prisoners waiting weeks to months;
- Backlogs for psychiatric assessments and follow-up visits; and
- A pervasive practice of MHPs using brief crisis evaluations as "proxy PCC contacts" to fulfill their technical obligation to see patients monthly while not actually providing a meaningful therapeutic contact with the assigned clinician.

On a positive note, MDOC did take two important steps toward compliance with the Paragraph 35 requirements during this reporting period. First, it increased the number of mental health professionals on site at SBCC during the evenings and weekends, in accordance with Paragraph 35(a). Instead of one clinician on site to respond to crises and see patients on TS, there are now two such clinicians, which has made the workload more manageable. Second, MDOC has made a concerted effort to foster collaboration between the mental health disciplines and to involve the psychiatrists more actively in the care of prisoners in crisis. This change was apparent during the DQE's site visits and is discussed further in relation to the "meaningful treatment" requirements of Paragraph 72.

Overall, much work needs to be done to obtain substantial compliance with Paragraph 35's requirements. Perhaps VitalCore will be more successful than Wellpath was at recruiting and retaining an adequate mental health workforce, though the shortage of mental health professionals is currently affecting the entire nation and is not limited to MDOC.

36. Staffing Plan for the Intensive Stabilization Unit (ISU): The supervising clinician of the ISU will be a Qualified Mental Health Professional, and all mental health staff on the unit will

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

Finding: Partial compliance

Rationale: The ISU's staffing plan was provided to the DQE on June 25, 2024.[14] The staffing is listed in *Table 2.*

Table 2. ISU Staffing Plan

Position	FTE
Mental Health/Medical	
Psychiatrist	0.5
Activity Therapist	1
Mental Health Professional	4
Support Person	3.6
Unit Coordinator	1
Nurse	4.2
Administrative Assistant	0.5
Security	
CO I	25.2
CO II	0
CO III	5.4

This plan seems to include the necessary clinical and security staff for the ISU except for a psychologist, which was strongly recommended in the DQE's first two reports.[15]

[14] The June ISU staffing plan included three activity therapists, but MDOC clarified in September 2024 that the correct staffing for that position is one, not three.

[15] First DQE Report, p. 107: "The DQE urges MDOC to consider staffing the ISU with a psychologist who can lead the treatment team's efforts to create and implement behavior plans for individuals with personality disorders and patterns of repeated self-injury." Recommendation on p. 128: "Continue with staffing plans for the ISU, including a psychologist with expertise in behavioral management plans." Second DQE Report, p. 107: "Including a psychologist in the ISU's treatment team will also be crucial, given that many individuals with personality disorders and patterns of repeated self-injury will likely be treated in that environment." Recommendation on p. 131: "Submit

MDOC's behavioral health leadership reported that regional psychologists are available for consultation on any patient, including those in the ISU. It remains to be seen whether this regional staffing model is effective in meeting the ISU's needs for psychological assessments and/or behavioral management plans.

Formation of a multidisciplinary team for the ISU, as described in Paragraph 36, is under way. During the July site visit, OCCC mental health leadership stated that a Mental Health Director from another MDOC facility has been recruited to be the Unit Coordinator, i.e., the supervising clinician of the ISU. The plan is for all other mental health staff to report to him.

Policy 103 DOC 650.12.C.a.i codifies the ISU's multidisciplinary treatment team structure:

> The ISUs utilize a multi-disciplinary treatment team. Treatment team membership may include the following: ISU Director; Special Housing Unit Captain; Unit Sergeant; alternating Correction Officers from all shifts; Correctional Program Officer; licensed mental health professionals, assigned nursing and support staff.

The DQE recommended that this policy language be amended to clarify that "multidisciplinary" means that the treatment team will include MHPs, psychiatrists, psychologists, Support Persons, activities therapists, and nurses, as clinically indicated. As written, the multidisciplinary aspect of the mental health team is vague.

Whether ISU's multidisciplinary team functions in accordance with the Paragraph 36 requirements cannot yet be assessed because the unit had not admitted any patients as of June 30, 2024. Thus, although MDOC is well on its way to meeting the requirements of this provision, a substantial compliance finding at this time would be premature.

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 has made little progress in increasing its mental health staff. Security staffing levels are improved, primarily because of two facility closures and the

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

reallocation of personnel to other institutions. Although the gains in security staffing are encouraging, given the minimal progress with mental health staffing, a finding of partial compliance seems most appropriate.

TRAINING

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

Finding: Partial compliance

Rationale: MDOC continues to provide pre-service and annual in-service training on mental healthcare, suicide prevention, and de-escalation techniques to all security staff. Because no policy revisions have been finalized, MDOC is not yet obligated to train staff about new policies. In practice, it has already begun retraining staff about Therapeutic Supervision using a revised curriculum in accordance with Paragraph 42b.

MDOC provided evidence of staff's annual in-service training completion from Training Year 2024 (TY24) to the DQE for review.[16] Between September 1, 2023, and June 4, 2024, 2,457 staff members at eight institutions where TS occurs were required to complete the training "Suicide Prevention & Intervention." Of these, 1,899 staff members completed the training, resulting in a 77% completion rate. For the "Therapeutic Supervision" training over the same period, 1,587 of 2,457 staff members completed the training, resulting in a 65% completion rate.

Of note, the DQE team's calculations differ significantly from MDOC's analysis of the same spreadsheet data. MDOC's calculations about training completion were provided to the DQE team on September 20, 2024. MDOC found that, in TY24, 2,332 staff members at eight institutions were required to undergo the suicide prevention and TS trainings. 2,098 staff (90%) completed the suicide prevention training, and 2.095 (90%) completed the TS training. The DQE team will need to dive deeper into this area during the next reporting period to understand why the two analyses are so different.

Wellpath continued to provide a variety of trainings to its clinical staff during this monitoring period, including:

[16] These trainings do not include the security staff at MASAC, who are Wellpath employees and undergo different trainings, for example, on de-escalation techniques.

- An eleven-week training curriculum on Therapeutic Supervision, including crisis treatment plans, property considerations, meaningful therapeutic interventions, psychiatry and upper-level provider consultations, and discontinuation of TS
- Other site-based trainings (e.g., availability of old health records, conducting BAU risk assessments, sex offender treatment planning and documentation)
- System-wide Grand Rounds presentations (e.g., sex offender treatment planning, de-prescribing, overview of Medication Assisted Therapy)
- Training about on-call procedures for new MHP managers
- Wellpath New Employee Orientation (NEO)
- Annual in-service trainings on suicide prevention and recognizing signs of mental illness.

Wellpath provided attendance logs for many of these trainings to the DQE for review. Given the change in vendors from Wellpath to VitalCore in July 2024, the DQE team did not review these records in detail except to verify pre-service training completion by Support Persons, as described in Paragraph 100. In the next reporting period, VitalCore will need to demonstrate that its staff training program is compliant with the Agreement, essentially starting at square one with the DQE team. The DQE will work with MDOC to obtain the necessary training materials.

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

Finding: Compliance not yet due

Rationale: No policy revisions have been completed since the Agreement's effective date, and no new policies have been developed. Therefore, MDOC is not yet required to incorporate new/revised policies into its annual training plan.

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

Paragraphs 27-31 of this Agreement, new security staff will receive this training as part of pre-service training.

Finding: Compliance not yet due

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

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

Finding: Partial compliance

Rationale: MDOC's trainings already include instruction on mental healthcare, suicide prevention, and de-escalation techniques, and they are provided using current evidence-based standards. In its June 2024 status report, MDOC reported that it continues to explore the feasibility of incorporating individuals with lived experience or their family members into the training materials, but such materials are "currently unavailable." According to the QIC meeting minutes, options being investigated include (1) asking incarcerated persons who have participated in MDOC's suicide prevention walks, and (2) the use of publicly available videos from Alaska.

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

Finding: Partial compliance

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

42a (Crisis Intervention Training): substantial compliance
42b (Revise suicide prevention training): partial compliance

42c (Pre-service and in-service training): compliance not yet due
42d (CPR training): partial compliance

MDOC's progress is discussed in each subsection below.

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

MDOC's June 2024 status report indicates the following:

> 8-hour Crisis Intervention Training refresher courses were completed on April 15, 2024, May 13, 2024, and May 15, 2024. The next 40-hour Crisis Intervention Training is scheduled for June 17-21, 2024. As of May 27, 2024, there have been a total of 195 people trained in CIT by the MDOC team.

MDOC provided sign-in logs for the CIT refresher trainings conducted on April 15 and May 13, 2024, for the DQE team to review. Six total individuals completed these trainings. In the DQE team's interviews with security staff, four of the 19 officers who were asked about CIT training reported they had completed it and found it beneficial. Of the mental health staff, the DQE team only asked Support Persons about CIT training, and none of them reported participating in it.

The Agreement does not create specific benchmarks for MDOC to meet regarding CIT training, so the current scheme meets the threshold for substantial compliance with Paragraph 42a.

b. Within six months of the Effective Date, MDOC will review and revise its current suicide prevention training curriculum, which will be submitted to the United States for review, comment, and the United States' approval in accordance with Paragraph 27 and include the following additional topics:
1. suicide intervention strategies, policies and procedures;
2. analysis of facility environments and why they may contribute to suicidal behavior;
3. potential predisposing factors to suicide;
4. high-risk suicide periods;
5. warning signs and symptoms of suicidal behavior (including the suicide screening instrument and the medical intake tool);

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

MDOC submitted its revised "Suicide Prevention & Intervention" curriculum to the DQE for review in September 2023. In January 2024, the DQE concluded that the revised curriculum meets all the criteria delineated in 42.b.1 through 42.b.9[17] and provided minor feedback about the training's content to MDOC. MDOC further revised the materials and resubmitted them to the DQE on April 25, 2024. MDOC's second revision of the suicide prevention training incorporates all of the DQE's feedback and made the following changes:

- Updated the suicide statistics through the end of 2023
- Suggested more options for how to intervene if a prisoner is exhibiting "warning signs," including referral to psychiatry, increasing PCC contacts, or revising the treatment plan
- Included reminders about how to respond if a prisoner refuses to answer questions related to suicide risk
- Emphasized the importance of obtaining collateral information from the medical record and correctional officers prior to conducting a suicide risk assessment

The DQE returned the materials to MDOC on August 5, 2024, with no further substantive revisions. They are now ready for the DOJ's review and approval.

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.

[17] Section 42b.6 requires the training on the observation of prisoners on mental health watch. This is a separate training from "Suicide Prevention and Intervention" called "Therapeutic Supervision," which the DQE has also reviewed.

Since no policies have been finalized, compliance with this provision is not yet due. In practice, MDOC (and Wellpath prior to its contract ending) already require all staff to complete eight hours of pre-service training on suicide prevention, and annual in-service training for all correctional officers already includes two hours of suicide prevention training. MDOC submitted training logs from TY24 to the DQE for review; they cover the period between September 1, 2023, and June 4, 2024. As described in Paragraph 38, the DQE team's analysis of those logs indicate that 77% of staff at eight institutions where TS occurs had completed annual in-service training on suicide prevention, while MDOC's analysis shows 90% completion. This discrepancy will be further assessed during the next reporting period.

MASAC security staff's training completion was reported separately because those staff are employed by Wellpath, not by MDOC. Wellpath's training logs indicate that 79 security staff members completed annual Suicide Prevention training between July 1, 2023, and June 30, 2024. It is not clear what percentage of the total security workforce this represents. Staff at MASAC participate in additional de-escalation training called MANDT training, which enhances their skills in managing mental health crises. Wellpath provided documentation of this training occurring as well.

In the DQE team's interviews of officers and mental health staff, it was clear that the requirement for annual in-service training is well established, with every interviewed officer who was asked reporting that they complete suicide prevention and mental health training annually.[18] Similarly, staff were familiar with the requirement for pre-service training on suicide prevention and mental health, with new staff members (e.g., Support Persons) reporting the completion of at least eight hours of training. MDOC's new employee orientation (NEO) records seem to support these statements, documenting 8 hours of mental health training in its NEO attendance logs. It is not clear whether the employees completing these NEO trainings include Paragraph 42c's required staff ("all correction officers who work in intake, Mental Health Units, and restrictive housing units"). MASAC's training logs indicate that 106 security staff have completed pre-service mental health training since December 14, 2018. It is not clear what percentage of the total security staff hired since that date were trained.

In the next monitoring period, the DQE team will work with MDOC to understand VitalCore's training scheme for security and mental health staff in preparation for Paragraph 42's due date, which is not until 15 months after the DOJ approves all policies.

[18] Twelve officers at seven institutions were queried about suicide prevention and mental health training.

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.[19] In the DQE team's interviews of security staff across seven institutions during this monitoring period, all who were asked about CPR training reported completing it every two years.[20] MDOC provided a spreadsheet containing CPR certification records for 2,470 staff who completed CPR training in TY23 and would therefore remain certified until TY25. This document indicates that 2,470 staff at the institutions where TS occurs were required to complete CPR training in TY23, and 222 of these individuals did not complete the training, leading to an overall completion rate of 91%.

Wellpath provided evidence of the MASAC staff's CPR certification as of May 6, 2024. These data indicate that 216 staff members of all job classes, not just security staff, have a current CPR certification, with just two security staff members out of compliance. This demonstrates excellent practice with CPR certification.

The DQE did not receive any information documenting CPR completion of newly hired security staff, but MDOC reported that a person cannot graduate from the training academy without completing CPR training. Overall, it appears that MDOC is well on its way to demonstrating compliance with the CPR training requirements.

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: The DQE has previously determined that MDOC's policies clearly state that, if a prisoner is thought to be at imminent risk of harm to self or others, staff members must inform mental health staff immediately and place the prisoner under constant

[19] 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.
[20] Twenty-two officers were asked about CPR training.

observation until assessed by mental health.[21] Officers, mental health staff, and leadership appeared well aware of these expectations when interviewed during each monitoring period.

There continue to be indications, however, that implementation may be uneven. The DQE team interviewed 41 prisoners, across seven institutions, on this point. Among those who commented on forwarding requests for crisis mental health care ("calling crisis"), 50% affirmed that officers consistently call MHPs quickly. An equal number, though, said security staff call mental health with only some of these requests and are unresponsive to others. This rate is consistent with reports made to the DQE in previous monitoring periods. Eight MHPs also said patients raise this complaint with them. MDOC provided its tracking of TS-related complaints against staff and related investigations. MDOC indicated the tracking draws primarily from confidential incident reports submitted by staff, and it contains four complaints this year of officers not forwarding patients' crisis requests.[22] Taking these sources together, this type of concern was raised most often at SBCC and Norfolk.

MHPs noted that patients say officers sometimes try to talk them out of "calling crisis," and a few interviewed prisoners mentioned either being subject to mocking, name-calling, indifference to their requests, or witnessing this happening to other prisoners. The misconduct tracking included a sustained allegation that an officer told a prisoner, "Just kill yourself."[23] These described behaviors might tend to support the patients' charges that their crisis requests may not always be forwarded. At the same time, an almost identical number of patients complimented officers' responsiveness, accessibility, and professionalism, so the concerns do not apply throughout the officer corps.

Patients and MHPs also said some calls are not made immediately, as required. About 20% of interviewed patients raised these complaints, with some giving specific examples. Some of their reported delays, along with those in six similar investigations pending on the misconduct tracking, appear to involve very lengthy times.

During previous monitoring, the DQE team interviewed officers and supervisors in areas that house prisoners on TS, mostly in Health Services Units and Behavior Assessment Units. In the current monitoring period, interviews concentrated on other units where crisis calls might originate, including the SAU, STP, BAU, RTU, Orientation or Intake, and general population. In terms of holding the prisoner under constant observation until

[21] See 103 DOC 650.08

[22] The DQE team did not select interviewees based on any foreknowledge of concerns they might have. The complainants in the Professional Misconduct tracking appear to be different from the DQR team's interviewees.

[23] MDOC reported that this officer was subsequently disciplined.

s/he can be evaluated by mental health staff, 60% of the officers affirmed that they always do this and described the logistics. A large majority of interviewed patients (75%) reinforced that this is their experience as well. The other officers said they call mental health for an assessment but remain with the prisoner only if they asserted that they may hurt themselves or others. As the DQE has written previously, this can be a viable and appropriate approach if implemented with careful guidance to staff.

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: The DQE team interviewed 15 correctional officers posted in a variety of housing settings at seven institutions, who commented on MHP times to respond to crisis calls. All characterized response times as typically quick, estimating them at 20 minutes or less. A small number of officers at OCCC and SBCC, where the patient populations are largest, said that rarely a response could take up to two hours.

The DQE team also interviewed prisoners at eight institutions about their experiences while living in general population, BAU, RTU, SAU, and STP. For the 24 prisoners who commented, the perception was very similar to officers' perceptions. All said MHPs typically respond within minutes. More prisoners than officers said that occasionally response times were much more extended, from two to five hours. It was noteworthy that a handful, across several institutions, also said that assessments take place cell-front or in other nonconfidential settings. These views were consistent with staff and prisoners interviewed in each of the monitoring periods to date.

The longer response times may be a product of a practice recently described to the DQE team. MDOC administration indicates that crisis clinicians, upon receiving a referral, may discuss what is known about the referral with the site Mental Health Director before assessing the patient. They may decide jointly that the crisis referral falls in an urgent category – meaning the patient should be seen the same day – and is not an emergent referral. Depending on the circumstances, this is a system that the DQE team could see fulfilling the purposes of Paragraph 44.

As a spot check, the DQE team reviewed a random sample of "crisis logs," chosen from within one recent month at all relevant facilities. The logs generally capture receipt and response times for crisis referrals, along with other activities. Among the 59 relevant referrals reflected in the sample, 81% are shown with a response within one hour. The

remaining cases were considered urgent referrals, and the logs show response times from about two to five hours.[24] This can be a reasonable practice in certain situations. For example, it might apply in cases where a prisoner says they are in crisis immediately after being denied or asked to wait for a service—a snack, for instance, or speaking with a sergeant—but it also depends on whether the prisoner is showing distress, has a pattern of similar requests that do not result in TS placement, and other factors. The DQE team will continue to monitor cases of urgent referrals in future monitoring periods.

The DQE team's review of electronic health records, which began to capture referral and response times when the note template was updated in February 2024, was also encouraging. In the 37 cases where referral times were noted, across eight institutions, the average response time was 13 minutes.[25]

Overall, MDOC is approaching substantial compliance with the Paragraph 44 requirements. The DQE team will work with MDOC to ensure that its recently described system of categorizing of referrals initially labeled as crisis calls is operating in alignment with Paragraph 44.

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

Finding: Partial compliance

Rationale: At least one clinician (MHP) is on site at each MDOC facility where TS occurs between 8 am and 9 pm, Monday through Friday. On Saturdays, a clinician is on site from 8 am to 4 pm, and on Sundays, a clinician is on site only in the event of a 1:1 TS placement. Outside of these hours, an independently licensed MHP is on call by phone. If a crisis occurs during non-coverage hours, MDOC's typical practice is for an on-site nurse (registered nurse or licensed practical nurse) to assess the patient, then call the on-call MHP to determine what intervention is appropriate. The next business day, an MHP conducts a follow-up visit with the patient. This process is outlined in the proposed revision of policy 103 DOC 650.08.A.1.

[24] An additional three outcomes could not be determined.
[25] These 37 cases were a subset of the 50 crisis calls described in Paragraph 47.

During this monitoring period, MDOC changed the format of the mental health staff's daily triage notes and end-of-shift reports to prompt the recording of follow-up contacts from overnight assessments. The DQE reviewed these notes from June 2024 in detail. Records from SBCC and Gardner indicate that MHPs conducted many such follow-up assessments, mostly for overnight BAU placements but also sometimes for traditional "crisis calls." Notes from OCCC indicated one crisis follow-up assessment in June, while those from Shirley, MTC, MASAC, Norfolk, and Framingham contained no such notations. It is not clear whether different rates of overnight crises or different documentation practices account for the lack of overnight crisis follow-ups found in most institutions' triage notes.

In a study of 100 therapeutic supervisions,[26] the DQE team encountered 21 patients placed on TS, and one patient determined not to need that placement, by an on-call MHP. In all cases, an MHP met with, or attempted to meet with, the patient to evaluate them on the next business day or when the patient returned from an outside hospital admission.

As another type of spot check, the DQE team reviewed the medical records in 10 additional cases where overnight crisis assessments, unrelated to TS placements, took place between February and June 2024.[27] Half of the cases involved overnight BAU assessments, while the other half were crisis calls. In all 10 cases, a timely follow-up note was completed on the next business day. However, the substance of these follow-up assessments was often lacking, with 70% of assessments (including all of those at SBCC) being conducted cell-front and 90% lasting seven minutes or less. In one case at SBCC, a prisoner had engaged in SDV and was sent to an outside hospital the night before, but his next-day follow-up was conducted cell-front for two minutes. Overall, it appears that the practice of following up with prisoners after overnight crisis contacts is established throughout MDOC, but the substance and documentation of these contacts needs improvement.

As noted in the previous DQE report, it appears that nurses inconsistently contact the on-call MHP for consultation when conducting overnight/Sunday crisis assessments. During the DQE's review of 10 overnight assessment cases, the nurse contacted the on-call MHP in all the cases that were "crisis calls" but none of the "BAU clearance" calls. This is likely due to MDOC's understanding (noted in their comments on the draft of this report) that BAU assessments are inherently different from "crisis calls" and that a different response procedure is therefore warranted. The BAU assessment template in the medical

[26] See Paragraph 52 for a description of the study methods

[27] These cases were drawn from the triage meeting minutes and were spread across four institutions: SBCC, OCCC, Gardner, and Concord. Cases at other institutions could not be readily located in the minutes.

record reflects MDOC's understanding, instructing nurses to contact an MHP only if a prisoner answers one of the risk screening questions in the affirmative, not in all cases.

To the DQE team, BAU assessments share many important characteristics with "traditional" crisis calls, most notably the over-arching concern about heightened suicide risk. Research has repeatedly demonstrated that restrictive housing conditions are associated with suicide in correctional facilities, and MDOC's only completed suicide since the Agreement began occurred in the BAU. For this reason, the DQE team has included BAU assessments in its evaluation of the Paragraph 45 and 47 requirements since its March 2024 report.[28] Further discussion with the parties is needed about whether BAU assessments fall under the term "crisis" for the purpose of this Agreement. This is a gray area, as the BAU was still under development when the Agreement was being negotiated, so the parties likely did not discuss procedures for BAU clearance in detail at the time.

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: During the monitoring period, the DQE team learned about and reviewed seven potential disciplinary cases for misuse of crisis. Half were initiated by mental health staff, and it seemed reasonable to conclude that the patient did not believe he was in mental health crisis. Two were written by security staff and, while there was no indication of a mental health consult in one instance, in another, an MHP agreed that the actions were a misuse. Two other potential cases could not be substantiated. In the cases that proceeded, charges were either dismissed or resulted in 15 to 30 days' loss of canteen.

In 24 patient interviews across eight institutions, 88% said they had not been disciplined for requesting a crisis contact since the Agreement went into effect, with some noting that this was a change from the past and others commenting that they had never heard of this practice.

Several interviewed MHPs said they *had* written such a ticket once, and all, drawn from five institutions, said it was nonexistent or rare at their facility. They emphasized that tickets would have to be advocated by mental health staff and that the patient's behavior

[28] Overnight assessment practices were not evaluated in detail during the first monitoring period, so the September 2023 DQE report is silent on the matter.

must be "blatant." One MHP said she likes to give the patient warnings to give an opportunity for change before considering a misuse of crisis ticket.

Among 22 officers interviewed, from eight facilities, only one said he personally writes this type of disciplinary report. While several expressed skepticism about this approach, officers' general impression was that misuse of crisis cases are rare or nonexistent at their facilities (though some noted it was common at Cedar Junction before closure) and routinely are dismissed. A handful offered that a case should be written by, or in collaboration with, mental health staff.

The documents and interviewees' beliefs and experience have been consistent across three monitoring periods. The low number of identified disciplinary cases, the institutions' cultural understanding that such cases are highly discouraged, and the fact that administrations routinely identify and dismiss these cases suggests a functioning system. Issues of concern are a small percentage of the tickets the DQE team has reviewed over time. Taken together, this supports a finding of substantial compliance with Paragraph 46.

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

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

Finding: Partial compliance

Rationale: During the April 2024 site visits, Wellpath allowed the DQE team to review some of its Quality Assurance audits from SBCC. The findings of these audits are detailed in Paragraph 137 below. None of the areas audited by Wellpath align with the Paragraph 47 requirement to ensure that crisis treatment plans contain the elements delineated in 47a-f. No information about VitalCore's audit process has been shared with the DQE team yet.

The DQE team reviewed a sample of 50 MHP crisis assessment notes to perform an independent audit.[29] As in the earlier DQE reports, a significant number of patients (36%) were assessed in a non-confidential setting. Ten percent of assessments occurred non-confidentially because the patient declined to meet out-of-cell. In the remaining 26% of cases, no reason for the cell-front assessment was documented, or the decision was made "per security." All the non-confidential crisis assessments in the DQE team's study occurred at OCCC, SBCC, and Shirley, which is consistent with information learned from MHP interviews and observation of crisis assessments during the DQE's site visits. The "New Man's" area at OCCC, BAU at SBCC, booking area at Shirley, and booking area at MTC[30] frequently result in MHPs conducting non-confidential assessments, either because of space limitations or because of security protocols. Gardner continues to work on improving the space available for crisis assessments, removing the toilet from the assessment room during this monitoring period, though the room's location on a housing unit still allows other prisoners to peer inside easily during assessments.

The quality of crisis assessments remained variable, with most contacts being brief. In the DQE's study, 48% of contacts were under 10 minutes, 32% were between 10 and 20 minutes, and 12% were over 20 minutes. The DQE team did notice that MHPs were more consistently reviewing data about a prisoner's history of self-injury and mental health treatment prior to conducting crisis assessments. In the current study, 72% of crisis assessments contained a notation that the MHP had reviewed the patient's self-injury in accordance with requirement 47d—a major improvement from 6% in the last monitoring period. This is excellent progress, likely stemming from MDOC's revision of their crisis assessment note template that now prompts clinicians to enter this information in the medical record, as well as Wellpath's trainings on risk assessments. However,

[29] This is a different sample from the study of 100 TS Placements described in Paragraph 50. The current study reviewed 50 randomly chosen crisis assessments from across eight institutions between January and June 2024, in approximate proportion to the TS placements across MDOC. 98% of the studied cases did not result in placement on TS. MASAC was excluded from the analysis because the DQE could not access patients' records in ERMA at the time of the study, but MASAC accounts for such a small percentage of crisis calls that it would not have affected the overall results significantly.

[30] In the DQE team's study of medical records, MTC's crisis assessments were conducted confidentially, but the lack of confidential space in the booking area has been raised by the mental health staff as a concern in each DQE site visit.

since many clinicians continued to report during the DQE team's site visits that they do not always have access to the medical record or IMS prior to conducting crisis assessments, especially at OCCC and SBCC, this area will continue to be monitored closely to see what clinicians' actual practice is.

The DQE team remains concerned that inexperienced clinicians base their decisions about risk exclusively on the patient's self-report of their own safety, though this does appear to be gradually improving. Assessments prior to BAU placement are still the most superficial type of crisis assessment, lasting less than 3 minutes, on average, in the DQE team's most recent study.[31] This is a disappointing result, considering how much effort MDOC and Wellpath put into retraining the staff on BAU risk assessments during this monitoring period, but it may be partially explained by understaffing and high staff turnover. Overworked clinicians, as well as those who are new, may not be adhering to the risk assessment practices being taught by the clinical leadership. Another contributing factor may be MDOC's understanding that BAU assessments are not crisis assessments, which may be reflected in staff's curtailed evaluation practices.

