MASSACHUSETTS DEPARTMENT OF CORRECTION

COMPLIANCE REPORT #6

DESIGNATED QUALIFIED EXPERT

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BACKGROUND

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

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

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

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

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

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

The parties agreed to a gradual implementation timeline, as outlined in the Agreement and discussed with the DQE team. Based on that timeline, all Agreement provisions were to have been implemented fully by December 20, 2025. By December 20, 2026, the goal is for MDOC to have maintained full compliance with every Agreement provision for one year.

EXECUTIVE SUMMARY

When we began monitoring the quality of crisis mental healthcare across MDOC in early 2023, our team shared many of the same concerns that DOJ expressed in its investigation from 2018-2019. Although we observed an admirable culture of collegiality, compassion, and enthusiasm among MDOC's mental health workforce and leadership, the staff's skill in preventing and managing mental health crises needed substantial improvement. Suicide risk assessments were cursory, prisoners were almost universally shackled when interacting with mental health professionals (MHPs), and "treatment" too often took the form of worksheets and puzzles. Security and mental health staffing levels were far from adequate, leaving time in the day only to manage the most urgent concerns. Overall, MDOC exhibited a strong work ethic and commitment to meeting the needs of incarcerated people, but it was not consistently providing the high-quality mental healthcare to which it aspired.

Three years later, including a change of healthcare vendors at seven of the eight sites subject to this Agreement,[2] we have seen incremental improvement at most facilities. MDOC's Health Services Division has done a good job of setting expectations about how crisis mental healthcare

[2] In July 2024, VitalCore Health Strategies replaced Wellpath as MDOC's healthcare vendor at all sites except MASAC. In January 2025, Wellpath split off its former "Recovery Solutions" division into an independent company called Recovery Solutions, which is now MDOC's contracted vendor for MASAC.

should be provided, and the staff's skills have improved in important ways. For example, clinicians can now articulate the importance of reviewing historical and clinical risk and protective factors when assessing suicide risk, and they know that a treatment plan should be individualized to a patient's needs. They understand that meaningful therapy requires privacy, time, and skill, and that it cannot be administered through the cell door or to patients routinely handcuffed behind their backs. They more often help prisoners prepare to handle stressors by identifying emotional triggers and methods to cope. Psychiatrists, psychiatric nurse practitioners, and psychologists are more consistently involved in care of patients in crisis, helping to create a multidisciplinary treatment model and guard against the risks of employing inexperienced MHPs to care for complex and acutely ill patients. Mental health staffing levels have improved in most facilities, and MDOC has created a culture of ongoing training and supervision to support gains in clinical quality and build on them. In addition, MDOC has created a therapeutic setting, the Intensive Stabilization Unit at Old Colony Correctional Center, that offers an off-ramp from repeated or severe crises that once resulted in months-long "mental health watches." This is all significant progress.

Our monitoring team has taken a data-driven approach to assessing the results of MDOC's improvement efforts, and we share a few findings here to illustrate the system's progress:

- In January 2023, MDOC employed approximately 89 full-time-equivalent (FTE) mental health staff members, compared with 148 FTE in November 2025—a 65% increase. All these staffing gains have been made since July 2024 under the new healthcare vendor, VitalCore Health Strategies.
- Self-injury that occurs while an incarcerated person is on therapeutic supervision (TS) has decreased by 11% compared with 2019 levels, including major decreases in cutting (80%) and hanging attempts (32%), possibly indicating more rigorous oversight and intervention by security staff.
- In 2019, DOJ found that "the majority of prisoners are kept long past [MDOC's] four-day goal" for discharge from TS, whereas in the latter half of 2025, the average TS stay was 4.1 days, and only 27% of TS stays exceeded four days. It is now exceedingly rare for a prisoner to spend more than 30 days on TS; just 7 people in the last 13 months did so—an 86% decrease from an equivalent period in 2018-2019.

These data are strikingly positive, though concerning incidents like those described in the DOJ investigation do still occur. For example, prisoners still harm themselves with prohibited items like razor blades or plastic utensils while reportedly under constant observation in a suicide resistant cell, and four deaths by suicide occurred in the latter half of 2025.[3] The ongoing systemic challenges identified by our team include:

[3] Our monitoring team has reviewed the suicides but makes no findings about the specific cases, as our focus is on systemic assessment of crisis mental healthcare. MDOC issued a press release on March 18, 2026, outlining a

Security practices

- Security staffing levels are only marginally better than they were in early 2023, despite the closure of MCI-Cedar Junction and MCI-Concord. MDOC facilities are operating with 76% of needed Correction Officer I staff, which has a detrimental effect on mental healthcare.
- Prisoners continue to report that officers delay or refuse to call mental health staff when prisoners are in crisis. These reports do not include all facilities or even all settings within a facility, but it is concerning that most of the documented allegations come from SBCC and Norfolk, the two facilities where five suicides occurred in 2025.
- When prisoners are handcuffed during crisis mental health contacts, the decisions are largely based on non-individualized factors such as the location of their TS placement, which is inconsistent with the Agreement.

Clinical care

- MHPs have improved their practice in many areas, but their recognition of serious mental illness, especially psychotic disorders (e.g., schizophrenia, delusional disorder), remains limited.
- Written treatment plans remain a work in progress, with some plans still using generic targets like "symptomology" and interventions like "provide mental health interventions" rather than individualized language.
- VitalCore has not demonstrated its quality assurance process in more than 18 months since it began providing healthcare services in MDOC. This is especially concerning in light of the five deaths by suicide in 2025.

In addition to these system-wide challenges, the situation at Souza-Baranowski Correctional Center (SBCC) remains deeply concerning. Violence and excessive force by security staff have been alleged at SBCC for years, including criminal charges filed against correction officers and the settlement of a multi-million dollar class action lawsuit in 2025. These allegations raise concerns about institutional practices that increase mental health crises and impede treatment access. Our monitoring team has also found serious and persistent problems with the provision of mental healthcare at SBCC:

- The vacancy rate for mental health professionals (MHPs) was 45% in November 2025, compared with 14% at the other seven sites. This is particularly problematic because the mental health caseload at SBCC has increased by 58% since the Agreement began, and the facility has become responsible for diverse missions that place more demands on

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systemwide suicide prevention and safety plan stemming from an independent review of the suicides by Dr. Sharen Barboza.

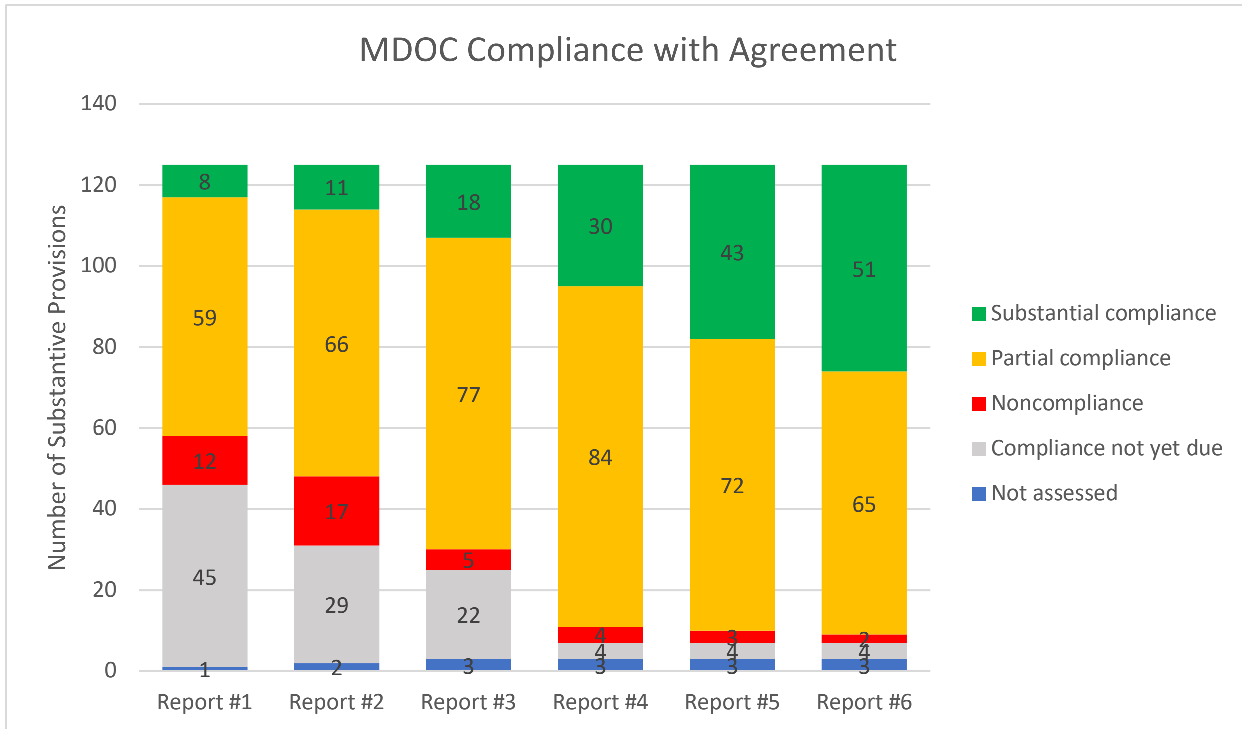
MHPs. In December 2025, there were just five MHPs assigned to manage almost 650 patients in general population—a completely untenable situation.

- As a result of understaffing, MHPs continue to engage in problematic clinical practices that fulfill a technical obligation (e.g., to see patients once per month) without providing meaningful assessment or treatment. Patients remain unassigned to a primary clinician for months on end. Clinicians count one-minute cell-front crisis evaluations as "proxy [primary care clinician]" contacts, complete TS follow-up visits before a patient has even returned to their housing unit, and, most recently, conduct "office hours" in housing units to provide non-confidential, brief check-ins in lieu of monthly confidential sessions. These practices risk depriving prisoners of regular, substantive treatment, and they further drive the demand for crisis contacts and short TS placements, creating a vicious cycle.
- Security/institutional factors continue to impede all aspects of crisis mental healthcare, including crisis assessments, follow up of on-call crisis assessments, TS contacts, and TS follow-up contacts. Between July and December 2025, we found that 78% of TS contacts with MHPs occurred through the cell door, which is worse than when the Agreement began. In addition, Support Persons did not have a single out-of-cell interaction with patients on TS, in contrast to improved practice in all other facilities.
- The conditions on TS are substantially less therapeutic at SBCC than at other facilities. Bright lights are almost always left on at night, patients are rarely allowed clothing or personal property in their cells, and they almost never have outdoor recreation.
- There are continued indications that security staff are not monitoring patients on TS according to protocol. Nearly every log of officers' TS observations we reviewed included improbable findings, such as multiple officers doing checks at the same time and recording different information, or a prisoner staying in the same position for 8 to 30 hours. This documentation raises the possibility of inadequate observation and untruthful recording.
- Use-of-force incidents with patients on TS remain troubling. Between July and December 2025, 64% of the statewide use-of-force incidents on TS occurred at SBCC. Many of these incidents occurred in November and December 2025, just after two deaths by suicide, raising concerns about a system that responds to risk of self-harm with force.

MDOC's leaders deserve credit for their continued efforts to improve the institutional climate and provision of mental health services at SBCC, but solutions remain elusive. Over three years of monitoring, the progress at SBCC has felt like "two steps forward, two steps back." Heading into the Agreement's fourth year, SBCC shows the greatest deficiencies—both in breadth and degree—when implementing crisis mental healthcare.

Overall, MDOC has now reached substantial compliance with 51 of the Agreement's 125 substantive provisions (41%), as illustrated in the figure below. During this monitoring period,

MDOC improved its compliance ratings for 11 provisions. Another 105 provisions remained unchanged, and two provisions slid backward. Compliance with four provisions is not yet due, and three provisions are not being assessed by agreement of the parties.



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

		Substantial Compliance	Partial Compliance	Non-Compliance	Compliance Not Yet Due
Policies and Procedures					
26	Within 6 months, consult with DQE to draft/revise policies and procedures	X			
27	Within one year, finalize all policies and procedures after approval by DOJ		**X**		
28	Within 6 months of finalizing policies, modify all post orders, job descriptions, training materials, performance evaluation instruments				X
29	Fully implement all policies within 18 months of DOJ approval				X
30	Follow public hearing process if any policy changes implicate MA public regulations				
31	Review policies annually and revise as necessary		X		
Staffing Plan					
32	Within 4 months, submit staffing plan to DQE and DOJ, and annually thereafter	X			

33	Increase security staffing to ensure out-of-cell activities for prisoners in crisis		X		
34	Rotate security staff on Constant Observation watches every 2 hours		X		
35	Increase mental health staffing and hours on site to ensure meaningful therapeutic interventions		X		
36	Staffing of ISU – supervising clinician, multidisciplinary team, make individual decisions about property/privileges		X		
37	Staff prisons within one fiscal year of each staffing plan		X		
Training					
38	Provide pre-service and annual in-service training on new policies, mental healthcare, suicide prevention, de-escalation techniques	X			
39	Within 6 months of policy's final approval, incorporate Agreement requirements and DQE recommendations into training				X
40	Within 12 months of DOJ policy approval, all security and mental health/medical staff trained				X
41	Training uses evidence-based techniques and incorporates videos of prisoners/family	X			
42	Ensure that all staff are sufficiently trained in suicide prevention. Offer CIT, pre-service and annual in-service suicide prevention training, CPR certification.		**X**		
Therapeutic Response to Prisoners in Mental Health Crisis					
43	Staff informs mental health immediately about concerns of suicide/self-injury, holds prisoner on Constant Observation until assessed		X		
44	QMHP responds within 1 hour during coverage hours		X		
45	During non-business hours, staff notify on-call QMHP, prisoner evaluated next business day		X		
46	Prisoners not disciplined for mental health crisis	X			
47	Initial mental health crisis evaluation includes required elements 47a-47f		X		
48	QMHP consults with psychiatrist/ARNP and clinical supervisor during initial assessment, as indicated		X		
49	Document initial assessment in progress note using DAP format	X			
50	If QMHP determines prisoner at risk of suicide/self-harm, will be placed on appropriate level of watch	X			
51	Mental health watch not used as punishment or for convenience of staff	X			
52	Crisis treatment plan includes required elements 52a-52k		X		
53	QMHP determines appropriate level of watch (close or constant)	X			
54	Prisoner placed in suicide-resistant cell or on constant observation if cell not suicide-resistant	**X**			
55	Implement cell safety checklist, supervisor reviews checklist if prisoner engages in self-injury		X		
56	Mental health watch conditions based on clinical acuity, disagreements referred to MH Director and Superintendent		X		
57	Individualized clothing determinations		X		
58	Shower after 72 hrs on watch unless contraindications documented, security documents when showers offered	**X**			
59	Lighting reduced during sleeping hours		X		

60	QMHP makes individualized, least restrictive property determinations		X		
61	QMHP makes individualized privilege determinations, provides access to reading materials after 24 hrs and tablet after 14 days unless contraindicated	**X**			
62	Individualized determinations about visits, phone, chaplain, activity therapist	X			
63	Outdoor recreation after 72 hrs on watch, security documents when offered. QMHP documents contraindications every day. Consider alternatives to strip searches		X		
64	Prisoners not restrained when removed from cell unless imminent threat, QMHP documents reasons why restraint necessary		X		
65	Meals out of cell after 72 hrs unless insufficient space or not permitted by DPH		X		
66	MDOC committed to providing constitutionally adequate mental healthcare to prisoners on watch				
67	Within one year, provide three daily out-of-cell contacts, document refusals and follow-up attempts		X		
68	Triage minutes reflect refusal of contacts (who/when/why), MH staff review prior triage minutes		X		
69	QMHP updates MH watch conditions daily Mon-Sat, and Sun if constant watch	X			
70	QMHP documents all attempted interventions and success in daily DAP notes	X			
71	Re-assess interventions if prisoner engages in self-injury while on watch		X		
72	Meaningful therapeutic interventions in group and/or individual settings		X		
73	Individualized determinations and documentation of out-of-cell therapeutic activities		X		
74	Therapeutic de-escalation room at MCI Shirley and ISU	X			
75	Consider peer program for prisoners on watch	X			
76	Consider therapy dogs in mental health units	**X**			
77	Within one year, prisoners transferred to higher level of care if clinically indicated	X			
78	Consult with program mental health director and notify Director of Behavioral Health after 72 hrs on watch	**X**			
79	Consult with Director of Behavioral Health and ADC of Clinical Services after 7 days, document consideration of higher level of care in medical record		X		
80	Consult with Director of Behavioral Health, ADC of Clinical Services, and DC of Reentry and Clinical Services at day 14 of watch and every day thereafter. Document consideration of higher level of care and reevaluation of treatment plan.		X		
81	Develop and implement step-down policy for prisoners released from watch	X			
82	Perform audits to ensure QMHPs are releasing prisoners from watch as soon as possible, after out-of-cell contact and consultation with supervisor or upper-level provider		X		
83	QMHP documents and communicates discharge plan that includes housing referral, safety plan, mental status, follow-up plan		X		

84	Follow-up assessment within 24 hrs, 3 days, 7 days. QMHP reviews and updates treatment plan within 7 days, consults with upper-level provider as indicated.		X		
85	Prisoners interviewed by upper-level provider prior to discharge from watch if clinically indicated		X		
86	If prisoner transferred under 18a commitment, reassessed upon return to MDOC for necessity of continued watch	X			
Supervision for Prisoners in Mental Health Crisis					
87	Establish and implement policies for Close and Constant Observation on watch		X		
88	Observation level determined by QMHP, reevaluated every 24 hrs	X			
89	No placement on MH watch for disciplinary purposes		X		
90	Notification procedures for SIB that occurs on MH watch		X		
91	Staff who discover SIB will report immediately to medical and QMHP		X		
92	Staff who observe SIB document in centralized location		X		
93	Investigate and/or discipline staff violations of policy or rules		X		
94	Security training on new MH watch policies and procedures, sign attestation, post policies on TS units		X		
95	CO remains in direct line of sight of prisoners on Constant Observation		X		
96	CO checks and documents signs of life every 15 minutes		X		
97	Door sweeps in MH watch cells to prevent contraband or foreign bodies		X		
98	Within 1 year, MDOC will ensure Wellpath retains Support Persons in facilities where MH watch occurs	X			
99	Support Persons provide additional non-clinical contacts, part of MDT		X		
100	40 hrs of pre-service training and CIT training for Support Persons		X		
101	QMHP on site to oversee Support Persons and ensure appropriate interventions	X			
102	Support Persons work 6 days a week on shifts when most SIB occurs	**X**			
103	QMHPs discuss Support Person activities during shift change		X		
104	Support Person's ~~documentation~~ contacts reviewed during triage meeting		X		
105	Update procedure for responding to SIB that occurs while on watch		X		
106	Call Code 99 immediately if SIB is life threatening		X		
107	If SIB not life threatening, staff engage with prisoner, encourage cessation, inform supervisor		X		
108	Complete SIBOR within 24 hours for all SDV incidents		X		
109	Officer documents all SIB that occurs while on watch		X		
110	QMHP assesses and modifies treatment plan as necessary within 24 hours of SIB		X		
111	Follow policies on ingestion of foreign bodies outlined in 112		X		
112	Update policies on foreign body ingestion to include monitoring procedures, roles of personnel, use of BOSS chair/body scanner/wand		X		
Intensive Stabilization Unit					
113	Within 1 year, draft ISU policies and procedures	X			

114	Within 18 months, operate ISU	X			
115	ISU provides services for prisoners who have been on MH watch and need higher level of care but not 18a commitment	X			
116	Treatment and programming in accordance with individualized plan		X		
117	Units that serve same purpose as ISU follow ISU guidelines from Agreement				
118	Prisoners referred to ISU if multiple other interventions have been ineffective, prisoners may request placement and be involved in treatment planning		X		
119	Each prisoner assigned stabilization clinician in ISU	X			
120	Prisoners evaluated daily (Mon-Sat) during initial phases of ISU	X			
121	Group programming in ISU based on individualized treatment plan	**X**			
122	ISU permits out-of-cell time and congregate activities	X			
123	Access to all on-unit programs without unnecessary restraints	X			
124	Assessment by QMHP at least once weekly	X			
125	Contact visits and phone privileges commensurate with general population		X		
126	Group meals on unit (MDOC to work with DPH)	X			
127	Clothing and property in cell commensurate with gen pop			X	
128	Indoor and outdoor recreation on unit	X			
129	Movement restricted to ISU	X			
130	Track out-of-cell time offered and whether accepted or refused	**X**			
131	Prisoners not restrained for off-unit activities unless necessary		X		
132	Support persons engage prisoners in non-clinical activities and document response	**X**			
133	Activity therapists provide group and individual programming		X		
134	Therapeutic intervention utilized prior to initiating MH watch	**X**			
135	Therapeutic de-escalation area in ISU		X		
Behavioral Management Plans					
136	QMHP creates individualized, incentive-based behavior plans when indicated, based on principles in 136a-136h		X		
Quality Assurance					
137	MDOC ensures that vendor engages in adequate quality assurance program			**X**	
138	Draft quality assurance policies to identify and address trends and incidents related to crisis mental healthcare		X		
139	Within 3 months, begin tracking and analyzing data delineated in 139a	X			
140	DQE reviews records and interviews prisoners re: clinical contacts and property/privileges while on watch	X			
141	Within 3 months, develop Quality Improvement Committee that engages in activities 141a-141f	X			
142	SIB Review Committee meets twice/month and includes required members	X			
143	SIB Committee reviews QI committee's data re: self-injury, conducts in-depth analysis of prisoners with most	**X**			

	self-injury, conducts MDT reviews of all episodes requiring outside hospital trip				
144	Minutes of SIB Committee meeting provided to treating staff		X		
145	Conduct timely morbidity/mortality reviews for all suicides and serious attempts		X		
146	Morbidity/Mortality Review Committee includes required members and conducts reviews in required format/time frames		X		
147	Notify DOJ and DQE and of all suicides and serious attempts within 24 hours	X			
Other					
159	Within 180 days, provide bi-annual compliance report to DQE and DOJ. Subsequent report due one month prior to DQE's draft report.	X			
169	Within 30 days, designate Agreement Coordinator	X			
170	Within 6 months, conduct quarterly meetings with staff to gather feedback re: implementation of Agreement	X			

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.

ASSESSMENT METHODOLOGY

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

1. **Site Visits**

The DQE team conducted site visits between October and December of 2025 at the eight MDOC facilities where TS occurs. The following activities were conducted by DQE team members during the visits:

	Framingham	Gardner	MASAC	MTC	Norfolk	OCCC	Shirley	SBCC
	10/27/25	12/4/25	10/7/25	10/28/25	10/6/25	11/17-18/25	12/3/25	12/1-2/25
Inspection of TS cells	RK	GM	RK	RK	RK	RK	GM	GM, SS
Interview of prisoners recently/currently on TS	JW	GM	None in facility	RK	JW	RK, VC	RK, GM	RK, JW, GM
Interviews of mental health staff	RK, JW	RK	RK	JW	RK, JW	VC, JW	RK	RK, JW
Interviews of security staff	RK	GM	RK	RK	RK	RK, VC	GM	GM, SS
Observation of MHPs responding to crisis calls	JW	RK		JW	JW	JW		RK, JW
Observation of MHPs conducting TS assessments	JW	none to see	none to see	JW	JW	JW	RK	RK, JW
Observation of MH group programming		RK	RK			VC		JW
Observation of other MH contacts (e.g., PCC, intake)		RK	RK	JW		JW		JW
Observation of MH triage meeting	RK, JW	RK	RK	RK, JW	RK, JW	JW, RK, VC	RK	RK, JW
Observation of BAU Interdisciplinary Assessment Team meeting	RK, JW		(N/A)	none	RK, JW		RK, GM	
Observation of Morning Meeting	RK, JW	RK, GM	RK	RK, JW	RK, JW	RK, VC	RK, GM	RK, JW, GM, SS

Observation of Crisis Clinician Sign-Out	JW					JW		
Observation of Support Person contacts	JW			Out sick				
Observation of noon TS review meeting						RK, VC		RK
Observation of Care Coordination meeting								RK
Review of security video footage					RK	not permitted	GM	GM, SS

During the site visits, the DQE team was given broad access to information and the facilities, as required by Paragraph 158 of the Agreement, except for reviewing security footage of an incident in the ISU that MDOC stated remains under investigation. 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 interviewed 39 prisoners, 24 MDOC security staff members, one nurse, and 32 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 the site visits; this information was also considered when assessing compliance.

2. Document Review

For this report, data from July 1 through December 31, 2025, across the eight facilities where TS occurred during the reporting period were reviewed, except where stated otherwise in the text. General categories of documents reviewed are listed here.

a. MDOC Status Report #6, dated January 5, 2026

b. Electronic health records

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

[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.

Facility	Approximate % of Records
Framingham	10
Gardner	7
MASAC	2
MTC	6
Norfolk	12
OCCC	18
SBCC	38
Shirley	6

Records were reviewed for technical compliance with the Agreement (e.g., number and timeliness of assessments by mental health staff, completion of TS Reports), for appropriateness of clinical interventions (e.g., matching treatment to the patient's documented diagnoses and symptoms), and for adequacy of documentation (e.g., quality of treatment plans and progress notes).[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, duration of TS placement, and other factors
2) A sample of officers' observation logs for TS placements
3) A sample of cell inspection checklists for TS placements
4) A sample of Therapeutic Supervision Reports
5) Log and incident reports for all restraint incidents during TS placements
6) Log and incident reports for all Use of Force incidents during TS placements
7) VitalCore Notification spreadsheets (for 72 hrs, 7 days, 14 days, 14+ days on TS)
8) Minutes of Daily Therapeutic Supervision Consultation meetings
9) Daily mental health Triage Meeting notes and End of Shift reports
10) A sample of Crisis Logs documenting receipt of referrals and responses
11) Disciplinary reports reported to be associated with mental health crisis
12) Emails from MDOC responding to questions about patients, Agreement-related practice, and physical plant

d. Policies related to mental healthcare

1) Monthly letters from MDOC Clinical Operations Analyst describing the status of MDOC's policy revisions
2) Policy 103 CMR 403.00 – Inmate Property
3) VitalCore A-05.00 – Policies and Procedures

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

4) VitalCore B 02.02 – Sentinel Event Reporting and Review
5) VitalCore C 02.00 – Clinical Performance Enhancement
6) VitalCore E 05.00 – Behavioral Health Screening and Evaluation
7) VitalCore I 03.00 – Therapeutic Relationship, Forensic Information & Disciplinary Actions

e. Staffing data

1) VitalCore mental health staffing matrix from November 2025, including filled, overage, and vacant positions
2) MDOC security staffing matrix dated January 3, 2026
3) Recovery Solutions staffing matrix for MASAC, November 2025

f. Training data

1) Crisis Intervention Training (CIT) attendance records
2) MDOC training records for all staff who completed CPR, suicide prevention, and Therapeutic Supervision training in TY25 and TY26
3) Recovery Solutions training records for all security staff at MASAC
4) VitalCore's New Employee Orientation (NEO) training records
5) Training materials and attendance logs for various VitalCore in-service staff trainings
6) VitalCore's "Read and Sign Training: Foundational Mental Health Principles," dated July 2025
7) VitalCore's "DOJ Quarterly Training Submission: Summary"
8) VitalCore's "Therapeutic Supervision Training TY 2025-2026"

g. Intensive Stabilization Unit data

1) ISU triage meeting minutes
2) Schedule of ISU activities, November 2025
3) Referral paperwork for all admitted ISU patients
4) ISU Handbook dated December 13, 2024, and draft of revised handbook dated January 15, 2026
5) OCCC Superintendent's memo re: ISU visitation dated January 23, 2025
6) Sample of group attendance sheets

h. Other mental health program information

1) VitalCore monthly "Mental Health Roll Up Report"
2) List of all prisoners referred to a higher level of care (Section 18(a), Section 18(a1/2), Section 15(b), ISU, RTU, or STU)
3) Summary of all Inter-Facility Clinical Case Conferences related to TS or ISU

4) MDOC and VitalCore staffing and other briefing materials prepared for site visits

i. Self-injury and Use of Force data

1) Log of all SDV incidents
2) Self-Directed Violence Occurrence Report (SDVOR, formerly known as SIBOR) for every incident of SDV
3) Incident reports written by security, MH, and medical staff for all SDV episodes
4) Incident reports related to four deaths by suicide
5) Log of foreign body ingestion/insertion
6) Incident reports and medical/MH documentation from all incidents of foreign body ingestion/insertion

j. Behavior management plans from OCCC, SBCC, MTC, and Framingham

k. Quality assurance materials

1) Minutes from monthly Quality Improvement Committee (QIC) meetings
2) Redacted version of "Professional Conduct Log"
3) Monthly Quality Assurance spreadsheets in accordance with Paragraph 139
4) Morbidity/Mortality Review materials and corrective action plans from four deaths by suicide
5) Self-Directed Violence/Suicide Attempt (SDV/SATT) Review Committee Meeting minutes
6) Time-stamped emails that shared SDV/SATT meeting minutes with mental health staff
7) Minutes from quarterly DOJ/MADOC Agreement Meetings

3. Stakeholder feedback

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

DETAILED FINDINGS

POLICIES AND PROCEDURES

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

Finding: Substantial compliance

Rationale: MDOC continues to consult with the DQE about policy revisions. During this monitoring period, one major policy was finalized: Policy 103 DOC 650, Mental Health Services. Over several monitoring periods, MDOC's pattern of consulting with the DQE about revisions has been sufficiently demonstrated.

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

Finding: Partial compliance

Rationale: We are over two years past the Agreement's deadline (December 20, 2023) for finalizing all policies and procedures. MDOC has finalized one policy, and no draft revisions for VitalCore policies have been submitted to the DQE team for review. In its January 2026 Status Report, MDOC stated that the outstanding MDOC and VitalCore policies are "in varying stages from development and review to approval by ADC of Clinical Services." Similarly, Recovery Solutions policies (for MASAC) are under revision.

Finalizing one policy and providing updates about others represents marginal progress from where things were in the previous DQE report. Accordingly, the DQE team has issued a partial compliance finding for Paragraph 27. The status of policy revisions, as of the drafting of this report, is listed in *Table 1*.

Table 1. MDOC Policy Revisions

Agency	Policy	Title	Status
MDOC	103 DOC 650	Mental Health Services	Finalized 10/29/25. Implementation in progress.
MDOC	103 DOC 601	DOC Division of Health Services Organization	Revision sent to DQE on 9/20/23, comments sent back 1/13/24. Has been undergoing second revision by MDOC for over two years.
MDOC	103 DOC 622	Death Procedures	Revision sent to DQE on 4/25/24, comments sent back 7/28/24. MDOC reports it is still under review.
MDOC	103 DOC 501	Institution Security Procedures	Revision sent to DQE on 9/13/24, comments sent back on 1/29/25. No update from MDOC since then.
MDOC	103 DOC 562	Code 99 Emergency Response Procedures	Revision sent to DQE on 9/13/24, comments sent back on 1/29/25. MDOC reports it is under review.
MDOC	103 DOC 216	Training and Staff Development	Undergoing first revision by MDOC.
VitalCore	VCHS G-5.0	Suicide Prevention	Submitted to MDOC Health Services Division
VitalCore	VCHS E-02	Receiving Screening and Admission Screening	Submitted to MDOC Health Services Division
VitalCore	VCHS G-2.0	Behavioral Health Programs and Services	Undergoing revision and merger with related policies
Recovery Solutions	CL 300-06	Crisis Intervention and Suicide Prevention	Undergoing revision
Recovery Solutions	HLTH 100-16	Emergency Medical Services	Undergoing revision

Because no additional policy revisions have been submitted to the DQE team, the overall status of MDOC's policy compliance with the Agreement has changed little since the DQE's fourth report, issued one year ago:

> The policies have been adequately revised to be consistent with paragraphs 43-75, 77-89, 92-104, 107-111, 113-137, and 140-144 of the Agreement.[6]

[6] Paragraph 75 (therapy dogs) is not addressed in policy because MDOC has chosen not to pursue such a program. This is considered compliant for the purposes of Paragraph 27.

a. Some Agreement provisions remain inadequately captured in the policy language, including paragraphs 38-42 (staff training), 75 (peer support), 90-91 (response to self-injury), 112 (BOSS chairs and body scanners prior to TS placement), 138-141 (quality assurance procedures), and 145-146 (morbidity/mortality reviews).

MDOC needs to accelerate the pace of policy revision to achieve substantial compliance.

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

Finding: Compliance not yet due

Rationale: The DOJ approved MDOC's policy 103 DOC 650, Mental Health Services, on October 1, 2025 so the requirements of Paragraph 28 will be due on April 1, 2026. MDOC stated in its January 2026 Status Report that the policy has been "implemented." In the next monitoring period, the DQE team will expect further details about what modifications, if any, to post orders, job descriptions, training materials, and performance evaluation instruments were completed. MDOC will also need to provide evidence of these changes to be found substantially compliant.

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: The 18-month clock for full implementation of policy 103 DOC 650, Mental Health Services, began on October 1, 2025, making full implementation due by April 1, 2027. According to MDOC's January 2026 Status Report, the policy went live on October 29, 2025, and has since been "implemented." No details about this implementation (e.g., completion of staff training on all the revised policies contained within 103 DOC 650) were provided. Further discussion with the DQE team and

demonstration of full implementation will be necessary before MDOC can be found substantially compliant.

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: In previous reports, the DQE team has found that MDOC's procedure for annual policy review, which is clearly delineated in policy 103 DOC 104, Internal Regulations/Policies, meets the Paragraph 31 requirement. Nothing has changed during the current monitoring period. The most recent revision dates for MDOC policies related to the Agreement are listed in *Table 2.*

Table 2. Annual Revision of MDOC Policies

Policy	Title	Most Recent Revision[7]
103 DOC 601	DOC Division of Health Services Organization	1/21/25
103 DOC 650	Mental Health Services	10/28/25
103 DOC 622	Death Procedures	3/10/25
103 DOC 501	Institution Security Procedures	9/3/25
103 DOC 562	Code 99 Emergency Response Procedures	7/22/25
103 DOC 216	Training and Staff Development	4/23/25

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

Based on this information, MDOC's procedure for annual policy review appears to be functioning, even as the policies have not yet been substantively aligned with the Agreement.

In previous reports, the DQE team noted that Wellpath employed a system for annual policy review. It is not clear whether Recovery Solutions, now MASAC's healthcare vendor, follows Wellpath's policies or has created its own since the two companies split. In either case, the Recovery Solutions policies have not been shared with the DQE team, so it is not possible to assess whether they meet the requirement for annual review.

Some relevant VitalCore policies have been shared with the DQE team. VitalCore's policy A-05.00, Policies and Procedures, specifies that each policy must be reviewed at least annually. MDOC provided five VitalCore policies for the DQE's review, each of which indicated that it had been reviewed in 2025. This indicates that a procedure for annual review of VitalCore policies is also functioning well.

The requirement to submit substantive policy changes to DOJ for approval annually will not take effect until October 1, 2026, one year after DOJ first approved policy 103 DOC 650. Currently, MDOC is very close to substantial compliance with Paragraph 31, needing only to demonstrate Recovery Solutions' annual policy review process.

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: Staffing plan submission is due in April of each year. MDOC submitted its most recent plans for security staff, VitalCore, and Recovery Solutions on April 22, 2025, so the substantial compliance finding from the last monitoring period carries over into the current one. The next annual staffing plan will be due in April 2026.

It is not clear that the DOJ has formally approved MDOC's staffing plans. The DQE team's remaining concerns about the adequacy of VitalCore's mental health staffing matrix are addressed in Paragraph 35.

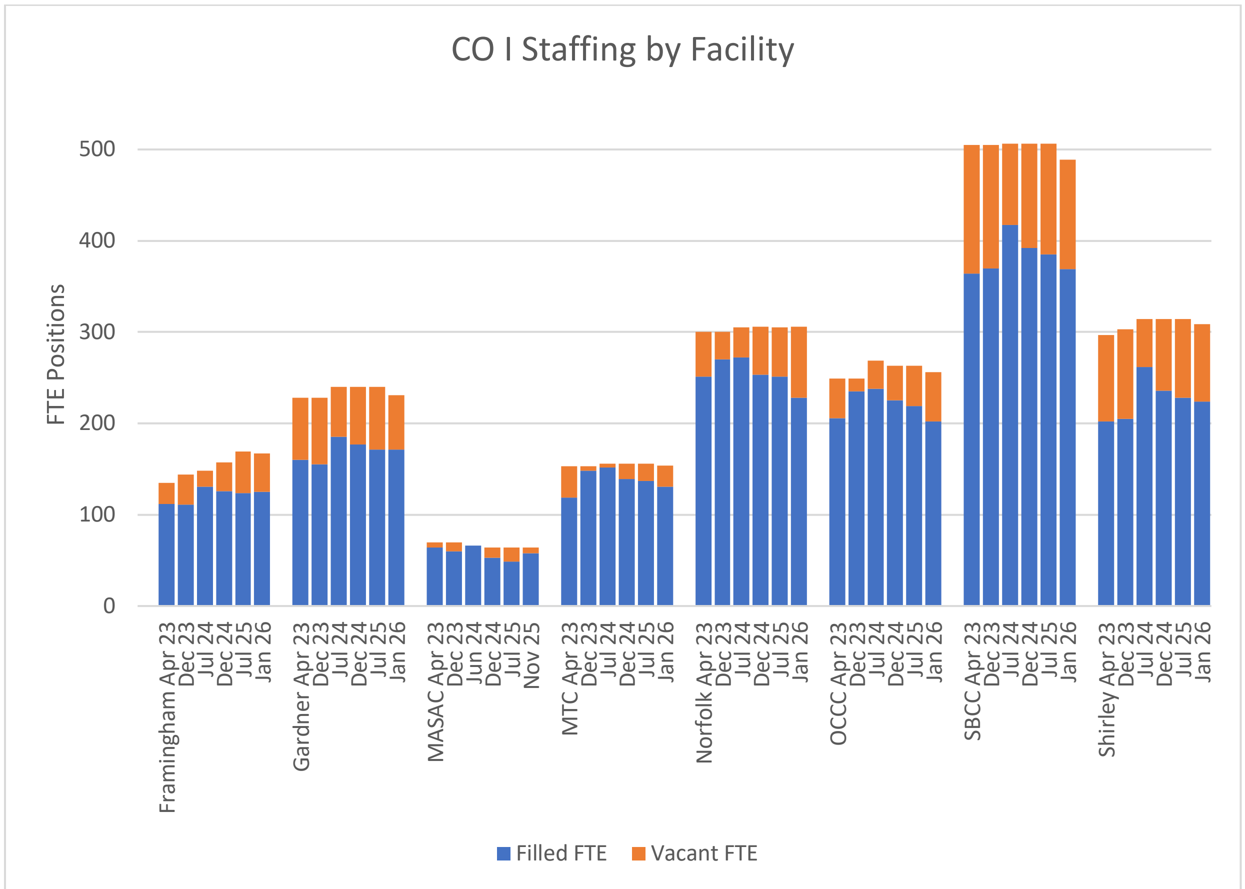
33. Security Staffing Escort: MDOC will increase security staffing as needed to ensure that there are sufficient staff to escort prisoners in mental health crisis to participate in out-of-cell activities such as recreational activities, group activities, etc., in accordance with Paragraphs 62 (Routine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

Finding: Partial compliance

Rationale: As noted in previous DQE reports, officers with the title Correction Officer I (CO I) most commonly interact with prisoners experiencing mental health crises. Officers with the title Correction Officer II (sergeants) and Correction Officer III (lieutenants) serve 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. Security understaffing has remained a significant concern, with no overall progress despite the closure of two MDOC facilities in 2023 and 2024 (MCI-Cedar Junction and MCI-Concord, respectively).

