Wisconsin Department of Corrections

Comprehensive Study of the Division of Adult Institutions Correctional, Mental Health, and Medical Practices with a focus on Restrictive Housing

FINAL REPORT

October 2025

Wisconsin Department of Corrections

Comprehensive Study of the Division of Adult Institutions Correctional, Mental Health, and Medical Practices with a focus on Restrictive Housing

Falcon Correctional & Community Services, Inc.
155 North Wacker Drive, Suite 4250, Chicago, IL 60606
Tel: 312.803.5666 | www.falconinc.com

Table of Contents

Executive Summary

The Wisconsin Department of Corrections (WIDOC) Division of Adult Institutions (DAI) has long served the Wisconsin community with its three stated goals:

- WIDOC works to protect the public through the constructive management of those placed in its charge.
- WIDOC offers education, programming, and treatment to persons in WIDOC's care that enables them to be successful upon returning to the community.
- WIDOC's mission is to achieve excellence in correctional practices while fostering safety for victims and communities.

The WIDOC Executive Leadership Team sought outside assistance to conduct a comprehensive system-wide assessment of correctional, mental health, and physical health operations and practices, with a particular focus on restrictive housing and organizational culture. The project, initiated through discussions with Secretary Jared Hoy and his executive team, was designed to build upon recent reform efforts and respond to persistent staffing and operational challenges.

The study used a multi-method approach that included data requests and analyses, staff interviews, workshops with DAI staff and other key stakeholders, site visits, interviews with incarcerated individuals, and policy reviews. The central objectives of the study were to (1) identify areas of strength that could be expanded upon throughout the department, (2) identify areas requiring improvements, and (3) provide actionable, evidence-based, and sustainable recommendations to achieve both short-term and long-term success.

This independent assessment was conducted by an interdisciplinary team of Falcon Correctional and Community Services, Inc. ("Falcon, Inc." or "Falcon") experts with expertise in the administration of state prison operations, correctional medical and behavioral health practices, the assessment of criminogenic risk, large-scale system studies, and restrictive housing reform. The purpose of this independent evaluation was to serve as a tool to collectively understand, navigate, and prioritize recommendations for system improvements.

Falcon would like to thank everyone at WIDOC for their assistance throughout this study. The time commitment was significant, from responding to data requests, organizing and facilitating site visits, and participating in workshops to providing the information necessary to complete this important project. We also thank you for the important work you do for the individuals in your care, your staff, and the Wisconsin community.

This report is comprised of the following main sections, each of which have numerous sub-sections:

Recommendations are contained in two main sections. The Review of Existing Systems sections contain a review of the three main disciplines: custody operations, mental health, and medical services. Within each of these sections, recommendations are provided and discussed in detail; however, the majority of recommendations are contained in the Recommendations for Collaborative Change Model section of the report.

The Falcon Team was impressed with staff throughout the department, including correctional officers, program staff, social workers, wardens, facility administrators, facility leadership teams, medical and mental health staff and leaders, administrative support staff, and the Executive Leadership Team. Falcon identified extremely competent and innovative staff at every level across the department.

Two potentially conflicting findings were realized during this study. First, at the facility level, leadership and staff reported feeling a general lack of autonomy in performing day-to-day job functions, and they perceived significant and often excessive and unnecessary scrutiny from outside entities. Second, the Falcon Team found a general lack of uniformity, consistency, and accountability throughout the system and across facilities.

This dichotomy represents an opportunity to align the insights of site-level leaders with the department's overarching goals of uniformity, transparency, consistency, and accountability. To achieve these goals, Falcon recommends the agency employ a collaborative decision-making process to affect change and address identified areas of need. Such an approach will ensure that the department incorporates facility-level experience and insights into system-wide decisions, which will also accelerate understanding and buy-in for new facility-level initiatives since facility-level staff will play a critical role in implementing these initiatives. By embracing such a collaborative approach that values both centralized oversight and local expertise, WIDOC can enhance its operational effectiveness and better serve its mission.

The recommended structure, key outcomes, and workstreams for this collaborative model are explained in detail in the Recommendations for Collaborative Change Model section of this report.

The following is an overview of the key findings from this study:

Table 1: Key Findings

Key Findings	
Department in Transition	WIDOC is a department in transition with significant changes over the past year in the Executive Leadership Team and Facility-Level Leadership Teams. The Executive Leadership and Facility-Level Leadership Teams are comprised of competent professionals dedicated to the department's mission and creating a vision toward "building a future." Like most correctional agencies today, WIDOC continues to 'reset' operational practices that were significantly disrupted by the COVID-19 pandemic. As of January 1, 2025, the majority of facility staff have returned to working on-site rather than working remotely. Some high-profile incidents have resulted in an undercurrent of anxiety and fear in the workforce, requiring patience and re-establishing trust.
Significant Staffing Issues	WIDOC has experienced a great deal of staffing changes, with a significant number of the current staff hired during or after the COVID-19 pandemic. Newer staff have limited experience with basic correctional practices and security operations due to receiving training while normal operations were suspended in response to the pandemic. Recent changes to salary structure, while needed and overall positive, have also resulted in some unintended consequences including: • Incentivizing non-uniform staff to transition to uniform positions, resulting in increased shortages in program staff. • Lack of monetary incentive for staff to promote to leadership positions due to close hourly rate (e.g., compression). • High rates of attrition after a very brief tenure. Inconsistent staff attendance related to the current sick call policy. Inconsistent staff attendance related to the Family Medical Leave Act (FMLA). In addition, the use of agency staff to fill clinical positions is extremely costly and leads to inconsistencies because the agency staff lacks experience in providing correctional healthcare.
Lack of Standardization	A general lack of uniformity across facilities is resulting in inconsistent procedures and practices and significant challenges in monitoring,

Key Findings	
and Accountability	oversight, and accountability. Facilities respond to issues internally rather than creating system-wide efficiencies. System-wide alignment in the following areas is needed: • Basic security practices. • Incident reporting. • Investigation processes. • Data collection and reporting. • Hiring practices.
Restrictive Housing Challenges	Restrictive housing initiatives continue to require support, particularly to improve the conditions for incarcerated individuals housed in restrictive housing, as well as staff working in these settings. Out-of-cell programming and recreation time is very limited. Each individual in restrictive housing should receive a minimum of two hours of out-of-cell time per day. The placement of individuals with mental health conditions in restrictive housing and the structural location of observation cells in restrictive housing both require attention.
Bed Management Challenges	Facilities are frequently at or above capacity. As a result, individuals are being housed at security levels that do not align with their classification level (e.g., remaining at maximum-security when classified as medium-security, or remaining at medium-security when classified as minimum-security).
Mental Health Practices	The department has the components of a comprehensive mental health program; however, several areas could be improved to focus attention on those with the most significant clinical needs. The system would benefit from: • Updating the mental health classification system to reflect clinical acuity as well as static conditions. • Creating additional mental health treatment units with clear admission and discharge criteria. ○ Structuring these units to serve the entire department rather than individual sites. • Monitoring and tracking mental health data more comprehensively throughout the system.

Key Findings	
Medical Practices	Issues related to polypharmacy were identified, as well as the need for additional medical specialty units. Improvements can also be realized in utilization management, medication administration, and the off-site transfer approval process.
Data Collection and System Monitoring	The WIDOC system collects and reports a great deal of data and information. The public-facing dashboard is an example of a best practice. Areas for improvement include expanding data collection and analysis in clinical areas (such as tracking admissions and discharges from mental health and medical units), standardizing data collection, communicating results and findings to staff, establishing systems for frontline staff and leadership to have timely access to current ("real time") data.

Section 1

Assessment and Methodology

Section 1: Assessment and Methodology

A. Project Overview

The Falcon Team conducted a comprehensive study of WIDOC DAI operations, focusing on correctional, behavioral health, and physical healthcare practices. Falcon conducted this study beginning in late-October 2024.

WIDOC oversees a complex network of facilities facing challenges common to corrections agencies nationally, including staffing shortages and the need for modernized correctional practices. Falcon, a nationwide consulting firm established in 2017, applied its extensive experience in correctional healthcare, behavioral health, and operations to develop this report and bring focus and clarity supporting WIDOC's commitment to evidence-based reforms under Secretary Hoy's leadership.

B. Study Phases

The study consisted of the following phases and tasks:

Task 1: Project Initiation

Falcon, Inc.'s work began in October 2024 by forming a Core Working Group with WIDOC's deputy secretary, DAI leaders, and Falcon experts. The Core Working Group met to outline phases, establish communication protocols, and assign points of contact, maintaining engagement through regular meetings and correspondence throughout the study.

Task 2: Data Request and Document Review

A comprehensive data request was issued to WIDOC's Research and Policy Unit, gathering quantitative and qualitative information on staffing, trends, healthcare delivery, and restrictive housing utilization. The Falcon Team reviewed WIDOC policies, procedures, statutes, and prior studies related to correctional, behavioral health, and healthcare practices, as well as restrictive housing, to establish a baseline understanding of existing frameworks and identify areas for improvement.

A list of data and documents requested can be found in Appendix C - Data Gathering and Review.

Task 3: Workshops and Client Meetings

Virtual workshops were conducted with WIDOC subject matter experts (SMEs) from departments and facilities across the agency, and with other key stakeholders, including formerly incarcerated individuals and advocates, to incorporate all viewpoints and perspectives, as well as areas of expertise and experience. The list of workshop topics and dates are as follows:

Table 2: Workshop Topics and Dates

Workshop Topic	Date
Intake/Reception Process	December 3, 2024
Disciplinary Process	December 6, 2024
Restrictive Housing	December 9, 2024
Access to Care	December 12, 2024
Medical and Mental Health	December 18, 2024
Psychological Services Unit (PSU) and Secure Residential Treatment Unit (SRTU) Program	December 18, 2024

Workshop Topic	Date
Suicide Prevention Program	December 18, 2024
WIDOC Behavior Management Planning	December 18, 2024
Inmate Complaint Process	December 19, 2024
New Employee Orientation	December 19, 2024
Classification	January 15, 2025
Medication Assisted Treatment (MAT) and Medications for Opioid Use Disorder (MOUD) Services	January 16, 2025
New Employee Orientation and Training	January 16, 2025
Staffing, Recruitment, and Retention	January 16, 2025
Medical Administration	January 17, 2025
Reentry, Parole, and Probation; Sex Offender Treatment and Housing; Program Services	January 17, 2025
Medical and Mental Health Staffing, Recruitment, and Retention	January 17, 2025
Women's Services	January 27, 2025
Medical	January 28, 2025
Transgender Policy	January 29, 2025
Medical Directors	February 14, 2025
Associate Medical Directors	March 10, 2025
Staff Investigations	March 26, 2025
Family and Medical Leave Act	April 2, 2025
External Stakeholders	April 3, 2025
Warden I	April 3, 2025
Warden II	April 3, 2025
Warden III	April 3, 2025

WIDOC leadership ensured robust participation across these workshops, with SMEs from health services, security, and operations providing critical insights. Through these sessions, Falcon could explore information gaps, highlight areas of interest for site visits, validate findings, and refine recommendations.

Task 4: Facility Studies

The Falcon Team visited 15 DAI facilities over two weeks in January and March 2025 observing admission processes, housing units, healthcare delivery, programming spaces, and any other unique facility areas. Interviews with staff and incarcerated individuals across various housing units offered lived experience perspectives and provided insight into operational strengths and challenges.

SITE VISITS

Week 1: January 21 - 24, 2025

Dodge Correctional Institution (DCI)

Waupun Correctional Institution (WCI)

Fox Lake Correctional Institution (FLCI)

Redgranite Correctional Institution (RGCI)

Oshkosh Correctional Institution (OSCI)

Green Bay Correctional Institution (GBCI)

Wisconsin Secure Program Facility (WSPF)

Week 2: March 4 - 7, 2025

Columbia Correctional Institution (CCI)

Taycheedah Correctional Institution (TCI)

Drug Abuse Correctional Center (DACC)

New Lisbon Correctional Institution (NLCI)

Racine Correctional Institution (RCI)

Racine Youthful Offender Facility (RYOC)

Milwaukee Secure Detention Facility (MSDF)

Also toured Wisconsin Resource Center (WRC)

During each site visit, the Falcon Team included a representative team of all three disciplines, including operations/custody, medical, and mental health. An initial meeting was held with the warden and their leadership team at each facility. These visits typically lasted approximately 90 minutes, including time for the Falcon Team to ask specific questions. This meeting was followed by a tour of the entire facility. During the tours, Falcon experts spoke with over 50 incarcerated individuals and asked specific questions about custody operations, programming, medical care, mental healthcare, general safety, and other relevant questions.

Task 5: Supplemental Data Gathering and Workshops

To fill in knowledge gaps, Falcon submitted additional requests for data, workshops, and meetings to fully understand the system.

Task 6: Formulation and Analysis

The Falcon Team discussed and analyzed all available data (including qualitative information from facility visits, interviews, workshops, and discussions with incarcerated individuals, etc.) to identify strengths, needs, and opportunities for WIDOC. This process included extensive formulation meetings for Falcon Team experts to

question all findings with the goal of coming up with the most impactful and sustainable recommendations designed to improve the lives of those who reside and work within WIDOC DAI facilities.

Task 7: Feedback Session

In May 2025, Falcon compiled and shared preliminary findings with the Core Working Group to ensure technical accuracy and alignment with the department's vision.

Task 8: Report Development

The Falcon Team refined the draft report and had several more formulation sessions/ discussions and updated all information into the final report.

Task 9: Final Report

Upon the completion of all formulation and analysis activities, the Falcon Team finalized this written report which reflects a synthesis of all study phases, delivering evidence-based, actionable, and sustainable recommendations tailored to WIDOC's strengths and needs.

C. Acknowledgment of WIDOC Staff

The Falcon Team expresses gratitude to all staff throughout the WIDOC DAI facilities for their transparency and willingness to accommodate requests, which were often time-consuming and laborious for individuals and departments. We would like to specifically thank members of the WIDOC Core Working Group, for making themselves and their staff available for collaboration as well as the coordination of data collection and on-site reviews. Special thanks to Jessica Y. Gross, DNP, RN, Director, Bureau of Health Services, DAI, and Zach Baumgart, PhD, Director, Research and Policy for their expeditious responses to data, documents, and policy requests.

The Falcon Team would also like to thank the facility wardens for convening their leadership teams to share operational practices during the statewide facility visits, participating in workshops, and being available for follow-up conversations.

D. Introduction to the Falcon Leadership Team and Experts

Falcon assigns highly experienced experts to each project. For this study, Senior Falcon Experts with extensive experience in managing large correctional departments and implementing system-wide improvements (the result of court order or self-developed initiatives) were assigned. These experts were led by Dr. Joel T. Andrade, Falcon Vice President and Senior Expert, who served as the project's Principal, and Kimberly Weaks, PhD, CCHP, a Falcon Senior Expert, who served as Senior Project Manager. The following is the list of Falcon experts who participated in this study:

Behavioral Health and Psychiatric SMEs

Joel T. Andrade, PhD, LICSW, CCHP-MH, Senior Behavioral Health and Psychiatric Expert

Dr. Joel T. Andrade is a Vice President and Senior Expert with Falcon, Inc. Dr. Andrade has spent over 27 years serving those who live and work inside prisons and jails and is recognized as a national leader in correctional healthcare. Throughout his career, Dr. Andrade has provided supervision and consultation to behavioral health clinical and operational directors for 19 state prison systems and several large county jail systems nationwide. He was previously the clinical director for the Massachusetts Department of Correction for five years and oversaw all behavioral health services. During that time, he responded to litigation related to the mental health needs of those in restrictive housing, where he designed and implemented treatment units as alternatives to restrictive housing. In 2021, Dr. Andrade was recognized with the *Edward A. Harrison Award for Excellence in Correctional Health Care Leadership* from the National Commission on Correctional Health Care (NCCHC). He is the author of peer-reviewed journal articles and book chapters and a regular presenter on such topics as applying the recovery model in correctional settings, violence risk assessment and risk management, suicide prevention, psychopathy, and alternatives to segregation. He is the author and editor of the *Handbook of Violence Risk Assessment: New Approaches for Mental Health Professionals*. Dr. Andrade has been an expert witness in district and federal courts throughout the country on violence risk assessments, suicide risk assessments, and the treatment needs of the transgender population within corrections.

Steven J. Helfand, PsyD, CCHP, Senior Behavioral Health and Psychiatric Expert

With over 28 years of correctional mental health leadership experience, Dr. Steven J. Helfand is a licensed psychologist, Vice President, and Senior Expert with Falcon, Inc. He is the former statewide director of mental health at the Connecticut Department of Corrections as well as deputy director of mental health at Rikers Island Jails. He has overseen mental health and health service delivery in over 70 small, mid-size, and large-scale jail, prison, and juvenile facilities in accordance with national and local standards, as well as multiple consent decrees and settlement agreements. Dr. Helfand holds long term certification as a Certified Correctional Health Professional (CCHP) through NCCHC where he was a contributor to the inaugural Mental Health Standards and a long-standing presenter of those standards. Dr. Helfand has shaped correctional mental health practices and shared his expertise through consultation and teaching engagements and has published throughout his career book chapters and articles on self-injury and treatment of

disruptive incarcerated individuals. He has also served as an expert witness for both plaintiffs and defendants in individual and class-action matters within jails and prisons. Dr. Helfand's dedication to the field is exemplified by his role as the two-time chair of the Academy of Correctional Healthcare Professionals and his active participation on various national and local boards and committees.

Corey Brawner, PhD, CCHP, Senior Behavioral Health and Psychiatric Expert

Dr. Corey Brawner is a clinical psychologist whose expertise includes systems research design, statistical analysis, and evidence-based practices for special populations, including veteran-specific programming, suicide prevention and training, and individuals with traumatic brain injuries. He began his career working with justice-involved families and problem-solving courts. Dr. Brawner then worked with the Department of Veterans Affairs, where he provided inpatient mental health services to veterans with serious mental illness and managed behavioral health providers in integrated primary care-mental health settings, focusing on reintegration into civilian society following military service and community reentry from confinement settings. Dr. Brawner is a Senior Behavioral Health Expert on Falcon's system analysis projects, developing assessment tools and managing data analysis, and presenting results and recommendations.

Kimberly Weaks, PhD, CCHP, Senior Project Manager

Dr. Kimberly Weaks, has worked in behavioral healthcare in the correctional industry since 2002; she is a licensed psychologist and serves as a Falcon Senior Expert and Senior Project Manager. She is instrumental in bridging the differing policies of state, facility, and correctional healthcare contractors and in meeting the quality assurance standards of each. She has trained hundreds of security, programming, and medical staff on various mental health topics and has provided numerous hours of consultation on the humane treatment of mentally ill individuals to corrections staff. An expert in behavioral health and crisis intervention, Dr. Weaks delivers expertise in behavioral healthcare; cognitive-behavioral techniques; treatment of the severely mentally ill; crisis intervention; psychological evaluations; treatment planning; reentry planning and coordination; assessment and treatment in restricted housing units; fitness-for-duty and weapons qualification evaluations for security staff; supervision of numerous facility-based behavioral health providers; and suicide prevention programming, training, and implementation. Dr. Weaks leverages her extensive

expertise in system management and clinical intervention to enhance mental health service delivery across correctional facilities nationwide.

Healthcare Experts

Jeffrey C. Fetter, MD, Senior Medical Expert

Dr. Jeffrey C. Fetter holds board certifications in both internal medicine and psychiatry. He is a highly respected physician specializing in forensic and correctional healthcare.

Currently serving as the chief medical officer at New Hampshire Hospital and an assistant professor of psychiatry at the Geisel School of Medicine at Dartmouth, Dr. Fetter brings a wealth of knowledge and leadership to the Falcon Team. His career spans over two decades, during which he has held significant positions in both academic and clinical settings.

