INVESTIGATION OF THE MASSACHUSETTS DEPARTMENT OF CORRECTION

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TABLE OF CONTENTS

I. SUMMARY 1

II. INVESTIGATION 2

III. BACKGROUND 3

IV. CONDITIONS IDENTIFIED 4

A. MDOC Fails to Provide Adequate Supervision to Prisoners in Mental Health Crisis and Thus Protect Prisoners from Serious Harm in Violation of the Constitution 4

1. Prisoners Face Substantial Risk of Serious Harm on Mental Health Watch When MDOC Staff Fail to Remove Instruments Used to Self-Harm 5

2. MDOC's Lack of Policies and Inadequate Officer Training Contribute to Inadequate Supervision for Prisoners in Mental Health Crisis 8

3. MDOC Officials Knew About the Mental Health Watch Risks to Prisoner Health and Safety Due to Inadequate Supervision and Disregarded Them 10

B. MDOC Fails to Provide Adequate Mental Health Care to Prisoners in Mental Health Crisis in Violation of the Constitution 11

1. Prisoners on Mental Health Watch Have Serious Mental Health Needs Requiring Treatment 11

2. Prisoners on Mental Health Watch Receive Inadequate Mental Health Care 12

C. MDOC's Use of Prolonged Mental Health Watch Under Restrictive Housing Conditions, Including the Failure to Provide Adequate Mental Health Care, Violates the Constitutional Rights of Prisoners in Mental Health Crisis 15

1. MDOC's Use of Mental Health Watch Is Restrictive Housing 15

2. MDOC's Prolonged Use of Mental Health Watch Under Restrictive Housing Conditions Subjects Prisoners in Mental Health Crisis to a Substantial Risk of Serious Harm 17

D. The Combination of Inadequate Mental Health Care and Restrictive Housing Conditions in MDOC's Mental Health Watches Results in Serious Harm 19

1. MDOC Officials Knew of the Substantial Risk of Serious Harm and Disregarded It .. 24

V. MINIMUM REMEDIAL MEASURES 25

VI. CONCLUSION 26

I. SUMMARY

After an extensive investigation, the United States Department of Justice (Department) provides notice, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997b, that there is reasonable cause to believe, based on the totality of the conditions, practices, and incidents discovered there, that the conditions in Massachusetts Department of Correction's prisons (MDOC) violate the Eighth Amendment to the U.S. Constitution, and these violations are pursuant to a pattern or practice of resistance to the full enjoyment of rights protected by the Eighth Amendment. The Department does not serve as a tribunal authorized to make factual findings and legal conclusions binding on, or admissible in, any court, and nothing in this Notice should be construed as such. Accordingly, this Notice is not intended to be admissible evidence and does not create any legal rights or obligations.

Consistent with the statutory requirements of CRIPA, this Notice identifies the Department's conclusions with respect to multiple constitutional violations, the facts supporting those conclusions, and the minimum remedial measures necessary to address the identified deficiencies. Specifically, the Department provides notice of the following identified conditions:

- **MDOC fails to provide constitutionally adequate supervision to prisoners in mental health crisis.** MDOC prisoners on mental health (or suicide) watch face substantial risk of serious harm because MDOC staff fail to remove instruments they use to commit acts of self-harm. In part, these harms occur because MDOC lacks clear and uniform policies that contribute to inadequate supervision of prisoners in mental health crisis. This is further compounded by MDOC's failure to provide appropriate training to security staff on how to supervise and protect prisoners from engaging in self-harm. Despite being on notice of the substantial risks of harm facing prisoners in crisis, MDOC is not adequately supervising prisoners to prevent current and future harm.
- **MDOC fails to provide adequate mental health care to prisoners in mental health crisis.** During a time when prisoners are most in need of treatment, MDOC fails to properly treat suicidal prisoners and prisoners who self-harm. And when treatment must entail more than segregation, MDOC instead places prisoners in segregated restrictive housing.[1]
- **MDOC's use of prolonged mental health watch under restrictive housing conditions, including its failure to provide adequate mental health care, violates the constitutional rights of prisoners in mental health crisis.** MDOC's mental health watch involves restrictive, isolating, and unnecessarily harsh conditions. It is restrictive housing. MDOC subjects prisoners who are in mental health crisis to restrictive housing

[1] Restrictive housing, sometimes referred to as solitary confinement, segregation, or isolation, is any type of detention that involves three basic elements: removal from the general prisoner population, whether voluntary or involuntary; placement in a locked room or cell, whether alone or with another prisoner; and inability to leave the room or cell for the vast majority of the day, typically 22 hours or more. *Porter v. Clarke*, 290 F. Supp. 2d 518, 528 (E.D. Va. 2018) (citing U.S. Dep't of Justice, Report and Recommendations Concerning the Use of Restrictive Housing 3 (Jan. 2016)). *See Davis v. Ayala*, 576 U.S. 257, 135 S. Ct. 2187, 2208 (2015) (Kennedy, J., concurring) (referring to the "usual pattern" of solitary confinement as being housed in "a windowless cell no larger than a typical parking spot for 23 hours a day; and in the one hour when [a prisoner] leaves it, he is allowed little or no opportunity for conversation or interaction with anyone"); *Wilkinson v. Austin*, 545 U.S. 209, 214, 223-24 (2005) (describing restrictive housing as limiting human contact for 23 hours per day).

for prolonged periods of time, which places them at a substantial risk of serious harm. For instance, during a 13-month period between July 2018 and August 2019, MDOC held 106 prisoners experiencing a mental health crisis on mental health watch for 14 consecutive days or longer. Because mental health watch is so restrictive and isolating, MDOC policy states that prisoners should only be on mental health watch for a maximum of four days. Contrary to this standard, 51 of those prisoners remained on mental health watch for a month or more; 16 remained there for more than three consecutive months; and seven spent six consecutive months or more there. Since 2018, four of the eight MDOC prisoners who died by suicide were on mental health watch at the time they died, or days prior to dying. This is alarming given that MDOC supposedly provides prisoners on mental health watch with heightened supervision, including one-on-one observation, and enhanced treatment to prevent suicide. And, although only approximately 1% of the MDOC's total population can be housed in one of its 88 mental health watch cells, between July 2018 and August 2019, more than 56% of MDOC's 1,200 "self-injurious behavior" incidents occurred in one of those mental health watch cells. This is a high concentration of harm in the areas that are supposed to be the most safe and therapeutic.

II. INVESTIGATION

On October 22, 2018, the Department notified MDOC of our intent to investigate its statewide prison system pursuant to CRIPA. Our investigation focused on: (1) whether MDOC violates the constitutional rights of prisoners who have serious mental illness, or who are otherwise at risk of serious harm from restrictive housing, by placing them in restrictive housing for prolonged periods of time; and (2) whether MDOC violates the constitutional rights of geriatric and palliative care prisoners by failing to provide them with adequate medical care. We are closing our restrictive housing – for housing other than mental health watch – and the geriatric and palliative care portions of our investigation without issuing a Notice of constitutional violations. On November 21, 2019, we notified MDOC of two additional focuses to our investigation: (3) whether MDOC provides prisoners in mental health crisis with constitutionally adequate mental health care; and (4) whether MDOC provides prisoners in mental health crisis with adequate supervision to provide reasonable protection from self-harm.

This investigation was conducted jointly by the Special Litigation Section of the Department of Justice's Civil Rights Division and the U.S. Attorney's Office for the District of Massachusetts. Three nationally recognized experts in correctional security and prison mental and medical health care assisted with our investigation. Our experts included a former state prison commissioner, a psychiatrist with experience in prison mental health services, and a medical doctor with experience running the medical and mental health department at one of the country's largest jails. These experts accompanied us on site visits to MDOC prisons, interviewed MDOC staff and prisoners, reviewed documents, and provided their expert opinions to inform our investigation and its conclusions.

Between April 2019 and November 2019, representatives from the Department and our experts conducted site visits at the nine prisons where the majority of the housing units at issue in our investigation are located: MCI-Cedar Junction, MCI-Framingham, MCI-Norfolk, MSAC at Plymouth, NCCI Gardner, Old Colony Correctional Center, MCI-Shirley, Massachusetts Treatment Center, and Souza-Baranowski Correctional Center. We also interviewed stakeholders, advocates, former prisoners, former MDOC staff, and family members of prisoners with firsthand knowledge of the conditions within MDOC. During our site visits, we

interviewed administrative staff, security staff, mental health staff, and hundreds of prisoners in specialized housing units. In addition to conducting tours and interviews, we reviewed an extensive number of documents, including policies and procedures related to security and MDOC's mental health provider, mental health records, incident reports, investigative reports, disciplinary reports, and training materials. We observed prisoners in various settings throughout MDOC, including in general population and restrictive housing units. We also conducted exit conferences with MDOC officials upon the conclusion of our visits to provide technical assistance during the course of the investigation.[2]

III. BACKGROUND

MDOC housed roughly 8,700 prisoners in 15 prisons in 2019.[3] It places prisoners in both general population housing units and specialized housing, which includes Restrictive Housing Units (used to punish prisoners with disciplinary infractions or hold prisoners whom MDOC determines pose an unacceptable risk to the operation of the prison) and Health Services Units (used to house prisoners needing medical treatment or mental health observation).

Prisoners with serious mental illness comprise approximately 24% (or 2,100 prisoners) of the prison population. This is an increase from about 7% (or 650 prisoners) in 2018, based mostly on Massachusetts' expanded definition of serious mental illness, which changed in an April 2018 criminal justice reform bill that went into effect on January 1, 2019. The lead sponsor of the bill wrote that the bill's purpose was to "avoid exposing people with mental illness to conditions of confinement that may make their illness more painful and debilitating."