According to the staffing matrix dated January 3, 2026, 76% of CO I positions across MDOC were filled. Staffing levels varied by facility, with the highest vacancy rates at Shirley, Gardner, and Norfolk (see *Figure 1*). CO I staffing levels are only marginally higher than when the Agreement began (76% of positions filled now, vs. 74% in April 2023), despite the hope that closing two MDOC facilities would allow redistribution of security staff to the remaining facilities.

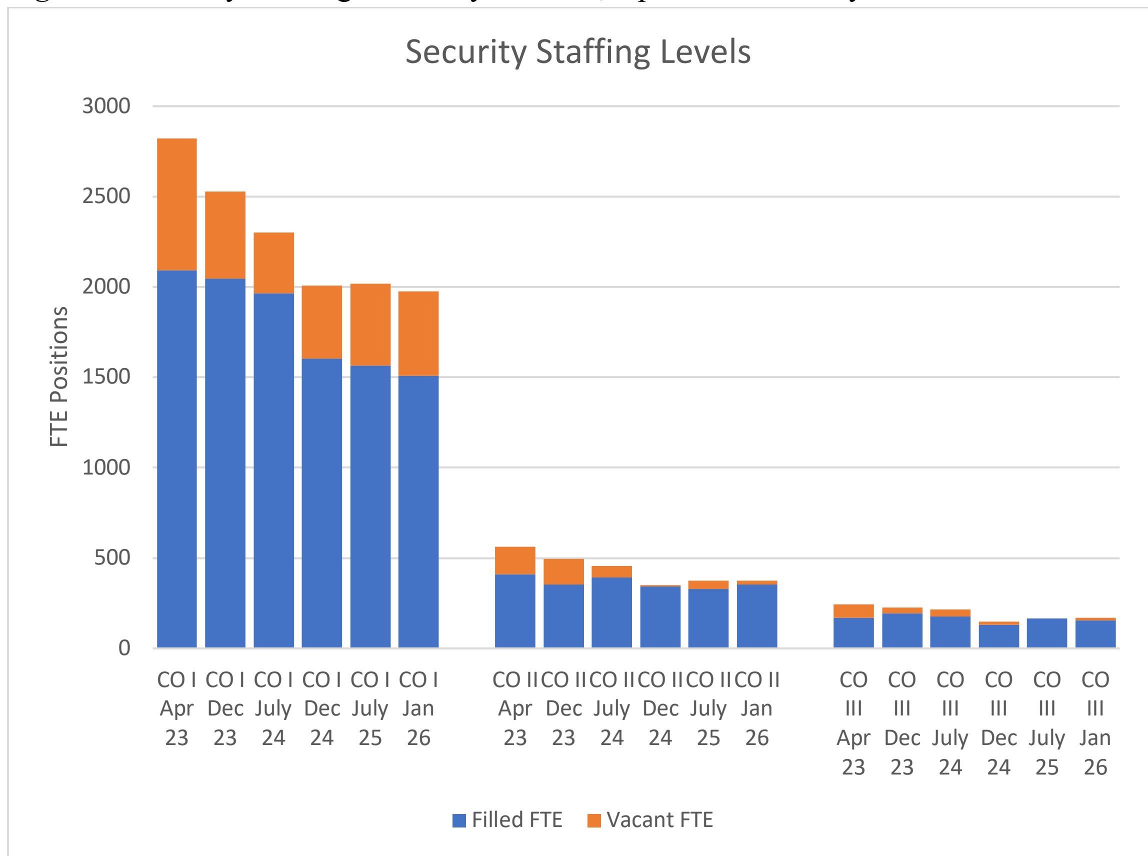
Figure 1. CO I Staffing by Facility[8]



As illustrated in *Figure 2*, the total number of CO I officers declined between July 2025 and January 2026, while CO II and CO III officers increased. This is because of promotions within the officer ranks, without commensurate recruitment of new CO I officers.

[8] MASAC does not employ correctional officers, but 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.

Figure 2. Security Staffing Levels by Position, April 2023-January 2026[9]



During this monitoring period, the DQE team found that security staffing levels had a detrimental impact on crisis mental healthcare in several areas:

- At SBCC, officers in the HSU, BAU, and sometimes other housing units were unable to accommodate out-of-cell mental health assessments or therapeutic contacts because of competing demands;
- In Norfolk and Framingham's HSUs, prisoners reported that security under-staffing contributed to them not being provided outdoor recreation on TS;
- System-wide, more than half of TS constant observations included shifts lasting longer than two hours, increasing the risk of fatigue and missing contraband items that can be used for self-injury;[10]
- At OCCC, officers continued to insist that crisis mental health assessments be conducted in nonconfidential areas (e.g., "New Man's" booking area) if security staff were unavailable to escort the prisoner to a private area in the HSU;

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

[10] See Paragraph 34 for further discussion of this issue.

- "STA" officers who are unfamiliar with specialized units' operations (e.g., ISU, RTU) routinely cover CO I responsibilities in those areas, causing inconsistent practice and, at times, a lack of understanding about mental health needs.

Overall, MDOC remains in partial compliance with Paragraph 33.

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: The great majority of correction officers and supervisors, interviewed over time, have described the practice of rotating responsibility for constant observation every two hours as long-established. This was reinforced by nearly all officers who spoke to this point during the current monitoring period, though a small number suggested the goal could not always be met. The 15 interviewed officers worked in six of the institutions and were posted to the BAU, HSU, ISU, ITU, SAU, and STP (which have TS cells); were "STAs" who are typically assigned constant observation duties; or observed prisoners on TS while working overtime. Prisoners also commented on recent experiences of constant observation.[11] They were aware of officers rotating. The prisoners' time estimates varied quite a bit, from endorsing the required schedule to stating that officers are potentially posted up to half of a shift.

Documents, too, demonstrated a structure to rotate officers as required. The DQE team reviewed a sample of officers' observation sheets from 28 TS placements with constant observation during the monitoring period. The sample was drawn from BAU, HSU, ITU, SAU, and STP across seven institutions.[12]

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[11] Ten prisoners across five institutions spoke of this experience.

[12] In a study of several TS-related security staff requirements, the DQE team reviewed 50 sets of custody observation sheets drawn from each institution providing TS, in proportion to its percentage of TS placements from July through December 2025. The sample was chosen from the TS Registry to include TS stays in BAU, HSU, ITU, SAU, STP, and MASAC's C Dorm. This sample was also used as the basis for analyses of the cell inspection checklist and other requirements for constant and close observation.

Within the sample, 28 records included constant observation. There were records from all the settings listed above and all institutions except MASAC. This represents a 13% sample of the placements that had constant observation in the last half of 2025, according to the TS Registry for that period.

These records showed practice declining since the previous monitoring period. Even allowing for some slightly extended observations, records demonstrated compliance[13] at these rates:

SBCC	33%
Rest of system	56%

The longest times on post appeared to be 8 to 9 hours. Although Paragraph 34 does allow exceptions to the two-hour rotation rule in emergency situations, the long observation periods are currently occurring too frequently to be explained by emergencies alone. Understaffing is a more likely explanation.

MDOC has reported continued efforts to bring this requirement into compliance, including security supervisor oversight in real time and reviewing completed observation sheets, Quality Improvement Committee projects, and emphasis during a mandatory site administration meeting in October 2025. While a system is in place, it has not yet produced timely officer rotation consistently enough for a substantial compliance finding.

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: Mental health staffing continued to improve during this monitoring period, reaching its highest level since the Agreement began. In November 2025, the total number of mental health-related contracted positions across VitalCore and Recovery Solutions was 169.75 FTE, compared with 130.85 FTE in January 2023.[14] The overall fill

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

[14] The following positions were included in the analysis of the VitalCore and Wellpath/Recovery Solutions staffing matrices: Activity Therapist, Psychiatric APRN/CNS, Clinical Director, MH Director, Mental Health Professional, Psychiatrist, Regional MH Director, Regional Psychologist, Unit Coordinator, Support Person, BA-Level Social Worker, and SUD Counselor.

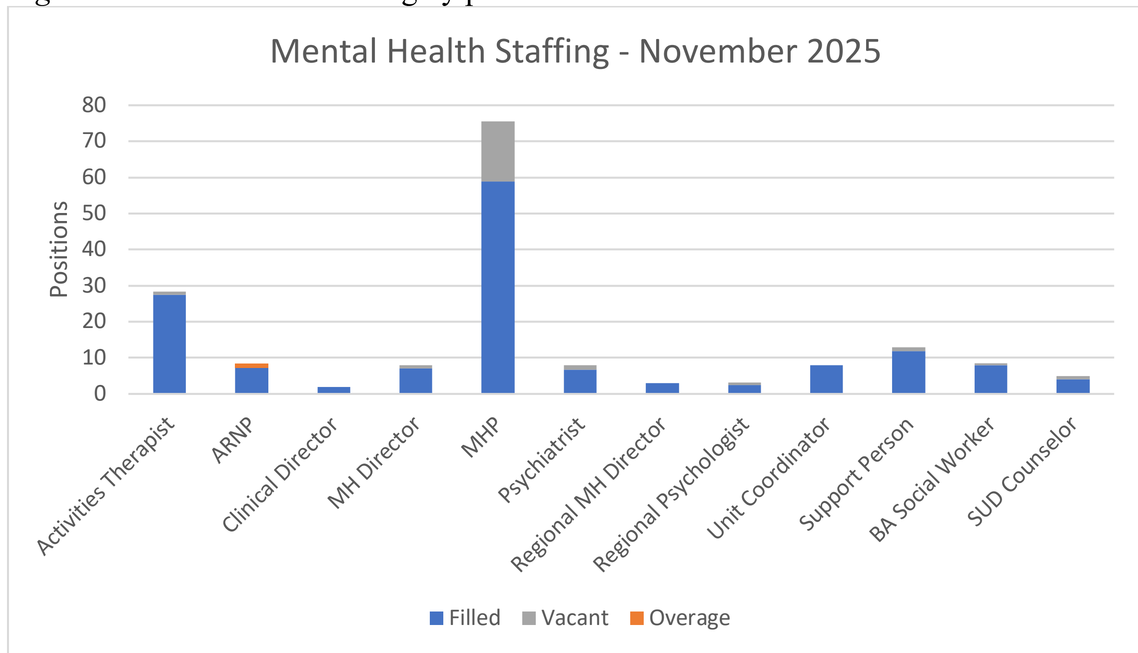
rate for mental health positions was 87% in November 2025 (147.7 FTE), compared with 68% in January 2023 (89.35 FTE). Thus, not only has the total number of contracted positions increased by 30% in three years, the number of filled positions has increased by 65%.[15] This change is particularly important in light of the increase in MDOC's population of prisoners with mental illness[16] and the redistribution of these prisoners among MDOC facilities after the closures of Cedar Junction and Concord.

Between July and December 2025, two changes to the staffing matrices (i.e., the number of contracted VitalCore and Recovery Solutions positions) were made:

- A change from 8 facility-based VitalCore substance use disorder (SUD) counselors to 5 regional positions.
- An increase in the number of contracted VitalCore psychiatrist positions from 6 to 7, and psychiatrist nurse practitioners (APRNs) from 5.1 to 6.25.

In November 2025, 87% of mental health positions were filled, compared with 67% in June 2024, just before VitalCore assumed MDOC's health services contract. The largest number and proportion of vacancies are still among MHPs, as illustrated in *Figure 3.*

Figure 3. Mental health staffing by position



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[15] One important caveat regarding staffing levels: most of these gains have come from so-called "ancillary mental health staff" positions—Support Persons, activity therapists, and bachelor-level social workers. While these positions have undoubtedly been positive additions to the mental health teams, they are not a substitute for licensed professionals.

[16] According to MDOC's monthly "Mental Health Roll Up" report, there were 2,574 prisoners on the mental health caseload in January 2023 and 2,783 in December 2025.

Staffing changes over time are depicted in *Figure 4*. Overall, staffing levels have increased steadily since June 2024, which is a positive development.

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

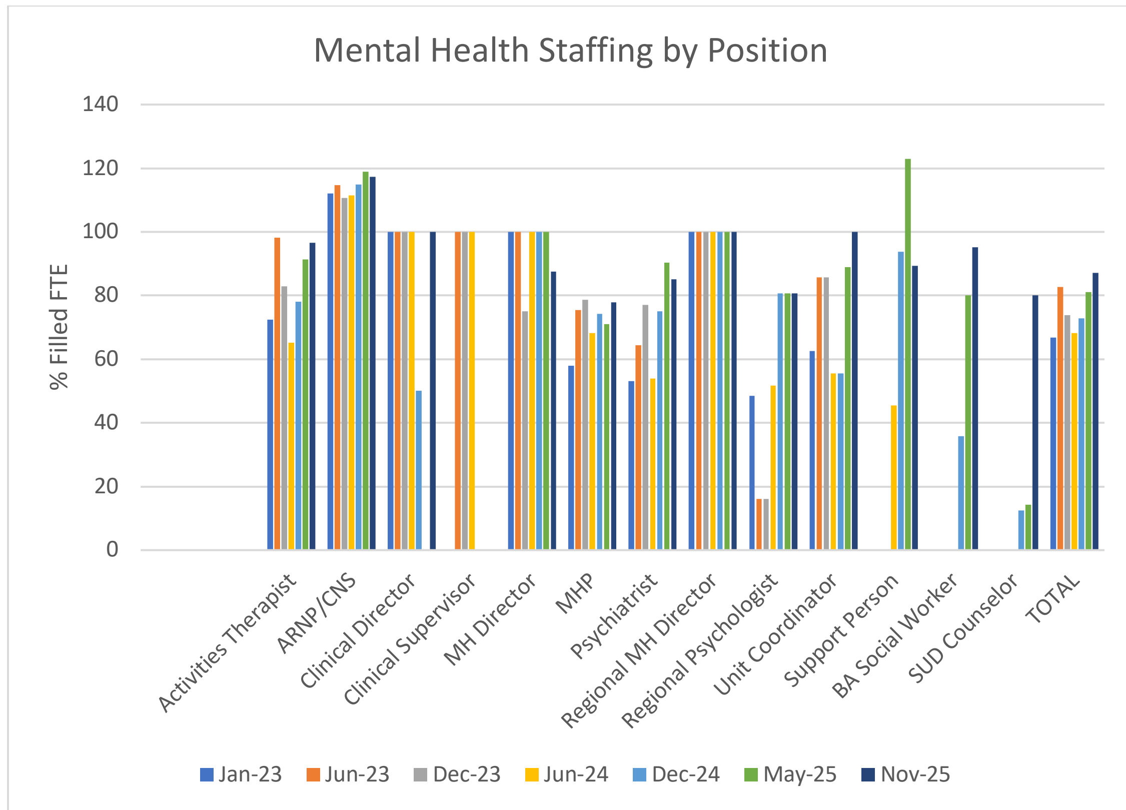
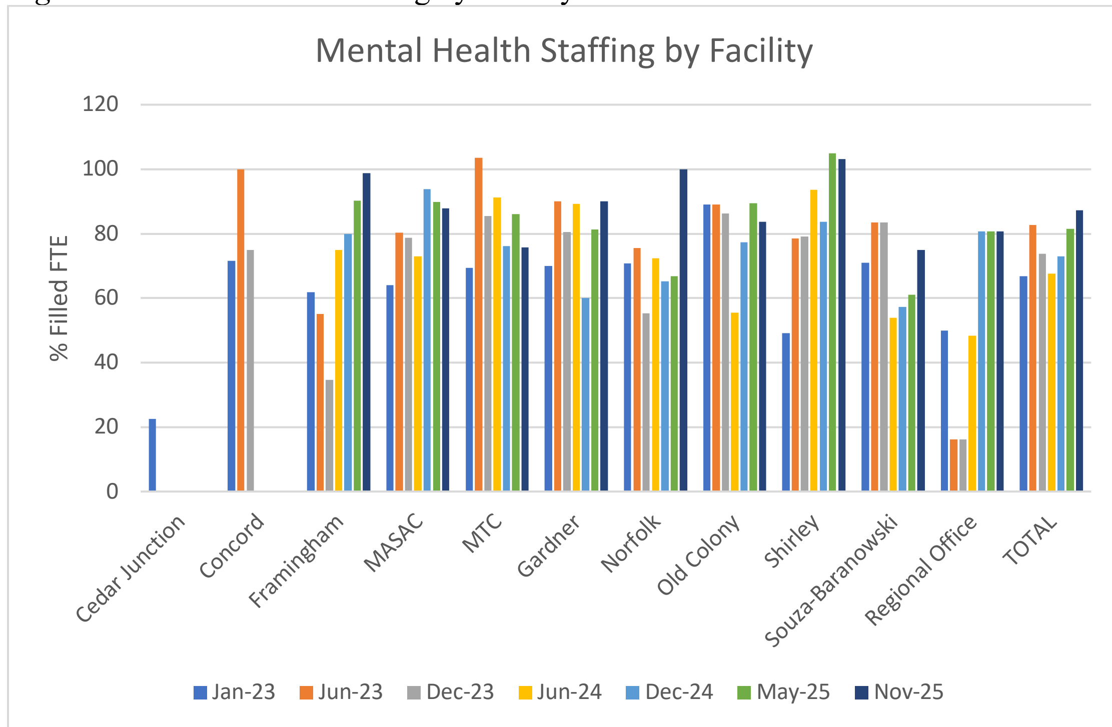


Figure 5 illustrates mental health staffing levels by facility. Among the facilities, SBCC remained worst off, operating with approximately 75% of necessary mental health staff in November 2025, including only 55% of its contracted MHP positions (11.1 out of 20 FTE). This represents a modest improvement from May 2025, when 40% of positions were filled, but it is still far too low, and it stands in contrast to the other seven MDOC facilities, where the MHP vacancy rate was 14% in November 2025. During this monitoring period, VitalCore increased salaries for MHPs at SBCC again, paying them more than at any other MDOC facility, which may have had a positive impact on recruitment.

Figure 5. Mental Health Staffing by Facility[17]



Since the Agreement began, the DQE team has reported concerns about the dearth of doctoral-level mental health professionals in the MDOC system. This concern persists, but VitalCore's efforts to increase the contracted psychiatrist and APRN positions is appreciated. In the DQE team's analysis of the current staffing plan, psychiatry and/or APRN hours have been added SBCC, Norfolk, Shirley, and MTC. The contracted number of psychiatrists and nurse practitioners is now 8 FTE psychiatrists and 7.25 FTE nurse practitioners across eight MDOC sites, serving approximately 2,800 prisoners on the mental health caseload. While this does still not meet the physician-to-patient ratio recommended by the American Psychiatric Association for carceral settings,[18] it is an improvement from the last monitoring period. The addition of nurse practitioners to SBCC has been particularly meaningful, with a team of four providers now involved with the mental health team. The higher fill rates for psychiatry positions under VitalCore are also positive; over 80% of psychiatry positions and over 100% of APRN positions were filled as of November 2025.

These are all positive developments, though clinical problems stemming from mental health understaffing persist at some MDOC facilities. As noted elsewhere in this report,

[17] On this chart, the "Regional Office" site includes only MDOC's Regional Psychologist positions (3.1 FTE total).
[18] The ratio recommended in the APA's *Psychiatric Services in Correctional Facilities, Third Edition* (2016) is 1:150 for "outpatients" in general population. Higher ratios are recommended for specialized settings like the RTU, STP, HSU, and ISU. MDOC's overall psychiatrist: patient ratio in November 2025 was approximately 1:183.

a substantial proportion of clinically indicated psychiatry contacts for TS patients are not occurring. In addition, the practice of conducting brief, cell-front "proxy PCC" contacts with a staff member other than the assigned clinician persists, driven by a desire to meet mandated once-monthly contact requirements in the context of severe understaffing. This practice was observed by the DQE team most commonly at SBCC, Norfolk, and Shirley, where MHP staffing levels have not kept pace with increases in the population of prisoners with mental illness.[19]

Finally, the DQE team has highlighted two additional challenges with mental health staffing in previous reports: (1) MDOC continues to employ a high proportion of MHPs who are not independently licensed, and (2) staff turnover is high. The DQE team did not undertake a systematic assessment of these issues during the current monitoring period, but based on observations and VitalCore's presentations during site visits, both problems are improving. VitalCore's leadership identified more independently licensed MHPs than during previous monitoring periods, and the staff at most facilities were reasonably stable over the preceding year.

Overall, the staffing improvements under VitalCore since July 2024 are a positive development. More work must be done to achieve full staffing, especially at SBCC, to achieve substantial compliance.

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

[19] According to MDOC's "Mental Health Roll Up" reports, SBCC saw a 58% increase in prisoners on the mental health caseload from January 2023 to December 2025. Norfolk's increase was 34% during the same period, while Shirley's was 43%.

Rationale: The ISU's staffing plan, as of the November 2025 OCCC site visit, is outlined in *Table 3.* The number of contracted positions is unchanged from the previous monitoring period.

Table 3. ISU Staffing Plan

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

The ISU's census has remained low, with typically just a few patients on the unit at a time, so the MHPs assigned to the unit have been able to handle the workload despite not being at full staffing levels. In fact, they have absorbed patients from other parts of OCCC, without any appreciable deterioration of the quality of care in the ISU.[20]

Similarly, security staffing levels appear adequate to meet the current patients' needs. On the first and second shifts, there are four officers and one lieutenant assigned to the ISU, and on third shift, there are three officers and one lieutenant or sergeant. There were no indications that insufficient officer staffing is hampering treatment in the ISU.

As required by Paragraph 36, the ISU's supervising clinician (i.e., unit coordinator) is an independently licensed MHP; all unit mental health staff report to her. In May 2025, a new full-time ISU coordinator began working at OCCC, replacing the acting coordinator. Since its opening, the ISU's multidisciplinary team has gathered for a daily triage meeting in which all major decisions about a patient's care are made. The team's composition, leadership, and functioning have been described in previous DQE reports and have not changed recently, meeting the requirements of Paragraph 36. Because the unit coordinator leads these meetings, it is reasonable to infer that she is making

[20] During the DQE's November 2025 site visit, independently licensed clinicians in the ISU were also tasked with co-signing notes in the health record written by SBCC's clinicians to help with that facility's backlog—another sign of understaffing at SBCC.

determinations about treatment decisions, as required by Paragraph 36. Additionally, the ISU Handbook indicates that the supervising clinician is to review and approve all treatment plans.[21]

Paragraph 36 also requires that the unit coordinator make decisions about the conditions appropriate for each patient (e.g., clothing, property, showers). Here, the issue identified in the most recent DQE report has not been resolved. During the November 2025 ISU site visit, patients, mental health staff, security staff, and facility leadership all reported that patients' property allowance is determined according to security protocols rather than according to the treatment team's recommendations. As noted in Paragraph 127, patients' property in the ISU is currently restricted beyond what is allowed in general population settings, even at the maximum-security site. This practice does not align with the Agreement's requirement that the ISU's supervising clinician make individualized decisions about property and privileges.

Security, mental health, and nursing staff offered their views on conditions decisions during the DQE team's site visit. Staff generally described disagreements as less common than in the past. An officer thought he would approach MHPs directly about such differences, and an MHP has seen issues be resolved by the Mental Health Director. None mentioned needing to go further up the chain of command. A security supervisor and an MHP both believed property and privilege decisions belong to Mental Health, though a nurse had the impression that security staff determine that.

Overall, MDOC's progress with ISU staffing and the other requirements of Paragraph 36 is sufficient for a partial compliance finding. Ensuring that ISU patients' property allowances are individualized and based on recommendations by the unit coordinator is necessary to achieve substantial compliance.

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). MDOC

[21] Staff reported during the November 2025 site visit that they have not been distributing the ISU Handbook to patients recently because it is undergoing revision. MDOC shared a draft of the revised ISU "Incarcerated Individual Manual," dated January 15, 2026, with the DQE team. This version confirms that the ISU Coordinator chairs the treatment team meetings where decisions are made about programming, progress, and discharge from the ISU.

improved its mental health staffing levels during this monitoring period, but security staffing is about the same, warranting a continued partial compliance finding.

TRAINING

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

Finding: Substantial compliance

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

Trainings for Security Staff:
Given the heightened emphasis on suicide prevention following the deaths by suicide at Norfolk and SBCC in the fall of 2025, the DQE team reviewed MDOC's training materials again. The "Recognizing Mental Illness and Suicide Prevention" training materials were substantively revised in August 2024 and approved by the DQE and DOJ. The DQE team continues to opine that the training materials are appropriate for teaching non-clinical staff (i.e., correction officers) about suicide prevention, though they do need to be updated to include data and lessons learned from the suicides in 2025.

MDOC also provides "Specialized Treatment Unit" training for officers posted to units such as the RTU, STP, ITU, and ISU. MDOC reported that this two-day training occurs at least annually and most recently occurred on December 15 and 16, 2025. In previous monitoring periods, the DQE team reviewed the training materials, which cover topics including behavior management plans, building effective teams, officer resiliency, correctional mental health services, and outcomes data of STUs. In interviews with the DQE team across several monitoring periods, staff have uniformly described the training in positive terms. The ongoing challenge has been to ensure that all security staff

working in the specialized units have undergone this training, as described in Paragraph 39.

In fall 2025, MDOC and VitalCore also revised the approach to annual TS training for security staff. The content is offered to small groups at each institution and taught jointly by mental health staff and the Institutional Training Officer. Materials are well-designed and draw heavily on the Agreement's terms. During several of the DQE's site visits, mental health staff and institutional leadership said the new format is well-received, emphasizing that localized examples make the material more relatable and engaging.

Trainings for Mental Health Staff:
For clinical staff, MDOC supplements its "Recognizing Mental Illness and Suicide Prevention" training with numerous in-service trainings provided by the healthcare vendors. Since assuming the healthcare contract in July 2024, VitalCore has greatly enhanced the trainings offered to its mental health staff. During this monitoring period, VitalCore provided the following trainings, as evidenced by training materials and sign-in sheets provided to the DQE team:

- VitalCore New Employee Orientation (NEO): 40 hours of training, in addition to DOC's NEO, are provided to new staff before they begin working at their designated site. Eight hours are dedicated to mental health topics including suicide risk assessment, clinical boundaries, clinical documentation, substance use disorders in corrections, and sex offender treatment.
- Ongoing discipline- or role-based trainings:
    - *Mental health directors (monthly):* Working effectively with traumatized patients, housing risk factors, PREA standards, educating correctional staff about TS protocols, BAU clinical assessments
    - *Ancillary mental health staff (monthly):* Training on self-care/staff wellness, group facilitation
    - *Support Persons (weekly):* group meeting with an independently licensed MHP to discuss case scenarios and relevant topics
    - *Unlicensed MHPs and licensed MHPs new to DOC (monthly):* grief therapy, countertransference when working with personality disorders, and working effectively with DOC colleagues
    - *Health Services Administrators and Directors of Nursing (part of a monthly meeting):* utilizing on-call mental health services, behavior plans
- Annual in-service behavioral health training (most recently in November 2025):
    - Suicide prevention training (same as for all DOC staff)
    - Suicide risk assessment
    - Working effectively with traumatized patients

    - Substance addiction
    - Core values and guiding principles
- Site-based in-service trainings:
    - Foundational mental health protocols, including emergent, urgent, and routine mental health referrals
    - Treatment planning
    - Clinical documentation
    - BAU clinical assessments
    - MDOC's Health Services Division audit results
    - Various sex offender trainings at MTC (e.g., case conceptualization, psycho-legal documentation, personality disorder, countertransference)

These trainings are crucial to enhancing the skills of relatively inexperienced clinicians. The DQE team remains pleased with the improved focus on clinical skills that VitalCore has undertaken.

At MASAC, Recovery Solutions also provides ongoing in-service clinical training to its mental health staff. MDOC provided evidence of twice monthly trainings between July and November 2025 on topics including countertransference, discharge planning, treatment teams, boundaries and ethics, suicide prevention, and abuse/neglect reporting. During the DQE's October 2025 site visit, mental health staff shared a training binder containing TS policies, instructions, and sample documentation, which they found particularly helpful because TS is a relatively rare occurrence at their site.

Overall, it appears that MDOC and its healthcare vendors continue to provide robust training on a variety of mental health topics, including the pre-service and annual in-service trainings required by Paragraph 38, to security and mental health staff. This practice warrants a continued substantial compliance finding.

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: The first policy to be revised under the Agreement, 103 DOC 650, Mental Health Services, was formally approved by MDOC on October 28, 2025, making the Paragraph 39 requirements due on April 28, 2026. Although this policy covers many aspects of mental healthcare and includes dozens of small changes in practice, the two

main topics that necessitate additional staff training are (1) Therapeutic Supervision protocols, and (2) Intensive Stabilization Unit (ISU) goals and operations.

To its credit, MDOC is already providing these trainings. Paragraph 94 discusses the completion of TS training; MDOC's performance in this area remains strong. During the DQE team's November 2025 site visit at OCCC, MDOC reported that all but two of the security officers bid into the ISU had completed ISU training (a problem previously identified by the DQE team) on November 13, 2025. In February 2026, MDOC confirmed that one of the two remaining officers had since completed the training, while the other is no longer assigned to the ISU. This is an improvement since the previous monitoring period.

Paragraph 39 also requires that MDOC consider the DQE's recommendations about its training plan. At this time, the DQE team recommends that MDOC develop a plan to train "STA" or other officers covering shifts in the specialized treatment units about their unique goals and operations. This training is necessary because, over several monitoring periods, the DQE team has found that officers without specialized training are routinely working in those settings, at times undermining their smooth functioning. The DQE also recommends that MDOC follow through on the refresher trainings identified in its Mortality Reviews (see Paragraph 42).

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: The revised Policy 103 DOC 650, Mental Health Services, was approved by DOJ shortly before its official implementation on October 28, 2025, so the DQE team considers the Paragraph 40 requirements due on October 28, 2026. MDOC is already training its security staff on one of the main policy revisions, Therapeutic Supervision, during annual in-service training, as described in Paragraph 94. MDOC also provides training on the newly developed ISU policies that is separate from the annual in-service training. Trainings for clinical staff on new policies and protocols are administered

through MDOC and its healthcare vendors on an ongoing basis, as described in Paragraph 38. Thus, although the Paragraph 40 requirements are not due until later this year, MDOC is well on its way to compliance.

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

Finding: Substantial compliance

Rationale: MDOC continues to instruct staff on mental healthcare, suicide prevention, and de-escalation techniques in two main trainings: "Recognizing Mental Illness and Suicide Prevention" and "Therapeutic Supervision." The DQE and DOJ reviewed and approved the trainings before they were finalized in August 2024, ensuring that the information provided was consistent with current standards for suicide prevention. Since September 2024, the Therapeutic Supervision training has included a video of incarcerated people discussing their experiences with mental health, as required by Paragraph 41.

MDOC provided staff training attendance logs that demonstrated that the suicide prevention and TS trainings were provided regularly between September and December 2025.[22] These practices are sufficient for a continued substantial compliance finding.

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

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.

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:

[22] MDOC does not provide annual in-service training in July or August; its training years run from September 1 to June 30.

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

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.

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").

Finding: Partial compliance

Rationale: MDOC was found substantially compliant with the Paragraph 42 requirements during the last monitoring period, but the four deaths by suicide in the fall of 2025 raised questions about whether all security and mental health staff "demonstrate the adequate knowledge, skill, and ability to respond to the needs of prisoners at risk for suicide," as required by Paragraph 42. MDOC's mortality review process following the suicides identified several areas where additional staff training was needed as part of a performance improvement plan:

Trainings for security staff:

- Emergency response, including cell lighting and ligature removal
- "Importance of quality rounds" and "the broad definition of distress"
- Suicide prevention refresher for all BAU and classification staff

Trainings for clinical staff:

- Cross-vendor communication between Spectrum and VitalCore
- Management of "individuals with chronic intent and high suicidality"

- Assessing substance use and withdrawal during BAU risk screenings

MDOC provided evidence to the DQE team that some of these re-trainings have since occurred, including the training materials and staff sign-in sheets. For example, BAU risk assessment training at Norfolk occurred within a few weeks of the deaths. Other trainings are reportedly in progress.

On March 18, 2026, MDOC announced additional systemwide suicide prevention and safety changes that stem from Dr. Sharen Barboza's independent review of the 2025 suicides. MDOC's plan is wide-ranging, and it includes a number of new or refresher trainings for clinical staff, such as on BAU risk assessments, clinical documentation, and continuity of care.

While these re-trainings are being implemented, a partial compliance finding for Paragraph 42 seems most appropriate, even as MDOC continues to provide trainings on CIT, CPR, and suicide prevention routinely (as required by subsections 42a-d). To achieve a substantial compliance finding again, MDOC must demonstrate that:

- the trainings identified in the 2025 Mortality Reviews and the 3/18/2026 press release have occurred;
- the Recognizing Mental Illness & Suicide Prevention training has been updated to include lessons learned from the 2025 suicides;
- CIT training continues to be offered; and
- CPR and Suicide Prevention trainings continue to be completed at the same high rates as in previous monitoring periods.

THERAPEUTIC RESPONSE TO PRISONERS IN MENTAL HEALTH CRISIS

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

Finding: Partial compliance

Rationale: MDOC's policies reflect this requirement, and officers, mental health staff, and leadership appeared well aware of these expectations when interviewed during each monitoring period. However, there have also been reports each time of substantial gaps in

this policy's implementation. For the current report, the DQE team interviewed security staff across all TS settings and other types of housing, mental health staff, and prisoners. In addition, the team reviewed a log of allegations against staff.[23]

Over time, mental health and security staff have spoken of officers and other types of staff referring a prisoner to mental health staff on an emergent basis because of their own concerns about the prisoner. As in the past, officers also affirmed during this monitoring period that they also inform mental health staff when a prisoner requests an emergent contact ("calls crisis").

Among interviewed prisoners, however, about half thought their crisis calls were delayed or not always conveyed. This was consistent across nearly all institutions. Shirley stood out as having strong practice, with nearly all interviewees reporting confidence that their requests were communicated timely. In the past, some prisoners have said they injured themselves, or observed others doing so, when they believed mental health staff had not been called on their behalf. More such cases came to the DQE team's attention in this monitoring period, including one where the self-harm was prolonged enough that progress notes capture the MHP's impressions that ligature marks were visible immediately afterward and five hours later.

A majority of the accusations documented in MDOC's Professional Conduct Log (58%) center on not passing along, or delaying notice of, crisis calls.[24] While those complaints came from four institutions, almost half were concentrated at Norfolk, where such reports have been much higher than at other facilities for several monitoring periods. It is unknown whether this reflects a higher rate of potentially problematic conduct or a higher rate of MHP reporting. Staff and prisoners in SBCC's BAU and Gardner's BAU have also consistently reported this concern over the years. It is important to note that this log relies on staff reports but does not gather information directly from any prisoner sources (e.g., written grievances). The allegations that surface in DQE team interviews suggest that prisoners perceive far more unanswered crisis calls than are captured in the Professional Conduct Log.

In previous monitoring periods, mental health staff expressed concerns that they receive little information from referring officers when they are notified of a crisis call, hindering

[23] Interviews included 18 security staff, 17 mental health staff, and 32 prisoners who spoke about some aspects of Paragraph 43 requirements. MDOC refers to the document as the Professional Conduct Log, which is managed by Health Services Division staff. They compile data from staff's confidential incident reports, track and record investigation outcomes, and share the log with the DQE team on request. See Paragraph 93 for additional information.

[24] See Paragraph 93 for further discussion of this log. There were 45 allegations of officer misconduct, some alleging more than one type of misconduct. Among these cases, there were 29 allegations concerned officers conveying crisis calls to mental health staff.

their ability to review the patient's history and to assess them comprehensively. Fewer MHPs commented on this in recent interviews, and some Gardner and OCCC MHPs described improved communication. Both of these are promising signs.

When staff and prisoners discussed whether officers maintain constant observation after a patient "calls crisis," this, too, suggested some positive developments. A majority—security staff, MHPs, and patients in equal measure—said officers always or usually fulfill this responsibility. A majority of security staff characterized their actions this way, while a strong minority said they maintain constant observation only when the prisoner expresses a potential for self-harm. Mental health staff reached similar conclusions, although a few said officers remained with prisoners less often.

Prisoners gave the most variable answers, including some saying this duty is rarely or never met, but the majority still said officers stay with them until they meet with mental health staff. There were few patterns apparent by institution except that Shirley officers were universally seen as fully meeting this requirement, and SBCC prisoners had the widest range of perceptions. Interviewees described prisoners waiting for mental health staff in the prisoners' own cells, a strip cage, split cells, restart chairs, or in a common area adjacent to where officers were working.

To the extent that officers are asking about potential self-harm to determine whether to maintain constant observation, it remains important to provide them definitions of a crisis call and guidance on when constant observation is required in this context and when it is optional.

Reported practice has been varied over time, so it is not clear that the above descriptions are improvements, but it appears so. More consistency will be essential to reaching substantial compliance.

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

Finding: Partial compliance

Rationale: Throughout Agreement implementation, a large majority of prisoners and security staff have indicated that MHPs respond well within the hour required by Paragraph 44. Usually, they say, the assessment begins within a few minutes of mental health staff being alerted to the request. Fourteen prisoners and 14 officers across six

facilities—90% of those who commented—continued to describe response times in this way during this monitoring period.

Just as in the past, a minority of SBCC prisoners and security staff continued to say that some crisis call response times extended up to five hours or that there was no mental health contact.[25] In the current monitoring period, a very small number of people raised this point. One officer indicated that, when this occurs, he and MHPs discuss the timing, he informs the prisoner, and he believes the prisoner usually finds that acceptable.

It is possible that some or all of the extended response times are explained by a process meant to classify crisis calls to more closely align with the urgency of the content already expressed by the requesting prisoner. As detailed in the most recent DQE report, MHPs, in consultation with an independently licensed clinician, may decide whether a crisis call is emergent—which is subject to the one-hour response requirement—or urgent, which allows for a response within 24 hours. Previously, all crisis calls were treated as emergent. This can be a reasonable process depending on how it is applied.

Documentation raises questions about whether that system is operating reasonably and as intended. Crisis Logs[26] record more crisis calls with extended response times[27] than are suggested by interviews, and what appear to be vast differences in urgency classification across facilities. The DQE team has reviewed VitalCore's training document on classifying referrals as routine, urgent, or emergent,[28] but the guidance in this document does not align with the decision-making documented in Crisis Logs. Under these conditions, it is not possible to say that prisoners in mental health crisis are being seen within Paragraph 44's timeframes often enough for substantial compliance.

Much of MDOC's practice has been strong on these requirements. The current concern seems more likely to stem from documentation that may not be accurate than from problematic practice, but that finding cannot be reached with certainty. To reach substantial compliance, it remains important that MDOC and/or VitalCore work with the DQE team to ensure that the system of categorizing referrals initially labeled as crisis calls is operating in alignment with Paragraph 44.

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[25] For the patients who named this issue, the dates of the potential incidents are unknown to the DQE team. There was not support for these allegations in Crisis Logs for the last half of 2025.