Dr. Fetter's tenure as chief medical officer at the New Hampshire Department of Corrections and Riverbend Community Mental Health Center highlights his expertise in overseeing comprehensive healthcare services for incarcerated populations. At the New Hampshire Department of Corrections, he supervised health services for 2,400 incarcerated individuals, focusing on utilization management, program development, and direct psychiatric care in specialized units. His contributions to the field are further evidenced by his involvement in numerous professional organizations, including the National Association of State Mental Health Program Directors and the American College of Correctional Physicians.

Dr. Fetter has been recognized with numerous awards for his contributions to public health and psychiatry. His commitment to advancing the field of correctional healthcare makes him an invaluable asset to Falcon.

Brandy McDonald, RN, Senior Medical Expert

Ms. McDonald has been involved in healthcare for the past 30 years. She is a registered nurse with a background in psychiatry, correctional medicine, pediatrics, primary care, and case management. She has been in senior management since 1995 with several national healthcare organizations. Ms. McDonald served as the nurse manager for the adolescent unit at Charter by the Sea, an inpatient psychiatric hospital, for ten years. She was also involved in the start-up and development of a multi-state correctional healthcare company. During that time, she was the director of operations with

supervisory responsibility over sites in four states and developed policies and procedures and created training programs for those policies. In addition, Ms. McDonald was responsible for quality improvement programs in several national healthcare organizations, developed suicide prevention training and implemented programs throughout large systems, and has led organizations through NCCHC accreditation and consent decree implementation plans. As a consultant, Ms. McDonald has served on executive leadership teams and as a liaison between leadership teams and clinical teams. She has been responsible for the implementation of behavioral health programming in correctional settings, including initial and ongoing staff training and direct communication and reporting to correctional staff. In her role as a Senior Medical Expert for Falcon, Ms. McDonald has been an integral part of teams in several states, traveling to correctional sites, doing on-site process assessments, and providing recommendations to correctional teams. Her approach focuses on changing attitudes, building skills, and developing a work environment where people can thrive.

Correctional Operations Practice Experts

Bernard "Bernie" Warner, Senior Expert

Mr. Bernie Warner is a highly experienced professional with over 34 years of expertise in both juvenile and adult corrections. From 2011 to 2015, he served as the secretary of the Washington State Department of Corrections, responsible for the supervision and care of over 35,000 incarcerated individuals. Currently, as a Senior Security Expert with Falcon, Mr. Warner provides valuable consultation on mental health and behavioral health program development in correctional facilities. Throughout his career, he has been a strong advocate for evidence-based system reform, working on initiatives such as fair sanctions, reduced segregation, gender-responsive practices, and gang interventions. With a Bachelor of Science degree in Administration of Justice and executive management programs from prestigious institutions, Mr. Warner has made significant contributions globally through his involvement with the International Correctional and Prisons Association. Additionally, his expertise as a court expert in critical cases has been instrumental in addressing access to care and the appropriate use of force for incarcerated individuals with disabilities. With Mr. Warner's remarkable dedication to correctional reform, he is a highly respected and influential figure in the field, driving positive change in the pursuit of safer and more rehabilitative environments.

Patrick T. DePalo, Jr., Senior Expert

Mr. Patrick T. DePalo, Jr. is a Senior Correctional Operations Expert with Falcon, Inc.; he has extensive experience in the criminal justice system. Mr. DePalo started as a correction officer in 1989, working each security rank as he rose to deputy commissioner of field services for the Massachusetts Department of Corrections. He oversaw critical units, including investigative services, special operations, incarcerated individual transportation, and security technology. Mr. DePalo served in diverse roles across minimum-, medium-, and maximum-security facilities, including a forensic psychiatric hospital, holding such positions as director of security, chief of investigative services, and deputy superintendent of operations.

Recognized for his leadership, Mr. DePalo was named Employee of the Year three times and received the *Governor's Outstanding Performance Award*. He was trained as a certified Prison Rape Elimination Act (PREA) auditor and mediator and held specialized certifications in internal affairs, active shooter response, and criminal investigations. Mr. DePalo was a member of the American Correctional Association, National Internal Affairs Investigators Association, FBI-Law Enforcement Executive Development Association (LEEDA), and the Joint Terrorism Task Force executive board.

With a bachelor's in sociology from Framingham State University and a master's degree in criminal justice from Boston University, Mr. DePalo is an adjunct professor at Anna Maria College and a Peace Officer Standards and Training (POST)-certified police officer in Massachusetts. As a recognized leader in advancing correctional security and investigative standards, he is a trusted expert for improving safety and operations.

Rick Raemisch, JD, Chief Correctional Practice Expert

Mr. Rick Raemisch is a Chief Correctional Practice Expert with Falcon, Inc. Mr. Raemisch has decades of experience working in numerous areas of the criminal justice system. He was appointed executive director of the Colorado Department of Corrections by Governor John Hickenlooper in July 2013. During his time there, Mr. Raemisch successfully implemented prison reforms and ended the use of restrictive housing altogether. A recognized leader in prison reform and highly sought after as a national and international SME, he was instrumental in assisting the Justice Department in reforming solitary confinement under President Obama. He also assisted and was a member of the U.S. delegation to the U.N. meetings in Cape Town and Vienna to rewrite prisoner standards, now known as the *Mandela Rules.* Mr. Raemisch received the *2018 International Corrections and Prisons Association Head of Service Award* and, in 2017, the nationally

distinguished *Tom Clements Award* from the Association of State Correctional Administrators, awarded annually to a member who displays innovation and achievement as a leader in the corrections profession. He was also awarded the *2016 Sam Cochran Award* by the National Alliance on Mental Illness for his work in implementing widespread reforms in the use of solitary confinement in Colorado prisons.

Legal and Operations Expert

Benjamin T. Rice, JD, Senior Expert

Mr. Benjamin T. Rice joined Falcon, Inc. in the spring of 2023 as a Senior Expert. He began his career in private practice, but after four years, Mr. Rice was hired as a deputy attorney general for the state of California, kick-starting his nearly 20-year corrections career. While serving as deputy attorney general, Mr. Rice litigated cases on behalf of the California Department of Corrections and Rehabilitation (CDCR), including three class-action cases for which he was appointed lead attorney. In recognition of his outstanding work, he was asked to join the Governor's Office of California as deputy legal affairs secretary for public safety. After two years in this position, Mr. Rice was recruited to become CDCR's chief counsel wherein they terminated several class actions. Nine years later, he was recruited by a private healthcare company to become its chief counsel. Through mergers, the company became the largest correctional healthcare company in the nation, with Mr. Rice at the helm of litigation as the senior vice president - litigation. In his last two years there, he helped manage the sites associated with class cases. After seven years, Mr. Rice left to open his own company, BTR Consulting, as a corrections consultant to help counties and states comply with or avoid class cases. In his time in the corrections field, Mr. Rice has worked on roughly 30 class cases with dozens of experts and has been on hundreds of expert and plaintiff prison/jail tours.

Section 2

Review of Existing Systems

Section 2: Review of Existing Systems

With the support and collaboration of WIDOC staff, the Falcon Team conducted an extensive review of DAI's existing facilities, practices, and systems. This section includes detailed findings and observations made during the review and analysis.

A. System-Wide Validations

The Falcon Team was impressed with multiple recent initiatives and accomplishments throughout WIDOC. The following are prominent areas of exemplary practices and improvements, which are strengths to build on throughout the department:

1. Knowledgeable and dedicated leadership is evident across headquarters, site-level, and unit-level teams, driving organizational progress.
2. Programming at medium-security and minimum-security facilities supports a range of rehabilitation efforts.
3. The establishment of the Bureau of Health Services highlights a commitment to centralized and efficient healthcare management.
4. Transitioning the mental health department reporting to the Bureau of Health Services reflects a strategic effort to streamline operations, strengthen coordination, and enhance oversight.
5. Partnerships with local colleges and universities extend the department's educational reach.
6. The MAT initiative demonstrates a proactive approach to address addiction through evidence-based medical treatment and support.
7. Updates to the classification system, particularly with the Instruments for Custody Classification (IFCC), suggest a focus on maintaining safety and improving classification procedures.
8. Significant improvements in data collection and reporting through the publicly available dashboard indicate a commitment to accountability and to using data to identify and address systemic issues.

Additionally, the Falcon Team recognized several concepts that could be further developed and expanded throughout the department. These include:

- The Field Training Officer (FTO) concept.
- The Transitional Treatment Center at Oshkosh.
- Special Management Unit (SMU) concept for vulnerable populations including individuals with:
    - Serious Mental Illness (SMI)
    - Intellectual Developmental Disorders (IDD)
    - Visual impairments

  Some SMUs also use certified peer specialists and manage restrictive housing and observation on the unit.

Observations indicate that a positive work environment is present at various sites across the system. These examples present an opportunity to identify and replicate effective practices more broadly to strengthen the work environment across all locations. The agency recognizes the importance of addressing the needs of young and emerging adults and has dedicated one facility specifically for this purpose. These trends demonstrate forward-thinking approaches and dedication to continuous improvement throughout the department.

B. Bureau of Health Services Validations

The establishment of the Bureau of Health Services in June 2022 has led to, or expanded, the following positive changes, innovations, and improvements:

- **Organizational Re-Alignment:** The significant reorganization of the Bureau of Health Services aligned healthcare staff to report within the healthcare structure rather than through custody leadership. Previously, Health Services Units (HSUs) reported to wardens or deputy wardens. This change has established a foundation for more clinically informed oversight and strengthened accountability.

- **Establishment of Statewide Policy Oversight:** A new nursing position for statewide policy oversight enables standardized policies and ensures consistent implementation across all facilities, including the development of a comprehensive policy management system and the facilitation of interdisciplinary workgroups to review and update medical, mental health, and dental policies. A central SharePoint site now houses all policies, which are updated in alignment with current statutes, and community standards (such as The Joint Commission (TJC)) and best practices.
- **Health Services SharePoint Site:** A new Health Services SharePoint site now centralizes resources for all healthcare staff. This site includes individualized discipline pages, up-to-date scheduling, onboarding materials, policy access, employment forms, and educational resources. With a dedicated nursing education portal, staff can register for courses, including the new Elsevier-based training program that offers continuing education units and incorporates evolving best practices.
- **Creation of a Mortality Resource Center:** This new center centralizes all relevant documentation and insights, including toxicology reports, investigative findings, suicide data, a key metrics dashboard, and a mortality review log into one accessible location. The system provides immediate access to critical information and supports timely and informed review processes.
- **Licensing and Credentialing Practices:** Restructured licensing and credentialing processes ensure real-time tracking and compliance. Automated alerts notify staff about upcoming license expirations, and continuous National Practitioner Data Bank (NPDB) monitoring identifies any licensure issues in real-time.
- **Initiation of Cultural Transformation:** A new initiative focused on workplace culture launched, emphasizing respectful conduct in the workplace and clear productivity standards. This transformation aims to foster a more supportive, accountable, and effective working environment for all healthcare staff.

C. Leadership

Executive Leadership

The Falcon Team engaged with the WIDOC Executive Leadership Team throughout the study, during which Falcon observed the Executive Leadership Team's dedication to transforming the correctional system with a clear commitment to honesty, transparency, and the safety and well-being of all WIDOC staff and incarcerated individuals.

Falcon, Inc. and its project experts were impressed by Secretary Hoy and his Executive Leadership Team's timely endeavors to implement significant changes that align with industry best practices.

The Falcon Team was granted access to the department through discussions with the Secretary and his Executive Leadership Team, site visits, discussions with staff at all levels during workshops and site visits, discussions with incarcerated individuals during site visits, and discussions with key stakeholders during workshops. In conjunction with key internal stakeholders, the Executive Leadership Team exhibited the requisite commitment and dedication that is critical to improving the overall DAI system.

Facility-Level Leadership

The Falcon Team was impressed with the commitment of the facility-level leadership teams. Leaders at all levels of the facilities are an asset to the agency and critical to understanding, planning and implementing the most impactful changes in the most effective way; however, limited years of experience in leadership positions were identified across facilities. Notably, the vast majority (83.3%) of wardens were promoted to their positions during or after COVID-19 restrictions were in place. This is also the case with deputy wardens; 77.8% were promoted to their positions during or after pandemic restrictions.

Designing, evaluating, and implementing system-wide changes will require strong connection and collaboration between agency executive leaders and facility leadership, as well as between facility leadership and line managers and staff.

A recent correctional staff study by the National Institute of Justice (NIJ)[1] found that new generations of employees expect to be able to actively participate in policy and decision-making that impacts their environment. A paramount concern for early career employees is the opportunity for growth and advancement and a sense of purpose.[2]

To craft and implement high-impact changes, leadership must incorporate the voices, insights, and experiences of staff at all levels, incarcerated individuals, and other key stakeholders. This also includes personnel in management, supervision, custodial, and support functions. The primary objective should be the system's progress as correctional professionals function as a cohesive unit to achieve priorities and contribute significantly to their work environment.

---

[1] Russo, J. (2019, December 1). Workforce issues in corrections. *National Institute of Justice.* https://nij.ojp.gov/topics/articles/workforce-issues-corrections

[2] Lawson, P. (2023, July 19). Delegate and elevate: Developing your early career professionals. *Forbes*. https://www.forbes.com/sites/forbesbusinesscouncil/2023/07/19/delegate-and-elevate-developing-your-early-career-professionals/?sh=33fdcff0793e

Falcon recommends the use of a collaborative change process – discussed in the Recommendations for Collaborative Change Model section of this report – as a way to implement meaningful changes that engage staff throughout the organization. Falcon also strongly recommends increasing investment in leadership skills and capabilities for all staff to develop a more knowledgeable and better equipped workforce.

Falcon is confident that with the appropriate engagement between the executive leadership, facility-level leadership, agency staff, incarcerated individuals, and other key stakeholders described throughout this report, vast improvements can be made to the system that will significantly improve the lives of those incarcerated and the staff charged with providing care and custody of this population.

D. Operations

Population Trends and Operational Capacities

To understand the security, operational, mental health, and physical healthcare needs of adults in custody,[3] a contextual understanding of the overall population is essential. This section provides an overview of the population within WIDOC DAI facilities. Population totals reflect data from the first weekly population report of each year between 2015 and 2025, unless otherwise noted.

The WIDOC DAI is entrusted with providing care and custody for approximately 23,000 incarcerated individuals across 37 facilities. WIDOC DAI operates 19 adult prisons, including two reception facilities, four maximum-security facilities, nine medium-security facilities, and four minimum-security facilities. DCI is the male intake facility and TCI is the female intake facility where newly received individuals are initially classified and receive initial healthcare and mental health screening and evaluation. DCI and TCI also house maximum-security and medium-security classifications. As of January 2025, DCI and TCI housed 1,664 and 961 individuals, respectively.

MSDF, with a census of 1,022 on 6/5/2025, includes 637 individuals from DAI and 385 individuals from Division of Community Corrections (DCC). MSDF has a unique mission as a medium-security facility that houses various security levels. Located in downtown Milwaukee, MSDF operates more like a county jail than a state prison, receiving admissions 24/7 with healthcare and mental health staff conducting immediate intake screenings.

[3] WIDOC DAI previously used the phrase *Persons in Our Care (PIOC)* to describe the incarcerated population. This did not translate directly in this report as the Falcon Team is not providing custody or care functions. Therefore, PIOC is only used when directly citing DAI policies.

WIDOC also oversees operations of the Wisconsin Correctional Center System (WCCS), a decentralized network consisting of 14 minimum-security facilities, focused on transition and reentry to the community at sentence completion. Each center, independently managed by a superintendent, is operationally self-contained and typically houses fewer than 300 individuals.

Additionally, as of January 2025, there were 400 individuals under DAI custody receiving treatment at the WRC including 39 women and 361 men, as well as 296 individuals in contracted beds in county jails.

Male prison facilities and correctional institutions with publicly published capacities are listed below with their capacity and census as of January 2025:

Table 3: Male Facilities and Capacity as of January 2025

Security Level	Facilities	Capacity	Jan 2025 Population	% of Capacity
Maximum	Columbia Correctional Institution	541	684	126%
	Green Bay Correctional Institution	749	1,074	143%
	Waupun Correctional Institution	882	719	82%
	Wisconsin Secure Program Facility	501	474	95%
	Maximum Total	**2,673**	**2,951**	110%
Medium	Fox Lake Correctional Institution	979	1,388	142%
	Jackson Correctional Institution	837	1,007	120%
	Kettle Moraine Correctional Institution	783	1,138	145%
	New Lisbon Correctional Institution	950	1,038	109%
	Oshkosh Correctional Institution	1,494	2,073	139%
	Racine Correctional Institution	1,171	1,811	155%
	Racine Youthful Offender	400	474	119%

Security Level	Facilities	Capacity	Jan 2025 Population	% of Capacity
	Redgranite Correctional Institution	990	1,023	103%
	Stanley Correctional Institution	1,500	1,561	104%
	Medium Total	**9,104**	**11,513**	126%
Minimum	Chippewa Valley Correctional Treatment Facility	450	464	103%
	Oakhill Correctional Institution	409	829	203%
	Prairie Du Chien Correctional Institution	326	515	158%
	Sturtevant Treatment Facility	150	147	98%
	Minimum Total	**1,335**	**1,955**	146%
Correctional Centers	Black River Correctional Center	66	131	198%
	Drug Abuse Correctional Center	125	306	245%
	Felmers O. Chaney Correctional Center	100	106	106%
	Flambeau Correctional Center	50	83	166%
	Gordon Correctional Center	52	95	183%
	John C. Burke Correctional Center	186	289	155%
	Kenosha Correctional Center	60	116	193%
	Marshall E. Sherrer Correctional Center	32	54	169%
	McNaughton Correctional Center	55	110	200%
	Oregon Correctional Center	78	132	169%
	Sanger B. Powers Correctional Center	60	119	198%

Security Level	Facilities	Capacity	Jan 2025 Population	% of Capacity
	St. Croix Correctional Center	94	120	128%
	Thompson Correctional Center	118	124	105%
	Winnebago Correctional Center	210	289	138%
	Correctional Centers Total	**1,286**	**2,074**	**161%**
Reception/Max/ Med	**Dodge Correctional Institution**	**1,165**	**1,664**	**143%**
	Men's Overall Total	**15,563**	**20,157**	**130%**

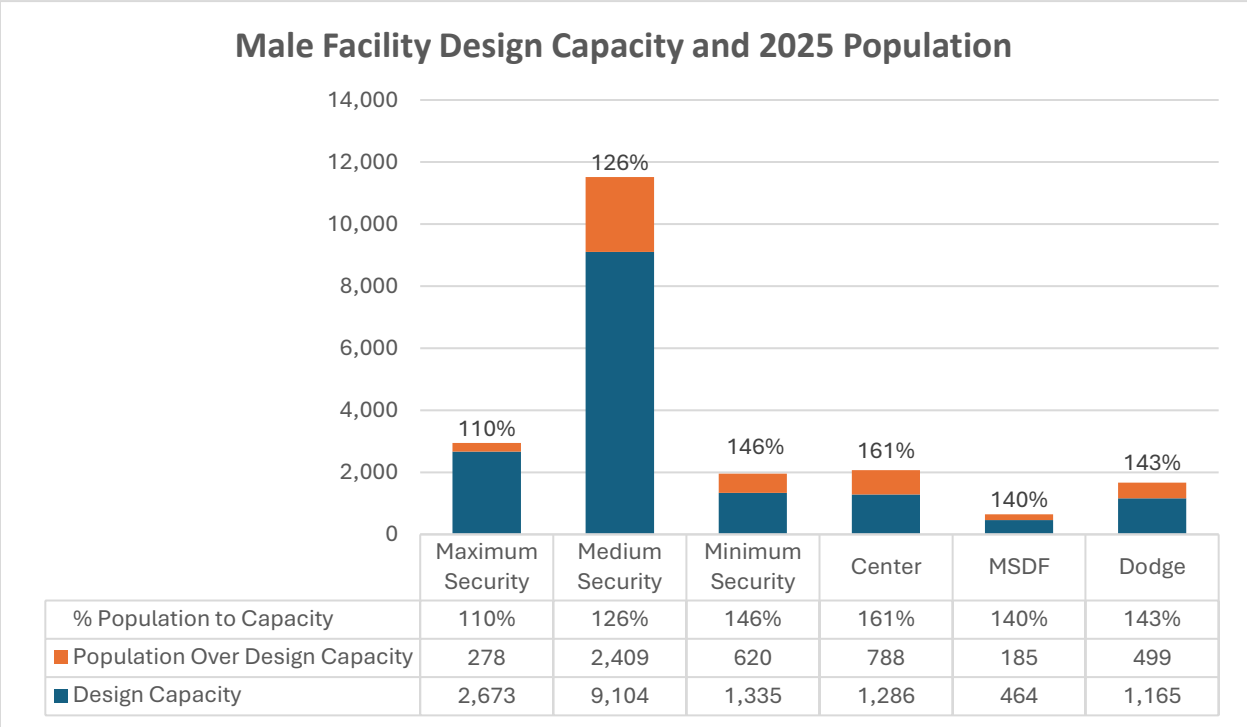
As of January 2025, most facilities with male populations were operating above their designated capacity. All maximum-security prisons except Waupun exceeded capacity, with Green Bay at 143% and Columbia at 126% of capacity. All medium-security facilities were above capacity. Minimum-security institutions and correctional centers were also above capacity. Facilities that house women were also over capacity across all security levels.