Our investigation focused on these prisoners with serious mental illness and on MDOC's response to the mental health crises experienced by these prisoners. MDOC places prisoners in mental health crisis onto a "mental health watch." Mental health watch is a mental health status used for prisoners "whose behavior is deemed concerning enough to warrant some level of increased observation" because the prisoner (1) is actively suicidal, (2) expresses suicidal ideation, or (3) acts in a manner that indicates the potential for self-injury. 103 DOC 650.13(B)(2)-(3). When a prisoner is placed on mental health watch, MDOC removes the prisoner from his or her housing unit and places the prisoner in a suicide resistant mental health watch cell, usually located in the facility's Health Services Unit or Restrictive Housing Unit. Officers then observe the prisoner on either "constant watch" or "close observation." On "constant watch," a correctional officer is assigned to observe a prisoner on a "one-to-one" or "1:1" basis, and the prisoner must remain in full view of the correctional officer at *all* times. MDOC staff and prisoners popularly refer to the status as "eyeball watch" because the supervision is theoretically constant. "Close observation" describes a status where the officer walks by the prisoner's cell at varying 15 minute intervals. The cells are small, measuring on average 93 square feet. Access to property and interactions with others are minimal. Prisoners are often initially placed in smocks and only have access to books, radio, or recreation at the discretion of the staff, and, at most, receive a daily 10-15 minute assessment by a mental health professional, sometimes conducted through the crack in the prisoner's cell door.

[2] In July 2019, we sent a letter to Commonwealth officials about a suicide and self-harm by certain prisoners that we had learned of during our tours.

[3] As of November 2020, the prison population has fallen to roughly 7,065.

Correctional mental health watches require initially placing the prisoner in a suicide resistant cell and ensuring that the prisoner does not have the means to self-harm. In this cell placement, a prisoner also typically receives therapeutic intervention, where mental health staff assess the cause of the prisoner's crisis and work to treat underlying mental health issues. The goal is to quickly step down the prisoner to a more normal housing setting, while maintaining mental health contact. *See Rasho v. Walker*, 376 F. Supp. 3d 888, 910 (C.D. Ill. 2019) ("The purpose of crisis cells or watches in correctional mental health systems is to, first, protect individuals from self-harm or harming others, and second, to provide appropriate mental health assessment and intervention, such as re-evaluating medication, re-evaluating the psychosocial treatment and addressing whatever issues precipitated the crisis"). Restrictions placed on a prisoner facing a mental health crisis should be individually tailored to the prisoner's acuity level, should avoid unnecessarily harsh elements which could escalate the crisis, and should last no longer than necessary.

MDOC's use of mental health watch does not meet constitutional standards. MDOC does not meaningfully increase therapeutic interventions for prisoners on mental health watch, and the restrictive conditions are often not individually tailored. As a result, these conditions often last longer than necessary—sometimes for weeks or months—and in conditions that perpetuate the prisoner's crisis or even escalate it, all while the prisoner decompensates and continues to engage in self-harm. Thus, prisoners in crisis placed on MDOC's mental health watch often face a harmful experience—not a therapeutic and protective one.

The use of prolonged mental health watch is widespread in MDOC facilities. In the 13-month period between July 1, 2018 and August 31, 2019, five of the ten prisons that have mental health watch cells housed at least one prisoner on mental health watch for 180 consecutive days or longer; all but one (MCI-Shirley) housed a prisoner on mental health watch for 90 consecutive days or longer; and every facility held at least one prisoner on mental health watch for 30 consecutive days or longer. Although MDOC's policy requires mental health watches to be "no longer in duration than necessary to deal with the mental health crisis," and sets out a 96-hour goal for discharge, the majority of prisoners are kept long past that four-day goal. In fact, MDOC held 106 prisoners on mental health watches that lasted 14 consecutive days or longer between July 1, 2018 and August 31, 2019. Fifty-one of those prisoners remained on mental health watch for a month or more consecutively; 16 remained there for more than three consecutive months; and seven spent six consecutive months or more there. Again, these statistics only reflect a 13-month window. During this same 13-month period, MDOC reported that prisoners engaged in self-harm 688 times while on mental health watch – even though correctional officers are assigned to closely monitor these prisoners (to put this in perspective, in the entire DOC system, more instances of self-harm occurred while prisoners were on mental health watch than for prisoners not on mental health watch); and 103 of these incidents were severe enough to require an outside hospital trip.

IV. CONDITIONS IDENTIFIED

A. MDOC Fails to Provide Adequate Supervision to Prisoners in Mental Health Crisis and Thus Protect Prisoners from Serious Harm in Violation of the Constitution

The Department has reasonable cause to believe that MDOC has engaged in a pattern or practice of failing to protect prisoners from serious harm, or the substantial risk of serious harm,

by not adequately supervising prisoners in mental health crisis in violation of their constitutional rights. The Eighth Amendment requires prisons to "take reasonable measures to guarantee the safety" of all prisoners. *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) (quoting *Hudson v. Palmer*, 468 U.S. 517, 526-27 (1984)). When a state takes a person into custody, the Constitution imposes a corresponding duty to assume some responsibility for that person's safety and well-being. *Cty. of Sacramento v. Lewis*, 523 U.S. 833, 851 (1998) (citing *DeShaney v. Winnebago Cty. Dep't of Soc. Servs.*, 489 U.S. 199-200 (1989)). To prevail on a failure to protect claim, the Department is required to first demonstrate that a prisoner was "incarcerated under conditions posing a substantial risk of serious harm." *Farmer*, 511 U.S. at 834. Second, it must be shown that "prison officials possessed a sufficiently culpable state of mind, namely one of 'deliberate indifference' to an inmate's health or safety." *Hope v. Pelzer*, 536 U.S. 730, 738-745 (2002) (holding that prison officials show deliberate indifference where they disregard obvious risks to prisoner safety); *Burrell v. Hampshire Cnty.*, 307 F.3d 1, 8 (1st Cir. 2002) (citing *Farmer*, 511 U.S. at 834); *Penn v. Escorsio*, 764 F.3d 102, 110 (1st Cir. 2014) (quoting *Camilo-Robles v. Hoyos*, 151 F.3d 1, 7 (1st Cir. 1998)). The Constitution requires prison officials to protect prisoners from the risk of future harm, even if no prisoner has suffered actual harm when the violation is found. *See Farmer*, 511 U.S. at 845-47; *Helling v. McKinney*, 509 U.S. 25, 33 (1993) ("a remedy for unsafe conditions need not await a tragic event" and "the Eighth Amendment protects against future harms to inmates," even when the harm "might not affect all of those exposed" to the risk and even when the harm would not manifest itself immediately).

1. <u>Prisoners Face Substantial Risk of Serious Harm on Mental Health Watch When MDOC Staff Fail to Remove Instruments Used to Self-Harm</u>

Many MDOC prisoners have access to instruments they use to self-harm, or engage in self-injurious behavior, while on mental health watch. This means that many prisoners have access to these instruments of self-harm despite the fact that a correctional officer has been assigned to provide heightened supervision to a prisoner either on constant or close observation. Prisoners reported to us, and documentation confirmed, that prisoners have access to instruments such as razors, batteries, dangerous debris such as paint shards, and other items, all while on mental health watch. Some prisoners reported to us that these instruments were already in their mental health watch cells when they were transferred there, and three prisoners told us that correctional officers gave them razors specifically to self-harm. Prisoners have access to these instruments of self-harm even though the principal purpose of mental health watch is to ensure a prisoner's safety, both by preventing the prisoner from accessing instruments that could be used to self-harm, and by assigning a correctional officer to observe the prisoner.

The following examples[4] illustrate the kinds of harms experienced by prisoners on mental health watch resulting from MDOC staff failing to remove instruments used to self-harm.: These examples of preventable harms are by no means the only instances of preventable self-harm that occurred during mental health watch, but simply illustrate broader patterns. For example, between July 1, 2018 and August 31, 2019, there were 217 instances of cutting, 85

[4] In this document, we include examples of individuals' experiences to illustrate the patterns of violations we identified. When prisoners described their experiences to us in interviews, we verified those experiences with our own observations, documents, and data provided by MDOC.

instances of prisoners inserting objects into their bodies, 77 attempted hanging incidents, 34 instances of ingestion of foreign bodies, and 17 attempted asphyxiations, all on mental health watch.

- On December 16, 2019, while on constant 1:1 mental health watch at NCCI Gardner, an officer observed AA[5] "cutting himself with a razor." The injury report stated: "The injury was a laceration close to the brachial artery [and] the [patient] actually cut a vein," which necessitated care at an outside hospital. Because AA was on mental health watch, he should not have been able to access a razor. Furthermore, because he was on *constant* 1:1 mental health watch, the officer assigned to observe him one-to-one should have been able to intervene before AA cut himself so badly.
- On July 17, 2019, BB, a prisoner at Souza-Baranowski Correctional Center, had razors and a ligature while on constant 1:1 mental health watch. We learned from interviews with a doctor and nurse that three days earlier, a Licensed Practical Nurse saw BB with the razor and ligature during morning medical pass, and reported this to a correctional officer. According to records, that evening, BB still had the razor. Indeed, he was able to cut his hand so badly that he had an arterial bleed and was transported to an outside hospital. After returning from the hospital to mental health watch the next day on July 15, BB cut himself again and received sutures on-site by a physician. On July 17, BB still had a ligature and razors inserted in his rectum, which we know because MDOC staff requested that he remove these instruments as a pre-condition to meeting with us that day. A week later, while also on mental health watch, he "inserted a piece of metal belonging to the sprinkler system into his left hand and swallowed pieces of metal."
- On July 10, 2019, CC, housed at Souza-Baranowski Correctional Center, cut himself so badly that blood can be seen pooling on his cell floor in the video obtained by the Department. The video captures correctional officers standing outside his cell door without intervening for 45 minutes – while he is on constant 1:1 mental health watch – before he is finally transported to an outside hospital. The video shows that at 1:47 a.m., CC cut his arm by the sink while facing away from the camera. Meanwhile, the officer assigned to this watch appears slumped in his chair outside the cell, possibly writing something down or talking to another officer, but not watching CC. At 1:50 a.m., CC's blood begins to drip all over his cell. Only at 1:51 a.m. does the officer notice, and at that point, he appears to watch CC bleed without any further action. Two additional staff walk up to CC's cell at 1:57 a.m., where there is blood on the floor. After exchanging words with him, the two staff leave at 1:59 a.m., and the watch officer returns to his seat across from the door. At 2:05 a.m., another officer (possibly one of the staff that walked by at 1:57 a.m.) looks into CC's cell and possibly exchanges words with him. A minute later, the officer shrugs and walks away. At 2:18 a.m., CC can be seen motioning and attempting to cut himself while attempting to hide from view of the officer. Five minutes later, CC blocks the window with his mattress, which prompts a greater response, and several officers arrive. The video from inside his cell shows CC continuing to cut his arm until 2:23 a.m., with blood actively spraying throughout the cell at 2:35 a.m., at which time he removes the mattress from blocking the door. He slumps back against the wall, and is cuffed through the slot in the cell door. Staff do not intervene to take CC out

[5] To protect the identity of prisoners, we use coded initials.

of his cell until 2:37 a.m., approximately 45 minutes after an officer became aware of the cutting.