Overall, the DQE team sees progress in the area of crisis assessment, though more work is needed. A partial compliance finding is being issued in recognition of the improvements in some areas, but the non-confidentiality of some crisis assessments and the superficiality of most BAU risk assessments continue to be concerning.

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: MDOC's revised template for crisis assessments has improved documentation of the clinicians' thought process around referrals to psychiatry. In 96% of cases in the DQE team's review of 50 crisis calls between January and June 2024, the clinician documented whether referral to psychiatry was indicated by checking a box at the end of the clinical note. In two cases (4% of the total sample), a clinician thought that psychiatry referral was indicated, and the patient saw a psychiatrist or ARNP shortly thereafter. In the remaining 46 cases (92% of the total sample), the clinician opined that psychiatry referral was not indicated.

[31] There were nine BAU assessment cases included in the DQE team's study. The duration of contact was not recorded in two cases.

When reviewing the cases independently, the DQE clinicians[32] agreed with the Wellpath clinicians' assessments about psychiatry referral in the vast majority of cases. There were just two cases (4% of the sample) where the DQE thought that psychiatry referral was obviously indicated and the MHP had not made such a referral. Both cases were at SBCC. In the first case, a patient reported "seeing and hearing things" and asked to see psychiatry, but no referral was made. In the second, a patient had written a suicidal letter to a state official and specifically requested to see psychiatry when assessed by the MHP, but no referral was made.

Overall, MDOC is making progress in this area. As noted elsewhere in this report, the DQE remains concerned about the skill level of inexperienced MHPs in detecting signs of serious mental illness and making appropriate referrals, especially at SBCC. MDOC is doing more to train clinicians, but these efforts are limited by understaffing and high staff turnover.

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

Finding: Substantial compliance

Rationale: In the DQE team's review of 50 crisis calls, 48 cases included a crisis progress note (now documented on the "Clinical Risk Assessment" form) in the DAP format (96%). In the two cases where a TS was initiated as a result of the crisis contact, the MHPs' practice was to complete a Crisis Treatment Plan in lieu of the crisis progress note, which contains the same information as a DAP note (and more). A substantial compliance 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 Paragraph 47.

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

Finding: Partial compliance

Rationale: As part of its analysis of this requirement, the DQE team reviewed 100 recent TS placements drawn from the spreadsheets referred to as the "TS Registry" that MDOC compiles monthly and provides to the DQE. Cases were selected from all nine

[32] "DQE clinicians" refers to Drs. Kapoor and Wright.

institutions that provided therapeutic supervision during the monitoring period of January through June 2024, in proportion to their percentages of the systemwide total. The sample was chosen to capture stays in the most common housing areas where therapeutic supervision takes place (HSU, BAU, STU, ITU, and RTU), drew from each month in the January through May 2024 timeframe, included a variety of reasons for placement, and favored stays of three days or longer. This sample represents 18% of the 556 total TS placements in the monitoring period.[33]

In this sample, an MHP determined that the prisoner was at risk of self-harm in 84 cases,[34] and in each instance, the MHP did place the prisoner on TS. While this method necessarily captures only cases that *were* placed, it provides some support that MHPs are making determinations about risk of self-harm and placing prisoners on TS accordingly. These data, combined with the DQE team's interviews and observations of typical clinical practice during the site visits, provide reassurance that MDOC has established the expectation that TS placement and supervision levels are to be based on a patient's risk.

Paragraph 50 also requires that prisoners be placed on clinically appropriate levels of therapeutic supervision. As in previous reports, the DQE defines "clinically appropriate" in this context to mean that the MHP conducted a suicide risk assessment in accordance with generally accepted standards of care and then exercised reasonable professional judgment in determining which level of TS to recommend (close or constant supervision). As noted in previous DQE reports and in Paragraph 47 above, the quality of risk assessments underpinning the TS decisions has been suboptimal since the Agreement began, with many assessments being cursory or conducted in non-confidential settings. To its credit, MDOC has worked hard on improving these assessments, noting in its June 2024 status report:

> [Wellpath's] Mental Health Leadership were participants in the Collaborative Assessment and Management of Suicidality (CAMS) curriculum. [Wellpath's] leadership is also developing a series of Risk Assessment Trainings which will be a mandatory part of Mental Health Professional Training. Unlicensed mental health professionals will be focusing on clinical risk assessment documentation skills as a mandatory part of their weekly individual supervision.

[33] This 100-TS sample was used to assess a number of Agreement requirements below. In some instances, conclusions may have been reached based on fewer than 100 stays because of information availability or 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.

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

These are very positive steps toward improving the quality of risk assessments, though, of course, the DQE will need to verify that they are not lost in the Wellpath-VitalCore transition.

During the most recent round of site visits, the DQE team did notice some improvement in risk assessment practices, though clinicians were still sometimes assessing patients without having reviewed their medical records in advance, particularly at OCCC and SBCC. Time constraints and lack of access to the medical record on the housing units continued to drive this practice, though more clinicians seemed to understand that an adequate risk assessment demands more than just asking a patient, "Will you be safe?" At SBCC, there may still be a knowledge/skill gap, as some MHPs reported a practice of reviewing the chart after seeing the patient, while writing the note, and reasoned that this was acceptable because they have often "heard about" the patient in triage meetings. They also cited difficulty accessing records, the high volume of crisis calls, and the time spent on seemingly redundant documentation as reasons they do not always conduct thorough risk assessments.

Overall, there has been some progress in relation to the Paragraph 50 requirements. The DQE team would need to see significant improvement at SBCC before a substantial compliance finding can be contemplated.

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 more than 300 chart reviews during the first three monitoring periods, the DQE team has not encountered any indicia that TS placements were initiated for any reason other than the prisoner's request or the prisoner's well-being. The same is true of the TS placements described during recent interviews with 23 prisoners, across five institutions, commenting directly on this point. Although the DQE team has encountered practices such as "[Intensive Treatment Unit] Phase 3" at Framingham and "security watches" at OCCC and MASAC, it does not seem that these statuses are being used as a workaround to avoid labor-intensive TS monitoring or to punish prisoners who might otherwise be on TS. They have different purposes, such as separating prisoners for security-related reasons (security watch) or providing a step-down phase from TS before transfer to general population (ITU phase 3).

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 150 crisis assessments across three monitoring periods, there have been no indications of over-use of TS. As noted in previous DQE reports, a remarkably small percentage of crisis contacts result in TS placement—just eight out of 150 crisis contacts in the DQE's samples (5.3%). Most crisis contacts are precipitated by institutional stressors, especially at high-volume sites like SBCC and OCCC. In this context, it makes sense why so few crisis contacts require TS placements; sometimes prisoners just need a moment to vent about the stressful environment in which they live. Notes from the mental health triage meetings indicate that MHPs review the crisis contacts as a group each business day, and they sometimes use interventions less intensive than TS to supplement a patient's treatment when the patient has been frequently calling crisis. Strategies employed during this monitoring period include more frequent contacts with their primary clinician, recreational therapy with an activities therapist, check-ins with a Support Person, and referral to psychiatry. Overall, it appears that MDOC clinicians use TS as a last resort, when less restrictive measures are inappropriate or have failed.

Of note, MDOC's policies are not yet in alignment with the Paragraph 51 requirements, but they are on their way. The draft revision of MDOC's policy, 103 DOC 650.08, Emergency Mental Health Services, adds language identical to Paragraph 51, making clear that TS cannot be used for punishment or the convenience of staff. Wellpath's policy on Therapeutic Supervision also contained language prohibiting the use of TS as a punishment, but the DQE team will now need to review policy and practice under VitalCore. This completion of this policy review will be addressed in the *Policy* section rather than in Paragraph 51.

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: To assess the presence of initial Crisis Treatment Plans, the DQE team reviewed a sample of 100 TS placements.[35] In this sample, an extraordinary 99% had a Crisis Treatment Plan completed when the TS was initiated.[36] A high rate of completion has been consistent through three rounds of DQE monitoring.

On the other hand, plans were occasionally completed without contact with the patient (for example, when the patient was at an outside hospital and seemingly without taking into consideration the patient's clinical status upon return) and, for those created with patients, the evaluations were not always confidential. While MHPs did not always record the location of the contact, 20% were documented as being completed in nonconfidential settings.

The DQE clinicians reviewed 50 crisis treatment plans[37] to assess their completeness and clinical appropriateness. There was substantial improvement in their quality, owing in part to MDOC's revision of the crisis treatment plan template in the electronic health record in February 2024. Before and after the revision, treatment plans generally contained all the elements of subsections 52a through 52j. Only 38% of treatment plans indicated that a prisoner's medication compliance had been reviewed (52k), but many of these cases occurred prior to the revision of the treatment plan template. This is improved from the previous monitoring period, when 13% of treatment plans contained any indication that medication compliance was reviewed.

Among the sample of 100 TS placements described in Paragraph 50, the DQE clinicians reviewed those cases where no psychiatry consultation occurred to assess whether it had been indicated (52k). In the full 100-stay sample, where consultation was indicated, 62% of patients were seen by psychiatry during their TS placement. This is a steady progress from the last monitoring period, when fewer than half of patients who should have been referred to a psychiatrist were seen.

[35] This is the same sample described in Paragraph 50.
[36] That is, completed on the day of placement or the next business day if placement was initiated by an on-call MHP after hours.
[37] These 50 cases are a subset of the 100 TS placements first described in relation to Paragraph 50.

The DQE's previous reports detailed significant problems with the quality of MDOC's crisis treatment plans, but an appreciable change was noticed during the review of 50 crisis treatment plans. This change is difficult to quantify, but in the DQE clinicians' opinion, the treatment goals and objectives were better related to the patients' presenting problems. 78% contained a risk assessment that the DQE clinicians rated as either "fair" or "good," with the remaining 22% containing a poor risk assessment that either cut and pasted the precipitating events into the risk assessment section of the treatment plan or simply stated the outcome of the assessment (i.e., that the patient would be placed on a 15-minute therapeutic supervision). This, too, is a significant improvement from the previous monitoring period.

Overall, it appears that MDOC's careful emphasis on treatment planning and TS documentation is starting to pay dividends. There are still concerns about follow-through on the plans identified (e.g., when treatment goals such as "identify 2-3 DBT coping skills" are created, it is not clear that a clinician subsequently works with the patient on DBT skills). Nonetheless, MDOC's improvement is noticeable, bringing it closer to compliance with Paragraph 52.

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

Finding: Partial compliance

Rationale: 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: Partial compliance

Rationale: In approximately May 2024, MDOC proactively examined all cells designated as suicide-resistant as part of its Quality Improvement efforts to prevent prisoners from using items found in the cell for self-harm. Reviewers reportedly determined that cells at eight of the institutions did *not* remain suicide-resistant and

required repairs or upgrades to return to that status.[38] MDOC informed the DQE that all TS placements would be constant observation in those cells until reinspection certified that the cells were again suicide-resistant. The DQE team is unable to verify through data whether this took place. According to MDOC's tracking and electronic health records, MHPs continued to designate a substantial number of patients to be on close observation, and the DQE team does not presently have housing information that could demonstrate that each such patient was housed in a suicide-resistant cell.[39]

During the April 2024 site visit to SBCC, the DQE team noted that the cells used for TS in SBCC's K3 unit are not suicide-resistant. MDOC provided a list of patients placed on TS in that unit since the Agreement went into effect. There was only one such placement in 2024; health records show it was limited to an overnight stay, but it was not designated as constant observation. MDOC indicates that six other patients were on TS in those cells in mid-2023. Since the DQE team does not know the condition of the cells at that time, we did not look into the question further.

Similarly, Gardner administration and officers have told the DQE team that they consider it mandatory for any TS placements in BAU to be conducted as constant observation, given that the physical plant makes visibility more difficult than in some other institutions. MDOC's TS tracking shows three BAU TS placements in the monitoring period; health records show that one patient was designated as constant observation while the other two were on close observation. In each of these situations, it is unknown to the DQE team whether security staff conducted constant observation nevertheless.

MDOC's behavioral health leadership reported that they are in the process of making the necessary repairs to suicide-resistant cells, with some institutions already completing projects such as repainting and recaulking the walls (to eliminate paint chips used for self-harm) and replacing restraint beds and toilets with ones that do not contain ligature points. The DQE team expects to see MDOC back on track with meeting the requirements of Paragraph 54 in the near future.

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

[38] The Clinical Operations Analyst reported that the cells at Concord did not undergo this inspection because the facility was due to close shortly.

[39] MDOC's TS tracking spreadsheet shows dozens of patients designated as close observation in the weeks following the initial inspections. The DQE team conducted a spot check of the spreadsheet entries. For each institution, the team identified the date on which MDOC determined that TSs should be constant, and then reviewed health records for the next three patients designated as close observation on the spreadsheet. In almost every case, MHPs had, in fact, indicated the patient should be on close observation.

prisoner later engages in Self-Injurious Behavior, a supervisor will review the checklist as an auditing tool.

Finding: Partial compliance

Rationale: MDOC's administration has informed the DQE team that it designed and distributed a form for use as a cell inspection checklist, and the DQE team has seen the form in use in multiple sites. The June 2024 MDOC status report indicates that MDOC revised the form and has discussed its use with site Superintendents. Minutes from the QIC meetings suggest that use of the cell checklists is being monitored system-wide.

The DQE team reviewed custody records for a sample of 78 TS placements. Fewer than one-third of the provided packets demonstrated the use of a cell inspection checklist.[40] Norfolk and Gardner showed the strongest practice in this regard. In previous monitoring periods, the DQE team interviewed officers in units responsible for TS, and their knowledge of the expected practice was greater than indicated in this document study. Implementation remains a work in progress.

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

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

Finding: Partial compliance

Rationale: During each monitoring period, the DQE team observes triage meetings – meetings of all mental health staff – at each institution providing TS and reviews mental health watch forms (now called TS Reports) for more than 100 placements, as well as

[40] Please see requirement 34 for a description of the overall study and methodology. Some institutions provided forms certifying that they had conducted cell inspections but did not appear to use a checklist as mandated by the Agreement. In other institutions it is unclear whether the absence of forms reflected a practice issue or a clerical one.

related progress notes. In triage meetings, staff consider a patient's clinical status when deciding whether to grant or remove permissions for property and privileges.

As will be discussed elsewhere in this report, it is common to allow clothing, a book, phone access, and visits upon placement or the next day. Where these items or other conditions are not initially allowed, staff and documents tend to describe a goal of phasing in property and privileges when a patient demonstrates a period of stability, reduced symptoms or risky behaviors, and/or voices their belief that they can manage particular items without using them for self-injury. Patients experienced with TS commonly mentioned this practice during DQE team interviews. Health records and TS Reports usually show additional conditions authorized over time. This approach tends to demonstrate that such decisions take into account the patient's acuity, whether an item is likely to increase risk and therefore be harmful to the patient, and the length of time on TS. In the DQE team's observations and studies, it is not always demonstrated that staff are considering whether additional property or privileges could help the patient improve.

During the monitoring period, MDOC revised the TS Report and the progress note template to prompt staff to think about and record each of the required property- and privilege-related decisions. Decisions about lighting level and whether restraints are contraindicated are newly added to the documentation; the DQE team has not observed these being discussed in triage meetings. Ensuring that decisions in progress notes are carried forward consistently to communication with security staff via the TS Report should reduce the potential for conflict with patients and among staff. This is a natural growing pain of a system change. More importantly, the form revisions appear to be yielding significant improvements in decision-making and demonstrating compliance.

A few mental health and security staff commented during interviews about implementing property and privilege decisions. Most acknowledged there are sometimes disagreements among different types of staff, but none described these as a large issue. In past interviews, most staff indicated the ultimate decision belongs to MHPs and that custody staff are implementers; in this monitoring period, some characterized relations as MHPs making recommendations and security staff having the role of deciding what to provide. There are occasional reports of officers not providing some items authorized on a TS Report.

Over time, line staff and leaders have said that, most commonly, disagreements are resolved directly by the involved staff or their immediate supervisors. Interviewees also note that triage meetings are a useful vehicle for resolving such differences through discussion with a participating sergeant. Sometimes, security staff discuss and decide with the shift commander, and they say they discuss it again with MHPs the next day.

MDOC leadership has agreed to monitor whether disputes on these decisions were escalating. They noted that Deputy Commissioners review site meeting minutes and communications from Superintendents, and, if the Deputy Commissioners learned of such conflicts, they would reach out to Superintendents to attempt to resolve them. MDOC leaders say they have asked the sites to record any such difficulties in Care Coordination meeting minutes. As of mid-August 2024, MDOC leaders said only one issue with a patient's property has risen to the level described in Paragraph 56. MDOC provided documents demonstrating that that facility's Superintendent consulted with the Deputy Commissioner of Clinical Services and Reentry. and they agreed on a plan.

The results of monitoring demonstrate continued progress on this requirement. Focusing on sustaining current good practice, MHPs considering more often whether a condition will improve the patient's functioning, and ironing out implementation of allowed conditions, will help MDOC reach substantial compliance.

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, the DQE team has reached its findings on this requirement after observing triage meetings and MHPs conducting TS contacts; interviewing MHPs, clinical leaders, and patients; and reviewing health records and

notices to leadership. In the current period, the records review included TS Reports, progress notes, and notices when relevant, for 100 TS placements.[41]

Making and documenting clothing decisions

As detailed elsewhere in this and previous DQE reports, MDOC has established that MHPs routinely make decisions about property and privileges, including clothing, and document them on the "TS Report."

24-hour goal

In the 100-placement analysis, MHPs authorized 58 patients to retain their clothing during the first day on TS. This rate has declined in the DQE analyses in each successive monitoring period (74% in the first period and 67% in the second).

Clothing at 48 hours or leadership notice and approval

The analysis determined that, in 83% of placements, patients were permitted to be in clothing by the end of the second day. Only ten patients were in a smock for longer periods, with one being in a smock for the entire placement.

MDOC tells the DQE team that, to satisfy the notice, consultation, and approval requirements, the health care vendor includes patients remaining in smocks beyond this threshold on a spreadsheet distributed to MDOC and vendor leaders each weekday, and many of those leaders, including MDOC's Director of Behavioral Health and the vendor's Director of Clinical Programs, meet each weekday to discuss these cases and patients who may need higher levels of care. The DQE team reviewed relevant spreadsheets and meeting minutes. The patients with smocks at the three-day point were almost universally listed on the notice spreadsheet, but minutes only named 30% of these patients and did not reflect discussion of clothing specifically or approval.

Demonstrated clothing-related risk

There was a very large improvement in demonstrating that clothing was being withheld because the patient had demonstrated that they would use it in a self-destructive manner. The DQE considers this to mean that the patient made a specific threat to hang or strangle

[41] The sample was selected to study nearly all of the property and privilege decision requirements. It overlaps with, but differs from, the sample described in Paragraph 50. Placements were drawn from each of nine institutions in proportion to its percentage of therapeutic supervisions from January through June 2024. The sample favored lengths of stay longer than three days and selected 15 placements that lasted 14 days or longer. Cases were chosen from HSU and BAU placements and a mix of close and constant observation. If information conflicted between progress notes and TS Reports, the analysis relies on the TS Reports.

To analyze the requirements for clothing decisions, this study was supplemented by a review of notice spreadsheets and Daily Consultation minutes for placements where clothes had not been authorized by the third day. Where this sample was analyzed for other requirements in this DQE report, supplementary materials and sample size may vary depending on a number of factors. Descriptions of those methods and differences are available on request.

themselves; a recent hanging or strangulation attempt, possession of a ligature, or other attempts or threats of self-harm using cloth; or a history of one of those. The existence of this type of risk was documented in 73% of placements where a smock was initially ordered.

There continued to be examples at many institutions, though, of patients whose clothes were removed, either initially or as the TS progressed, where their demonstrated risk relates to inserting or swallowing items, cutting, head-banging, or jumping from heights. MHPs are encouraged to narrow the decisions to *clothing*-related risks to reach an ever-higher level of compliance.

Specific, individualized contraindications

There was even greater improvement in noting contraindications specific to the individual each day that clothing was not authorized. These were documented in progress notes in 90% of the relevant placements in the study.

Norfolk and OCCC MHPs stood out with 100% practice on withholding clothing only for specific, individualized, clothing-related risk and restoring clothing by the end of two days, with one exception each in which the reasons for extended smock use were documented daily. This was especially impressive with the large number of TS placements each of these facilities manages.

MHPs at four facilities described approaches similar to those detailed above. The DQE team also interviewed 35 patients, across all eight institutions visited, who commented on clothing. About equal numbers said they began TS in their clothes or outlined their understanding of a routine to begin in a smock and be phased into clothes as they demonstrate safety. The rates of having clothing by the second day, and reports from more people who said they spent their entire TS in a smock, appeared somewhat less complimentary than the rates seen in the records analysis. Some interviewees had very short placements, and many did not estimate the clothing-related timeframes, so the rates might or might not be expected to be comparable.

Frequency of decisions reviewed

TS Reports have been evident in health records once or twice per day, or once on Sundays for constant observation patients, in most cases the DQE team has reviewed over three monitoring periods (please see Paragraph 69 for more detail). The team has not encountered evidence that smocks are reconsidered three times per day.

Overall, MDOC took strong steps forward toward demonstrating compliance with the requirements of Paragraph 57. Sustaining good practice, making decisions more closely

related to clothing risk, and demonstrating that the vendor's Director of Clinical Programs is consulted and approves when patients are in smocks longer-term will be key to reaching 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: Based on chart reviews, MHP and security staff interviews, and observation on the units and in meetings, the DQE team has found that MHPs consistently decide daily whether to authorize showers and document these decisions on "Therapeutic Supervision Reports." In the current monitoring period, the DQE team reviewed TS Reports for 100 TS placements;[42] in every case, the patient was approved for a shower well within the required timeframe. This is consistent with practice observed in similar-sized DQE studies in each of the previous monitoring periods.

The institutions are increasingly sending documentation of showers being offered, but the DQE team does not presently have sufficient information on which to base conclusions. Five interviewed officers, most of whom said they were sometimes responsible for showers, detailed the routines for offering and providing them, and the officers affirmed that TS patients are included in those routines. Among patients interviewed at seven institutions who had a recent TS longer than three days, 93% confirmed they were offered showers. Those who estimated frequency almost all said showers took place at least three days per week, and some said it was daily. There were single examples of a patient saying officers sometimes falsely claim the patient refused, put the onus on a patient to ask, or that patients are not allowed showers when they are on constant supervision.

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

[42] Please see Paragraph 57 for a description of the study and overall methodology

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

Finding: Partial compliance

Rationale: MDOC made additional progress on this requirement in the monitoring period. As an initial matter, equipment must be installed to be able to reduce lighting. Different facilities employ light switches, key-controlled lights, or computer-controlled settings; some changes reportedly require significant electrical projects in older buildings. The DQE team has observed that installation is fully accomplished in three institutions. In the other facilities, the administration has described the plans and progress for modifications, and the DQE team has seen that the majority of those are complete as well. A site survey cited in MDOC's June 2024 status report suggests that even more progress may have been made since some of the DQE's site visits. Implementation has been limited by some equipment not working and a lack of information among interviewed officers, some of whom were unaware of the dimmer option and others who believed full lighting is required for TS patients.

On the other hand, patients' experience suggests that the use of reduced lighting is improving. Among the 33 patients who commented on lighting, almost one-third said the lights had been dimmed or off during recent TS stays. A few others were aware of the dim setting and objected that officers had not agreed to dim lights when the patient asked. A few others say it is staff's belief that dimming is allowed after a certain length of stay or is based on patients' observation status. This may be consistent with a new practice wherein MHPs indicate on the TS Reports whether reduced lighting should be permitted for each patient. Such an instruction is very likely inconsistent with Paragraph 59, which does not permit clinical judgment about lighting.

More physical plant and practice changes are needed, but MDOC is making positive steps toward fulfilling this requirement.

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: MDOC revised its "TS Report" format, initial treatment plan forms, and progress note template to prompt thinking about property other than clothes, reading and writing material, and tablets, and to record decisions about whether to allow it. This yielded substantial improvements during the monitoring period.

In the DQE's analysis of the TS Reports for 100 TS placements, MHPs authorized additional property in 69% of the sample. Frequently allowed items included medical and ADA supplies and religious items. While these categories were generally considered, they were not universally allowed, and other types of property were sometimes considered; this suggests individualized decision-making is occurring. Some patients were also permitted to have photos, a radio, legal materials, an address book, envelopes and stamps, a journal, a watch, or jewelry. Concord, Framingham, and OCCC did an extraordinary job with this requirement. Shirley and SBCC seemed to have the furthest to go to meet it.

Among interviewed patients who had spent more than one day on TS, about equal numbers said they did or did not have additional property. Consistent with the DQE team's records review, patients specified that they received items such as glasses, medical shoes, mail, legal mail, religious items, a book stand, and a radio.

The DQE team did not undertake an assessment of whether the approach taken was the least restrictive possible, but in interviews, MHPs articulated a clinically reasonable framework for making property decisions. Overall, MDOC is well on its way to compliance with the requirements of Paragraph 60.

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

Finding: Partial compliance

Rationale: As detailed elsewhere in this and previous DQE reports, MDOC has established that MHPs decide about privileges and property, including reading and

writing material and tablets, usually six days per week. They document the decisions on "TS Reports" and, more recently, in progress notes in the EHR.

During this monitoring period, the DQE's assessment included the 100-placement analysis described in relation to Paragraph 57 above. In it, reading material was allowed timely in 91% of the TS stays. In the remaining cases, mental health staff did not document individual reasons that reading material would be contraindicated on each day that the materials were not authorized.

Writing materials were permitted less often. Only 47% of the TS stays authorized writing material in the required timeframe, and an additional handful permitted it later in the TS. Here, too, there were few examples of MHPs documenting daily the specific, individual reasons that writing material would be contraindicated.

The study selected 15 patients with lengths of stay in which tablets would be required. MHPs authorized a tablet for 87% of these patients. In the two exceptions, specific contraindications were recorded daily in one case, but this requirement was not met in the other case. Additionally, MHPs allowed tablet access for many more patients well before it would have been required. Patients could access this resource in 61% of the reviewed TS stays.

Patient interviews, however, suggested that the picture on implementation was unclear. Only 55% of interviewees said they have been allowed to have books. Some said they knew of approvals, but books were not provided, while others believed it was policy to provide reading material only after several days. Patients' description of their access to writing materials was consistent with, though slightly less than, that shown in the records analysis of approvals.

Most patients reported having access to tablets; the only interviewees saying they could not were discharged from TS well before the requirement would have been in effect. Some patients noted the difficulties inherent in approving books but not eyeglasses, or approving tablets when there is no wifi in the unit where the TS is occurring.

Some of the measures above are quite high and show incremental improvement. Attention is needed for permissions for writing material and documenting contraindications for any of these items when disallowed. If the differences between authorizations and patient perception here continue, as well as patient and MHP comments elsewhere in this report about gaps in providing property, it may be warranted for MDOC to look into any barriers to implementation.

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

Finding: Substantial compliance

Rationale: Based on chart reviews, MHP and security staff interviews, and observation on the units and in meetings, the DQE team has found that MHPs consistently decide daily on property and privileges and that they document these decisions on "TS Reports." These documents have long included decisions on phone access and visits, and after more recent revisions to the progress note format, MHPs also document whether patients are allowed contact with activity therapists and religious representatives.