[26] A Crisis Log is maintained at each facility and contains crisis calls as well as many other types of contacts. As a sample, almost every institution responsible for TS provided its crisis logs for the second week of each month in the period July through December 2025.

[27] This refers to crisis calls that MHPs continued to classify as emergent.

[28] The document is called the "Read and Sign Training: Foundational Mental Health Principles," dated July 2025.

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

Finding: Partial compliance

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

In previous monitoring periods, the DQE team has found a well-established practice of MHPs following up with patients after overnight crisis calls. In the most recent DQE report, the barriers to substantial compliance with Paragraph 45 were (1) nurses' inconsistent documentation of consultation with on-call MHPs, and (2) a high proportion of brief, non-confidential follow-up sessions with MHPs.

In June 2025, VitalCore implemented a new note template for nurses' BAU screenings (form 1901, "Special Housing Clearance"), which has substantially improved documentation of their consultations with on-call MHPs. In the DQE team's review of 12 crisis assessments that occurred during non-business hours in December 2025,[29] 100% of the health records contained a progress note about the contact written by a nurse, and 75% documented consultation with the on-call MHP.[30] Rarely was the substance or outcome of such consultation captured in the progress notes, but it was apparent from follow-up notes and triage meeting minutes what course of action the MHP had

[29] The DQE team reviewed all December 2025 triage meetings and selected 12 cases across 5 sites for review. (The remaining three sites' triage notes did not mention any overnight crisis or BAU assessments.) This methodology would not capture overnight nursing assessments that were *not* referred to mental health for follow-up or where that follow-up did not occur. The DQE team is unaware of a method to identify those cases, but lack of mental health follow-up has not arisen as a significant problem through interviews with patients or staff in three years of monitoring.

[30] In three cases, there was no evidence of on-call MHP consultation. In one case, the patient was assessed by the nurse for an urgent medical concern and, in that process, requested follow-up with mental health, so the encounter may not have been viewed by the nurse as a "crisis call." In another case, the patient was assessed because of suspicion of drug intoxication, and he was admitted for medical observation. Again, this may not have been viewed by the nurse as a mental health crisis.

recommended. On another positive note, 100% of the nurses' BAU screenings (as opposed to traditional "crisis calls") documented consultation with the on-call MHP. Overall, this represents a substantial improvement from previous monitoring periods, and the DQE team appreciates that MDOC has set an expectation that on-call MHPs are consistently involved in overnight BAU risk assessments.

Regarding follow-up with mental health staff, 100% of "overnight crisis" health records reviewed by the DQE team contained a progress note written by an MHP on the next business day. 75% of these contacts occurred cell-front or in non-confidential settings. Of the contacts that occurred cell-front, two thirds are recorded as the patient's preference or "patient declined," while the rest were due to institutional factors or did not document the reason.

At SBCC, all contacts were non-confidential, lasting between 1 and 2 minutes. SBCC was the only facility where institutional factors (e.g., facility being on lockdown, office being used by another staff member) were documented as interfering with MHPs' ability to conduct confidential follow-up assessments. In its January 2026 Status Report, MDOC indicated that it is taking steps to address this problem. Mental health staff have been given guidance about navigating barriers to providing confidential sessions (for all types of contacts) and escalating the issue when it takes place. Options reportedly include a standing SBCC Operations meeting where access issues are discussed.

One other data source sheds light on MDOC's practice in relation to Paragraph 45. In the DQE team's study of 64 therapeutic supervisions,[31] a few of the TS placements were initiated after hours by a nurse in conjunction with an on-call MHP, according to nursing or MHP notes.[32] In all cases, an MHP met with the patient on the next business day.

[31] The DQE team studied a sample of 64 TS placements to assess different aspects of the Agreement. To construct the study sample, the team drew upon the spreadsheets referred to as the TS Registry, which MDOC provides monthly to demonstrate all TS placements. Cases were selected from all eight institutions where TS occurred from July through December 2025, in proportion to their percentages of the systemwide total. The sample was chosen to capture stays in all housing areas where TS takes place (HSU, BAU, STU, ITU, ISU, RTU, SAU, and MASAC's C Dorm) and drew from each month in the period. The selection favored stays of four days or longer to be able to observe patterns of practice and requirements that go into effect as of the third day.

This sample was used to assess several Agreement requirements in this report. In some instances, conclusions may have been reached based on fewer than 64 TS placements because the requirement only occurs in the circumstances of a smaller number of patients. For some requirements, additional cases were selected to reach an adequate sample size for the question being examined. Not all method variations will be captured in this report, but descriptions are available on request.

[32] The DQE team is not aware of any data source that identifies all evaluations handled through the on-call system, so it is not possible to systematically select a sample or to determine whether this sample size is sufficient to be representative.

Overall, MDOC has made good progress with the Paragraph 45 requirements during this monitoring period. Only SBCC's practice is holding the system back from achieving a substantial compliance finding.

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

Finding: Substantial compliance

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

During the current monitoring period, the DQE team learned about and sought to review one additional disciplinary case potentially for misuse of crisis. In it, auxiliary behavior in the incident was charged (related to refusing to move), but there were no charges brought for misuse of crisis. The case resolution seemed appropriate, and the penalty was minimal, with all but one charge dismissed. Twenty-three other patients said they had not been disciplined for requesting a crisis contact, though three thought they had heard of it happening to others.

Fifteen mental health staff and nine security staff or supervisors said they had not seen any misuse of crisis cases in recent years.[33] Another four security staff said the practice is rare—one estimated being involved in two such cases in his career—and most said tickets would only be written at mental health staff's discretion or in collaboration with them. Some MHPs emphasized working to educate security staff on this matter.

MDOC remains in substantial compliance. As noted in Paragraph 51, the DQE continues to recommend that MDOC codify its current practice around issuing misuse of crisis disciplinary reports only if mental health staff supervisors or administrators have determined that the request was blatantly inappropriate.

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:

[33] One mental health staff member thought he had heard of it happening.

a. Prisoner's mental status;
b. Prisoner's self-report and reports of others regarding Self-Injurious Behavior;
c. Current suicidal risk, ideation, plans, lethality of plan, recent stressors, family history, factors that contributed to any recent suicidal behavior and mitigating changes, if any, in those factors, goals of behavior;
d. History, according to electronic medical records and Inmate Management System, of suicidal behavior/ideation - how often, when, method used or contemplated, why, consequences of prior attempts/gestures;
e. Prisoner's report of his/her potential/intent for Self-Injurious Behavior; and
f. Prisoner's capacity to seek mental health help if needed and expressed willingness to do so.

Finding: Partial compliance

Rationale: MDOC has reported that its Health Services Division regional mental health administrators audit 10% of health records, including TS and crisis contacts, for each facility every six months. Similarly, the healthcare vendors reportedly conduct chart audits as part of a quality assurance program. The DQE team has not reviewed any of these audit results and therefore cannot determine whether the process meets the Paragraph 47 requirements.

MDOC's January 2026 Status Report states that it has taken several steps to improve the quality of crisis mental health assessments. First, VitalCore's mental health staff underwent training on BAU risk assessments between August and October 2025. (Training records provided by VitalCore to the DQE team are consistent with this report.) Second, the Information Technology department has been working to provide wi-fi access so that mental health staff can review the electronic health record in areas of the facilities where crisis assessments occur. Third, SBCC and Norfolk staff received additional training by VitalCore's clinical leadership on suicide risk assessment in November 2025, following the deaths by suicide of four incarcerated individuals. Fourth, the DQE team learned of a new practice at OCCC called "702 Alpha," which identifies a back-up crisis clinician who can respond to crises. These are all positive steps taken by MDOC to correct a deficit that has been consistently identified by the DQE team since the Agreement began three years ago.

VitalCore and Recovery Solutions both use templates in the electronic health record to prompt clinicians' assessment of the factors delineated in subsections 47a-f. Over three years of monitoring, the DQE team has found variable documentation in the health record, but also consistent problems with MHPs meaningfully assessing the specified factors and basing clinical decisions on more than just a patient's statements about

whether they want to harm themselves. Gradually, the latter problem seems to be improving. During facility site visits between October and December 2025, the DQE team observed MHPs more consistently reviewing a patient's history before responding to a crisis call, and they were less often stymied by problems like correction officers refusing to tell them the prisoner's name or to facilitate confidential assessments.

SBCC was a different matter. Here, too, clinicians reviewed records and tried to conduct confidential assessments, but they were often presented with insurmountable institutional challenges. At least half of the crisis assessments observed by the DQE team during the SBCC site visit occurred cell-front because of institutional factors (e.g., confidential spaces were occupied by other staff, officers were busy with other tasks). An officer stood directly behind the MHP, greatly reducing the MHP's ability to conduct a meaningful assessment. In another problematic scenario, crisis contacts occurred in a converted cell outside the Health Services Unit, where the prisoner was expected to stand inside a secured area of the room while an MHP sat behind a yellow painted line on the floor, next to a toilet. Both parties were either locked inside the room, dependent upon a correction officer to open the door remotely, or the evaluation was conducted with the door wide open. A third problem was with the confidential spaces used for crisis assessments on the housing units; the DQE team observed garbage on the floor and a dried reddish brown liquid in one "therapeutic module" where prisoners sit while talking to an MHP.

To assess the quality of crisis assessments more systematically, the DQE team reviewed a sample of 30 MHP notes in the electronic health record.[34] The results were consistent with previous monitoring periods and with information learned from staff and prisoner interviews during the site visits. 75% of crisis contacts in the sample were conducted confidentially. The New Man's area at OCCC, booking area at MTC, and BAU and STP at SBCC continued to offer inconsistent access to confidential assessment spaces.

Overall, the DQE team has seen a moderate improvement in the quality of crisis assessments, especially with MHPs trying to review records before crisis contacts and to see patients confidentially. The persistent institutional factors impeding adequate crisis assessments are most apparent at SBCC. Important next steps toward compliance include providing access to confidential spaces and contemporaneous access to the electronic health record for all crisis assessments.

[34] This is a different sample from the study of TS placements described in Paragraph 45. Here, the reviewer randomly selected 30 crisis contacts from the eight institutions' triage meeting minutes between July and December 2025, in approximate proportion to the TS placements across MDOC.

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: Over multiple monitoring periods, the DQE clinicians have opined that MHPs were missing cases where referral to psychiatry at the time of crisis assessment was clinically indicated. There are signs, however, that this may be improving.

During facility site visits, the DQE team observed two cases where referral to psychiatry was made after discussing a crisis contact during the daily triage meeting. Referral to psychiatry was a more consistent part of triage discussions, and psychiatrists or APRNs were present at all 12 triage meetings, either in person or virtually.[35] The psychiatrists and APRNs were more involved in clinical discussions and seemingly made themselves available for urgent evaluation or consultation. Compared to when the Agreement began, the change in practice was palpable.

In the DQE team's study of 30 crisis contacts, first described in Paragraph 47, MHPs did not refer patients for psychiatric evaluation in any cases, nor was there evidence in the health record of consultation with a psychiatrist. However, it is important to note that, in the DQE clinicians' independent analysis of whether psychiatry consultation was indicated, there was just one crisis contact (out of 30 reviewed) where this was the case.[36] The sample size is too small to draw meaningful conclusions about whether MHPs are doing a better job of documenting referral to, or consultation with, psychiatrists during crisis assessments. Further assessment in the next monitoring period is needed.

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

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[35] The DQE team observed a total of 12 triage meetings, including in the ISU, at eight sites over 10 days of site visits between October and December 2025.

[36] The MHP documented several behaviors that raised suspicion of acute psychosis, which had not been previously diagnosed or treated, and would therefore warrant psychiatric assessment.

Overall, MDOC's practice of consulting with psychiatrists during crisis assessments (or shortly thereafter) appears to be improving. Because this has been a persistent problem since the Agreement began, a partial compliance finding is being issued until a longer period of improved practice has been demonstrated.

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: MDOC's practice in this area continues to be strong. In the DQE team's review of 30 crisis calls, 29 cases included a progress note (BH-7.0) in the DAP format (97%). In the one case where TS was initiated as a result of the crisis contact, the MHP documented the contact on a different form, the "Behavioral Health Therapeutic Supervision Contact Note" (BH-5.0), which contains all the essential elements of a DAP note.

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

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

Finding: Substantial compliance

Rationale: Since monitoring began, the DQE team has consistently found that MDOC and its healthcare vendors have a culture that conservatively places prisoners on TS where there is perceived risk or uncertainty about risk. Although there have been concerns about the quality of risk assessments and treatment planning, those concerns are addressed in Paragraphs 47 and 52 rather than here. Paragraph 50 addresses only whether, once risk of self-harm has been identified, the prisoner is placed on TS.

To assess this requirement, the DQE team reviewed 64 TS placements. In this sample, the MHP determined that the prisoner was at risk of self-harm in 54 cases,[37] and in each instance, the MHP did place the prisoner on TS. This is consistent with the practice observed in all previous DQE team chart reviews on this topic. While this method

[37] See Paragraph 45 for a description of the study and its methods. The other placements were based on concerns about psychosis or harm to others.

necessarily captures only cases that *were* placed, it provides some support for there being sustained, compliant practice.

Interviews with prisoners and mental health staff provide an additional data point. All MHPs interviewed by the DQE team, across eight institutions, identified the risk of self-harm as an indication for TS placement (among other indications) and expressed a desire to err on the side of caution. Similarly, although some interviewed patients took issue with having been placed on TS, when the DQE team reviewed the clinical documentation of those incidents, a reasonable rationale for the placement was apparent.

Overall, MDOC's demonstration of practice during this monitoring period is sufficient for a continued finding of substantial compliance.

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: MDOC's policy prohibiting the use of TS as a punishment was finalized and implemented in October 2025, and it has been incorporated in TS trainings for security staff since September 2025.[38] The healthcare vendors' equivalent policies remain under revision, but over three years of monitoring, the DQE team has not found any evidence of TS being used as punishment or for staff convenience.[39] In the current monitoring period, 17 prisoners confirmed during interviews that they had not experienced TS used as punishment.

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 280 crisis assessments across three years, there have been no indications of over-use of TS. In fact, a remarkably small percentage of crisis contacts result in TS placement—just 11 out of 280 crisis contacts in the DQE's samples (4%). The DQE team has continued to observe staff in triage meetings, and at other times, recommending interventions such as more frequent mental health check-ins, referral to a specialized housing unit, or contacts with ancillary staff

[38] The DQE team noted this content when reviewing training slides. MDOC has also provided training logs demonstrating that some officers received this training in the last quarter of 2025. MDOC represents that all officers will receive this training by the end of June 2026.
[39] As noted in Paragraph 46, the DQE team continues to recommend that MDOC codify its practice of not punishing prisoners for requesting a crisis mental health contact. Currently, "misuse of crisis" tickets are only adjudicated if mental health staff supervisors or administrators have determined that the request was blatantly inappropriate.

(e.g., activity therapists, Support Persons) as alternatives to TS. Overall, the DQE team remains satisfied that, when TS is used, it is the least restrictive option based on clinical risk, warranting a continued finding of substantial compliance.

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

Finding: Partial compliance

Rationale: In the first DQE report, MDOC's crisis treatment plans were grossly inadequate, described as "boilerplate" and "insufficiently tailored to the patient's individualized needs." Since that time, MDOC's healthcare vendors have conducted several trainings on treatment planning and documentation, and the vendors have revised their TS contact note templates several times to prompt clinicians to consider the factors delineated in subsections 52a-k. During this monitoring period, clinicians' practice has improved. Compared with the Agreement's early days, MDOC's treatment plans are, on average, more individualized and thoughtfully crafted.

As in previous monitoring periods, the DQE team reviewed TS treatment plans to assess their completeness and clinical appropriateness. In a review of 50 TS placements[40], 98% had a treatment plan documented in the electronic health record at the time of TS initiation, likely because the treatment plan is built into the TS contact note (BH-5). Most treatment plans did a good job of identifying clinically appropriate problems toward which treatment interventions should be targeted (e.g., "suicidal ideation," "frustration with housing conditions"). The appropriateness of identified treatment interventions was

[40] This is a subset of the TS study first described in Paragraph 45.

more variable, with a significant portion of plans using generic language like "engage in contacts" or "provide mental health interventions to client." Similarly, although all treatment plans checked boxes stating that historical risk factors had been reviewed, it seemed unlikely that such review had occurred in some cases.[41] Despite these issues, on balance, the treatment plan quality was improved from previous monitoring periods.

Paragraph 52 also requires that patients on TS be referred to psychiatry when clinically indicated (52k). To assess this, the DQE clinicians again reviewed 50 TS patients' medical records. In assessing whether such contact was indicated, the DQE clinicians used the following criteria[42]:

- Self-injury that led to outside hospital evaluation (precipitating TS placement or while on TS)
- Medication noncompliance or evidence of medication misuse/diversion
- TS lasting >7 days
- More than one TS admission within 7 days
- New admission to MDOC with confirmed medications in the community[43]
- Diagnostic uncertainty after assessment by MHP
- Bizarre symptoms or out-of-character behavior
- Display or self-report of psychotic symptoms (e.g., hallucinations), even if suspected of feigning or exaggeration
- Prolonged hunger strike (to assess whether serious mental illness is contributing to the individual's food refusal)

Using these criteria, the DQE clinicians found that psychiatry referral was indicated in 86% of the sampled TS placements. Of the cases where referral was indicated, patients were seen by a psychiatrist or nurse practitioner in 58% of cases,[44] a rate nearly identical to previous monitoring periods (54-58%). Theses differences were observable between the facilities' practice with psychiatry referrals:

SBCC	53%

[41] For example, some treatment plans checked a box saying "For daily TS contacts, protective factors reviewed" even when it was the TS initiation contact, lasting 1-3 minutes and conducted out of cell, and the patient had not engaged with the clinician. Under these circumstances, it is not clear how one would review protective factors such as family supports, reasons to live, future orientation, etc.

[42] These criteria are based on the DQE clinicians' best professional judgment and experience working in correctional settings. They have not changed since the previous monitoring period.

[43] This applies mostly at Framingham and MASAC, where patients are sometimes admitted from the community rather than from other correctional facilities. If a patient is new to the system, has never seen a psychiatrist in MDOC, and is ill enough to warrant TS, their psychiatric evaluation should be expedited.

[44] The reviewers gave credit for psychiatry referral if the patient was referred at any time during the TS placement, not just as a result of the MHP's initial assessment and treatment plan.

Rest of system 63%

On a positive note, MHPs did a much better job of documenting their review of a patient's medication compliance, with most crisis treatment plans containing evidence of this review.

Overall, it appears that crisis treatment planning has improved slightly across MDOC, though almost half of indicated psychiatry referrals are still being missed. A continued finding of partial compliance is warranted.

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

Finding: Substantial compliance

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

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

Finding: Substantial compliance

Rationale: Before Agreement implementation began, MDOC invested in designating cells for TS and modifying them for suicide resistance based on expert advice. In 2024, MDOC determined that some of the designated cells no longer met their standards for suicide resistance. MDOC conducted repairs and modifications, and the DQE team understands that nearly all are complete, with the exception of the designated cells in SBCC's SAU and MTC's BAU.

As to sight lines, the DQE team has detailed in previous reports its methods of review and has found that, on the whole, the sight lines are reasonable for observing prisoners on TS. Framingham's ITU is a significant exception. There, a two-foot gap between the bed and the wall with a window obscures an observing officer's view, and built-in furniture facilitates prisoners covering the cameras. These issues should be addressed.

The DQE team has found, through interviews and observation, that the culture of using suicide-resistant cells is well established. In many locations, there are enough designated cells for the demand. In recent DQE team interviews,[45] for example, officers posted to, and/or mental health staff providing treatment in, more than half of the TS units said their suicide-resistant cells are never at capacity. Staff for nearly all the other units were readily familiar with the expected location for placing any additional TS patients, most of which also contain suicide-resistant cells.

Throughout monitoring, including the current period, interviewed officers, leaders, and mental health staff commonly volunteered that any TS that occurs in a non-suicide resistant cell is monitored under constant observation. This is also reinforced in recent security staff training materials the DQE team has reviewed. A spot check of security observation sheets tended to support that constant observation is standard practice for non-suicide resistant cells.[46] The sheets clearly reflected a structure of two-hour rotations associated with constant observation; the sheets showed some TS placements fully compliant with that rotation, while others met that goal sometimes but had some extended observation periods as well.[47] This is consistent with previous monitoring. The issue of officer rotation is assessed in Paragraph 34 rather than here.

A continued finding of substantial compliance is warranted. Nevertheless, MDOC should remedy the issues of obstructed vision in Framingham's ITU.

55. Cell Checklist: MDOC will develop and implement a checklist for security staff to ensure that the cell is free from potential hazards prior to placing a prisoner in the cell. If a prisoner later engages in Self-Injurious Behavior, a supervisor will review the checklist as an auditing tool.

Finding: Partial compliance

Rationale: MDOC continues to employ an excellent cell safety checklist. It is well designed to guide staff to think about physical plant risks particular to TS patients, as well as checking on some other Agreement requirements such as lighting dimmers.

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[45] In the current monitoring period, 12 security staff or supervisors, 13 mental health staff, a nurse, and two patients, drawn from seven institutions, spoke to some aspects of suicide-resistant cell use.

[46] The DQE team reviewed a convenience sample of records from 11 TS stays that likely took place in non-suicide resistant cells. These were drawn from Gardner, MTC, Norfolk, and SBCC's STP unit.

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

In a 50-record study,[48] it appeared that implementation of the checklist improved substantially to 78%. The overall compliance rate suggests that the practice is becoming more established, and there were no significant differences between the facilities' compliance rates. A few more checklists were completed hours or days after TS placement. While any cell check is beneficial, placing a patient in an unchecked cell potentially increases the risk of harm, so completion before TS initiation is both preferable and consistent with the Paragraph 55 requirement.

To reach substantial compliance, MDOC must employ checklists at a rate of at least 85% and demonstrate how supervisors use the checklist after patients' self-injury to identify any ways the cell condition may have facilitated the self-injury and methods to prevent a recurrence. As noted in Paragraph 144, MDOC Health Services Division regional administrators contribute to that effort by following up with facility security supervisors when contraband or cell issues are identified during SDV-SATT meetings. While this does not speak directly to the question of supervisors reviewing the cell checklists, it is a helpful supplementary effort to reduce self-harm risk in cells.

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

Finding: Substantial compliance

Rationale: As detailed in previous DQE reports, MDOC has a well-established, well-functioning system to make decisions about TS patients' clothing; showers; lighting; property; privileges; activities; exercise; and, to some extent, restraints. The DQE team continues to observe mental health staff consistently discussing and deciding on these conditions in triage meetings and with supervisors at other times.

Discussions often center on criteria analogous to those outlined in Paragraph 56: whether the patient has had a period of behavioral stability during the TS stay, for example, or is

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

engaging with mental health staff, expressing intent for self-harm, or using an item to cope. These are all reasonable clinical considerations and consistent with guidance on assessing property and privileges provided by VitalCore during the annual mental health staff training in November 2025.

In documentation, much of the mental health staff's reasoning was commonly captured in progress notes, triage meeting minutes, and Daily Consultation meeting notes. The decisions are consistently communicated to mental health and security staff on "TS Reports," the replacement for the Mental Health Watch form mentioned in the Agreement. All these practices were sustained in the DQE team's observations and document reviews during this monitoring period.[49]

In recent interviews, 13 security staff and supervisors and 15 mental health or nursing staff commented on whether there are disagreements about property or privileges and how these are resolved.[50] Most characterized disagreements as uncommon, though a few mental health and nursing staff thought conflicts were more frequent. It was common for security staff to say that mental health staff make the final call. Almost no mental health staff agreed, and a few believed they are required to defer to security staff's judgment. Several mental health staff described officers withholding approved property, as did one officer, either based on a belief that it is their right to decide, or as an indirect way to express disagreement, or merely a miscommunication. The practice of security staff directly or indirectly exerting control over these items was reported across most institutions and was not concentrated at any one facility.

In terms of resolution methods, about one-quarter of interviewees—security and mental health staff in about equal numbers—said they feel comfortable speaking directly about these issues. A few security staff stated that the triage meeting is the key vehicle for addressing differing views. The majority of interviewees favored taking the issues to their supervisors and up the chain of command, though few, if any, reported needing to proceed beyond their own supervisors. A security staff training, initiated in September

[49] To analyze practices for many of the requirements of Paragraphs 57 through 65, the DQE team selected a sample of 59 TS stays drawn from each of the eight TS institutions corresponding to their proportion of total TS stays. There were stays from each month between July through December 2025 and from every type of TS setting except ISU. The sample included some cases from the study described in Paragraph 34 and some from the study described in Paragraph 45. For some property or privilege questions, other cases were substituted if necessary to answer the question posed. The number of records reviewed sometimes varied between requirements; not all variations are described in this report, but they are available on request.

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

[50] Security staff interviews were drawn from BAU, general population, HSU, ISU, and STP. Mental health and security staff and supervisors at seven institutions commented about conditions decisions.

2025, reinforces that officers are to take any disagreements to their supervisors and not to make changes to property on their own.[51]

These described approaches are consistent with the Paragraph 56 requirements. On balance, MDOC has maintained 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: The DQE team has reached its findings about this paragraph after observing triage meetings and MHPs conducting TS contacts; interviewing 15 MHPs or clinical leaders, 30 patients, and eight security staff or supervisors; and reviewing TS Reports and progress notes for 59 TS placements.[52] These sources combined to create a picture of individualized decision-making about clothing, with a preference for starting patients in smocks but transitioning to clothes within the first or second day.

When MHPs described their approach, common themes included assessing each patient and issuing smocks to patients with suicidal ideation and a plan. Some discussed taking into account historical and dynamic factors and/or patient statements about their ability to

[51] Per TS training slides reviewed by the DQE team
[52] See Paragraph 56 for a description of the records sample selection.

be safe with clothing. Only two MHPs mentioned considering whether the patient's risk is related to clothing.

Only patients in general population and the RTU said they usually or always kept their clothes while on TS. Some patients in all other programs described spending some time in smocks and some in clothes. The largest cohort, especially SBCC patients, said they usually or always wore smocks, sometimes for the entirety of their TS placements.

24- and 48-hour benchmarks: In the DQE team's records analysis, half of the patients were authorized to be in clothes within a day, which appears to be a significant decline from the previous monitoring period. This breaks out as:

SBCC	36%
Rest of system	62%

By the end of the second day, 92% had clothes returned. This is an excellent result, and practice was similar across MDOC facilities. MDOC has also been briefing officers about these expectations in a training offered since September 2025.

Demonstrated clothing-related risk: When clothing was found clinically contraindicated in this sample, progress notes indicated that 59% of those patients had demonstrated they would use clothing in a self-destructive manner. The DQE considers this to mean the patient made a specific threat to hang or strangle themselves; had a recent hanging or strangulation attempt, possession of a ligature, or other attempts or threats of self-harm using cloth; or had a history of one of those.[53] Overall, this also appears to show improvement.

On the other hand, for a significant minority of those placed in smocks (41%), records showed no clear link to clothing being a risk for them. Clothing was sometimes removed because of headbanging, assault, bizarre and threatening behavior, insertion, ingestion, cutting, and suicidal ideation without plan or history of attempts.

Notice and consultation, daily documentation: There is a well-established system for notice and consultation concerning several Agreement provisions, including Paragraph 57.[54] Only five sampled patients remained on smock status beyond two days. Most had clothes returned, or were discharged from TS, in three days, so only one required

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[53] To seek this information, the DQE team reviewed the progress note initiating the TS placement. If additional information was needed to demonstrate clothing-related risk, the reviewer examined nursing and hospital transfer notes shortly preceding the TS and MDOC's SDV log for 2025.
[54] See Paragraph 78 for a description of that system.

leadership approval.[55] For that patient, documents show the reasons for smock status captured daily and timely notice and consultation with MDOC's Director of Behavioral Health and VitalCore's Director of Clinical Programs. Meeting notes reflect clinical information about these patients but do not capture any discussion or approvals.

Frequency of decisions reviewed: Through all monitoring periods, including the present one, documentation shows clothing decisions typically made once per day, including Sundays for constant observation patients. For several patients in the current study, smock status was revisited, and clothes returned, at a second contact within the first 24 hours. The DQE team has not encountered evidence of smocks being reconsidered three times per day.

Conclusion: MDOC remains in partial compliance with Paragraph 57. It appears common for staff to recommend smocks until there is a better sense of the patient's condition. This conservative approach is understandable and also is contrary to the focus of Paragraph 57, which seeks to make clothing the default decision and smocks the exception.

Fortunately, there is a growing record of staff then concluding quickly that clothing can be returned. The goal of 24 hours is not met, but clothing restoration by 48 hours is strong. Leadership oversight also is consistent with the Paragraph 57 mandates. The key to reaching substantial compliance is staff narrowing the use of smocks to those whose risks relate to misusing cloth for self-harm; those decisions are likely to address some of the other elements that are not yet in 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: Substantial compliance

Rationale: Practice remains the same in this monitoring period as in the last two. The DQE team has found that MHPs consistently decide daily whether to authorize showers and document these decisions in progress notes and TS Reports. In the current monitoring

[55] Records show the patient refusing clothes for several days and ultimately having clothes returned on the sixth day of TS.

period, the DQE team's property and privileges study found that prisoners were approved for showers upon TS placement.[56] There were only two exceptions, and both patients discharged from TS in far less than 72 hours. Nearly all interviewed mental health staff[57] said they or their colleagues always, or usually, authorize showers. Some noted exceptions would be possible if the patient threatened to self-harm in the shower, had had a very recent suicide attempt, or was extremely dysregulated. It appears these contraindications would be used sparingly, as the DQE team has almost never encountered them in chart reviews.

Paragraph 58 also requires demonstrating that showers are offered and provided unless the patients decline. Among the 24 patients interviewed on-point, 93% confirmed they were approved for, and received, showers or were not on TS long enough for the requirement to apply. Some described showering every two to three days, while others mentioned a daily schedule. Rarely, a patient mentioned access barriers such as showers not being offered, an officer incorrectly saying there was no approval, or a system making it the patient's responsibility to request the shower. Recent security staff training reinforces the obligation to provide showers,[58] and staff interviewed across six types of units responsible for TS, affirmed that they provide showers, sometimes specifying a near-daily schedule. Their reports were consistent with those of officers interviewed previously.

Paragraph 58 also requires documentation. MDOC has informed the DQE team that a documentation method for out-of-cell activities on TS has been launched and is in the process of becoming established.

The rates at which patients and officers report provision of showers has consistently been so high over time, it both warrants a substantial compliance finding and makes it highly unlikely that the documentation system would show different results. The DQE team will find Paragraph 58 in substantial compliance. The team will monitor the documentation when it becomes available and, should it produce information that calls good practices into doubt, the substantial compliance finding will be revisited.

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

[56] See Paragraph 56 for a description of the study and overall methodology.
[57] Fourteen mental health staff, across five institutions, commented on shower authorizations.
[58] Per training slides reviewed by the DQE team

Rationale: Using methods detailed in previous reports, the DQE team has verified that 15 TS settings, or 83% of TS settings reviewed, have equipment that allows staff to dim lights in TS cells. It was unclear whether this was present in Gardner's BAU, Shirley's BAU, and SBCC's SAU.

In terms of authorizing the use of dim lighting, among MHPs who spoke to this point, a large majority said they always approve this. A few described applying discretion, including one who believed dim lighting should never be approved for patients on constant observation. TS Reports also illustrate approval practices; the DQE team's study of property and privileges found these permissions in 90% of sampled cases.[59] While this practice remains strong, it is a decline from the previous monitoring period. One apparent pattern was dim lighting not being authorized during TS placements initiated outside of business hours, so it would likely be beneficial to remind nurses and on-call clinicians about this mandate.

Despite th high rate of approvals, there are indications that dim lighting is not always implemented consistent with the TS Report. Security officers' observation sheets provide one source of information. During the monitoring period, MDOC revised the sheets that officers complete when observing TS patients to include a field to record whether dim or full lighting was used. Within the DQE team's property and privileges study, a few TS placements were recent enough to employ the revised form and provide a spot check. A review of the overnight shift in these sheets showed:

> SBCC: full lighting predominated[60] in all sampled records where TS Reports called for dim lighting
>
> Rest of system: practice varied record by record, and only 40% aligned to both approve and provide dim lighting[61]

Interviews are also useful in assessing whether lighting is reduced as required. A few officers commented, and, while they generally expressed a commitment to follow the TS Report instruction, there were examples of officers understanding that dim lighting is never allowed for patients on constant observation or that the instruction can be overridden if a patient is actively trying to hide (the latter may fall within exceptions allowed by Paragraph 59).

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[59] See Paragraph 56 for a description of the study methods. The lighting analysis relied upon a subset of 49 records within that study.

[60] Each TS placement showed full lighting on all overnight sheets, most of them, or a majority of them

[61] Of the five records containing the revised form, two showed all dim lighting overnight, and another showed this on a majority of overnight sheets. Another showed full lighting when dim had been approved, while the final record showed dim lighting was provided despite it not being authorized on the TS Report.

MHPs reported a range of experiences. A slight majority said dim lighting is implemented or that no issues had been reported to them. Others said practice varies greatly by officer, or the MHP perceived that officers often do not carry out the instruction as written.

Among 27 interviewed patients, 26% confirmed that lights are dimmed or turned off routinely. A similar number of patients said lighting is reduced only sometimes, or they did not distinguish between the two lighting levels. The largest cohort believed that the lights remain on full throughout the night.

In September 2025, MDOC began offering new training to security staff that includes instruction that lighting will be reduced during prisoner sleeping times. More than 650 officers have taken this training, and more are slated to do so in 2026. This should help implement this requirement more consistently.[62]

Over the years, MDOC has made significant progress through physical plant changes that make dim lighting possible, updating policy, implementing a method to make and communicate lighting decisions, and initiating the use of reduced lighting. It remains necessary to institutionalize these changes to reach substantial compliance.

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

Finding: Partial compliance

Rationale: In interviews, 12 mental health staff described authorizing property for TS patients other than reading and writing material and tablets. They most commonly named medical or Americans with Disabilities Act (ADA) supplies,[63] headphones, and glasses; some also mentioned religious items, legal paperwork, personal mail, and a wedding ring. The results of the DQE team's property and privilege analysis[64] was consistent with this, showing MHPs authorizing one of these types of property in 49% of the records. This breaks out as:

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[62] These findings are based on the DQE team's review of training slides, a trainers' agenda, a training department attendance printout, and communication with MDOC.

[63] In records, there was rarely an indication that the patient needed this item. It is a data field that can be checked off, but it is unclear how many patients benefit from this authorization.

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

SBCC	20%
Rest of system	71%

When additional property was authorized, it was almost exclusively one item. Four patients were permitted to have two types of additional property.

Among interviewed patients, two felt that additional property allowances are flexible, and another said he was permitted to have a music player. All other patients (81%) believed they were not authorized any additional property.

On the other hand, it is helpful that MDOC is raising awareness about additional property through trainings. Security staff training materials discuss some purposes for increasing property and provide examples of property that could usefully be allowed.[65] Additionally, MDOC's January 2026 Status Report indicates that VitalCore's guidance for property decisions has been integrated into new employee orientation throughout 2025.

With a minority of patients receiving authorizations, the limited variety of items, and only one item allowed per person, it is very unlikely that additional property authorizations are the least restrictive possible. The DQE team encourages MDOC and VitalCore to continue considering, and providing when appropriate, items that support TS patients' coping and treatment. MDOC remains in partial compliance with 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: Substantial compliance

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

[65] Per TS Training slides and trainer's agenda reviewed by the DQE team

In the DQE team's study, first described in Paragraph 56, reading material was allowed timely in 91% of the sample—an improvement since the Agreement went into effect that has been sustained at this level for two years. In the few instances where this item was not approved, or authorized later than required, specific contraindications were not recorded daily. Six mental health or security staff, and all but one of 19 interviewed patients, affirmed that patients are permitted to have books. Encouragingly, no patients spoke of access issues, as they have in the past.

Writing materials were permitted less often. Interviewed MHPs all said they do authorize this material, and two-thirds of patients said they were allowed writing materials in some form. Similarly, in the DQE team's records study, 54% of the sample showed timely authorizations, and another 14% had permissions granted later.[66] When materials were not allowed, only 22% of those placements recorded individualized contraindications each day.

As to tablets, the DQE team selected additional TS cases to review 12 patients with lengths of stay in which tablets would be required.[67] There, 75% of patients were approved to have tablets or individual contraindications were recorded. Additionally, in the larger property and privileges data set, MHPs continued to allow tablets for about half of patients well before it would have been required. Interviewed patients also often reported having tablets. Among those who commented, 12 either had a length of stay exceeding 14 days and were permitted tablets or received that authorization earlier, and only one person did not.[68]

MDOC has sustained access to books and tablets at a high level and exceeds the tablet requirement by allowing earlier access for many patients. Written materials are authorized less often, and documentation could be stronger, but on balance, the DQE team finds practice is sufficient for substantial compliance.

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

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[66] These were completed on days 3, 4, or 5.

[67] This sample size represents 35% of the TS stays exceeding 13 days between July and December 2025. Stays of this length took place at four institutions; cases were selected from each of those facilities in roughly proportionate fashion. The cases were drawn from BAU, HSU, ITU, and STP.

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

for a particular activity, due to clinical contraindication, during a day, a Qualified Mental Health Professional will document individual reasons why that particular activity is contraindicated.

Finding: Substantial compliance

Rationale: The DQE team previously found this requirement to be in substantial compliance based on chart reviews; MHP, patient, and security staff interviews; and observation of practice during site visits. In the current monitoring period, the DQE team continued to observe decision-making about property and privileges in triage meetings. In addition, the team analyzed TS Reports and progress notes.[69] All sampled patients were allowed phone calls and visits, 95% were authorized for religious rounds, and 92% had permissions for activity therapy. The few exceptions occurred because of the patient's behavioral dysregulation posing a risk to staff and one patient who was on TS only overnight.

A large majority, 86%, of interviewed patients affirmed that they were allowed phone calls while on TS, although two of the SBCC patients said officers would sometimes deny them access. One Framingham patient understood that calls are not allowed while on constant observation.

The largest number of interviewees did not know whether visits were allowed, often saying they do not receive visits in general and therefore do not track that information. Among the remaining group, a slight majority believed that visits are permitted, a higher rate than in previous monitoring periods. One patient reported having such a visit.

No other routine activities were specified in the reviewed documents, but the DQE team has observed MHPs' good practice of discussing whether patients were stable enough to participate in court hearings, legal visits, and off-site medical appointments, especially during long-term TS stays. MDOC also recently reinforced these requirements in security staff training initiated in September 2025.

MDOC continues to be in substantial compliance with these requirements.