Incident reports merely stated: "CC then continued to manipulate the wound with his fingers which caused further bleeding . . . . Several attempts were made by Security and medical staff to get CC to the trauma room to be treated again. . . . He then complied with orders to be placed in restraints. Medical evaluated him and sent him to [an outside hospital] for further treatment." During the next month, CC cut himself two more times while on mental health watch.

- On July 4, 2019, DD, while on mental health watch at Souza-Baranowski Correctional Center, cut himself to the point where "blood was coming from under the cell door." The clinical nursing assistant described seeing a "significant amount of blood on and around" him and that he "was not breathing without stimulation." The next day, still on mental health watch, and this time on constant 1:1 watch, DD "accessed a blade and began cutting his neck and ankle," and was "bleeding profusely from his neck and legs" as described by one officer. Two weeks later, again while on constant 1:1 watch, an officer observed him "produce[] a razor and beg[i]n to cut his throat and chest areas."

  Two months later, in September 2019, DD was housed in a new facility, NCCI Gardner, but was still able to self-harm while on mental health watch. On September 18, 2019, he "utilized a razor blade to make multiple cuts to his neck." Two months later, yet again, he was able to self-harm under mental health watch: On December 16, 2019, while on 1:1 mental health watch, DD cut his neck with a razor for the second time on the same day in the same area. MDOC staff told us that DD is talented at releasing large amounts of blood from his body before staff realize that he has self-injured; however, DD told us that correctional officers observe him "bloodletting" and do not care, making callous remarks such as, "not good enough," intimating that he needs to engage in more serious self-harm before they will call for medical attention.

- On June 18, 2019, EE was on a constant 1:1 watch at MCI-Cedar Junction after he swallowed a battery. Though the correctional officer assigned to his constant watch should have been on alert to retrieve the battery after EE passed it, during a DOJ interview with EE, EE held the battery up to show it to DOJ staff, while the correctional officer did nothing to try to confiscate it.

- On April 22, 2019, FF, while on mental health watch at MCI-Norfolk, was observed by an officer "us[ing] a razor blade to self-inflict injuries to his right wrist area as well as his left forearm." Less than two weeks later, while on constant 1:1 mental health watch, security staff saw him engaging in self-injurious behavior with an unknown object, believed to be a razor blade. The medical provider came on-site to provide seven sutures and dress the wound, as reported in the injury report.

- On March 12, 2019, an officer observed GG inserting a piece of a razor blade in his left eye while on constant 1:1 mental health watch at Souza-Baranowski Correctional Center. A month and a half later, on April 30, 2019, again on constant 1:1 watch, an officer watched him insert "a thin wire object," which he said was a paper clip, into his penis. Three days later, still on constant 1:1 watch, an officer observed him "insert what appeared to be a razor blade into his lower left eye lid." The next day, still on constant

1:1 watch, an officer observed GG extract a piece of a razor from his penis, which he then used to cut his wrist.

- Between January 24, 2019 and May 15, 2019 at MCI-Norfolk, HH cut himself with debris, reported to be paint chips,[6] on at least 15 separate days, all while on mental health watch. Seven of the cuttings occurred while he was on constant 1:1 watch and five while on 15-minute watch (three were unclear from the records). Separately, on ten additional days during that same time period on mental health watch, he self-harmed in some other way. While it was unclear from the records the exact nature of the self-harm, nine of the ten incident reports for these incidents used words such as "cut," "bleeding," "laceration," or "cut with an unknown object." MCI-Norfolk's mental health watch cells were repaired after the Department raised concerns about the conditions of the cells and prisoners' ability to self-harm using paint chips on May 3, 2019. Notably, after mid-May, MDOC's incident reports show no instance of HH using paint chips to self-injure.

2. MDOC's Lack of Policies and Inadequate Officer Training Contribute to Inadequate Supervision for Prisoners in Mental Health Crisis

A correctional officer's failure to take preventative action despite knowing that "a substantial risk of serious harm would befall" the prisoner demonstrates deliberate indifference. *See Penn v. Escorsio*, 764 F.3d 102, 108-10 (1st Cir. 2014) (holding that a correctional officer failing to take any preventative action despite a prisoner's repeated threats of self-harm could constitute deliberate indifference); *see also Elliot v. Cheshire Cnty., N.H.*, 940 F.2d 7, 10-11 (1st Cir. 1991) (finding that prison officials could be deliberately indifferent if they knew that a prisoner presented a significant risk of suicide but failed to respond reasonably); *Torraco v. Maloney*, 923 F.2d 231, 235 (1st Cir. 1991) (holding that failure to respond to a prisoner's known suicidal tendencies can constitute deliberate indifference); *Cortes-Quinones v. Jimenez-Nettleship*, 842 F.2d 556, 558 (1st Cir. 1988) (internal citations omitted) (holding that deliberate indifference "encompasses acts or omissions so dangerous (in respect to health or safety) that a [prison guard's] knowledge of a large risk can be inferred"). MDOC's correctional officers fail to intervene or act in situations where their primary job is to "observe" and intervene to prevent prisoners who are on mental health watch from self-harm.

In part, prisoner self-harm occurs because MDOC lacks uniform, clear, and detailed policies to govern the operation of mental health watches, specifically with respect to both the access to instruments of self-harm and the monitoring of foreign body ingestion while on mental health watch. Records document that many prisoners had access to instruments used to self-harm while on mental health watch, but no clear policy or guidelines dictate how MDOC staff should retrieve those items to prevent future incidences of self-harm. Because of the rampant use of razors to commit acts of self-harm while on constant 1:1 mental health watch, Souza-Baranowski Correctional Center stopped selling razors as of December 1, 2019. MDOC previously eliminated razors at Old Colony Correctional Center and MCI-Framingham. While these are positive initial measures to address self-harm, we are not aware of formal guidelines governing how MDOC officers should remove instruments of self-harm from individuals on mental health watch, and/or how to appropriately search a mental health watch cell both before a prisoner is placed into the cell and while the prisoner is confined to the cell to ensure that

[6] MDOC told us that the prisoner did not use paint chips, but rather clear epoxy finish from the floors and fiberglass material from the corner of the bed.

prisoners cannot access harmful instruments. Many prisoners told us, and records confirmed, that because correctional officers conduct such a cursory inspection, prisoners can smuggle razors or other instruments of self-harm into mental health watch cells by hiding them between their gums and teeth.

Although MDOC's mental health provider, Wellpath, has a policy on "Ingestion of Drugs or Foreign Body," the guidelines are vague and not followed. The policy states that "[a]ny patient who is placed on a security watch for retrieval of evidence after reporting alleged ingestion of drugs and/or foreign body shall be medically monitored as ordered by the Wellpath provider," and that the "patient shall be monitored until the foreign body has been passed and the patient is medically and mentally stable." Interviews with MDOC staff and prisoners confirmed that prior to or during a prisoner's stay on mental health watch, MDOC inconsistently uses body scanners to determine whether prisoners hide instruments of self-harm in or on their person. We reviewed multiple records where prisoners passed a foreign body on mental health watch only to use it to self-harm again.

The minimal coordination between the mental health and security staff allows for gaps in prisoner care and inconsistencies in ensuring that prisoners are adequately supervised and protected from engaging in self-harm. At the housing unit level, security staff and mental health staff each report through separate chains of command, which makes it difficult to effectively communicate and coordinate about a prisoner's well-being and to effectively prevent self-harm. For example, mental health staff were not aware of the foreign body retrieval policy and stated that that was an area under the security staff's purview. Security staff do not always know why mental health staff place a prisoner onto mental health watch, or what happened to a prisoner while on mental health watch, which would be important information to monitor once the prisoner returns to his regular housing unit.

Additionally, the lack of training for security staff contributes to the harms experienced by prisoners in mental health crisis. Correctional officers receive no training tailored specifically to the unique needs of a mental health watch assignment, be it a constant 1:1 or a close observation. Based on interviews with security staff, we learned that any officer can be assigned to mental health watch, and that, in practice, junior officers without seniority get assigned to this post, because it is considered an undesirable posting. *See e.g., Cox v. Massachusetts Dep't of Corr.*, 18 F. Supp. 3d 38, 48 (D. Mass. 2014) (finding a basis for Eighth Amendment liability where the prison officials were alleged to have "some official responsibility for policies, procedures, and training that led to plaintiff's injury and subjective knowledge of the danger to his safety"); *Chao v. Ballista*, 806 F. Supp. 2d 358, 382 (D. Mass. 2011) ("Prison officials have the duty to protect their inmates by training and supervising guards….")

We understand that our investigation has prompted MDOC to begin implementing some reforms. For example, in September 2019, MDOC began to hold bi-weekly self-injurious behavior team meetings at its headquarters to discuss the histories of prisoners who regularly self-harm and to work on developing interventions that might abate acts of self-harm. In November and December 2019, MDOC also provided additional training to staff, including officers in mental health housing units and those interacting with prisoners in crisis. We commend MDOC for taking action to begin curbing these long-standing issues that have contributed to so many prisoner harms. We also understand that MDOC is investigating other methods of making mental health watch safer, including using special thin "jumpers" that cover the entire body and prevent prisoners from retrieving and reinjecting contraband from and into

their bodies; using narrower blankets that provide sufficient privacy while simultaneously preventing a prisoner from covering his entire person; using edible spoons that dissolve if ingested or inserted; and using secondary door shields and door sweeps to prevent the transfer of contraband under cell doors.