In the current monitoring period, the DQE team reviewed TS Reports for 100 TS placements;[43] in 99%, the patient was approved for phone calls and visits. In the rare event this was not allowed, the reasons for contraindication were not reflected in the health record. These findings are consistent with those in similar-sized DQE studies in each of the previous monitoring periods.

The large majority (82%) of patients, interviewed at seven institutions, confirmed that phone calls are allowed on TS. The others were unsure, said it would not apply to them, or thought it was not permitted. A few SBCC patients understood the policy to be that calls are allowed only after three days on TS. Patients were less clear about visits. The majority did not know or said it would not apply to them in any event. Somewhat higher numbers of prisoners thought visits were allowed than thought they were not.

Since many facilities structure their daily TS contacts to include one with an activity therapist, it is very likely that there are not barriers to this access. No patient has said they had wanted a phone call, visit, or any other routine activity and been denied.

It would perhaps be beneficial to reinforce during patient education what activities are allowed, but this sustained level of performance is sufficient for a finding of substantial compliance.

[43] Please see requirement 57 for a description of the study and overall methodology

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: MDOC revised its progress note template to prompt discussion of the reasoning for recreation decisions. Based on a study of documents for 90 TS placements that exceeded three days, the DQE team found substantial improvement on this requirement. Concord, Framingham, MTC, Norfolk, OCCC, and Shirley approved every patient for recreation within the Agreement's timeframe, including some patients on constant supervision.[44] Interviews with five MHPs reinforced this, with some indicating they would only see recreation as contraindicated if the patient was actively self-injuring or has a history of taking the yard hostage. MDOC's TS tracking shows that MASAC rarely, if ever, has a TS longer than three days, but staff noted that, should it occur, they do not believe there is outdoor space that would be safe for recreation. MASAC's

[44] In the DQE team study of privileges and property for 100 TS placements, 90 exceeded three days. Please see Paragraph 57 for a description of the study and overall methodology There was only one patient from all these institutions for whom decision-making and documentation did not comply with this requirement. MASAC did not have any patients on TS for longer than three days except those who spent much of their TS at an outside hospital.

administration hoped that this would change with the planned construction at the facility, which will eventually create new housing, treatment, and recreation spaces.

Issues with approving recreation were only present at Gardner and SBCC. At those facilities, in 60% of the stays, recreation was approved timely or there was daily documentation of the reasons recreation was contraindicated for the patient. While this rate is not compliant, practice continues to improve in each successive DQE team analysis.

It is less clear whether MDOC is providing access to recreation to the extent required by the Agreement. Institutions have begun providing some documentation of recreation being offered, but the DQE team does not currently have sufficient information to make findings based on documents. Many of the officers interviewed during this and previous monitoring periods detailed the routines for offering and providing recreation and said that they apply equally to TS patients. However, some at SBCC and OCCC, the facilities with the largest TS populations, believed recreation is not permitted for either constant observation patients or all types of TS patients.

This may contribute to some of the experiences patients reported. Across seven institutions, a slight majority said they were offered recreation, while similar numbers said it was provided inconsistently or was not offered.[45] The only clear trends were that OCCC patients most often said they were offered recreation and that patients with a TS in Norfolk's BAU said they were not. Individual patients noted barriers such as recreation being available on TS in BAU but not HSU (Framingham, Shirley), recreation categorically being denied to patients on constant observation, frequent cancellations due to modified operations and emergencies (SBCC), officers offering recreation but sometimes not pulling the patient out for it, and the disincentive of spending entire recreation periods shackled (OCCC). Themes of not accessing recreation have recurred often enough over three monitoring periods that this likely bears looking into.

During the current and previous monitoring periods, officers at six facilities almost uniformly said the routine is to have an officer continuously monitor yard time for all prisoners, and this was the case during DQE team's spot checks. This would satisfy the requirement to provide supervision consistent with the level of TS. The DQE team did not learn enough to reach conclusions about considering individualized decisions for strip searches. The team will continue to develop information in the future.

[45] This analysis includes only patients whom the DQE team later confirmed had had a TS of longer than three days and for whom MHPs had approved recreation.

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

Finding: Partial compliance

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

In practice, it does not appear that prisoners in mental health crisis are only restrained if there is an imminent or immediate threat to safety. In interviews of 19 security staff and 10 MHPs, across all visited institutions, only 40% described taking this approach. They outlined different routines in different facilities, but each facility has a practice of restraining *all* prisoners either during escort to a crisis assessment, during a crisis assessment, during escorts to TS contacts, and/or during TS contacts. Only MASAC and Framingham described making individual determinations in all of these circumstances or not restraining prisoners at all. Additionally, staff frequently mention that BAU status prisoners are always restrained out of cell; this is another categorical approach, rather than determining whether the individual poses an immediate threat at the time of contact. The routines described in these staff interviews were consistent with those voiced in previous monitoring periods.

In patient interviews, 27 patients, from six institutions, gave information about some aspect of restraint practice when calling for a crisis contact or during TS. The large majority, from all types of populations, said they were restrained during escort and during the crisis assessment. About half said they were restrained during thrice daily TS contacts, while the other half said they were sometimes or never restrained for those contacts.

Restraints for patients with mental illness is an area where collaboration is often the most effective practice. While there are requirements for making and documenting certain types of decisions, what often serves staff safety best are those conversations officers and MHPs have at the time of contact about how the patient has been behaving and what each of them prefers on whether the patient is restrained that day. Over time, some MDOC staff have described these practices, and the DQE team has seen them be highly effective in this and other carceral settings.

MDOC revised its progress note template and TS Report form to guide MHPs to advise security staff whether restraints are contraindicated for a patient. The DQE team conducted a spot check of these forms to assess practice on this element of Paragraph 64.[46] There seems to be a fair amount of confusion concerning this decision such that conclusions cannot be drawn. Most notably, MHPs noted in more than half of the sample that restraints were contraindicated for patients "per security" or because of BAU status. This answers a different question than the one being asked on the form, which seeks the MHP's clinical opinion of whether it harms the patient's mental health to be subject to restraints. The sample reflected MHPs determining that restraints *were* contraindicated in some cases, but the reasons for contraindication were not always captured. It appears more guidance would be helpful.[47]

As MDOC starts to institutionalize changes to come into compliance with Paragraph 64, the DQE team recommends considering the extent to which patients are restrained as well. During each monitoring period, there are reports of officers routinely handcuffing patients behind their backs while they are already restrained to a restart chair and keeping patients restrained while they are in split cells or visiting rooms, where they are unable to make contact with mental health staff. These additional measures do not enhance safety, while extended, painful restraint can be a disincentive to engaging in meaningful therapeutic contact and feed extended or repeat TSs and oppositional behavior. The DQE team recognizes the complexities in these decisions and remains open to discussing how to balance the different, important factors.

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

Finding: Partial compliance

Rationale: In its June 2024 status report, MDOC stated that it had sent a survey to the superintendents of each site where TS occurs about the feasibility of providing meals out

[46] The reviewer examined a subset of the property and privileges sample described in Paragraph 57. TS Reports and progress notes were reviewed for 32 TS placements; they drew from each facility that provides TS in proportion to that institution's percentage of TS placements in the monitoring period. Cases were selected from March through June 2024 to maximize the likelihood that the new information in the revised forms was routinely completed.

[47] Additionally, different MHPs recorded whether there was a mental health reason *to* restrain the patient or recorded reasoning in the progress note that seemed to support a recommendation different from the one captured on the TS Report. With the progress note format asking whether restraints are *indicated* and the TS Report format asking whether they are *contra*indicated, this may be contributing to differing perceptions of the responsibility.

of cell. As a result of that survey, MDOC concluded that, "due to Department of Public Health (DPH) guidelines, there are no locations in the areas of any institution where Therapeutic Supervisions occur that can be utilized for out of cell meals." This is a disappointing outcome, as communal meals can be an important therapeutic and rehabilitative activity. It also contradicts information provided to the DQE during the previous monitoring period, when OCCC reported that it provides meals out of cell to prisoners on TS in the BAU. Upon further clarification with MDOC in September 2024, it appears that meals could be served out of cell in the BAU at OCCC, but the decision would be "subject to safety/security concerns" and would require a mental health assessment about clinical appropriateness. It is not clear whether out-of-cell meals have ever occurred in practice.

When asked in August 2024 to explain the DPH guidelines that prohibit meals out of cell in *all* the locations across MDOC where TS occurs[48], MDOC provided the following response:

> DPH regulations are one reason for the limitations, but that is not the only reason MDOC is unable to accommodate out of cell meals. The sites were surveyed and it has also been determined that space is insufficient for meals.
>
> The DPH regulations that govern MDOC facilities expressly incorporate by reference, at 105 CMR 451.200, all the DPH regulations for food establishments (105 CMR 590.000: *Minimum Sanitation Standards for Food Establishments State Sanitary Code Article X*), which, in turn, incorporate the 2013 Food Code issued by the FDA. Thus, by virtue of 105 CMR 451.200, the DPH regulations set forth in 105 CMR 590 e*t seq.,* and the 2013 Food Code issued by the FDA (subject to any amendments/limitations in 105 CMR 590 series) expressly apply to MDOC correctional facilities.

The detailed references to sections of the CMR and FDA guidelines are helpful, but they do not explain what parts of these regulations are violated by serving out-of-cell meals in, for example, the BAU at MTC (which as a dedicated group treatment space and is not a traditional health care setting) or a housing unit at SBCC. It is still not possible for the DQE team to determine whether every TS location falls within Paragraph 65's exceptions to the requirement that meals be provided out of cell: (1) if space is insufficient, or (2) if prohibited by Department of Public Health regulations. Therefore, a partial compliance finding is being issued.

[48] See Paragraph 139 for a detailed breakdown of TS locations during this monitoring period. They include BAUs, housing units, and specialized treatment programs, not just Health Services Units, where DPH regulations might be expected to apply.

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 patients on TS, Monday through Saturday, with a single contact on Sundays and holidays for patients on constant observation status. Those findings were based on staff interviews, onsite observations of contacts and meetings, and review of charts and other documents; the DQE team continued to employ those methods during this monitoring period and found sustained practice.

While this satisfies a substantial amount of the Paragraph 67 requirements, MDOC and DOJ disagree about whether this Agreement provision allows reduced contact on weekends and holidays. The DQE must assess based on the Agreement language ("three daily out-of-cell mental health contacts") unless MDOC and DOJ reach a different understanding.

For this report, the DQE team analyzed 100 therapeutic supervisions and found that only 35% of *placements* were fully compliant with three daily out-of cell-contacts.[49] While low, this rate has increased during each monitoring period.

[49] See Paragraph 50 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 if it was completed or the patient refused.

Moreover, the number of missed *contacts* also continues to improve and is approaching a reasonable rate. That is, 83% of required contacts were made. Of those not completed, 87% were on a weekend or holiday. According to progress notes, institutional factors and MHP workload did not pose a significant barrier to completing contacts. Practice was similar across institutions.

A minority of contacts in the sample (47%) took place out of cell, which appears to be a decline from past practice.[50] While institutional factors and MHP workload did not cause many *missed* contacts, these did cause a substantial amount of the cell-front contacts (20%), which is concerning.

MHPs documented the patient declining to come out of cell or refusing the contact altogether as the reason for the large majority of cell-front contacts. Refusals were far more prevalent at OCCC, Shirley, and SBCC than at the other facilities, raising questions about systemic factors that may deter prisoners from coming out of cell.

During this monitoring period, templates in the medical record were revised to help staff capture the prisoners' reasons for declining out-of-cell contacts. Follow-up attempts to meet with a prisoner who refuses contacts have not been apparent 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. This limitation is worst at SBCC, where modified operations due to security understaffing, combined with an inability to schedule use of the limited treatment spaces on the housing units where TS occurs, often leave MHPs unable to see patients even once, let alone a second time. Similarly, the HSU at SBCC provides just one out-of-cell room in which MHPs can conduct TS contacts; this room is also used for crisis contacts and is often occupied.

In interviews, about two-thirds of patients confirmed being seen three times per day while on TS. A similar number noted that contacts are usually out of cell or that patients choose whether to meet in or out of cell. Interviewed security and mental health staff almost universally confirmed this practice and specifically identified the spaces routinely used. Where interviewees estimated the rates of out-of-cell contacts, their estimates were consistent with the data in the DQE team's review. Few interviewed patients described their reasons for choosing a cell-front contact, but among those who did, the reasons were personal and not a result of institutional culture or barriers, with one exception.

[50] Where no location was indicated, the contact was counted as being out of cell.

A significant minority of patients, however, reported there is a set routine for a certain contact to be cell-front (for example, the first contact of the day), that all contacts were cell-front, or that they sometimes requested an out-of-cell session that was not provided.[51] The DQE team observed too few TS contacts during the site visits to determine whether these reports of systematized cell-front contacts are consistent with actual practice. MDOC's recently revised progress note template, which now tracks the location and timing of TS contacts, may allow more detailed analysis in future monitoring periods.

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: MDOC has updated its template for triage meeting minutes to prompt the mental health staff to discuss and record whether each TS contact (1) occurred or was refused, and (2) occurred cell-front or out-of-cell. In the DQE team's study of 100 TS placements,[52] the reviewer assessed the frequency and reasons for refusals and staff's response as described in progress notes and triage meeting minutes. There were 48 TS stays that involved more than *de minimis* refusals to come out of cell or to meet at all. Triage meeting minutes did not capture discussion of these refusals, but they did note in most cases that a contact was refused or that the patient declined an out-of-cell contact. This is a good start toward demonstrating compliance with subsections (1) and (2) of Paragraph 68.

Although the minutes did not often reflect it, the DQE team did notice a positive change in the quality of clinical discussions when observing triage meetings during the site visits. There were more substantive discussions involving staff from multiple disciplines (e.g., MHPs, psychiatry, Support Persons, security staff), trying to understand the patients' motivations underlying their behavior. Some of these discussions included hypotheses about why a prisoner was not engaging with mental health staff, including being angry with particular staff members, not wanting to get out of bed in the early morning, being

[51] Eleven custody or mental health staff and 31 patients commented on some or all of these points. Where patients did not confirm the three-contacts-per-day practice, they thought contacts occurred once or twice per day and a few said there were missed days. Patients reporting undesirable out-of-cell contact practice were not concentrated at any particular institution.

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

intoxicated or confused, not wanting to come out of cell while wearing a smock instead of regular clothing, and wanting to prolong a TS stay to avoid an undesirable housing placement.

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, the DQE team has verified that MDOC and its vendors have a well-established system for generating and updating these documents ("Therapeutic Supervision 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. Using similar methods, the DQE team confirmed that the practice is sustained, leading to a substantial compliance finding.

In the DQE team's review of the electronic health records from 100 recent TS placements,[53] 91% showed daily TS Reports on Monday through Saturday. This shows continued improvement from previous monitoring periods. For patients on constant observation on a Sunday, TS Reports were on file for 85%.

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

The DQE team offers one caution. It caught the reviewer's attention that, in more than 25% of cases at SBCC, TS Reports showed permissions for some property vacillating day to day without clear indication that this was deliberate.[54] While the team did not systematically examine this, it was apparent in at least a few cases at other institutions. Such a practice has the potential for confusion and frustration among staff and to lead to

[53] Please see requirement 52 for a description of the overall chart review. For this study specific to requirement 69, the reviewer examined the electronic health records for the sampled cases and, if a relevant document was missing, MDOC was given the opportunity to produce it from IMS, the information system in which it is originally stored. Thus, MDOC has confirmed that, where a Therapeutic Supervision Report was missing in the study, this is an accurate reflection of practice.

[54] In these cases, contemporaneous progress notes did not indicate an intention to remove or restore the item, and/or the progress note content conflicted with the Therapeutic Supervision Report. The property showed as allowed on Day 2, not on Day 3 and 4, again on Day 5, not on the following day and so on, without a change in risk or circumstances, for example.

oppositional behavior by patients that can escalate. Improving the consistency and accuracy of TS Reports could pay significant dividends for corrections and mental health staff already stretched thin and working with a highly demanding population.

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

Finding: Substantial compliance

Rationale: This area is unchanged except that MDOC revised its TS progress note template during this reporting period. The DAP format was preserved, and clinicians are now prompted to document several additional items related to the Agreement:

- Whether the contact was out of cell
- The reason for cell-front contact
- Approved property and privileges
- Treatment goals and any necessary revisions
- Whether consultation with an upper-level provider is indicated

In the DQE team's chart review of 100 TS placements, first described in conjunction with Paragraph 50, clinicians documented their attempted interventions in each case. Descriptions of these interventions and the prisoner's response were succinct, generally stating what the clinician said or did and whether the prisoner was "receptive" or "agreeable." When a patient did not engage, the clinician documented what they tried to do and how the patient responded, such as ignoring the clinician or declining to meet out of cell. In cases where the patient did not engage, many clinicians demonstrated good practice by documenting information from collateral sources, such as medication compliance records and officers' reports of a prisoner's behavior, sleep, meal completion, hygiene, and recreational activity.

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

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

Finding: Partial compliance

Rationale: MDOC logs continue to show that, in the large majority of self-injury incidents during TS, patients use only their bodies (for example, head-banging, scratching, or jumping from a height). There were, however, substantially more events than in the previous six months of patients attempting hanging or asphyxiation, ingesting or inserting objects, or using items to cut themselves. In some cases, it would have been very difficult to avoid access to the items used (for example, paint chips and the security smock), while a few other cases were more concerning. It appears promising that no overdoses were reflected.

In the DQE team's study of 100 TS placements,[55] there were 10 TS stays in which patients injured themselves. This is similar to the rate of TS self-harm determined by a comparison of MDOC lists of TS placements and self-injury, so the cases examined may fairly represent overall practice when it comes to reassessing care. It is noteworthy, however, that the DQE team's analyses have identified a small but increasing number of self-injury incidents that are not captured in MDOC's Self-Directed Violence tracking.[56]

MHPs reassessed the patient's care after self-injury, or no reassessment was clinically indicated, in 90% of the relevant cases, according to the DQE's judgment. This appears to be improvement since the previous monitoring period. This may reflect greater emphasis by MDOC's clinical leadership. For example, Wellpath provided documentation of training its staff about the need to reassess patients after SDV that occurs while on TS; OCCC completed this training on June 6, 2024. It is not clear whether other facilities will be scheduled for similar training under VitalCore.

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

Finding: Partial compliance

Rationale: Paragraph 72 focuses on the quality of treatment provided to prisoners on TS, including meaningful, out-of-cell group and individual therapy. As described above, the expectation for MHPs to conduct three daily contacts with TS patients, Monday through Saturday, is well established throughout MDOC. In the DQE team's study of 100 TS

[55] See Paragraph 50 for a description of the study.
[56] In its study of 100 TS placements, the DQE team identified 10 cases where SDV occurred by reading the progress notes in the EHR. In three of these cases, all at SBCC, the incidents of SDV found in the progress were not captured in the facility's SDV log.

placements, first described in Paragraph 50, 44% of mental health contacts occurred in a non-confidential setting (i.e., cell-front). Another 17% of contacts that should have occurred under the criteria articulated in Paragraph 37 were not completed.[57] This leaves 42% of contacts required under Paragraph 67 occurring in a confidential, out-of-cell space, which is increased from 34% during the last monitoring period. All recorded contacts were individual; the DQE team found no examples of group therapy occurring for prisoners on TS during the current study.[58]

MDOC cannot be expected to provide out-of-cell therapeutic interventions when a prisoner refuses to engage with MHPs or prefers to speak cell-front, provided that reasonable efforts are made to facilitate and encourage out-of-cell contact. During the DQE team's site visits, it did appear that such efforts are being made at most facilities, but some facilities still had high rates of cell-front contacts because of "institutional factors." In the study of TS medical records, 9% of completed TS contacts occurred cell-front at the direction of security staff, with higher-than-average rates at Shirley, SBCC, and Framingham. In addition, it is not clear to what extent security practices such as shackling prisoners' hands behind their backs during out-of-cell mental health contacts contributed to the rate of refused TS contacts. During the DQE team's site visits, this practice remained prevalent throughout MDOC, with most prisoners who are "BAU status" being shackled during mental health contacts, sometimes even when sitting in a different room from the clinician.[59]

The DQE team continued to observe examples of meaningful, therapeutic interactions between patients and MHPs during the site visits, but some concerning patterns from the chart reviews persist. For example, in 10% of TS cases, no out-of-cell contacts took place at all prior to the discharge contact; practice in this area was worst at SBCC and Shirley. In many cases, contacts occurred but were very brief. For example, one patient at OCCC was seen for a total of 26 minutes over a five-day TS placement, while another had only one contact lasting longer than five minutes over a five-day TS placement. At SBCC, a prisoner was denied out-of-cell contacts on nine occasions during a six-day TS placement because of institutional factors. While these cases are not the norm observed in the DQE team's study of 100 TS cases, they happened often enough to warrant ongoing concern.

[57] This deficiency rate includes three contacts on Sundays and holidays, which are required under Paragraph 37 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.
[58] At MTC, the same unit houses both BAU and TS prisoners. Wellness groups are offered in that unit, but the DQE team did not encounter cases during the chart reviews where TS prisoners participated.
[59] For example, the BAU and HSU at OCCC use a "split cell" for mental health contacts, where the clinician and patients are in separate rooms, talking through a plex-glass window. Some prisoners remained shackled under these circumstances.

During the DQE team's site visits, observations of MHPs' TS contacts also raised concerns about the clinicians' skill level when interacting with patients in crisis. As noted in the *Staffing* section of this report, most of MDOC's clinicians are unlicensed, generally because they have recently graduated from a degree program and are still working toward meeting the requirements for independent licensure. The clinical workforce is inexperienced, and some of this inexperience was on display during the site visits, especially when combined with time pressures to see patients and with security practices that dissuade out-of-cell contacts. The clinicians clearly care deeply about their work and are good at, for example, suggesting ways for prisoners to pass the time with worksheets and puzzles. They remain less skilled at conducting real therapy, despite using mental health terminology in their documentation. For example, one MHP wrote in a note, "[This] writer provided reflective listening, [acceptance and commitment therapy], thinking errors, thought challenges, and reframing," when describing a three-minute patient contact. It is not clear how all those therapeutic modalities could occur in a such a brief interaction.

The DQE's impression remains that understaffing and inexperience of MHPs contribute significantly to the problem with the quality of care with therapeutic supervision. MDOC also has created a system with poor continuity of care for TS (i.e., the patient will often be seen by different clinicians during every shift and every day of a TS placement), which can make it difficult to build rapport, engage patients in true therapy, and measure progress. Finally, the lack of a multidisciplinary approach to TS placements may also be contributing to the limited quality of therapeutic interactions, as less experienced MHPs may have few opportunities to see patients together with other members of the treatment team, leaving them with a limited skill repertoire.

Significant improvement in this area is needed before MDOC can be considered compliant with the requirements of Paragraph 72. The DQE does see signs of improvement, especially around multidisciplinary case discussion of patients on TS. At OCCC and MASAC, MHPs also reported seeing TS patients together with psychiatrists, which is another positive step.

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

Finding: Partial compliance

Rationale: Paragraph 73 focuses on individualization of treatment decisions and documentation of those decisions in the health record. During the DQE team's

interviews with MHPs and clinical leadership, it was clear that they intend to provide individualized, out-of-cell therapeutic activities for prisoners on TS three times daily. Generally, the first daily contact is focused on assessing a patient's risk, while the other two might be therapeutic or recreational/activity contacts.

The challenge remains not with the structure of TS treatment, but rather with the implementation and individualization. As in previous monitoring periods, many prisoners spoke of receiving pre-assembled psychoeducation and activity packets through the institutional mail, and the DQE team observed this practice during the site visits. However, during the review of 100 TS patients' charts, the DQE clinicians observed a better match between the patient's presentation and the clinician's planned interventions, indicating a higher degree of individualization. For example, in a case at Concord where a patient lit a fire in his cell out of frustration with housing conditions, the identified strategies on his treatment plan included identifying coping skills to use when frustrated about lack of phone access, completing distress tolerance worksheets with the mental health staff, and learning pathways to advocate for himself with security administration. Not all the plans were this well-considered, with many including generic treatment interventions such as "engage in mental health contacts," "participate in collaborative safety plan," and "be treatment compliant," regardless of the events precipitating the TS placement. Clinicians generally did little to include the underlying reasons for a patient's behavior into the treatment planning. For example, several patients in the DQE's study of TS treatment plans were placed on TS because of agitation and lack of participation in a risk assessment during their BAU screening. The treatment plans made no mention of understanding why the patients were agitated as a goal of the TS placement, instead listing goals like "engage with MH in TS contacts, maintain safety of self and others, utilize prosocial communication skills." These treatment goals are not necessarily incorrect, but they do seem to be missing the main point of assessing what led to the BAU placement, what the patient's baseline level of functioning was, and what strategies might be needed to get the patient back to baseline.

Overall, individualized treatment plans remain a work in progress, but there has been improvement during this monitoring period. MDOC's documentation of clinical contacts remains good, with clinicians now taking care to record the start time, stop time, and setting of TS contacts, in addition to the clinical details of the encounter. There is no systematic way to assess whether some TS contacts were not documented in the medical record, but the DQE team did not encounter any such examples in the review of 100 TS placements.

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

Finding: Partial compliance

Rationale: The therapeutic de-escalation room at Shirley has existed since the Agreement began. During the DQE team's site visits to MCI Shirley, officers, mental health staff, and prisoners reported that 1:1 contacts with mental health take place in the therapeutic de-escalation room. Although group therapy can, in theory, be conducted in that room, it has not been used for that purpose because not enough patients were on TS simultaneously to warrant holding a group.

MDOC made progress in creating a therapeutic de-escalation room in the ISU; in fact, two such rooms are planned. At the time of the July 2024 OCCC site visits, the rooms were still empty, but the plan was for them to contain molded plastic rocking chairs and soothing sensory items. Once these rooms are properly outfitted and used by patients in the next few months, the DQE anticipates that MDOC will be substantially compliant with the Paragraph 74 requirements.

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

Finding: Partial compliance

Rationale: No formal decisions have been made about the use of peer support for patients on TS, but MDOC provided an update in its June 2024 status report. MDOC noted that peer support programs are being developed at Framingham and Norfolk, and if they are successful with non-TS prisoners, they would then be considered for use with TS prisoners.

During the DQE's site visit, Framingham's leadership reported that they were in the process of revitalizing their facility-wide peer support program, which had dwindled during the pandemic. As of May 2024, the facility had recruited 19 prisoner volunteers and anticipated offering a 6-week training in June. The peer support plan included having a monthly newsletter, BAU and ITU rounds, and a drop-in center. Framingham's leadership reported that they were already using peer support for one prisoner in the BAU. Minutes from the QIC meeting on June 27, 2024, indicate that the program was "up and running."

The QIC meeting minutes indicate that Norfolk's peer support program is also being developed, though its schedule is a bit behind Framingham's. As of May 2024, Norfolk was working on a training curriculum, and it had not yet started recruiting volunteers.

The QIC meeting minutes from June 27, 2024, indicate that there had been no recent movement on the project.

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

Finding: Partial compliance

Rationale: MDOC's June 2024 status report indicates that they continue to discuss the use of therapy dogs for prisoners on TS, but the project has been placed on hold during the transition to VitalCore. Wellpath leadership had been investigating the prospect of working with an agency that provides therapy dogs, but this agency's staff stated that they were no longer interested. Hopefully, VitalCore will resume investigating options for therapy dogs with patients on TS, as this idea was nearly universally supported by the patients and staff the DQE team asked during the site visits. MDOC prisoners work with dogs in other contexts, training puppies to become support animals for disabled individuals in the community, so the precedent for engaging dogs with prisoners in a positive manner has already been set.