63. Exercise: After 72 hours on Mental Health Watch, all prisoners will have access to outdoor recreation/exercise. If a prisoner is not clinically approved such access, the assessing Qualified Mental Health Professional, in consultation with the prison's Mental Health Director or designee, will document on the Mental Health Watch form individual reasons why outdoor

[69] See Paragraph 56 for a description of the study and overall methodology. It was necessary to review the corresponding progress notes for the sample for recommendations on activity therapy and religious rounds, as those are not captured on TS Reports.

exercise is contraindicated to the prisoner's mental health. Correctional staff will document when a prisoner is offered approved recreation.

a. Similarly, if after 72 hours on Mental Health Watch a prisoner is not clinically approved access to outdoor exercise five days per week for one hour, the assessing Qualified Mental Health Professional, must document individual reasons why outdoor exercise is contraindicated to the prisoner's mental health each and every day, and communicate to appropriate security staff. Correctional staff will document when a prisoner is offered approved recreation.

b. During outdoor exercise, escorting officer(s) will provide supervision during the exercise period, consistent with the level of Mental Health Watch. As with considerations regarding use of restraints, MDOC will consider alternatives to strip searches on an individual basis. MDOC may conduct strip searches if deemed necessary to ensure the safety and security of the facility, the staff, the prisoner on watch and/or all other prisoners. In determining whether a strip search is necessary, MDOC may consider factors including but not limited to, whether: the prisoner has a documented history of inserting or hiding implements to self-injure or harm others; the prisoner has a documented history of behavior that may constitute a security risk (e.g., assaulting staff or prisoners, possession of weapons, inserting or swallowing items to use for self-harm or harm of others); the prisoner has a history of engaging in self-injurious behavior; and the property items that have been approved for retention by the prisoner while on watch.

Finding: Partial compliance

Rationale: The DQE team relied on TS Reports, staff and patient interviews, and MDOC's January 2026 Status Report to assess the Paragraph 63 requirements.

Approvals: Among 17 mental health staff interviewees, the Framingham, OCCC, and Gardner MHPs reflected a culture strongly oriented toward recreation, describing their teams as always or typically approving it. Others described more variable practice—sometimes expressing strong caution—and offered a number of contraindications: history of SDV during recreation, plan to use metal for SDV, active or recent SDV, active plan to kill oneself, anyone on constant supervision or in a smock, not participating in a risk assessment, risk of harm to others, bizarre actions, dysregulation, or slipping out of handcuffs. Some of these are quite broad disqualifiers.

Patterns of approvals are also evident when reviewing TS Reports. In the DQE team's property and privileges study, [70] the rates of timely recreation approvals were:

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[70] The DQE team studied privileges and property for 58 TS placements; see Paragraph 56 for a description of the study and overall methodology. To assess recreation authorization within that sample, the reviewer included TS stays that exceeded three days, as well as three-day stays where recreation was already allowed, and did not include cases where the patient was discharged on the morning of the fourth day. This totaled 44 TS stays. Where progress notes and TS Reports conflicted, the reviewer relied on the TS Reports.

SBCC	25%
Rest of system	88%

A few patients were authorized within a few additional days, up to Day 8.

This rate at SBCC has been consistent across three monitoring periods. Contraindication reasons were universally recorded as "due to risk," regardless of the patient's circumstance and without reference to what risk recreation might pose for that patient's mental health or safety. This suggests a near-uniform treatment of recreation as contraindicated rather than weighing risks and benefits in an individualized decision-making process as required.

Providing recreation and documenting it: MDOC has been reinforcing in security staff training the requirement to provide recreation to TS patients. Ten security officers and supervisors recently affirmed that recreation is offered and provided to TS patients in the BAU, HSU, ISU, ITU, and STP. Some offered supporting detail. One SBCC officer thought that recreation is never allowed on constant observation status, however.

Among the 25 interviewed patients subject to this requirement,[71] a minority said they had been offered recreation. Interviews reflected these rates:

SBCC	30%
Rest of system	40%

The SBCC patients were drawn from all TS locations, and that rate of offers is consistent with the rate of approvals above, suggesting recreation is offered when MHPs have approved it. It was also noteworthy that, despite Framingham MHPs universally authorizing recreation in the records reviewed, patients said they were provided recreation in ITU but not in HSU, which an MHP echoed, saying this sometimes occurs when there is a shortage of HSU officer staffing. A Norfolk patient similarly understood that his authorized recreation was not provided because of officer short staffing.

MDOC also plans to provide documentation of recreation offers, acceptances, and refusals, which will both meet Paragraph 63 requirements and could help clarify some differences in staff's and patients' perceptions. MDOC has informed the DQE team that the documentation system was launched during the monitoring period and is in the process of becoming established.

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

Anecdotally, officers in STP and Shirley's BAU and HSU noted that it is extremely rare for TS patients to accept an offer of recreation, with one estimating that 99% do not. At least four patients interviewed at those prisons reinforced that idea, saying they had refused all offers when they were on TS.

Monitoring use, strip searches: In previous monitoring periods, security staff spoke of routinely posting an officer outside whenever any prisoner is in the recreation yard, and the DQE team observed that in operation. A few officers reaffirmed that protocol during this period's site visits. An SBCC officer said the practice in the BAU, instead, is that constant observation patients are not allowed on the recreation yard, and 15-minute rounds continue for any close observation patient. Officers noted that camera monitoring supplements the in-person presence.

Some officers commented on search practices related to recreation, indicating they employ universal practices and do not consider alternatives to strip searches on an individual basis. OCCC, SBCC, and Shirley officers said strip searches are always used. A Framingham supervisor said they are used if the patient is going off unit, while pat searches are used for on-unit activity.

MDOC remains in partial compliance. The most helpful next steps toward substantial compliance will be providing data from the documentation system, once it is consistently in use, to provide support for recreation being offered, as well as MHPs thinking through the risks and benefits of recreation for an individual and documenting that analysis, particularly at SBCC.

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

Finding: Partial compliance

Rationale: MDOC has established means to implement this set of requirements. Policy 103 DOC 650, Mental Health Services, instructs staff with the language of Paragraph 64. The requirement for restraint (i.e., metal hand/leg cuffs) only when there is imminent or immediate threat to safety, and for consulting with mental health staff, has been integrated into new TS training for security staff. About 650 officers and supervisors were trained on this material in the first quarter it was offered, beginning in September

2025, and MDOC indicates that training is ongoing.[72] MDOC's January 2026 Status Report describes top leadership emphasizing this requirement in the November 2025 Quality Improvement Committee meeting and plans to do so in future meetings with institutional leaders. Some Superintendents spoke to the DQE team about their efforts to shift security staff's mindsets toward restraining patients only when they are making threats or presenting overt safety risks and of developing mental health staff's skills in asking for this approach.

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. To assess this, the DQE team interviewed 17 security staff or supervisors, 19 mental health staff, and 30 patients who commented on some aspects of restraints practice for crisis calls and TS. Interviewees were drawn from seven institutions, and there was some representation from every type of TS setting. Documentation does not provide a means to assess the actual application of restraints.[73]

Interviewees described different restraint practices at different steps of crisis calls and TS treatment. They consistently reported that restraint use is the default when escorting a patient who has "called crisis" to meet with mental health staff. A minority (22%) instead said that security staff makes this decision based on situational factors—different people cited agitation, violence, suicidal ideas, SDV, or thoughts of harming others—or said the patient is never restrained. Restraining at this step appears to be the most universal and restrictive, along with MDOC's policy to restrain all BAU patients when they are out of cell for this and any other reason.

Staff reportedly take a similar approach while the patient meets an MHP in response to the crisis call. Interviewees stated that restraints are frequently maintained for this assessment at most institutions, and almost universally at Gardner and Shirley. (In the DQE team's experience, this is also true at SBCC.) About 33% of interviewees described a more variable approach dependent on behavior or MHP preference, or said the patient is never restrained.

During TS treatment contacts, there appears to be more flexibility in restraint decision-making. For those contacts, 66% of staff and patients described several methods that can result in restraint applications consistent with Paragraph 64 mandates:

[72] The DQE team reaches these findings after reviewing the referenced policy, training slides, trainer's agenda, and training printout.

[73] It would not be feasible for security staff to document each application of restraints or decision not to do so. VitalCore made efforts to support mental health staff in recording this by including a field in one of the progress note templates. The DQE team conducted spot checks and learned that information from this source to date is more limited than what is needed to draw conclusions.

- Some staff described a mental health-security collaboration, particularly at MTC and Shirley. In the past, Norfolk staff have indicated this as well. Framingham leadership indicated the Mental Health Director leads a meeting three times per week where patients' restraint status is discussed. Some Framingham staff also noted they have the option to ask security leadership spontaneously not to restrain an individual, but in practice, they do not find that requests are granted.

- Other mental health staff stated that restraint decisions for TS treatment contacts are made individually based on factors such as current or historical assaultiveness, heightened risk because of SDV, or not disclosing intentions by declining to answer risk-related questions.

- Patients report, at a much higher rate than with crisis assessments, that they are never, or only sometimes, restrained for TS treatment, and some mental health staff endorse this. This suggests an approach more tailored to individual circumstance as well. It may also reflect the types of meeting space employed, as contacts often take place in split cells or visiting rooms where security staff are more comfortable leaving a patient uncuffed because there is physical barrier between them and the mental health staff.

It was encouraging that there were fewer reports than in the past of troubling practices such as handcuffing behind the back to a restart chair or within a split cell (though there were a few such reports from OCCC and Shirley security staff), or leaving patients restrained on the recreation yard. One OCCC MHP remarked that there has been a substantial positive change from six months prior.

Mental health staff continue to record determinations of whether restraints are contraindicated for a patient. In the DQE team's property and privileges study, first described in Paragraph 56, MHPs at Framingham and OCCC found that restraints are contraindicated for all but one patient. In the rest of MDOC, MHPs found restraints are *not* contraindicated for all but one patient. These strongly suggest blanket approaches and not an individualized assessment.

Reasons for contraindication generally were not recorded in the health record. There also continues to be a trend at some institutions of MHPs forgoing giving input, instead documenting that restraints are, or are not, contraindicated "per security protocols" or "because of BAU status."

While much of the restraint practice is similar to previous monitoring periods, it appears there may be some improvement in the approach to TS contacts. MDOC remains in partial compliance with Paragraph 64.

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 previous monitoring periods, the DQE team has accepted MDOC's assertion that meals cannot be served out of cell in health service units (HSU) because of sanitation and food service regulations.[74] This limitation applies to some TS cells, but each of the eight sites also has TS cells outside the HSU. In its January 2026 Status Report, MDOC repeated its findings from a June 2025 survey, stating that meals are being served out of cell at Framingham and MASAC. All the other sites have either stated that they have insufficient space or that they were exploring the idea.

The DQE team did not see evidence of meals being eaten out of cell on TS during this monitoring period. Interviewed patients stated that they had eaten all meals in the cells, and interviewed staff were unsure of practice. VitalCore did amend its progress note template for TS contacts (BH-5.0) to prompt clinicians' documentation of the reasons for in-cell meals. In the DQE team's study of 64 TS placements, these notes indicated a variety of reasons, including "no DPH approved cell available" to "not an option on this unit" to "per security." A minority of patients were permitted meals out of cell, according to their TS Reports and progress notes, but it is not clear whether this actually occurred.

Overall, there has been no significant change to MDOC's practice in this area, leading to a continued partial compliance finding.

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

[74] 105 CMR 590.000: Minimum Sanitation Standards for Food Establishments State Sanitary Code Article X, and 105 CMR 451.200, Food Storage, Preparation, and Service

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

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

Finding: Partial compliance

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

Frequency of contact: In the DQE team's chart review in this monitoring period,[75] 82% of the required TS contacts were documented.[76] A large majority of interviewed patients also confirmed being seen with about the expected frequency.[77]

Some essential components supporting meaningful contacts include access to records ahead of, or during, the contact; continuity with previous TS contacts; and conditions that promote speaking freely about emotional and behavioral issues. While interviewed mental health staff described frequent conversations to communicate recent observations

[75] See Paragraph 45 for a description of the selection method. The expected number of contacts was prorated to accommodate time of placement, time out of the institution (for example, trips and/or admissions to community hospitals), and approximate time of discharge. A contact was credited whether it was completed or the patient refused.
[76] Most of the missed contacts occurred on Sundays and holidays.
[77] Of the 19 patients who commented on frequency of contact, 74% confirmed this. Others estimated contacts once or twice daily, "every few days," or not at all; these estimates were inconsistent with progress notes in their health records.

and patient developments, their access to records remains uneven. At OCCC, there were reports of bringing a laptop into contacts or reviewing records ahead if meeting in a split cell that makes laptop use impractical. At SBCC, leaders noted that the pace and high patient demand make it very difficult to review records ahead of time. New MHPs indicated barriers to reviewing a patient's history in that they do not have access to the previous vendor's electronic health record, and they find that not all records transferred into the current system as intended.

Where expected contacts were not documented in the DQE team's study, 89% were on a Sunday or a holiday. Records showed no indication that institutional factors or MHPs' workload prevented any significant number of contacts, with only 2% of contacts missed for these reasons or where the reasons were not recorded.

Confidentiality: Contacts in nonconfidential settings were a much larger concern. MHPs described designated private spaces—offices, therapy rooms, rooms with split cells, visiting rooms, or law libraries—associated with each TS setting. Although those spaces are shared with other professionals, in most facilities, MHPs indicated they could still offer confidential contacts despite the space competition.[78] SBCC has been the major exception and, despite efforts in this monitoring period, MHPs said space access has not improved, particularly in HSU.[79] HSU officers continue not to permit out-of-cell contacts in the mornings,[80] prioritizing medication pass and other activities. SBCC initiated a system for scheduling shared spaces, but it allows for unintentional double-booking. The administration also converted a cell to create more treatment space, but its remote operation (by an officer in the nearby "bubble") leads to the door frequently remaining wide open, negating the privacy purpose. Additionally, the heavy mesh behind which the patient is placed reduces visibility, there is no seat for the patient, and MHPs are required to sit far away, next to a toilet. All these conditions combine to risk rendering treatment less effective, and patients, who have said they like it even less than previous conditions, are more likely to refuse out-of-cell contact.

The rate of nonconfidential contacts that are required by security staff or result from institutional factors held steady in most of MDOC during this monitoring period. However, sampled records show these practices caused 17% of all contacts to be nonconfidential at SBCC, more than double the rate in the rest of MDOC's facilities with TS. Further, there are indications that progress notes may drastically underrepresent the frequency of security-driven nonconfidential TS contacts at SBCC. Recent triage meeting

[78] One individual MHP at each of OCCC and Shirley also pointed to space competition as a significant barrier to manage.
[79] Data from the DQE team's chart review seems to support this perception. Please see discussion below.
[80] This was evident in MHP interviews and in progress notes in the DQE team's chart reviews.

minutes designated *half* of all contacts over a month as nonconfidential because of institutional factors.[81]

The result is a rate of nonconfidential contacts that continues to be higher than early in the Agreement's implementation. In the current DQE team chart review, the rates were:

SBCC	78% of contacts nonconfidential[82]
Rest of system	51% of contacts nonconfidential

In the most extreme cases, there were only one or two confidential contacts in the entire TS placement.[83]

Refusals: Among the other reasons for cell-front contacts, patient refusals continued to dominate. The majority of interviewed patients and security staff believed that the patient or mental health staff determine the location for TS contacts, and they estimated the resulting out-of-cell contacts as 50% or better.[84] Progress notes and interviews reflected patients not engaging in contacts or declining to come out of cell because the patient wished to sleep, was sick or undergoing detoxification from illicit substances, did not want to come out in a smock, did not consider a contact useful, preferred another activity or another mental health staff member, wanted a brief answer to a specific question, had a conflict with security staff, or appeared unable to engage. Reasons were consistently recorded for only half of the sampled patients.

Patients who refused contacts altogether were much less common than those recorded as declining to come out of cell; in the DQE team study, about 14% of the patients frequently refused, or appeared unable, to engage. Evidence of follow-up attempts to engage them has been very limited. 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 a 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.

Summary: Three contacts per day are offered at a reasonable rate, if short of the full requirement as written. MHPs have increased documentation of patients' refusals and the reasons and MHPs meet patients at a variety of times of day. The DQE team has

[81] Based on a DQE team review of all SBCC triage minutes for December 2025
[82] This is also higher than the previous monitoring period, when 74% of sampled contacts were nonconfidential.
[83] These five placements lasted 4 to 10 days.
[84] Twenty-four patients and 10 security staff or supervisors commented on point. Their estimates of what patients chose was higher for private contacts than the chart review revealed. There were not strong patterns by institution. Additional numbers available on request

encountered limited examples of follow-up attempts to meet with a patient who refuses contacts altogether. To reach substantial compliance with Paragraph 67, the most needed improvement is to increase access to confidential contacts at SBCC.

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

Finding: Partial compliance

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

Although the DQE has observed that triage meetings demonstrate reasonable practice, Paragraph 68 requires specific documentation in the triage meeting minutes. To assess this, the DQE team identified, within the chart review first described in Paragraph 45, the patients who had more than *de minimis* refusals to engage in TS contacts. The DQE team reviewed triage meeting minutes and progress notes for a sample of nine records, drawn from six institutions.[85]

Triage minutes consistently recorded that the patients refused contact, although sometimes far fewer refusals were identified in the minutes than in the health records. Minutes did not record reasons; two-thirds of the charts had at least one progress note indicating the patient's reasons, which are understandably difficult to discern if the patient is not engaging. Triage minutes did not reflect additional efforts or interventions for mental health staff to try, but this information increased in progress notes to two-

[85] These patients refused one-quarter or more of their TS contacts. This data set is nearly all the cases meeting this definition within the DQE team's 64-chart study.

thirds of records as well.[86] Staff described highlighting something the patient was particularly interested in, or the MHP expressing interest in learning from the patient, for example.

Triage documentation rates appear lower than actual practice, but overall, the information required by Paragraph 68 is more often shared through the health record and is improving. If MDOC's demonstration is sustained at a similar level, the DQE team foresees finding substantial compliance in the near future.

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

Finding: Substantial compliance

Rationale: As detailed in previous DQE reports, MDOC and its vendors have a well-established system for generating and updating these documents ("TS Reports") and distributing them to the security staff involved in therapeutic supervisions. Accordingly, MDOC has been found substantially compliant with the Paragraph 69 requirements since the second monitoring period, and practice has been strong except for the period immediately following the change in healthcare vendors and documentation systems. The DQE's findings were based on interviews with correction officers and leaders and mental health staff, observation on the units and in meetings, and review of charts and meeting minutes.

In the current monitoring period, the DQE team studied the TS Reports associated with 59 TS placements.[87] For the Monday through Saturday requirement, significantly fewer therapeutic supervisions than in the past had all required TS Reports. Some of the gaps occurred on holidays, but 75% of the gaps did not have any apparent explanation.

On the other hand, when examining the total number of *days* requiring a TS Report, only 6% were missing. Additionally, for patients on constant observation on a Sunday, TS

[86] Reasons for refusal and alternative approaches are found in the body of the progress notes, not in the field designated for this purpose.

[87] The sample largely overlaps with the study described in Paragraph 45 and draws on unique records as well. The number of records reviewed from each institution corresponds to the facility's proportion of the total therapeutic supervisions. Where records appeared to be missing, MDOC was provided an opportunity to send supplementary materials; staff either did so or confirmed that there was no TS Report in MDOC information systems. This data set represents an 11% sample of all therapeutic supervisions in the monitoring period.

Reports were present in 100% of sampled cases.[88] In both respects, SBCC's practice was consistent with that of the rest of the system.

In the DQE team's various audits, the health care records continued to show at least one progress note per day by an MHP[89] or by a nurse if an on-call professional initiated the TS placement after hours, which is common documentation practice in mental health settings and consistent with the intent of the Agreement.

Overall, despite a slight decline in practice, the DQE team continues to consider the compliance rate to be sufficient for substantial compliance.

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

Finding: Substantial compliance

Rationale: Since monitoring began, MDOC has been found substantially compliant with Paragraph 70, which requires only that MHPs document their TS interventions and patients' response to these interventions daily. The DQE team's concerns about the quality and appropriateness of those interventions are addressed elsewhere (Paragraphs 52, 72, and 73).

In the current monitoring period, clinicians continued to document their TS contacts on progress notes in the electronic health record that are specific to that purpose. The note template contains the required elements: data, assessment, and plan. In the DQE team's study of 64 TS placements,[90] notes were written at least once per day, as required by Paragraph 70, and usually three times per day, in alignment with MDOC's TS protocols. Clinicians documented their interventions and the patient's response (in a section of the note called "progress toward goals"). In contrast to the previous monitoring period, when clinicians were leaving large sections of the note template blank, documentation was overall improved. The quality of assessments was variable, but the DQE clinicians could determine from the totality of documentation (sometimes supplementing the progress

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[88] In the sample, there were 11 such cases. The DQE team understands that there is no tracking system that would be able to identify this particular population, and it is not practical to determine its size. However, in the DQE team's previous reviews, it appeared that such cases were rare. Thus, the team believes that this sample gives a reasonable impression of MDOC's practice on this element of Paragraph 69.

[89] This refers to at least one note per day Monday through Saturday, and one note on Sundays if the patient was on constant observation status.

[90] See Paragraph 45 for details.

notes with triage meeting minutes or End-of-Shift reports) what the MHP's assessment and plan were.

Overall, the TS notes conveyed enough information to satisfy the requirements of Paragraph 70, leading to a continued finding of substantial compliance.

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

Finding: Substantial compliance

Rationale: To assess this requirement, the DQE team examined 12 TS placements where a patient engaged in SDV.[91] Of these cases, MHPs appropriately modified the patient's care after self-injury, or no such modification was necessary, in 92% of cases, according to the DQE's clinical judgment. This is a slight improvement from previous monitoring periods, when practice was already strong (78-90% of such SDV cases were handled as clinically indicated).

As before, it was unusual for MHPs to formally revise the treatment plan document after SDV. Only one case in the current study contained a treatment plan update on the first business day after the SDV occurred, and this progress note was written by a statewide supervisor rather than a site-based MHP. In all cases, one could see how patients' treatment was modified by reviewing successive progress notes in the electronic health record. Treatment modifications included referring to psychiatry, sending the patient to an outside hospital for medical care, administering emergency medication administration and four-point restraints, "upgrading" the patient's TS status to 1:1, and helping the patient work through institutional stressor(s) that led to SDV. These actions were all clinically appropriate.

The one noncompliant case, at SBCC, added to a pattern the DQE team has observed since monitoring began: that SDV is sometimes inappropriately handled as a security matter, especially on nights and weekends. In this case, a patient engaged in repeated self-injury over a few hours. After less intrusive interventions by the mental health and medical staff failed, a psychiatrist ordered therapeutic (soft) restraints and emergency intramuscular medications. For the next four hours, incident reports indicate that the patient was placed in soft restraints (per psychiatry) *and* leg irons and waist chains (per

[91] This review draws on the study first described in Paragraph 45. Five TS placements in the study involved a patient harming themselves. To create an adequate sample, additional cases from MDOC's "LOG OF RESTRAINT ON TS" and "SDV Log" spreadsheets were added, resulting in 12 total cases.

security). That evening, after the physician's order expired, the Superintendent ordered that the soft restraints remain for another 3 hours 35 minutes, at which point the patient was "transitioned to metal waist chains and leg irons" for unclear reasons. He remained in those restraints until the next morning. In total, the patient was restrained for at least 14 hours after engaging in SDV, with a minority of that time under a physician's orders.

Although this incident was concerning, it is important to note that it is an outlier case. We raise it here to draw MDOC's attention to the need for increased discussion about how SDV is managed, especially during non-business hours and at SBCC more generally. At other facilities, the DQE team saw appropriate management of SDV in the cases reviewed during this monitoring period. Overall, MDOC's demonstration warrants a continued finding of substantial compliance.

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

Finding: Partial compliance

Rationale: Paragraph 72 focuses on the quality of treatment provided to prisoners on TS, including meaningful, out-of-cell group and individual therapy. MDOC has made gains in this area since the Agreement began, with the DQE team observing more substantive, confidential, and therapeutic interactions between clinicians and patients on TS during the site visits. This trend has continued during the current monitoring period.

Across MDOC, individual TS contacts remain the norm. Only Framingham and the ISU provide group therapy for patients on TS, and even at those sites, patients are often unable to participate for safety or clinical reasons. Thus, the vast majority of TS contacts are 1:1, and there are no indications that group therapy will soon be implemented for patients on TS. At many sites (e.g., Gardner, MASAC, MTC, Shirley), it is rare for there to be more than one patient on TS at the same time, while at other sites (e.g., OCCC, SBCC, Norfolk), no group programming space has been identified.

In the DQE team's study of 64 TS placements, first discussed in Paragraph 45, 62% of the patients' contacts with mental health staff occurred in a non-confidential setting (cell-front, which is identical to the previous monitoring period. Of the non-confidential contacts, 77% were documented as being the patient's preference or because the patient did not engage with the clinician at all. The remaining cell-front contacts were largely due to security or institutional factors.

To assess the quality of treatment, the DQE clinicians reviewed documentation in the health record for 50 TS placements and directly observed TS contacts at six facilities during the site visits.[92] When out-of-cell contacts occurred, they appeared to be more meaningful, lengthy, and individualized. Several clinicians impressed the DQE team with their clinical abilities during difficult patient interactions, and interviewed patients gave similarly positive reports of their interactions with MHPs. While the clinicians remained somewhat "green," they seemed to understand the importance of confidential, substantive interactions with patients.

One area where MHPs' skills are still consistently lacking is in recognizing psychosis. Through direct observation of clinical interactions and triage meetings, and in reviewing health records, it remained clear that some clinicians do not understand what psychosis is or that expeditious referral to psychiatry is indicated in cases of unexplained or new-onset psychotic symptoms. The DQE clinicians found many examples in the health record of MHPs describing patients as "disorganized," "delusional," "bizarre," or "not making sense," seemingly without recognizing these as possible psychotic symptoms. This remains an area for growth throughout the MDOC system.

As in previous monitoring periods, the situation at SBCC is the most problematic, with 78% of TS contacts conducted cell-front in the DQE team's study. Disappointingly, the facility's efforts to improve access to mental healthcare have not yielded significant results. During the DQE team's December 2025 site visit, clinicians were once again observed conducting TS contacts through the gap between the cell door and doorframe, within a few feet of an officer, throughout the institution. It appeared that both patients and clinicians had resigned themselves to this situation, with neither party insisting that security staff facilitate a confidential contact. Furthermore, the scheduling system that SBCC put into place for confidential office spaces on the housing units has significant flaws, and all interviewed MHPs reported that it has made no difference in improving their access to patients.

Overall, the DQE team has seen significant improvement in the provision of meaningful therapy to patients on TS at most MDOC facilities. At SBCC, no such improvement is apparent despite the facility leadership's continued efforts to improve access to mental healthcare.

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

[92] At MASAC and Gardner, there were no patients on TS when the DQE team visited, so it was not possible to observe MHPs' TS contacts.

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, which is closely related to the Paragraph 72 requirement for meaningful and consistent out-of-cell treatment. The DQE team's findings are, therefore, similar to Paragraph 72. Although the expectation to provide individualized, out-of-cell treatment to patients on TS is well established across MDOC, logistical barriers and understaffing still get in the way at some institutions.

In the DQE team's review of 64 TS placements, MHPs' individualized decision-making was more apparent in the health record than in previous monitoring periods. Most of the identified treatment goals were individualized to the patient's presenting problem. The documented treatment interventions were sometimes specific and appropriate, but a significant minority were so vague as to be meaningless (e.g., "provide mental health interventions" or "engage three times daily"). As noted in Paragraph 72, recognition of psychotic symptoms was particularly weak. Overall, however, there was a noticeable improvement in MHPs' individualization of treatment and documentation.

The improvement may stem from VitalCore's continued focus on treatment planning in its in-service training programs. In addition, MDOC reported that VitalCore has provided clinicians with increased therapeutic resources (e.g., evidence-based treatment manuals and corresponding workbooks for patients, psychological testing materials). Improved mental health staffing levels at most facilities have also helped, allowing more manageable caseloads and more time to spend on patient interaction and documentation. Stable staffing (i.e., less turnover) at many facilities has enhanced team camaraderie and helped retain a more experienced clinical workforce. These are all positive steps toward compliance.

Paragraph 73 also requires the documentation of all out-of-cell time on TS. Currently, out-of-cell time for MHP, Support Person, and activity therapist contacts is generally documented in the progress notes, but all other out-of-cell time—showers, recreation, visits, etc.—has not been documented. In its January 2026 Status Report, MDOC stated that such a system, called the "daily TS log," had recently been launched, which is an important next step toward meeting the Paragraph 73 requirements.

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

Finding: Substantial compliance

Rationale: The therapeutic de-escalation room in the HSU at Shirley has existed since the Agreement began. The DQE team confirmed during the December 2025 site visit that the room continues to function. On the day of the site visit, it contained books, a television, telephone, SCORE kiosk, and table and chairs. Interviewed MHPs were not sure how frequently patients on TS use the room, but they described it as the "day room for all of HSU," indicating it was available as a recreation space.

During this monitoring period, half of Shirley's TS placements occurred in the HSU, while the other half were in the BAU. It is not clear that the therapeutic de-escalation room would be available to patients on TS outside the HSU. This is an area for MDOC to improve, but since Paragraph 74 does not specify that *all* patients on TS must have access to the therapeutic de-escalation room, current practice is considered compliant.

As described in Paragraph 135, a "comfort room" has been developed in the ISU, and MDOC has been trying to make it more inviting and accessible to patients. Although some work remains, those concerns are addressed in Paragraph 135 rather than here. In its January 2026 Status Report, MDOC also reported that the "finishing touches" are being applied to a comfort room at Framingham. These activities indicate that MDOC continues to meet the Paragraph 74 requirements.

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

Finding: Substantial compliance

Rationale: Peer support activities around MDOC continued to grow during this monitoring period. In addition to the programs already established at Framingham and Norfolk, MDOC is expected to launch a peer mentorship program at Shirley in the coming months. During the DQE team's site visits, staff at Framingham and Norfolk reported that the peer programs have been going well, with no major problems encountered to date. An independently licensed MHP meets with the peers monthly for supervision at both sites. The eventual goal is for all the prison sites to have a peer mentorship program supported by VitalCore's training and supervision.

During the DQE team's October 2025 site visit, Framingham leadership reported that peers had recently begun "rounding" in the ITU, which houses patients on TS and others in need of intensive mental health support. At that time, peers were only allowed to speak with patients through the cell door, and some mental health staff reported that

security officers did not support the presence of peers on the unit.[93] While MDOC has taken an important step toward fulfilling the Agreement's vision of peer support for patients on TS, hopefully, Framingham will soon allow out-of-cell contact with peers in the ITU. If successful, this model can be applied to the men's facilities as well.

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

Finding: Substantial compliance

Rationale: In its January 2026 Status Report, MDOC stated that the Director of Behavioral Health is "reviewing the feasibility of a staff member with a therapy dog." In contrast to previous monitoring periods, the topic of therapy dogs did not appear in the Quality Improvement Committee (QIC) or Quarterly DOJ Implementation meeting minutes, which may indicate that this is not an active area of discussion. This interpretation is consistent with MDOC's Status Report, which says that the idea has not been "ruled out" and may be assessed in the future.

While the DQE team still does not understand why it is so difficult to utilize therapy dogs in the mental health units when there are dozens of therapy dogs being trained across the prison sites (albeit for the community), the DQE team agrees that MDOC has demonstrated its consideration of the idea over three years. A substantial compliance finding is now being issued.

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

Finding: Substantial compliance

Rationale: In over three years of monitoring, MDOC has demonstrated its efforts to transfer patients expediently to psychiatric hospitals once the need for a hospital level of care has been identified. This practice has not changed during the current monitoring period. Wait times for the STP, which were long during previous monitoring periods,

[93] Officers in the ITU, where many TS placements occur, declined to be interviewed by the DQE team during the October 2025 site visit, so it was not possible to solicit their views.

have now been alleviated. The remaining challenge is with female prisoners awaiting transfer to a DMH facility. The wait times for DMH beds are growing longer with each monitoring period, but since DMH bed availability is not within MDOC's control, the delays have not affected the DQE team's overall compliance determination for Paragraph 77.

Outside hospital transfers under Section 18(a)

Data from MDOC's log of transfers to higher levels of care indicate that, between July and December 2025, 33 patients were transferred to an outside hospital under Section 18(a). Each of the seven prison sites transferred at least one patient, but most transfers were initiated by staff at OCCC (27%) and SBCC (36%).[94] Upon commitment by the court, five female patients were admitted to DMH facilities (Solomon Carter Fuller and Worcester Recovery Center), two civilly committed patients at MTC were admitted to Bridgewater State Hospital's main campus, and the remaining 26 patients were admitted to the ISOU at Bridgewater State Hospital.

All the patients bound for Bridgewater State Hospital were transferred on the day they were committed by the court, but the patients awaiting DMH beds experienced delays of 13-30 days. 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 continues to worsen.

Figure 6 illustrates the number of 18(a) hospitalizations between 2018 and 2025.[95]

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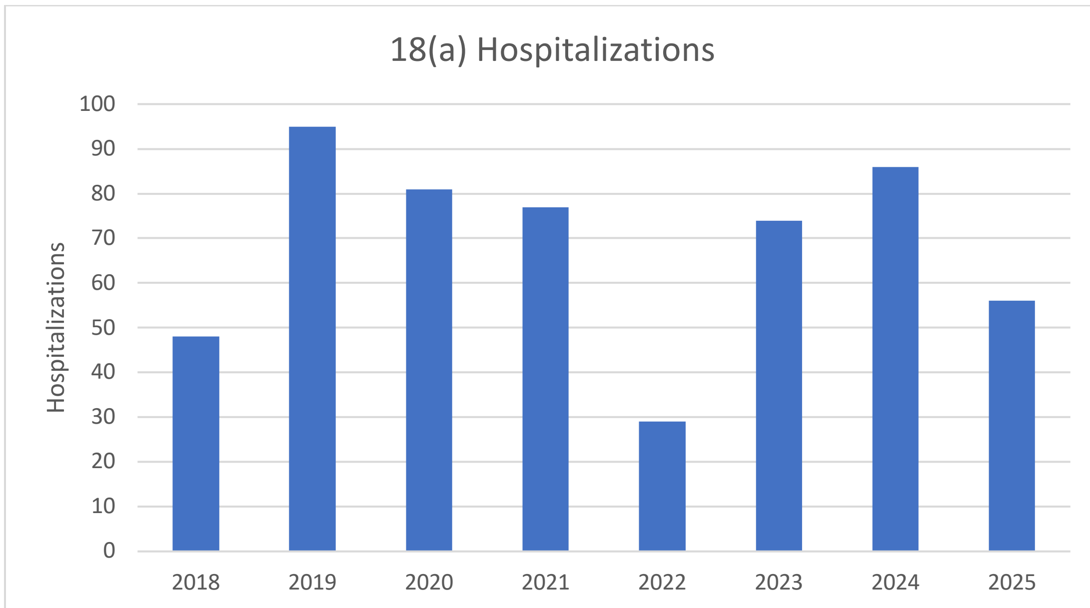
[94] Patients at MASAC are not eligible for 18(a) transfers; they are discussed in relation to Section 12 transfers below.

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

Figure 6. Annual 18(a) Hospitalizations, 2018-2025



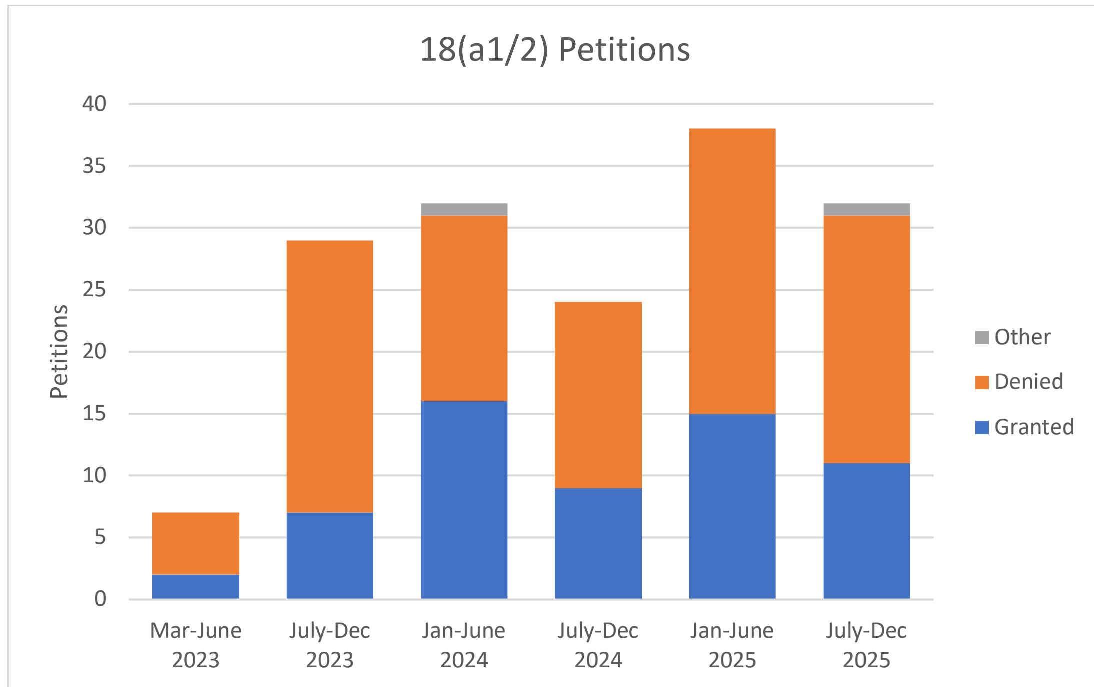
MDOC transferred fewer patients in 2025 than in any recent year except 2022. It is not clear what accounts for this finding, but it is possible that the ISU's implementation has alleviated some of the need for outside hospitalization. This issue warrants monitoring to ensure that prisoners in need of hospitalization are not being missed.

Outside hospital transfers under Section 18(a1/2)

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

Figure 7 illustrates use of the Section 18(a1/2) statute since 2023. Between July and December 2025, 32 prisoners petitioned the courts under Section 18(a1/2), and 11 of these petitions (34%) were granted. For male patients, transfer occurred on the day of the court approval, while female patients waited between 5 and 33 days, again due to DMH bed availability. In all 11 cases that were approved by the courts, patients were returned to MDOC after a brief assessment. In fact, since MDOC began tracking data about Section 18(a1/2) petitions in March 2023, not even one of the 61 patients admitted to Bridgewater State Hospital or a DMH facility has been assessed as needing hospitalization beyond the brief assessment period.

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



Outside hospital transfers under Section 12

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

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

Patients are transferred to outside hospitals for competency to stand trial evaluation and restoration under M.G.L.c. 123, Sections 15(b) and 16(a), respectively. Transfers followed the same pattern as in other areas: patients from the male facilities were transferred on the day of the court decision, while those from the female facilities waited between 2 and 23 days.

Secure Treatment Program and Behavior Management Unit transfers

Between July and December 2025, six patients were referred to the Secure Treatment Program (STP) at SBCC, and no patients were referred to the Behavior Management Unit (BMU) because it is not operational. All transfers happened within a week of approval, which was consistent with information learned from staff during the DQE team's site visits, who stated that the STP no longer has a wait list.

Intensive Stabilization Unit transfers

Thirteen patients were referred to the ISU between July and December 2025, and all were accepted into the program. MDOC's data indicate that, once ISU placement was approved, transfers happened quickly, in 2.8 days on average (range 0-5 days).