Table 4: Female Facilities and Capacity as of January 2025

Security Level	Facilities	Capacity	Jan 2025 Population	% of Capacity
Minimum	Milwaukee Women's Correctional Center	42	97	231%
	Robert E. Ellsworth Correctional Center	230	475	207%
	TOTAL	**272**	**572**	**210%**
Reception/ Max/Med	Taycheedah Correctional Institution	653	961	147%
	Women's Overall Total	**925**	**1,533**	**166%**

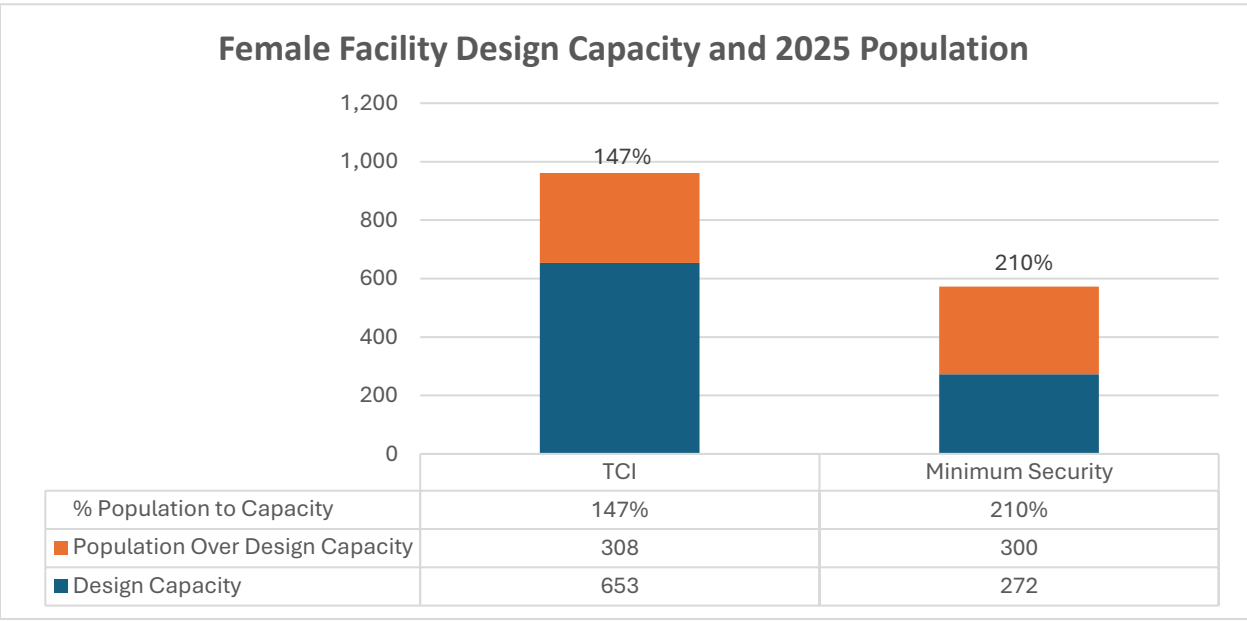
The following graphs illustrate capacity levels by security level for males and females.

Graph 1: Male Facility Design Capacity and 2025 Population



	Maximum Security	Medium Security	Minimum Security	Center	MSDF	Dodge
% Population to Capacity	110%	126%	146%	161%	140%	143%
Population Over Design Capacity	278	2,409	620	788	185	499
Design Capacity	2,673	9,104	1,335	1,286	464	1,165

Graph 2: Female Facility Design Capacity and 2025 Population



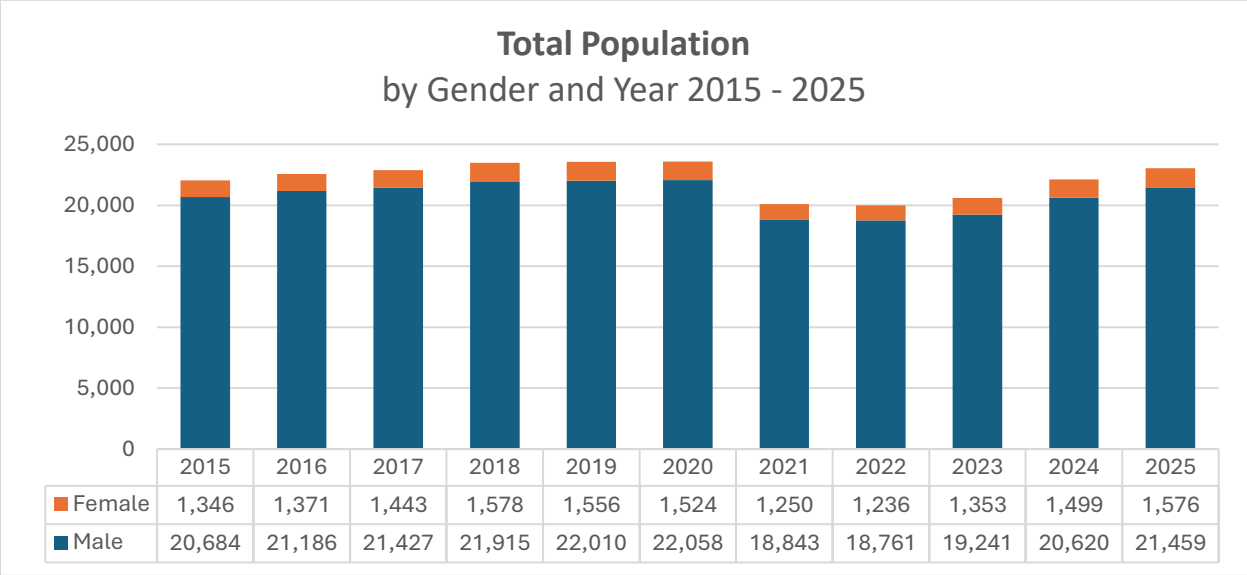
	TCI	Minimum Security
% Population to Capacity	147%	210%
Population Over Design Capacity	308	300
Design Capacity	653	272

Male facilities across all security levels are functioning above capacity, with medium-security and correctional centers operating above capacity at 126% and 161%, respectively. Female facilities also exceed capacity across security levels, most notably minimum-security facilities operating at 210% of capacity.

Total Population

The following graph illustrates total WIDOC population changes between 2015 and 2025, and lists male and female population changes:

Graph 3: Total Population by Gender and Year 2015 - 2025



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Female	1,346	1,371	1,443	1,578	1,556	1,524	1,250	1,236	1,353	1,499	1,576
Male	20,684	21,186	21,427	21,915	22,010	22,058	18,843	18,761	19,241	20,620	21,459

Between 2015 to 2019, the total WIDOC DAI population increased annually, by 7% over this four-year period (6.4% for males and 15.6% for females). In 2020, the growth leveled off, and the female population declined by 2.06%, likely the result of early COVID-19 response efforts.

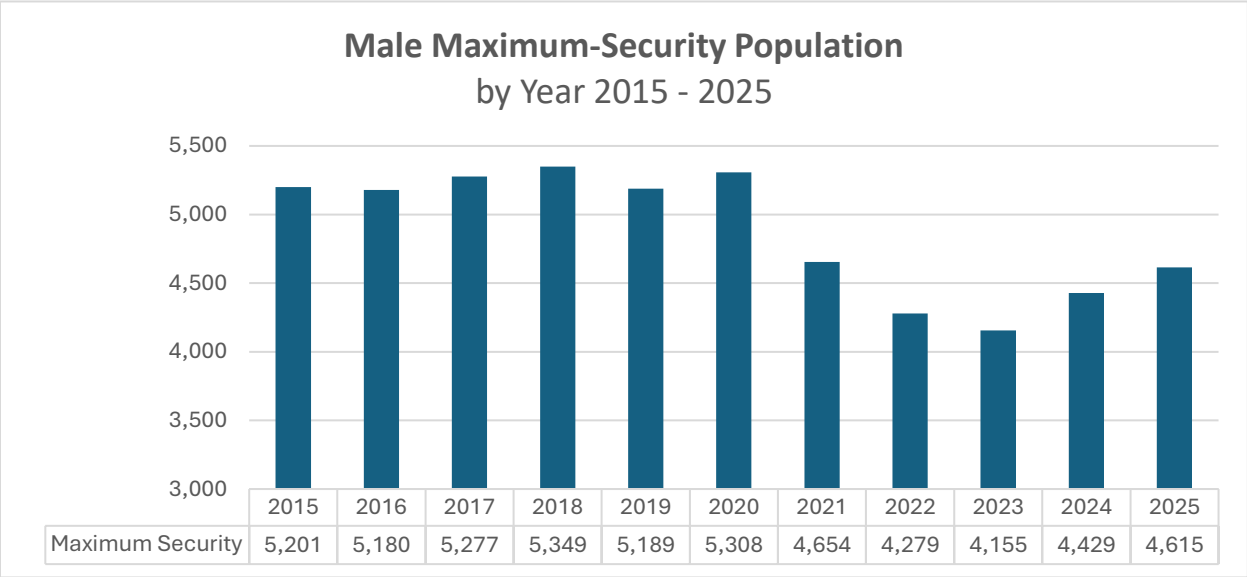
In 2021, the overall population decreased significantly, with the total population declining 14.8% (14.6% for the male population and 18% for the female population). This is consistent with correctional departments throughout the country in response to COVID-19.

Following the lowest population total in 2022, the population began to gradually increase again. In 2022 there was minimal change overall; between 2023–2025 the overall population increased by 11.9% (11.5% for the male population and 16.5% for the female population). By 2025, the total prison population had nearly returned to pre-pandemic levels.

Male Population

The following graphs illustrate the male population housing placement trends between 2015 and 2025 by security level:

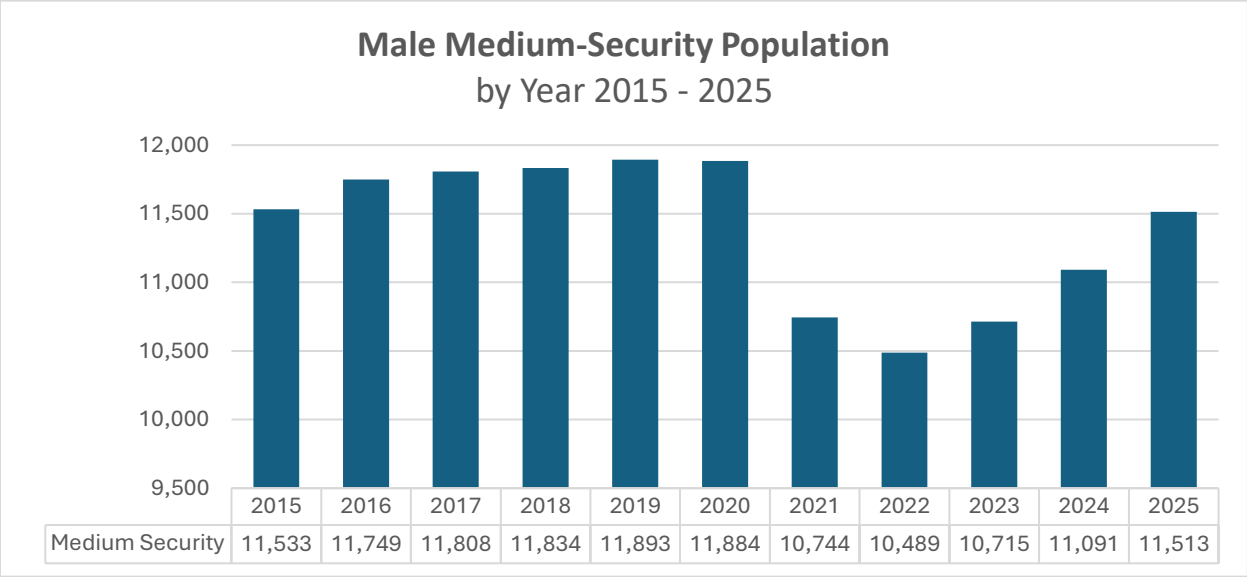
Graph 4: Male Maximum-Security Population by Year 2015 - 2025



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Maximum Security	5,201	5,180	5,277	5,349	5,189	5,308	4,654	4,279	4,155	4,429	4,615

The male population housed at maximum-security increased by 2.1% between 2015 and 2020. The population then decreased by 10.7% between 2021 and 2023. Between 2023 and 2025 the male population housed at maximum-security increased by 11.1%.

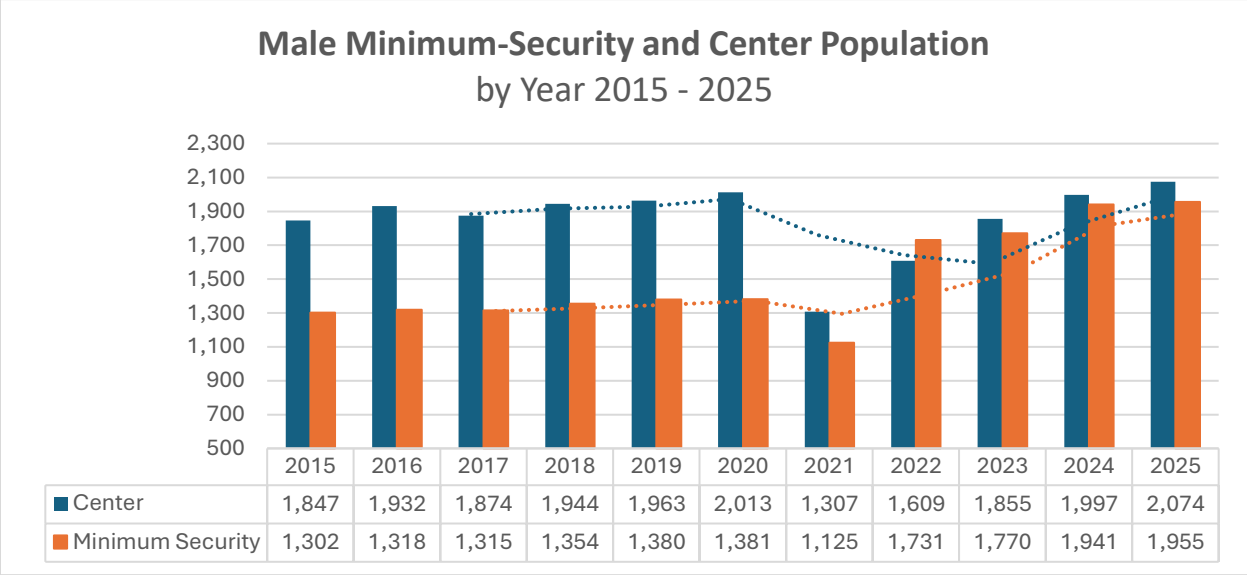
Graph 5: Male Medium-Security Population by Year 2015 - 2025



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Medium Security	11,533	11,749	11,808	11,834	11,893	11,884	10,744	10,489	10,715	11,091	11,513

The male population housed at medium-security shows an increasing trend. Between 2015 and 2020, the total population increased by 3.0%. It then dropped by 11.7% between 2020 and 2022 but then increased by 9.8% between 2022 and 2025. While there is a slight, overall decrease from the highest year, 2022, (11,884 males were housed at medium-security), to 2025 (11,513 males were housed at medium-security), if the trend from 2022 to 2025 continues, the overall male population housed at medium-security should surpass 2020 levels within two years.

Graph 6: Male Minimum-Security and Center Population by Year 2015 - 2025

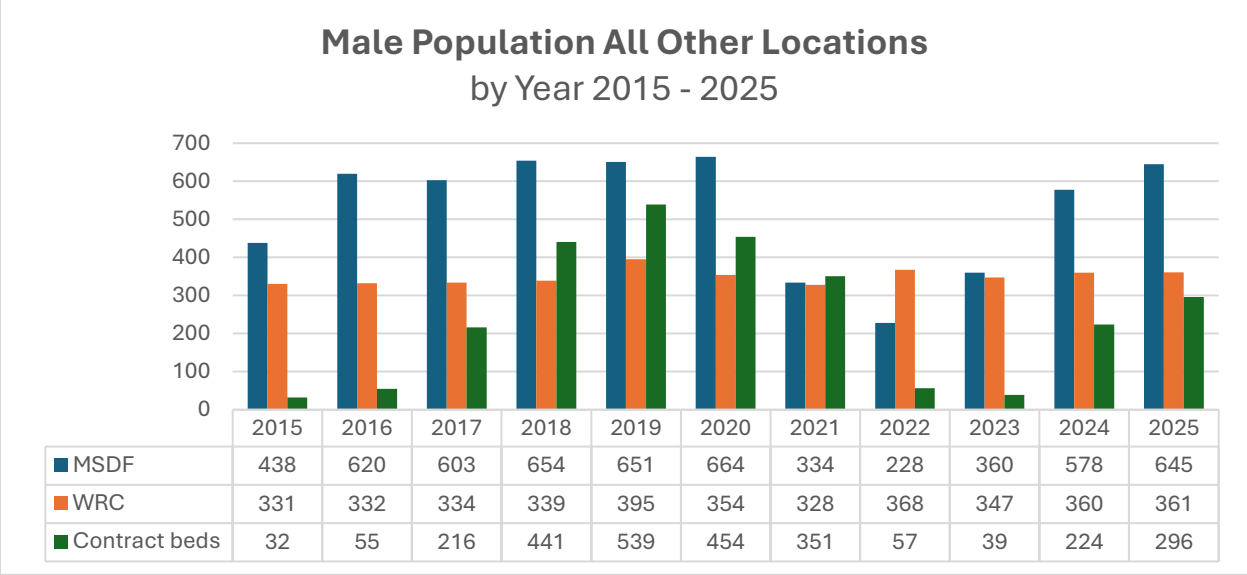


	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Center	1,847	1,932	1,874	1,944	1,963	2,013	1,307	1,609	1,855	1,997	2,074
Minimum Security	1,302	1,318	1,315	1,354	1,380	1,381	1,125	1,731	1,770	1,941	1,955

At the centers, the male population fluctuated from a low of 1,307 individuals in 2021 to a high of 2,074 in 2025.

The percentage of males housed in minimum-security settings increased by 50.2% between 2015 and 2025. The most significant increase occurred between 2021 and 2022 (53.9%), when Prairie du Chien converted from medium-security to minimum-security.