3. <u>MDOC Officials Knew About the Mental Health Watch Risks to Prisoner Health and Safety Due to Inadequate Supervision and Disregarded Them</u>

MDOC officials are on notice about the substantial risk of serious harm facing prisoners on mental health watch in the following ways, and still do not provide adequate supervision to protect prisoners in crisis from harm. First, MDOC officials are on notice of the substantial risk of harm a prisoner faces each time an act of self-harm occurs during a mental health watch stay. Yet, on numerous occasions summarized in Section IV.A.1. above, prisoners repeatedly harmed themselves, frequently using the same instrument or method of self-harm, and often within the span of just a few days. By definition, prisoners on "constant 1:1 watch" are meant to be carefully and *constantly* observed so that they do not have access to instruments used to self-harm, much less harm themselves repeatedly. In each of these instances, despite being put on notice that the prisoner is at risk to harm himself on mental health watch, MDOC did not retrieve the items of self-harm or appropriately protect the prisoners from further injury.

Second, correctional officers assigned to constant 1:1 mental health watch fall asleep when they are supposed to supervise prisoners they know are in a mental health crisis and at acute risk of self-harm. *See e.g*., *Beaulieu v. Hanks*, 2019 WL 7039619, at *4-5 (D.N.H. Nov. 19, 2019) (holding that "sleeping on the job" can constitute deliberate indifference if there is a known risk of serious harm to a prisoner and the correctional officer falls asleep instead of monitoring the prisoner). Prisoners regularly report that correctional officers fall asleep while assigned to constant watch posts, particularly during the shift from 11 p.m. to 7 a.m. MDOC has been on notice of this challenging issue. When we talked to a Deputy Superintendent at one facility about whether he had ever heard of correctional officers falling asleep while assigned to 1:1 posts, he stated that he had heard of that and that those incidents were investigated and staff were disciplined accordingly. He also stated that because of staff shortage issues and a limited pool of available officers who could be on the nighttime constant observation assignment, even officers who had been disciplined for falling asleep on the job might still be assigned to a nighttime constant observation post. In a 2017 internal affairs investigation related to a MDOC prisoner who died while on constant 1:1 watch, investigators determined that a mental health worker had a hard time staying awake during his 1:1 assignment, and quite possibly fell asleep because video showed him resting his head against the wall, on his forearm, along with periods of having his eyes closed. Prisoner II recalled a time while on mental health watch when he saw the former superintendent of the facility wake up a sleeping correctional officer without reprimanding him.

Third, some correctional officers consciously refuse to call for medical attention or purposefully delay making such a call, which shows a deliberate indifference to the substantial risk of harm prisoners face. *See e.g., Perry v. Roy*, 782 F.3d 73 (1st Cir. 2015) (holding that a reasonable jury could find that delaying bringing a patient to the hospital for 17 hours after suffering a broken jaw from a severe beating by officers could be "deliberate indifference"); *Lemire v. California*, 726 F.3d 1062 (9th Cir. 2013) (delay of calling medical assistance from knowledge that prisoner was found unconscious at 3:10 and 3:30 a.m. until 3:40 a.m. combined with failure to provide CPR and other life-saving methods until arrival of medical personal could

be deliberate indifference); *Olson v. Bloomberg*, 339 F.3d 730, 738 (8th Cir. 2003) (affirming denial of summary judgment in favor of plaintiff and finding Eighth Amendment violation if guard intentionally delayed providing assistance, told prisoner "do what you have to do" and left him alone after hearing of his intention to commit suicide). In Section IV.A.1 above, we described the incident involving CC in which an officer delayed intervening for 45 minutes after he became aware of CC cutting his body so badly that blood pooled on the floor. JJ, a prisoner at Old Colony Correctional Center reported to our expert that while on mental health watch, an officer said to him, "I know that you are bleeding, but when I finish my lunch I will call in a code." KK, a Souza-Baranowski prisoner, reported that a correctional officer once told him, "When you're done cutting, let me know."

Finally, prisoners have reported that correctional officers actively taunt and encourage them to harm themselves, which, if true, also evidences an Eighth Amendment deliberate indifference to prisoners' risk of harm. *See Torraco v. Maloney*, 923 F.2d 231, 235 (1st Cir. 1991) (recognizing that deliberate indifference to known suicidal tendencies could constitute an Eighth Amendment violation); *Jordan v. Gardner*, 986 F.2d 1521, 1530–31 (9th Cir. 1993) (en banc) (finding that psychological harm inflicted on psychologically vulnerable prisoners violated the Eighth Amendment); *Barros v. Claytor*, 2010 WL 2292173, at *3 (D. Mass. June 7, 2010) (citing *Jordan*, 986 F.2d at 1526) (holding that correctional officers may violate prisoners' constitutional rights by intentionally inflicting psychological harm). Multiple prisoners reported to us that correctional officers verbally taunt them and encourage them to self-harm. For example, BB told us, "I'm able to cut on mental health watch because [correctional officers] let me do it. They say, 'You can do better.'"

B. MDOC Fails to Provide Adequate Mental Health Care to Prisoners in Mental Health Crisis in Violation of the Constitution

Prisoners do not receive adequate mental health care while on mental health watch. *See Torraco*, 923 F.2d at 234 (recognizing that in addition to medical needs, "the eighth amendment also protects against deliberate indifference to an inmate's serious mental health and safety needs"). Deprivations of mental health care violate the Eighth Amendment if they are sufficiently serious and if the prison official was deliberately indifferent to prisoner health or safety. *Wilson v. Seiter*, 501 U.S. 294, 298 (1991). Courts have emphasized the critical importance of adequate mental health care for prisoners experiencing a mental health crisis and who are placed on a crisis watch with restrictive housing conditions because it is precisely during these crises and in these conditions when prisoners need treatment the most. *See, e.g., Rasho v. Walker*, 376 F. Supp. 3d 888, 910 (C.D. Ill. 2019) ("[I]nmates who are on crisis watch [in Illinois prisons] are in isolation and additional care is necessary to avoid exacerbating their mental health issues."); *Braggs v. Dunn*, 257 F. Supp. 3d 1171, 1219 (M.D. Ala. 2017) ("Identification, treatment, and monitoring of those who have heightened suicide risks are important because they provide the last safety net before the worst possible outcome in mental-health care: suicide").

1. Prisoners on Mental Health Watch Have Serious Mental Health Needs Requiring Treatment

Prisoners experiencing a mental health crisis have serious mental health needs requiring treatment. These prisoners are at serious risk of harm if their needs are not adequately addressed. A medical need is sufficiently serious if it has been "diagnosed by a physician as mandating treatment" or is "so obvious that even a lay person would easily recognize the necessity for a

doctor's attention." *Gaudrealt v. Municipality of Salem, Mass.*, 923 F.2d 203, 208 (1st Cir. 1990). In MDOC, mental health staff determine that a prisoner is in crisis, "regardless of the inmate's mental health diagnosis," if the prisoner is actively suicidal, expresses suicidal ideation, or acts in a manner that indicates the potential for self-injury and "warrant[s] some level of increased observation" on mental health watch. Thus, all prisoners placed on mental health watch are identified by MDOC mental health staff as having serious mental health needs. Each year, MDOC staff determine that hundreds of prisoners require mental health watch. For instance, between July 1, 2018 and August 31, 2019, DOC placed 916 prisoners on mental health watch.

2. Prisoners on Mental Health Watch Receive Inadequate Mental Health Care

Among the areas courts have identified as "basic, essentially common sense, components of a minimally adequate prison mental health care delivery system," three are particularly relevant: (1) "a basic program for the identification, treatment, and supervision of inmates with suicidal tendencies;" (2) "treatment must entail more than segregation and close supervision of the inmate patients;" and (3) "treatment requires participation of trained mental health professionals, who must be employed in sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders." *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *rev'd in part on other grounds*, 679 F.2d 1115 (5th Cir. 1982). *See also Braggs*, 257 F. Supp. at 1206 n.34; *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 n.10 (E.D. Cal. 1995); *Balla v. Idaho State Bd. of Corr.*, 595 F. Supp. 1558, 1577 (D. Idaho 1984).

While courts require treatment to consist of "more than segregation," MDOC's mental health watch—its program for treating and supervising prisoners with suicidal tendencies—is not "more than segregation." Treatment interventions, such as "counseling, group therapy, individual psychotherapy, or … therapeutic activities," are not provided to prisoners on MDOC's mental health watch. *See Ruiz*, 503 F. Supp. at 1332. One critical "purpose of crisis cells or watches in correctional mental health systems is . . . to provide appropriate mental health assessment and intervention, such as re-evaluating medication, re-evaluating the psychosocial treatment, and addressing whatever issues precipitated the crisis." *Rasho*, 376 F. Supp. at 910. Both mental health staff and prisoners told us that prisoners on mental health watch are supposed to have a daily encounter with a mental health professional to assess the prisoner's "suicide risk" and "level of observation." We were told consistently, however, that this encounter occurs only in the morning and if a prisoner, for any reason, does not meet with the clinician in the morning, he must wait 24 hours before his next opportunity.

Further, by policy, these assessments are supposed to occur out-of-cell "[a]s a matter of routine." Yet staff and prisoners told us that, more routinely, prisoners were assessed through the crack in their cell door because of space, time, or security staffing constraints needed to move the prisoner. When the assessment is done cell-side, privacy and confidentiality are jeopardized. Prisoners told us that they are rarely assessed by their regular clinician because the mental health watch cells are monitored by a specific group of clinicians, which presents a barrier to maintaining and developing therapeutic relationships. Even when the assessment does occur out-of-cell, and even when it is conducted by a known clinician, little therapeutic treatment occurs. Staff told us that the purpose of the assessment encounter is to assess the prisoner's suicidality and not to provide individual therapy. When we interviewed prisoners on mental health watch, they consistently told us that no individual or group therapy is offered. At most,

they might receive a brief, often 5-10 minute, meeting with a clinician. As one prisoner, LL, told us: "There is no real help [on mental health watch]. They just keep me in a cell by myself until I say I won't hurt myself anymore then they let me go. [But] there's no therapy."