Residential Treatment Unit transfers

The Residential Treatment Units (RTUs) continued to operate at OCCC, Gardner, SBCC, and Framingham during this monitoring period, with no change in bed capacity. In December 2025, the RTUs were about 56% full, as described in Paragraph 139. MDOC's data indicate that 25 patients were referred to the RTU in the second half of 2025, and all were accepted into the program. The time from referral to transfer remained variable, with some patients admitted to the RTU before the formal referral was completed, while others waited up to 30 days. Admission delays seemed to stem from security factors, such as a prisoner awaiting classification or returning to the BAU before RTU transfer.

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: Substantial compliance

Rationale: Sixty-four percent of TS placements in the monitoring period ended by the close of the third day, a rate similar to that found in previous monitoring periods. For TS stays exceeding three days, the DQE team examined progress notes to determine whether a higher level of care was considered and documented shortly thereafter. The reviewer selected 57 TS health records, which represents 29% of the relevant placements in the monitoring period.[96] Two patients were referred to a higher level of care at this stage.

This analysis relies on MDOC and VitalCore representing that checking a box in the progress note form indicates that staff considered a higher level of care. This occurred in 87% of the sample, a rate that has been sustained for at least a year. To the extent that progress notes documented any rationale for decision-making, the most common phrase

[96] The sample for Paragraphs 78 through 80 overlapped with the sample described in Paragraph 45 but differs in significant ways. All cases had TS stays of four days or longer during July through December 2025. They were drawn from each institution that provides TS, keeping in mind their proportions of the stays *longer than three days* (which differs from their proportion of all TS). MASAC was an exception, as it did not have any TS stays subject to these requirements (all concluded by the morning of the fourth day or the patient was at a community hospital for most of the time he was listed as TS status). Cases were drawn from all types of housing that provide TS except RTU (that is, cases were drawn from BAU, HSU, ISU, ITU, SAU, and STU). Some cases, beyond those in the data set for Paragraph 45, were substituted in order to have a sufficient sample meeting all these criteria.

was "due to needs being met at the institution level," which does not offer much explanation (e.g., what needs and how they are being met).

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

In the current monitoring period, the DQE team analyzed the spreadsheets and meeting minutes for the sample described above. Notice was provided to MDOC's Director of Behavioral Health (and others) in 94% of the sample. As for consultation, the parties and DQE team agreed, for a trial period, to consider that participation by VitalCore's Program Mental Health Director[97] or a skilled and knowledgeable designee could satisfy the requirement. Under this definition, consultation took place in 92% of the sample. In the remaining cases, the patients were listed in the notice spreadsheet, but there is no record of them being discussed in the Daily Consultation meeting.[98]

MDOC has implemented a system that informs MDOC and VitalCore leadership and allows them to consider higher levels of care for patients at the three-day point. Both the system and high compliance rates have been sustained. MDOC has achieved substantial compliance with Paragraph 78.

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

Finding: Partial compliance

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

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

Rationale: The DQE team has confirmed over time that the personnel specified in this requirement consult in the Daily Consultation meeting, described in Paragraph 78, each weekday except holidays. To assess fidelity to that system during this monitoring period, the DQE team analyzed records for 29 TS placements, which represents 39% of placements longer than seven days.[99] Applying the criteria described in Paragraph 78, meeting notes showed consultation in 81% of the sampled TS stays. In the remaining cases, generally the patient was listed in the notice spreadsheet, but no related discussion appeared in the Daily Consultation notes. This particularly occurred with SBCC patients for unknown reasons.

The health records suggested that staff considered a higher level of care for 90% of the sampled patients. Through this local decision-making or leadership's consultations, an additional six patients[100] were referred to a higher level of care at or near the seventh day of their TS.

An important component of Paragraph 79 is not clearly met, however. Where staff concluded that a higher level of care was not indicated, specific reasons were very rarely recorded in the charts This is not only a matter of documentation; it raises questions about how thoroughly key factors were considered and whether patients who could benefit from more intensive care are being missed.[101] Reasons do appear more often (though still a minority of cases) in Daily Consultation meeting notes, even if not expressly labeled as such. Mental Health Directors, or other site mental health leaders, participate in those meetings, so there is a possibility that the reasons can be shared with treating staff, if the discussion occurred only in the Daily Consultation meeting.

MDOC remains partially compliant with these requirements. To reach substantial compliance, it will be key to guide MHPs to think about and record specific reasons that a patient does not need a higher level of care. A bit more consistency in capturing all relevant patients in the Daily Consultation will also be needed.

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

[99] See Paragraph 78 for the selection methods, definitions, and criteria applied.
[100] This is in addition to those described in Paragraph 78.
[101] MDOC's January 2026 Status Report asserts that VitalCore provides ongoing training about documenting these decisions. The DQE team has not yet reviewed those training materials.

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: During this monitoring period, there were 34 TS placements lasting 14 or more days. These took place at Framingham, OCCC, Shirley, and SBCC. The DQE team examined health records, notification spreadsheets, and Daily Consultation notes for 35% of these placements drawn from each of these institutions.[102]

Progress notes showed 100% compliance with facility staff considering a higher level of care at the 14-day point.[103] Six more[104] patients—half of the sample—were referred to a higher level of care in the days surrounding this benchmark. Notably, the wait for an inpatient bed was the only reason the length of stay exceeded 14 days for the sampled Framingham patients, and interviewed MHPs noted this as well.

However, where staff thought a higher level of care was not indicated, *none* of the charts, and only one case in Daily Consultation meeting notes, captured individual reasons for this. This has been the practice for the last two years.[105] As noted in the Paragraph 79 analysis, this could suggest that the question is not being considered thoroughly and result in missing patients who could benefit from more intensive treatment, especially in light of the low utilization of the ISU.

Documents show that VitalCore's Program Mental Health Director, MDOC's Director of Behavioral Health, MDOC's Assistant Deputy Commissioner of Clinical Services, and MDOC's Deputy Commissioner of Reentry and Clinical Services, or their designees, continue to meet with facility mental health leaders on weekdays, except holidays, to discuss patients with extended lengths of stay. Notice of a patient's 14th day on TS, and each subsequent day, was demonstrated in 100% of the cases in the DQE team sample.

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[102] The cases were selected exclusively for this analysis in approximate proportion to each institution's percentage of TS exceeding 13 days in length. See Paragraph 78 for additional definitions and criteria applied.

[103] One or more patients had a self-initiated 18a(1/2) petition pending; while staff did not record their own assessment of whether a higher level of care was warranted, the DQE team analysis treated these cases as compliant.

[104] These patients are in addition to those discussed in Paragraphs 78 and 79.

[105] Practice appeared to be improving as of the DQE's Compliance Report #2 but dropped to 0 or 1 compliant case in each monitoring period since then. Examples of notes that more clearly reflect staff's reasoning might include "depression symptoms have been reducing," "actively preparing patient for discharge," or "started on new medication, will assess effects," for example.

While the leadership met and discussed these patients, a minority of the sample showed the four-leader cohort on each required day.[106]

Records continued to show improvement in adopting changes in interventions after the 14th day on TS. Nearly all sampled cases reflected changes. Where they did not, staff were actively preparing the patient for discharge, and the TS ended shortly thereafter. Changes were captured in progress notes but not in the crisis treatment plan. This improvement has been sustained for one year.

Practice on most components of Paragraph 80 is very strong. Documenting individualized reasons that a higher level of care is or is not indicated will be most important to reaching substantial compliance.

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

Finding: Substantial compliance

Rationale: MDOC policy 103 DOC 650.08, *Emergency Mental Health Services*, contains language about stepping down patients from constant to close observation before discharge from TS. The policy was finalized and implemented in October 2025, and MDOC reported that the healthcare vendors' corresponding policies are now under revision. The slow pace of policy revisions is addressed in the *Policy* section rather than here.

MDOC's implementation of a step-down procedure for TS patients remains strong. In the DQE team's study of 64 TS placements,[107] 32 patients experienced 1:1 observation for part of their TS stay, and 94% were stepped down to 15-minute checks prior to discharge from TS. (The remaining cases were transferred to an outside psychiatric facility.) These findings were consistent with the DQE team's observations in previous monitoring periods, when clinicians routinely stepped patients down during TS stays.

As noted in Paragraph 84, the expectation of post-discharge follow-up contacts is also well established across MDOC. Here, too, practice was strong in the DQE team's study. Of the 64 TS placements reviewed, 51 patients were available for post-TS follow-up contacts. (The remainder were transferred to a higher level of care, released from custody, or readmitted to TS). 94% of follow-up occurred in a timely manner. In eight

[106] By temporary agreement of the parties, this finding counts as compliant the use of designees and the absence of meetings on holidays and weekends. Nevertheless, many meetings lacked one or more members or, rarely, a weekday meeting apparently was not held, as there were no notes.

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

cases at SBCC, the first follow-up contact was documented within minutes of discharge from TS and/or while the patient was still in TS housing—a practice the DQE team has repeatedly stated was unacceptable. These cases were relatively rare and isolated to SBCC, so an overall substantial compliance finding is still warranted.

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

Finding: Partial compliance

Rationale: As detailed in previous DQE reports, it is routine practice for MHPs to conduct a mental health assessment using a suicide risk assessment format and to discuss potential discharge with the mental health team during daily triage meetings. Meeting minutes show that the site's Mental Health Director almost always participates and that psychiatrists or nurse practitioners often do.[108] The DQE team has observed this meeting composition consistently during site visits as well.

Discharge contact: In the DQE team's review of TS discharges,[109] 94% contained a detailed progress note, with a section for suicide risk assessment, on the day of the patient's discharge. The risk assessment section was completed in the records reviewed, along with a brief mental status exam, a notation that the patient was briefed on next steps, and sometimes a collaborative safety plan.

Confidential contacts prior to discharge improved to 86%, according to the progress notes. This is far higher than the privacy rate for TS contacts overall. There was a

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[108] In triage minutes reviewed for discharge information in the DQE team's study, for example, psychiatrists or nurse practitioners were listed as present in 78% of records examined.

[109] The full study, first described in Paragraph 45, examined 64 TS placements. Among them, between 36 and 51 cases were examined for information on the different elements of Paragraph 82 requirements. Typically, the reasons a record would not be included would be that the TS ended not with discharge but with transfer to a higher level of care, continued TS at another facility, or release from custody.

rationale recorded for the majority of cell-front contacts, and those were generally reasonable (e.g., the patient had Covid-19, had recently assaulted staff, or had declined out-of-cell contact throughout the TS).

When TS placements arose from risk of self-harm, the rate of MHPs documenting that the patient presented a lower risk at discharge continued to decline to 28%.[110] Typically, however, progress notes did contain facts and observations reflecting improvement, and one could reasonably infer that the MHP thought there was lower risk. Such an interpretation is consistent with the DQE clinicians' observations during site visits, when it was clear that TS was being discontinued because the treatment team determined that the patient's risk could be managed in a less restrictive setting. On this particular requirement, documentation indicates that SBCC's practice was much stronger than the system as a whole (39% vs. 21% for the rest of MDOC).

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

The DQE team reviewed a subset of its TS study for progress notes concerning discharge and cross-referenced those cases with triage meeting minutes and/or End-of-Shift reports on the dates of discharge. In 88% of the sample, the patient's discharge was clearly discussed in the triage meeting or in a separate consultation with the site's Mental Health Director.[111] Cases that appeared noncompliant typically involved consulting with program coordinators rather than the director.

Upper-level provider consultation: The DQE team also analyzed whether consulting with an upper-level provider was indicated for these patients and whether that took place. Within the chart reviews, DQE clinicians determined that an upper-level provider consult before discharge was indicated for 12 patients.[112] For all but one of these patients,[113] a

[110] In the sample, 46 TS placements were initiated for risk of self-harm; 13 of those TS stays documented the required finding. The other examined placements arose from concerns about harm to others or potential psychosis.
[111] Consultations with the site Mental Health Directors, or anyone to whom they report, were considered compliant.
[112] See Paragraphs 52 and 85 for descriptions of the criteria.
[113] In the one apparently noncompliant case, psychiatry was not present at the triage meeting, and no patient contact or MHP consult was demonstrated in the chart.

consult was evident, either by triage meeting minutes documenting a psychiatrist or nurse practitioner as present at the meeting where a discharge decision was made, or those professionals meeting with the patient within a day before discharge and conveying their thoughts to mental health staff through an 18a assessment or progress note. This is very strong practice and shows continued improvement.

Audits: Paragraph 82 also requires that MDOC conduct audits to ensure that MHPs are making appropriate discharge decisions. MDOC's June 2025 and January 2026 Status Reports point to audits it conducts of various practices arising out of this Agreement, but quality improvement information provided to the DQE has not reflected audits to date of whether patients are discharged as early as possible from TS.

MDOC has made strong progress on most documentation requirements of Paragraph 82 and in demonstrating an expanded role for psychiatry when the team is considering discharging TS patients. MDOC should be able to reach substantial compliance if it sustains these practices and provides demonstration of audits focused on the specified quality-of-care issue—that discharges take place as early as possible. TS lengths of stay have improved substantially throughout Agreement implementation, and signs are promising for being able to make this demonstration.

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: Communication of TS discharge plans between mental health professionals typically occurs at the daily triage meeting or in End-of-Shift reports. As in previous monitoring periods, MHPs also described following notification protocols to make security leaders and officers in the housing units aware of a TS discharge. MHPs do not routinely share the content of discharge plans with security staff out of concern for patient confidentiality.

As in the past, TS discharge notes typically delineated the number of follow-up sessions planned for the patient, but documentation of additional details improved during this monitoring period. In the DQE team's review of TS placements first described in

Paragraph 45, there were 52 patients requiring a discharge plan.[114] Records demonstrated a brief mental status examination for all but three patients. The creation of safety plans continued to improve substantially: about half of the charts likely had safety plans,[115] and another subset had some elements of a safety plan integrated in the discharge progress notes (e.g., protective factors or coping skills identified by the patient). Framingham clinicians routinely made choices for housing based on clinical need. Recommended follow-up included a specified number of sessions and sometimes a referral to another profession, such as psychiatry. Specifying a treatment focus or goals was rare. While practice has further to go, these compliance rates continue to improve in each recent monitoring period.

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 after discharge from TS is well-established; this was determined through observing triage meetings and MHPs providing contacts, interviewing staff and patients, and reviewing meeting minutes and electronic health records. Employing those same methods, the DQE team confirmed that the system has been sustained.

In the DQE team's chart review, progress notes showed that all TS follow-up contacts were consistently made within required time frames.[116] Interviewed patients usually confirmed that there was follow-up, but their estimates of the frequency were wide-ranging. Only 16% remembered three contacts approximating the schedule outlined in Paragraph 84, with most others believing there were fewer contacts and a few patients

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

[115] This includes plans the DQE team reviewed and plans referenced in progress notes but apparently not uploaded into the health record

[116] See Paragraph 45 for a description of the selection methods. In the sample, 51 patients required MHP follow-up after discharge. The other patients in the sample transferred to a higher level of care, left MDOC, or were immediately readmitted to TS. If a patient had some follow up contacts and then left the facility or was readmitted to TS, the record was treated as compliant if the MHPs had completed the number of contacts required as of the date those events rendered further follow up impossible.

asserting there were none. The reasons for the differences between their perceptions and the sampled health records are unknown.

Issues of concern continue to include meeting the patient within an hour after discharge and/or within the TS setting, which is not a follow-up contact, and meeting patients in nonconfidential settings. The overall rate of confidential TS follow-up contacts is identical to the rate when Agreement implementation began. The results differed quite a bit depending on location, as shown in *Table 4.*

Table 4. TS Follow-Up Contacts

Issues of concern	**SBCC** *(% of contacts)*	**Rest of MDOC** *(% of contacts)*
Follow-up while the patient was still in TS housing and/or very soon after TS discharge	13%	0
Nonconfidential contacts	90%	39%
Nonconfidential for staff or institutional reasons	38%	5%

MHPs at four institutions identified private spaces on or near different housing units to conduct follow-up contacts, although some units at MTC do not provide this privacy. Progress notes show nonconfidential contacts taking place at officers' desks; in dayrooms; in recreation yards; and cell-front, where there are also difficulties hearing and visually assessing the patients when they are speaking. The large majority of nonconfidential contacts were recorded as being at the patient's request or that the patient was "agreeable" to this. Interviewed patients were about evenly split in whether they supported this characterization.[117]

As for treatment plan reviews and updates, few of the relevant records[118] contained an indication that the treatment plan had been reviewed. The rates were:

[117] Twenty patients drawn from Gardner, Norfolk, SBCC, and Shirley gave their opinions about follow-up contact, and a subset of them commented on confidentiality. Just over half said contact was in private spaces or was at the patient's discretion, and a similar-sized group noted some follow up is private and some is not, without indicating reasons.

[118] In the same sample, 43 stays were subject to the requirement to review and potentially update treatment plans. For the remaining patients in the sample, before the seven-day deadline for treatment plan review, they were readmitted to TS, transferred to a higher level of care, or left MDOC custody.

This number of stays differs from the number of placements requiring the three follow-up contacts. This difference occurs when the change in circumstance takes place after the first one or two contacts were due (making the patient subject to the follow-up contact requirement) but before seven days when the treatment plan requirement would be applicable.

Records were considered compliant if a new treatment plan was issued and mentioned the TS stay and whether changes were indicated, a progress note mentioned a decision that no changes were indicated, or a change in approach occurred (for example, making a psychology referral) without being captured in the treatment plan.

SBCC	22%
Rest of system	12%

This remains lower than in other monitoring periods.

Overall, the DQE team believes MHPs are successful in consistently completing follow-up contacts. To reach substantial compliance, more contacts should be confidential. Treatment plans must be reviewed and updated if clinically indicated, or MHPs must document that such an update is not clinically indicated.

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

Finding: Partial compliance

Rationale: As noted in Paragraph 82, the DQE team analyzed a sample of TS placements[119] and determined that psychiatry consultation and/or contact before discharge was clinically indicated for 12 patients (31% of cases).

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

- Patients had not had an initial psychiatric evaluation since their entry into MDOC *(i.e., new admissions to the system who were placed on TS and should have been prioritized for evaluation by psychiatry)*
- Cases where TS was being discontinued while a patient was still actively threatening harm to self or others (*as an added check on an MHP's judgment about risk)*
- The team was considering a referral to a higher level of care
- Cases where medication-related issues should be addressed before discharge

Where upper-level provider contact was indicated in this sample, practice improved, with 75% of the patients being seen by a psychiatrist or nurse practitioner. There was no evidence of patient contact with a psychologist prior to discharge in the DQE team's study. Practice was strongest at SBCC, where 100% of clinically indicated psychiatry contacts occurred.

[119] See Paragraphs 45 and 82 for descriptions of the sampling method and the methods involved in the discharge-related study.

This warrants a finding of partial compliance but shows improvement over previous monitoring. If MDOC can sustain this level of psychiatry involvement where it is clinically indicated, a substantial compliance finding is possible soon.

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

Finding: Substantial compliance

Rationale: In previous monitoring periods, the DQE team determined that this practice is in substantial compliance. In the current monitoring period, the team reviewed a 21% sample of the health records of patients who had been placed at Bridgewater State Hospital or a Department of Mental Health facility and had returned to MDOC.[120] In every case, MHPs completed the form and decided whether to readmit the patient to therapeutic supervision. Unfortunately, only 25% of the contacts were confidential. Health records continue to show that MDOC exceeds the Paragraph 86 requirements by having these patients meet with a psychiatrist as well as an MHP.

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

SUPERVISION FOR PRISONERS IN MENTAL HEALTH CRISIS

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

[120] The study drew from the spreadsheet titled Higher Level of Care 2025.xlsx, which MDOC provides monthly to demonstrate all referrals to higher levels of care. There were 37 patients shown as having returned to MDOC from August through December 2025 (July was assessed in the DQE's Compliance Report #5). A random sample was chosen by selecting every fifth case.

Finding: Partial compliance

Rationale: MDOC's policy 650.08, *Emergency Mental Health Services,* which includes policies for therapeutic supervision, was finalized in October 2025. Full compliance with Paragraph 87 requires that the healthcare vendors' policies be revised as well, which MDOC has stated is underway.

88. The level of observation needed will be determined by a Qualified Mental Health Professional based on their assessment of the prisoner's risk of Self-Injurious Behavior, and will be re-evaluated every 24 hours if the prisoner is on Constant Observation. If the prisoner is on Close Observation, the prisoner will be evaluated every 24 hours (with the exception of Sundays and holidays).

Finding: Substantial compliance

Rationale: As described in previous DQE reports, it is well established practice for MHPs to determine a patient's level of observation as a key part of daily updates to TS conditions. MHPs' decisions are based on a patient's risk of self-injury, as required by Paragraph 88, though other clinical factors are also appropriately considered. Patients who are on 1:1 (constant) observation are assessed by an MHP every day, including Sundays, and those who are on close observation are assessed Monday through Saturday.

Based on the DQE team's observations of clinical practice, interviews with patients and staff, and review of health records, MDOC's practice has not changed significantly during the current monitoring period. Triage meeting minutes, End-of-Shift reports, and progress notes continue to include information about patients' level of observation, including on Sundays for those who are on constant observation. As an additional information source, the DQE team reviewed a sample of TS Reports, where those determinations routinely are documented, for 59 TS stays.[121] For patients on constant observation on a Sunday, compliance was perfect. Surprisingly, for daily TS Reports Monday through Saturday, practice appeared to decline. Where compliance had been 92% in the last monitoring period, the current review showed 83% compliance overall, with a lower rate (74%) at SBCC.[122]

[121] The sample overlaps with the sample first described in Paragraph 45. Some TS stays were substituted, as some TS Reports were available in the electronic health record and others were provided as part of custody observation packets. The sample maintains the facilities' approximate proportions of the total TS placements and is an 11% sample of all TS in the monitoring period. Where it appeared that an expected TS Report was missing, MDOC was given the opportunity to provide it separately.

[122] These rates differ from those shown in Paragraph 69 because Paragraph 88 allows exceptions for holidays.

Overall, MDOC has demonstrated strong practice across several monitoring periods in reviewing prisoners' level of observation every 24 hours. The slightly lower rate in recent months is noteworthy, warranting continued monitoring by the DQE team, but MDOC will retain its substantial compliance finding for Paragraph 88.

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

Finding: Partial compliance

Rationale: MDOC's revised policy 103 DOC 650.08, *Emergency Mental Health Services*, was finalized in October 2025 and clearly prohibits the use of TS for punishment or staff convenience. MDOC stated in its January 2026 Status Report that the healthcare vendors' draft policies also include this prohibition and that they will be submitted to the DQE and DOJ for review soon. Until the vendors' policies are finalized, a partial compliance finding for Paragraph 89 is appropriate.

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: MDOC's policies about the response to self-injurious behavior that occurs on TS are contained in three policies: 103 DOC 650.09 (*Management of Potentially Suicidal Incarcerated Individuals and Self-Directed Violence* in Mental Health Services), 103 DOC 562 (Emergency Response Guidelines), and 103 DOC 501 (Institution Security Procedures). Policy 103 DOC 650 has now been finalized, while the other two policies remain under revision by MDOC.

In addition to revising MDOC's own policies, compliance with Paragraph 90 requires that VitalCore and Recovery Solutions establish policies and procedures to notify medical, mental health, and security staff in response to SDV that occurs on TS. In its January 2026 Status Report, MDOC reported that the healthcare vendors' policies are also being revised and that they will be submitted to the DQE and DOJ soon.

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: MDOC's finalized policy 103 DOC 650.09, *Management of Potentially Suicidal Incarcerated Individuals and Self-Directed Violence,* states:

> If the incarcerated individual has attempted suicide or otherwise engaged in self-injurious behavior, the incarcerated individual shall receive immediate medical attention. Notifications of self-directed violence must be made immediately to a Qualified Mental Health Professional.

This language is consistent with Paragraph 91.

In previous monitoring periods, the DQE team found that security staff discovering SDV did not notify mental health staff as consistently or as immediately as they notify medical staff. To assess MDOC's current SDV notification practices, the DQE team drew upon observations during site visits, review of SDV-related incident reports, and review of "Self-Directed Violence Occurrence Reports" (SDVORs). From these sources, one can see that medical and mental health staff are notified, but it is not possible to discern the speed and frequency with which the notifications occur. It is also not possible to discern whether notification about additional incidents of SDV was missed or delayed.

In interviews across all eight institutions where TS occurs, security staff interviewed by the DQE team consistently stated that they would immediately call a supervisor or "Code 99" upon discovering self-injury, depending on whether the behavior was life-threatening. Most reported that medical personnel respond to Code 99s, and some stated that mental health staff also respond.[123]

Mental health staff continued to state, as in previous monitoring periods, that they are not generally involved in the immediate Code 99 response, but they may be called a short time later to assess whether the patient needs TS placement. Incident report packets are consistent with that view; they generally contain reports submitted by nurses but not MHPs, suggesting that notice to mental health staff occurs later. Interviewed prisoners generally stated that they were unsure of security's notification procedures. A significant minority of prisoners, concentrated at SBCC, reported that officers ignored, goaded, or laughed at them in response to SDV.

The immediate aftermath of mental health and medical staff notification also remains concerning. Since the Agreement began, the DQE team has noted the persistent use of

[123] Some of the DQE team's interviews took place before policy 103 DOC 650 was finalized on October 28, 2025, so the policy and practice around SDV may have been different at that time.

harsh security practices (e.g., metal restraints and pepper spray) in response to self-injury. During the current monitoring period, the DQE team again reviewed several cases of SDV that occurred while on TS, continuing to find no clear clinical rationale for why some cases of SDV were handled with security protocols (waist chains, leg irons, "kuzi" mitts), while others were handled as medical events (soft restraints, intramuscular medication, assessment for hospitalization). In its January 2026 Status Report, MDOC reported that it is reviewing guidelines by the National Commission on Correctional Health Care (NCCHC) and American Psychiatric Association (APA) before concluding its policy revisions, which is much appreciated.

Overall, MDOC's notification procedures in response to SDV are gradually moving toward compliance with the Agreement. In addition to completing the necessary policy and post order revisions, the remaining areas for improvement are (1) consistently notifying mental health staff, not just medical staff, immediately upon discovery of SDV, (2) ensuring that all incidents of SDV result in *immediate* notification, especially at SBCC, and (3) ensuring that an appropriately therapeutic response follows notification of medical and mental health personnel (e.g., using therapeutic rather than security restraints and medication when clinically indicated).

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 that mental health and medical staff will write progress notes in the health record as clinically indicated. These protocols meet or exceed the requirements of Paragraph 92. In previous monitoring periods, the DQE team also established that the notes' content meets the requirements of Paragraph 92, documenting a prisoner's statements and behaviors related to self-harm.

MDOC leadership has been trying to improve staff's completion of the required documentation, reviewing completion rates in its monthly Quality Improvement Committee (QIC) meetings. Between July and November 2025, monthly completion rates for incident reports remained stable for medical staff (ranging from 42 to 51% completed) and security staff (ranging from 71 to 76% completed). The mental health staff's performance improved dramatically, from 33% completion in July to 96%

completion in November. This was likely due to a small change in protocol; the SDVOR form was revised to prompt MHPs to enter the incident report number on it.

If this positive trend continues and includes medical and security staff, MDOC can achieve substantial compliance with Paragraph 92.

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

Finding: Partial compliance

Rationale: MDOC leaders continued to state that they thoroughly investigate all allegations of staff misconduct, though many prisoners do not convey specific enough information to gather necessary evidence (e.g., name of staff member, time of incident). The DQE team reviewed a redacted version of the "Professional Conduct Log," a document compiled by the Clinical Operations Analyst from staff-generated confidential incident reports and from other issues that come to the attention of top MDOC leadership. This log does not include complaints generated from prisoner grievances or Staff Access hours, so it gives an incomplete picture of alleged misconduct, but it is one of the only sources of data available to the DQE team to assess the Paragraph 93 requirements.

There were allegations of 45 new incidents of staff misconduct related to crisis/TS added to the log in the second half of 2025.[124] As in the DQE's last report, a disproportionate number of these allegations stem from Norfolk (49%), similar to the previous monitoring period. Seven prison sites had at least one allegation, with SBCC accounting for 22%, OCCC 16%, and Framingham 7%. The nature of the allegations is as follows:

Refusing or delaying crisis call to mental health staff = 58%
Ignoring or encouraging SDV = 18%
Name-calling or other disparaging/unprofessional remarks = 8%
Physical or sexual assault = 6%
Threatening disciplinary action for requesting crisis services = 4%
Threatening physical harm = 2%
Other[125] = 4%

[124] There are 47 total incidents on the log that allegedly occurred between July and December 2025. Two cases were excluded from the analysis because they did not clearly describe allegations related to crisis mental health services. Some incidents alleged more than one type of misconduct, resulting in 50 total allegations.
[125] Two incidents involved threatening to keep the lights on all night and disclosing confidential information

As in previous monitoring periods, much of MDOC's investigation process and its basis for concluding that no misconduct occurred remains opaque. The DQE team requested to review video footage from an alleged assault in the ISU and were told this was not possible because the investigation is ongoing, more than a year later. Similarly, the Professional Conduct Log does not provide much information, listing outcomes such as "no further investigation warranted" or "no staff misconduct found" for the vast majority of allegations, without mentioning what steps were taken to investigate or the basis for the conclusions. In the few cases where a bit more information is provided, the findings sometimes do not make sense in light of the allegations. For example, a prisoner alleged that an officer turned their cell light on and said they would "bother [the prisoner] all night long." The incident was "not risen to the level of an inquiry." In another case, where an officer admitted to telling a prisoner to "sit the f--- down," the supervisor merely "spoke with the staff member and directed him to refrain from such profanity." These actions do not demonstrate a well-functioning system for investigating staff misconduct.

As to the specific concern about officers sleeping while responsible for constant observation, the DQE team has never seen this issue captured on the Professional Conduct Log and has never been informed of any investigations despite claims of this behavior in every DQE report. During this monitoring period, the DQE team interviewed 15 prisoners with recent experience on constant observation, across seven institutions, who commented on officers sleeping. About one quarter of interviewees reported observing an officer fall asleep on duty once or multiple times. Notably, this is a much lower rate of allegations than in past monitoring. Moreover, for each patient reporting this experience, two of their peers said they believed officers remained awake.[126] These may be promising indicators of improvement on this particular type of misconduct.

To reach substantial compliance, MDOC will need to demonstrate the methodology and rationale behind its investigative conclusions. Encouragingly, MDOC's January 2026 Status Report states that is trying to convey more information about the investigation process and outcomes in the Professional Misconduct Log, and there is mention of those efforts in QIC meeting minutes. Entries from November and December 2025 trend in that direction.

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

[126] At Framingham, for example, one patient reported seeing an officer sleeping, while two others said the officers remained awake. The same was true in interviews at SBCC and Shirley. Some patients said they themselves are awake during the night and that this was the basis for their knowledge.

mental health crisis in an appropriate way. This means that Correctional Officers who observe prisoners on Mental Health Watch will participate in in-service training about how to appropriately observe prisoners on Mental Health Watch as that training is available and scheduled. Until the in-service training is available, Correctional Officers will read the new policies about how to observe Mental Health Watch, and attest to the fact that they have read, understand, and will follow those policies. This read and attest will occur within six (6) months of the Effective Date of the Agreement. MDOC will post the current policy about observing Mental Health Watch in visible places on every unit where Mental Health Watches take place.

Finding: Partial compliance

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

In interviews with the DQE team during this monitoring period, about two-thirds of security staff who commented about training said they had been trained in how to observe TS, while the others had not or were unsure.[127] MDOC provided records of staff training in Training Year (TY) 25, which show that 1,902 of 2,047 staff members (93%) at the seven prison sites where TS occurs completed the TS training.[128] MASAC's records indicate that 90% of security staff completed the TS training within one year of the report's run date.[129] The training records did not specify the staff members' job class, so it is not possible to say with certainty that staff who "observe prisoners on mental health watch" (the requirement of Paragraph 94) have the same completion rate as the full group. However, MDOC's overall demonstration of excellent completion of TS training across several monitoring periods is sufficient to satisfy the DQE.

In the previous monitoring period, the parties agreed on a policy summary, captured in a large, laminated poster, to satisfy the posting requirement of Paragraph 94. MDOC distributed the "TS poster" to the facilities and exercised oversight to ensure its display. During the current monitoring period's site visits, the DQE team verified the poster being placed in about half of the 18 units where TS occurs.[130] Once MDOC has demonstrated

[127] Fourteen officers or supervisors, across six institutions, spoke directly to this point.
[128] Records for TY26 (September 2025 to June 2026) were also provided, but the data were not analyzed because it was too early in the training year for the results to be meaningful.
[129] The training reports for MASAC and the prison sites were created on December 15, 2025.
[130] Rarely, the posting location could not be considered a "visible place" and should be rethought.

the TS poster's visibility in all 18 units, substantial compliance with the Paragraph 94 requirements is likely.

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

Finding: Partial compliance

Rationale: During site visits, the DQE team has always observed numerous officers in position for constant observation, and officer interviewees have always described maintaining an uninterrupted view as their primary duty when assigned to that role. Most interviewed prisoners with recent, relevant experience said that officers did monitor them continuously. Some asserted that officers sometimes fell asleep (see Paragraph 93), but none described any other major interruptions in fulfilling this responsibility.[131]

Officers' TS observation sheets tended to support that officers are carrying out this responsibility as required. The DQE team's study of 28 constant observations[132] found that officers routinely captured their observations while on that post. Some records, however, had recording gaps of more than 30 minutes, at these rates:

SBCC	50% of sets
Rest of system	25% of sets

These gaps could suggest that the task was intermittently not being performed, but the timing—often the length of one rotation on the post or a whole shift—point toward a greater likelihood of issues in document transmission.

In general, the content of constant observation sheets was more informative than sheets documenting close observation and had more indicia of reliability. SBCC was an exception, which will be discussed in Paragraph 96. An additional exception was about 14% of the sets where multiple officers completed sheets as though they were on the same post for an extended period, raising questions about the veracity of recording.

In terms of the visibility available to these officers, the DQE team continued to observe the sight lines for cells in different units used for TS and has tested the seating

[131] In the current monitoring period, 15 TS patients, across seven institutions, commented on officer behavior when those patients were on constant observation status in the preceding year. These patients' opinions were generally consistent with those of interviewees in previous monitoring periods.
[132] See Paragraph 34 for a description of this study. When assessing completeness of the records, the DQE team considered a set of observation sheets compliant if entries were usually made every 15 minutes -- or at staggered, similar intervals – with occasional gaps of no longer than 30 minutes.

arrangements and visibility in some locations. While there are some limitations, particularly at Framingham, the DQE team finds generally that sight lines are reasonable for observing prisoners on constant observation.[133]

The practice at SBCC is not sufficiently demonstrated. That will be necessary for MDOC to reach substantial compliance.

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

Finding: Partial compliance

Rationale: Throughout the Agreement's implementation, MDOC staff and leaders have described to the DQE team the expectations for 15-minute checks and the practices to carry them out. During the current monitoring period, the team learned that the standards for conducting *housing unit* rounds had shifted in recent years from the type of check described in Paragraph 96 to checking only for signs of distress. It is unknown whether officers making checks on TS continue to check for signs of life with TS patients—that is, observe them differently from the other prisoners in the unit during rounds. The DQE team did not systematically review videos of rounds, but late in the monitoring period, encountered a video in which rounds were conducted without stopping at the cells.[134]

MDOC requires officers to record the checks they have made on a specified form. MDOC redesigned the form with the intention of improving the capture of observations. The DQE team understands that the new form was implemented in November 2025, and MDOC's January 2026 Status Report describes substantial efforts to support its adoption. MDOC routinely provides sets of these forms to the DQE team to demonstrate compliance with Paragraph 96. In the current monitoring round, the DQE team reviewed sets for 41 TS placements drawn from all institutions that conducted TS.[135] The presence of complete records remains below the performance observed at the beginning of Agreement implementation.

In the current study, staff recorded contacts every 15 minutes—or a similar interval if contacts were "staggered"—or missed contacts only very rarely[136] at these rates:

[133] See Paragraph 54 for further discussion.
[134] This was part of a review of videos of deaths by suicide.
[135] See Paragraph 34 for a description of the 50-set sample. Within that sample, 41 cases included some close observation.
[136] In this analysis, a TS set was considered compliant if there usually were entries every 15 minutes and, if there were gaps, those gaps did not exceed a half-hour.

SBCC	63% of sets complete
Rest of system	79% of sets complete

Among noncompliant records, the absence of recorded contact ranged from 45 minutes to multiple days.[137] There was an additional, potential concern at SBCC, where there were at least seven examples of a check not being recorded at a shift change in the BAU. This could reflect merely a documentation oversight at a busy time. However, if it is correct that sometimes those checks are not made, it is particularly problematic because self-injuring patients can observe, predict, and exploit that gap, with greater harm potentially resulting in a longer period before discovery. The DQE team encourages MDOC leadership to look into this potentially risky issue.

Similarly, the practice of staggering contacts (making them at unpredictable intervals) to prevent and quickly identify patients' self-injury is in little use. OCCC officers recorded using it consistently, and there were occasional examples elsewhere. SBCC appeared not to use it at all.

Most institutions reasonably captured prisoners' activity, and sometimes their mood, and some forms were very informative. At OCCC and Shirley, practice varied greatly by officer, ranging from poor to well done, and SBCC remained an exception, as described below.

There remained some records, at different facilities, that showed strong indications of being completed ahead of, or long after, the times recorded, making it unlikely that the entries reflected the TS patient's actual status. These did occur less than in previous monitoring periods, suggesting improvement. Additionally, nearly every set from SBCC continued to show improbable entries such as a patient sleeping exactly the length of an officer's shift every night, extended periods of multiple officers doing checks at the same time and recording different information, or a patient being in the same position for 8 to 30 hours. In several cases, 90-96% of the entries in a multi-day TS are identical. At best, these sheets are uninformative; they equally raise the possibilities of inadequate observation during the checks and untruthful recording.[138]

[137] Where there were no records for several hours, the DQE team attempted to control for hospital visits and, for any that were identified and coincided with missing records, those files were counted as compliant. MDOC was also given the opportunity to provide additional records in case they had become separated from the main set.

[138] This is particularly concerning because, in two of the videos of in-cell suicides (one at SBCC and one at Shirley), video does not show officer rounds at one of the standard times officers typically record. That is, officers typically record checks as having occurred every quarter hour (e.g., 4:00, 4:15, 4:30, and 4:45). In these two videos, rounds did not take place at one of those times; one occurred 10 minutes later and, in the other, no rounds were apparent by about four minutes after the typical time.

The DQE team does not have the observation sheets in those cases and is NOT saying there was (or was not) a problem with those cases' documents. Rather, the point is that videos show that rounding times can vary, which is

Because by far the largest percentage of TS occurs at SBCC, its practices are essential to the assessment of the system's compliance. All elements of Paragraph 96 would need to improve at SBCC to reach substantial compliance.

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

Finding: Partial compliance

Rationale: MDOC's institutional leadership, Health Services Division, and Division of Resource Management have made efforts to address this requirement at all facilities providing TS. Some of the efforts have been extensive because of difficulties in obtaining materials needed for the renovation, designs incompatible with existing physical plant or safety, and other obstacles MDOC has worked to overcome.

During site visits, the DQE team observed door construction for TS cells and verified that 12 units have installed effective door sweeps or have door construction sufficient to prevent harm without them. Other units have sweeps on some TS cells but not others, have employed flexible material that allows for easy transmission of contraband that could be used for self-harm, or are continuing to seek solutions to installation challenges.