Graph 7: Male Population All Other Locations by Year 2015 - 2025



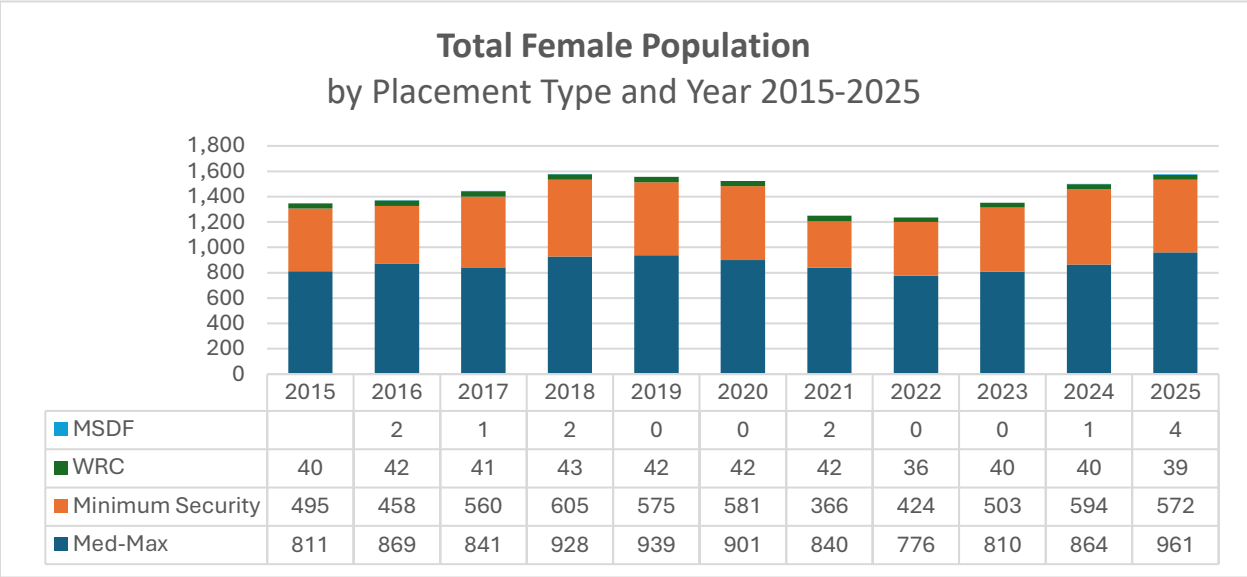
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
MSDF	438	620	603	654	651	664	334	228	360	578	645
WRC	331	332	334	339	395	354	328	368	347	360	361
Contract beds	32	55	216	441	539	454	351	57	39	224	296

The previous graph lists the male population housed at MSDF, WRC, and in contract beds between 2015 and 2025. The overall population at MSDF decreased significantly in response to COVID-19 (from 664 individuals in 2020, to 228 individuals in 2022) but is back at pre-pandemic levels. The overall WIDOC DAI population at WRC has remained fairly consistent over the past 11 years. However, the use of contract beds significantly shifted year-to-year, with a low of 32 in 2015 and a high of 539 in 2019.

Female Population

The following graph illustrates WIDOC's female total population between 2015 and 2025 by security level:

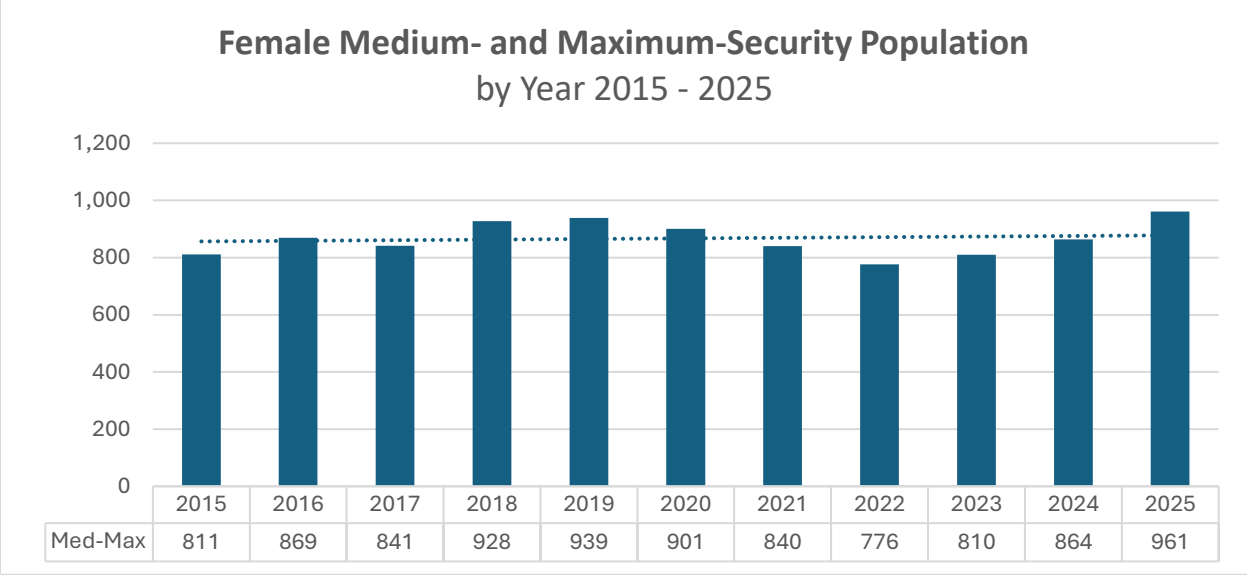
Graph 8: Total Female Population by Placement Type and Year 2015 - 2025



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
MSDF		2	1	2	0	0	2	0	0	1	4
WRC	40	42	41	43	42	42	42	36	40	40	39
Minimum Security	495	458	560	605	575	581	366	424	503	594	572
Med-Max	811	869	841	928	939	901	840	776	810	864	961

The total female population increased by 17.2% between 2015 and 2018 and then decreased by 21.7% between 2018 and 2022, likely due to COVID-related responses. During the three-year period between 2022 and 2025, the female population increased by 27.5%, and is now higher than pre-pandemic levels.

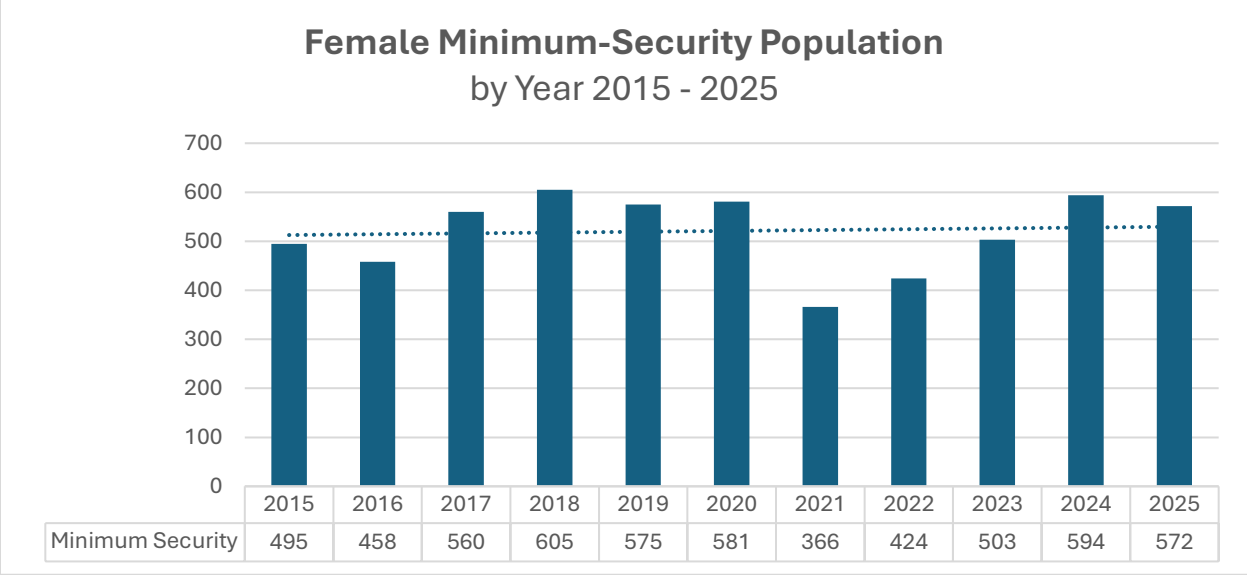
Graph 9: Female Medium- and Maximum-Security Population by Year 2015 - 2025



A similar trend occurred at the Taycheedah Correctional Institution,[4] with a 15.8% increase between 2015 and 2019, and a 17.4% decrease between 2019 and 2022. Then between 2022 and 2025, the medium-maximum population increased by 23.8% to the highest level over the 11-year analysis.

[4] The available data did not allow for the medium- and maximum-security levels to be separated, so are reported together here.

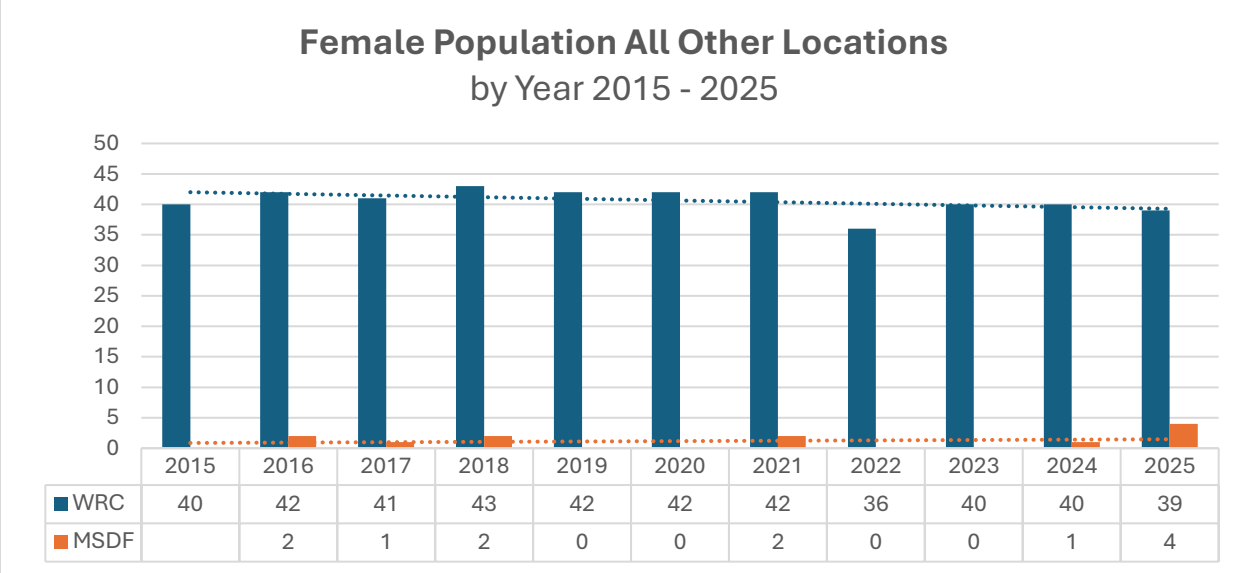
Graph 10: Female Minimum-Security and Center Population by Year 2015 - 2025



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Minimum Security	495	458	560	605	575	581	366	424	503	594	572

The female population housed at minimum-security fluctuated between 2015 and 2020. Over that period, the population increased by 17.4%, then dropped significantly (by 37.0%) between 2020 and 2021. The population is now at pre-COVID-19 levels.

Graph 11: Female Population All Other Locations by Year 2015 - 2025



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
WRC	40	42	41	43	42	42	42	36	40	40	39
MSDF		2	1	2	0	0	2	0	0	1	4

The female populations at WRC and MSDF remained consistent between 2015 and 2025.

Conclusions

System-wide, the total WIDOC population has returned to pre-pandemic levels. WIDOC facilities were at 130% of capacity at male facilities and 166% of capacity at female facilities. Overcapacity issues vary from facility to facility, but all medium-security facilities and all maximum-security facilities, except WCI, are currently over capacity. When a system is at or over capacity, routine transfers between facilities are extremely challenging. This results in a backlog of individuals at classification levels that do not reflect the individual's actual classification (e.g., individuals with a medium-security classification level that are housed at a maximum-security facility because not enough medium-security beds are available). Additionally, transfers within facilities (e.g., from restrictive housing to a general population unit) can also be challenging. Bed capacity and movement are significant challenges for WIDOC and require a concerted effort to oversee bed management.

Objective Classification

WIDOC partnered with the National Institute of Corrections (NIC) to modernize and increase the objectivity of its custody classification system. The initiative led to the development and implementation of the IFCC, replacing the Risk Rating Tool that had been in use since 1988. The IFCC was designed to enhance the validity and reliability of custody decisions, incorporate gender-responsive components, and reduce the overuse of discretion in classifications. Launched on December 11, 2023, the updated system is consistent with national standards, prioritizes institutional adjustment factors, and allows for better data monitoring and bed management.

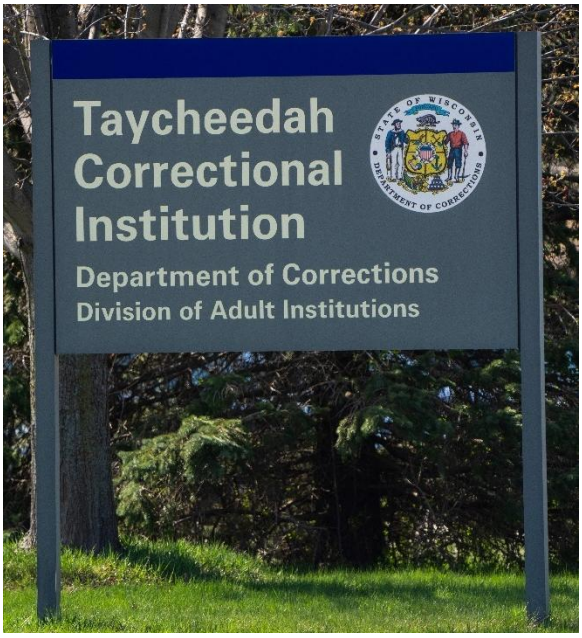
The development process involved a multidisciplinary workgroup of WIDOC staff from various facilities and disciplines. Through focus groups and consultations with NIC and classification expert Dr. Patricia Hardyman, the workgroup identified weaknesses in the previous tool and defined outcome measures aligned with institutional misconduct. Using statistical analyses, the Falcon Team selected objective, research-informed factors that were predictive of serious or disruptive behavior in custody. These factors were weighted and categorized to reflect their relative predictive value, with distinctions made between male and female populations to ensure gender responsiveness.

The resulting IFCC consists of four distinct tools: male and female initial classification instruments and male and female re-classification instruments. These tools use point-based scoring systems to generate gender responsive custody level recommendations. The instruments also incorporate mandatory restrictors, legacy processes, and discretionary overrides to maintain operational flexibility and policy compliance. Early results indicated that the IFCC has created a more consistent, transparent, and data-driven classification process.

WIDOC plans to revalidate the instruments every three to five years, ensuring ongoing alignment with current research and institutional needs.

Intake/Reception/Orientation/Assessment

Reception for male incarcerated individuals is conducted at DCI and at TCI for females.



At DCI, the classification and intake process follows a structured 12-week protocol aligned with national standards. During this time, individuals undergo comprehensive assessments, including medical screenings and mental health evaluations (including assignment of the mental health classification score). Unit 19 is designated for initial classification and assessments, including those related to PREA compliance. On average, there are between 30 to 40 admissions per day. Over the 12-month period between April 2024 and March 2025, 7,194 males were admitted to WIDOC facilities. The facility also uses Correctional Offender Management Profiling for Alternative Solutions (COMPAS) as part of its classification strategy and generally does not segregate individuals by race or gang affiliation. The new classification tool has been well received by staff.

At TCI, the classification and intake process is also aligned with national standards, and newly incarcerated women receive comprehensive assessments, medical screenings and evaluations, and mental health evaluations. Over the 12-month period between April 2024 and March 2025, 878 females were admitted to WIDOC facilities.

Restrictive Housing

The negative effects of solitary confinement have been widely studied and documented, especially regarding certain vulnerable groups. In 2021, the Vera Institute of Justice published

an *Evidence Brief* [5] that provided a comprehensive overview of the potential impacts of solitary confinement. This included physical harm, the development of health issues, and negative effects on mental health and overall well-being. Solitary confinement is also associated with an increased risk for self-directed violence and suicide, and social deprivation can lead to slowed brain activity and neurological damage. Solitary confinement also disproportionately affects incarcerated people who are Black, Indigenous, and People of Color (BIPOC), and sexual minority populations, such as Lesbian, Gay, Bisexual, Transgender, Queer (or questioning), and more (LGBTQ+) people living with mental illness and those with disabilities.

Specifically, individuals with SMI placed in restrictive housing are more likely to become violent and, if released from restrictive housing, are more likely to return.[6] Those individuals housed in restrictive housing are also more likely to die by suicide than those living in other housing settings.

Group-level research consistently shows that solitary confinement as a tool does not decrease institutional misconduct or violence, including assaults on staff, nor does it decrease the risk of recidivism. In fact, it may increase that risk in some instances. Reducing solitary confinement utilization still allows for urgent circumstances and individual-level use as a last resort.

[5] James, K. & Vanko, E. (2021). The impacts of solitary confinement. *Vera Institute.* Microsoft Word - Impacts of Solitary Confinement FINAL.docx (vera.org)

[6] Kupers, T. A. (2017). Solitary: the inside story of supermax isolation and how we can abolish it. *Oakland,* California, University of California Press.

When examining the rates of individuals in some isolation settings across state departments of correction, the *Time-In-Cell: A 2021 Snapshot of Restrictive Housing*[7] found that states varied widely from zero percent of individuals in restrictive housing in Colorado, Delaware, North Dakota, and Vermont to 14.8% of individuals in restrictive housing in Utah.

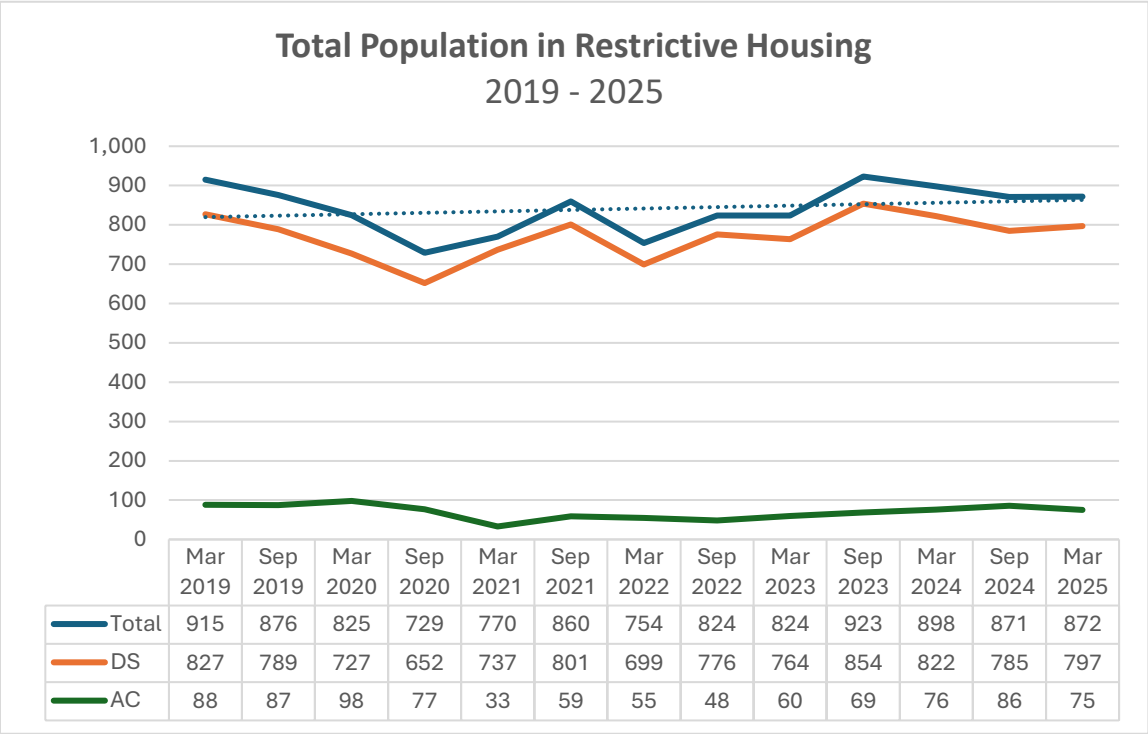
WIDOC has begun to address the number of individuals in restrictive housing and the length of time they spend there. The next sections provide an overview of recent trends in restrictive housing throughout the department.