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: Partial compliance

Rationale: As in the earlier monitoring periods, MDOC generally facilitated expedient transfers to psychiatric hospitals once a prisoner was identified as needing that level of care. The DQE's detailed assessment is broken down by type of transfer below. Overall, practice in this area appears to be going well. However, since this is the first monitoring period for Paragraph 77, which became active on December 20, 2023, and because MDOC is in the midst of a healthcare vendor transition, more demonstration of practice will be needed for a substantial compliance finding.

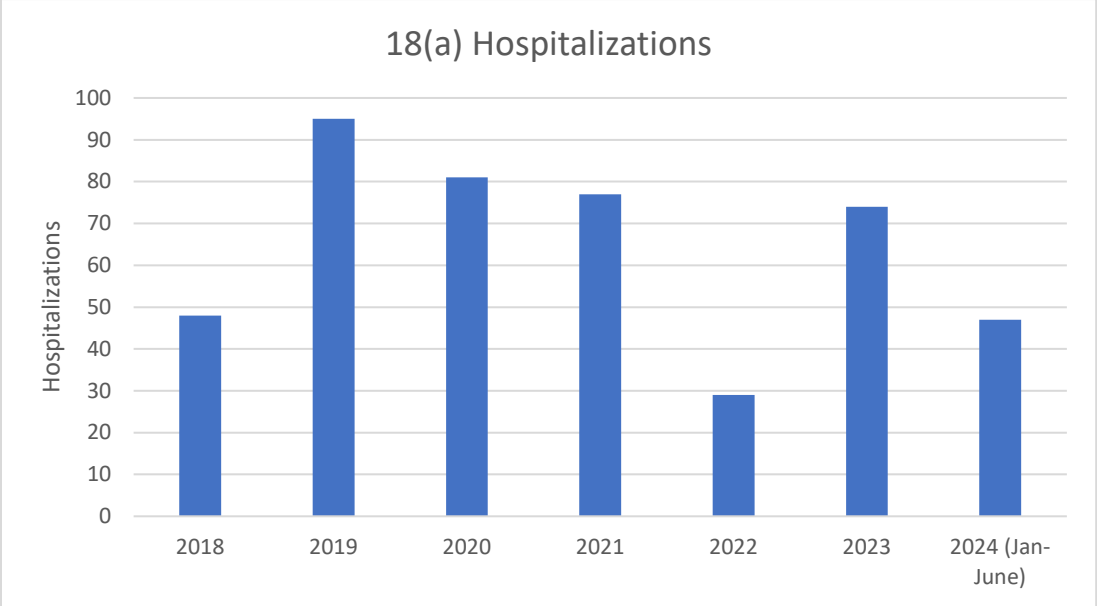
Outside hospital transfers under Section 18(a)

Data from MDOC's log of transfers to higher levels of care indicate that, between January and June 2024, 47 patients were transferred to an outside hospital under Section

18(a). Most transfers were initiated by staff at OCCC (38%) and SBCC (26%), but all eight institutions transferred at least one patient.[60] Upon commitment by the court, 42 patients were admitted to the ISOU at Bridgewater State Hospital, the only option available for male patients. The five female patients committed under Section 18(a) were transferred to Department of Mental Health (DMH) facilities: Solomon Carter Fuller Hospital and Taunton State Hospital. All but two patients were transferred on the same day they were committed by the court. Two patients experienced delays of one and five days, respectively, 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.

MDOC's suicide prevention training includes data about 18(a) hospitalizations from 2018 to 2023, to which the DQE added data from January-June 2024. This is illustrated in *Figure 6.*

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



The year-to-year variability is too great to draw meaningful conclusions from these data, especially since some years were heavily impacted by the COVID pandemic. For now, one can say only that MDOC is on track to match its highest number of annual 18(a) hospitalizations by the end of 2024.

Outside hospital transfers under Section 18(a1/2)

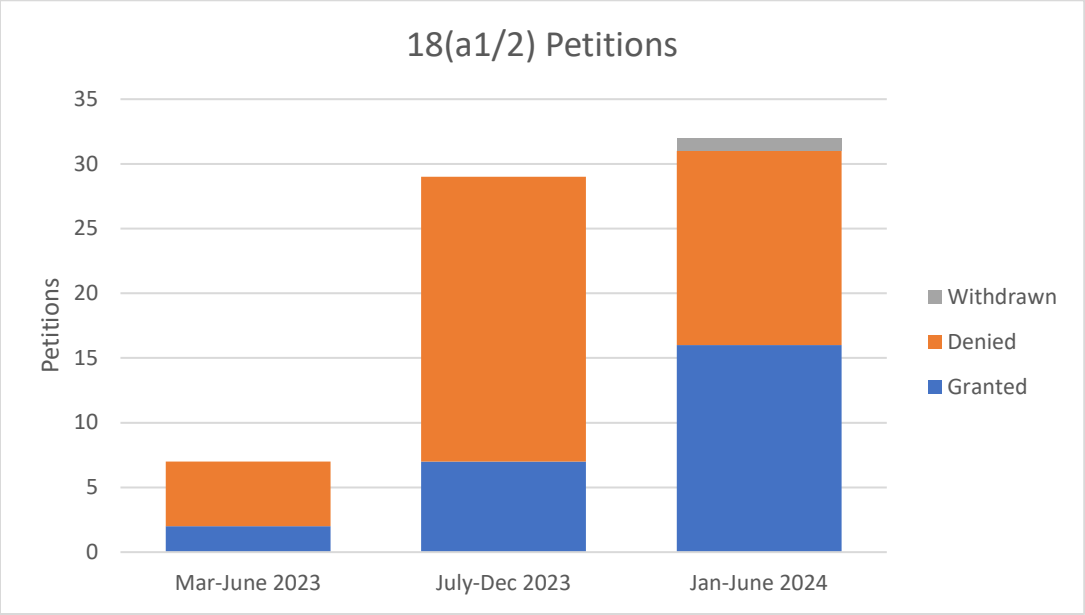
[60] Patients at MASAC are not eligible for 18(a) transfers; they are discussed in relation to Section 12 transfers below.

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

MDOC's data indicate that the law is being used more often. Between January and June 2024, 32 prisoners petitioned the courts under Section 18(a1/2), and 16 of these petitions were granted.[61] An average of 2.3 days elapsed between the court's notice to MDOC of the 18(a1/2) petition and MDOC's transfer of the patient to a psychiatric hospital. In all 16 cases, the patients were admitted to a hospital for evaluation, but none were determined to need longer-term hospitalization according to DMH's assessment. They returned to MDOC within the 30-day assessment period, usually after just a few days. Of note, the DQE team learned during the site visits that DMH is employing an abbreviated assessment methodology at Bridgewater State Hospital for patients admitted under Section 18(a1/2) when compared to those admitted under Section 18(a). This practice seems inconsistent with the spirit and intent of Section 18(a1/2), but it is out of MDOC's control.

MDOC began tracking 18(a1/2) petitions in March 2023, and it appears that such petitions are steadily increasing, as illustrated in *Figure 7.*

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



[61] Of the remaining petitions, 15 were denied by the court, and one was withdrawn at the prisoner's request.

Outside hospital transfers under Section 12

The DQE has learned during three site visits to MASAC that transferring patients to outside hospital emergency departments (EDs) for psychiatric evaluation is a routine matter. This occurs when a patient has been assessed by the mental health staff at MASAC and determined to need a higher level of psychiatric care than MASAC offers. Some of these patients are committed under M.G.L.c. 123 §12 after being evaluated in the outside hospital ED. This commitment is initiated and facilitated by the hospital staff, but MASAC's security personnel stay with the patient until they are admitted to a psychiatric hospital unit.

Data from MASAC's TS Registry indicate that patients were sent to the hospital for Section 12 evaluation in 40% of TS cases between January and June 2024. The DQE observed discussions of such patients during each site visit, and MASAC's clinical leadership reported that the process works relatively smoothly, though sometimes it takes several days for a patient to move from the ED to a psychiatric unit. The delays are due to bed availability in community hospitals, which is beyond MASAC's control.

Outside Hospital Transfers under Section 15(b)

A small number of patients are transferred to outside hospitals for competency to stand trial evaluation under Section 15(b). In the first half of 2024, six such transfers occurred. Two of the patients were on TS at the time.

Secure Treatment Program and Behavior Management Unit Transfers

Between January and June 2024, six patients were referred to the Secure Treatment Program (STP) at SBCC, and no patients were referred to the Behavior Management Unit (BMU). In cross-referencing data from the TS registry with data from the STP referral log, it appears that only one of these patients was on TS when referred to the STP. This patient was transferred within five days of referral. Overall, the data indicate that STP placement is not often utilized as a pathway out of TS, which is consistent with MHPs' reports during the DQE team's site visits. MHPs reported that they do not consider the STP and BMU particularly therapeutic because of the restrictions on patients' movement, so they try to avoid referring to these settings if other options are available and appropriate.

Residential Treatment Unit and Intensive Stabilization Unit Transfers

As described in Paragraph 115, the ISU did not accept its first referral until August 1, 2024, so its functioning was not assessed for this report. The Residential Treatment Units (RTUs) continued to operate at OCCC, Gardner, SBCC, and Framingham. The RTU at Gardner moved to a new location and has 10 additional beds, while the RTU at OCCC has 12 fewer beds. To the DQE's knowledge, these changes did not cause any delays in

patients being transferred from lower levels of care, though some Gardner RTU patients did express strong feelings to the DQE about the disruption to their routines caused by the move, as well as MDOC's recent practice of housing small numbers of general population prisoners in the RTUs.

In June 2024, the RTUs remained about 60% full, as described in Paragraph 139. MDOC's data indicate that 20 patients were referred to the RTU in the first half of 2024, and all were accepted into the program. Six of these patients were on TS at the time of their referral, indicating that some patients do use the RTU as a higher (or longer-term) level of care after discharge from TS. The time from referral to transfer was highly variable, from between 0 to 58 days. Some patients were admitted to the RTU even before the formal referral was completed, while another waited almost two months while housed in the BAU at Shirley, the same setting in which he had attempted suicide twice in the weeks preceding his TS placement. It is not clear from the medical record what accounts for the delay, but MDOC explained to the DQE that the patient was waiting for the resolution of a complex security matter before he could be cleared for RTU placement. MDOC reported that the patient received enhanced mental health services during the waiting period, but from the DQE's review of the medical records, it appears that this enhanced treatment included only two additional mental health contacts,[62] both cell-front, for 2 and 6 minutes each.

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: MDOC's registry of TS placements indicates that 254 stays (45%) lasted three days or longer between January and June 2024. In the DQE team's review of 100 TS placements, first described in Paragraph 50, there were 64 TS placements for which consultation, notification, and higher level of care consideration should have taken place under this requirement. To assess compliance, the DQE team reviewed formatted notifications, notification spreadsheets, daily consultation call minutes, progress notes, and higher level of care referral tracking; observed daily consultation calls; and consulted with MDOC about interpreting some information.

[62] Between the time of his TS ending and his transfer to the RTU, the patient was seen 4 times by an MHP and once by psychiatry. Two of the MHP contacts occurred according to the routine of seeing patients once in 30 days, so the DQE counts only two "enhanced" sessions of 2 and 6 minutes' duration.

Consultation with the Program Mental Health Director appeared to be the least successful component of this requirement. To fulfill its consultation obligations, MDOC convenes an online meeting each weekday with the leaders specified in Agreement paragraphs 78 through 80. The DQE team observed four such meetings during the monitoring period and seven in the previous period. The site Mental Health Directors update the MDOC and vendor clinical leaders with useful, detailed information about the patients' functioning, treatment, and institutional concerns. In both observations and an extensive review of meeting minutes, it appears rare for the leaders to provide feedback about diagnosis, formulation, or treatment, as would be typical of a consultation.[63] Feedback about systemic issues (e.g., anticipated outcomes of the classification or disciplinary process, or suggestions about coordinating between mental health and security staff at the facility) occurs more commonly. It appears the Program Mental Health Director is not always able to attend the meeting, with participation documented in 61% of the sampled cases. This is, however, an improvement over the rate seen in previous DQE analyses.

As a routine practice, the healthcare vendor notifies MDOC's Director of Behavioral Health and other leaders each weekday, either by a templated form or a spreadsheet, of the patients whose lengths of stay had reached three or more days. The DQE team has confirmed this in documents MDOC provides monthly, along with a sample email demonstrating the distribution list. In the above-referenced analysis, notices were demonstrated in 91% of the cases. The notice has been expanded to highlight various treatment, property, and privilege requirements, which should be helpful to the consultation discussions and to Agreement implementation oversight.

Documented consideration of a higher level of care was evident in two-thirds of reviewed health records and typically took the form of a conclusory statement that a higher level of care was not warranted. This, too, is an improved rate over that found in previous DQE analyses. Notably, 11 patients were identified at this stage as needing a higher level of care and transferred soon afterward.

Overall, MDOC has made some effective changes in support of meeting this requirement and is making progress toward that end.

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

[63] Some of the meeting minutes refer to upcoming internal case conferences (ICCs) or inter-facility case conferences (IFCCs) about patients, where more detailed clinical consultation may be occurring.

individualized reasons if a higher level of care is not clinically indicated in the medical record using the Description/Assessment/Plan (DAP) progress note.

Finding: Partial compliance

Rationale: The DQE team has confirmed MDOC's system for accomplishing this consultation and documented consideration of a higher level of care, as described in Paragraph 78. MDOC's tracking system shows that 59 TS placements (10%) between January and June 2024 lasted 7 days or longer. The DQE reviewed a subset of 21 such cases, selected specifically to assess compliance with Paragraph 79. The sample includes cases from all institutions where a patient had this length of stay during the monitoring period.

Minutes from the daily TS consultation meetings demonstrate that the Program Mental Health Director, Site Mental Health Director, MDOC Director of Behavioral Health, and Assistant Deputy Commissioner of Clinical Services convened concerning 62% of the sampled cases, meeting the specific attendance requirements of Paragraph 79. In most of the remaining 38% of cases, the patient was on the meeting agenda, but not all of the specified leaders were able to attend. This demonstration is much improved from the previous monitoring period.

Facility staff documented that they considered a higher level of care at the 7-day benchmark in 76% of examined cases, and three patients were found appropriate for transfer. The reasons that a referral was not clinically indicated were only made explicit in 39% of the relevant cases, however.

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

Finding: Partial compliance

Rationale: MDOC tracking shows 26 TS placements in the monitoring period (5%) with a length of stay exceeding 14 days. The DQE team examined records for eight of them, drawn from all five institutions that had such lengths of stay.

In Paragraph 78, we also described MDOC's system designed to ensure that the notification and consultation requirements of Paragraphs 78 through 80 are satisfied. The sampled records demonstrate that the leadership does meet each weekday and that the site Mental Health Directors present these longer-term patients on each weekday after the fourteenth day. Minutes showed that required personnel's participation fluctuated significantly, however; there were almost no patients for whom the entire specified leadership group met about that patient on every required day.

MHPs usually documented considering a higher level of care at Day 14, but specific, individualized reasons that a transfer was not indicated were recorded for only one patient. Only one of these patients was thought to need a higher level of care. Health records reflected a change in treatment for half of these patients on or after Day 14, although DQE team observations of the daily consultation calls and interactions with MHPs onsite suggest that more changes in treatment approach are being attempted than recorded. As discussed in relation to Paragraph 139, only one TS placement lasted longer than three months during this monitoring period, which may stem from the enhanced TS consultation process under the Agreement.

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, and Wellpath policy 66.00, Therapeutic Supervision, contain identical language for stepping down patients from constant to close observation before discharge. The DQE has reviewed MDOC's proposed revisions to policy 105 DOC 650, and they remain consistent with the requirements of the Agreement. No information is known about VitalCore's TS policies. In order to maintain its substantial compliance in the next reporting period, MDOC will need to demonstrate that VitalCore has a TS policy that includes a procedure for decreasing supervision levels and discharging patients from TS.

In the DQE team's study of 100 TS placements, 55 prisoners' placements included time on a constant watch. All these patients were either stepped down to close (15-minute) watch before discharge, or they were transferred to an outside hospital pursuant to M.G.L.c. Sections 18(a), 18(a1/2), 12, or 15(b). The post-discharge follow-up contacts

are also widely implemented, as detailed in the DQE's analysis of Paragraph 84. Overall, MDOC remains substantially compliant with the requirements of Paragraph 81.

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

Finding: Partial compliance

Rationale: MDOC's policy and practice requires that MHPs perform a suicide risk assessment before discharge from therapeutic supervision. The DQE team has observed the "Discontinuation from Therapeutic Supervision" form in consistent use in chart reviews conducted during each monitoring period. The template was revised in March 2024 along with several other clinical documentation templates to capture additional information such as the location of the contact. The MHP's risk assessment at the time of discharge is still included in this form.

In the DQE team's recent analysis of 100 TS placements, the discontinuation form was again present in all relevant cases except one. Where the location of the discharge assessment contact could be discerned, 75% were conducted out of cell. Norfolk and MASAC had especially strong practice. Concord, Shirley, and SBCC had particularly low rates of out-of-cell contacts. MHPs did not always record the reasons for cell-front assessments.[64]

[64] In the study first described in conjunction with Paragraph 50, there were 83 TS stays in which one would expect to find a Discontinuation of Therapeutic Supervision/MH Watch form. Among these cases, 65 recorded the location of the contact. Other sampled cases would not have such a risk assessment because they were transferred to another institution's therapeutic supervision, transferred to an outside psychiatric hospital, or released directly from TS to the streets.

Where the patient had been placed on TS because of a risk of self-harm, the MHPs universally documented that the patient presented a low risk of imminent self-injury at the time of discharge.[65]

In terms of consultation about discharge, the DQE team has observed there is a well-established routine of considering potential discharges during weekday meetings of the mental health team, referred to as triage meetings. However, meeting minutes and the electronic health record indicate that only 66% of studied discharge decisions were made in this setting. Most commonly, decisions made outside of that meeting were made in consultation with the site Mental Health Director or other supervisors, either later on a weekday or on a Saturday. The study thus showed compliance with the supervisor consultation requirement at a rate of 89%.[66]

The DQE clinicians also examined a set of records to determine whether consultation with an upper-level provider at the time of discharge was clinically indicated.[67] As a preliminary matter, the DQE clinicians reviewed nationally accepted guidelines, including the NCCHC *Standards for Mental Health Services in Correctional Facilities* (2015) and American Psychiatric Association's *Psychiatric Services in Correctional Facilities, Third Edition* (2016), about the clinical indications for such consultations. The NCCHC guidelines are silent on the matter, while the APA guidelines indicate that all suicidal patients should be evaluated by an upper-level provider prior to discharge or step-down: "Any mental health clinician may order an increase in monitoring level, but a decrease in level may be ordered only by a psychiatrist or doctoral-level mental health clinician after an in-person evaluation" (APA, p. 15). The DQE clinicians did not employ a standard this high, though we continue to recommend a multi-disciplinary "rounds" approach to seeing patients on TS, with MHPs and upper-level providers seeing patients and assessing risk together daily. For the purposes of the current assessment, the DQE clinicians employed clinical judgment, considering an upper-level consultation indicated in cases such as: (1) a patient was newly admitted to the facility and had not

[65] In the sample, 73 TS placements were initiated for this reason (the other placements arose from concerns about harm to others or potential psychosis). In each case, MHPs documented "low" or "mild" in the sections rating Risk and Global Rating of Distress. The initial Crisis Treatment Plan no longer has these sections, so it is not always possible to discern whether the MHP found the risk to be *lower*, though some progress notes contained descriptions to this effect.

[66] In the 100-TS analysis described in Paragraph 50, there were 83 discharges back to MDOC housing. The analysis for the instant requirement relies on the TS Registry, Triage Meeting minutes, Discontinuation of Therapeutic Supervision/MH Watch documents, and progress notes when necessary. The Site Mental Health Director consultation requirement was considered met if it occurred as part of, or outside, a Triage Meeting, and if the consulted person held that title or was a regional supervisor or on-call supervisor.

[67] To the extent possible, the DQE clinicians tried to distinguish the clinical indications for upper-level consultations required under Paragraph 82 from those required under Paragraph 85. The Paragraph 82 consultations are about the discharge decision itself, while the Paragraph 85 are more about whether the patient needed a psychiatric/psychological assessment during the TS placement.

been evaluated at all by a psychiatrist during the TS placement, (2) a patient continued to threaten self-harm, possibly for secondary gain, at the time of discharge, or (3) a patient continued to exhibit bizarre or psychotic behavior.

In the current DQE study, a consultation with a psychiatrist or nurse practitioner was evident in 72% of the cases where it was indicated, and there were no discussions with psychologists.[68] This is an improvement from the previous monitoring period, when 24% of indicated consultations with a psychiatrist/ARNP occurred. Practice was most concerning at SBCC.

Paragraph 82 also requires that MDOC's healthcare vendor employ an auditing process to ensure that prisoners are discharged from TS as early as possible. During this monitoring period, the DQE team did review some of Wellpath's mental health audits, as described in Paragraph 137. These audits contained one question relevant to the Paragraph 82 requirement, assessing whether the clinician's rationale for the plan (e.g., discontinuing TS, downgrading TS, or continuing TS) was clearly described, including relevant risk and protective factors. The DQE team does not yet have any information about VitalCore's quality assurance process in relation to Paragraph 82.

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

Finding: Partial compliance

Rationale: Discharge planning practice is consistent with previous monitoring periods; almost no reviewed TS placements met all the elements of this requirement.[69]

As described in previous DQE reports and above, MHPs universally employed the required Discontinuation from Therapeutic Supervision form and completed the form's section for brief mental status updates. MHPs also marked the type of housing or

[68] The DQE team examined the course of care for 52 of the therapeutic supervisions within the 100-stay sample. Additionally, 13 stays in the sample ended by transfer to Bridgewater State Hospital or a Department of Health facility; these were each initiated by psychiatric documentation, so a psychiatric consult was treated as both indicated and fulfilled. Similarly, these findings include a few records from the 100-stay sample that had psychiatric progress notes referencing discharge.

[69] The DQE team reviewed discharge documentation in the 100-TS sample described in requirement 50 above. In that sample, 83 patients discharged to MDOC housing and 6% of those demonstrated a brief mental status update, housing, safety plan, and plan for follow up and continued plan of care.

program to which the patient would be discharged, though it was not indicated whether this was clinically recommended or just a statement of fact.

Safety plans were demonstrated in 11% of the sample. In the large majority of cases, there was no plan mentioned, or the note referenced the creation of a plan that could not be confirmed in the health record. Similarly, MHPs recorded the patient's risk factors and an overall rating of risk, but the provided safety plans did not always connect to those risk factors.

The forms did not contain descriptions of the issues that the mental health staff and patient would focus upon, goals, outcomes, or interventions planned for upcoming contacts, as would be typical for a continued plan of care. As will be discussed in the analysis of Paragraph 84, it was also rare for this information to be captured elsewhere. In a few cases, a safety plan or a plan of care was present but did not appear to relate to the precipitating factors for the TS.

When discharge plans were created, they were communicated to appropriate mental health staff by inclusion in the electronic health record, though, as noted, safety plans generally were not included. Mental health staff told the DQE team they do not share discharge plans with security staff out of concern for patient confidentiality. This is likely a good practice for most patients, though there may be cases where closer communication with security is necessary for a successful discharge plan. To the extent relevant discharge information was shared with security staff, this was not demonstrated in the documents made available to the DQE team.

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

Finding: Partial compliance

Rationale: As detailed in previous DQE reports, the system for providing three follow-up contacts 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 is sustained.

In the DQE team's current 100-TS analysis, 90% of the follow-up contacts were completed within the required timeframes. SBCC continued to conduct some of the first contacts while the patient was still in TS housing and/or just a few minutes after TS discharge. This cannot be considered a follow-up contact that satisfies the requirements of Paragraph 84. This occurred in almost half of the sampled SBCC cases and accounts for nearly all of the noncompliant cases. MDOC's June 2024 status report indicates that Wellpath acted to address this practice by communicating this DQE feedback to staff after the DQE's last report.

In interviews, 24 patients, drawn from seven institutions, commented on TS follow-up. Most affirmed that it took place after their discharges. About one-third described three contacts, while most others thought there were one or two. A few SBCC patients, who knew the requirement from previous TS experiences, said they were not seen at all after a TS placement that occurred this year.

It remains concerning that the majority of follow-up contacts are conducted in nonconfidential settings—including cell-front, at officers' desks in housing units, in dayrooms, or in the recreation yard—and that the rate has increased in each monitoring period. While the majority of these contacts are recorded as being at the patient's request, or the patient was "agreeable" to this arrangement, fully 28% of all non-confidential follow-up contacts appear to be driven by institutional or staff reasons.

MDOC and its vendors employed different methods during the monitoring period to encourage MHPs to consider whether treatment plan changes were needed after a TS. In early 2024, the discharge document contained a field to indicate that this question had been considered and that no changes were warranted. After a revision, the document calls for the MHP to insert the goals from the pre-existing treatment plan and to indicate whether changes are appropriate.

In the DQE team's chart review, there was a timely review and update, or the MHP used one of the methods above and reasonably concluded that no change was needed, in 64% of the relevant cases.[70] In another 10%, a treatment plan review was conducted slightly later than required, within two weeks. Troublingly, there were examples of patients new to the caseload who had no treatment plans weeks after a TS, as well as updates that did not mention the recent TS, so may not have fulfilled the purpose of this requirement. While more is needed to achieve substantial compliance, these results show significant improvement over previous analyses.

[70] The analysis removes cases where the patient was released from custody, transferred to Bridgewater State Hospital or another outside psychiatric hospital, or was readmitted to therapeutic supervision within seven days.

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

Finding: Partial compliance

Rationale: To assess this requirement, the DQE team drew on its analysis of 100 TS placements, first described in Paragraph 50. The DQE clinicians reviewed the course of treatment and determined that psychiatric contact was clinically indicated in 55 of the placements for reasons such as:

- medication noncompliance or need for psychiatric follow-up that was noted by the MHP
- lack of diagnostic clarity
- active psychosis or other signs of decompensated mental illness
- bizarre symptoms or out-of-character behavior
- self-injury severe enough to require an outside hospital trip, either precipitating the TS placement or occurring during the TS stay

A psychiatrist or psychiatric nurse practitioner met with 67% of those patients. This rate has improved somewhat during each monitoring period. OCCC continued to show the strongest performance; Concord and SBCC showed far fewer psychiatric contacts than were needed. There was no indication in the health record of contacts with other types of upper-level providers as defined in the Agreement. Given the inexperience of most MHPs, increasing the involvement of upper-level providers in the routine care during therapeutic supervisions is highly recommended.

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 observed that MHPs use a form to assess patients returning from Section 18 placements; the form calls for an express decision about whether to initiate therapeutic supervision. The team also verified that the forms were consistently in use with patients who returned from Section 18 transfers.

In the current monitoring period, the team reviewed the health records of 17 patients who had been placed at Bridgewater State Hospital or a Department of Mental Health facility and had returned to MDOC.[71] In every case, MHPs completed the form and decided whether to readmit the patient to therapeutic supervision.