MDOC's insufficient number of mental health professionals contributes to the inability to provide adequate therapeutic treatment to prisoners on mental health watch. "[T]reatment requires the participation of trained mental health professionals, who must be employed in sufficient numbers to identify and treat in an individualized manner those treatable prisoners suffering from serious mental disorders." *Ruiz*, 503 F. Supp. at 1339. In January 2019, the number of prisoners with serious mental illness in MDOC increased overnight by 300% – from about 650 to more than 2,000 – because new Massachusetts legislation expanded the definition of serious mental illness. Yet, mental health staffing levels remain substantially unchanged. Prisoners diagnosed with serious mental illness require increased contacts and interventions. Thus, according to one mental health staff member, although the same number of prisoners are on medications, mental health staff are asked to engage in more clinical contacts and interventions with the same number of staff.

MDOC's failure to provide adequate mental health care to prisoners in mental health crisis results in serious harms, such as in these examples:

- GG self-harms when in isolated conditions like those of mental health watch, but stabilizes in non-isolated settings where he can engage in therapy and treatment. Even though the mental health watch setting was itself a trigger for GG to engage in self-harm, MDOC continued to place him on prolonged mental health watches in response to his self-harm, ensuring that self-harm would continue. For example, on June 12, 2019 at Souza-Baranowski Correctional Center, GG inserted a piece of a razor into each eye and his urethra while on constant 1:1 mental health watch. In the preceding five months, all spent on mental health watch, he harmed himself more than a dozen times, including: inserting a piece of a razor blade into his left eye; inserting a paperclip in his penis, and swallowing approximately 15 pills from his medications—all while on a constant 1:1 watch. Nearly all of these incidents required treatment at a hospital. On May 29, he was released from mental health watch and the next night, in his restrictive housing cell, he reported inserting two plastic spoon handles and one whole spoon in his penis after dinner the night before. Four days later, he told a psychiatrist: "When my clorazil was higher, the voices were less. I wake up every night of the week with nightmares, when I was getting molested when I was young and I'm hurting people too, which isn't me. I keep wanting to hurt myself… ." When we met him a month and a half later, he was back on mental health watch – having been there for nearly all of the previous six months – and told us: "It's hard being locked down all the time;" and that he hurts himself because "the pain takes the voices away."

  He also told us that he wished that the mental health care he received on mental health watch was like the care he received at Bridgewater State Hospital. Tellingly, in contrast to his six-month cycle of mental health watch and self-harm at Souza-Baranowski, when he was previously committed to Bridgewater State Hospital's mental health unit located at Old Colony Correctional Center, GG had no incidents of self-harm for nearly 30 days, participated in mental health group sessions, wrote in a journal, played cards, had access

to a Walkman, and became medication compliant.[7] These type of therapeutic activities are not offered on MDOC's mental health watch.

Months after we met him, he was again on mental health watch and continuing to harm himself.: On September 7, 2019, while on constant 1:1 mental health watch, GG inserted a spoon into his urethra and was taken to a hospital.

- MM experiences suicidal ideation triggered by mental health watch, yet MDOC's response to her self-harm is to keep her on prolonged mental health watches, causing further decompensation. On March 3, 2019 at MCI-Framingham, she attempted suicide while on mental health watch by tying her bra around her neck. This incident occurred on her ninth consecutive day of mental health watch, where she remained for another 19 days. Six days earlier, a mental health clinician noted that MM was experiencing paranoia and hallucinations. The day following her attempted suicide, she reported ongoing suicidal ideation, increased depression, hopelessness, and auditory hallucinations telling her to kill herself, and stated that mental health watch was not addressing her mental health needs. The next day, March 5, she told a mental health clinician: "I really can't stop the voices[, t]hey really are telling me to hurt myself and it's getting worse and worse." Then on March 17, MM engaged in self-harm by banging her head repeatedly.

  Notably, four months earlier, MM told mental health staff that "she was going downhill" as a result of mental health watch and that the climate on mental health watch may have contributed to her psychiatric hospitalization. Despite this warning, MDOC placed MM back on mental health watch on February 23. After her suicide attempt on March 3, MM again told mental health staff that her mental health watch placement "increase[ed] [her] anxiety and 'voices' which increased [her] suicidal ideation and led to her suicide attempt."

- NN fixates on self-harm while on mental health watch because the isolated conditions exacerbate her auditory hallucinations, yet MDOC's response to her self-harm is continued placement on mental health watch. Between September and November 2018 at MCI-Framingham, she was treated at an outside hospital five times, all for injuries to herself while on mental health watch. The first occurred when she was observed by staff "bang[ing] her head hard[] against the wall" after telling them she wanted her auditory hallucinations to go away. Four days later, she told staff: "I just try to ignore [the voices] but it's hard when I have nothing to do, could I have a book or something?" For the next few weeks, she continued to harm herself by swallowing a rock and plexiglass, and tying ligatures around her neck.

  On November 6, she told a clinician that "[mental health watch] check-ins are 'counterproductive,'" and that "sometimes I just need to talk out my urges but I am afraid I will get in trouble for being honest…it will get me upgraded to eyeball watch." The clinician took note: "Client stated [mental health watch] is not real psych treatment,' noting being in her cell most of the day." A week later, NN lost consciousness while on

[7] This Bridgewater State Hospital mental health unit, called the Intensive Stabilization and Observation Unit (ISOU), also places prisoners on mental health watch status; however, its use of mental health watch is different than MDOC's mental health watches. In the ISOU, when a prisoner is on mental health watch status, he is out-of-cell in the dayroom participating in therapeutic activities accompanied by a Recovery Treatment Assistant to monitor him, deescalate problems, encourage medication compliance, and interact with him.

mental health watch in front of staff after she swallowed a portion of an EKG lead she obtained during an outside hospital visit four days earlier. After being transferred to an outside hospital for medical care, she returned to the same mental health watch cell, where she again engaged in self-harm by "head banging." Three days later, while on a constant 1:1 watch, she was again found unresponsive after ingesting an EKG pad from another outside hospital visit. After two months of this cycle of harm, prison officials committed her to a higher level of mental health care through the commitment process.

- OO experiences depression when on mental health watch, and his depression exacerbates his desire to self-harm. His depression is only improved by engagement with treatment that he is unable to receive while on mental health watch, making it difficult for him to leave mental health watch once on it. Between July 2018 and September 2018, while at MCI-Norfolk, he spent 74 consecutive days on mental health watch.[8] Mental health staff repeatedly documented that his depression is significantly improved with medications and engagement, including group therapy, and that his self-harm is a feature of, and worsened by, depressive episodes. OO's mental health treatment is significantly disrupted when he is placed on a mental health watch, in part because he often becomes non-compliant with medication on watch. Therapeutic engagement, such as group therapy, is unavailable for prisoners on mental health watch, and this lack of treatment results in medication non-compliance in OO's case. This isolation often results in further depression.

C. MDOC's Use of Prolonged Mental Health Watch Under Restrictive Housing Conditions, Including the Failure to Provide Adequate Mental Health Care, Violates the Constitutional Rights of Prisoners in Mental Health Crisis

MDOC's use of mental health watch is restrictive housing, and its prolonged use violates the constitutional rights of prisoners in mental health crisis. The restrictive conditions – including the stark physical conditions, the isolating and unnecessarily harsh approach to mental health watch, and the prolonged length of time prisoners spend on mental health watch – subject prisoners to a substantial risk of serious harm. MDOC's use of mental health watch also fails to provide prisoners with adequate mental health care at the precise time they most need it. This combination of conditions, including inadequate mental health care, provides reasonable cause to believe that MDOC's use of mental health watch for prisoners experiencing a mental health crisis is resulting in serious harm, or substantial risk of serious harm, and violating prisoners' rights under the Eighth Amendment because MDOC officials know of the serious harms and are disregarding them.

1. MDOC's Use of Mental Health Watch Is Restrictive Housing

Although MDOC excludes mental health watch from its institutional definition of "restrictive housing,"[9] its use of mental health watch functions, in all but name, as restrictive

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[8] MDOC provided data that show he was on mental health watch for 525 consecutive days, from April 6, 2017 to September 13, 2018. To maintain consistency with only reviewing prisoner records for the 13-month time period between July 2018 and August 2019, we did not review his record from April 6, 2017 to July 1, 2018.

[9] MDOC defines "Restrictive Housing" as: "A placement that requires an inmate to be confined to a cell for at least 22 hours per day for the safe and secure operation of the facility. … Restrictive Housing shall not include … the placement of an inmate on mental health watch." 103 CMR 423.06. The legislation creating this definition stated:

housing because prisoners there are confined alone in their cells, typically for 23 hours or more, under restrictive and isolating conditions.

MDOC has approximately 88 mental health watch cells, spread across 11 facilities. The physical conditions of the cells are stark, measuring on average 93 square feet,[10] and most have only a combination metal sink and toilet and a bed frame with a mattress (although some do not have a bed frame). Some also have a desk and stool. Windows and doors in the cells vary in the different facilities, but most mental health watch cells that we visited had small windows at the back of the cell (although it was often fogged to allow light in but to prohibit prisoners from seeing outside). Most of the cells have solid metal doors with narrow slots at waist level, wide enough for food trays to pass through, and small foggy, plexiglass windows facing into the hallway. Some doors had larger plexiglass windows for greater staff observation.

Prisoners on mental health watch experience isolating conditions. Prisoners generally experience limited social interaction – with other prisoners, officers, or mental health staff – and they experience restrictions on other forms of stimulation, such as recreation. A prisoner on mental health watch is housed alone and has no interactions with other prisoners unless he yells through the crack in his cell door. Officers are required to either observe the prisoner one-on-one through his cell window (constant observation or constant 1:1 watch) or walk by his cell at varying 15 minute intervals (close observation). Despite their proximity, both officers and prisoners consistently told us that officers do not interact with prisoners while observing them. Mental health staff also have limited interactions with prisoners on mental health watch. Both mental health staff and prisoners told us that prisoners on mental health watch are supposed to have a daily mental health encounter to assess the prisoner's "suicide risk" and "level of observation." While prisoners sometimes come out of their cell to have their level of suicidality assessed in a small room, staff and prisoners told us that more often prisoners were assessed for, at most, 5-10 minutes through the crack in their cell door. One prisoner, PP, described this lack of a therapeutic environment: "There's nothing therapeutic about [mental health watch]…. it's basically solitary [confinement]. At least at [the state psychiatric hospital], they actually have mental health [staff] and psychiatrists coming around and talking with you [and] you actually get a magazine, a Walkman, crayons, and get out of your cell for things to do."