Restrictive Housing Trends

While the number of individuals placed in restrictive housing has not changed significantly over the past five years, WIDOC has demonstrated improved compliance system wide, with the disciplinary guidelines revised in early 2024, and began decreasing sanctions (i.e., the length of time) in the months leading up to the effective date.

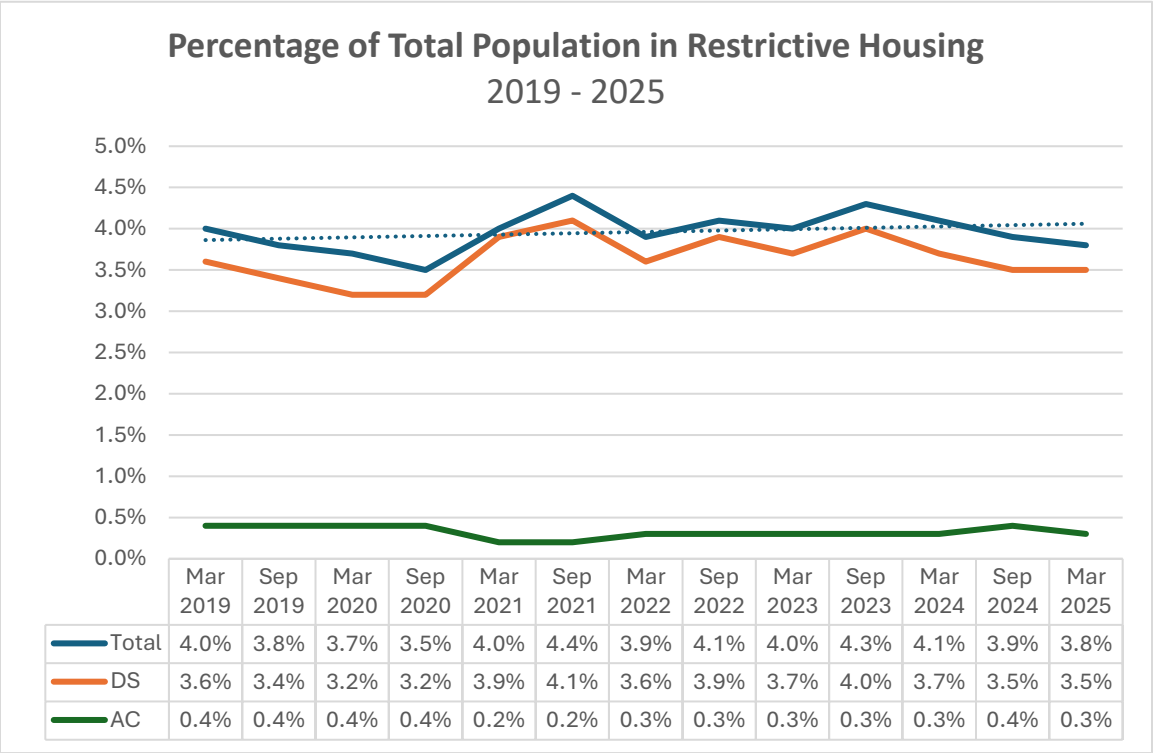
[7] Time-in-cell A 2021 snapshot of restrictive housing based on a nationwide survey of U.S. prisons. (2022, August). Retrieved from Time-In-Cell 2021 | Yale Law School.

Graph 12: Total Population in Restrictive Housing 2019 - 2025



	Mar 2019	Sep 2019	Mar 2020	Sep 2020	Mar 2021	Sep 2021	Mar 2022	Sep 2022	Mar 2023	Sep 2023	Mar 2024	Sep 2024	Mar 2025
Total	915	876	825	729	770	860	754	824	824	923	898	871	872
DS	827	789	727	652	737	801	699	776	764	854	822	785	797
AC	88	87	98	77	33	59	55	48	60	69	76	86	75

Graph 13: Percentage of Total Population in Restrictive Housing 2019 - 2025



	Mar 2019	Sep 2019	Mar 2020	Sep 2020	Mar 2021	Sep 2021	Mar 2022	Sep 2022	Mar 2023	Sep 2023	Mar 2024	Sep 2024	Mar 2025
Total	4.0%	3.8%	3.7%	3.5%	4.0%	4.4%	3.9%	4.1%	4.0%	4.3%	4.1%	3.9%	3.8%
DS	3.6%	3.4%	3.2%	3.2%	3.9%	4.1%	3.6%	3.9%	3.7%	4.0%	3.7%	3.5%	3.5%
AC	0.4%	0.4%	0.4%	0.4%	0.2%	0.2%	0.3%	0.3%	0.3%	0.3%	0.3%	0.4%	0.3%

As illustrated in the previous two graphs, the restrictive housing population size has fluctuated month-to-month over the past five years. However, the five-year population trend is essentially flat in absolute terms and proportionally. On the last day of March 2019, 915 individuals were housed in restrictive housing versus 872 in March 2025. Proportionally, 4.0% of individuals were housed in restrictive housing in March 2019 versus 3.8% in March 2025. This change is not a statistically significant[8] difference ($z=1.09$, $p=.28$).

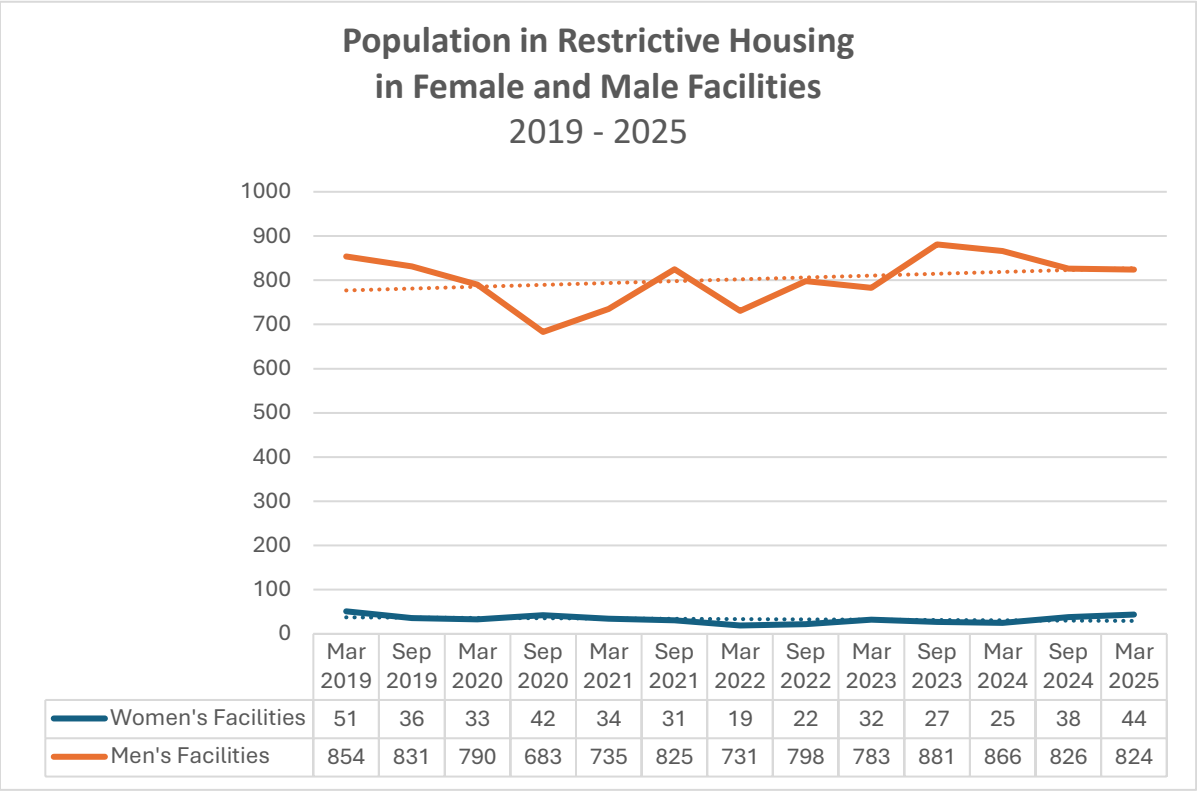
The available restrictive housing data indicates populations by facility. The following analysis is of group populations by gender typically housed in each facility, excluding individuals whose housing is listed as other.[9]

The five-year restrictive housing population trend is essentially flat for both male and female facilities, in absolute terms and proportionally.

[8] Statistical significance in this section is based on a two-proportion z-test.

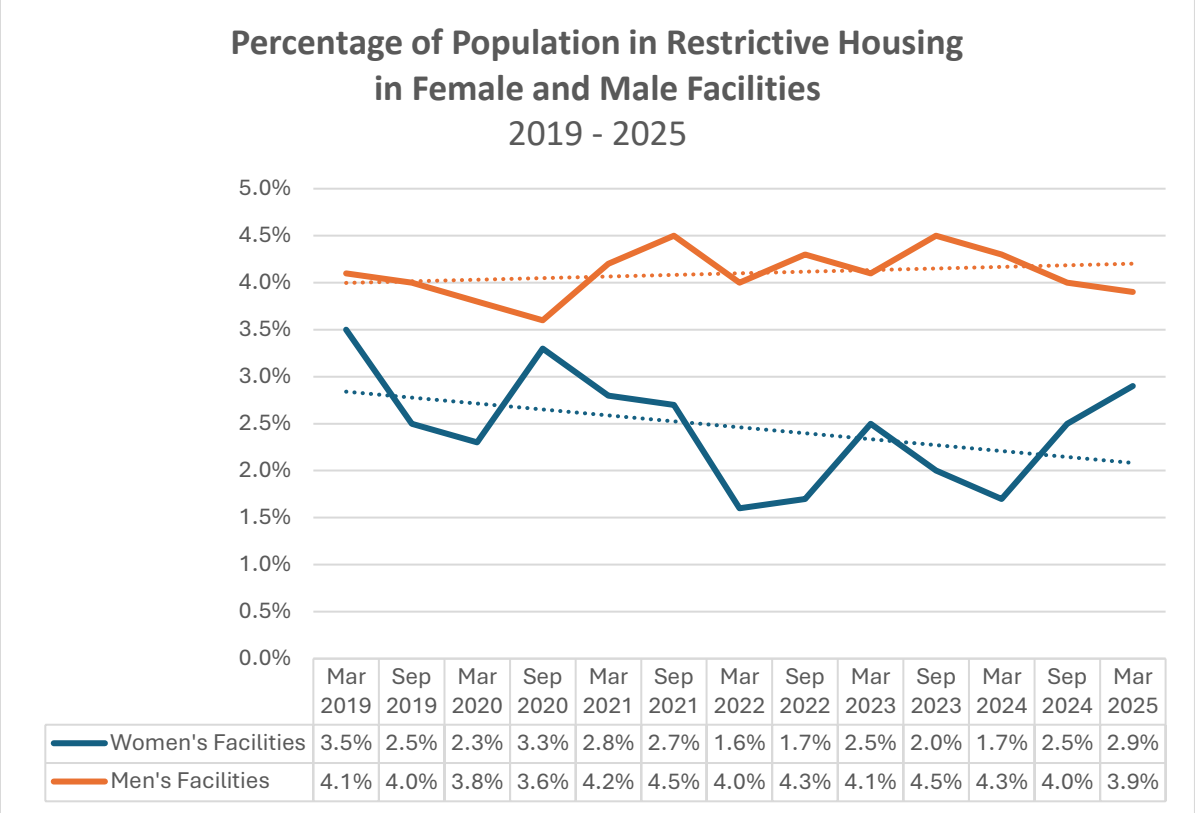
[9] A small number of individuals with a restrictive housing status are identified as being in an "Other" facility and therefore are not included in either the women's or men's facilities groupings.

Graph 14: Population in Restrictive Housing in Female and Male Facilities 2019 - 2025



	Mar 2019	Sep 2019	Mar 2020	Sep 2020	Mar 2021	Sep 2021	Mar 2022	Sep 2022	Mar 2023	Sep 2023	Mar 2024	Sep 2024	Mar 2025
Women's Facilities	51	36	33	42	34	31	19	22	32	27	25	38	44
Men's Facilities	854	831	790	683	735	825	731	798	783	881	866	826	824

Graph 15: Percentage of Population in Restrictive Housing in Female and Male Facilities 2019 - 2025

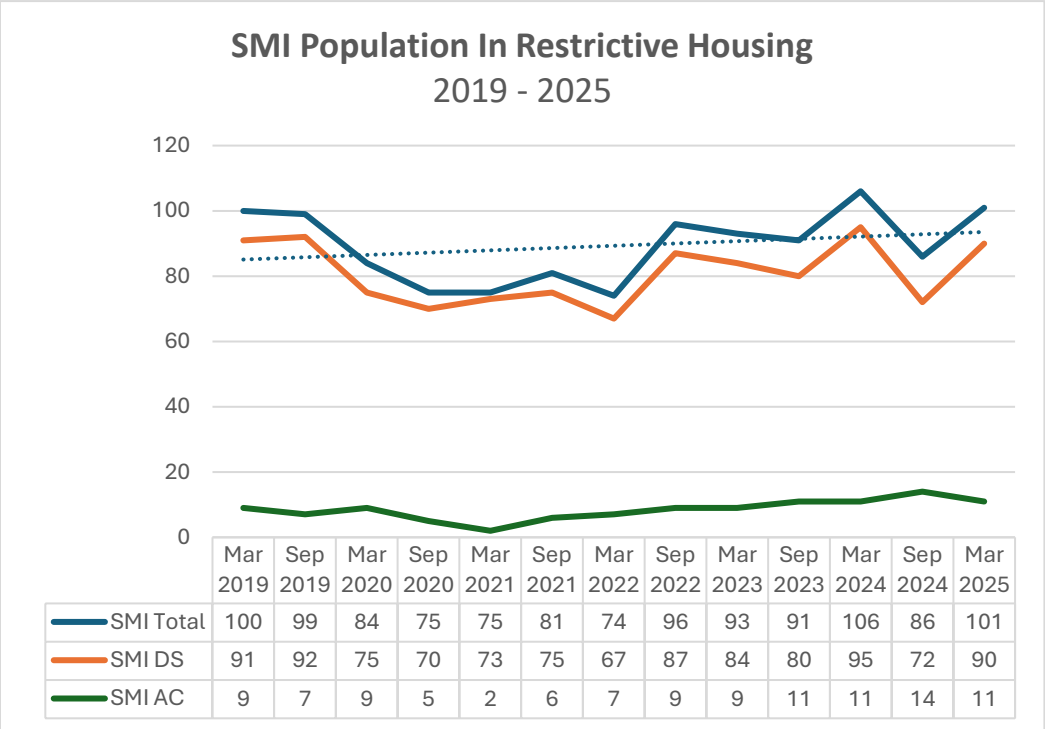


	Mar 2019	Sep 2019	Mar 2020	Sep 2020	Mar 2021	Sep 2021	Mar 2022	Sep 2022	Mar 2023	Sep 2023	Mar 2024	Sep 2024	Mar 2025
Women's Facilities	3.5%	2.5%	2.3%	3.3%	2.8%	2.7%	1.6%	1.7%	2.5%	2.0%	1.7%	2.5%	2.9%
Men's Facilities	4.1%	4.0%	3.8%	3.6%	4.2%	4.5%	4.0%	4.3%	4.1%	4.5%	4.3%	4.0%	3.9%

The difference from 4.1% to 3.9% in male facilities is not statistically significant (z=1.05, *p*=.29), and the slight five-year decline in female facilities from 3.5% to 2.9% is also not statistically significant (z=0.93, *p*=.35).

SMI Population Trends in Restrictive Housing

Graph 16: SMI Population in Restrictive Housing 2019 - 2025



	Mar 2019	Sep 2019	Mar 2020	Sep 2020	Mar 2021	Sep 2021	Mar 2022	Sep 2022	Mar 2023	Sep 2023	Mar 2024	Sep 2024	Mar 2025
SMI Total	100	99	84	75	75	81	74	96	93	91	106	86	101
SMI DS	91	92	75	70	73	75	67	87	84	80	95	72	90
SMI AC	9	7	9	5	2	6	7	9	9	11	11	14	11

For individuals designated as SMI, the five-year trend for placement in restrictive housing is also flat based on absolute population size; however, there appears to be a slight increase in the proportion of individuals classified as SMI who are in restrictive housing, though the difference is not statistically significant (z=1.38, *p*=.17).

Population in Restrictive Housing by Race

The restrictive housing population by race was compared to the total WIDOC population by race as of April 30, 2025. The labels for race are the ones currently used by WIDOC.

Table 5: Restrictive Housing Population by Race

RACE	Total Population April 30, 2025	% of Population Total	RH Total	% of RH Total	% of Population Total	% of Race Population Total	SMI	SMI %
All Racial Classifications	23,240	100.0%	797	100.0%	3.43%	3.4%	89	11.2%
White	12,111	52.1%	297	37.3%	1.28%	2.5%	38	12.8%
Black	9,530	41.0%	436	54.7%	1.88%	4.6%	44	10.1%
Asian/Pacific Islander	301	1.3%	6	0.8%	0.03%	2.0%	0	0.0%
American Indian/ Alaskan Native	1,288	5.5%	58	7.3%	0.25%	4.5%	7	12.1%

While White individuals account for 52% of the WIDOC population, this group makes up 37% of those in restrictive housing. Black individuals comprise 41% of the WIDOC population and account for 54% of the restrictive housing population.

Overall, 3.4% of the WIDOC total population was in restrictive housing at the time of this analysis. When examining the percentage of each racial classification in restrictive housing, the following results were found:

- 2.5% of the White population.
- 4.6% of the Black population.
- 4.5% of the American Indian/Alaskan Native population.
- 2% of the Asian/Pacific Islander population.

Additionally, Black individuals in restrictive housing were slightly less likely to be designated SMI.

Table 6: Restrictive Housing and Length of Stay by Race

RACE	Restrictive Housing Total as of 4/30/2025	# with Current Restrictive Housing stays over 30 days
White	319	83
Black	472	165
Asian/Pacific Islander	4	1
American Indian/Alaskan Native	53	14
TOTAL	**848**	**263**

Of the 848 individuals housed in restrictive housing on April 30, 2025, 263 (31.0%) were there for over 30 days. Of those in restrictive housing for over 30 days, 63% were Black, whereas 32% were White, and less than 1% were classified as Asian/Pacific Islander or American Indian/Alaska Native.