As noted in previous DQE reports, MDOC and Wellpath policies do not appear to require consideration of TS placement upon return from 18(a) hospitalizations. A policy revision was recommended to clarify this requirement, and MDOC's draft of the policy 103 DOC 650.08 does now contain the needed language. In the next monitoring period, the DQE team will need to verify VitalCore's policies around this provision, which will be assessed in the *Policy* section rather than in relation to Paragraph 86. Thus, MDOC continues to be 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 addresses therapeutic supervision and is currently being revised in accordance with the Agreement. Wellpath's policy 66.00, Therapeutic Supervision, had not been revised as of June 30, 2024, and the DQE does not yet have any information about VitalCore's corresponding policy. Finalizing the MDOC policy 103 DOC 650, Mental Health Services, will be the next step toward compliance with Paragraph 87.

[71] About half of the cases were apparent in the 100-stay analysis described in Paragraph 50. The other cases were selected from the spreadsheet titled Higher Level of Care 2024.xlsx, which MDOC provides monthly to demonstrate all referrals to higher levels of care. The sample includes cases from each institution that referred to Bridgewater State Hospital or the Department of Mental Health during the monitoring period. This sample represents 36% of the referrals made from January through June 2024.

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

In the DQE team's study of 100 TS placements during this monitoring period, Therapeutic Supervision Reports were completed on Monday through Saturday in 91% of cases. On Sundays, 85% of the required reports were completed. The DQE team reviewed medical records in the three cases where a report was not completed on a Sunday. In one case, the MHP wrote a Sunday progress note indicating whether to "maintain," "upgrade," or "downgrade" the level of supervision. In another case, the patient was placed on TS on Sunday morning by the on-call MHP; the nurse's note documents the MHP's assessment that 1:1 supervision was necessary. In the third case, the MHP wrote a thorough assessment of the contact and the rationale for maintaining the patient's 1:1 supervision level.

Thus, it appears that the relatively infrequent instances where a Therapeutic Supervision Report is not completed represent more of a paperwork problem than a problem with MDOC's clinicians determining the level of supervision daily. MDOC's overall practice in this area remains strong, warranting a continued finding of substantial compliance.

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

Finding: Partial compliance

Rationale: MDOC's policy 103 DOC 650.08, Emergency Mental Health Services, is in the process of revision. The DQE has reviewed the draft language, and it aligns with Paragraph 89, prohibiting the use of TS for punishment or staff convenience. Wellpath's policy 66.00, Therapeutic Supervision, contains similar language, but no information has been provided to the DQE about VitalCore's TS policies. If VitalCore adopts the same language used by Wellpath and if MDOC finalizes policy 103 DOC 650, a substantial compliance finding can be achieved.

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

Finding: Partial compliance

Rationale: No significant change has occurred in this area since the DQE's last report, when it was recommended that MDOC revise its policy to clarify the notification process to all disciplines (security, medical, and mental health) and for all types of self-injury. MDOC continues to revise its relevant policy, 103 DOC 501, Institution Security Procedures. The DQE has reviewed neither the original policy nor the revision, so it is impossible to say whether MDOC's practice is following its policies or whether those policies align with the Agreement. In its June 2024 status report, MDOC provided the following update:

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

As noted in the discussions below of Paragraphs 91, 107, and 110, currently, there seems to be no consistent manner of responding to self-injury in MDOC, with a confusing mixture of security and mental health protocols being employed. This only underscores the need for MDOC to complete its revision of security policies in accordance with the Agreement and to begin retraining staff.

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

Finding: Partial compliance

Rationale: There have been no significant changes in this area since the DQE's last report; MDOC stated in its June 2024 status report that the emergency response and institutional security policies remain under review.

In the meantime, the DQE team learned more about how SDV is typically handled in MDOC through interviews with 39 staff and prisoners across eight institutions, as well as a review of incident reports related to SDV. While many interviewed officers could not recall being involved with a recent episode of self-injury, others stated that they have typically responded by calling the shift commander and attempting to convince the prisoner to "give up" the item with which they were self-injuring. If the prisoner did not comply, the shift commander would decide whether to use force. The procedures about medical and mental health notification are less clear, though there does appear to be a practice of calling a nurse to assess the patient's physical injuries and a mental health clinician to assess whether the patient needs TS placement. In cases where force is used, there appears to be a practice of mental health follow-up with the patient, as evidenced by notations in the triage meeting minutes of clinicians conducting these assessments.

Throughout MDOC, security staff handle the vast majority of self-injury, with medical and mental health staff playing ancillary roles at best. In the first half of 2024, 461 total incidents of SDV occurred; 326 of these occurred while a patient was on TS. Only four times was a prisoner determined to need mental health restraints (i.e., those that are ordered by a physician because a patient poses a danger to themselves or others). In all other cases, uses of force and restraints were authorized and implemented by security staff. This pattern of handling self-injury as a security matter rather than a mental health issue remains concerning to the DQE.

Recent examples of SDV incidents may help illustrate this concern. One prisoner at OCCC repeatedly engaged in SDV severe enough to require outside hospital treatment. An incident report from June 2024 indicates, "[The prisoner] was ordered by [the Superintendent] to be placed into therapeutic four-point restraints due to self-injurious behavior." He spent approximately 10 hours in "therapeutic" restraints that were ordered and managed by security personnel, without any assessment by a psychiatrist. In another example from Norfolk, a prisoner was observed ingesting a foreign body. He was simultaneously placed in security restraints and on a 1:1 therapeutic supervision. For the

next 36 hours, the prisoner remained in security restraints while on TS. Mental health clinicians checked in on him three times per day, noting him to be lethargic and likely intoxicated. At no point was a physician or ARNP referral initiated. After being removed from restraints, he remained a "closed" mental health case.

These examples illustrate the conflation of security and mental health responses to SDV. The DQE continues to recommend that MDOC review its own practices in relation to the restraint guidelines published by the National Commission on Correctional Health Care and American Psychiatric Association, working to revise restraint use accordingly.

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

Finding: Partial compliance

Rationale: When an incident of self-injury occurs, MDOC's expectation is that all involved staff will write an Incident Report in the Inmate Management System (IMS), and mental health and medical staff will write a progress note in the health record as clinically indicated. Thus, it appears that the basic structures are in place to obtain compliance with this Paragraph 92. However, MDOC's audits of incident reports, as completed by the Clinical Operations Analyst and discussed in the monthly QIC meetings, continue to indicate poor completion rates among some disciplines of staff.[72] Security staff's completion rates have improved with reminders, but the mental health staff's completion rates have actually decreased during this monitoring period. This could reflect the mental health staff's struggle to keep up with what they described to the DQE team as "redundant" documentation requirements (e.g., documenting self-injury in both a progress note and an incident report). In any case, the completion of all incident reports remains a work in progress. MDOC is also in the midst of revising policy 103 DOC 501, Institution Security Procedures, to clarify the requirement for all staff to document self-injury.

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

Finding: Partial compliance

[72] Please see Paragraph 109 for a detailed discussion of the audit results.

Rationale: The DQE team continued to hear anecdotal reports of staff misconduct such as name-calling, threats, and encouraging self-harm, but it was not always clear that the allegations were specifically related to crisis contacts or therapeutic supervision. In interviews with the DQE team, most prisoners who were asked reported that they had observed an officer falling asleep while on a 1:1 TS at least once.[73] None reported other types of inattention, such as an officer walking away from their post to attend to another matter. A handful of prisoners and mental health staff reported hearing of officers who encouraged self-injury or made fun of individuals with mental illness.

MDOC's policy 103 DOC 522, Professional Standards Unit, mandates investigations of all staff misconduct. In October 2023, the Clinical Operations Analyst began tracking the allegations and investigations related to crisis contacts and TS in a document called the "Professional Conduct Log," a redacted version of which was shared with the DQE team. The Clinical Operations Analyst indicates that the log principally is compiled from staff-generated confidential incident reports and from other issues that come to the attention of top leadership. This is a healthy start to a tracking process. In time, including prisoner sources of information (for example, grievances and letters to facility administration), and potentially advocate information (e.g., letters, emails, or phone calls to facility administration), will give a more complete picture of misconduct allegations relevant to the Agreement.

The current log indicates that 21 allegations of staff misconduct related to crisis/TS have been made in 2024.[74] Most of these allegations are still under investigation. Over half of the allegations involve staff at Norfolk, with smaller numbers at SBCC, Framingham, MTC, OCCC, and Concord. Most of the allegations involve correctional officers, with a few allegations against nurses. About half the reports involve officers allegedly refusing to call mental health or walking away from a prisoner who was requesting crisis services; these allegations are all at Norfolk and SBCC. Another group of incidents alleges that staff encouraged self-injury by stating that prisoners should kill themselves, bang their heads, or cut themselves. Several incidents allege name-calling. One incident each of physical assault and providing unauthorized property to a patient on TS were alleged.

The Professional Conduct Log indicates that three of the misconduct allegations have been substantiated, resulting in officer discipline. Three incidents were determined to be unfounded. The remaining investigations are in progress, one since as long ago as October 2023. It is not clear what accounts for the long investigations without resolution.

[73] Thirteen prisoners commented directly on this point, with eight prisoners across four institutions saying they had observed an officer falling asleep.
[74] The log also includes one complaint from October 2023.

Overall, MDOC continues to have a process in place for investigating allegations of professional misconduct, and the conduct being investigated is similar to the conduct reported by prisoners and staff during the DQE's site visits. It all paints a picture of unprofessional conduct that, while certainly not the norm among the MDOC staff, occurs often enough to warrant continued monitoring by the DQE team.

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

In practice, MDOC's Therapeutic Supervision training has been provided in different formats in recent years. As noted in the DQE's first report, the TS training was a standalone, in-service training until July 2022. It was then combined with the annual Suicide Prevention training for TY23. In TY24, the TS training went back to being a standalone training. MDOC's records for TY24 indicate that that 2,503 staff members at eight institutions where TS occurs were required to complete TS training, of which 1,626 completed it.[75] This resulted in a 65% overall completion rate.

[75] MASAC's security staff are not included in this accounting because they are Wellpath employees. MASAC's training records indicate that 78 staff completed TS training in Training Year 24, and it is not possible to determine what percentage of total staff or security staff required under Paragraph 94 are represented by this number.

In an email, MDOC's Director of Staff Development clarified that the staff members required to complete annual in-service training include the following job classes: Correction Officers I-III, CO Cooks/Chefs, Correctional Program Officers A/B-D, Recreation Officers I-II, and Industrial Instructors I-III. This is a much larger group of staff than those who "observe prisoners on mental health watch" (the requirement of Paragraph 94). During the DQE team's site visits and interviews with staff, Correction Officers I were most involved with TS, including doing constant supervision and TS rounds, calling crisis on prisoners' behalf, responding to SDV, and facilitating out-of-cell activities for TS patients. From the training records MDOC provided, the DQE was unable to determine whether this subgroup of staff had higher or lower TS training compliance rates than the overall rate of 65%. This can be assessed in future monitoring periods.

The status of the TS "read and sign" is unclear. The DQE reviewed a draft of this document and returned it to MDOC on January 30, 2024, along with suggested revisions to the Therapeutic Supervision lesson plan and PowerPoint slides for the live training. In its June 2024 status report, MDOC stated that it was revising the training materials based on the DQE's feedback and would resubmit them when ready. The TS poster also seems to be a work in progress; the DQE did not observe such a poster in any of the housing units during this monitoring period's site visits.

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

Finding: Partial compliance

Rationale: The DQE team continued to observe the sight lines for cells in different units used for therapeutic supervision and has tested the seating arrangements and visibility in some locations. Changes during this monitoring period included new doors in Norfolk's BAU and Shirley's HSU, which improved visibility. Cells with good sight lines were created in the newly opened ISU.

Officers continued to describe maintaining an uninterrupted view as their primary duty when assigned to constant observation. In a study of 37 constant observations,[76] though, at least seven showed gaps in observation sheet entries lasting more than a half-hour, raising questions about whether these were lapses in observation or recordkeeping.

[76] Please see Paragraph 34 for a description of this study.

Thirteen prisoners, across six institutions, commented about officers' conduct during their constant observation TS. Most said officers maintained a direct line of sight continuously, though a few wondered if the officers always kept full attention. Most, however, thought that officers did not maintain constant observation because they fell asleep, with several prisoners describing specific instances.

It is likely that the demand for constant observation increased significantly during the monitoring period because MDOC found TS cells at each institution that would no longer qualify as suicide-resistant until repairs or improvements were completed. This may have had an impact on officers' ability to rotate every two hours and to maintain attention on the prisoners they were monitoring, as discussed in relation to Paragraph 54 above.

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 77 placements drawn from all institutions that conducted TS.

In 64% of the placements, there were recorded contacts every 15 minutes – or a similar interval if contacts were "staggered" – or missed contacts only very rarely. The best practices were demonstrated at OCCC, Gardner, and Norfolk.

Observation sheets were present for the other placements as well, but there were longer or more frequent gaps in recording. It is not possible to discern whether these absences indicate an issue of documentation or practice, but compliance was not demonstrated in these cases. Similarly, there were some recording practices that raised questions about accuracy – for example, multiple officers submitting forms for the same multi-hour time period or identical entries for stretches of 9 to 25 hours.

The content of observations recorded in some placements provided very useful information. Entries were consistently well done at MASAC, MTC, and Norfolk. MDOC leaders have also encouraged staff to adopt the practice, recommended by suicide prevention specialists, of varying the timing of the contacts by a few minutes ("staggering") so they are less predictable to a patient planning to self-injure. Very few

sets of documents consistently reflected this practice, but about one-third of placements showed officers making an effort, particularly at OCCC, Framingham, Gardner, and MASAC.

With recording gaps occurring at this frequency and questions about the accuracy of the officers' documents, significantly more is needed to demonstrate compliance with this requirement. However, it is encouraging that this is an area frequently discussed and monitored in MDOC's Quality Improvement Committee.

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 could ease transmission of contraband that could be used for self-harm. MDOC continues to make progress by installing or modifying doors.

The DQE team observed that four facilities have completed installation of door sweeps. OCCC and SBCC have door sweeps in some TS settings, and their administrations indicate that modifications are continuing in the other relevant units. At MASAC, it did not appear that efforts to address the gaps at the bottom of the TS doors had begun. MDOC tracks the progress of door sweep installation in its quarterly DOJ Implementation meetings, so the DQE team is optimistic about eventual compliance with the Paragraph 97 requirements.

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: Partial compliance

Rationale: Although it occurred slightly after the deadline of December 20, 2023, Support Persons are now working within all the MDOC facilities where TS occurs. Wellpath's June 2024 staffing matrix indicates that a total of 13.2 FTE Support Person positions are spread across eight facilities: 1.2 FTE for each facility except OCCC, which has an additional 3.6 FTE positions allocated to the ISU, for a total of 4.8 FTE.

Wellpath's staffing matrix in June 2024 indicates that 6 out of the 13.2 FTE Support positions were filled, which includes full-time (1.0 FTE) Support Persons at Gardner, MASAC, MTC, OCCC, SBCC, and Shirley. A seventh full-time support person was assigned to Concord; this individual transferred to Norfolk upon Concord's closure. Thus, by the end of June 2024, all facilities where TS occurs, except Framingham, had a full-time Support Person on board. Per diem Support Persons were also working throughout the MDOC facilities, including at Norfolk, Framingham, Gardner, MTC, OCCC, SBCC, and Shirley. Thus, MDOC's obligation under Paragraph 98 to ensure that its contracted healthcare vendor retains Support Persons is well underway. The change of contracted healthcare vendor from Wellpath to VitalCore may affect the recruitment and/or retention of Support Persons, so the DQE will monitor this area closely in the next reporting period.

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

Finding: Partial compliance

Rationale: Based on the DQE team's site visits and review of medical records, Support Persons have been integrated into the mental health teams at all facilities where they have been hired. During the May 2024 site visit, Framingham staff reported that they had not yet integrated a Support Person into the treatment team because the first person hired had left the position after a week and a half. At all other facilities, it was clear from observing the triage meetings and informal interactions among the mental health staff that Support Persons have joined MHPs, psychiatrists and ARNPs, unit directors, and activities therapists in caring for patients on TS.

Because Support Persons began working at the MDOC facilities at different times during the monitoring period, the DQE team did not systematically study the rates of attempted and actual Support Person contacts with patients on TS. This will be added to the DQE team's study of 100 TS placements during the next monitoring period. For now, we can say that Support Persons' role with patients on TS has varied by the needs of the facilities and patients. At facilities where TS placements were relatively rare, such as Shirley and Gardner, the Support Persons spend most of their time with other types of patients, most commonly those in the RTU. At facilities such as OCCC and SBCC, where there are often multiple patients on TS per day, Support Persons were more likely to interact with TS patients regularly. So far, there is no indication that these contacts are replacing those conducted or attempted by MHPs; they are conceived of as an adjunct to the established

practice of assessing TS patients three times daily. Some interviewed Support Persons noted that they provide important continuity of care for patients on TS, who otherwise interact with multiple different MHPs for their thrice-daily contacts.

The DQE team has not yet systematically assessed Support Persons' documentation, but many such notes were encountered when reviewing the electronic health record for other reasons. In interviews with eight Support Persons across six institutions, all reported that they document their contacts in the health record. Based on interviews and record review, the Support Persons appear to be engaging patients in activities ranging from mindfulness meditation to art projects to board games. They also provide reminders about medication compliance, hygiene, and upcoming mental health appointments. At some facilities, they help create and distribute the psychoeducational packets distributed to prisoners, and at others, they lead groups.

Of note, a few Support Persons reported difficulty either obtaining needed supplies (e.g., puzzles, stress balls, art supplies) or getting permission from the facility's security leadership to use them with patients on TS. For example, at OCCC in July 2024, the administration had not yet approved Support Persons to engage in recreational contacts with TS patients. During the site visits, MDOC agreed to consider creating a system-wide list of approved items for Support Persons to use with patients (after consulting with the mental health clinicians about their appropriateness in a particular case) to avoid confusion and disparities among facilities. The development of Support Person policies, which do not yet exist, should also help this problem.

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: In interviews with the DQE team, Support Persons who were asked about pre-service training reported that they completed two weeks of New Employee Orientation (NEO) with MDOC and Wellpath prior to beginning work.[77] NEO records from January to March 2024 indicate that the Support Persons hired during that period completed 40 hours of Wellpath training, including eight hours of Suicide Prevention and Mental Health training. The DQE has previously reviewed the training materials and verified that they include appropriate information on mental health conditions frequently

[77] The DQE team interviewed eight Support Persons across six institutions during this round of site visits.

encountered with TS patients, though further review of whether the training covers "how to appropriately interact with" TS patients is needed. Overall, it appears that MDOC has a good foundation for pre-service training of Support Persons in place. With sustained practice and integration of Support Persons into CIT training, which has not yet begun, MDOC will be 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: Partial compliance

Rationale: MDOC provided a sample of agendas and attendance records for Support Person group supervision, which supplements onsite guidance and began as a weekly Microsoft Teams meeting on April 2, 2024. The DQE team observed this supervision meeting on two occasions during the site visits and interviewed eight Support Persons across six institutions about supervision practices.

All 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. In its June 2024 status report, MDOC reported that Support Persons' work schedules have been designed to align with MHPs' onsite work hours, and the DQE team did not find any examples where this was not the case. Overall, it appears that the structures necessary for on-site supervision of Support Persons by MHPs are in place.

The DQE team has not yet systematically assessed the decision-making or communication process between MHPs and Support Persons to determine the clinical appropriateness of interactions with patients on TS. This will be addressed during the next monitoring period, both in policies and in practice.

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

Finding: Partial compliance

Rationale: According to the June 2024 Wellpath staffing matrix, each of the eight MDOC facilities where TS occurs is allotted 1.2 FTE Support Persons: one full-time position (40 hours a week), plus one 0.2 FTE position (8 hours a week). This adds up to the time

required by Paragraph 102: 6 days per week, 8 hours per day. All but one of the Support Persons interviewed by the DQE team work a Monday-to-Friday schedule during regular business hours, roughly 8 am to 4 pm, with slight variations (e.g., 7:30 am to 4 pm or 8 am to 4:30 pm). One interviewed Support Person reported working Saturdays. Overall, MDOC has made a good start toward filling the Support Person positions six days a week, though it has not quite reached the goal.

The DQE team was able to analyze data from the SDV logs (January through June 2024) to determine that most SDV occurs during the first shift, as indicated in *Table 3.*

Table 3. Time of Day when SDV Occurred, January-June 2024

Shift	SDV Incidents
First (7a-3p)	252
Second (3p-11p)	147
Third (11p-7a)	35
Unknown time	27
TOTAL	461

Most SDV also occurs on the weekdays rather than the weekends, as shown in *Table 4.*

Table 4. Day of Week when SDV Occurred, January-June 2024

Day	SDV Incidents
Sunday	33
Monday	83
Tuesday	76
Wednesday	83
Thursday	72
Friday	70
Saturday	40
Unknown Day	4
TOTAL	461

Thus, it appears that the Support Persons' assignment to regular business hours, Monday to Friday, aligns with the timing of when most SDV occurs in MDOC, meeting the Paragraph 102 requirement.

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

Finding: Noncompliance

Rationale: In its June 2024 status report, MDOC stated that clinicians routinely check in with each other around shift transitions, including Support Person contacts and what activities are clinically appropriate for prisoners on TS. Currently, there is no documentation of the transition communication process, so MDOC has not yet demonstrated its occurrence. During the DQE team's interviews of eight Support Persons across six institutions, none reported that they have been involved in the shift transition. One Support Person stated that, if anything significant needed to be conveyed to the evening clinician, he would write an email.

In the next monitoring period, the DQE team can make an extra effort to observe shift transitions during the site visits, as suggested by MDOC to assess the Paragraph 103 requirements. MDOC may also consider how to document the integration of Support Person contacts into its end-of-shift reports.

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: The DQE team does not know of a way to systematically identify all patients who had contact with a Support Person, but several such cases were noted while reviewing medical records for the study of 100 TS cases. This, of course, demonstrated that Support Persons are documenting at least some interactions. A more thorough assessment of Support Person contacts with TS patients will occur in the next monitoring period.

In interviews, the DQE team asked Support Persons how they document contacts with patients.[78] All reported that they document patient encounters in the electronic health record using a progress note template created for them. They reported that, initially, their notes were reviewed and co-signed by the site Mental Health Director, but they were later allowed to document independently. During the DQE team's observation of triage meetings at eight facilities, none included a review of the Support Person's documentation. However, Support Persons were present at triage meetings at seven of the eight institutions, and they sometimes discussed their contacts with patients on TS. It appeared that mental health teams were gradually establishing a practice of reviewing

[78] Five Support Persons at five institutions commented on the Paragraph 104 requirements.

Support Persons' activities with TS patients during the daily triage meetings, so the DQE team is optimistic about MDOC's eventual compliance with Paragraph 104's 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:

Finding: Noncompliance

Rationale: Per MDOC's June 2024 Status Report, policy 103 DOC 562, Code 99 Emergency Response Guidelines, is still being revised in accordance with the Agreement. On September 13, 2024[79], MDOC provided the policy to the DQE team, and it will be reviewing during the next monitoring period. For now, a noncompliance finding is being issued.

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

Finding: Noncompliance

Rationale: MDOC still has not shared its Code 99 policy with the DQE, so the team cannot assess whether it is being followed. MDOC has not yet demonstrated compliance.

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

Finding: Partial compliance

Rationale: In DQE team interviews in all monitoring periods, security and mental health staff have consistently described an officer's routine response to a prisoner's in-progress

[79] The policy was provided well after the end of the data collection period for this report (June 30, 2024).

self-injury as being an immediate call to a supervisor and nursing and then remaining with the prisoner until the security supervisor directs other action.

Some staff say that officers also call mental health staff, although their role is understood to be helping the patient after the incident has concluded. Two recently interviewed patients, however, said an MHP was part of the response to those patients' SDV in the STP and RTU.

Many officers have said that, after they have made their calls and while waiting for supervisors and officers to respond, they personally attempt to influence the prisoner to stop self-injuring. Of the 12 officers who commented recently, drawn from six facilities, about half clearly said this is their approach, while a few others rejected the idea. Over time, many also have said that a routine part of the response is for sergeants and lieutenants also to try to encourage the prisoner to stop the SDV and come out of the cell for a nursing examination.

Among recent interviews of eight patients who discussed self-injuring, a majority said security staff or supervisors convinced them to stop and relinquish items they were using, or that an MHP and security officer responded jointly (as above). Others said there was a use of force but generally did not mention whether there were informal efforts first. The DQE team also reviewed a sample of SDV events for several Agreement requirements. In the 10 events reviewed, all contained incident reports that reflected security staff or supervisors successfully persuading the prisoner to end the SDV. At the same time, Quality Assurance data show an increase in use of force on TS (please see Paragraph 139 below). It is not immediately clear how to reconcile these different data sources.

In general, 17 recently interviewed officers, drawn from all eight institutions visited, commented on the value of de-escalation, its essential nature for their work, and their personal approach to it. Several pointed to routinely building rapport so they can be more effective when things escalate. Several spoke of reading the prisoners to be able to gauge the best response and seeking to prevent or deescalate situations by volunteering to try to solve the underlying problems. These are themes the DQE team has heard from some officers in each monitoring period in some specialized units, general population, and units housing TS. These attitudes and skills may be one indication that officers are fulfilling the requirements of Paragraph 107.

On the other hand, it remains a concern that patient and MHP reports persist of officer provocation, abusive language, and indifference to patients with mental illness and those who self-injure. Encouragingly, some MHPs said they have *not* witnessed or had patients report officers egging people on while they self-harm. However, at least one group said

officers are reasonable with some patients but target others for this kind of provocation. One patient reported that a BAU officer said, "I hope you die" and "I hope he is dead under [that blanket]."

Some MHPs and prisoners indicate ongoing harassment of vulnerable prisoners through name-calling, particularly linked to mental illness, disability, gender, or race. Some patients gave examples of officers insulting and laughing at them when they called crisis and while they waited together for the crisis assessment. Two patients said officers are very responsive when they are in crisis, but they are troubled watching the officers' indifference to some other men in that condition. One patient said he wrote on a BAU cell wall with his own blood and that the only response was to tell him to clean it. These reports from patients and MHPs are distributed across six institutions.

A substantial number of other patients and MHPs described officers as responsive, respectful, good to work with, and taking patients' concerns seriously. The examples above, even if it is a small proportion of staff, stands in stark contrast and potentially heighten the risk of bad outcomes with patients who engage in SDV. Both trends have been evident throughout the time the DQE has been monitoring MDOC.

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

Finding: Partial compliance

Rationale: The expectation to complete a SIBOR within 24 hours of an SDV incident is well established among MDOC's mental health staff. MDOC provided to the DQE a SIBOR for each episode of SDV listed in tracking as occurring while a prisoner was on TS. Between January and June 2024, all 461 incidents of SDV listed on the SDV Registry were accompanied by a completed SIBOR, which is extraordinary given that that these incidents increased by 81% since the previous six-month period.[80]

The DQE team reviewed 50 cases for SIBOR completion within 24 hours of the SDV incidents. Cases were chosen in proportion to the percentage of SDV incidents that occurred at each facility between January and June 2024. *Table 5* illustrates the results.

[80] As noted in Paragraph 71, the DQE found a few cases of SDV at SBCC during this monitoring period that were not included in the SDV log, raising slight concern about accurate reporting at that facility.

Table 5. SDV Incidents with Timely SIBORs

	% of Total SDV	# of cases audited	SIBORs completed on day of SDV or following day	% completed within 24 hrs
Concord	2	1	1	100
Framingham	25	12	9	75
Gardner	2	1	1	100
MASAC	4	2	2	100
MTC	4	2	1	50
Norfolk	8	4	4	100
OCCC	27	14	10	71
SBCC	20	10	8	83
Shirley	7	4	4	100
TOTAL	**100**	**50**	**40**	**80**

Overall, 80% of SIBORs were completed within 24 hours of the event, which is identical to the previous six-month period. OCCC showed improvement, moving from 53% compliance in the last DQE report to 71% compliance currently. Even in the 20% of cases where a SIBOR was late, it was, on average, completed 2.5 days after the SDV incident. If MDOC can sustain this good practice and achieve 85% completion within 24 hours, a substantial compliance finding is likely in the next monitoring period.