While policy dictates that prisoners on mental health watch should have routine access to recreation, staff and prisoners told us that prisoners were usually denied recreation because of security concerns or staffing deficiencies. The recreation policy contains provisions that allow denials for such reasons, but rather than the exception to the rule, these denials appear to be the norm. In interviewing prisoners on-site and reviewing prisoner records, our experts consistently found that prisoners did not have access to recreation. With no access to recreation and little to no out-of-cell time for mental health treatment, prisoners spend nearly all hours of their day in their cells. Prisoners told us and our experts that when on mental health watch, they rarely have access to reading materials, phone calls, in-cell music, or tablets, and therefore are in conditions

"'Restrictive Housing', a housing placement where a prisoner is confined to a cell for more than 22 hours per day; provided, however, that observation for mental health evaluation shall not be considered restrictive housing." Massachusetts Senate Bill 2371, Section 87 (2018). The legislature's decision to exclude mental health units from the definition of "restrictive housing" does not make it so.

[10] The cells varied in size from 66.5 to 160 square feet. Sixty-five of the 88 cells measured less than 85 square feet.

more austere than MDOC's other restrictive housing units, where prisoners can have access to these items.

Prisoners on mental health watch also experience unnecessarily harsh conditions. One MDOC psychiatrist expressed concern that MDOC's typical practice of escorting prisoners on mental health watch to an out-of-cell encounter in leg shackles and handcuffs (often behind their back) was anti-therapeutic, and constrained their ability to provide meaningful mental health treatment when a prisoner must sit for sessions in such uncomfortable restraints. Clothing is also often restricted and our experts observed prisoners in security smocks past the time it was clinically necessary. Prisoners told us that not having their own clothing when they should be deemed clinically safe made them feel inhuman.

In sum, because of the restrictive, isolating, and unnecessarily harsh conditions, MDOC's mental health watch is restrictive housing.

2. MDOC's Prolonged Use of Mental Health Watch Under Restrictive Housing Conditions Subjects Prisoners in Mental Health Crisis to a Substantial Risk of Serious Harm

MDOC's prolonged use of mental health watch under restrictive housing conditions, including the inadequate mental health care described above, subjects prisoners who are in mental health crisis to serious harm, or a substantial risk of serious harm, and shows deliberate indifference to their health and safety in violation of the Eighth Amendment.[11] *See Palakovic v. Wetzel*, 854 F.3d 209, 216-17, 225-26, 230 (3d Cir. 2017) (holding that a prisoner with serious mental illness who was held in a 100 square foot restrictive housing cell approximately 23 hours a day for "multiple 30-day stints," and who received only mental health interviews through his cell door slot stated a plausible Eighth Amendment claim "in light of the increasingly obvious reality that extended stays in solitary confinement can cause serious damage to mental health"). The Third Circuit has acknowledged the "robust body of legal and scientific authority recognizing the devastating mental health consequences caused by long-term isolation" including "anxiety, panic, paranoia, depression, post-traumatic stress disorder, psychosis, and even a disintegration of the basic sense of self-identity," as well as physical harm such as "suicide and self-mutilation." *Id.* at 225-26. *See also United States v. Lopez*, 327 F. Supp. 2d 138, 143 (D.P.R. 2004) (recognizing the harmful effects that continued restrictive confinement has on a prisoner's "psyche" and citing five supporting court decisions); *Braggs v. Dunn*, 367 F. Supp. 3d 1340, 1345 (M.D. Ala. 2019) (noting that "overwhelming research shows that prolonged

[11] The First Circuit has not addressed the constitutionality of conditions similar to those in MDOC's mental health watches. *But see Jackson v. Meachum*, 699 F.2d 578, 583-85 (1st Cir. 1983) (distinguishable because, as the court acknowledged, "the current state of the law" – nearly four decades ago – had not found prolonged restrictive housing for prisoners with mental illness to violate the Eighth Amendment, but also suggesting that in the future prisoners may have a "constitutional right to preventive therapy where psychological deterioration threatens" and that "the threat of substantial, serious and possibly irreversible if not critical psychological illness together with prolonged or indefinite segregated confinement would increase the burden on prison authorities to explore feasible alternative custodial arrangements"); *Morris v. Travisono*, 499 F. Supp. 149, 160 (D.R.I. 1980) (ruling on a due process rather than Eighth Amendment claim, nonetheless noting that "[e]ven if a person is confined to an air conditioned suite at the Waldorf Astoria, denial of meaningful human contact for… an extended period of time may very well cause severe psychological injury").

isolation has gravely detrimental effects on mental health, especially for those with existing mental illness").

MDOC's use of mental health watch for prolonged periods of time subjects those prisoners experiencing mental health crises to a substantial risk of serious harm. Although MDOC's policy requires mental health watches to be "no longer in duration than necessary to deal with the mental health crisis," and sets out a 96-hour goal for discharge, the majority of prisoners are kept long past that four-day goal. In fact, MDOC held 106 prisoners on mental health watches that lasted 14 consecutive days or longer during a 13-month period between July 1, 2018 and August 31, 2019.[12] Fifty-one of those prisoners remained on mental health watch for a month or more consecutively; 16 remained there for more than three consecutive months; and seven spent six consecutive months or more there. Because these prisoners are already experiencing a mental health crisis, 14 days in the restrictive conditions described above subjects them to a substantial risk of serious harm. *See Rasho v. Walker*, 376 F. Supp. 3d 888, 910-11 (C.D. Ill. 2019) (referring to an Illinois DOC settlement agreement which required that prisoners should be on "crisis watch" in restrictive housing for "generally no longer than ten (10) days unless clinically indicated." Below are examples of prisoners who spent months in a row on mental health watch in restrictive housing during the 13-month period we examined and the resulting serious harm that occurred during those prolonged stays:

- QQ spent 352 consecutive days on constant 1:1 mental health watch at MCI-Cedar Junction between August 2018 and August 2019. When we interviewed him in June 2019, he told us that he had been in some form of restrictive housing/mental health watch for 11 years and during that time had only been to outside recreation six times. MDOC's records did not enable us to confirm the duration, but one MDOC official told our expert that 11 years "sounded about right." On July 5, 2019, QQ asked a security officer for "a piece of sheet so he could hang himself." He then told another officer that he "[did] not feel right in the head," and "claim[ed] not to know what he [was] doing … [but] in the same breath claimed he [was] getting out of [constant 1:1 watch] one way or another." An hour and a half later, a third officer watched QQ bang his head against his cell door repeatedly and drink his own urine. Fifteen minutes later, a fourth officer "witness[ed] [QQ] eating what appeared to be his own fecal matter on a Styrofoam tray." Twelve days later, QQ told a mental health clinician that he did not know why he ate his own feces and urine but compared himself to a gorilla, and said that "people think that he is 'mentally strong' but that 'being in a cell 24 hours a day for 14 years' has had an impact on him." That clinician also wrote that QQ "appear[ed] tearful when discussing certain topics." Five days later, on his 50th birthday, an officer watched QQ "take the phone cord he was using to make an attorney phone call and wrap it around his neck in an attempt to commit suicide." During our interview, QQ told us he has had no access to television or radio and little property and that he has been under these conditions for multiple years. MDOC officials maintain that QQ is dangerous and warrants strict security precautions. While we do not underestimate the security precautions needed to manage QQ, we note that no behavior management plan exists to assist MDOC staff to

[12] We believe this number is a substantial undercount. When we reviewed individual prisoner records, we identified mental health watch stays with longer durations than were captured in the data provided by MDOC.

advance him to a more normalized housing experience, or one that would at least take him out of such extreme conditions.

- BB spent 77 consecutive days on mental health watch at Souza-Baranowski Correctional Center. He had been on mental health watch for 50 consecutive days, when, on May 15, he attempted to hang himself with his security smock tied around his neck. Two days earlier, on May 13, 2019, a note in his medical record stated that "his name is now Zachariah" and that "voices told him to play with his own feces." During the next 27 days he continued to harm himself, including: inserting a chicken bone and Styrofoam in his urethra; attempting to strangle himself with a scrub top; and tying a ligature around his neck."

  On June 11, 2019, BB was released from mental health watch but was again placed on mental health watch two days later. Eight days later, he told mental health staff he was "not doing too good," had "racing thoughts," and was "hopeless" and "'never has a plan' for when he will engage in [self-injurious behavior]." The next day, he attempted to strangle himself with his scrubs. He returned to mental health watch where he remained for another 49 consecutive days. These two prolonged stints on mental health watch interrupted BB's engagement with mental health treatment and did not address his underlying issues.

- EE spent 63 consecutive days on mental health watch at Souza-Baranowski Correctional Center, including 55 days on constant 1:1 watch. He also requires a colostomy bag. During this two-month period on mental health watch, he harmed himself 21 different times, including 19 times while on constant 1:1 mental health watch, and he needed hospitalization six different times due to his self-inflicted injuries. EE's self-injurious behavior during this period included: cutting up his stomach with a razor blade and then swallowing it to cause a 5 centimeter deep open abdominal wound; "standing naked at the cell door with blood coming from his open abdominal wound" with "a piece of his intestine in his hand," and then swallowing the piece of intestine; "'scratching' at his abdominal wound" and then standing "at cell door with a long strand of unknown red substance hanging from his abdominal wound;" "actively cutting his chest wound with a small piece of a razor blade," resulting in a part of his intestines coming outside of his abdominal cavity; and "sticking [his] finger in [his] abdomen wound and arm [and] rubbing blood all over [the] cell walls." All of these incidents occurred on a constant 1:1 watch, where he should not have had access to razors or the ability to self-harm so significantly.

  When we met EE at MCI-Cedar Junction on June 18, 2019, he was on mental health watch and remained there for nearly three weeks until he was transferred to a higher level of mental health care through the commitment process. He told us, "Being on [mental health watch] is like being locked in a cell like an animal" and triggers his PTSD because he relives his childhood when he was locked in a closet by his family.