Length Of Stay in Restrictive Housing for Disciplinary Separation

Between January 2019 and April 2025, the average length of stay (LOS) in disciplinary separation (DS) decreased from 39.7 days to 27.4, a 31.0% decline over five years. However, there is substantial variability between facilities as illustrated in the following table that lists the average and median LOS for each facility:

Table 7: Average and Median LOS by Facility as of April 2025

FACILITY	Average LOS	Median LOS
Green Bay Correctional Institution	48.8	32
Wisconsin Secure Program Facility	48.5	31
Redgranite Correctional Institution	43.9	35
Columbia Correctional Institution	38.7	28
Black River Correctional Center	38.0	38
Jackson Correctional Institution	32.5	30
New Lisbon Correctional Institution	31.7	29
Racine Correctional Institution	29.2	23

FACILITY	Average LOS	Median LOS
Other	28.2	26
Fox Lake Correctional Institution	28.2	23
Prairie Du Chien Correctional Institution	26.6	29
Oshkosh Correctional Institution	26.3	18
Waupun Correctional Institution	26.2	29
Taycheedah Correctional Institution	25.7	16
Oakhill Correctional Institution	25.2	19
Robert E. Ellsworth Correctional Center	23.3	16
Milwaukee Secure Detention Facility	22.6	16
Stanley Correctional Institution	22.2	16
Kettle Moraine Correctional Institution	21.4	16
Racine Youthful Offender Correctional	17.7	15
Dodge Correctional Institution	16.3	11
John C. Burke Correctional Center	14.5	15
Winnebago Correctional Center	13.0	10
Chippewa Valley Treatment Facility	7.6	8
Felmers O. Chaney Correctional Center	7.5	1
Gordon Correctional Center	5.5	6
Thompson Correctional Center	3.0	2
Kenosha Correctional Center	1.0	1

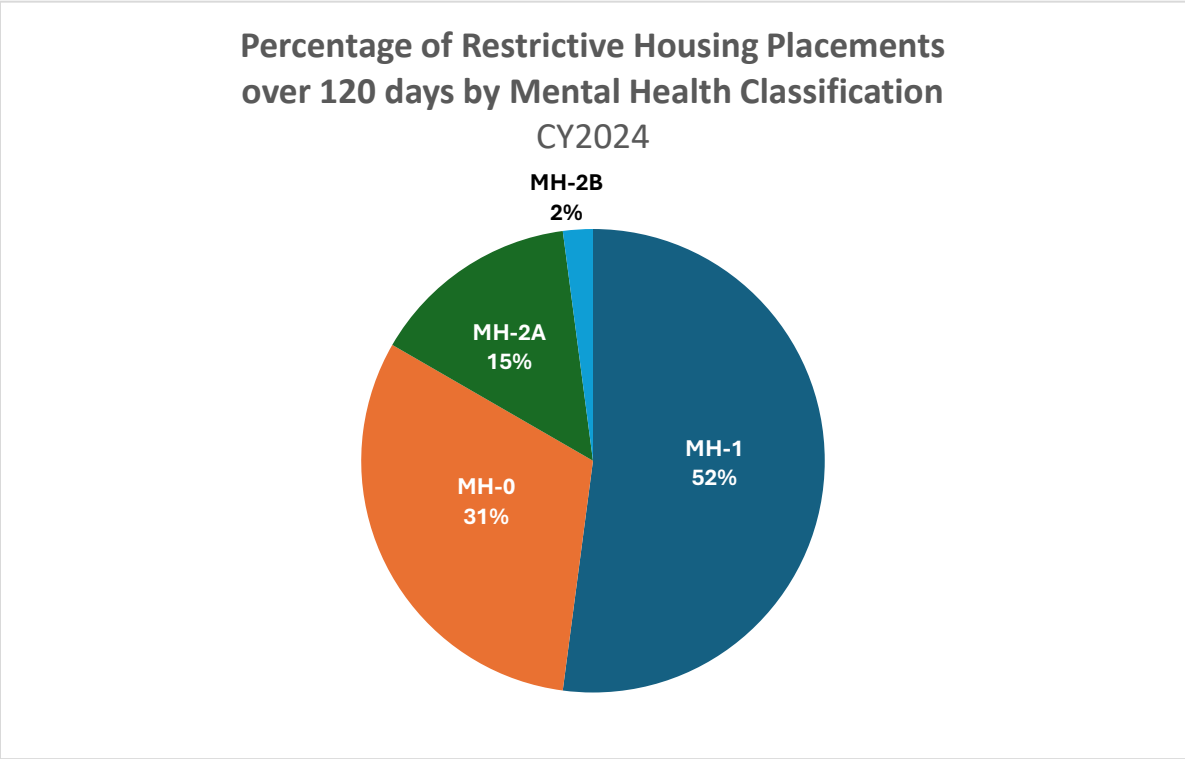
FACILITY	Average LOS	Median LOS
McNaughton Correctional Center	1.0	1
Oregon Correctional Center	1.0	1
Sanger B. Powers Correctional Center	1.0	1

Discipline and Restrictive Housing

Conduct Reports Data

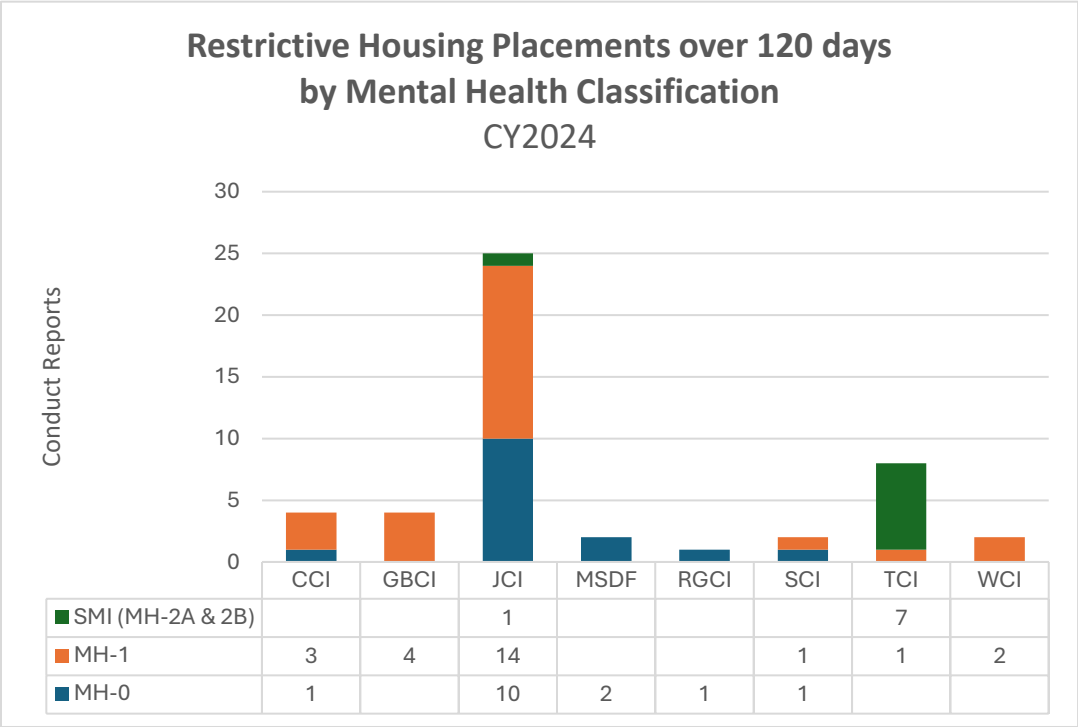
WIDOC implemented a policy change on May 13, 2024, that any restrictive housing placement exceeding 120 days is required to be approved by the DAI assistant administrator. The goal of this policy change is to reduce the length of time individuals spend in restrictive housing and to ensure consistency in the process for extended restrictive housing placements. A total of 48 occurrences of restrictive housing placement of over 120 days was approved between January 1, 2024 and November 30, 2024. The following figure illustrates the mental health classification of those sanctioned to restrictive housing for more than 120 days.

Figure 1: Percentage of Restrictive Housing Placements over 120 days by Mental Health Classification CY2024



Overall, 69% of those sanctioned to restrictive housing for more than 120 days were on the mental health caseload. 52% were classified as MH-1, while 15% were MH-2A and 2% were MH-2B.

Graph 17: Restrictive Housing Placements over 120 days by Mental Health Classification CY2024



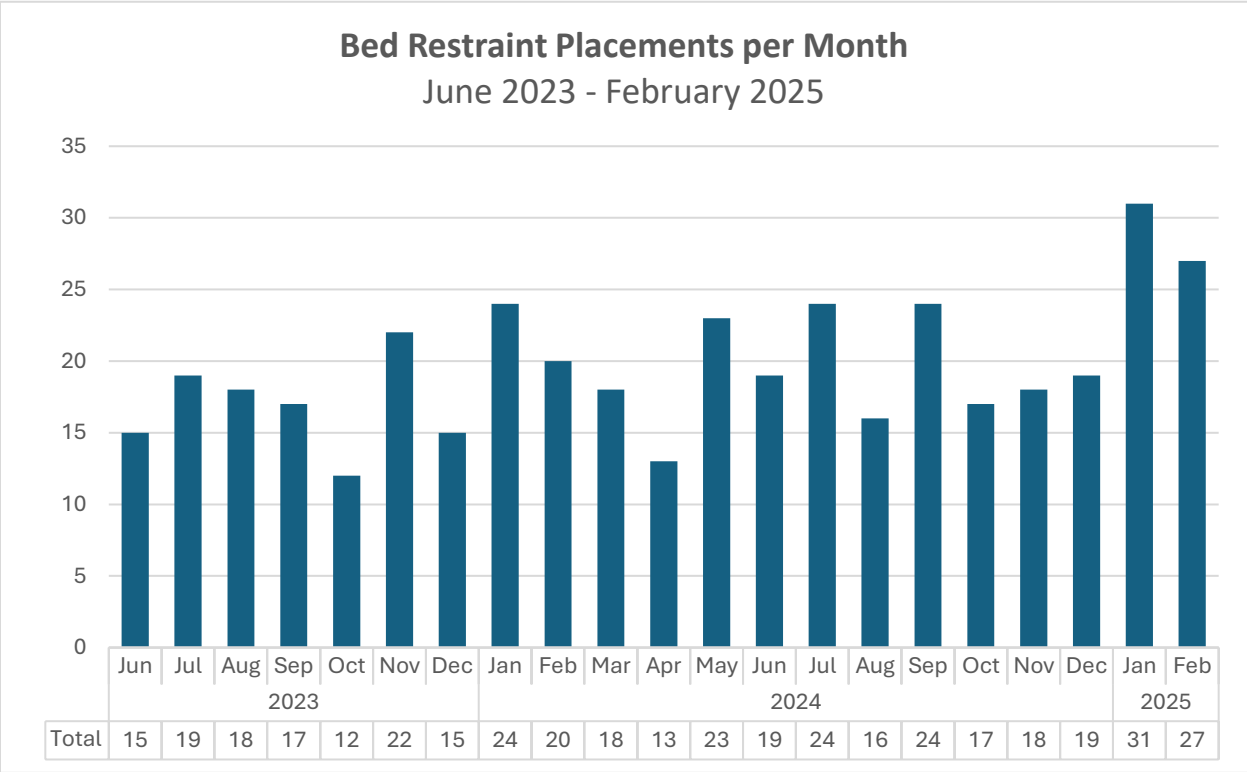
Of the 40 placements approved for over 120 days at male facilities, 63% occurred at Jackson Correctional Institution (JCI). At TCI, seven of the eight (88%) placements in restrictive housing for over 120 days were for individuals designated SMI.

To continue decreasing the use of restrictive housing and improving the conditions for those placed in restrictive housing, as well as for staff working in restrictive housing units, Falcon is recommending a focus on next steps. This is further described in the Next Steps in Restrictive Housing section and includes detailed recommendations.

Use of Restraints

Data on the use of bed restraints was available for three maximum-security facilities, Columbia, Green Bay, and Waupun, over a 21-month period between June 2023 and February 2025. The following graph illustrates the number of bed restraint placements per month over this time:

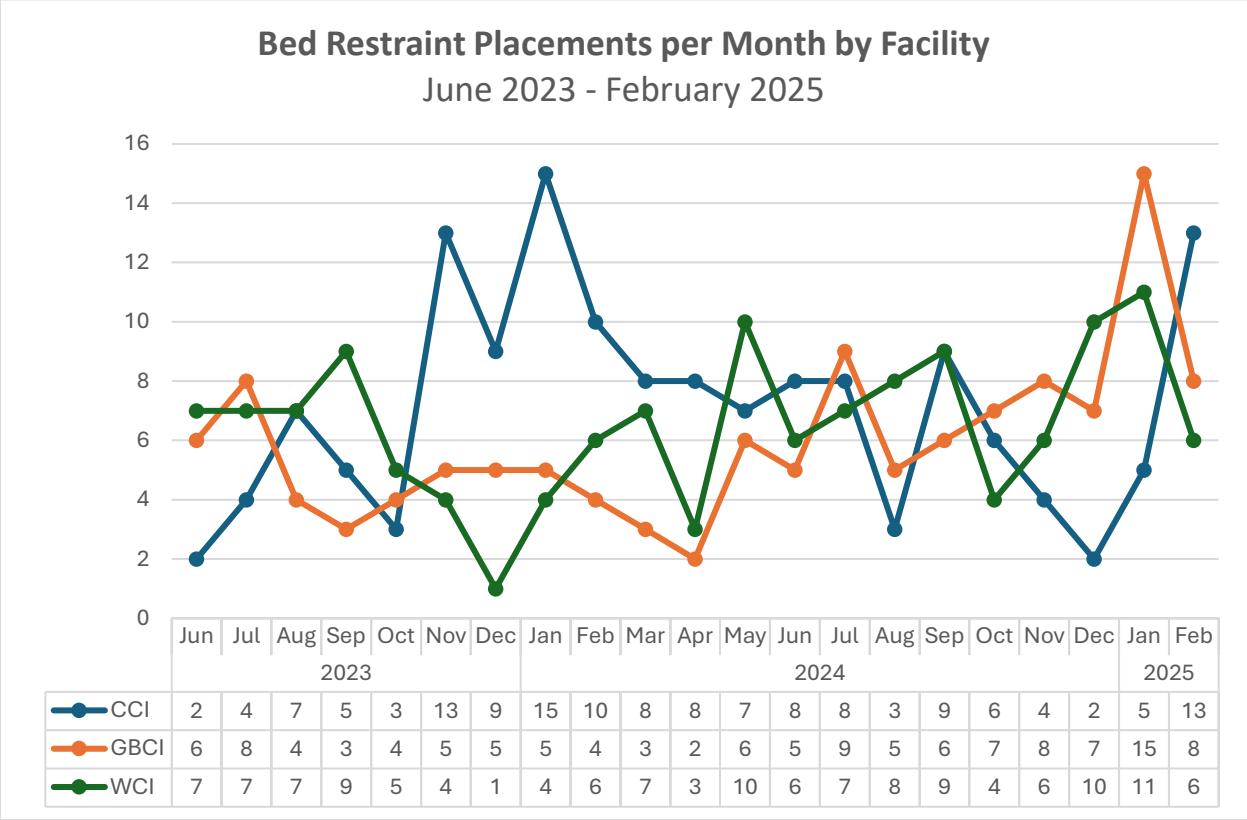
Graph 18: Bed Restraint Placements per Month, June 2023 - February 2025



The use of bed restraints increased in this time frame. The average number of bed restraint placements between June 2023 and April 2024 was 17.6 per month, whereas the average number of bed placements between May 2024 to February 2025 was 21.8 per month.

The following graph illustrates the number of bed restraint placements per month at each of the three maximum-security facilities.

Graph 19: Bed Restraint Placements per Month by Facility, June 2023 - February 2025



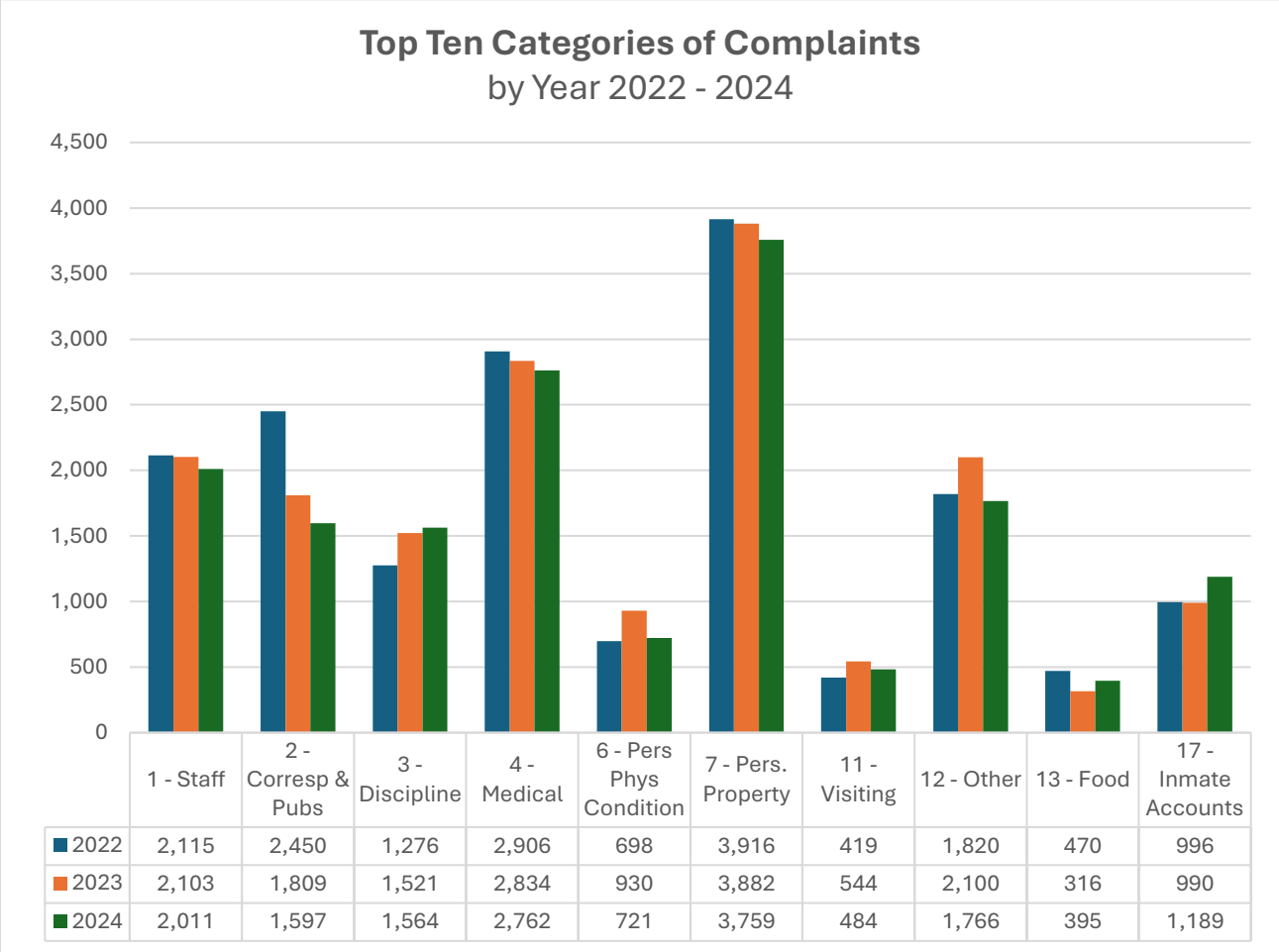
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
	2023							2024												2025	
CCI	2	4	7	5	3	13	9	15	10	8	8	7	8	8	3	9	6	4	2	5	13
GBCI	6	8	4	3	4	5	5	5	4	3	2	6	5	9	5	6	7	8	7	15	8
WCI	7	7	7	9	5	4	1	4	6	7	3	10	6	7	8	9	4	6	10	11	6

The above graph illustrates the significant variability month-to-month at each facility.

Complaints by Incarcerated Individuals

All formal complaints by incarcerated individuals are classified into one of 27 categories. The following graph illustrates the ten most frequent categories.