Completing solid construction door sweeps at MTC, OCCC's HSU and ISU, Shirley's HSU (one cell) and BAU, and SBCC's HSU will bring MDOC into substantial compliance with this requirement.

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

Finding: Substantial compliance

Rationale: The staffing matrices from VitalCore and Recovery Solutions indicate that, in November 2025, each of the eight MDOC sites where TS occurs employed at least one full-time Support Person, Monday through Friday. Norfolk, Shirley, and MTC had achieved full staffing of Support Persons (1.2 FTE), while the other five sites were still

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normal, and it illustrates that recording standard times, instead of the actual time of rounds, can be inaccurate in ways that matter to quality improvement efforts and investigations.

trying to recruit a part-time Support Person. (0.2 FTE on Saturdays). Overall, MDOC's obligation to retain Support Persons remains fulfilled.

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

Finding: Partial compliance

Rationale: As noted in previous DQE reports, Support Persons have been integrated into the multidisciplinary mental health teams at all facilities subject to the Agreement. During this monitoring period, Support Persons interacted with patients on TS more consistently, though cell-front contacts still occurred too frequently.

From interviews with Support Persons, MHPs, and supervisors, it remains clear that Support Persons' role is to engage in non-clinical contacts with patients on the mental health caseload. At all eight facilities, interviewees acknowledged that Support Persons should interact with patients on TS, as required by Paragraph 99, and they reported attempts to implement this practice. The DQE team observed several Support Person contacts during this monitoring period, though mostly with patients *not* on TS, and found them to be appropriate and beneficial to the patients.

In the DQE team's study of 64 TS placements, 53% of the patients' health records documented at least one Support Person contact during the TS stay. Practice was strongest at Framingham, Norfolk, and OCCC, where nearly all patients on TS interacted with a Support Person. Conversely, at SBCC, only 29% of patients on TS had any contact with a Support Person, and in all cases, the contact was a single cell-front interaction during TS stays lasting between 2 and 10 days.

Across the facilities, confidential contacts were more the exception than the norm, with 73% of all Support Person contacts on TS occurring cell-front. At MASAC, Norfolk, Shirley and SBCC, none of the contacts were out-of-cell, while Gardner and Framingham had high rates of confidential contacts. These findings are slightly improved from the previous monitoring period, when 80% of Support Person TS contacts occurred cell-front. During this monitoring period, Support Persons did not always document the reason for cell-front contact, but among those that did, half were recorded as the patient's preference, while the other half were "per security."

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

Overall, MDOC has moved further toward compliance with the Paragraph 99 requirements, implementing TS Support Person contacts across all eight facilities. Improving access to out-of-cell contacts, or at least consistently documenting why such contacts did not occur, will be important next steps. Greater involvement of Support Persons with TS patients at SBCC is also needed.

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100. A Support Person will receive 40 hours of training pre-service training prior to engaging with prisoners on Mental Health Watch, which will include training about how to appropriately interact with, and document interactions with, prisoners on Mental Health Watch. Support Persons will also receive Crisis Intervention Training.

Finding: Partial compliance

Rationale: VitalCore's staffing matrix indicates that four full- or part-time Support Persons were hired between July and November 2025. No new Support Persons were hired by Recovery Solutions (for MASAC). The DQE team reviewed the New Employee Orientation (NEO) records provided by MDOC and VitalCore and confirmed that each new Support Person completed at least 40 hours of pre-service training. The mental health-related NEO training was primarily focused on suicide prevention and mental health basics, not specifically addressing "how to appropriately interact with, and document interactions with, prisoners on Mental Health Watch" (as required by Paragraph 100). As in previous monitoring periods, Support Persons interviewed by the DQE team confirmed that they learned these skills by shadowing MHPs at the facilities before working independently and by having their notes in the electronic health record reviewed by supervisors.

Although this training scheme may not meet the technical requirement of Paragraph 100 for instruction on TS interactions and documentation to occur *during the 40-hour pre-service training*, it is consistent with the DQE clinicians' experience of how ancillary or front-line staff (i.e., those without formal licensure) are trained in mental health settings. Thus, MDOC's practice is sufficient to meet Paragraph 100's requirement for pre-service training.

Paragraph 100 also requires that Support Persons receive CIT training. In its January 2026 Status Report, MDOC stated that two Support Persons have completed CIT training since VitalCore took over the healthcare contract in July 2024, which is consistent with the DQE team's review of CIT training records and interviews with Support Persons. MDOC's Status Report also states that VitalCore's Director of Training is working to develop a modified version of CIT training for all Support Persons. With improved completion of CIT training, whether modified or not, MDOC can achieve compliance with the Paragraph 100 requirements.

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

Finding: Substantial compliance

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

As in previous monitoring periods, interviewed Support Persons reported frequently consulting with MHPs throughout the day about their work with patients, and all identified the site Mental Health Director as their main supervisor. Interviewed Mental Health Directors and MHPs reported the same. The DQE team observed during the site visits that Support Persons typically interact with a patient and then immediately "triage" the encounter with their supervisor. In addition, Support Persons attend a weekly Teams meeting for group supervision. This is where ideas are shared across facilities about non-clinical interactions that can benefit patients (on TS and in other settings).

Overall, it appears that the structures necessary for on-site supervision of Support Persons by MHPs are still in place, and the DQE team is unaware of Support Person contacts during this monitoring period that were clinically inappropriate or detrimental to patients. This is sufficient for a continued substantial compliance finding.

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

Finding: Substantial compliance

Rationale: As noted in previous DQE reports, each of the eight MDOC facilities where TS occurs is allotted at least 1.2 FTE Support Persons, which adds up to the time required by Paragraph 102: 6 days per week, 8 hours per day (Monday through Saturday). Including the ISU's Support Persons, there are 13.0 FTE Support Person positions across MDOC.[139]

As of November 2025, 11.6 out of 13.0 FTE positions (89%) had been filled. All the full-time positions were filled, while three of the eight part-time (0.2 FTE) positions were filled. Although the Saturday positions remain difficult to fill because of the less desirable weekend shift and limited weekly hours, MDOC has made additional progress with staffing the Support Person positions during this monitoring period. As noted in previous DQE reports, their shifts align with the times when most self-injury occurs. Overall, with staffing levels approaching 90% during this monitoring period, MDOC has now achieved substantial compliance with the Paragraph 102 requirements.

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

Finding: Partial compliance

Rationale: The main shift transition where TS contacts are discussed occurs around 1 p.m. on weekdays at most sites. At that time, the morning "crisis clinician" hands off the two-way radio and responsibility for responding to crises to an MHP who works from 1 pm to 9 pm.[140] Based on the DQE clinicians' interviews with MHPs and direct observation of practice at three facilities during this monitoring period, Support Persons' contacts are not often discussed during shift transitions. Although this finding may be partially explained by the rarity of TS placements at some facilities (e.g., Gardner, MTC, MASAC), it is equally true of high-volume sites like OCCC and SBCC.

In its January 2026 Status Report, MDOC stated that it is working with the healthcare vendors to revise the template for triage meeting minutes to capture the shift transition discussions. This will undoubtedly help demonstrate the consistent sharing of Support Person information across shifts. Currently, a partial compliance finding is warranted.

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[139] According to VitalCore's November 2025 staffing matrix, OCCC has a total of 4.6 contracted Support Person positions, including the ISU. In practice, the DQE team observed some Support Persons splitting their time between the ISU and rest of the facility, covering shifts Monday through Saturday.

[140] OCCC recently implemented a different system for crisis response termed "702 Alpha," but it is not directly relevant to the Agreement so is not discussed in detail here.

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: As noted in Paragraph 99, in the DQE's study of TS placements, 53% of patients had documented Support Person contacts, and many had multiple such contacts during the TS. There is no way to know whether any additional, undocumented contacts occurred. However, four Support Persons interviewed by the DQE team across four institutions knew of their need to document all contacts and reported doing so in the electronic health record. Given the consistency of data obtained from chart reviews and interviews across three monitoring periods, the DQE finds that MDOC is meeting the documentation requirements of Paragraph 104.

In the previous monitoring period, the parties agreed to interpret Paragraph 104 as requiring review of Support Persons' TS *contacts* rather than their *documentation* during triage meetings. Using this revised metric, MDOC's practice has been improving. The DQE team observed Support Person contacts being discussed during five of the eight sites' triage meetings. Additionally, in the DQE team's review of December 2025 triage minutes from across all eight facilities, the practice of documenting discussion of Support Person contacts was beginning to take hold. Such contacts were documented at least once in the minutes from Gardner, OCCC, Norfolk, and SBCC. There were no such notations at MTC, Framingham, MASAC, or Shirley.[141] The DQE team did not assess whether the lack of documentation was due to a lack of discussion during the triage meeting or a lack of Support Person contact.

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

105. Self-Injurious Behavior: MDOC will update its policy and procedure for responding to Self-Injurious Behavior that occurs during a Mental Health Watch. Upon identification of an incident of Self-Injurious Behavior, MDOC will:

[141] The template for triage meeting minutes was revised in March 2025 to capture discussions of Support Person contacts, but not all facilities were using the revised template as of December 2025. This may account for the lack of documentation at Framingham and MASAC, where the health record indicates that Support Persons are interacting with patients on TS regularly.

Finding: Partial compliance

Rationale: As noted in Paragraph 90, MDOC has finalized some of its policies around self-injury that occurs on TS (103 DOC 650.08, *Emergency Mental Health Services*, and 650.09, *Management of Potentially Suicidal Incarcerated Individuals and Self-Directed Violence*), but two other key policies remain under review by MDOC: 103 DOC 562, Code 99 Emergency Response Guidelines, and 103 DOC 501, Institution Security Procedures. The healthcare vendors' corresponding policies also remain under review.

To align with the Agreement, the revised policies will need to (1) delineate what types of self-injury are included in the emergency response procedures, (2) identify the factors that staff should consider when determining the type of protective equipment and clothing to utilize in a Code 99 response, and (3) specify that mental health staff should be notified in the event of SDV.

106. If the incident of suicide attempt or Self-Injurious Behavior is life threatening, the Code 99 (103 DOC 562) procedure will be activated immediately.

a. Code 99 Procedures will take into consideration factors such as whether there are suspected weapons in the room, communicable diseases, barricaded doors, safety of the scene, and the severity of the harm when determining the type of protective equipment and clothing to be utilized when responding to a Code 99 for a prisoner on Mental Health Watch.

Finding: Partial compliance

Rationale: As in previous monitoring periods, correction officers and supervisors interviewed by the DQE team uniformly stated that Code 99 procedures would be activated immediately upon discovery of life-threatening SDV. The DQE team's primary task, then, was to assess whether this is happening in practice.

Interviewed prisoners continued to report incidents of officers refusing to "call crisis" or encouraging or dismissing SDV, though it was not clear that these incidents were in response to life-threatening behavior. The reported incidents occurred disproportionately at SBCC. Mental health staff at SBCC, Norfolk, OCCC, and Shirley confirmed that they continued to hear reports from their patients of officers refusing to "call crisis." Again, it was not clear from available information that these alleged incidents were life-threatening. In the "Professional Conduct Log" that MDOC's Clinical Operations Analyst keeps as a quality assurance measure, nine incidents involved officers

encouraging or dismissing SDV. Many others allegedly involved officers not "calling crisis," without clear evidence of life-threatening circumstances.[142]

As another data point, the DQE examined the incident reports stemming from 10 incidents of SDV during this monitoring period, including four deaths by suicide, four cases where restraints were used to prevent life-threatening injury, and two other potentially life-threatening incidents chosen from the SDV log.[143] From this documentation, one can tell that Code 99 procedures were activated by an officer when observing a prisoner engaging in self-injury. It is not possible to determine whether this occurred immediately or what factors were considered when determining the type of protective equipment and clothing to use in the response (as delineated in Paragraph 106). The facts of at least one case raise questions about how quickly officers responded when alerted to possible self-injury.

The DQE team also reviewed video footage of officers' response to five SDV incidents at SBCC, Shirley, and Norfolk. The Norfolk video was inconsistent with the prisoner's report of delayed response to SDV, showing that less than a minute elapsed between an officer discovering the incident and emergency responders entering the cell. Another incident from SBCC was similar, showing that officers entered the cell about 1.5 minutes after discovery. In the other cases at Shirley and SBCC, the time to open the cell door was longer, up to five minutes, but the video footage was insufficiently detailed to see clearly when the Code 99 was called.

Overall, MDOC has clearly established an expectation that officers initiate Code 99 procedures in response to SDV. Based on prisoner and staff interviews, concerns about whether the policy is being followed consistently, especially at SBCC, persist. This is sufficient for a partial compliance finding.

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: Interviewed mental health and security staff said self-injury is rare at most institutions, with several focusing their comments on SDV during TS placements. Of 39

[142] See Paragraph 93 for further discussion.

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

prisoners interviewed, only seven said they had injured themselves in recent years. As in the past, some staff noted that a small number of patients accounted for most of the SDV incidents in their units.[144]

In contrast to previous interviews, staff discussed a wider range of SDV methods they observe. Most commonly, they cited headbanging, ligatures, and cutting, with several specifying that the patients used paint chips, staples, and paper clips. Staff also mentioned seeing insertion, ingestion, scratching, and punching oneself.

In interviews in all monitoring periods, security and mental health staff have consistently described an officer's routine response to a prisoner's in-progress self-injury as being an immediate call to a supervisor, who then calls nursing and mental health staff.[145] In this period's interviews, a majority of security personnel—both supervisors and officers—said they personally attempt to influence the prisoner to stop self-injuring. Some gave examples of successes, including a Shirley HSU officer who discussed a practice of observing escalation and intervening to prevent SDV, as well as acting to deescalate once it is underway. Occasionally, the DQE team encountered descriptions in TS progress notes of officers successfully convincing the patient to stop self-injuring.

Mental health staff had mixed impressions of whether officers attempt deescalation. Some agreed, and two said that occasionally MHPs can be involved in deescalation as well. Others have not seen officers using these techniques much and believe officers are quick to physically intervene and to use force (e.g., OC spray) to stop the patient's self-harm. Data showing an increase in use of force on TS may also support this view.[146] Patients also said staff quickly used force or OC spray, and one described an officer goading her to continue swallowing a harmful substance. No patients remembered any officers encouraging the patients to stop SDV.

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

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

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[144] Among interviews in the current monitoring period, 18 officers or supervisors, 16 mental health staff or nurses, and 9 patients spoke to some aspect of Paragraph 107 requirements.
[145] See Paragraph 43 for discussion of the timing of mental health notification
[146] See Paragraph 139 for a discussion of data regarding use of force on TS

Finding: Partial compliance

Rationale: The expectation to complete a Self-Directed Violence Occurrence Report (SDVOR)[147] within 24 hours of an SDV incident is well established among MDOC's mental health staff. As in previous monitoring periods, MDOC provided a SDVOR for each episode of SDV listed in the tracking spreadsheet as occurring while a prisoner was on TS, and the DQE team reviewed 50 such cases, a 31% sample.[148] Cases were chosen in approximate proportion to the percentage of SDV incidents that occurred on TS at each facility. *Table 5* illustrates the results of the DQE team's analysis.

Table 5. SDV Incidents with Timely SDVORs

	# of cases audited	SIBORs completed on day of SDV or following day	% timely
Framingham	9	8	89
Gardner	1	0	0
MASAC	2	1	50
MTC[149]	0	0	N/A
Norfolk	4	3	75
OCCC	13	6	46
SBCC	17	10	59
Shirley	4	4	100
TOTAL	**50**	**33**	**64**

64% of SDVORs were completed within 24 hours of the event, which is within the typical range of MDOC's performance since the Agreement began (e.g., 52% in December 2024, 74% in June 2025). Unsurprisingly, the institutions with the highest numbers of SDV had the lowest rates of timely SDVOR completion, reflecting the MHPs' increased workload. Timely completion of at least 80% is necessary to achieve substantial compliance with the Paragraph 108 requirements.

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

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[147] This document was formerly called Self-Injurious Behavior Occurrence Report (SIBOR).
[148] There were 163 total SDV incidents that occurred while a prisoner was on TS between July and December 2025.
[149] There were no SDV incidents that occurred while a prisoner was on TS at MTC between July and December 2025.

Finding: Partial compliance

Rationale: This requirement is similar to Paragraph 92's documentation requirement, but it is specific to the officer responsible for observing a prisoner who engages in SDV while on TS. As noted in previous reports, the DQE team has reviewed hundreds of incident reports documenting SDV, and their content meets the Paragraph 109 requirement for officers to describe the self-injurious behavior as it occurred. The remaining compliance question is whether such documentation is being completed consistently.

MDOC continues to audit the completion of incident reports related to SDV and review the results in the monthly QIC meetings. Minutes from the QIC meetings between July and November 2025 indicate that security staff completed incident reports for 71-76% of SDV episodes. However, these rates include all security staff and all SDV, not just officers responsible for TS observation. In its January 2026 Status Report, MDOC once again stated its intention to analyze SDV incidents that occur while a prisoner is on TS separately from the overall SDV incidents, so in the next monitoring period, MDOC will likely be able to provide data specifically related to Paragraph 109. Currently, a partial compliance finding is warranted.

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

Finding: Partial compliance

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

The DQE team reviewed minutes from all SDV/SATT meetings, and from the notes, it appears that multiple interventions are frequently considered and/or employed in response to a prisoner's SDV on TS. These include "upgrading" the prisoner's observation status from 15-minute to constant; transferring them to an outside hospital for medical care; referring them for evaluation by psychiatry or psychology; transferring them to a higher level of mental health care, including the ISU, RTU, or psychiatric hospital; asking for consultation around a behavior plan; increasing Support Person contacts; and referring them to Spectrum for substance use treatment. From the DQE

clinicians' standpoint, all these interventions are clinically appropriate, and they demonstrate modification of treatment in response to SDV.

As noted elsewhere in this report, patients' written TS treatment plans remain a work in progress, and this is also true of the response to self-injury. In the DQE clinicians' study of 50 TS placements during this monitoring period, five cases involved SDV. Of these, in only one case was the treatment plan immediately following the SDV occurrence modified appreciably. In all other cases, the same treatment goals and interventions were repeated verbatim until the end of the TS placement, without any acknowledgement that the plan needed modification (or that it already had been modified).

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

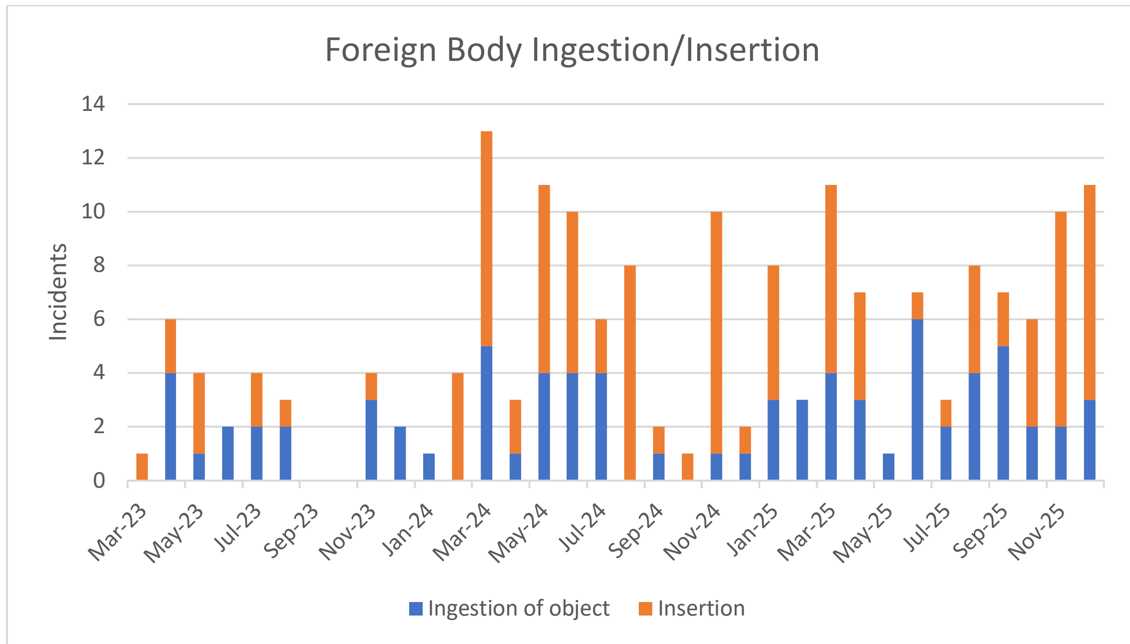
111. If necessary, follow the procedures laid out in its ingestion of foreign body policy enumerated in Paragraph 112.

Finding: Partial compliance

Rationale: MDOC's policy on ingestion of foreign bodies is in subsection 501.09 of policy 103 DOC 501, Institution Security Procedures, which is still being revised to align with the Agreement. Since the policy has not been finalized, the DQE team did not undertake a formal study of whether it was being followed during this monitoring period. Based on interviews, observations during the site visits, and review of health records, MDOC's general practice of evaluating prisoners using body scanners and BOSS chairs continues to be followed.

Of note, data from the monthly Quality Assurance reports indicate that the number of foreign body ingestion and insertion incidents per month increased again during this monitoring period *(Figure 8)*.

Figure 8. Foreign Body Ingestion and Insertion



There were 45 incidents of foreign body ingestion or insertion between July and December 2025, vs. 37 between January and June 2025. It is not clear what accounts for this increase.

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

Finding: Partial compliance

Rationale: Three MDOC policies address the Paragraph 112 requirements:

- 105 DOC 501, Institution Security Procedures
- 103 DOC 650, Mental Health Services, sections 650.08, 650.09, and Attachment 14

- 103 DOC 506, Search Policy, and its two accompanying Standard Operating Procedure documents[150]

In the previous monitoring period, the DQE recommended that the policies and procedures for handling foreign body ingestions be consolidated in one place, likely policy 103 DOC 501, Institution Security Procedures, so they would be readily accessible and comprehensible to staff. Policy 103 DOC 501 is "pending final internal approval by MDOC," according to its January 2026 Status Report, leading to a continued partial compliance finding.

INTENSIVE STABILIZATION UNIT

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

Finding: Substantial compliance

Rationale: MDOC drafted, and DOJ approved, the language in policy 103 DOC 650, Mental Health Services, regarding the operation of the ISU. The policy was officially implemented in October 2025.

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

Finding: Substantial compliance

Rationale: The ISU was officially opened on June 16, 2024, and MDOC's records indicate that there have been 39 admissions since that time. The DQE team's November 2025 visit confirmed that the ISU remains fully functional, if under-utilized. There are MHPs, activity therapists, a unit coordinator, a nurse, a psychiatrist and nurse practitioners, a psychologist, and Support Persons contributing to treatment. Patients have multiple group and individual contacts per day, treatment team meetings occur daily on weekdays, and indoor and outdoor recreation spaces are being used. These activities all demonstrate compliance with the requirements of Paragraph 114.

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

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

Finding: Substantial compliance

Rationale: The DQE reviewed the referral paperwork for the 13 patients admitted to the ISU between July and December 2025. Patients were referred from OCCC, SBCC, Norfolk, and Bridgewater State Hospital. Across three monitoring periods, prisoners have been referred to the ISU because of difficulty functioning in general population, RTU, or STP settings due to serious mental illness and/or personality disorder. Of the 13 patients admitted to the ISU, 10 were on TS at the time of their referral, and the remaining patients had had multiple TS placements in the preceding weeks/months or were referred as a step-down from Bridgewater State Hospital. Overall, it appears that the patients admitted to the ISU continue to meet the definitions set forth in Paragraph 115 (i.e., unable to effectively progress on TS or in general population, not meeting statutory criteria for hospitalization but still in need of a higher level of care).

Paragraph 115 also requires that the ISU focus its treatment on patients' immediate clinical needs, restore their safety and stability, and prepare them to function in a non-ISU environment. These requirements are substantively identical to Paragraph 116; please refer to the DQE's compliance assessment below.

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

Finding: Partial compliance

Rationale: In the two previous monitoring periods, the DQE team observed that most of the Paragraph 116 requirements were being met, including providing a supportive, intensive milieu; stabilizing the symptoms leading to referral; and preparing patients for reintegration into their home sites. After observing unit operations, reviewing health records and other documents, and interviewing current and former patients during the current monitoring period, those elements appear to be sustained.

MDOC does not yet track outcome data for the ISU (e.g., the setting to which patients are discharged, whether they engage in SDV or return to TS placement), but anecdotally, the DQE team has seen several patients benefit from the program and remain in general population for the medium-to-long term. Even those who return to the ISU or to TS placement do not represent failure of the program. Instead, this demonstrates MDOC's responsiveness to clinical need and the potential value of program extension beyond 90 days.

The ISU's orientation materials clearly state that treatment planning will be individualized, and patients sign an attestation upon admission that they understand, among other things:[151]

- *The length of each Phase will be dependent upon my clinical progress.*
- *I understand that progression through the phases and access to incentives is contingent upon my behavior, overall adjustment and compliance with the ISU programming in addition to my individual behavioral/treatment plan.*
- *I understand I will be evaluated regularly by the treatment team for individual progress towards treatment goals and compliance with my individual behavioral/treatment plan.*

Based on these documents, the ISU's intent is clearly to individualize treatment, as required by Paragraph 116.

To assess treatment planning in practice, the DQE clinicians reviewed health records for 5 of the 17 patients treated in ISU between July and December 2025; this represents a 29% sample.[152] As in the previous monitoring period, patients' treatment plans were updated approximately once per week after discussion among the treatment team members. Patients reported variable participation in this process. Most treatment plans from October 2025 onward were signed by the patient, though only one interviewed

[151] Excerpt from the "Intensive Stabilization Unit – Incarcerated Individual Orientation Manual Receipt Form" in the electronic health record.

[152] The DQE team reviewed the electronic health records of five patients who were treated in ISU between July and December 2025 and had lengths of stay of at least six weeks. The DQE team reviewed at least six plans per patient.

patient said he contributed to the plans' formulation. The others stated that the document was merely presented to them for signature, rather than reviewed and discussed, or said they did not know whether they had treatment plans.

The quality of initial treatment plans was assessed by the DQE clinicians. The plans generally identified appropriate symptoms/problems as treatment targets, and they were reasonably consistent with the problems and goals outlined in the ISU referral paperwork. From there, the treatment plan quality deteriorated, with almost every plan containing a slight variation of this catch-all "treatment intervention," regardless of the target symptom or behavior:

> *ISU Primary Care Clinician will provide 1:1 contact at least once a week or as clinically indicated by ISU phase. Psychiatry will assess [incarcerated person] at least every 90 days or as clinically indicated for medication management. The PCC will provide cognitive behavioral and dynamically oriented interventions and maintain therapeutic relationships to facilitate [incarcerated person's] progress towards his goals. The PCC will collaborate with [incarcerated person] to identify ongoing treatment progress and goals.*

Additionally, group programming was not included in the treatment plans, other than checking a box to indicate that groups would be one modality of treatment.

This cannot be considered adequately individualized treatment planning. The uniformity of treatment plan language has been consistent problem since the DQE team began reviewing ISU records over a year ago. To its credit, VitalCore has continued to enhance its clinical training around treatment planning, and the ISU is operating well in many other respects. With improvement in the individualization and quality of treatment plans, MDOC can achieve substantial compliance with the Paragraph 116 requirements.

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

Finding: Not assessed (by agreement of the parties)

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

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

Finding: Partial compliance

Rationale: In previous monitoring periods, the DQE's review of ISU referral paperwork confirmed that most of Paragraph 118's technical requirements for referrals were being met, such as documenting duration of symptoms, prior TS placements, goals of ISU placement, and barriers to care. However, there was no evidence in any of the referral paperwork that behavior plans had been considered. During the current monitoring, the DQE team found evidence in 2 of the 13 ISU referral packets[153] that a behavior plan was considered. This is an improvement, though still far from substantial compliance.

MDOC's written records continue to indicate that every patient referred to the ISU by a clinical team has been accepted into the program, which likely means that true screening of referrals occurs upstream, before the paperwork is completed. The DQE team has observed this process during the site visits, with MDOC clinical leaders routinely conducting intra- and inter-facility case conferences, as well as the Daily Consultation meetings, to talk about difficult clinical cases and potential ISU referrals. It appears that that MDOC's health services leadership sets the bar high for ISU admissions, seeking patients who are likely to participate in treatment and unlikely to pose acute security challenges. In addition, mental health supervisors noted that referrals are no longer accepted from the Secure Treatment Program at SBCC.[154]

MDOC's screening approach is understandable for a relatively new program, but it also results in a low number of ISU admissions overall. For example, during the DQE team's November 2025 site visit, just two of the 15 ISU beds were filled, and the unit had been empty shortly before that. The DQE team urged MDOC and VitalCore's leadership to consider whether additional patients who do not meet the strict definitions they are

[153] The DQE reviewed the packets for all referrals made between July and December 2025.
[154] In comments on a draft of this report, MDOC stated that there is no explicit prohibition on referrals from the STP.

employing for ISU admission (e.g., lengthy or multiple TS placements) would benefit from the program.

The Agreement identifies a much broader group as candidates for ISU treatment, including those “unable to effectively progress with placement on Mental Health Watch or general population due to serious mental illness or marked behavioral dysregulation,” those “who have been on Mental Health Watch [no length specified] and are clinically appropriate for a higher level of care,” and those who are “dysregulated and/or decompensated for whom multiple interventions have been ineffective.” The DQE team has met many such prisoners across MDOC who might benefit from ISU placement. In addition, using the ISU as a step-down from Bridgewater State Hospital, as MDOC has already been doing, seems clinically appropriate. As a third strategy to consider, patients with severe substance use disorders and multiple overdoses within MDOC could benefit from the ISU’s higher level of care.

Paragraph 118 also requires that prisoners be allowed to request ISU admission. Policy 103 DOC 650.13.B.4, which was finalized in October 2025, states that prisoners can request to be considered for the ISU, though the healthcare vendor has ultimate say over admissions. During the current monitoring period, two of three patients interviewed by the DQE team about this topic knew that they could request ISU placement. In addition, during triage meetings observed by the DQE team, mental health staff mentioned several times that they had discussed the option of ISU placement with patients on TS, and this was mentioned in some progress notes in the DQE team’s chart reviews as well. Thia demonstrates that information about the program is being disseminated by staff.

Overall, MDOC appears well on its way to meeting the Paragraph 118 requirements. With more consistent demonstration that behavior plans are considered prior to ISU placement, MDOC can achieve substantial compliance.

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

Finding: Substantial compliance

Rationale: To assess several of the Agreement’s ISU-related provisions, the DQE team performed a detailed study of five ISU patients’ health records, as described in Paragraph 116. In this study, the patient’s primary clinician was apparent from a consistent staff member documenting 1:1 contacts, being listed as the primary clinician on treatment plans, and updating treatment plans. In interviews with five patients, it remained clear that patients are assigned a primary clinician in the ISU. This information is consistent

with the previous two monitoring periods, warranting a continued substantial compliance finding.

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

Finding: Substantial compliance

Rationale: Across three monitoring periods, the DQE team has observed the ISU treatment team meeting. Every patient was discussed in every meeting. In addition, as part of the study of five ISU patients, [155] the team reviewed all ISU triage meeting minutes between mid-July and November 2025. It was apparent that each of the five patients was discussed in the meeting daily during their respective ISU admissions and that the treatment team met each weekday, except holidays and rare other exceptions.

In previous monitoring periods, triage meeting participants usually included the unit director, MHPs, a security staff representative, a nurse, activity therapists, and Support Persons; a psychologist, psychiatrist, and/or APRN commonly joined as well. This is an excellent team composition. In the current monitoring period, DQE team observations and spot checks of minutes[156] found meeting composition similar to the past. Minutes reflect details of patients' functioning, group participation, and other interactions. The practice of reviewing all patients daily exceeds Paragraph 120's requirement to evaluate patients in the initial phases of the ISU program.

On Saturdays, there is no triage meeting, but patients are evaluated by different staff members during group programming. As part of the five-patient study, group attendance logs showed several groups are offered on Saturdays, providing multiple opportunities for assessment. Taken together with the weekday practice, the DQE finds this sufficient for substantial compliance.

Paragraph 120 also requires that the frequency of individual contacts and group programming be documented in the patient's treatment plan. As in the previous monitoring period, all sampled treatment plans in the DQE team's study indicated a standardized frequency for primary clinician and psychiatry contacts and indicated that

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[155] See Paragraph 116 for a description of this study. For this requirement, reviewers examined at least 20 progress notes per patient

[156] The DQE team reviewed the ISU triage meeting minutes for the first five weekdays of each month in the period July through December 2025, looking at team composition. The review included additional days in November 2025.

group programming was appropriate. Some treatment plans delineated the group names and the duration of the group cycle. The recommended frequency of groups was not included in the plans but is reflected in an activity schedule for the unit that is applied to all patients.[157]

Overall, MDOC's demonstration is sufficient for a continued substantial compliance finding.

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: Substantial compliance

Rationale: As noted in the previous DQE report, group programming is abundant in the ISU. Unit schedules continue to show that groups are held Monday through Saturday, with up to six clinical or recreational groups per day. Groups operate on a 12-week cycle, with the curriculum starting anew every 12 weeks. Staff informed the DQE team that patients enter groups on a rolling basis, and the goal is for them to have completed the entire curriculum by their "graduation" 90 days after admission.

As in previous monitoring periods, four interviewed ISU patients reported that the groups typically occur as scheduled, and a review of group attendance sheets in five medical records confirmed that cancellations were rare. These sources also reflected rolling admission, with each patient beginning in groups on his day of arrival, the following day, or as soon as his TS concluded. During each site visit, the DQE clinicians have observed ISU groups taking place, and their quality and format has been clinically appropriate. Additionally, from staff and leadership interviews throughout monitoring, every indication is that this group structure and assignments are made at the sole discretion of the ISU treatment team.

The only remaining question about MDOC's compliance with Paragraph 121 is whether the ISU groups are assigned based on a patient's "progress in treatment and individualized treatment plan…and length of stay." The DQE team has observed that,

[157] The DQE team has some reservations about the boiler-plate nature of the treatment plans, including the frequency at which group and individual contacts are recommended. This issue is addressed in Paragraph 116 rather than here, so as not to penalize MDOC doubly for the treatment plan deficiency.

since the ISU opened in June 2024, every patient has been assigned to every offered group, without variation.[158] This is true of patients with vastly different clinical presentations, from severe psychotic symptoms to trauma-related disorders to impulse control problems. In the current monitoring period, clinical groups included START NOW (a modification of Dialectical Behavior Therapy), Cognitive Behavioral Therapy, Psychoeducation, Group Choice, Intergenerational Trauma, Acceptance and Commitment Therapy, Dealing with Triggers, Seeking Safety, Coping Skills, Dealing with Feelings, "Mental Health and ...," and Process Group.

At first glance, offering every group to every patient may not seem like individualized treatment, but in the DQE clinicians' experience, it is a common practice in intensive mental health settings that provide group therapy (e.g., psychiatric hospitals, intensive outpatient programs). In addition, the ISU's group curriculum addresses many common clinical issues, including substance use, self-injury, sequelae of trauma, emotional dysregulation, and cognitive distortions. It is difficult to imagine a patient whose needs would not be addressed by the ISU's group curriculum, so the DQE clinicians consider Paragraph 121's requirement for groups to be based on individualized need fulfilled.

Overall, MDOC's practice over two monitoring periods has been sufficient for a substantial compliance finding.

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

Finding: Substantial compliance

Rationale: Over three monitoring periods, all 10 interviewed ISU patients reported that they were permitted out-of-cell time and opportunities for congregate activities. During the DQE team's site visits, patients have been observed enjoying indoor and outdoor recreation in between structured groups. Interviewed patients and staff reported no restrictions on patients' ability to move about the unit freely except when on Phases 1 and 2 of the ISU program, the equivalent of therapeutic supervision. Such freedom of movement undoubtedly supports patients' recovery (i.e., "reinforces symptom and behavioral stability," as required by Paragraph 122).

[158] Staff consistently describe this as the program design, and it has been confirmed in patient interviews and reviews of group attendance logs.

Paragraphs 122-129 also require access to certain privileges and clinical contacts "following the discontinuation of Mental Health Watch in the ISU." As noted in previous reports, the DQE team has interpreted these requirements to apply to a patient's ISU admission *except when on TS*, not just to the period *following* a TS placement.[159] It is important to note that not all patients spend time on TS in the ISU; most are admitted on Phase 3 and are never subject to the restrictions of TS. In the DQE team's review of ISU medical records, six of the 17 patients who were present on the unit between July and December 2025 were placed on TS at least once.

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

Finding: Substantial compliance

Rationale: In interviews across three monitoring periods, patients and staff have consistently reported that restraints are not routinely used during ISU treatment activities. In the DQE team's study of ISU health records, first described in Paragraph 116, 100% of the 134 reviewed notes written by MHPs and ancillary staff indicated that the prisoner was unrestrained during the contact.

Paragraph 123 also requires that patients have access to all on-unit activities outlined in their treatment plan. Here, too, the DQE team has found consistent practice across three monitoring periods. All interviewed patients and staff reported that patients can access individual contacts and groups as delineated on the unit schedule. Group attendance logs consistently show patients participating in all their scheduled groups (unless the patient declined), with very rare cancellations for institutional factors or schedule conflicts.[160] In addition, many of health records reviewed by the DQE team documented additional "mental health check-ins" with ancillary or clinical staff. Overall, available information consistently indicates that the ISU provides access to therapeutic activities and minimizes the use of restraints, warranting a continued substantial compliance finding.

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

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

[160] Group attendance logs are found in the electronic health record. See Paragraph 116 for a description of the sampled records in the current monitoring period. The DQE team conducted a similar study in the preceding monitoring period with similar results.

Finding: Substantial compliance

Rationale: In the DQE team's study of ISU health records, documentation of MHP contacts at least once weekly was strong. 80% of the reviewed health records contained notes of 1:1 "PCC contacts" at least weekly, with the one remaining record showing 10-day intervals between PCC notes on a few occasions. All the records contained additional documentation of mental health "check ins," crisis assessments, and psychiatric contacts, making it clear that patients were assessed by clinicians far more frequently than once a week. Interviewed patients almost universally confirmed this as well. This practice has been consistent for over a year, warranting a continued substantial compliance finding.

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

Finding: Partial compliance

Rationale: Three patients interviewed by the DQE team during this monitoring period reported that phone privileges in the ISU are the same as in general population. This is consistent with other prisoners' reports in the previous monitoring period, and it is supported by language in the revised ISU Handbook reviewed by the DQE team.[161]

MDOC's ability to provide contact visits to ISU patients has been evolving. In its January 2026 Status Report, MDOC reported that contact visits had been added to OCCC's operations, which was a new development during this monitoring period. OCCC's visiting schedule from January 2025 was provided to the DQE team, and this document confirmed that the ISU had weekly contact visitation hours assigned at that time. However, the Superintendent of OCCC has since changed, and MDOC reported that the practice was under review as of February 2026.

Three ISU patients interviewed by the DQE team in October 2025 about visits gave mixed responses. None of the patients reported having contact visits, but this was because two of the patients did not receive visitors at all. The third patient reported seeing others on the unit conducting video visits and was unsure about whether contact visits were allowed.