D. The Combination of Inadequate Mental Health Care and Restrictive Housing Conditions in MDOC's Mental Health Watches Results in Serious Harm

The combination of inadequate mental health care and restrictive housing conditions on MDOC's mental health watches not only results in a substantial risk of serious harm, but also results in *actual* serious harm, including self-harm and suicide. Courts have described this

combination and its exacerbating impacts on prisoners. Recently a court found that when a prisoner experiencing a mental health crisis is placed in restrictive confinement he "is exposed to a heightened risk of worsening symptoms, while [also] having less access to treatment [he] need[s]." *Braggs v. Dunn*, 257 F. Supp. 3d 1171, 1237 (M.D. Ala. 2017); *see also Coleman v. Wilson*, 912 F. Supp. 1282, 1320 (E.D. Cal. 1995) (finding that California's form of restrictive housing violated the Eighth Amendment rights of prisoners with mental illness because placement there "cause[d] further decompensation" *and* because it "denied [prisoners] access to necessary mental health care"); *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 911 (S.D. Tex. 1999), *rev'd and remanded sub nom. Ruiz v. United States*, 243 F.3d 941 (5th Cir. 2001) (citing expert testimony that explained that "inadequacy or absence of [mental health] care *combined* with the conditions of confinement" in Texas' form of restrictive housing "contributes to an increase in the patient's suffering from the ravages of his disease" (emphasis added)). This is the case in MDOC's mental health watches: prisoners are exposed to a substantial risk of serious harm because of both the prolonged restrictive confinement *and* because they have inadequate access to the mental health care they need. Because these prisoners are already experiencing mental health crises, mental health watch should "provide the last safety net before the worst possible outcome in mental-health care: suicide." *Braggs*, 257 F. Supp. at 1219. Yet, MDOC's mental health watch often does not.

As described above, prisoners have experienced serious harm on mental health watch. For some, it is like "mental torture," "exacerbat[ing] all [of one's] mental health issues" where being locked in a cell one "can't do anything except think about killing [one]self." For others, the mental harm reaches the point of inflicting injury on themselves. In fact, a majority of the "self-injurious behaviors," or self-harm, that occurs in MDOC prisons occurs in MDOC's mental health watch cells. Although only approximately 1% of the MDOC's total population can be housed in one of its mental health watch cells at any given time, between July 1, 2018, and August 31, 2019, more than 56% of the 1,200 systemwide "self-injurious behavior" incidents occurred in a mental health watch cell. During that 13-month period, 106 prisoners injured themselves on mental health watch by a variety of means, totaling 688 incidents of self-harm, including: cutting themselves; banging their heads on their cells walls or door; attempting to hang or otherwise asphyxiate themselves; and inserting an object in their body or ingesting an object.[13] Of those 688 incidents, 103 were serious enough for MDOC to transport the prisoner to an outside hospital for medical treatment.

In addition, four of the eight prisoners who died by suicide in 2018 and 2019 were held on a mental health watch when they died or shortly before they died. Had MDOC provided these prisoners with adequate mental health care rather than subjecting them to restrictive housing, devoid of mental health treatment, these suicides may have been avoided.

- On June 21, 2019, RR, a transgender man, died by suicide after lodging a stress ball in his throat while on mental health watch at MCI-Framingham. MDOC knew that restrictive housing settings exacerbated RR's mental health issues, yet confined him to mental health watch, where he felt particularly isolated, and also the Restrictive Housing Unit, causing him to decompensate, for the month prior to his suicide. Less than one month before his suicide, he arrived at MDOC, and within two days attempted suicide by

[13] We believe this number is a substantial undercount. Many instances of self-injurious behavior documented in prisoners' mental health records were not captured in the data provided by MDOC.

“impal[ing]” a plastic comb 1-inch into his right arm, which necessitated an outside hospital evaluation. The next day, he was placed on mental health watch, where he told mental health staff that he had tried to kill himself by cutting an artery, that he had a history of suicide attempts, including stabbing himself in the chest in February, and that he had current suicidal ideations with a plan but would not disclose his plan. The staff member noted that RR “was unable to identify anything worth living for.” The next day, still on mental health watch, he was found unresponsive in his cell with a piece of his security mattress tied around his neck. Five days later, still on mental health watch, he inserted a crayon into a wound on his arm, telling mental health staff that he had been hearing voices all day and that the voices “laugh, call me names, and [are] mean to me.” Two days later, he again told mental health staff that he was hearing voices that “just get bad sometimes;” that he “just need[s] to distract [himself];” that “talking to MH [mental health] helps;” and that having a book would help. No book was provided. The next day, he covered his entire body with feces while on mental health watch. About a week later, mental health staff felt he was well enough to be taken off of mental health watch. However, he was not moved to a different housing unit and was provided only access to books and television. The next day, he was placed back on mental health watch after tying earbud cords around his neck because he said, “the voices got to me.” When he was placed on watch, a mental health staff member wrote that he was “contraindicated from [Restrictive Housing Unit] setting due to continued decompensation that would likely be exacerbated.” Yet, despite contraindication from restrictive housing, he was placed in the same housing unit under the same restrictive conditions he had been under the entire month. Three days later, he was authorized to have a stress ball in his cell, and two days after that while still on mental health watch, prison staff found him unresponsive in his cell with this stress ball lodged in his throat. RR remained unconscious and was transported to a local hospital where he was pronounced dead.

Three other prisoners died by suicide just days after being removed from mental health watch. Because prisoners experience such anti-therapeutic conditions on mental health watch, some feign improvement to clinicians in order to gain their release from mental health watch. For instance, LL told us: “[Staff] just keep me in a cell by myself until I say I won’t hurt myself anymore, then they let me go.” In the case of the three prisoners whose suicides are described below, without thorough suicide risk assessments or adequate step-down processes to determine whether they were still at risk of self-harm, MDOC clinicians were unable to accurately assess their mental health, and they died by suicide shortly after securing their release from mental health watch.

- On October 29, 2019, SS, a gay man who had issues with incontinence because of prostate cancer, died by suicide after hanging himself in his Restrictive Housing Unit cell at MCI-Shirley. His death occurred just 12 days after being released from a nine-day mental health watch stay. While he was on mental health watch, MDOC did not address the underlying issues that put SS on watch in the first place, and released him without an adequate step-down process that would have provided him enhanced therapeutic engagement and may have prevented his continued deterioration from the isolation he experienced. During the month prior to his death, SS exhibited signs of possible psychosis: while in the Restrictive Housing Unit a psychiatrist recorded that SS was hypomanic, tangential, unkempt, and had a fake accent. Five days later, SS shattered a window in his cell and was placed on mental health watch, where he remained for nine

days. During his crisis assessment, a mental health staff member noted that he had conflicts with peers, and we learned that he had been "tormented" by peers and officers for being gay and for having to wear a diaper. Four days into that watch, a mental health staff member wrote that SS told her he was "doing worse probably" and "went on to discuss feelings of hopelessness" because he had recently lost a chance at parole, and that he expressed that he would "hang [himself]" if returned to restrictive housing. Three days later, he again was speaking with a fake accent and again told a clinician that he would hang himself if he went to restrictive housing. The next day, on October 16, his medication dosages were altered to stabilize his mood and help with his delusional thinking. Yet the following day, he was discharged from mental health watch by a mental health technician because he had improved his medication compliance, gained insight into his hypomanic behavior, and had expressed that he would be safe in the Restrictive Housing Unit. The clinicians took his word that he would be safe and was doing better even though his medication had only been changed the day before and two days earlier he had repeated his desire to hang himself if he was placed in restrictive housing.

SS's sister visited him the day after he was returned to the Restrictive Housing Unit and described him as "the most depressed [she had] EVER seen him . . . . He looked and sounded totally defeated, dejected and hopeless."

Ten days later, the day before his suicide, prison staff received a phone call from his sister, who had received a letter from him stating that "by the time she received the letter, he would be gone," and that he planned to kill himself. She called the prison to have staff do a wellness check on her brother. According to the medical records, a clinician performed a security referred crisis call at that evening and from the cell door reported that SS appeared stable and stated that he was fine. The next morning, SS was found unresponsive with a ligature around his neck. There is no evidence in the records that clinicians addressed his loss of a parole opportunity or the tormenting of prisoners and officers who targeted him for being gay and needing to wear diapers prior to his release from mental health watch. Further, there is no evidence that an adequate step-down process was implemented.

- On June 21, 2019, TT died by suicide after hanging himself in an altered Restrictive Housing Unit[14] at MCI-Cedar Junction, just three days after being released from mental health watch. While he was on mental health watch, MDOC did not address his underlying risk factors and released him without an adequate step-down process that would have provided him enhanced therapeutic engagement and may have prevented his continued deterioration from the isolation he experienced. In the 15 months prior to his

[14] TT died by suicide in a newly created Limited Privileges Unit (LPU). The LPU became operational on June 16, one day before the Department was scheduled to tour that prison and five days before his suicide. During our tour, officers in the LPU stated to our security expert that it was "basically the Restrictive Housing Unit." The LPU is located in a wing that had been an Restrictive Housing Unit the day before it was operational. According to MDOC, the LPU is an alternative to the Restrictive Housing Unit because it offers prisoners "1.5 hours daily out-of-cell time in the program room 7 days per week, plus 1.5 hours daily out-of-cell recreation time 7 days per week. In addition, LPU inmates are offered weekly structured out-of-cell contact with mental health clinicians and weekly [sic] and a weekly mental health group in the program room, plus twice weekly access to a mental health clinician during mental health rounds."

suicide, he had made six suicide attempts. In the month prior to his suicide, he had either been in restrictive housing or mental health watch. Two weeks earlier, he attempted suicide by hanging in his restrictive housing cell, which resulted in “significant ligature marks” around his neck, a “loss of oxygen,” “seizing after the attempt,” and outside hospital evaluation. Four days after that attempt, he made statements about sacrificing himself to prove how bad the system is. Our expert identified risk factors that were not addressed by mental health staff, particularly this statement about his need to prove how bad the system is and his mother dying of cancer. When we interviewed him five days before his death, he was on mental health watch and told us that he had a broken plastic utensil inserted into his urethra, and that he experienced thoughts about harming himself when alone in his cell because he got “really bad panic attacks and shaky” when he had nothing to do. We advised staff on the day of our interview. He told a mental health clinician the same thing the next day: “Client reported he wanted to come off the [mental health watch],” “stating he self-harms when he is bored.” He was released from mental health watch the next day and placed in an altered restrictive housing unit. Similar to the example above, mental health staff took his word that he would not harm himself and granted his request to leave mental health watch without addressing his risk factors or implementing an adequate step-down process to determine if he was still at risk of self-harm. Two days later, he died by suicide.