Graph 20: Top Ten Categories of Complaints by Year 2022 - 2024



	1 - Staff	2 - Corresp & Pubs	3 - Discipline	4 - Medical	6 - Pers Phys Condition	7 - Pers. Property	11 - Visiting	12 - Other	13 - Food	17 - Inmate Accounts
2022	2,115	2,450	1,276	2,906	698	3,916	419	1,820	470	996
2023	2,103	1,809	1,521	2,834	930	3,882	544	2,100	316	990
2024	2,011	1,597	1,564	2,762	721	3,759	484	1,766	395	1,189

Over the three years of complaint data, total complaints were consistent, ranging between 18,480 and 19,283 per year. Within the top ten categories of complaints, the total complaints per category were also consistent with one notable decrease of 34% related to “2 - Correspondence and Pubs” between 2022 and 2024.

The following table lists the number of complaints across all categories between 2022 - 2024.

Table 8: Complaints by Category and Year

Code-Category	2022	2023	2024
1 - Staff	2,115	2,103	2,011
2 - Corresp and Pubs	2,450	1,809	1,597
3 - Discipline	1,276	1,521	1,564
4 - Medical	2,906	2,834	2,762
5 - Parole	54	40	63
6 - Pers Phys Condition	698	930	721
7 - Pers. Property	3,916	3,882	3,759
8 - Rules	195	172	153
9 - Religion	154	195	144
10 - Work/School Program	357	320	345
11 - Visiting	419	544	484
12 - Other	1,820	2,100	1,766
13 - Food	470	316	395
14 - Classification	191	199	253
15 - ICRS	260	302	290
16 - Discrimination	23	18	15
17 - Inmate Accounts	996	990	1,189
18 - BCE	35	13	5
19 - Breach of Conf Health Info	115	78	77
20 - Staff Sexual Misconduct	124	132	140
21 - Inmate Sexual Misconduct	77	100	100
22 - Dental	190	289	293
24 - Staff Misconduct	199	105	95
25 - Psychology	168	224	196

Code-Category	2022	2023	2024
26 - Psychiatry	75	65	57
27 - Unknown			6
Total Complaints	**19,283**	**19,281**	**18,480**

Reentry Services

WIDOC has a reentry unit comprised of a director and ten staff members. This unit oversees contracted programming and begins working with individuals approximately three to nine months prior to release and provides support for up to one year post-release. Northpointe and the Wisconsin Integrated Corrections System (WICS) are used to track enrollments, waitlists, and individual accounts. The overall release planning process is intended to be continuous, beginning at intake and is guided by the COMPAS assessment tool, which is updated throughout an individual's incarceration. The development of a continuous case plan that begins at the facility and then transitions to the community is a best practice; however, the Falcon Team was not able to confirm if it was a routine practice throughout the department. Social workers (non-clinical social workers) and agents collaborate with the incarcerated individual to develop a personalized release plan that addresses critical needs such as housing, transportation, healthcare coverage, identification, and connection to community resources. Reentry efforts also focus on public safety and community engagement through electronic monitoring, proactive education, and opioid overdose response teams. These efforts underscore a broad, multidisciplinary strategy aimed at reducing recidivism and fostering successful reintegration, even as the system contends with an aging population, increasing mental health needs, and evolving community safety expectations.

In 2009, Act 28 created the *Becky Young Community Corrections Recidivism Reduction Community Services Appropriation* to fund, implement, and expand reentry initiatives across the department and with community partners. In FY24, a total of $14 million was invested in this program, with 51.3% directed to reentry support services, 22.4% to employment strategies, and 15.4% to housing services. Top initiatives included the following:

- Opening Avenues to Reentry Success (OARS) program.
- Reentry Legal Services (RLS).
- Windows to Work (W2W).
- Career and Technical Education (CTE) and mobile labs.

These initiatives provided comprehensive support ranging from mental health case management to vocational training and legal assistance.

The OARS program was particularly effective in reducing recidivism among participants with SMI. In FY24, the program served 369 individuals across 21 counties. Participants demonstrated significantly lower three-year recidivism rates compared to matched control groups:

- 21.3% lower reincarceration.
- 15.1% lower reconviction.
- 12.3% lower rearrest rates.

Similarly, the W2W program (a pre- and post-release employment readiness initiative) also showed positive outcomes. After three years, W2W program participants had a higher employment rate (by 7.6%) and a lower incarceration rate (by 6.6%) than non-participants. CTE participants also had an 11.5% lower reincarceration rate and showed increased employment engagement post-release.

Another important reentry initiative is connecting individuals to Medicaid services to ensure healthcare services continuity upon release. In FY24, 7,193 individuals were released from WIDOC DAI custody with 5,216 (72.5%) approved for Medicaid programs and approximately 70% of these approvals were secured before the individual's release.

Mental health classification data indicates that those with more acute mental health needs receive Medicaid approval at higher rates. For example, individuals with a classification of MH-2Bs are approved at a 20.4% higher rate than that of other individuals, followed by MH-2As and MH-1s, which are 9% and 6.5% respectively. Providing Medicaid coverage prior to reentry reduces the burden on emergency services and local health systems by ensuring that the formerly incarcerated are linked to healthcare services, including behavioral healthcare. These outcomes support maintaining and expanding such initiatives.

Some challenges related to reentry services identified during this review:

- Social workers are frequently pulled into multiple roles, reducing their capacity to focus solely on reentry-related tasks. Agents are responsible for reviewing completed programming and conducting post-release risk assessments. These reentry social worker and agent positions experience high vacancy rates.

- Providing reentry services for individuals at high risk, such as those classified as sex offenders or those with SMIs, is a challenge. For example, sex offenders often face significant barriers to securing approved housing, even years after completing required treatment, resulting in release delays.

Summary of Workshop and Site Visit Discussions with Staff Related to Operational and Custody Issues

The following section summarizes information gleaned from staff on operational and custody issues during the operational/custody workshops and during the facility visits.

Common themes include staffing shortages, classification and bed management concerns, inconsistent communication and training practices, and a desire for greater institutional autonomy in decision-making.

The most cited issue was chronic staffing shortages, including non-uniform roles like food services, medical personnel, and administrative staff. While recent pay increases have helped recruit and retain uniform staff, a significant wage disparity remains for non-uniform employees, which hinders hiring and increases turnover. This disparity has also resulted in non-uniform staff transitioning to uniform positions, which has a negative impact on programming. Facility management proposed decentralizing the hiring system, so facilities can have more control. Delays in onboarding—sometimes as long as six months—were reported.

Bed management was identified as a persistent operational challenge. Wardens across security levels reported significant backlogs in moving incarcerated individuals to appropriate custody levels because of limited bed space in medium and minimum facilities. The current backlog reportedly includes over 1,000 individuals waiting for reclassification.

Disciplinary processes and restrictive housing usage were discussed at length, with general support for the recent reduction in restrictive housing use. Staff in some facilities, however, reported that the changes to reduce time in restrictive housing has had a “negative impact,” as they perceived restrictive housing placement as a “useful tool” for managing dangerous behavior.

Frequent cycling between restrictive housing and general population, without sustained programming or behavioral interventions, was a concern, as there was limited specialized training for hearing officers.

Reentry and community supervision were identified as areas of both innovation and concern. Staff in the “social worker” positions are stretched thin, limiting their ability to provide consistent release planning. Housing in the community, especially for sex offenders, remains a critical bottleneck. The case planning tools are often seen by staff as administratively

burdensome with limited practical value. Leaders recommended enhancing coordination between institutions and community corrections.

The revised Correctional Officer Training Academy curriculum, introduced in 2022, emphasizes communication, respect, and de-escalation, and has been linked to reduced attrition. However, challenges persist in fully implementing the FTO model, reportedly due to staffing shortages.

The Complaint and Grievance System was identified as a strength for its structure and data analysis, but with some highlighted gaps in transparency and follow-up, particularly in informing complainants of outcomes. It is generally recognized that the system helps de-escalate tensions and provides meaningful oversight, but it needs improvements in responsiveness to ensure credibility and fairness.

Taken together, information gathered from workshops and facility visits reflects a correctional system in transition—one that is actively modernizing its policies and practices.

E. Mental Health

WIDOC DAI's mental health program has the basic policies and components necessary for a comprehensive program. This section is an overview of the overall mental health program, which will be followed by a review of areas that could be modified to improve the overall mental health program safely and effectively.

Initial Assessment at Reception: Upon intake at a reception facility, nursing staff conduct an initial mental health screening, which includes questions related to the individual's mental health history, risk factors for suicide, and history of treatment with psychotropic medication. PSU staff then complete a comprehensive mental health screening within two working days of intake. At the completion of the mental health assessment, a mental health classification code is determined. The mental health classifications are as follows (as written in *DAI Policy #: 500.70.01, Mental Health Screening, Assessment and Referral*):

- **MH-0** – PIOC has no current mental health need, does not need a scheduled follow-up visit with PSU, and is not seeing a psychiatrist for any reason.
- **MH-1** – PIOC is receiving mental health services but does not suffer from a serious mental illness. This code is not appropriate for PIOC who are receiving only program services, such as substance abuse or sex offender treatment, and have no other mental health needs.
- **MH-2A** – PIOC has a current diagnosis of, or is in remission from, the following conditions: Schizophrenia, Delusional Disorder, Schizophreniform Disorder, Schizoaffective Disorder, Other Specified (and Unspecified) Schizophrenia Spectrum and Other Psychotic Disorder, Major Depressive Disorder, Bipolar I Disorder, and Bipolar II

Disorder. MH-2A also includes inmates with current or recent symptoms of the following conditions: Brief Psychotic Disorder, Substance / Medication-Induced Psychotic Disorder, head injury or other neurological impairments that result in behavioral or emotional dyscontrol, chronic and persistent mood or anxiety disorders, and other conditions that lead to significant functional disability.

- **MH-2B** – PIOC has a primary personality disorder that is severe, accompanied by significant functional impairment and subject to periodic decompensation (i.e., depression or suicidality). If PIOC has stable behavior for two years, the code may be reassessed. Excluded from MH-2B classification are PIOC who have a primary diagnosis of Antisocial Personality Disorder and whose behavior is primarily the result of targeted goals rather than impairment from diagnosed mental illness.
- **Intellectually Disabled (ID)** – An IQ of approximately 70 or below with concurrent impairments in present adaptive functioning and age of onset before 18 years.

If an individual is a MH-1, MH-2A, MH-2B, or ID, they are placed on the mental health caseload and seen routinely by PSU staff.

Ongoing Mental Health Services: Mental health services in general population settings are tailored according to the individual's classification. PSU staff provide routine therapeutic services and coordinate with psychiatry and health services staff (*DAI Policy #500.70.16*). MH-1 PIOC are seen at least every six months; MH-2A, MH-2B, and ID-coded individuals are seen at least once per quarter. Mental health services include individual and group therapy, psycho-educational programming, medication monitoring, and crisis response. Individuals with fluctuating symptoms or complex conditions may receive more frequent monitoring as clinically indicated.

According to *DAI Policy #500.70.19*, all individuals receiving mental health services must have a treatment plan. PSU staff develop an initial treatment plan at intake and update it every 180 days for MH-1 patients and every 90 days for MH-2A, MH-2B, and ID patients. Psychiatry staff develop and update separate psychiatric treatment plans at every psychiatric contact. These plans document the treatment course, clinical goals, interventions, and assigned roles of health professionals. Complex cases may require more detailed interdisciplinary plans, especially in restrictive or special housing settings.

Regarding frequency of contact for individual on the mental health caseload, *DAI Policy #500.70.16* states:

1. PIOC classified as MH-2A, MH-2B or ID shall be seen by PSU staff at least once every three months and more often as clinically necessary.
2. PIOC classified as MH-1 shall be seen by PSU staff at least once every six months and more often as clinically necessary.
3. For PIOC who are stable and at minimum-security centers without on-site PSU staff, the above monitoring schedules may be satisfied by psychiatry visits.

Access to Mental Health Services: If not identified as requiring mental health services upon intake, all incarcerated individuals can request to meet with mental health staff through *Psychological Service Requests*, with urgent issues responded to the same day and others within three working days (*DAI Policy #500.70.12*).

Informed Consent: Mental health staff need to obtain informed consent prior to initiating non-emergent treatment or evaluations. Consent discussions are documented in either the PSU or medical record. The incarcerated individual may refuse treatment unless under court order. Such refusals are documented with follow-up plans noted, and patients cannot be disciplined for refusing participation in mental healthcare.

Suicide Prevention Program: WIDOC's suicide prevention program includes components consistent with national standards, including training, identification, referral processes, assessment procedures, treatment and intervention, housing, monitoring, communication procedures, and debriefing and review procedures outlined in several policies including *DAI*

Policy #500.70.05-Mental Health Treatment-Crisis Services, DAI Policy #500.70.25-Suicide Prevention in Adult Correctional Facilities, and *DAI Policy # 500.70.24-Clinical Observation*. All DAI staff who interact with the incarcerated population receive six hours of pre-service mental health training, including suicide prevention and recognition of psychiatric symptoms (*DAI Policy #500.70.02*). Annual suicide prevention training is also required for all staff.

Specialized Mental Health Units: Specialized mental health units address the needs of incarcerated individuals who require structured or intensive treatment. SMUs serve individuals needing enhanced monitoring or structured out-of-cell treatment (*DAI Policy #500.70.17*). The SRTU, located at OCI, is a phased, incentive-based program for medium-custody individuals with MH-2A or ID codes who exhibit chronic maladaptive behavior or cannot function in the general population (*DAI Policy #500.70.31*). In the initial phase within the SRTU, a Behavior Management Plan (BMP) is developed. In later phases, compliance with treatment objectives is outlined in the BMP and used to approve a transition to higher phases. BMPs are defined as:

"A non-punitive and multidisciplinary written plan to address patient behaviors that threaten the safety of the patient or others, impair the safe and secure operation of the facility, or result in disciplinary action. The plan shall identify target behaviors, the appropriate staff responses to those behaviors, and guidance to the patient about more constructive behaviors."

Restrictive Housing: PSU staff are required to assess anyone with a mental health classification of MH-2A, MH-2B, and ID within one working day of placement in restrictive housing (*DAI Policy #500.70.18*). The following are the requirements for out-of-cell mental health contact for individuals designated SMI:

A. PSU staff shall offer out-of-cell interview to PIOC in restrictive housing settings who have mental health codes of MH-2A, MH-2B or ID on the following schedule:
    1. For medium- and fenced minimum- facilities, at least once per week.
    2. For maximum-security facilities, at least once per month.
    3. Group therapy or programming shall count as an out-of-cell contact.
    4. Refusal of an out-of-cell contact shall be documented in a Case Management note within the Health Care Record (HCR).
B. For MH-2A, MH-2B or ID PIOC, who do not have an out-of-cell interview in a particular week, PSU staff shall conduct a brief cell-side contact to:
    1. Document each restrictive housing round in the HCR.
    2. Interact with PIOC in a confidential manner and provide the opportunity for PIOC to express mental health concerns.

3. Promptly notify HSU staff of any urgent medical or dental problems that PIOC reports.
4. Promptly notify security staff of any security concerns.

According to *DAI Policy# 500.70.30*, a BMP is also created for any individuals with a mental health classification of MH-2A, MH-2B or ID who receives a disciplinary separation disposition of 60 days or in administrative confinement. The BMP is to be developed within ten days of placement.

Emergency Mental Health Services: DAI maintains 24/7 on-call coverage to manage after-hours mental health crises (*DAI Policy #500.70.03*). Licensed PSU staff respond within 15 minutes of contact and conduct in-person assessments when clinically indicated. If a PIOC is placed in observation after hours, an in-person PSU assessment must occur within 16 hours. For mechanical restraints initiated for clinical reasons, an assessment is required within two hours and repeated every 12 hours, consistent with *DAI Policy #500.70.10*. PSU staff may consult the mental health director or supervising psychologists during emergencies.

Psychiatric Services: Psychiatric services include diagnostic assessments, treatment planning, prescribing psychotropic medication when appropriate, and medication management (*DAI Policy #500.70.07*). Psychiatrists collaborate with PSU, HSU, and custody to ensure integrated treatment and attend interdisciplinary team meetings to support care coordination and treatment planning.

Access to Inpatient Psychiatric Care: Incarcerated individuals within DAI have access to inpatient psychiatric services at WRC. WRC is accredited by the NCCHC and was recognized by NCCHC in 2022 when the facility received the *R. Scott Chavez Facility of the Year Award* for its strong focus on resident care. PSU staff use a formal referral process to refer an incarcerated individual to WRC. If an individual is not approved for admission at WRC and continues to have a significant clinical need for a higher level of care, the psychologist supervisor/designee may request that the Bureau of Health Services psychology director/designee or mental health director review the case with the WRC clinical director to determine next steps. WRC is managed by the Department of Health Services (DHS) in partnership with the DOC.

The following list contains the major mental health policies discussed in this section including policy title, DAI policy number, and the new effective date.

Table 9: Policy and Effective Date

Policy Title	DAI Policy #	New Effective Date
Continuous Quality Improvement Program	500.10.27	12/16/2024
Mental Health Screening, Assessment and Referral	500.70.01	7/20/2015
Mental Health Training	500.70.02	2/3/2025
On-Call Mental Health Services	500.70.03	7/1/2015
Mental Health Crisis Services	500.70.05	12/21/2020
Consent for Mental Health Services	500.70.06	6/6/2016
Psychiatric Treatment	500.70.07	4/1/2019
Wisconsin Resource Center Transfers	500.70.08	12/02/2024
Mechanical Restraints	500.70.10	6/27/2024
Psychological Service Requests	500.70.12	1/11/2016
Mental Health Multidisciplinary Teams	500.70.14	7/2/2013
Mental Health Treatment – General Population	500.70.16	5/15/2023
Mental Health Treatment – Special Units	500.70.17	4/24/2012
Mental Health Treatment – Restrictive Housing	500.70.18	5/13/2024
Mental Health Treatment Plans	500.70.19	1/7/2019
Clinical Observation	500.70.24	7/13/2021
Suicide Prevention in Adult Correctional Facilities	500.70.25	1/25/2021
Mental Health Release Planning	500.70.29	7/1/2019
Behavior Management Plans	500.70.30	1/25/2021
Secure Residential Treatment Unit	500.70.31	5/1/2017

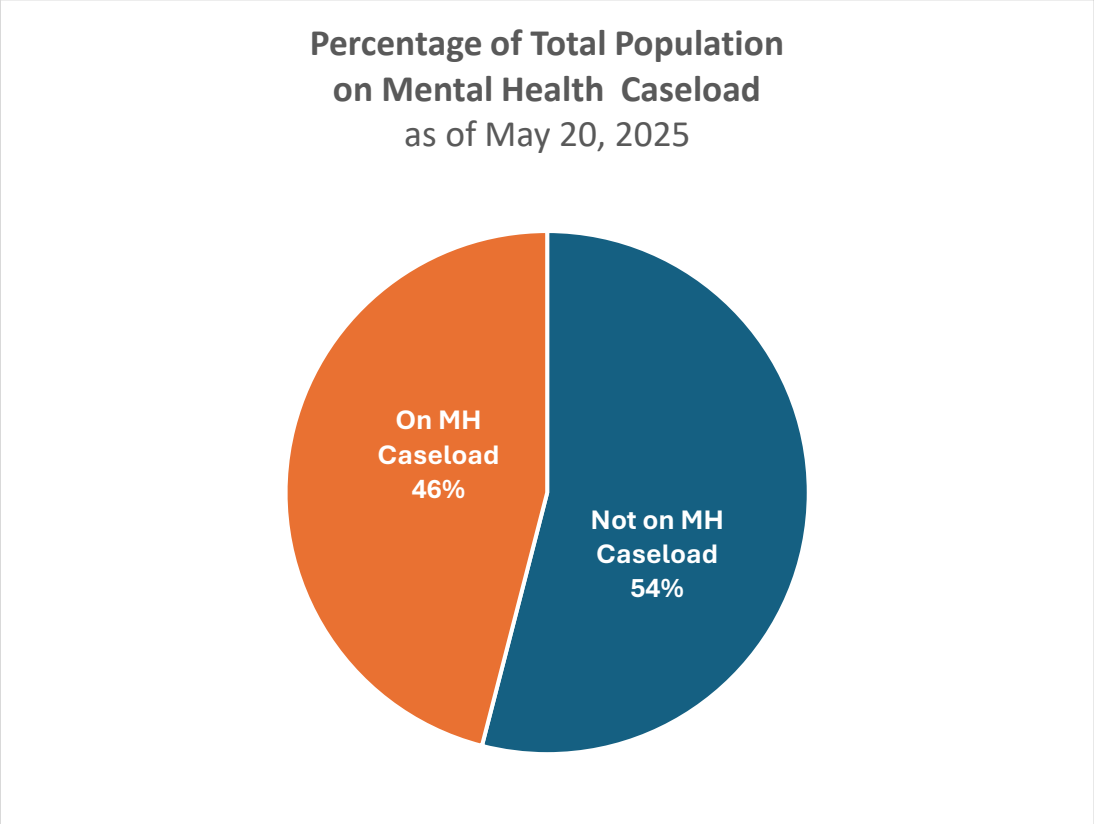
The next sections of this report review the overall mental health population serviced within WIDOC DAI and identify areas within the mental health system that could be improved.