In summary, MDOC has taken significant steps during this monitoring period to provide contact visits to ISU patients, and phone privileges have been commensurate with general

[161] Draft ISU "Incarcerated Individual Manual" dated January 15, 2026

population for at least a year. Once the practice of offering contact visits has been implemented consistently, MDOC will likely achieve substantial compliance with the Paragraph 125 requirements.

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

Finding: Substantial compliance

Rationale: MDOC's policy 103 DOC 650.12.C.4.i, which was finalized in October 2025, states that meals in the ISU will be provided in a group setting in the unit's dining area unless clinically contraindicated. Although MDOC does not track patients' out-of-cell time, including where/when they eat their meals, staff and patients interviewed across three monitoring periods have consistently indicated that meals in the ISU are routinely served in the unit's common area on Phases 3 and 4 of the program. On Phases 1 and 2 (the equivalent of TS), meals are served in-cell. During the current monitoring period, clinical and security supervisors confirmed that congregate meals are available, and three ISU patients interviewed by the DQE team stated that they were given a choice of eating meals in their cells, alone at one of the tables in the day room, or with others. These practices appear to meet the Paragraph 126 requirements.

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

Finding: Noncompliance

Rationale: In the previous two DQE reports, a noncompliance finding was issued for this provision because MDOC was routinely restricting property in the ISU beyond what is permitted in general population. This practice has not changed, as uniformly reported by interviewed patients and staff at OCCC during the current monitoring period.

During the DQE team's November 2025 site visit, and in their January 2026 Status Report, MDOC explained what the barriers to meeting this requirement are. Patients arrive at the ISU from other MDOC facilities, which have different security levels and different property allowances in general population. The ISU wishes to have consistent property allowances within the unit for two reasons: (1) so that patients do not feel disparities between themselves and others regarding property, and (2) so that security staff can consistently enforce rules. This creates an implementation challenge for

MDOC's leadership, as the Agreement does not specify *which facility's* general population property allowances should be followed in the ISU.

An additional challenge involves the logistics of property movement between MDOC facilities. By design, prisoners do not bring all their property from the transferring facility to the ISU because it is a short-term (90-day) program. They bring only a "ditty bag," typically containing a small amount of clothing and toiletries.[162] Their remaining property, or specific items, can later be transferred from the home institution, but MDOC policies do not specify a time frame for doing so. In interviews with the DQE team, prisoners and security staff reported that it can take weeks to months for property requests to be processed. In the meantime, patients in the ISU are left with almost no personal property, such as photos and canteen items, in a treatment setting that is intended to be therapeutic. Security and mental health staff, as well as patients, noted that this is a disincentive to participating in the program. Additionally, where legal paperwork does not transfer timely, it poses a risk for a patient's legal processes, as security staff observed in at least one example.

Moving forward, MDOC's task is to design a system that allows patients access to the property they wish to bring with them to the ISU, within the bounds of what is allowed in general population. This goal can be accomplished through different means, such as allowing patients to pack a bag before transferring to the ISU or expediting requests for property from the home institution once they have arrived at the ISU. Without this type of change, MDOC will remain noncompliant with the Paragraph 127 requirement.

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

Finding: Substantial compliance

Rationale: As noted in previous DQE reports, the ISU Handbook states that indoor and outdoor recreation is provided during Phases 3 and 4 of the program. Recreation can be restricted for clinical reasons (e.g., when a patient is on TS) and as a disciplinary sanction (commensurate with general population). MDOC does not track non-clinical activities in the ISU, but interviewed patients and staff across three monitoring periods have consistently reported access to indoor and outdoor recreation throughout the day. During the November 2025 site visit, the DQE team once again observed patients participating in recreational activities when not in clinical groups. These practices are sufficient for a continued substantial compliance finding.

[162] According to policy 103 CMR 403.00, a ditty bag is "a bag which contains Department of Correction approved items and sent along in the same vehicle as the inmate when he or she is being transported."

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

Finding: Substantial compliance

Rationale: The DQE team is unaware of changes in this area since the most recent report. Interviewed patients said they left the ISU on discrete occasions for dental care, a visit, and haircuts, and one patient said he did not leave the unit at all. All other needs, including meals, mental health programming, phone calls, video visits, access to the law library, showers, recreation, and medication administration, reportedly are handled on the unit. The DQE team has observed activity consistent with this practice, and review of available medical records and incident reports from the ISU over three monitoring periods demonstrates off-unit trips only to outside hospitals in emergencies (e.g., after self-injury). The revised ISU Handbook also supports this requirement, stating that movement will be restricted to the unit except for visits, medical appointments, or activities approved by the treatment team.

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

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

Finding: Substantial compliance

Rationale: According to MDOC's January 2026 Status Report, "Since the approval of the updated [policy] 103 DOC 650, the Department has been utilizing the daily TS log in IMS." The DQE team has not yet reviewed these logs, but even if it had, the TS logs would only track patients' movement during Phases 1 and 2 of the ISU program. Activities during Phases 3 and 4, where patients spend the vast majority of their time in the ISU, would remain untracked.

That being said, the DQE team has previously recommended that a detailed tracking system for the ISU is unnecessary, as it has been apparent from multiple sources over three monitoring periods that out-of-cell time is offered routinely throughout each day. The last DQE report encouraged the parties to discuss this issue, and MDOC indicated its agreement with the DQE's position. In February 2026, the DOJ also agreed that a tracking system for out-of-cell time is not needed and that compliance can be demonstrated by offering sufficient out-of-cell time to patients in the ISU. Accordingly, the DQE team now finds MDOC substantially compliant with Paragraph 130.

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

Finding: Partial compliance

Rationale: MDOC has finalized policy 103 DOC 650.13.C.4.m, which states that ISU prisoners will not be restrained during off-unit activities unless necessary. In its January 2026 Status Report, MDOC provided an update about implementation of this policy:

> During the November 2025 QIC meeting, ADC of Prison Southern Sector shared the implementation of not using restraint in site procedure and post orders, unless exigent circumstances, as stipulated in the updated and updated 103 DOC 650.

This suggests forward movement in implementing the policy, although the meeting minutes did not clearly reflect that the discussion pertained to off-unit movement from ISU.[163]

Of the three patients interviewed by the DQE team about restraint use when being transported outside of the ISU, none recalled being restrained. Two reported visits to the barbershop, visiting room, and dentist without being restrained, and the third could not recall going off the unit.

Officers reported that prisoners might be restrained if they said they were going to hurt themselves or others, which could be considered "necessary" under the terms of Paragraph 131. Otherwise, the practice for off-unit movement of ISU prisoners is just to secure the corridor so they move separately from other prisoners at OCCC. One interviewed mental health staff member thought that restraints are used when patients go off-unit.

Overall, MDOC is making progress toward compliance with the Paragraph 131 requirements. With demonstration that the practice of prisoners being escorted off unit unrestrained will be sustained (e.g., from site procedure and post orders capturing this requirement, and continued patient reports and/or incident reports reflecting whether restraints were used), substantial compliance is achievable in the near future.

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[163] The DQE reviewed the November 2025 QIC meeting minutes, which include a discussion about modifying officers' post orders to allow individualized restraint decisions during crisis calls and TS placements. The discussion notes did not mention the ISU, and it is not clear that the post order modification would apply to escorting prisoners in phases 3 and 4 of the ISU off unit for non-crisis related 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: Substantial compliance

Rationale: Paragraph 132 requires that Support Persons interact with ISU patients only while they are on TS (Phases 1 and 2), but the ISU's three assigned Support Persons routinely interact with patients during all phases of the program. Patients interviewed by the DQE team described these interactions as positive and helpful, which is consistent with patients' reports during previous monitoring periods.

In the DQE team's study of five ISU health records, only one of the patients spent time on TS while in the ISU. During this three-day TS placement, the patient had one documented interaction with a Support Person. This carries forward the practice from the prior monitoring period of Support Persons contributing to care on TS.[164] In all studied cases, this contact was in addition to the three daily sessions provided by MHPs or activity therapists.

The other four sampled patients, although not on TS, met with a Support Person approximately twice per week during their ISU stay. Documentation of these contacts, during TS as well as outside of it, was consistent with other Support Person notes the DQE team has reviewed. Most were 1:1 "support contacts" to talk about something that was upsetting the patient (e.g., unit rules, interactions with peers) or to help with group homework, but a few involved playing games and puzzles.

With consistent practice over at least one year, MDOC has now achieved substantial compliance with the Paragraph 132 requirements.

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

Finding: Partial compliance

Rationale: The DQE team's interviews with patients and staff indicate that activity therapists are an integral part of treatment in the ISU, engaging in groups with patients

[164] In the study described in the DQE's Compliance Report #5, TS patients had Support Person contacts unless they were in TS too briefly for that to be practical.

and attending triage meetings daily. A review of the ISU weekly schedules and patients' health records supports this conclusion. In the DQE team's study of five ISU patients, each attended at least 4 to 8 groups per week led by activity therapists; it was not clear whether there were both structured and unstructured groups. In addition to group contacts, three of the five patients had at least one 1:1 session with an activity therapist. It is not apparent from the health record why this modality is in such limited use or why the remaining two patients did not have any such 1:1 interactions.

Paragraph 133 also requires that patients' treatment plans indicate the nature of their recommended interactions with activity therapists. In the DQE team's review of five ISU patients' treatment plans, none contained any link between the patients' goals and their contact with activity therapists in group or individual settings. This deficit has been consistent across three monitoring periods. In the DQE clinicians' opinion, the problem has more to do with treatment plan documentation than with incorporating activity therapists meaningfully into patients' care. Overall, MDOC is making progress with Paragraph 133, but improvement in treatment plan documentation is needed to achieve substantial compliance. In its January 2026 Status Report, MDOC stated that VitalCore is already working on a treatment plan form revision that will prompt treatment teams to document the role of activity therapists in the overall treatment plan.

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

Finding: Substantial compliance

Rationale: In the DQE team's review of ISU health records, six of the 17 patients who spent time in the ISU between July and December 2025 had at least one TS placement. As in the previous monitoring period, most TS placements occurred either at the beginning of the ISU admission, as a precautionary measure, or in response to acute self-injury. In all cases involving self-injury, the dangerousness of the situation and/or rapid escalation of the patient's behavior left essentially no opportunity for the treatment providers to intervene or deescalate. The DQE found just one case where there may have been time to consider alternatives to TS—the patient requested to be placed on TS over the Christmas holiday weekend—but the patient did not respond to the clinician's attempts to engage him around what was causing his distress.

In interviews with the DQE team across three monitoring periods, patients have described several strategies short of being placed on TS to manage their distress, such as speaking with a Support Person, using the comfort room, or requesting a crisis contact or "check-

in" with a mental health clinician. A review of ISU triage notes and interviews with mental health staff confirm that such unscheduled contacts do occur on the unit, and clinicians try to deescalate situations and avoid TS. In addition, MDOC has now finalized policy 650.13.D.4.b, which clearly states that therapeutic interventions are to be employed, when clinically indicated, prior to initiating TS,

After three monitoring periods, the DQE team is confident that the intent of Paragraph 134—to ensure that clinicians are not reflexively placing patients on TS without trying less restrictive measures first—is being fulfilled. There are, however, many instances where patients' behavior escalates quickly, and TS is the only reasonable option. On balance, MDOC's demonstration is sufficient for a substantial compliance finding.

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

Finding: Partial compliance

Rationale: The DQE team observed the ISU's therapeutic de-escalation room ("comfort room") during the November 2025 site visit, focusing on areas that had previously been identified for improvement. These areas included (1) providing access to calming materials and activities, and (2) allowing prisoners to use the room without being locked inside.

In November 2025, the comfort room had recently been painted butter yellow, and inspirational quotes had been added to the walls. It contained a molded plastic rocking chair, desk, mirror, colored pencils, crayons, chalk, games, and silicone "bubble wrap." The room's appearance was significantly more inviting than during the previous DQE visit. The ISU's practice was still that the comfort room's door should be closed while a patient was inside, and only one patient at a time was permitted.

Despite these limitations, four out of five current or recent ISU patients interviewed by the DQE team reported being reasonably satisfied with the comfort room, and some had seen others use it as well. The fifth patient was aware of the room but had never asked to use it because he did not think he needed it. Four patients recalled using the room to calm themselves down or "get away [from others]," stating that they had listened to music, rocked in the chair, or created artwork in the room. Two patients reported that the door was *not* kept locked while the room was in use and that they were free to leave whenever they wanted. One patient reported that security staff sat outside the door.

In contrast, two interviewed mental health and security staff members reported that the comfort room is used infrequently. One explained, "There is nothing you can do in the [comfort room] that you can't do in your cell." They believed that policy still requires that the door be locked while a patient is in the comfort room to prevent contraband from being passed to the TS cells across the hall. This practice was confirmed by OCCC's security leadership, who cited concerns about TS patients' safety but also acknowledged that the comfort room's door is kept locked even when there are no ISU patients on TS. Mental health staff said they continue to see some patients declining to use the room because of being locked in.

Overall, MDOC has made significant progress with creating an inviting and therapeutic comfort room. By removing barriers that cause the room to be mostly unused, substantial compliance can be achieved. This demonstration could include changes in the ISU Handbook, sustained reports of patient use, and/or addressing the concern about TS contraband by means that do not deter a large percentage of patients from using the comfort room.

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: MDOC continued to enhance its training and implementation of behavior management plans during this monitoring period. In its January 2026 Status Report, MDOC stated that there are active behavior plans at OCCC, SBCC, MTC, and Framingham, which is consistent with the DQE team's findings during site visits.

To assess the details of Paragraph 136, the DQE team reviewed eight behavior plans from MTC, SBCC, and Framingham.[165] Each of the plans identified behaviors to be incentivized and encouraged, including appropriate sexual behavior (e.g., not exposing oneself in public spaces), keeping a clean and hygienic cell, decreasing verbal outbursts and/or staff assaults, and being respectful of property (e.g., not destroying tablets or writing on walls). Individualized incentives included additional leisure activities or 1:1 therapy sessions, increased use of a tablet, on-unit meals, and "points" that can periodically be exchanged for something of value. Time frames for achieving rewards varied from daily to every 10 days. The behavior plans were generally put into effect for three months, some with "phases" that progress every month if the prisoner is successful.

VitalCore leadership reported that they have continued to train staff about behavior plans. During this monitoring period, the Director of Training met with Health Services Administrators and Directors of Nursing to educate them about behavior plans and answer questions about implementation. In addition, after a concerted effort to train security leadership, staff at OCCC reported more openness among security leadership to approving and implementing individualized behavioral incentives.

Overall, these efforts represent significant progress with behavior plan implementation across MDOC. By the next monitoring period, there will likely be enough active plans for the DQE team to assess the technical details of subsections 136a-j. A partial compliance finding is currently warranted, but the trend has been in a positive direction.

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

[165] OCCC staff stated that they do use behavior plans in the RTU, but the DQE had reviewed the active plans during previous monitoring periods.

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: Noncompliance

Rationale: MDOC requires in policy 103 DOC 650.20, *Records and Continuous Quality Improvement*, that the contracted healthcare provider engage in continuous quality improvement (CQI) activities, and MDOC's June 2025 Status Report delineated a multi-faceted plan for quality assurance. According to MDOC's January 2026 Status Report, VitalCore began its CQI program on July 1, 2025, but MDOC has not yet seen any results of this CQI process, more than 18 months after VitalCore began delivering healthcare services. The CQI studies reportedly consist of auditing 20% of the TS documentation, or a minimum of two charts per facility per month, to assess the quality of crisis treatment plans.

During the fall 2025 site visits, the DQE team requested to review documentation of VitalCore's CQI studies and was told that the information would not be provided. Thus, there is no information by which to measure the adequacy of VitalCore and MDOC's quality assurance process, leading to a noncompliance finding for Paragraph 137. MDOC did, however, state that VitalCore's CQI materials will be made available during the DQE team's next round of site visits in spring/summer 2026.

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

Finding: Partial compliance

Rationale: There has been minimal progress with this provision over the past year. Previous DQE reports identified two areas where MDOC's policies did not yet align with the Agreement's requirements for quality assurance: the Morbidity/Mortality Review process and the SDV/SATT Review Committee. These processes are outlined in policies 103 DOC 622, Death Procedures, and 103 DOC 601, DOC Division of Health Services Organization, respectively. In its January 2026 Status Report, MDOC reported that these policies, along with the corresponding VitalCore and Recovery Solutions policies, are still under revision.

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 measures 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 continues to track data and issue a monthly a Quality Assurance report in accordance with Paragraph 139. Important findings from the Quality Assurance reports between July and December 2025 include:

Number of TS Placements and Length of Stay

Between July and December 2025, there were 523 new TS placements across MDOC, which is almost identical to the previous six-month period (522 TS placements), as illustrated in *Figure 9)*. Reviewing the data since March 2023, there are no significant trends.

Figure 9. Average Monthly TS Placements

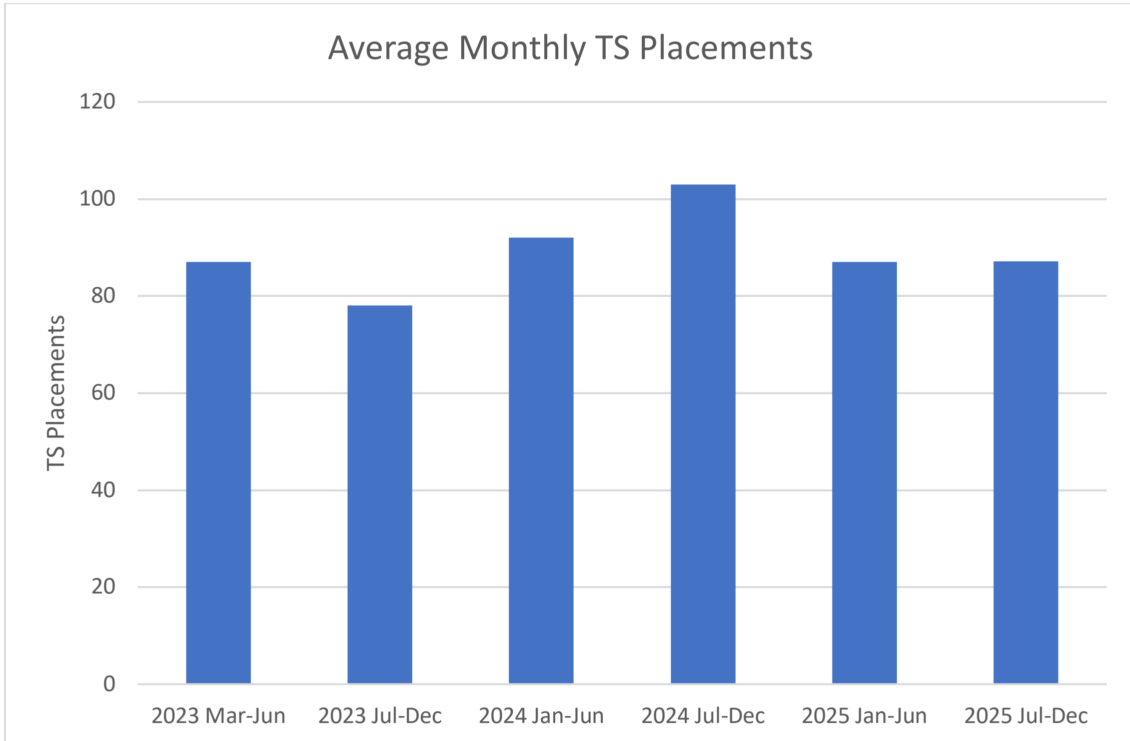
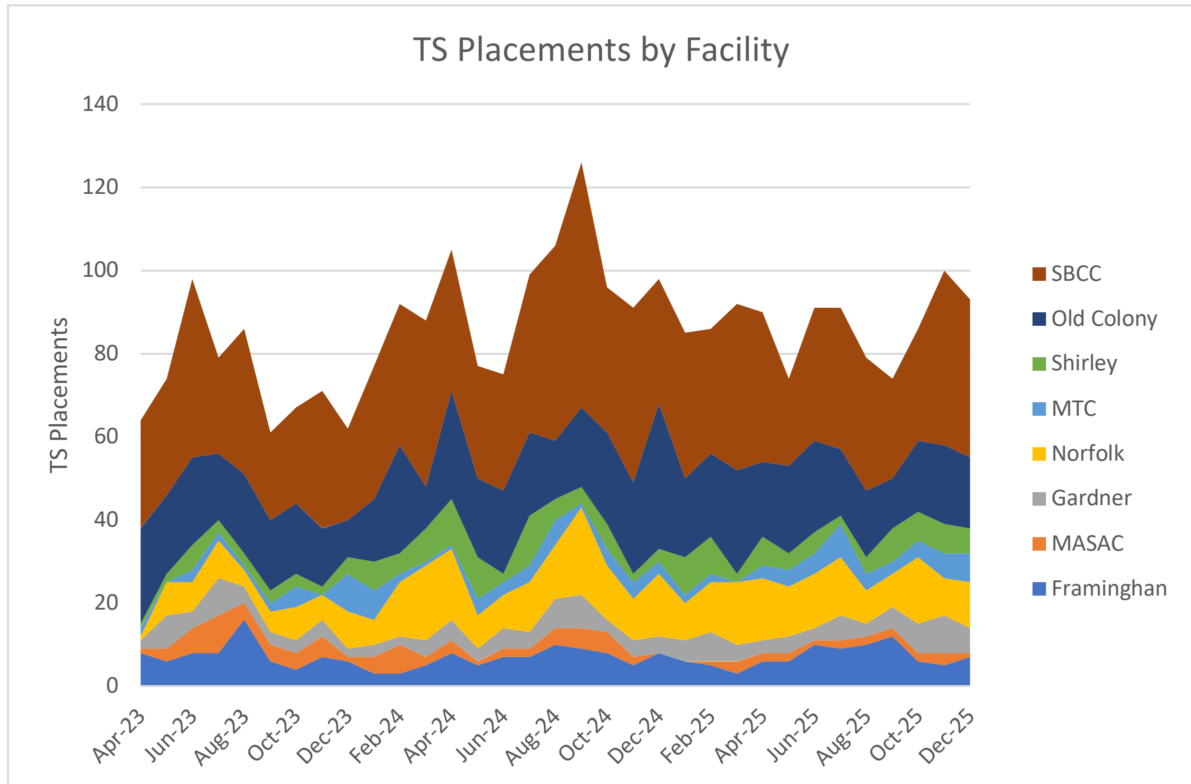


Figure 10 illustrates that the majority of TS placements continue to occur at OCCC and SBCC, with slight increases at Gardner and MTC in recent months.

Figure 10. TS Placements by Facility, March 2023-December 2025



Between July and December 2025, the mean length of stay on TS was 4.1 days[166], which is similar to the previous two monitoring periods (3.7 and 4.5 days, respectively).

The DQE team continued its practice of analyzing whether the overall number of lengthy TS placements has changed since the DOJ's 2019 Findings Letter. When comparing the 2019 data to present day, one must consider the substantial decrease in MDOC's total population during that time, from approximately 8,700 prisoners in 2019 to approximately 5,800 in December 2025. *Table 6* highlights the DQE team's findings.

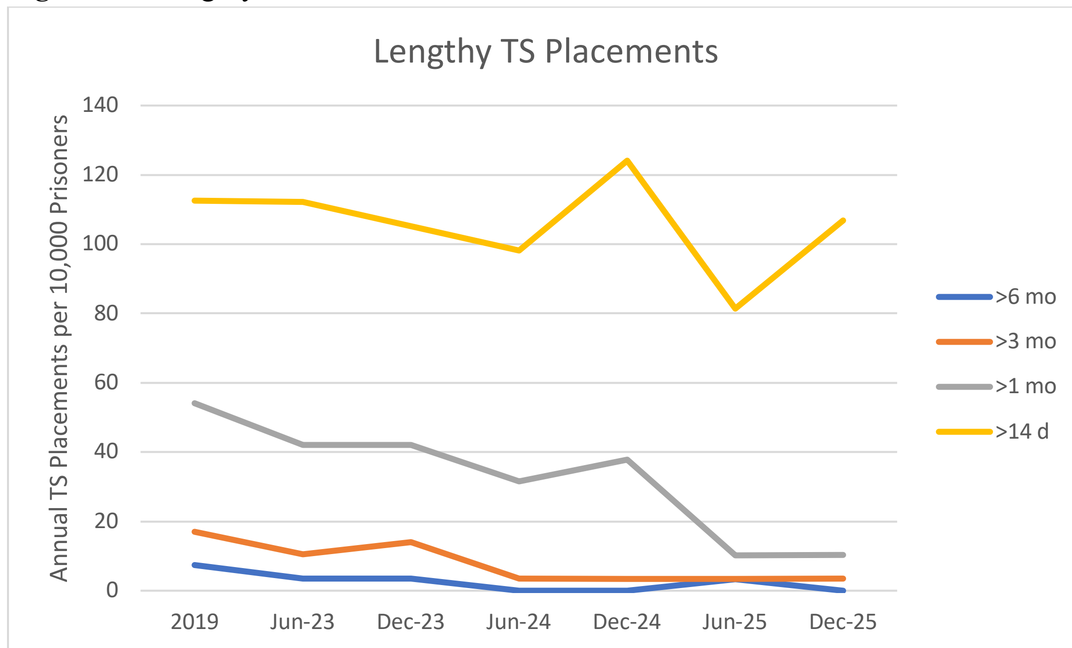
[166] Compiled and calculated from the 523 cases listed in the December 2025 TS Registries (MASAC + Prison Sites), with one outlier case at Framingham excluded.

Table 6. Lengthy TS Placements, 2019 vs. July-December 2025

	2019		December 2025		
TS duration	Total placements in 13 months	Annual placements per 10,000 prisoners[167]	Placements in July-Dec 2025	Annual placements per 10,000 prisoners[168]	**% Change since 2019**
>6 mo	7	7.4	0	0	**-100%**
>3 mo	16	17.0	1	3.4	**-79.7%**
>1 mo	51	54.1	3	10.3	**-80.9%**
>14 days	106	112.5	31	106.9	**-5.0%**

As illustrated in *Figure 11*, lengthy TS placements remained lower than 2019 levels during this monitoring period in all categories (>14 days, >1 month, >3 months, and >6 months), with the most dramatic decreases in the 1-month, 3-month and 6-month categories. Only four patients spent more than a month on TS between July and December 2025, compared with the DOJ's findings letter in 2019, when 51 patients in a 13-month period spent more than a month on mental health watch.

Figure 11. Lengthy TS Placements



167 Calculated based on 8,700 total prisoners, as noted in the DOJ Findings Letter.

168 Calculated based on approximately 5,800 total prisoners in MDOC in December 2025 (derived from "Monthly Mental Health Roll-up" and MASAC population data).

Finally, the DQE examined the location where TS placements occur within each facility. Between July and December 2025, the TS registry indicates that 51% of TS placements occurred in the HSU, as noted in *Table 7*. This is similar to the previous six-month period. Overall, there has been a trend toward conducting TS outside of designated health service units since the Agreement began. In December 2023, 74% of TS placements occurred in the HSU; in June 2024, 65%; December 2024, 48%; and June 2025, 51%.

Table 7. Location of TS Placement within Facility[169]

Unit	Facilities Using Unit for TS	# of TS placements	% of TS placements
Health Services Unit	Framingham, Gardner, Norfolk, OCCC, Shirley, SBCC	273	52.2%
Behavior Assessment Unit	SBCC, Norfolk, MTC, Shirley, OCCC	157	30.0%
Secure Treatment Unit	SBCC	23	4.4%
Secure Adjustment Unit	SBCC	7	1.3%
Residential Treatment Unit	SBCC	10	1.9%
Intensive Stabilization Unit	OCCC	8	1.5%
Intensive Treatment Unit	Framingham	32	6.1%
Booking	Framingham	1	0.2%
Housing Unit	MASAC	12	2.3%
TOTAL		**523**	**100%**

These data are similar to the previous monitoring period, though it is encouraging that TS placements in the BAU continued to decrease overall (from 38% in December 2024 to 30% in December 2025). OCCC continued to improve, with 74% of TS placements now occurring in therapeutic locations (HSU or ISU), compared with 20% in December 2024.[170] At SBCC, 64% of TS placements occurred in a therapeutic location (HSU, STP, or RTU), while the remainder occurred in the BAU or SAU.

[169] MDOC's TS Registry lists only one location per TS placement. At some institutions, particularly OCCC and SBCC, prisoners are sometimes moved from HSU to BAU for a portion of their TS placement due to space concerns and medical patients' need for HSU beds, which would not be captured in these data.

[170] As noted in previous DQE reports, MDOC's statistics likely under-count the number of BAU placements because the TS log only lists one location.

The DQE team appreciates MDOC leadership's emphasis on avoiding the BAU as a TS location because it conflates treatment with punishment and because prisoners' access to property and privileges is sometimes restricted in those settings for reasons unrelated to mental health. MDOC's strategy appears to be yielding positive results.

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 36 times with prisoners on TS between July and December 2025, which is more than double the previous six-month period (15 uses) and the highest number since June 2024. As shown in *Figure 12*, most of the incidents (64%) occurred at SBCC, and 19% occurred at Framingham, all with one patient. As noted in the DQE's earlier reports, MDOC's data do not include incidents where force was used to gain the prisoner's compliance during the incident precipitating the TS placement (because the Agreement does not require such disclosure), so they likely underestimate the use of force in relation to the TS process. Overall, the increased use of force at SBCC is concerning.

Figure 12. Use of Force While on TS

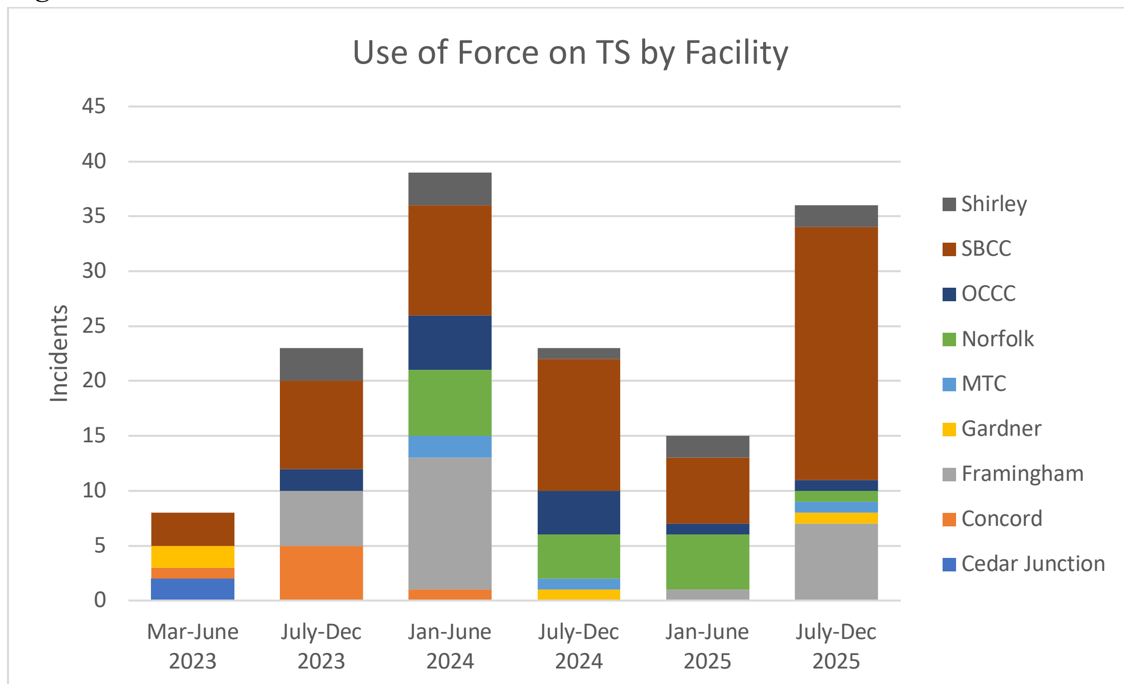
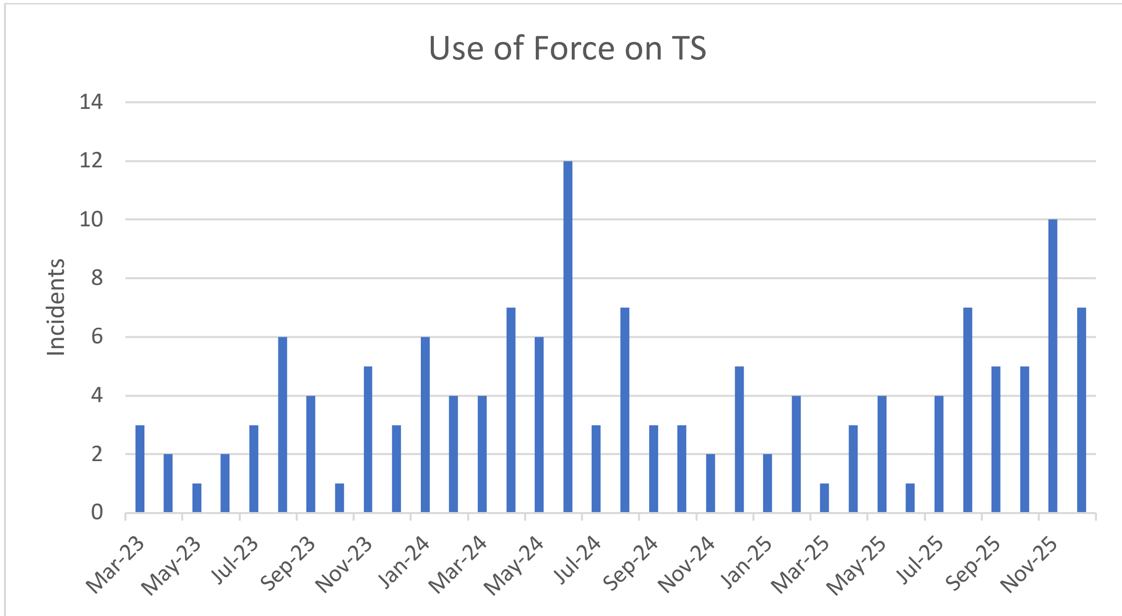


Figure 13 illustrates monthly use of force incidents on TS, which were significantly higher in August, November, and December 2025 than earlier in the year.

Figure 13. Use of Force on TS, March 2023-December 2025



Psychiatric Hospitalizations

This issue is discussed in detail in Paragraph 77.

RTU Census

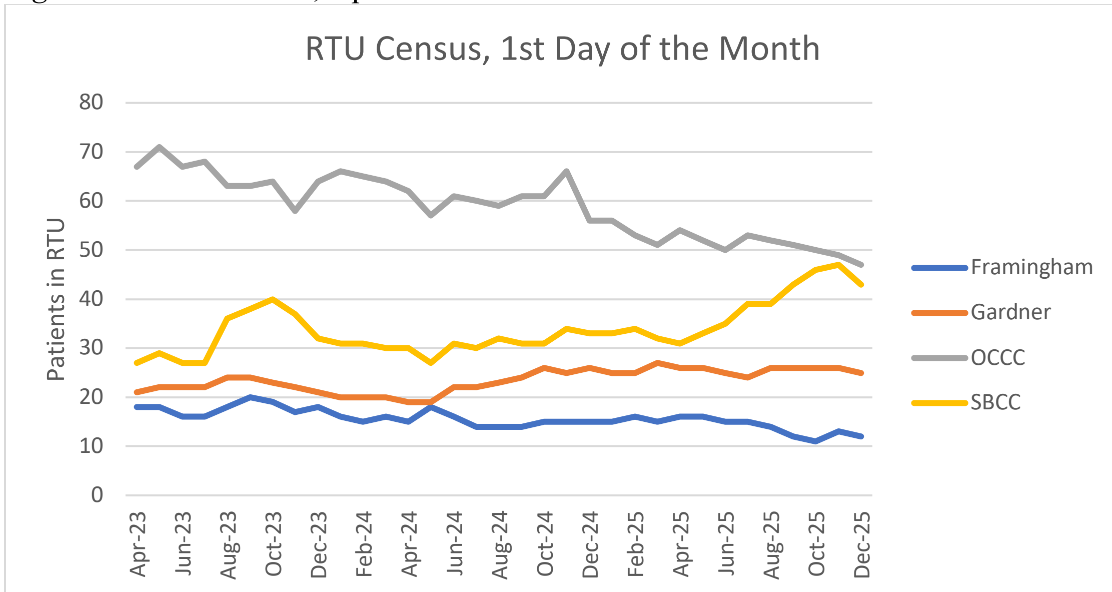
MDOC continues to designate a total of 226 RTU beds across four units: 42 at Framingham, 34 at Gardner, 86 at OCCC, and 64 at SBCC. The typical census of these units is much lower than capacity, with only 56% of the beds filled in December 2025. The relatively high vacancy rate of RTU beds has been consistent since the Agreement began, for reasons unclear to the DQE team since there are many prisoners with SMI across MDOC who might benefit from extra support and programming.

As illustrated in *Figure 14*, the RTU population of OCCC has been declining in 2025, while the population at SBCC has increased. The reason for this change was not apparent from the DQE team's site visits, but it may be that the two facilities are reporting RTU census data differently.[171] The RTU patients at OCCC seemed fairly stable (in number

[171] In comments on a draft of this report, MDOC stated that the increase in RTU census reported by SBCC is due to the total number of prisoners on the housing unit (J1) increasing, including those who are not designated as RTU patients. OCCC may be reporting its data differently.

and symptom acuity), while those at SBCC expressed complaints that "non-RTU" prisoners were being housed in the same unit.

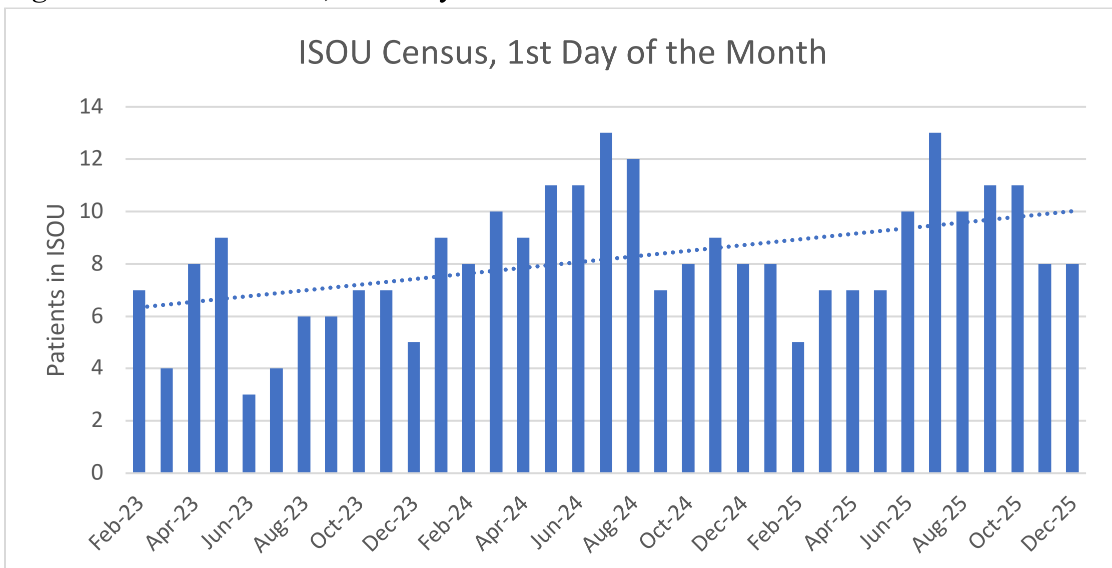
Figure 14. RTU Census, April 2023-December 2025



ISOU Census

The Intensive Stabilization and Observation Unit (ISOU) is the Bridgewater State Hospital unit at OCCC where prisoners are evaluated pursuant to a Section 18(a) or Section 18(a1/2) commitment. Although there has been a slight upward trend in admissions since the Agreement began (see *Figure 15*), the unit remained over 80% vacant in December 2025.