- On June 15, 2018, UU died by suicide after hanging himself in his Restrictive Housing Unit cell at Souza-Baranowski Correctional Center, one day after being released from mental health watch. While he was on mental health watch, MDOC did not address his underlying risk factors, including his father’s recent death by overdose, and instead took his word that he would not harm himself and granted his request to leave mental health watch and be placed in a less restrictive unit. During the six months prior to his suicide, UU was placed on at least five mental health watches. He also reported having at least ten seizures due to anxiety, in about that same six month period. About two weeks prior to his suicide, he was having thoughts of hurting himself and was placed on mental health watch. Two days later, while still on the mental health watch, UU learned that his father had overdosed and was on life support. That same day, he suffered a seizure, and told mental health staff that he was “dealing with a lot.” Two days later, a clinician wrote that the he was “struggling to cope with father[’]s situation . . . [and was] having constant thoughts and feeling ‘why does it matter anymore[?]’” The next day, mental health staff told him his father died, and a day later he was observed “randomly punching” the walls and windows of his cell. Staff noted his mood as being “unstable” since receiving news of his father’s passing. The week prior to his death, while still on a close observation mental health watch, UU informed mental health staff that he was “struggling to cope with the loss of his father appropriately” and particularly cited feelings of guilt about being in prison. Later that day, he ripped a long piece of fabric from his scrub top and fashioned it into a noose. When staff attempted to get him to relinquish the fabric, he placed it around his neck and threatened to tighten it. After several minutes, he agreed to relinquish the fabric to a correctional officer. The following day, he was found making hanging gestures and saying that he wanted to die. Three days before his death, he again expressed that he was having thoughts of hanging himself, and two days before his death he told mental health staff that recent contact with his sister “increased his feelings of guilt.” Staff found that he had attempted to make a ligature. Yet, the next day, he was

released from mental health watch to the Restrictive Housing Unit after telling staff that he was ready to return. He stated that hanging gestures he had made were to get attention from staff but that acting that way would not bring his father back. Like the other two examples above, mental health staff took his word that he would not harm himself and granted his request to leave mental health watch without stepping him down with enhanced therapeutic engagement. The next day – eight days after his father had died – he died by hanging himself.

MDOC does not have effective oversight mechanisms for assessing the risk mental health watch poses to prisoners experiencing mental health crisis. MDOC does not aggregate or analyze the data it keeps on the number of prisoners on mental health watch, nor their length of stay there, nor the number of repeated placements there. This absence of data analysis impedes MDOC's ability to connect stays in mental health watch to risk of harm, and actual incidents of mental health deterioration, self-harm, and suicide.

1. MDOC Officials Knew of the Substantial Risk of Serious Harm and Disregarded It

MDOC staff have long been on notice of the serious harms experienced by prisoners on prolonged mental health watch. There have been many instances of self-harm inflicted by prisoners on mental health watch, and in some cases, repeated identical kinds of self-harm and even suicide. *See Hope v. Pelzer*, 536 U.S. 730, 735-38 (2002) (disregarding an obvious risk to prisoner health and safety shows deliberate indifference); *see also Palakovic*, 854 F.3d at 226 (finding that it is an "obvious reality that extended stays in solitary confinement can cause serious damage to mental health"). In a 2007 report, a nationally-recognized expert on suicide prevention hired by MDOC to evaluate its management of suicidal prisoners reported the following: "[C]urrent management of suicidal inmates within the DOC is overly restrictive and seemingly punitive. Confining a suicidal inmate to their cell for 24 hours a day only enhances isolation and is anti-therapeutic. Under these conditions, it is also difficult, if not impossible, to accurately gauge the source of an inmate's suicidal ideation."[15] His follow-up report in 2011, found similar concerns.[16] Despite this clear guidance and notice that MDOC's use of mental health watch for prolonged periods of time, without adequate mental health care, is "overly restrictive and seemingly punitive," MDOC continues to operate its mental health watch units in

[15] The 2007 report was requested by MDOC after it experienced a spike in suicides in 2005 (four suicides) and 2006 (eight suicides). The expert reviewed 10 of those suicides and found the following: "Half (5 of 10) of the victims had recently been on suicide precautions (i.e. mental health watches), with discharge from that observation level ranging from a few hours to a few weeks prior to their deaths; and included one victim who was on mental watch at the time of the incident."

[16] For instance, he reported: "Although a prior concern that correctional staff were primarily driving these practices has been somewhat abated, and mental health staff are now more directly involved in management mental health watches, this writer sensed that practices have not appreciably changed. For example, although the issue of clothing removal is to be determined commensurate with the individual level of risk, almost all suicidal inmates (regardless of risk level) are still stripped of their clothing and issued safety smocks. Although mental health staff are responsible for competing Mental Health Watch Sheets that are taped to each cell door, these sheets invariably will indicate that visits, non-legal telephone calls, and recreation are prohibited. No justification of these decision can be found in the inmate's progress notes. Many inmates interviewed by this writer complained about these restrictions. The level of discontent was most apparent at MCI-Framingham. Most women complained that the conditions of mental health watch were punitive and they were often reluctant to express their suicidal ideation to staff because it meant being locked down on the [Health Services Unit] in a smock."

this fashion. Further, since January 2019, MDOC has been implementing legislation designed to reduce the harmful effects of restrictive housing on prisoners with mental illness. But this legislation does not address restrictive housing in mental health watch units. And, as evidenced in the harm experienced by MDOC prisoners more than ten years later, MDOC's lack of action to address these harms bespeaks deliberate indifference.

V. MINIMUM REMEDIAL MEASURES

To remedy the constitutional violations identified in this Notice, we recommend that the MDOC implement, at minimum, the remedial measures listed below. In listing these remedies, we note that over the course of our investigation, MDOC has been making changes to address some of the violations identified in our Notice.

A. Supervision of Prisoners on Mental Health Watch

MDOC should:

1. Ensure prisoners cannot access instruments used to self-harm, or engage in self-injurious behavior, while on mental health watch. MDOC should monitor instances of self-harm on mental health watch for patterns or common instruments used for self-harm, determine how prisoners are accessing these instruments, and respond by developing individualized strategies to address the risks associated with these.
2. Develop and implement a clear and consistent policy and training for correctional officers and mental health clinicians assigned to mental health watch, including what interactions they may or may not have with prisoners, how to monitor prisoners on constant 1:1 observation and close observation and prisoners who have a history of engaging in self-harm, and how to properly monitor a prisoner who has previously ingested or inserted a foreign body.
3. Institute strict disciplinary action if and when officers do not comply with policies related to their role on constant 1:1 mental health watch, including falling asleep.
4. Ensure communication and coordination between the mental health and security staff under a unified chain of command to prevent self-harm.
5. Increase security staffing to ensure that there are adequate numbers of staff to observe prisoners on mental health watch and to escort prisoners to out-of-cell therapeutic activities.

B. Mental Health Care on Mental Health Watch

1. Conduct daily out-of-cell mental health assessments, document when and why a prisoner requests the assessment cell-side or refuses the assessment, and offer assessments at different times of the day.
2. Ensure all prisoners on mental health watch receive meaningful therapeutic interventions, including regular, consistent therapy and counseling, in group and/or individual settings, as clinically appropriate.
3. Hire a sufficient number of mental health clinicians to ensure that MDOC has adequate numbers of staff to provide meaningful therapeutic interventions to prisoners on mental health watch.

4. Ensure prisoners who engage in repeated self-harm receive individualized crisis treatment plans and, when clinically appropriate, behavioral management plans.
5. Ensure prisoners are transferred to an inpatient psychiatric level of care when clinically appropriate, instead of spending prolonged time on mental health watch.
6. Develop and implement a policy and procedure for step-down placement of prisoners being released from mental health watch.
7. Report and review data regarding lengths of stay in mental health watch and self-harm/ mental health deterioration to connect stays in mental health watch to incidents of self-harm and mental health deterioration, and take appropriate corrective action.

C. Restrictive Housing Conditions of Mental Health Watch

1. Ensure that its policies, procedures, and practices regarding it use of mental health watch for prisoners experiencing a mental health crisis comport with the Constitution.
2. Minimize isolation on mental health watch. Prisoners on mental health watch should have access to clinically appropriate structured and unstructured out-of-cell activities with the goal of quickly stabilizing prisoners. MDOC should expand its use of Recovery Treatment Assistants to monitor and interact with prisoners on mental health watch, which it already uses in its Bridgewater State Hospital mental health unit, the Intensive Stabilization and Observation Unit (ISOU), at Old Colony Correctional Center.
3. Reduce the unnecessarily harsh nature of mental health watch. Removal of a prisoner's clothing (excluding belts and shoelaces), as well as use of physical restraints and shackles, and cancellation of routine privileges (e.g., showers, visits, telephone calls, recreation), should be avoided whenever possible, and only utilized as a last resort for periods in which the prisoner is physically engaging in self-destructive behavior.

VI. CONCLUSION

The Department has reasonable cause to believe that MDOC has engaged in a pattern or practice of resistance to rights protected by the Eighth Amendment because it fails to provide constitutionally adequate supervision and mental health care to prisoners in mental health crisis and places them in mental health watch for prolonged periods of time under restrictive housing conditions that violate their constitutional rights.

We are obligated to advise you that 49 days after issuance of this letter, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies identified in this letter if State officials have not satisfactorily addressed our concerns. 42 U.S.C. § 1997b(a)(1). The Attorney General may also move to intervene in a related private suit 15 days after issuance of this letter. 42 U.S.C. § 1997c(b)(1)(A). Please also note that this Notice is a public document. It will be posted on the Civil Rights Division's website.