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

Finding: Partial compliance

Rationale: During this monitoring period, the number of SDV incidents on TS (311 episodes between January and June 2024) was too large for the DQE team to review every incident report. Fortunately, this is an area where MDOC already performs its own audits. Minutes from the QIC meetings indicate that the completion of incident reports related to SDV on TS remains a work in progress. Security officers' and medical staff's practice has improved, while mental health lags behind, as illustrated in *Table 6.*[81]

[81] While Paragraph 109 creates obligations only for officers, it is helpful context to also understand the practice of other professional disciplines.

Table 6. QIC Meeting Minutes' Report of IR Completion

Meeting Date	Notes about IR Completion
1/25/24	security 63% completion of IRs, medical 41%, mental health 38%
2/29/24	"There was a general increase in the number of IRs submitted across the board. The highest percentage belonged to security."
4/5/24	"Security was much better with submitting them, while Medical/Mental Health were not as good."
4/25/24	security 77% completion of IRs, medical 50%, mental health 32%
5/23/24	security 60% completion of IRs, medical 70%, mental health 24%. "There may be some confusion about when an IR is needed, so retraining is under way."
6/27/24	"Mental health is struggling in this area. It was noted that MCI Framingham is doing very well."

Additionally, the DQE team reviewed a set of security officers' observation sheets for whether the patients' SDV was reflected there. The team selected 14 cases from the spreadsheets MDOC maintains to track SDV incidents, or events the team noted during chart reviews for other purposes. The officer responsible for observing the patient documented the SDV on the observation sheet in two-thirds of these incidents.

Given MDOC's active engagement with this issue and the improvement in security and medical staff's practice in recent months, the DQE team remains optimistic about the capacity for substantial compliance with the Paragraph 109 requirements. As in previous DQE reports, when present, the incident reports contain a reasonably detailed description of the patient's self-injurious behavior, including whether the prisoner was on close or constant TS, so no changes to the report format are needed to achieve compliance with the Paragraph 109 requirements.

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

Finding: Partial compliance

Rationale: The DQE team has found that patients who self-harm on TS are routinely assessed by an MHP within 24 hours. Staff say that an MHP is sometimes called to respond after the self-harm has stopped and a nurse has examined the patient, and this was evident in some incident reports the DQE team reviewed. Certainly, all patients are evaluated later that day or early in the next business day by virtue of the practice of seeing TS patients three times daily.

In the DQE team's study of 100 TS placements first described in Paragraph 50, ten involved SDV during the TS stay. The study found that, in 90% of the relevant cases, the MHP made adjustments in monitoring, care, and/or the treatment plan, or a change was not clinically indicated in the DQE's judgment.

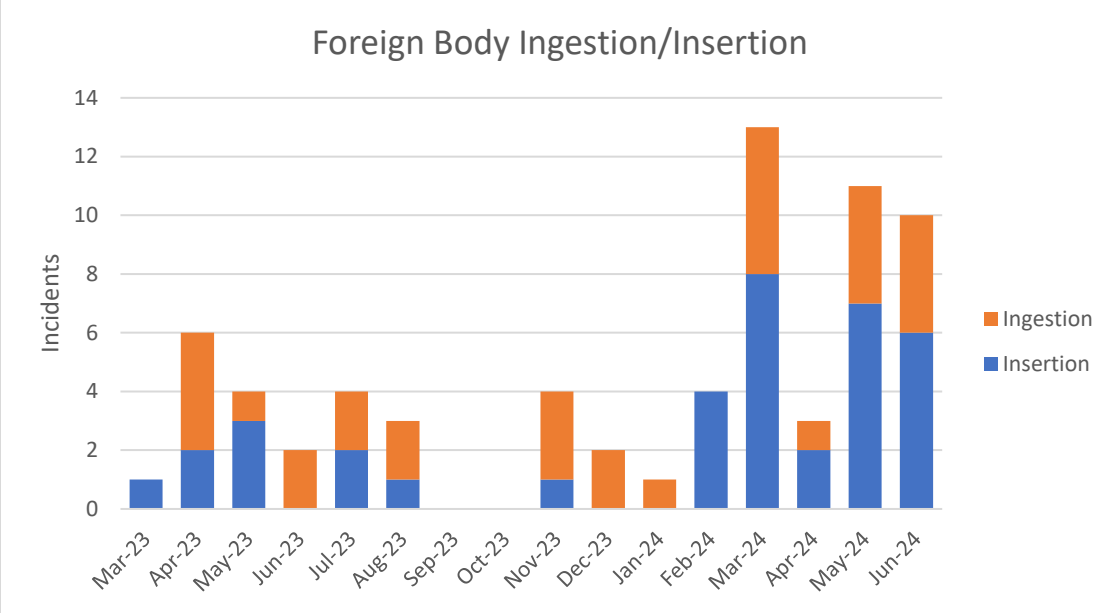
Overall, it appeared that MDOC consistently met the requirements of Paragraph 110 during this monitoring period. The DQE anticipates that, with sustained practice, MDOC will reach substantial compliance.

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

Finding: Noncompliance

Rationale: MDOC has not provided its original or revised foreign body policy to the DQE team; the June 2024 status report indicates that the policy is still under review. Thus, the DQE cannot determine whether MDOC is following its policy. In the meantime, the DQE team continued to review data from the monthly Quality Assurance reports that indicate the number of foreign body ingestion and insertion incidents per month *(Figure 8)*.

Figure 8. Foreign Body Ingestion and Insertion



It appears that incidents of foreign body ingestion/insertion increased between January and June 2024, which is consistent with the overall trend for SDV during the same period.[82] The reasons for this trend are not clear.

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

Finding: Noncompliance

Rationale: MDOC's policy on foreign body ingestions reportedly is contained within policy 103 DOC 501, Institution Security Procedures. This policy has not yet been provided to the DQE. MDOC reported that it is still being revised. A noncompliance finding is being issued because the DQE team has not seen the original policy or any evidence of its revision, and because Attachment #14 to MDOC's policy 103 DOC 650, Therapeutic Supervision Procedures, which also addresses foreign body ingestion, has not been further revised.

INTENSIVE STABILIZATION UNIT

Before delineating the compliance findings for Paragraphs 113-135, a brief explanation of the DQE team's methodology is warranted. The Agreement's deadline for MDOC to begin operating the ISU (June 20, 2024) left only 10 days for MDOC to demonstrate the unit's operations before the DQE team stopped collecting data for this report (June 30, 2024). For almost all the ISU-related provisions (e.g., treatment planning, out-of-cell activities, property and clothing decisions), it would have been impossible for MDOC to demonstrate sufficient practice to inform a compliance finding in just 10 days. Therefore, the DQE team chose to rate most provisions in this section as "compliance not yet due," and they will be assessed in detail during the next monitoring period.

The only exceptions to this rule are Paragraphs 113 (ISU policies), 114 (opening/operating the ISU), 115 (ISU purpose), and 118 (ISU referral process), which could have been demonstrated even prior to June 20, 2024. Those provisions have been rated "partial compliance" based on the DQE team's assessment of MDOC's current practice.

[82] See Paragraph 143 for further discussion of SDV trends.

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: Partial compliance

Rationale: Policies pertaining to the ISU were included in the revision of 103 DOC 650 provided to the DQE on April 25, 2024, a few months after the one-year deadline of December 20, 2023. The DQE team reviewed policy 103 DOC 650.12, Intensive Stabilization Unit, in detail, finding that the policy language is consistent with Agreement paragraphs 113-135 except for one aspect of Paragraph 118. That paragraph states:

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

This language is not included in the draft ISU policies. Once 103 DOC 650.12 is revised to include this language, the policy is finalized, and the DOJ has given its approval, MDOC will likely meet the requirements of Paragraph 113.

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

Finding: Partial compliance

Rationale: MDOC's status report indicates that the ISU was opened on June 16, 2024. However, the DQE team learned during the OCCC site visit on July 15, 2024, that no patients had yet been admitted to the unit, and a few essential physical plant changes remained to be completed. VitalCore leadership reported that the "finishing touches" were being put on referrals, but no patients had yet been referred or screened for admission almost one month after the unit was declared "open."

In July 2024, the DQE team toured the Samson unit where the new ISU is located, and it appeared almost ready to accept patients. The newly renovated unit contains 21 cells, six of which are suicide-resistant, for a maximum of 15 patients. It also contains two group treatment rooms, private interview rooms for mental health contacts, staff offices, a day room, a nursing/medication administration room, a medical triage room, two therapeutic de-escalation rooms, two property rooms, and an outdoor recreation area. The common

areas are painted a soothing blue-green color with navy blue trim. Each cell is equipped to hold one prisoner, containing a suicide-resistant bed, desk, and stool. On July 15, 2024, the ISU cells did not yet contain mattresses. A few door sweeps had been installed, but most cell doors had at least a ½-inch gap between the door and the floor.

Staffing for the ISU was a work in progress. OCCC leadership reported that officers had bid into the ISU posts during the spring "job pick." These officers had been temporarily assigned to other areas of the facility because of the lack of patients in the ISU, but they would be ready to go when needed. Mental health staffing had been less successful as of July 15, 2024:

- Unit coordinator: 1 out of 1 FTE filled, though this person had not yet started work at OCCC
- Psychiatry: 0 out of 0.5 FTE filled
- MHP: 1 out of 4 FTE filled; this person was in New Employee Orientation and had not yet started work at OCCC
- Activity therapist: 1 out of 1 FTE filled[83]
- Support persons: 2 out of 3.6 FTE filled

There is no psychologist included in the ISU staffing plan, though VitalCore leadership stated that the unit will have access to the two regional psychologists as needed.

Overall, although major progress has been made with the ISU, it would not be accurate to say that the ISU was operating by the Agreement deadline of June 20, 2024, or at the time of the OCCC site visit on July 15, 2024. The DQE remains optimistic about the ISU's potential, especially after seeing how carefully the physical plant was designed and after learning from MDOC on August 1, 2024, that the first patient had been admitted.

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.

[83] MDOC's staffing matrix for the ISU originally stated that there were 3 activity therapist positions for the ISU; MDOC clarified on September 19, 2024, that this was revised to one activity therapist.

Finding: Partial compliance

Rationale: The draft of MDOC's ISU policy, 103 DOC 650.12.A, clearly states that the ISU will serve the population described in Paragraph 115. The first patient was admitted to the ISU on August 1, 2024, and this patient does seem to fit into the therapeutic gap between TS and inpatient hospitalization. A longer demonstration period and larger patient population in the ISU will be needed to assess the other facets of Paragraph 115.

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

Finding: Compliance not yet due

Rationale: MDOC's draft policy, 103 DOC 650.12.C.b.v states that patients in the ISU will have individualized treatment plans and that the goals of treatment will be consistent with those outlined in Paragraph 116. This is a promising first step. MDOC has not demonstrated a practice consistent with this requirement, but the draft policies make clear its intent to do so once the unit is up and running.

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

Rationale: No other units have been developed to serve the same purpose as the ISU, so the DQE team cannot assess whether they follow the same guidelines.

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: MDOC has developed a referral form for the ISU, and one patient was recently admitted. While these are positive steps, this is not yet sufficient to demonstrate a practice consistent with the requirements of Paragraph 118. The ISU referral form (see 103 DOC 650, Attachment 16, "Intensive Stabilization Unit Referral") appears to have been created with the requirements of Paragraph 118 in mind, prompting the referring party to identify treatment goals and potential barriers to treatment. During the next monitoring period, the DQE team will assess the ISU referral process in practice as a greater number of referrals are made.

As noted in Paragraph 113, MDOC's most recent revision of policy 103 DOC 650.12.B does not mention the ability of prisoners to request ISU placement for themselves. It is not clear whether this was omitted purposely or was an oversight during the policy revision. In either case, it would need to be included in policy, and MDOC would need to demonstrate its practice before being found substantially compliant with Paragraph 118.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 119's requirement. A draft of the revised policy 103 DOC 650.12.C.d.iii does demonstrate MDOC's intent for ISU patients to be assigned a stabilization clinician upon admission.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 120's requirements. A draft of the revised policy 103 DOC 650.C.b.i is consistent with Paragraph 120 and demonstrates MDOC's intent to implement its requirements.

MDOC's June 2024 status report indicates that a bi-annual audit process will monitor whether the system is being followed.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated the availability of group programming or the process of referring patients based on their individualized treatment needs. A draft revision of policy 103 DOC 650.12.C.d.iv indicates MDOC's intent to do so.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 122's requirement to permit out-of-cell time commensurate with patients' clinical stability.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 123's requirement to avoid restraints during on-unit activities.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 124's requirement for patients to meet with an MHP weekly.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 125's requirement to provide contact visits and phone privileges in the ISU that are commensurate with general population settings.

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

Finding: Compliance not yet due

Rationale: During the OCCC site visit on July 15, 2024, the facility's leadership stated it had worked with the Department of Public Health and determined that DPH does not need to approve out-of-cell meals in the ISU. The plan is for ISU patients to eat in the unit's day room. A draft revision of policy 103 DOC 650.12.C.d.ix demonstrates MDOC's intent to effectuate this plan and provide meals out of cell. MDOC will eventually need to demonstrate that the plan was effectuated, but these first steps make the DQE optimistic about MDOC reaching substantial compliance as to meals.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 127's requirements regarding property and clothing allowed in prisoners' cells.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 128's requirements, but the DQE is optimistic about its implementation. The ISU does contain adequate indoor and outdoor recreation areas to meet patients' needs.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 129's requirements. The Samson unit does appear adequate to meet most of the patients' daily needs on the unit, including meals, mental health programming, phone calls, video visits, access to the law library, outdoor recreation, and medication administration.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated any tracking practices consistent with Paragraph 130's requirements.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 131's requirement to limit restraints during off-unit activities.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 132's requirements, but it is encouraging that two full-time Support Persons have already been hired to work in the unit.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 133's requirements to provide structured and unstructured interactions in accordance with patients' treatment plans, but it has taken steps in that direction. The ISU staffing matrix includes one full-time activity therapist, which reflects MDOC's intent to integrate the position into the daily functioning of the unit. A draft revision of policy 103 DOC 650.12.C.a.iii further supports MDOC's intent to implement the requirements of Paragraph 133.

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

Finding: Compliance not yet due

Rationale: MDOC has not yet demonstrated a practice consistent with Paragraph 134. However, MDOC's intent with the ISU is clearly to de-escalate patients and intervene with therapeutic modalities whenever needed, as indicated in a draft revision of policy 103 650.12.C.d.ii.

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

Finding: Compliance not yet due

Rationale: During the OCCC site visit on July 15, 2024, the DQE team observed two empty rooms, one on each floor of the ISU, that will be used as "comfort rooms" (i.e., therapeutic de-escalation rooms). The Superintendent stated that the rooms will be outfitted with a molded plastic rocking chair and sensory items. The furniture had not yet arrived, and no patients had used the rooms.

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: As noted in the previous DQE report, Wellpath hired a new regional psychologist in January 2024 with experience developing behavior plans, which was a positive step toward compliance with Paragraph 136. The psychologist is primarily based at SBCC, but during the April 2024 site visit, she had not yet been involved in the development of specific behavior plans. When the DQE team inquired about behavior plans during site visits at several MDOC facilities, the mental health staff reported that no new plans had been developed or implemented. In an email prior to drafting this report, the Clinical Operations Analyst confirmed that no new behavior plans had been developed or implemented between January and June 2024.

The DQE did find two cases that referenced behavior plans while reviewing the triage meeting notes for other reasons. In one at MTC, the patient's treatment plan in the health record refers to a "DOC approved behavior plan" to manage head-banging when he is

dysregulated, but there is no record of what that plan might entail in any of the contemporaneous mental health notes (e.g., psychiatry note written one day earlier, two crisis contacts with MHPs in the subsequent week). Thus, it does not appear that the mental health staff were meaningfully involved in the implementation of this plan. In the second case, a complex patient at Framingham with chronic SDV and frequent TS placements, the triage notes mention a behavior plan at times, but no such plan is referenced any of the patient's mental health progress notes or treatment plans.

During the April 2024 site visit to SBCC, the facility's leadership mentioned to the DQE team that a patient remains on a behavior plan "developed by the previous administration" and that he had recently progressed to Phase 2 of the plan. A review of the health record dates this behavior plan to January 2022. It does appear to be an incentive-based plan, but it also appears not to be integrated into the mental health treatment plan any longer, as no treatment plans after September 2022 refer to it.[84]

Other behavior plans were developed in the RTU at OCCC between 2019 and 2023. For two patients, the plans appear either to be still active or to have been ended purposely because they were successful in achieving their goal behaviors. Two other plans were no longer referenced in the patients' treatment plan reviews during this monitoring period; it is not clear what became of them.

Overall, the DQE team does not see much progress toward compliance with Paragraph 136. This is particularly disappointing given that, during previous monitoring periods, MDOC's leadership had cited the hiring of a new regional psychologist in January 2024 as a turning point in the implementation of behavior plans. It is certainly possible that the transition from Wellpath to VitalCore delayed MDOC's plans to revise its behavior plan template and retrain staff in this important area. It is also possible that the regional psychologist, who is primarily based at SBCC, is simply overwhelmed with other demands. The latter explanation seems likely, given how intense and inefficient the daily work of SBCC can be, and how poorly staffed the MDOC system is with psychologists overall.

The DQE's hope is that, now that the transition to VitalCore has occurred and the ISU is open, MDOC will redouble its efforts around behavior planning. As noted in the DQE's two previous reports, including a psychologist in the ISU's treatment team will be crucial for the management of individuals with personality disorders and patterns of repeated self-injury. A psychologist was not included in the ISU's staffing matrix, so the DQE

[84] There is only one other treatment plan review in the record, from September 2023. The DQE also read recent MHP progress notes, which do not mention the plan.

will expect to see robust involvement of the regional psychologists, as clinically indicated.

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 policy 103 DOC 650.20, Records and Continuous Quality Improvement, that its contracted healthcare provider engage in continuous quality improvement (CQI) activities. As noted in the last DQE report, Wellpath was reluctant to provide copies of minutes from its quarterly CQI meetings to the DQE because it considered them to be a "patient safety work product." Wellpath did, however, agree to allow the DQE access to some CQI documents during the site visits.

On April 3, 2024, the DQE reviewed Wellpath's CQI materials from SBCC during the period between July 2023 and February 2024. These materials indicated that Wellpath conducts audits of its medical records in two areas related to the Agreement: Psychiatry Services and Suicide Prevention.

The Suicide Prevention audit questions were revised substantially in 2024 to reflect the Agreement's requirements more closely, with new auditing procedures going into effect on January 29, 2024. Wellpath behavioral health supervisors audited ten charts between February 1, 2024, and February 29, 2024. The audit's findings are illustrated in *Table 7.*

Table 7. Wellpath's Suicide Prevention Audit Results, February 2024

Audit Area	Number of charts reviewed	Number of charts compliant	% Compliant
Correct forms are used and filled out completely?	10	10	100
There is consistency within responses on the form (e.g., not indicating low risk in one part of the note and high risk in another)?	10	10	100
Rationale for plan (i.e., discontinuing watch, downgrading watch or continuing watch) is clearly described with relevant risk and protective factors?	10	10	100
Collaborative Safety Plan (CSP) includes coping skills available in the current setting?[85]	1	1	100
Clinical interventions are described in the suicide watch documentation?	10	10	100
Patient is seen for all follow-up sessions?	10	9	90
Patient is enrolled in special needs, if meets criteria?	0	0	N/A

The DQE team is not aware of Wellpath's detailed methodology for these audits, but differing methodology may account for Wellpath's higher assessment of its treatment quality than the DQE team's assessment.

The Wellpath Psychiatry Services audits to which the DQE was provided access were from May to July of 2023, so they do not provide proof of CQI practice relevant to the current monitoring period.[86] The audits reviewed practice areas such as the completion of initial psychiatric evaluation; informed consent documentation; abnormal involuntary movement scale (AIMS) completion; laboratory studies in accordance with clinical guidelines; use of correct health record forms; psychiatric evaluation upon return from a hospital; medication "bridging" orders upon return from a hospital; documentation of a schedule for follow-up visits; and timely completion of follow-up visits.

The DQE also reviewed minutes from a Wellpath quarterly CQI meeting held at SBCC on December 31, 2023. The meeting was attended by the facility's Deputy Superintendent of Reentry, Mental Health Director, and Health Services Administrator. Although the data are somewhat outdated, they are worth mentioning here because they demonstrate MDOC and Wellpath's awareness of issues at SBCC highlighted in earlier

[85] The DQE team did not delve into why only one of the ten audited charts required that a CSP be completed. Likewise, we did not delve into what "special needs" were available for patients to be enrolled in or why none of the audited patients' charts met the enrollment criteria.
[86] It is possible that more recent audits were completed, but they were not shared with the DQE team.

DQE reports and some of their efforts to address the challenges. Agenda items related to the Agreement included risk management, critical clinical events (e.g., emergency hospital trips), and access to healthcare (including mental healthcare).

The DQE's plan had been to review similar CQI materials at other MDOC facilities, but the April 2024 site visits were cut short because of inclement weather. By the time of the May 2024 site visits, the DQE team had learned of MDOC's plans to change healthcare vendors on July 1, so it did not seem worthwhile to spend more time studying Wellpath's CQI process.

Between the chart audits and quarterly CQI meeting minutes, it was apparent that Wellpath has a basic structure in place for quality assurance. A review of initially provided materials raised questions about the adequacy of the sample size to be representative of the care being delivered and to reliably identify deficiencies. Where needs for change were surfaced, documented analysis of the underlying causes and actions to address them were limited. None of the agenda items addressed practice issues specific to mental health, although a few of them arguably affect both MHPs and medical care providers.

During the next monitoring period, the DQE team will be starting from scratch to learn VitalCore's CQI process. As noted in previous DQE reports, the hope is that the healthcare vendor will create a process to address the problems with healthcare quality identified by the DQE team. It remains to be seen whether VitalCore's CQI metrics will inadvertently encourage the mental health staff to engage in the same practices they did under Wellpath to satisfy performance metrics rather than patients' needs, such as conducting "proxy PCC contacts" (i.e., documenting a crisis assessment or other brief contact as a monthly therapeutic contact, even if not conducted confidentially or by the patient's actual clinician) and TS follow-up contacts within minutes of a patient's removal from TS placement.

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: The majority of MDOC's policies related to Quality Assurance are consistent with the Agreement, but the last DQE report identified two areas where policies did not yet match: the Morbidity/Mortality Review process and the SDV/SATT Review

Committee. MDOC submitted revised versions of policies 103 DOC 650 and 103 DOC 622, both of which touch upon Quality Assurance practices, to the DQE for review on April 25, 2024. Policy 103 DOC 601, which covers the bulk of the Quality Assurance program, is still being revised.

As currently written, none of the relevant policies outline a procedure for reviewing deaths by suicide and serious suicide attempts that aligns with the NCCHC's template of Clinical Review, Psychological Autopsy, and Administrative Review, as required by Paragraph 146. In addition, there are no policies related to the SDV/SATT Review Committee. Finally, Wellpath's Quality Assurance program does not appear to have reached the point of identifying practice or procedure changes that would address problematic trends or incidents. A more robust Quality Assurance should be implemented with the new healthcare vendor, VitalCore.

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

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

Length of Stay Data

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

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

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

i. 24 hours or less - Defined as Cohort 1
ii. 24 - 72 hours - Defined as Cohort 2
iii. 72 hours - 7 days - Defined as Cohort 3
iv. 7 days - 14 days - Defined as Cohort 4
v. Longer than 14 days - Defined as Cohort 5

Self-Injurious Behavior (SIB) Data

5. An attached Excel spreadsheet of all incidents of Self-Injurious Behavior that occurred on Mental Health Watch during the month organized as follows:
i. A separate row for each incident (which could show repeat prisoners if they had multiple incidents during the month)
ii. Prisoner first and last name
iii. Prisoner ID number
iv. Date of incident
v. Time of incident
vi. Type of incident
vii. Type of Watch – Close or Constant when Self-Injurious Behavior occurred
viii. Whether an outside hospital trip occurred as a result of the Self-Injurious Behavior
ix. Whether an outside medical hospital admission occurred as a result of the Self-Injurious Behavior
6. The total number of incidents of Self-Injurious Behavior that occurred on Mental Health Watch:
i. The overall total;
ii. Self-Injurious Behavior incident that occurred on Close Observation Watch versus Constant Observation Watch;
iii. The total broken down by type of Self-Injurious Behavior:
(1) Asphyxiation
(2) Burning
(3) Cutting
(4) Head banging
(5) Ingestion of object
(6) Ingestion of substance
(7) Insertion
(8) Jumping
(9) Non-suspended hanging
(10) Other
(11) Overdose
(12) Scratching
(13) Suspended hanging
iv. The total broken down by Cohort (defined in Paragraph 139(a)(4) above), at the time of the SIB.

Other Mental Health Watch Data
7. Uses of Force on Mental Health Watch: The number of Uses of Force on prisoners on Mental Health Watch separated by facility, whether such use was spontaneous or planned, and whether there was use of OC Spray.
8. Psychiatric hospitalization: The prisoners admitted for inpatient psychiatric level of care, or transferred to outside facility for psychiatric hospitalization
Census Data
9. Census at first of month in each Residential Treatment Unit.
10. Census at first of month in Intensive Stabilization and Observation Unit.
Staffing Data
11. Mental health staffing matrix for each facility by position, showing FTEs budgeted, filled and vacant.

Finding: Substantial compliance

Rationale: MDOC began issuing a Quality Assurance report in March 2023 and has done so monthly since that time. In March 2024, three subsections were removed from the reporting requirement upon agreement by the parties and DQE, in an effort to eliminate redundancy: 139.a.3, 139.a.5, and 139.a.6.iv.

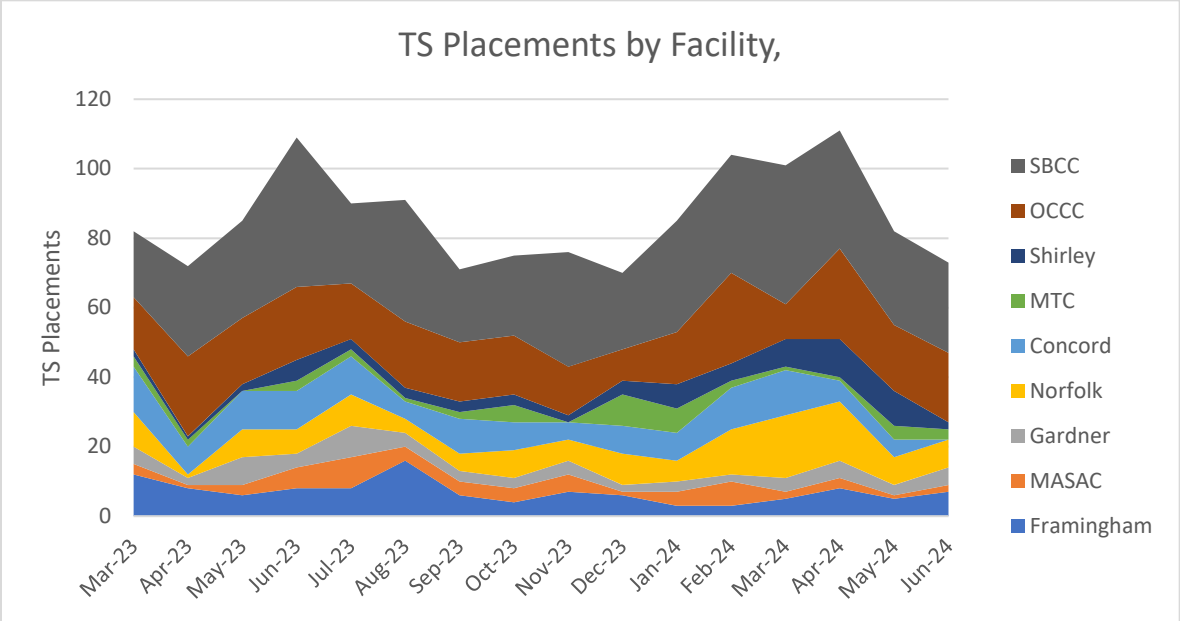
Some important findings from the Quality Assurance reports include:

Number of TS Placements and Length of Stay

Between January and June 2024, there were 556 new TS placements across MDOC[87], which is a 33% increase over the previous six-month period (475 TS placements). *Figure 9* illustrates that the majority of TS placements continue to occur at OCCC and SBCC, which account for 55% of the total statewide placements.