Figure 15. ISOU Census, February 2023-December 2025



Mental Health Staffing

This issue is discussed in detail in Paragraph 35.

140. Other Mental Health Watch Data Subject to Review by the DQE

a. During any site visits conducted by the DQE, the DQE may conduct reviews of inmates' medical and mental health records, as requested in advance, supplemented with interviews of prisoners, to gather information on the following topics:

1. Clinical contacts on Mental Health Watch

i. visits between prisoner and Qualified Mental Health Professional that occurred out of cell per day,

ii. time spent by prisoner with Qualified Mental Health Professional per day,

2. Property and Privileges approved while on Mental Health Watch

i. clothing,

ii. media unrelated to mental health,

iii. exercise and recreation,

iv. other out of cell activities.

Finding: Substantial compliance

Rationale: MDOC's only obligation under Paragraph 140 is to allow the DQE's assessment of the delineated areas and to provide information as requested. MDOC has remained entirely cooperative with the DQE team during this monitoring period, facilitating site visits of eight facilities.

141. Quality Improvement Committee: Within three months of the Effective Date, MDOC will begin to develop and implement a Quality Improvement Committee that will:

a. review and analyze the data collected pursuant to Paragraph 139(a);

b. identify trends and interventions;

c. make recommendations for further investigation of identified trends and for corrective actions, including system changes; and,

d. monitor implementation of approved recommendations and corrective actions.

e. Based on these monthly assessments, MDOC will recommend and implement changes to policies and procedures as needed.

f. All monthly reports will be provided to the DQE and the United States, along with a list of any recommendations and corrective actions identified by the Quality Improvement Committee.

Finding: Substantial compliance

Rationale: The Quality Improvement Committee (QIC) continued to meet monthly during this monitoring period: on July 31, August 27, September 25, October 30, November 26, and December 29, 2025. As noted in previous DQE reports, the format and content of these meetings meet the Paragraph 141 requirements.

Meeting minutes from July to December 2025 indicate that the QIC continued to track several areas relevant to the Agreement monthly:

- Completion of incident reports related to SDV
- Trends in SDV on TS
- Trends in use of force on TS
- Status of the Peer Support Program
- Wait times for DMH beds

In addition to these standing agenda items, the QIC discussed other ad hoc items related to the Agreement:

- How to capture/document individualized decision-making around restraints while on TS
- The need for security staff to complete 15-min checks on TS in a staggered manner, without pre-filling times on the observation sheets
- Ligature risk assessment of BAU cells

A few items that had previously been tracked no longer appear in the QIC meeting minutes, including:

- Trends in 18(a1/2) requests and admissions
- Confidential incident reports regarding staff misconduct
- Status of the therapy dog project

In previous reports, the DQE urged MDOC to add a standing agenda item about developing a log of prisoners' TS privileges and out-of-cell time. In its January 2026 Status Report, MDOC stated that this information is now being captured in IMS, which is a positive development.

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 continued to conduct an SDV/SATT Review Committee meeting at least twice monthly via Teams, as listed in *Table 8.*

Table 8. SDV/SATT Committee Meetings

Prison Sites	MASAC
July 2 and 16, 2025	July 29, 2025
August 6 and 20, 2025	August 11, 2025
September 3 and 17, 2025	September 8 and 22, 2025
October 1 and 15, 2025	October 6 and 20, 2025
November 5 and 19, 2025	November 3 and 18, 2025
December 3 and 17, 2025	December 1, 15, and 30, 2025

The prison sites met twice monthly. MASAC scheduled meetings every two weeks, but it did not meet if there were no SDV incidents during the two-week period being reviewed.[172] The DQE reviewed minutes of all meetings listed in *Table 7*, concluding that the meetings continue to meet the leadership and attendance requirements of Paragraph 142. A continued substantial compliance finding is warranted.

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

Finding: Substantial compliance

Rationale: The SDV/SATT Review Committee meetings occur twice a month for up to 90 minutes, and every SDV incident over the preceding two weeks is analyzed in detail by a multidisciplinary group. Based on the meeting minutes, MDOC does identify breaches in clinical care and security protocol that could have contributed to SDV, such as prisoners having access to contraband items while on TS. When such problems are identified, they are flagged for the Mental Health Regional Administrator to follow up with facility leadership. This satisfies the Paragraph 143 requirement for timely and adequate multidisciplinary reviews of SDV.

Previous DQE reports noted that MASAC's SDV/SATT Committee meeting minutes did not document the committee's review of SDV data from the monthly Quality Assurance

[172] The DQE agreed that no meetings were necessary if there were no SDV incidents to review.

reports. This issue was not remedied during the current monitoring period, but in its January 2026 Status Report, MDOC stated that MASAC's leadership will be invited to the prison sites' SDV/SATT meetings when the data are reviewed. Once implemented, this practice would satisfy the Paragraph 143 requirement.[173]

Paragraph 143 also requires that the SDV/SATT Committee conduct an "in-depth analysis of prisoners who have engaged in the most Self-Injurious Behavior over the past month." Previous DQE reports noted there is no distinct part of the SDV/SATT meeting that highlights these individuals; they undergo the same review and analysis as every other incident of SDV. In its June 2025 Status Report, MDOC noted, "Beginning in June 2025, a deeper review and identification of those individuals who have engaged in the most Self Directed Violence for the month will be discussed during the Self Directed Violence/ Suicide Attempt meeting." Meeting minutes during this monitoring period identified which individuals had the most episodes of SDV during the two-week period under review, and they indicated a separate discussion of trends that could be gleaned from these cases. This practice fulfills the remaining requirement of Paragraph 143, leading to a substantial compliance finding overall.

The following figures and tables highlight trends in SDV since the Agreement began. MDOC's tracking of SDV data indicates that 368 total SDV incidents occurred between July and December 2025.[174] The change in rates of SDV over time is illustrated in *Figure 16.* SDV rates remained slightly below 2019 levels during this reporting period, both on and off TS, but they were 17% higher than the first half of 2025.

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[173] In addition, MASAC's clinical leaders attend the monthly QIC meetings where the SDV data are reviewed. This may not meet the technical requirement of Paragraph 143 for these data to be reviewed *during the SDV/SATT meeting,* but it seems to fulfill the intent of keeping clinical leadership abreast of trends in SDV across the MDOC system.

[174] There is a discrepancy between two data sources about SDV provided by MDOC in December 2025. The "SDV log" shows 350 total incidents between 7/1/25 and 12/31/25, of which 168 occurred while on TS. The spreadsheet labeled "QUAL ASSU DEC 2025" shows 368 total incidents, of which 188 occurred while on TS. The DQE team used the latter spreadsheet for the current SDV data analysis to maintain consistency with previous analyses.

Figure 16. SDV Rates Over Time

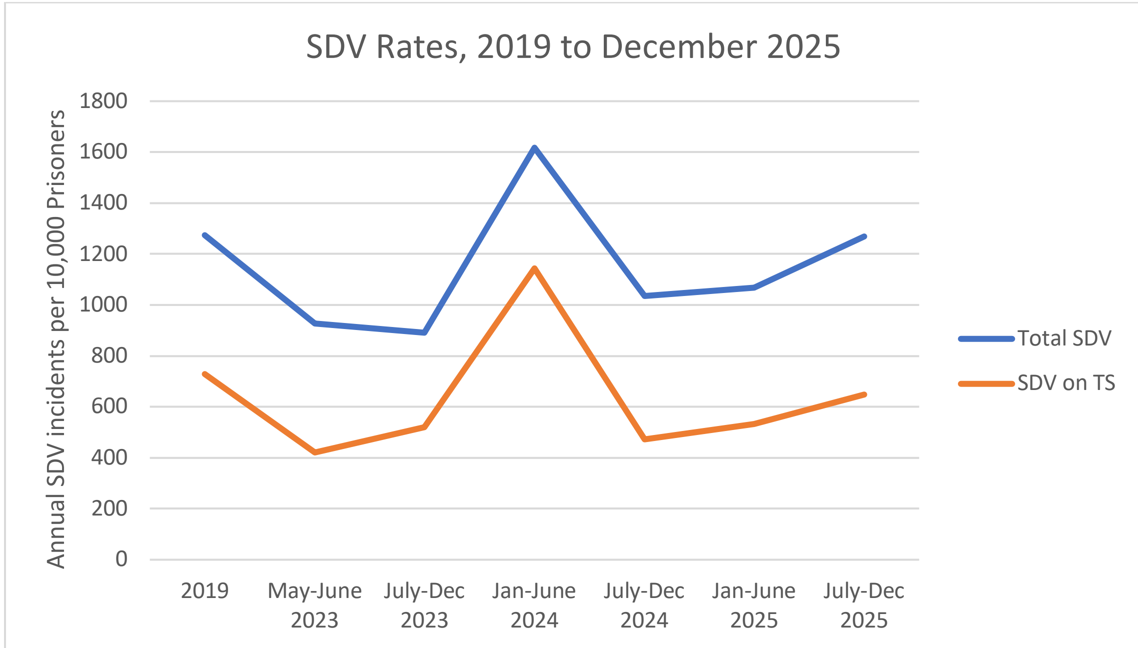


Table 9 shows the percent change in SDV rates between 2019 and the second half of 2025.

Table 9. Rates of SDV, 2019 vs. July to December 2025

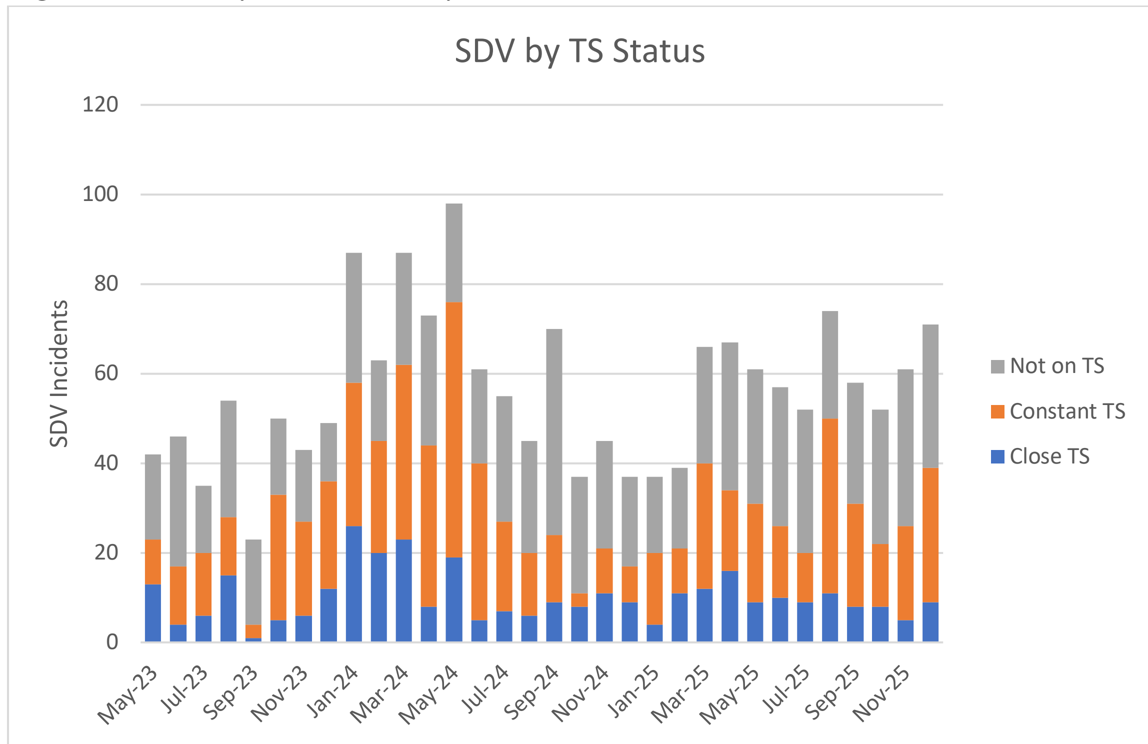
	2019		**December 2025**		
	SDV incidents in 13 months	Annual incidents per 10,000 prisoners[175]	SDV incidents in July-Dec 2025	Annual incidents per 10,000 prisoners [176]	**% Change since 2019**
Total SDV	1200	1273	336	1269	**-0.3%**
SDV while on TS	688	730	188	648	**-11.2%**
Cutting while on TS	217	230	13	44.8	**-80.5%**
Hanging while on TS	77	82	16	55	**-32.4%**
Insertion of foreign bodies while on TS	85	90	27	93	**+3.2%**
Ingestion of foreign bodies while on TS	34	36	18	61	**+72.1%**
Asphyxiation while on TS	17	18	4	13	**-23.5%**

[175] Calculated based on 8,700 total prisoners, as noted in the DOJ Findings Letter.
[176] Calculated based on approximately 5,800 total prisoners in MDOC in December 2025

SDV decreased overall, but ingestion and insertion of foreign bodies increased. However, it is important to note that the increase in insertion is small enough to be statistically insignificant and that almost all the ingestion incidents were attributable to one patient at OCCC who was eventually admitted to the ISOU.

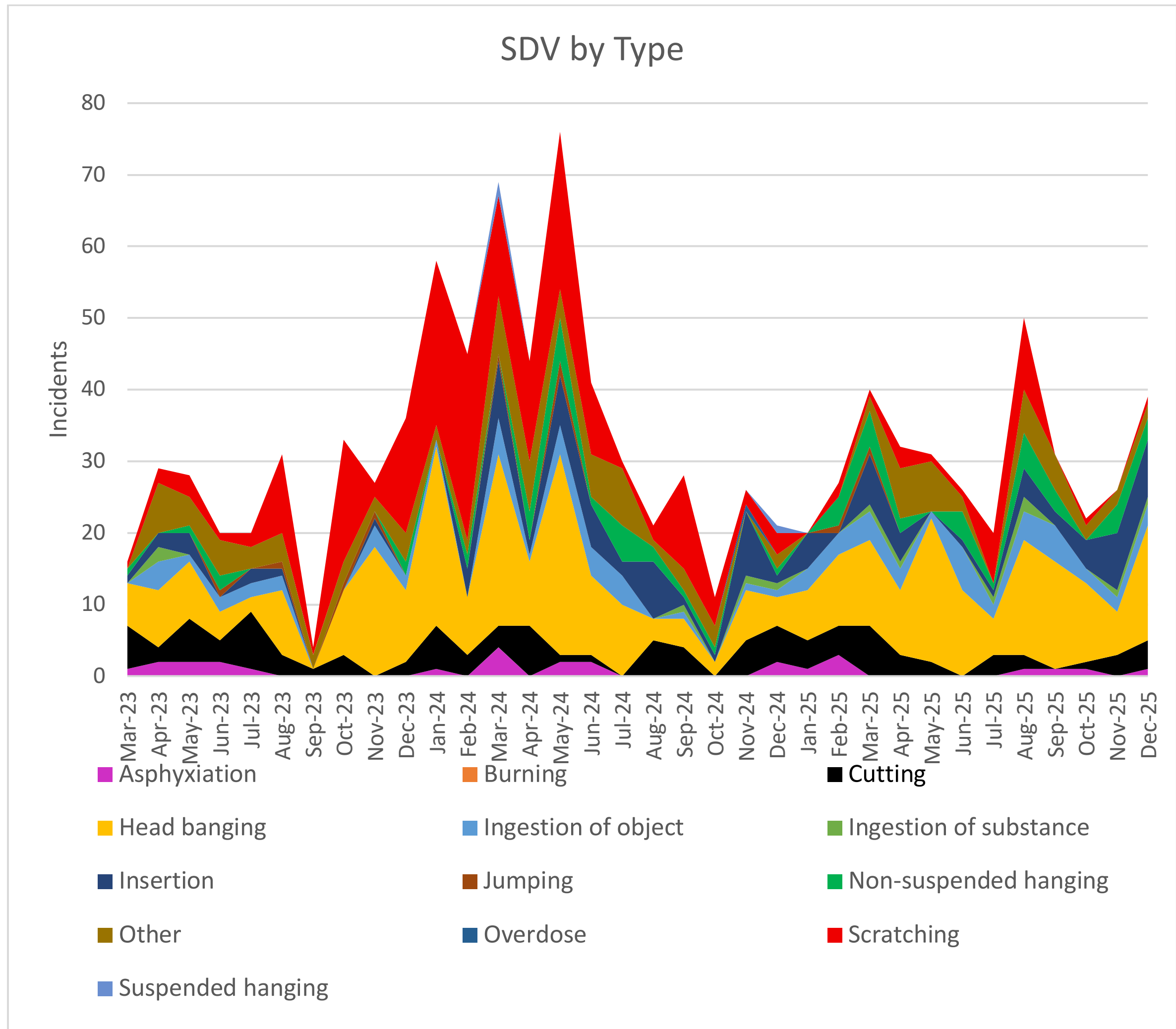
Figure 17 shows that, between July and December 2025, 188 of the 368 total SDV incidents in MDOC occurred while a prisoner was on TS (51.1%). This is similar to the previous two monitoring periods.

Figure 17. SDV by TS Status, May 2023-December 2025



Head-banging still accounted for the greatest proportion of SDV, as illustrated in *Figure 18*.

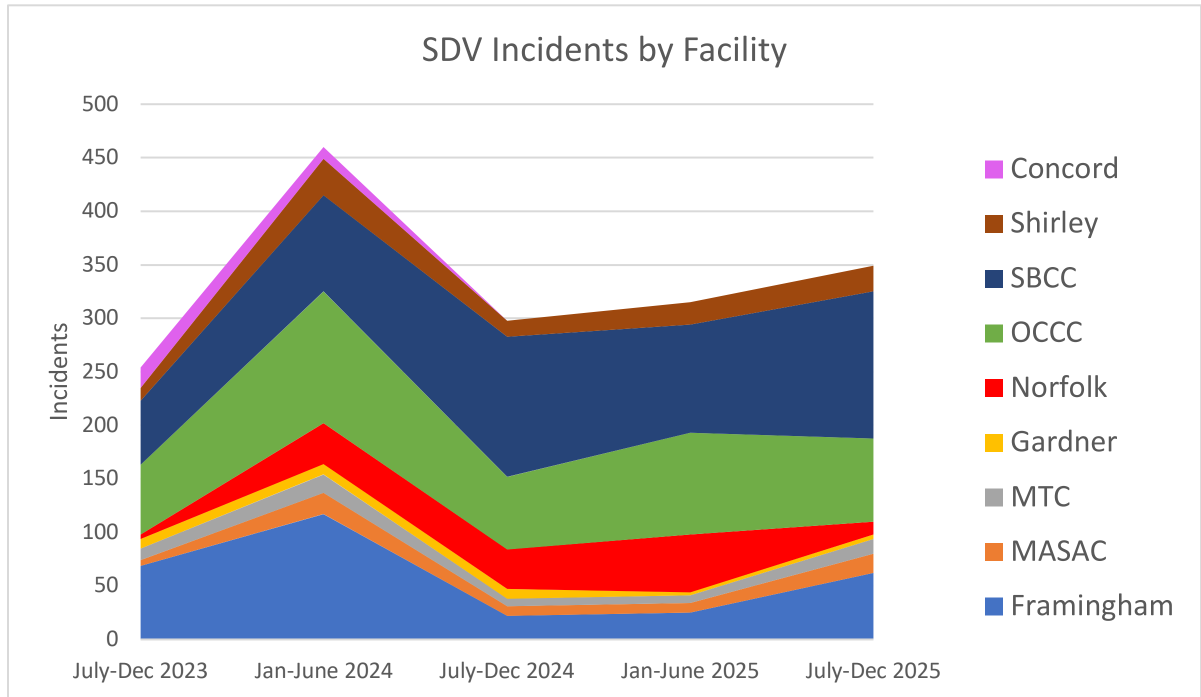
Figure 18. Type of SDV while on TS, March 2023-December 2025



The total incidents of self-injury (not just those that occurred on TS) were divided across MDOC facilities as illustrated in *Figure 19.* SBCC still accounts for a disproportionate share of SDV incidents: 39%.[177] Norfolk's share of SDV incidents was way down during the same period, from 17% of SDV incidents to just 3%. Framingham's share rose dramatically, but this is due to two outlier patients.

[177] In December 2025, SBCC accounted for 21% of MDOC's total population and 26% of its mental health caseload.

Figure 19. SDV Incidents by Facility, July 2023 to December 2025



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

Finding: Partial compliance

Rationale: As of the most recent DQE report, MDOC had not begun sharing the SDV/SATT meeting minutes with all treating staff at the facilities, though it did share the minutes with MDOC's leadership. During the current monitoring period, MDOC provided time-stamped emails beginning in June 2025 that demonstrate sharing of the SDV/SATT meeting minutes with all treating staff. Practice was strongest at OCCC, with the minutes being shared by email twice monthly. Practice was not perfect but was fairly consistent at Framingham, Gardner, MTC, Norfolk, and Shirley. SBCC was far less consistent, with no evidence of sharing the minutes between August and November 2025, and no evidence of sharing the data with MASAC staff was provided to the DQE team. Overall, MDOC is off to a very good start. With consistent demonstration of these email communications, including at SBCC and MASAC, substantial compliance with this requirement can be achieved.

Paragraph 144's other mandate is to take corrective action around systemic problems identified during the SDV/SATT meetings. In the SDV/SATT meetings between July to December 2025, MDOC identified seven problems requiring facility-level follow-up. Most problems were related to prisoners having contraband items while on TS, such as

plastic utensils or small metal objects like staples. Five of the seven incidents requiring follow-up were at SBCC, and the other two were at Framingham.

The DQE team spot-checked three of these incidents, representing a 43% sample, to confirm facility follow-up. For an incident of SDV that occurred at Framingham on 8/20/25 and was reviewed in the SDV-SATT meeting on 9/3/25, follow-up with the facility occurred on 9/5/25. By that time, the Superintendent had spoken with staff about the expectation of constant observation of individuals in crisis while waiting for mental health staff to evaluate them. For two incidents of SDV at SBCC on 10/24/25 and 11/8/25, MDOC reported to the DQE that no facility follow-up had occurred as of 2/3/26.

Overall, MDOC has taken steps to demonstrate compliance with Paragraph 144. By providing SDV/SATT meeting minutes to treating staff more consistently, and by improving facility follow-up at SBCC after systemic problems are identified, MDOC can achieve substantial compliance.

145. Morbidity-Mortality Reviews: MDOC will conduct timely and adequate multidisciplinary morbidity-mortality reviews for all prisoner deaths by suicide and all serious suicide attempts (i.e., suicide attempts requiring medical hospital admission).

Finding: Partial compliance

Rationale: Four completed suicides occurred during this monitoring period, and MDOC conducted timely mortality reviews in half of these cases, as indicated in *Table 10.*

Table 10. MDOC Mortality Reviews, July to December 2025

Incident Date	Mortality Review Meeting Date	Days Elapsed
September 20, 2025	October 16, 2025	26
September 27, 2025	October 24, 2025	27
October 28, 2025	December 5, 2025	38
November 2, 2025	December 12, 2025	40

Since the Agreement began, MDOC has had 14 serious suicide attempts and seven deaths by suicide (as of December 31, 2025). Of these 21 incidents, a morbidity or mortality review was completed within 30 days for 15 cases (71%). It is not clear why there was a slight delay in the two most recent mortality reviews, but in general, MDOC continues to conduct timely morbidity and mortality reviews.

During the current monitoring period, MDOC shared its case summaries of the four deaths by suicide, as well as its recommendations and requests for corrective action, with

the DQE team. Although the mortality review process does not meet several of the technical requirements of the Agreement, as described in Paragraph 146, it does appear to be thorough. Data to support this opinion include:

- MDOC involves an outside consulting forensic psychiatrist, Dr. Debra Pinals, in each mortality review;
- In the wake of the four deaths by suicide in close proximity, it commissioned an additional review by a consulting psychologist, Dr. Sharen Barboza;
- MDOC requests corrective actions from its security/operations staff and its healthcare vendors after each mortality review;
- VitalCore reportedly also holds internal mortality reviews with an outside consultant;[178] and
- MDOC's mortality reviews often identify the same problems with mental healthcare that the DQE team has found in its assessments.

Over the past year, the DQE team has seen evidence of the morbidity/mortality review and corrective action protocols being implemented. For example, after a death at SBCC in April 2025, MDOC recommended that VitalCore retrain its mental health staff on BAU risk assessments, and the DQE team was provided sign-in sheets and training materials from trainings that occurred in the summer of 2025. The status of other recommendations to VitalCore, such as retraining psychiatrists about documenting the rationale for medication changes or ensuring cross-vendor communication with Spectrum, is less clear from the materials provided to the DQE team. The same is true of recommendations made to security/operations staff, such as inspecting cells in the BAU to reduce ligature points and referring staff for investigation (both were recommended to the SBCC Superintendent following the April 2025 death).

Considering that some of the same issues arose in the fall 2025 mortality reviews that were identified for corrective action earlier in the year (e.g., cross-vendor communication, quality of BAU risk assessments, continuity of care by MHPs), the DQE team needs to see consistent follow-through on corrective action plans by MDOC and its healthcare vendors before a substantial compliance finding can be issued for Paragraph 145. However, it warrants acknowledgement that MDOC does have a substantive process for morbidity/mortality review in place. The DQE team will work with MDOC in the next monitoring period to develop a method for MDOC and VitalCore to demonstrate their follow-through on corrective actions.

[178] The DQE team has not seen evidence of this practice, but it is mentioned in MDOC's January 2026 Status Report.

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 and above, MDOC has a functioning Morbidity/Mortality committee that reviews deaths by suicide and serious suicide attempts, but its process does not meet all the requirements of Paragraph 146. In its January 2026 Status Report, MDOC stated its opinion that it has demonstrated substantial compliance with Paragraph 146 by sharing documentation of the morbidity and mortality reviews that have occurred. While it is true that MDOC has shared these materials, to

achieve substantial compliance, MDOC must revise its Morbidity/Mortality review procedure by:

1. Ensuring that all three parts of the NCCHC's schema for morbidity/mortality reviews are completed within 30 days of the sentinel event: Administrative Review, Clinical Review, and Psychological Autopsy;
2. Developing corrective action plans for serious suicide attempts, in addition to completed suicides;
3. Demonstrating timely completion of all corrective actions recommended by the committee;
4. Completing a final mortality review report within 60 days of the sentinel event (typically this is done after the review meeting);[179] and
5. Providing documentation to the DQE that the committee's recommendations have been shared with the facility's staff.

MDOC stated in its January 2026 Status Report that the policy addressing the morbidity/mortality review process, 103 DOC 622, Death Procedures, remains under review. It is possible, therefore, that these changes are already being implemented.

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

Finding: Substantial compliance

Rationale: Four reportable incidents, all deaths by suicide, occurred between July and December 2025. The DQE was notified within 24 hours of all four cases, as noted in *Table 11.* Each notification included the required elements of Paragraph 147a, as well as the incident reports documenting the immediate staff response.

[179] Currently, MDOC's Health Services Division writes memos following the morbidity/mortality review meetings to the healthcare vendor and/or the relevant facility's Superintendent. These memos contain the review committee's recommendations and request completion of an action plan. It is not clear to the DQE team whether MDOC intends for these memos to serve as the final mortality review report identified in Paragraph 146d.

Table 11. Notification of Reportable Incidents

Date of incident	Date of DQE/DOJ notification	Days to notification
September 20, 2025	September 20, 2025	0
September 27, 2025	September 27, 2025	0
October 28, 2025	October 28, 2025	0
November 2, 2025	November 2, 2025	0

MDOC's timely notifications during this monitoring period warrant a continued substantial compliance finding.

OTHER

159. MDOC will provide to the DQE and the United States a confidential, bi-annual Status Report detailing progress at MDOC, until the Agreement is terminated, the first of which will be 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. After the DQE and DOJ agreed to a brief extension, MDOC submitted its most recent Status Report on January 5, 2026. The Status Report contains all the elements required by Paragraph 159, including action steps, responsible persons for each provision, due dates, a section for current status, description of where pertinent information is located, DQE recommendations, and date completed. As noted in previous DQE reports, the document could be greatly enhanced by providing evidence or data to support MDOC's conclusions (e.g., what documents were checked, who were the sources of the information (types of staff or professional roles), was there an audit, etc.).

169. Within 30 days of the Effective Date, MDOC will designate an Agreement Coordinator to coordinate compliance with this Agreement and to serve as a point of contact for the Parties and the DQE.

Finding: Substantial compliance

Rationale: During this monitoring period, a Mental Health Regional Administrator served as the Agreement Coordinator while MDOC's Clinical Operations Analyst (COA) was on leave. This transition went very smoothly, with the Regional Administrator and Director of Behavioral Health coordinating the site visits and responding to numerous requests for information and clarification from the DQE team. The DQE team remains deeply appreciative of how complete and well-organized MDOC's monthly and quarterly data submissions have been, and how smoothly the site visits have gone, even during this period of coverage.

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

Finding: Substantial compliance

Rationale: The DQE reviewed the minutes from MDOC's "Quarterly DOJ Implementation" meetings that occurred on September 8, 2025, and January 8, 2026.[180] These meetings were attended by MDOC's behavioral health and security leadership, as well as the Superintendent and Deputy Superintendent of Reentry from each facility where TS occurs.[181]

Meeting minutes indicate that many aspects of Agreement implementation were discussed, including:

- The ISU's functioning, including changes to the comfort room and prisoners' property allowances
- Data about SDV that occurs while prisoners are on TS
- Progress with implementing the TS activity log in IMS
- Providing of out-of-cell meals on TS and contacting DPH to clarify why exactly it is not permissible in some spaces
- Implementation of new TS cell inspection and observation forms for officers
- Status of individualized restraint decisions for crisis assessments
- Status of TS posters

[180] According to the minutes, the December 2025 meeting was delayed by a few weeks because of "Department wide technical issues" and holiday vacation schedules.
[181] In previous communication with MDOC's leadership, they reported that "prison staff" as described in Paragraph 170 was interpreted as the leadership, not the line staff, from each facility.

- Status of Hayes-compliant (i.e., suicide resistant) cells, including problems with beds at SBCC and door sweeps at MTC
- Creating more confidential space for mental health assessment/treatment at SBCC
- Sharing information with housing units upon a prisoner's discharge from TS
- How to convey more information about staff misconduct investigation outcomes to DQE

The DQE remains pleased that the meetings are occurring regularly, are attended by leadership from each facility, and discuss many of the challenges the DQE team has raised around Agreement implementation. MDOC's demonstration is sufficient for a continued finding of substantial compliance.

RECOMMENDATIONS

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

POLICIES AND PROCEDURES

1. Prioritize the revision of MDOC policies for immediate completion, as several other Agreement provisions depend on completion of this task (e.g., training staff about new policies, demonstrating full implementation of policies).

2. Submit all VitalCore and Recovery Solutions policies relevant to the Agreement to the DQE and DOJ immediately.

3. As noted in previous reports, define "mental health crisis" in policy as a first step toward clarifying security staff's responsibilities and the time frame in which they must occur.

4. Formalize in policy the current practice of issuing "misuse of crisis" disciplinary reports only when initiated or approved by mental health staff and in cases of blatant misuse.

5. Clarify and consolidate policies around the use of BOSS chairs and body scanners prior to placing a prisoner on TS. These protocols currently exist but are spread across five different policy/procedure documents.

6. Clarify policy and procedures around notifying mental health staff in the event of SDV, including in Code 99 procedures.

7. Develop a clear policy for property allowances in the ISU, including time frames and procedures for transferring property from a prisoner's home institution.

STAFFING PLAN

8. Continue all efforts to improve mental health staffing levels throughout MDOC, particularly focusing on MHPs at SBCC and independently licensed clinicians throughout the system.

9. Conduct a mental health staffing analysis at SBCC, Norfolk, and Shirley to determine whether current staffing levels are sufficient to meet the substantially increased demands for mental healthcare at those institutions since the closures of Cedar Junction and Concord.

10. Continue efforts to fill CO I positions across the MDOC system.

11. Revise security staffing patterns and/or retrain staff at SBCC so that they facilitate out-of-cell contacts for all patients on TS, which is currently not being done consistently in the HSU or BAU.

12. Revise security staffing patterns at OCCC to prioritize consistently assigning trained, mental health-experienced staff to the ISU so the program can fulfill its therapeutic milieu mission.

13. Continue hiring part-time Support Persons to cover Saturday shifts, especially at facilities where TS occurs frequently (e.g., OCCC, SBCC, Norfolk, Framingham).

TRAINING

14. Update the training materials for "Recognizing Mental Illness & Suicide Prevention" to include data and lessons learned from the 2025 deaths by suicide in MDOC.

15. Develop a plan to train STA and other security staff who frequently cover specialized treatment units (e.g., RTU, STP, ITU, ISU) about their unique goals, operations, and expectations for security personnel.

16. Continue posting Therapeutic Supervision policies in visible areas of all 18 units where TS occurs.

17. Follow through on the re-training recommendations made in MDOC's Mortality Reviews of the deaths by suicide in 2025.

18. Enhance training for clinicians on psychotic disorders.

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

    a. Contacting mental health without delay and maintaining constant observation of prisoners who request crisis contacts, regardless of whether the individual expresses suicidal ideation (paragraph 43)
    b. Making individualized decisions about whether to restrain a prisoner during crisis evaluations, out-of-cell contacts on TS, and escort to these contacts (paragraph 64)
    c. Removing clothing from prisoners on TS only if risk of self-harm relates to clothing/material (paragraph 57)
    d. Dimming lighting at night on TS, with training focused on nurses and on-call MHPs in addition to officers (paragraph 59)
    e. Assessing the risks and benefits of recreation and additional property during TS placements (paragraphs 60 and 63)
    f. Assessing, with specificity, whether a higher level of care is indicated and recording the reasons for that finding (paragraphs 79 and 80)

THERAPEUTIC RESPONSE TO PRISONERS IN MENTAL HEALTH CRISIS

20. Continue with physical plant modifications and/or space reallocations to allow for adequate, confidential assessment and treatment of patients in crisis and/or on therapeutic supervision:

    a. Create additional treatment/assessment space in the HSU at SBCC. Resolve issues with control of door locks in the recently converted cell. Modify the scheduling system for confidential spaces at SBCC to avoid inadvertent double-booking.
    b. Consider moving Gardner's crisis assessment room to an area with more privacy from other prisoners.
    c. Utilize confidential spaces at MTC, not the booking area or tables in common areas of the housing units, for crisis assessments.
    d. Utilize confidential spaces at OCCC rather than the "New Man's" area for crisis assessments.

21. Clarify the rationales for why referrals are designated routine, urgent, or emergent. Provide oversight to ensure that recategorizations were made consistent with those rationales.

22. Continue with plans to provide contemporaneous access to the electronic health record to MHPs when conducting crisis assessments and TS therapeutic contacts.

23. Minimize practices that deter prisoners from requesting crisis mental health services, including routine shackling during mental health assessments, conducting assessments in areas without adequate sight/sound confidentiality, and locking down units while a prisoner is waiting for mental health assessment.

24. Conduct individualized decision-making about recreation for patients on TS.

25. Conduct individualized assessments of prisoners' risk with clothing and remove clothing only in cases where a prisoner has demonstrated a risk of using clothing in a self-destructive manner.

26. Consider and document specific reasons why patients are not being referred to a higher level of care, especially at the 7-day and 14-day benchmarks.

27. Ensure that TS follow-up contacts and assessments upon return from Bridgewater State Hospital or a DMH facility are being conducted in confidential settings.

28. Ensure that treatment plan updates after a TS placement are completed and that the patient's goals and objectives are appropriately revised.

29. Continue strategizing with DMH about how to prioritize MDOC's female patients for hospital beds and decrease wait times, which are currently unreasonably long.

SUPERVISION OF PRISONERS IN MENTAL HEALTH CRISIS

30. Fix the obstructed sightlines for monitoring prisoners in the ITU at Framingham.

31. Ensure that officers posted to units that house TS are checking for signs of life when conducting 15-minute checks with TS patients and that these checks are staggered.

32. Ensure that officers in the BAU at SBCC are mot missing 15-min checks of prisoners on TS around the time of shift change.

33. Facilitate out-of-cell Support Person contacts with patients on TS, especially at SBCC.

34. Complete all necessary renovations to ensure the suicide-resistance of TS cells, including the installation of solid door sweeps where cell door construction allows.

INTENSIVE STABILIZATION UNIT

35. Ensure that property in the ISU is commensurate with general population settings and revise the ISU handbook accordingly.

36. Offer contact visits to ISU patients.

37. Improve the quality and individualization of written treatment plans, with problems and goals clearly tied to specific group and individual treatments offered in the ISU, including those of activity therapists.

38. Reconsider policies that discourage use of the ISU's comfort room, such as locking patients inside.

BEHAVIORAL MANAGEMENT PLANS

39. Continue implementing behavior plans, including training of security, nursing and ancillary staff where needed to ensure consistent responses to target behaviors.

QUALITY ASSURANCE

40. Demonstrate the healthcare vendors' current CQI processes to MDOC and the DQE team.

41. Demonstrate the vendors' efforts to address problems with the quality of mental healthcare identified throughout this report. Emphasize the unacceptability of problematic practices including:

    - Conducting "proxy PCC" contacts (seen frequently at SBCC, Norfolk, and Shirley)
    - Conducting the first TS follow-up contact a few minutes after discharge from TS and while the patient is still in the TS housing unit (seen at SBCC)

42. Conduct an internal review of officers' documentation that raises questions about its veracity, such as multiple officers documenting constant observation of a prisoner at the same time.

43. Revise the morbidity/mortality review policies to require completion of a clinical mortality/morbidity review, administrative review, and psychological autopsy within 30 days of a serious suicide attempt or death by suicide.

44. Ensure that the healthcare vendors are completing the corrective actions recommended by the Morbidity/Mortality Review Committee in a timely manner after each suicide <u>or serious</u>

attempt (the latter is not part of current policy and practice). Provide evidence to the DQE team that this occurring consistently.

CONCLUSION AND NEXT STEPS

Over the next six months, MDOC is encouraged to focus its efforts on the numerous challenges with quality and access to mental healthcare at SBCC, as well as increasing utilization of the ISU. A few areas of technical compliance with the Agreement also need attention:

- Completing all policy revisions, including VitalCore and Recovery Solutions' policies;
- Demonstrating VitalCore's CQI process to the DQE team, including its corrective actions after recent suicides; and
- Revising the format of morbidity and mortality reviews to comply with the requirements of Paragraph 146.

The DQE team anticipates conducting the next round of site visits between May and June of 2026, visiting only SBCC, OCCC, Norfolk, and Framingham.

Because the Agreement's aspirations of MDOC demonstrating substantial compliance with all provisions by December 20, 2025, have not come to pass, it is also not possible for MDOC to meet the goal of substantial compliance with all provisions for a full year by December 20, 2026. The DQE team anticipates that the parties will discuss in the coming months whether the Agreement will be extended, modified, or terminated after December 20, 2026.