[87] Six patients remained on TS from the previous monitoring period, resulting in 562 total TS stays between January and June 2024.

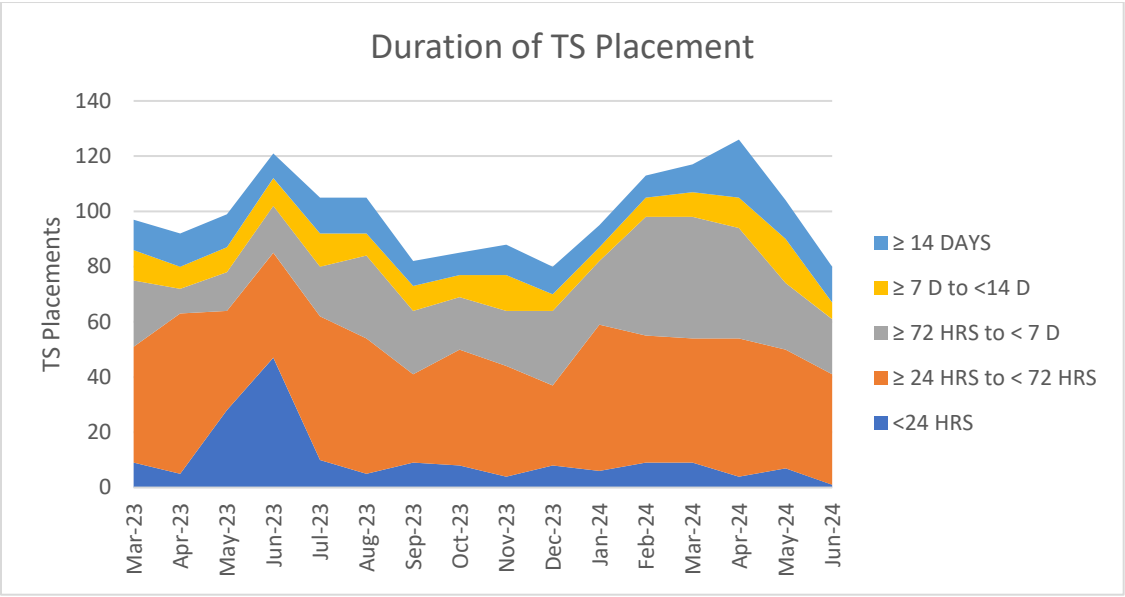
Figure 9. TS Placements by Facility, March 2023-June 2024



Between January and June 2024, the mean length of stay on TS was 4.3 days[88], slightly decreased from the previous six-month period (4.7 days).

When examining the duration of TS placements, MDOC divides them into five cohorts: <24 hours, 24-72 hours, 72 hours to 7 days, 7 to 14 days, and greater than 14 days. As *Figure 10* illustrates, most TS placements are relatively brief, lasting less than 72 hours.

Figure 10. Duration of TS Placement



[88] Calculated from the 556 cases listed in the June 2024 TS Registry.

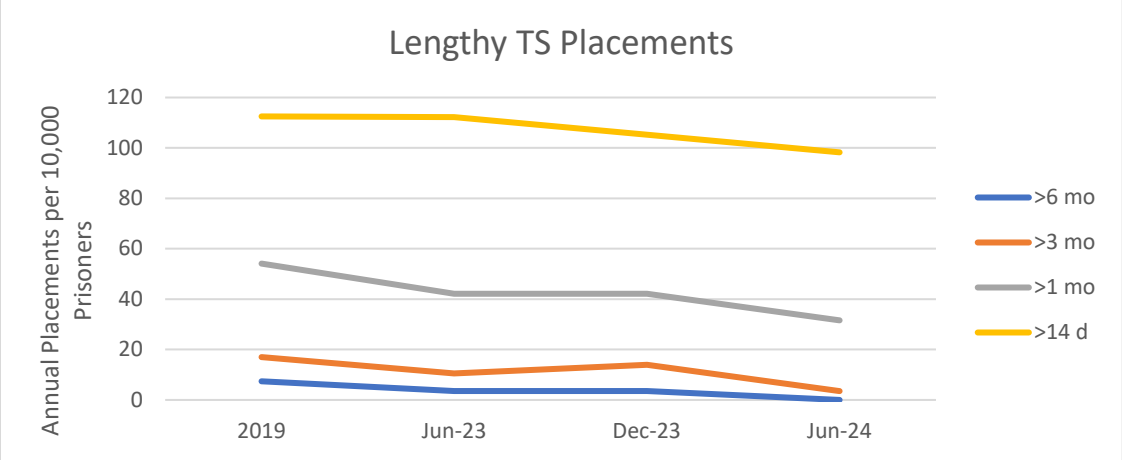
The DQE team continued its practice of analyzing whether the overall number of long TS placements has changed since the DOJ's 2019 Findings Letter. When comparing the 2019 data to present day, one must take into account the substantial decrease in MDOC's total population during that time, from approximately 8,700 prisoners in 2019 to approximately 5,700 in 2024. The DQE found that the rate of long TS placements (>14 days, >1 month, >3 months, and >6 months) continued to decline during this reporting period. *Table 8* highlights these results.

Table 8. Lengthy TS Placements, 2019 vs. January-June 2024

	2019		**June 2024**		
TS duration	Total placements in 13 months	Annual placements per 10,000 prisoners[89]	Jan-June 2024	Annual placements per 10,000 prisoners[90]	**% Change since 2019**
>6 mo	7	7.4	0	0	**-100%**
>3 mo	16	17.0	1	3.5	**-79.4%**
>1 mo	51	54.1	9	31.6	**-41.6%**
>14 days	106	112.5	28	98.2	**-12.7%**

There has been an overall downward trend in the number of lengthy TS placements since the Agreement began, as illustrated in *Figure 11*.

Figure 11. Lengthy TS Placements



[89] Calculated based on 8,700 total prisoners, as noted in the DOJ Findings Letter.
[90] Calculated based on approximately 5,700 total prisoners in MDOC in 2024

The longest TS placements continue to involve prisoners with significant personality disorders, many of whom are involved in a dispute with security personnel about discipline or classification matters. Some of them engage in serious self-injury out of frustration or to avoid transfer to undesirable housing locations. Mental health staff are often caught in the middle, trying to manage the patients' self-injury in the short-term while being unable to alleviate their underlying stressors. Hopefully, the ISU's opening will provide an alternative pathway for patients like this.

Finally, the DQE examined the location where TS placements occur within each facility. Between January and June 2024, the TS registry indicates that approximately 65% of TS placements occurred in the Health Services Unit, as noted in *Table 9*. This represents a significant decrease from the previous six-month period, when 74% of TS placements were in the HSU. Most of the change comes from OCCC's practices. This facility has been using the BAU more often as an "overflow" TS placement area because there are only two suicide-resistant cells in the HSU, and these cells are sometimes occupied by prisoners needing medical observation.

Table 9. Location of TS Placement within Facility

Unit	Facilities Using Unit for TS	# of TS placements	% of TS placements
Health Services Unit	Concord, Framingham, Gardner, Norfolk, OCCC[91], Shirley, SBCC	367	65.3%
Behavior Assessment Unit	SBCC[92], Norfolk, MTC, Shirley, OCCC	144	25.7%
Secure Treatment Unit	SBCC	26	4.6%
Residential Treatment Unit	SBCC	9	1.6%
Housing Unit	MASAC, SBCC	15	2.6%
TOTAL		**561**	**100%**

The trend toward use of the BAU for TS is concerning, and the extent of the BAU's use is likely under-reported in OCCC's and SBCC's current statistics because it does not account for cases where a prisoner started a TS placement in the HSU but was later moved to the BAU. For example, the prisoner with the longest TS placement (106 days) is listed in the TS Registry as having been placed in the HSU, but minutes from the

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

SDV/SATT Review Committee meetings clearly indicate that he has moved to the BAU and engaged in SDV because of distress about this move.

Self-Injurious Behavior

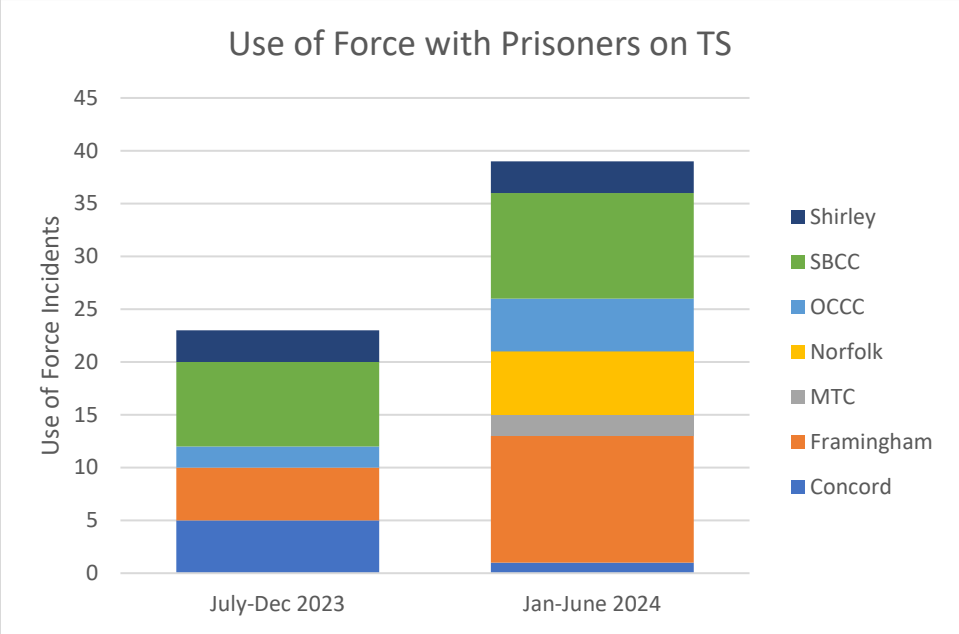
This issue is discussed in Paragraph 143, in relation to the SDV-SATT Review Committee.

Use of Force

In accordance with Paragraph 139.a.iii.7, MDOC reports data on uses of force that occur while a prisoner is on TS. MDOC's data indicate that force was used 39 times with prisoners on TS between January and June 2024, which is a 69% increase over the previous six-month period (23 uses). As noted in the DQE's earlier reports, these data do not include incidents where force was used to gain the prisoner's compliance during the incident precipitating the TS placement, so they likely underestimate the use of force in relation to the TS process.

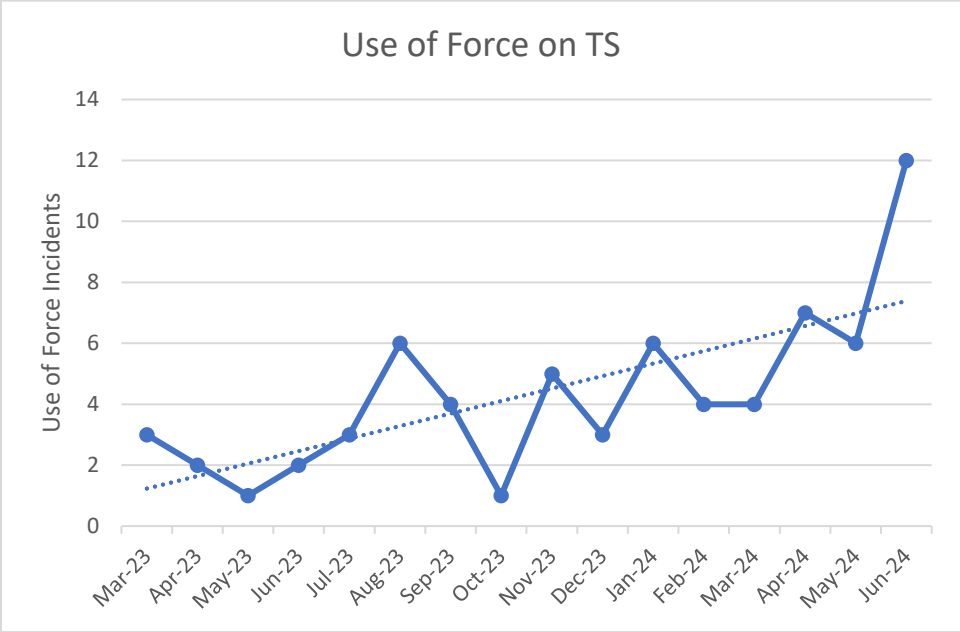
As illustrated in *Figure 12*, the increase in use of force comes largely from Framingham and Norfolk, though OCCC, SBCC, and MTC also experienced an increase.

Figure 12. Use of Force While on TS



Use of force has trended upward since MDOC began reporting the data in March 2023, as illustrated in *Figure 13*. It is not clear what accounts for this trend, so it will need to be monitored closely by MDOC's Quality Improvement Committee and the DQE team during future reporting periods.

Figure 13. Use of Force on TS, March 2023-June 2024



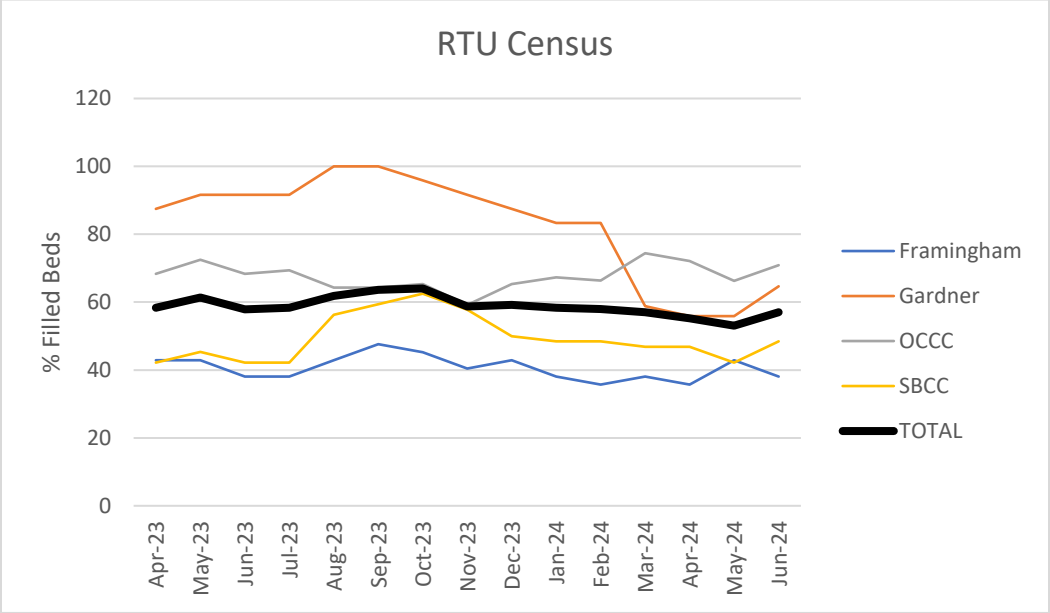
Psychiatric Hospitalizations

This issue is discussed in detail in Paragraph 77.

RTU Census

MDOC's data indicates that some RTU beds reduced at OCCC and increased at Gardner in March 2024. Since that time, MDOC has operated a total of 226 RTU beds across four units: 42 at Framingham, 34 at Gardner (increased from 24), 86 at OCCC (decreased from 98), and 64 at SBCC. *Figure 14* illustrates that, in any given month, approximately 60% of these beds remained filled. It is not clear why so many RTU beds are empty, but prisoners at OCCC and Gardner reported during the July 2024 site visits that the beds have recently been filled with general population (non-RTU) prisoners, which has caused some anxiety about "mixing" of the groups.

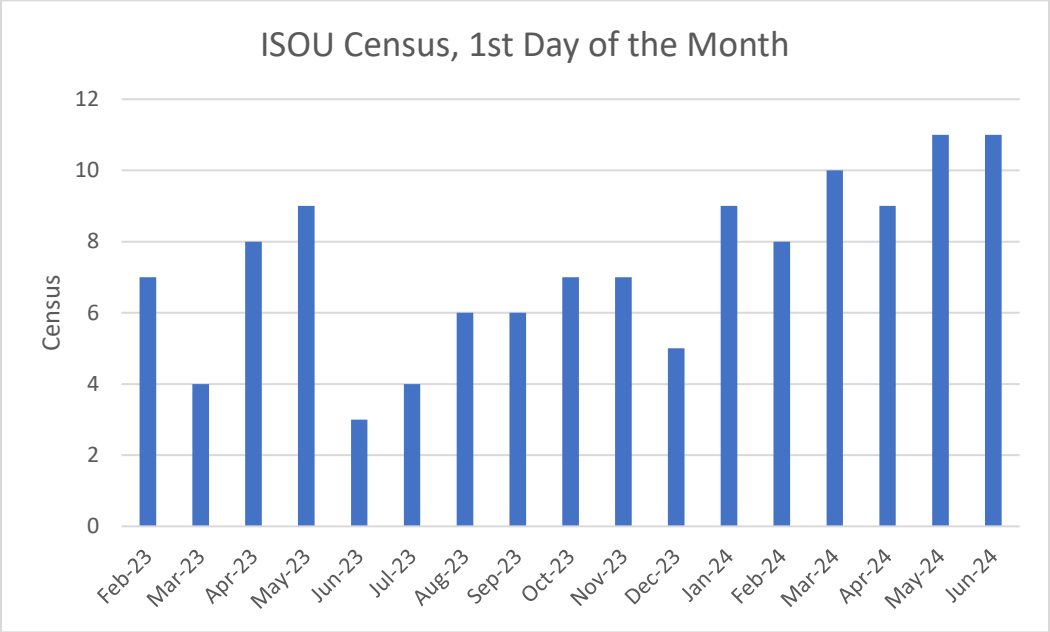
Figure 14. RTU Census, April 2023-June 2024



ISOU Census

The Intensive Stabilization and Observation Unit (ISOU) is the Bridgewater State Hospital unit at OCCC where prisoners are evaluated pursuant to a Section 18(a) or Section 18(a1/2) commitment. The unit's capacity is 50 prisoners, and its census has been trending upward, as illustrated in *Figure 15*.

Figure 15. ISOU Census



Even with this trend, the unit remains mostly empty, with an average census of 10 patients between January and June 2024. Thus, these beds are a resource not being used to their full potential. It is important to note, however, that the courts control admission to Bridgewater State Hospital, and the hospital determines patients' length of stay and discharge readiness. Both of these factors may also contribute to the low daily census of the ISOU, in addition to the limited number of referrals by MDOC staff and patients.

Mental Health Staffing

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

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

Finding: Substantial compliance

Rationale: MDOC's only obligation under Paragraph 140 is to allow the DQE's assessment of the delineated areas and to provide information as requested. MDOC has remained entirely cooperative with the data gathering process, both during site visits and outside of those times. During this monitoring period, MDOC also facilitated the DQE team's review of video footage where there were questions about a prisoner's account of events. The Clinical Operations Analyst has responded swiftly to dozens of requests from the DQE team for clarifying information or additional data, many of them with tight turnaround times. Her work as MDOC's primary liaison to the DQE team remains exemplary.

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 approximately monthly throughout this reporting period: on January 25, February 29, April 5, April 25, May 23, and June 27, 2024. Minutes indicate that MDOC and Wellpath leaders attended the QIC meetings and collaborated in making recommendations for improvement. Action items, person(s) responsible, and deadlines are tracked in the minutes. Overall, the meetings appear to meet the requirements delineated in Paragraph 141a-e.

Meeting minutes indicate that the QIC discussed the increase in SDV incidents with prisoners on TS and hypothesized that the data were influenced by a handful of outlier patients. In addition to reviewing these trends in the TS and SDV data, MDOC worked on the following QI issues between January and June 2024:

- Tracking and documenting the systemic follow-up of Confidential Incident Reports regarding staff misconduct in areas related to the Agreement
- Reducing the use of razor blades for SDV, noting that the BOSS chairs need to be calibrated appropriately to detect small pieces of metal
- Considering the use of padded cells to reduce the harmful sequelae of head-banging, investigating whether this method is used at Bridgewater State Hospital
- Discussing how to handle cases where a prisoner on TS covers their head or hands with a blanket
- Exploring how prisoners had access to the cleaning materials that were ingested in two SDV incidents
- Reviewing TS cells at each facility from a perspective of suicide resistance standards, which resulted in the detection of many cells being used for TS that did not meet all the criteria for suicide resistance
- Tracking completion of Incident Reports related to SDV
- Shackling procedures for prisoners placed on TS in the BAU (addressing questions raised by the DQE team during the Shirley site visit)

- Developing a log for prisoners' TS privileges and out-of-cell time (e.g., showers, outdoor recreation)
- Developing policies for Support Person activities and boundaries, as well as shift-change discussions of Support Person contacts in accordance with Paragraph 103

One area that seemed under-explored in the QIC meeting minutes was the use of force with prisoners on TS. The minutes note the increase in use-of-force incidents, but no explanation or plan for reducing these incidents was ever mentioned. This could be due to the relatively small numbers of these incidents monthly, making it harder for the QIC to see trends than for the DQE team, who reviews the same data in six-month blocks. The DQE team recommends that the QIC examine this issue more closely in the next monitoring period.

Overall, MDOC's QIC meeting continues to function in accordance with the Paragraph 141 requirements, resulting in a continued substantial compliance finding.

142. Self-Injurious Behavior (SIB) Review Committee: MDOC will continue to operate a Self-Injurious Behavior Review Committee that will meet twice per month, be led by a member of mental health clinical staff, and include mental health staff, MDOC Health Services Division staff, and related clinical disciplines as appropriate.

Finding: Substantial compliance

Rationale: MDOC continues to conduct an SDV/SATT Review Committee meeting twice monthly via Teams for two hours. The DQE reviewed minutes of meetings that occurred on January 3 and 17; February 7 and 21; March 6 and 20, April 6 and 17; May 1, 15, and 29; and June 12 and 26, 2024. The SDV/SATT meetings were led by the healthcare vendor. Other attendees included the Wellpath Mental Health Directors from each MDOC facility, the Wellpath statewide leadership (Psychiatric Medical Director, Program Mental Health Director, Assistant Program Mental Health Director), leadership from MDOC's Health Services Division (Director of Behavioral Health, Mental Health Regional Administrator), and the Wellpath CQI Mental Health Coordinator. This structure meets the requirements of Paragraph 142.

143. The Self-Injurious Behavior Review Committee will review and discuss the Quality Improvement Committee's data regarding Self-Injurious Behavior, conduct an in-depth analysis of the prisoners who have engaged in the most Self-Injurious Behavior over the past month, and conduct timely and adequate multi-disciplinary reviews for all instances of Self-Injurious Behavior that require an outside hospital trip.

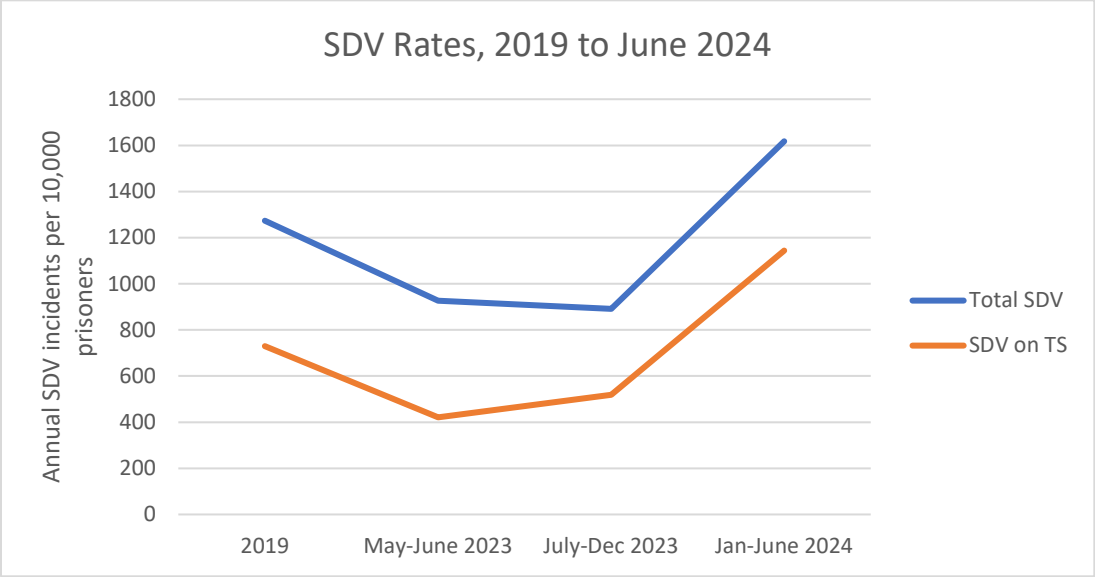
Finding: Partial compliance

Rationale: As noted in Paragraph 142, SDV/SATT Review Committee meetings occur twice a month, and each SDV incident over the preceding two weeks is discussed in detail by a multi-disciplinary group, not just those incidents that require an outside hospital trip. Based on the meeting minutes, MDOC does pay attention to breaches in protocol that could have contributed to the SDV, such as prisoners having access to dangerous items while on TS and mental health staff not being notified immediately of SDV. When such problems are identified, the Mental Health Regional Administrator follows up with the facility regarding a corrective action.

The second DQE Report noted that MDOC was not compliant with Paragraph 143 because the SDV/SATT committee did not systematically review the SDV data from the monthly Quality Assurance reports. MDOC has since taken steps to remedy that deficiency, reporting in its June 2024 status report that the QIC Committee's data are reviewed in one SDV meeting per month. In the DQE's review of the meeting minutes from January to June 2024, a notation about review of the QIC data was found in the minutes for May 1 ("monthly data was reviewed by all parties"), May 29 ("QIC meeting discussion"), and June 26, 2024 ("SDV data was reviewed by all participants"). The minutes for meetings between January and April 2024 did not contain such notations. If MDOC can sustain the practice implemented consistently since May 2024 of reviewing the QIC data and recording that review in the SDV Committee minutes, a substantial compliance finding is likely in the next monitoring period.

Unfortunately, SDV incidents increased by 81% during the past six months, with 461 total SDV incidents between January and June 2024, compared with 254 incidents from July to December 2023. The rates of SDV are now higher than those reported in the DOJ's 2019 findings letter, as illustrated in *Figure 16.*

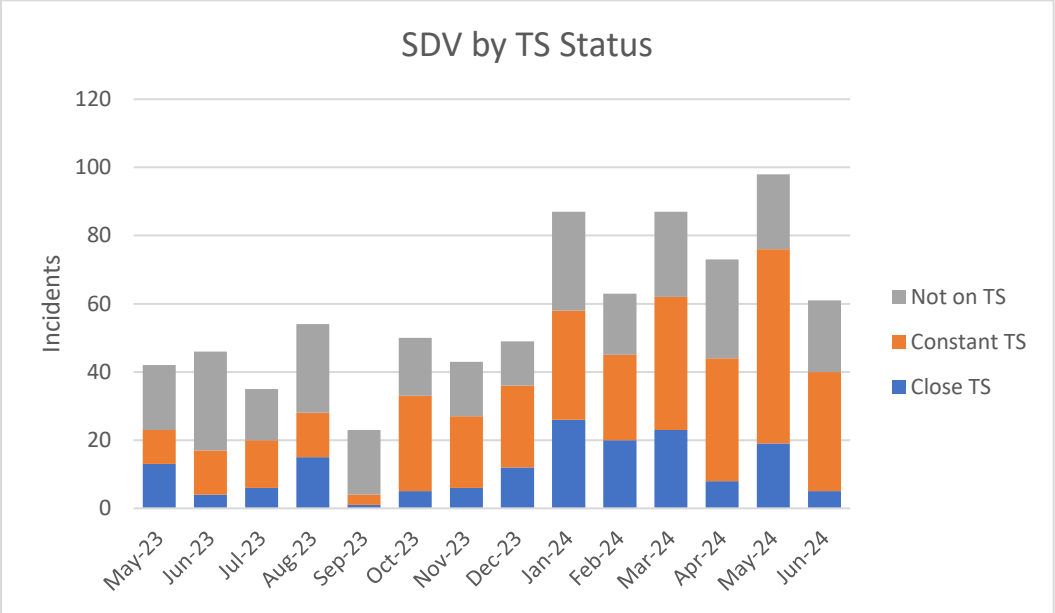
Figure 16. SDV Rates Over Time



The increase in total SDV incidents and those that occurred while a prisoner was on TS are obviously concerning. However, a large number of incidents are attributed to a small number of patients: 107 incidents attributed to one patient, 70 incidents to another, and 31 incidents to a third. If one excludes the 208 SDV incidents attributable to these three outlier patients from the data analysis, SDV rates from January to June 2024 are nearly identical to those from July to December 2023 (253 and 254 SDV cases, respectively). Thus, the high rates of SDV recently may say more about the clinical status of three high-risk patients than it does about broader trends in MDOC.

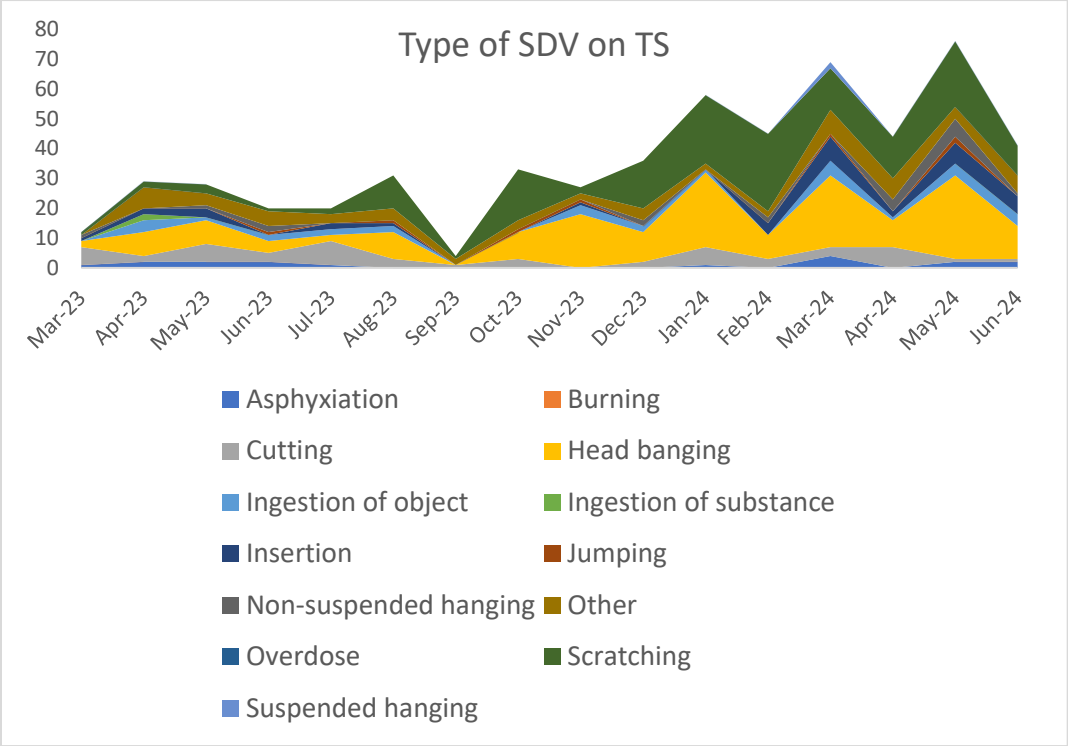
Figure 17 shows that, between January and June 2024, 326 of the 461 SDV incidents in MDOC occurred while a prisoner was on TS (70.7%). This is a substantial increase from the previous six-month period, when 55.5% of SDV incidents occurred while on TS. Most of these incidents occurred under constant supervision, which is consistent with the previous six-month period. Again, these data are heavily skewed by three outlier patients, who accounted for 204 SDV incidents while on TS and 4 while not on TS.

Figure 17. SDV by TS Status, May 2023-June 2024



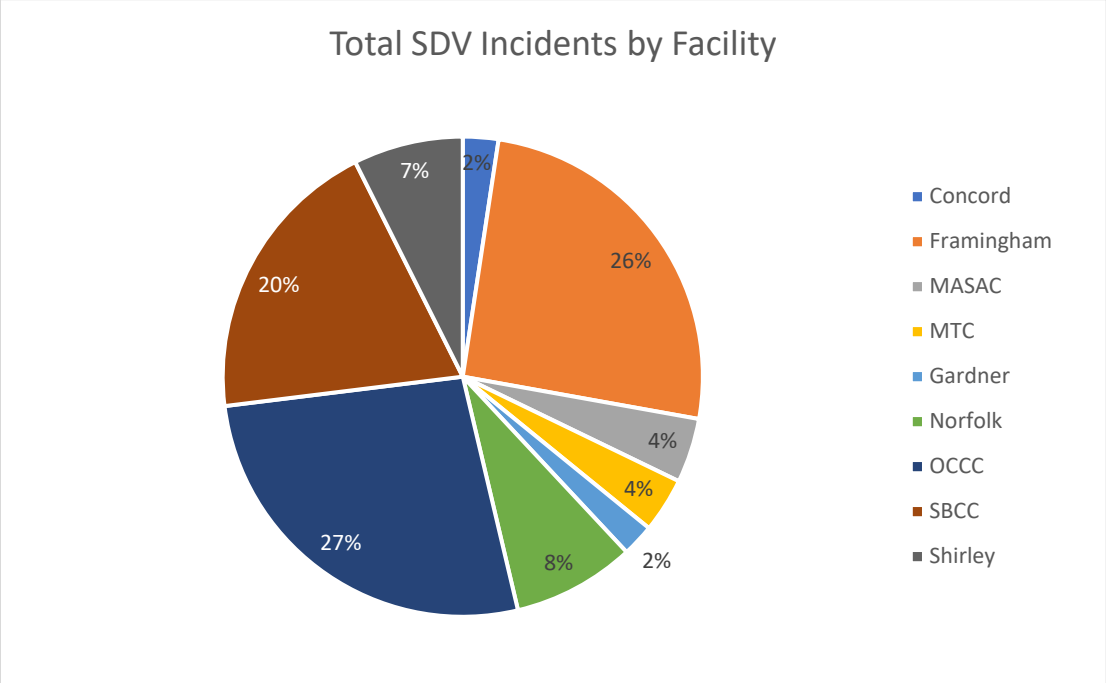
Head-banging and scratching accounted for the greatest increase in SDV, as illustrated in *Figure 18*. Other types of SDV were also trending up between January and June 2024, including ingestion and insertion of objects.

Figure 18. Type of SDV while on TS, March 2023-June 2024



The total incidents of self-injury (not just those that occurred on TS) were divided across the MDOC facilities as illustrated in *Figure 19.* There were no major changes from the previous monitoring period except for Norfolk, which increased from 2% to 8% of total SDV incidents.[93] As in the earlier DQE reports, SBCC and OCCC accounted for about half of MDOC's SDV incidents from January to June 2024.

Figure 19. SDV Incidents by Facility, January-June 2024



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

Finding: Partial compliance

Rationale: In its June 2024 status report, MDOC reported that it continues to facilitate meetings with facilities to address issues that have been identified during the bi-monthly SDV/SATT meetings. The SIB/SDV Committee meeting minutes indicate that two such incidents were identified, both in January 2024, at MTC and Shirley. In the first case, a prisoner was using paint chips or possibly pieces of a flex pen for SDV while in TS; the committee recommended review with the facility about the condition of the TS cells and the presence of unauthorized items in the cell. Two follow-up meetings with the MTC leadership occurred; the facility sanded down and repainted the walls in the TS cells and

[93] This increase is likely due to one individual, who accounted for 18 of Norfolk's 38 SDV incidents between January and June 2024.

reminded staff of expectations for TS cell searches. In the second case, the SDV-SATT committee flagged a spontaneous use of force incident with a prisoner engaging in head-banging on TS for further review at the facility level. This meeting did not occur because the SDV incident was later determined not to have occurred while the prisoner was on TS. A third significant incident of SDV by overdose occurred at OCCC and was reviewed in the SDV-SATT Review meeting; it was later followed up by a Morbidity Review to investigate, among other things, how the prisoner had access to approximately 200 pills of a medication not prescribed to him. The review determined that the medications were administered as "keep-on-person" and that the pills were likely obtained from other incarcerated individuals, so no further action was taken.

Paragraph 144 also requires that the SDV/SATT meeting minutes be shared with "all treating staff," which did not appear to be happening while Wellpath was the contracted vendor. Perhaps VitalCore's arrival will provide another opportunity to address this requirement.

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: Four serious suicide attempts occurred between January and June 2024, and MDOC conducted morbidity reviews within 30 days for each, as noted in *Table 10.*

Table 10. MDOC Morbidity Reviews, January-June 2024

Incident Date	Morbidity Review Meeting Date	Days Elapsed
January 3, 2024	February 2, 2024	30
January 17, 2024	February 15, 2024	29
March 14, 2024	April 3, 2024	20
May 15, 2024	June 4, 2024	20

MDOC's morbidity/mortality process is outlined in policy 103 DOC 622, Death Procedures, Section 622.09 and Attachment D. This process does not align with the technical details required by Paragraph 146 of the Agreement (see discussion below), but it does describe a thorough system of reviewing all aspects of a suicide, including staffing, training, equipment, identification/referral/assessment, communication, housing, levels of supervision, mental health treatment, medical treatment, intervention/code response, and follow-up.

Since the Agreement's inception, two documents stemming from MDOC's morbidity review process have been shared with the DQE following each serious suicide attempt or death by suicide: (1) a memo titled "Scheduled Morbidity Review" containing a clinical case summary written by the 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. No minutes of the review committee meeting have ever been provided to the DQE, though we were permitted to attend one meeting to get a sense of its structure and typical attendance.

For the four incidents occurring between January and June 2024, the Morbidity Review Committee made the recommendations contained in *Table 11*.

Table 11. Morbidity Review Committee Recommendations

Incident Date	Morbidity Review Recommendations
January 3, 2024	None
January 17, 2024	If clinically indicated, incarcerated individuals with limited distress tolerance will receive enhanced support, in the form of at least one clinical follow-up the next business day, following placement in a BAU. These additional contacts will serve to support the individual in their transition to BAU. The contracted healthcare vendor shall ensure ongoing training of all qualified mental health professionals regarding clinical documentation and coordination of care. Such trainings shall include, but not be limited to, the elements of a mental status examination, suicide risk assessment, timely communication of information regarding suicide risk, and for those rare occasions when handwritten documentation is utilized, requirements for handwritten documentation that is uploaded timely.
March 14, 2024	When substance use is being ruled out as a reason for behavioral presentation, mental health will ensure a referral for a toxicology screen is submitted to medical and follow up accordingly to ensure completion
May 15, 2024	When an incarcerated individual leaves a suicide note with a specific plan, a qualified mental health professional shall assess the incarcerated individual to directly address the identified plan. The contact and clinical assessment will be documented in a progress note.

It is not possible from the materials provided to discern why these recommendations stemmed from each case. Some of the recommendations imply that a gap in care may

have occurred around the time of the suicide attempt, but without any idea of the committee discussion, the DQE simply cannot draw meaningful conclusions. For now, all that can be said is that a timely review occurred for all four serious suicide attempts between January and June 2024. The adequacy of these reviews cannot be properly assessed, leading to a partial compliance finding.

During this monitoring period, MDOC also completed its review of the death by suicide that occurred at Norfolk on November 17, 2023. A timely mortality review began with a meeting on December 15, 2023, including an outside psychiatric consultant, and several follow-up meetings were held to complete the review. In a memo dated March 5, 2024, the review committee made five recommendations:

1) Train all clinical staff on how to access older mental health records in real time.
2) Include open-ended questions in BAU risk assessments about the incarcerated person's perception and impact of being placed in the BAU.
3) Ensure that emergency response training includes placing an unresponsive person on a hard surface for CPR.
4) Reeducate [security] staff on the components of effective rounds.
5) Family history of suicide should be included into BAU risk assessments.

Wellpath was required to submit a corrective action plan within 30 days of the memo. That plan was submitted on March 29, 2024, identifying eight corrective action steps. It is not clear what became of these action steps in the next few months, as their target dates for completion were very close to the end of Wellpath's contract with MDOC. During the DQE team's discussion with MDOC's behavioral health leadership on July 16, 2024, they reported acting upon some of the Mortality Review Committee's five recommendations, with others later determined to be unnecessary:

1) Train all clinical staff on how to access older mental health records in real time → This was included in Wellpath's trainings at each site about how to do a BAU risk assessment. The training materials and dates of completion at Norfolk and Concord were shared with the DQE. It is not clear whether similar trainings occurred at other facilities.
2) Include open-ended questions in BAU risk assessments about the incarcerated person's perception and impact of being placed in the BAU → As above, Wellpath reportedly did a training for each site about how to do BAU risk assessments, though documentation was only provided for Norfolk and Concord.
3) Ensure that emergency response training includes placing an unresponsive person on a hard surface for CPR → MDOC verified that the CPR training already includes this information, so no further action was necessary.

4) Reeducate [security] staff on the components of effective rounds → Reeducation was determined to be unnecessary after a reviewing the officers' rounds in the instant case and concluding that they were adequate.
5) Family history of suicide should be included into BAU risk assessments → A recommendation was made by the SDV/SATT Committee to the Quality Improvement Committee to include this in the electronic health record note template for BAU assessments. This was put on hold during the Wellpath-Vitalcore transition.

Overall, it appears that MDOC has most pieces in place for an adequate and timely morbidity/mortality review process. With more consistent demonstration of practice in this area, as well as the technical adjustments to the morbidity/mortality review documentation described in Paragraph 146, MDOC can likely achieve substantial compliance with the Paragraph 145 requirements.

146. The Morbidity and Mortality Review Committee will include one or more members of MDOC Health Services Division staff, the medical department, the mental health department, and related clinical disciplines as appropriate. The Morbidity and Mortality Review Committee will:

a. ensure the following are completed, consistent with National Commission of Correctional Health Care standards, for all prisoner deaths by suicide and serious suicide attempts:

1. a clinical mortality/morbidity review (an assessment of the clinical care provided and the circumstances leading up to the death or serious suicide attempt) is conducted within 30 days;
2. an administrative review (an assessment of the correctional and emergency response actions surrounding a prisoner's death or serious suicide attempt) is conducted in conjunction with correctional staff;
3. a psychological autopsy (a written reconstruction of an individual's life with an emphasis on factors that led up to and may have contributed to the death or serious suicide attempt) is performed on all deaths by suicide or serious suicide attempts within 30 days;
4. treating staff are informed of the recommendations formulated in all reviews;
5. a log is maintained that includes:
    i. prisoner name or identification number;
    ii. age at time of death or serious suicide attempt;
    iii. date of death or serious suicide attempt;
    iv. date of clinical mortality review;
    v. date of administrative review;
    vi. cause of death (e.g., hanging, respiratory failure) or type of serious suicide attempt (e.g., hanging, overdose);
    vii. manner of death, if applicable (e.g., natural, suicide, homicide, accident);
    viii. date recommendations formulated in review(s) shared with staff; and
    ix. date of psychological autopsy, if applicable.

b. recommend changes to medical, mental health and security policies and procedures and ensure MDOC takes action to address systemic problems if identified during the reviews;
c. develop a written plan, with a timetable, for corrective actions; and
d. ensure a final mortality review report is completed within 60 days of a suicide or serious suicide attempt.

Finding: Partial compliance

Rationale: As noted in previous DQE reports, MDOC has a process in place to review completed suicides and serious suicide attempts, but this process does not meet all the requirements of Paragraph 146. Nothing has changed in the most recent monitoring period. Although one of the relevant MDOC policies, 103 DOC 622, Death Procedures, was revised, the section on morbidity reviews (622.09, "Performance Improvement Mortality Review Committee") remained unchanged. The language of this policy, as well as the morbidity/mortality review documents provided to the DQE, are not yet consistent with the technical details of Paragraph 146. In order to achieve substantial compliance, MDOC must improve its current review procedure by:

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

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

Finding: Partial compliance

Rationale: Four reportable incidents occurred between January 1 and June 30, 2024. The DQE was notified within 24 hours in one of the four cases, as noted in *Table 12.*

Table 12. Notification of Reportable Incidents

Date of incident	Date of DQE/DOJ notification	Days to notification	Notes
January 3, 2024	January 5, 2024	2	Admitted to outside hospital 1/3-1/5/24
January 17, 2024	January 22, 2024	5	Admitted to outside hospital 1/17-1/31/24
March 14, 2024	March 20, 2024	6	Admitted to outside hospital 3/14-3/15/24
May 15, 2024	May 16, 2024	1	Admitted to outside hospital 5/15-5/21/24

In discussions with MDOC, it appears that some of the delayed notifications are due to Wellpath's practice of interviewing patients after an incident of serious self-injury to determine whether the patient's intent was suicidal. When a patient is at an outside hospital immediately after the event, sometimes this discussion cannot be held within 24 hours, resulting in a delayed determination that an event was a suicide attempt and therefore reportable to the DQE and DOJ. Based on the DQE's review of relevant medical records, this may have been a factor in MDOC's delayed notification of the incidents on January 3 and January 17, 2024. However, for the case on March 14, 2024, it would have been possible to interview the patient and notify the DOJ and DQE within 24 hours, as the patient was already back at his MDOC facility on March 15, 2024. Given these circumstances, a finding of partial compliance seems most appropriate.

OTHER

159. MDOC will provide to the DQE and the United States a confidential, bi-annual Status Report detailing progress at MDOC, until the Agreement is terminated, the first of which will be submitted within 180 days of the Effective Date. Status Reports will make specific reference to the Agreement's substantive provisions being implemented. The Status Reports will include action steps, responsible persons, due dates, current status, description of (as appropriate) where pertinent information is located (e.g., DAP note, meeting minutes, Mental Health Watch sheet, etc.), DQE recommendations, and date complete. Subsequent Status Reports will be submitted one month before the DQE's draft report. MDOC, however, retains the discretion to achieve compliance with the Agreement by any legal means available to it and may choose to utilize methods other than those identified or recommended in any reports.

Finding: Substantial compliance

Rationale: By agreement of the parties, MDOC's bi-annual status reports are due on June 20 and December 20 of each year. MDOC submitted its most recent status report to the DQE and DOJ on June 20, 2024. The format of the status report was completely revised since the December 2023 report, now containing all the elements required by Paragraph 159, including action steps, responsible persons for each provision, due dates, current status, description of where pertinent information is located, DQE recommendations, and date completed. While there is a field to capture current status that is sufficient for substantial compliance, the DQE encourages MDOC to strengthen some of the content in that field in future reports, providing data or evidence to support conclusions about practice.

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 a Clinical Operations Analyst who serves as the Agreement Coordinator. Her work has been excellent, coordinating site visits, providing reports and documentation to the DQE team, and responding to multiple requests from the DQE team for additional data. At some point, we will need to discuss the feasibility of MDOC's Agreement Coordinator (or other designated individuals) performing some audits internally that the DQE team has been conducting, in an effort to develop self-auditing practices that will be sustained long after the Agreement's formal termination. This discussion does not seem feasible in the short term because of the big projects of getting the ISU operational, changing contracted healthcare vendors, and moving forward major policy revisions.

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: In its June 2024 status report, MDOC stated that quarterly DOJ Implementation meetings have been held since June 2023. The DQE reviewed the most recent meeting minutes from March 4 and June 13, 2024. The 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. Topics discussed included:

- Sharing statistics and data (e.g., 18(a) referrals) at the quarterly meetings
- Sharing the DQE's feedback from the site visits with all sites at the quarterly meetings, promoting cross-facility learning
- Progress with door sweep installation for TS cells
- Use of the cell safety checklist for TS cells
- Proper protocol for officers' use of the "TS watch logs"
- Progress with getting staff to complete incident reports for all SDV

Although it is difficult for minutes to capture the extent of discussion in a meeting, it does appear that the basic intent of the Paragraph 170—gathering feedback about events, successes, and setbacks with Agreement implementation—is being fulfilled. After 13 months of demonstrated good practice in this area, a substantial compliance finding is warranted, although the meetings could be strengthened by soliciting more feedback from the sites about challenges in implementing the Agreement requirements.

RECOMMENDATIONS

The following recommendations stem from the information in the *Detailed Findings* section of this report. As always, the DQE appreciates that some recommendations can be accomplished in the next six-month reporting period, while others will take much longer to implement fully.

POLICIES AND PROCEDURES

1. Continue submitting revisions of DOC policies to the DQE and DOJ. Although this is in progress, the pace is far behind that outlined in the Agreement.

2. Gather VitalCore's policies relevant to the Agreement and submit them to the DQE and DOJ.

3. Provide the Code 99 and Institutional Security Procedures policies to the DQE so that we understand current practice and can assess Paragraphs 106 and 112.

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. Develop policies for Support Persons, including the tools/supplies they may utilize and activities they may engage in with prisoners on TS.

6. Develop a policy about the SDV-SATT Committee's role and functioning, which does not currently exist.

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. Continue recruiting and onboarding mental health staff for the ISU so that understaffing does not limit the number of patients who can be admitted or the nature of treatment provided in that setting.

9. Continue hiring Support Persons across facilities where TS occurs, especially the part-time or per diem staff needed to cover Saturday shifts.

TRAINING

10. Develop a strategy for the training divisions of MDOC and VitalCore to demonstrate that staff have completed trainings required under the Agreement:
    - Pre-service and annual in-service training on policy updates – all security and mental health staff (Paragraph 40)
    - 8 hours of pre-service training on Suicide Prevention – all security and mental health staff (Paragraph 42c)
    - 2 hours of annual in-service training on Suicide Prevention – security staff who work in Intake, Mental Health, and Restrictive Housing units (Paragraph 42c)
    - CPR certification – all security staff (Paragraph 42d)
    - Therapeutic Supervision training – all CO I staff (Paragraph 94)

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

12. Continue efforts to train the healthcare vendor's clinicians, particularly those who have recently completed a degree program and are not yet independently licensed, on diagnosis, treatment planning, risk assessment, and documentation. SBCC and OCCC deserve specific attention, given the high volume of crisis calls and TS placements at those facilities.

13. When revising pre-service and annual in-service training, enhance content in areas where the DQE team has repeatedly found confusion or variable practices across institutions, including:

    a. Contacting mental health without delay for prisoners who request crisis contacts, regardless of whether the individual expresses suicidal ideation
    b. Conducting BAU risk assessments with the same degree of thoroughness as other types of crisis evaluations

c. Individualized decisions about whether to restrain a prisoner during crisis evaluations, out-of-cell contacts on TS, and related escorts
d. Lighting protocols for prisoners on close and constant watch in TS cells
e. Clothing being removed only if used for self-harm

THERAPEUTIC RESPONSE TO PRISONERS IN MENTAL HEALTH CRISIS

14. Continue with physical plant modifications and/or space reallocations to allow for adequate assessment and treatment of patients in crisis and/or on therapeutic supervision:
    a. Create a group space for TS/ITU patients at Framingham.
    b. Create an outdoor recreation area for TS patients at MASAC.
    c. Provide adequate treatment and assessment space at SBCC on the housing units, beginning with implementing a schedule (e.g., times of day for use by medical, mental health, Spectrum, and security staff)

15. Clarify policy and practice around requesting urgent (i.e., within the same day) and emergent (i.e., within one hour) evaluation by the mental health staff. Currently, staff at some institutions are making these distinctions without clear guidance.

16. Minimize practices that deter prisoners from requesting crisis mental health services, including routine shackling during mental health assessments and conducting assessments in areas without adequate sight/sound confidentiality. Staff at SBCC, MTC, OCCC, and Gardner continue to report challenges in conducting confidential assessments and treatment.

17. 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.

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

19. 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.

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

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

22. Continue investigating the feasibility of therapy dogs and peer mentors for TS patients at all facilities.

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

24. Ensure that TS follow-up contacts are being conducted in confidential settings whenever feasible.

25. Ensure that treatment plan updates after a TS placement acknowledge that this event occurred and take it into account when revising a patient's goals and objectives.

SUPERVISION OF PRISONERS IN MENTAL HEALTH CRISIS

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

27. 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.

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

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

30. Develop a strategy to demonstrate the adequacy of investigations of alleged staff misconduct related to the Agreement.

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

BEHAVIORAL MANAGEMENT PLANS

32. Follow through with plans to involve a psychologist in revising the behavior plan template to be consistent with the requirements of Paragraph 136.

33. Continue with plans to re-train the healthcare vendor's clinicians on behavior planning once the template has been revised.

QUALITY ASSURANCE

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

35. Revise the morbidity/mortality review policies to require completion of a clinical mortality/morbidity review, administrative review, and psychological autopsy within 30 days.

36. Share the minutes of the SDV-SATT Review Committee with all treating clinicians.

CONCLUSION AND NEXT STEPS

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

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

Improvements in Patient Care

- Complete Support Persons' integration into the care of patients on TS, ensuring that security protocols permit their engagement with patients (as clinically indicated)
- Enact the long-promised plans to revise the behavior plan template and retrain clinical staff in this area
- Demonstrate the multidisciplinary treatment team model with patients in the ISU, including psychiatry and psychology as clinically indicated
- Continue efforts to train the mental health staff about adequate risk assessment and meaningful treatment while on TS

Technical Compliance with the Agreement

- Hasten the pace of policy development and revision, which is far behind the Agreement's schedule
- Revise the format of morbidity and mortality reviews to comply with the requirements of Paragraph 146

The DQE team anticipates resuming site visits of MDOC facilities at the end of September 2024. SBCC will remain a focus because of its significant difficulty providing mental healthcare in accordance with the Agreement. The ISU at OCCC should be fully functioning by the time of the next scheduled site visit to OCCC in December 2024; the DQE team looks forward to seeing its multidisciplinary team in action.