Understanding the Mental Health Population Served

A mental health classification system serves to identify acute, chronic, and long-term mental health conditions. Such a system allows for aligned communications within and across disciplines and with incarcerated individuals that facilitate expectations for minimum frequency of contact, types of care, programming, and in some cases, housing. *DAI Policy 500.70.01, Chapter: 500, Subject: Mental Health Screening, Assessment and Referral* details the current mental health classification system, which is described in the Mental Health section above.

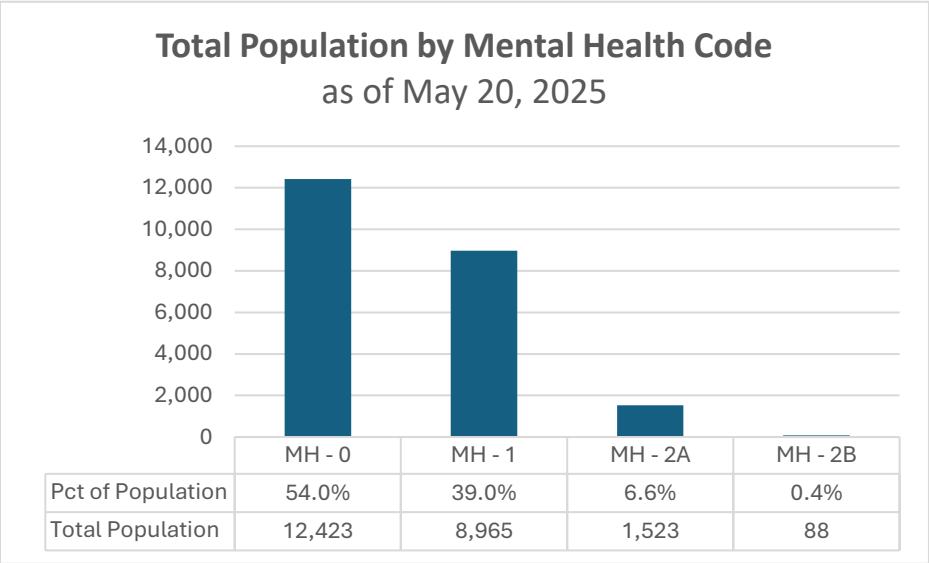
The current mental health classification system results in the following system-wide breakdown:

Figure 2: Percentage of Total Population on Mental Health Caseload as of May 20, 2025



Throughout DAI facilities, 46% of all incarcerated individuals were on the mental health caseload. The following graph lists the breakdown by each mental health classification.

Graph 21: Total Population by Mental Health Code as of May 20, 2025

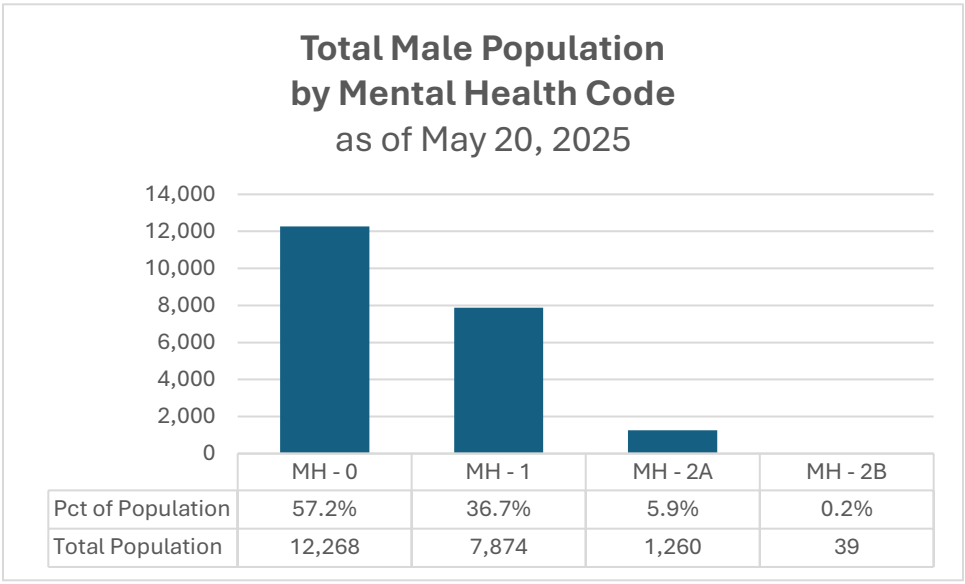


	MH - 0	MH - 1	MH - 2A	MH - 2B
Pct of Population	54.0%	39.0%	6.6%	0.4%
Total Population	12,423	8,965	1,523	88

Nearly half (46%) of all incarcerated individuals in WIDOC were on the mental health caseload, which is a much higher rate than seen in other state correctional departments.

The following graph shows the breakdown of the male incarcerated population by mental health classification.

Graph 22: Total Male Population by Mental Health Code as of May 20, 2025

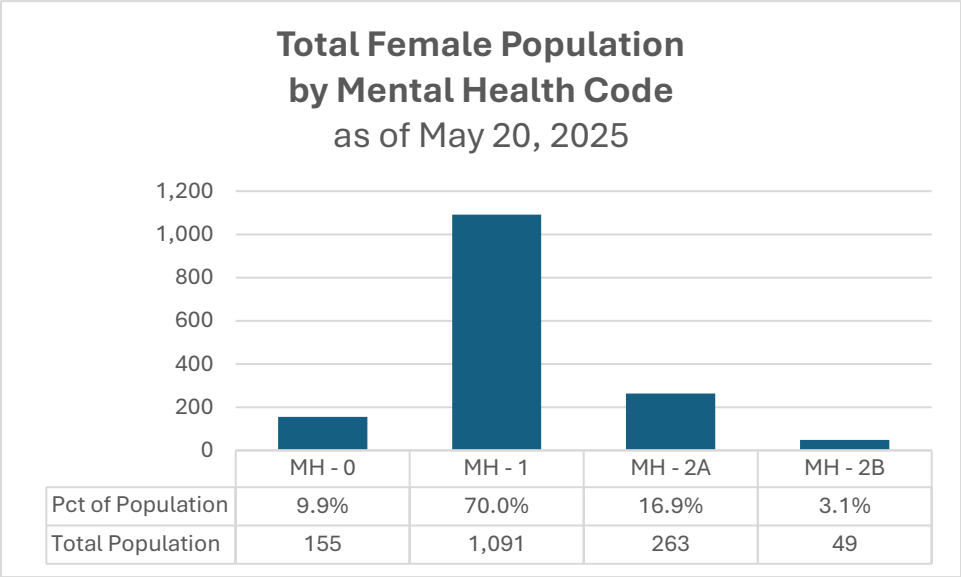


	MH - 0	MH - 1	MH - 2A	MH - 2B
Pct of Population	57.2%	36.7%	5.9%	0.2%
Total Population	12,268	7,874	1,260	39

In total, 42.8% of men within WIDOC were on the mental health caseload, with 36.7% designated as MH-1, 5.9% MH-2A, and 0.2% MH2-B. Of the entire male population, 6.1% were designated as SMI.

The following graph illustrates the breakdown of the mental health classification for females.

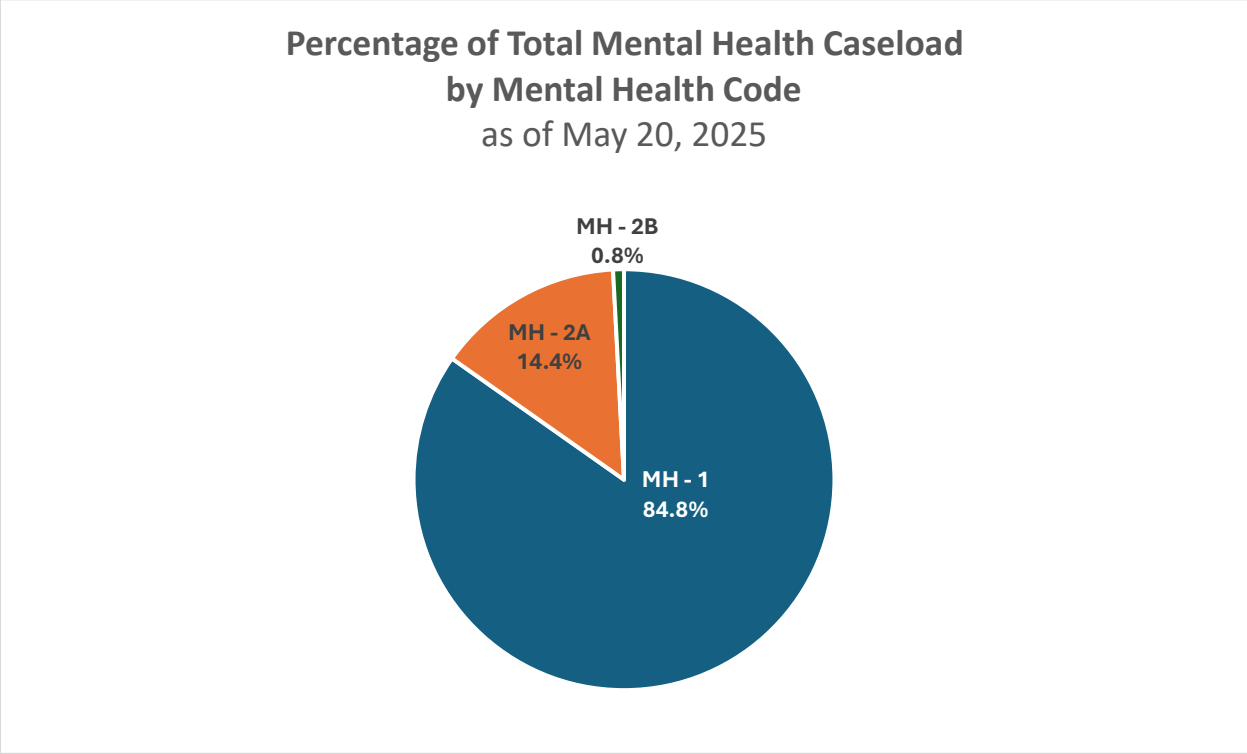
Graph 23: Total Female Population by Mental Code as of May 20, 2025



Unlike the male population, nearly all incarcerated women were on the mental health caseload (90.1%), and a much higher percentage of women were designated as SMI (20%) compared with men (6.1%).

The following figure illustrates the percentage of the total mental health caseload that is designated as SMI (MH-2As and MH-2Bs).

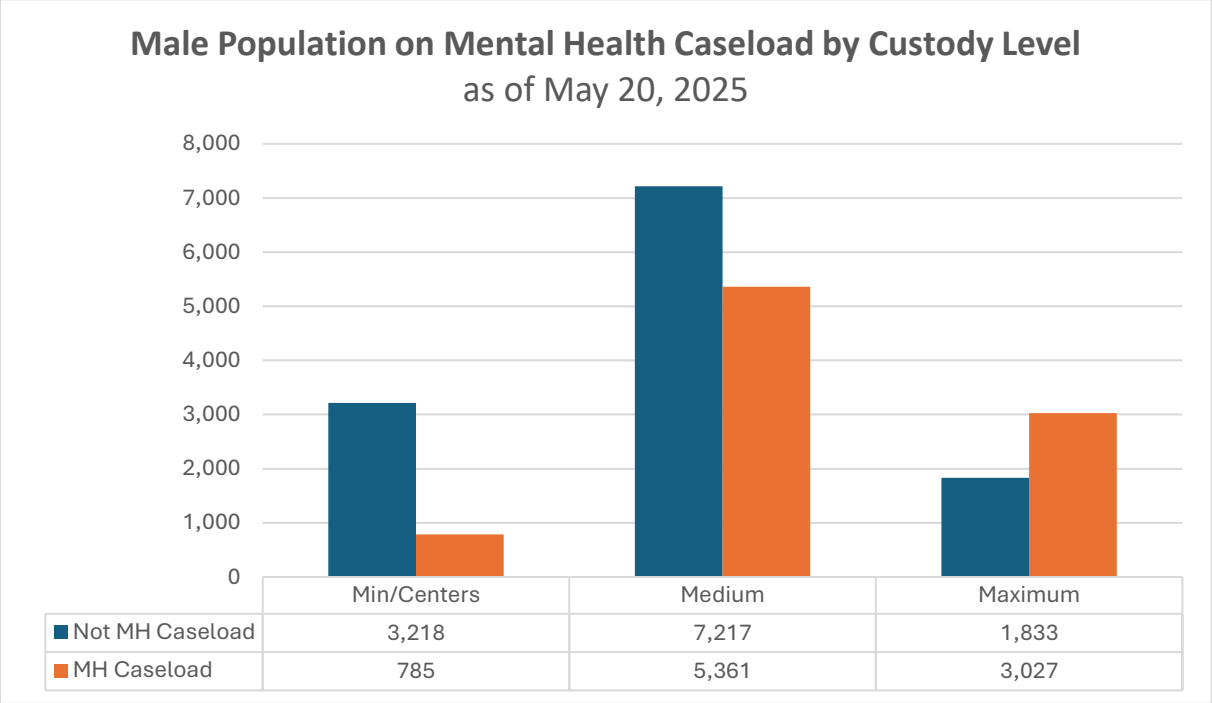
Figure 3: Percentage of Total Mental Health Caseload by Mental Health Code as of May 20, 2025



The majority of those on the caseload (84.8%) were classified as MH-1 (non-SMI) whereas 14.4% of the mental health caseload was designated as SMI.

The following graph illustrates the mental health classification breakdown for males by security level.

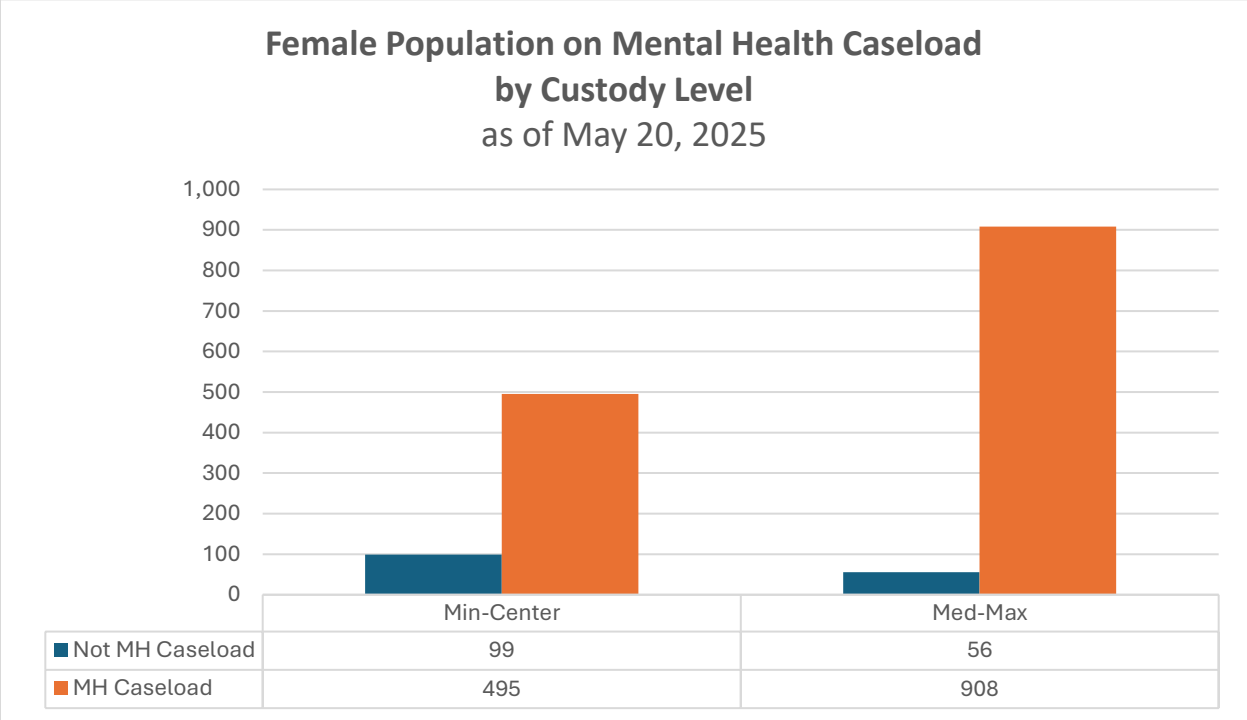
Graph 24: Male Population on Mental Health Caseload by Custody Level as of May 20, 2025



Maximum-security facilities housed proportionally more individuals with mental health needs. At minimum-security facilities, 19.6% of the total population was on the mental health caseload, while at medium-security and maximum-security facilities, 42.6% and 62.3% of the total population were on the mental health caseload, respectively. While higher proportions of individuals with mental illness are housed at higher security levels in other jurisdictions, the significant increase by each security level is more than other systems.

The following graph illustrates the mental health caseload by custody level for the female population:

Graph 25: Female Population on Mental Health Caseload by Custody Level as of May 20, 2025



Although over 90% of the female population was on the mental health caseload, the same trend exists for individuals with mental health needs being placed at higher security levels. At minimums and centers for women, 83.3% of the total population was on the mental health caseload. At the medium/maximum-security facility (i.e., TCI), 94.2% of women were on the mental health caseload.

As of May 20, 2025, 47.8% of the total population at DCI was on the mental health caseload (and 6.1% were designated as SMI), and at TCI, 94.2% of the total population was on the mental health caseload (and 24.7% were designated as SMI).

The following tables list the percentage of total population at each facility on the mental health caseload and designated as SMI.

Table 10: Mental Health and SMI Population Percentage by Maximum/Male-Facility

FACILITIES	% of Population on the Mental Health Caseload	% of Population with SMI
Columbia Correctional Institution	76.4%	23.2%
Green Bay Correctional Institution	73.4%	4.4%
Waupun Correctional Institution	75.2%	19.1%
Wisconsin Secure Program Facility	49.1%	0.2%
TOTAL	**70.7%**	**11.7%**

Within the four male maximum-security facilities, 70.7% of the total population was on the mental health caseload and 11.7% were designated as SMI.

Table 11: Mental Health and SMI Population Percentage by Medium/Male-Facility

FACILITIES	% of Population on the Mental Health Caseload	% of Population with SMI
Fox Lake Correctional Institution	40.1%	5.9%
Jackson Correctional Institution	40.8%	2.4%
Kettle Moraine Correctional Institution (KMCI)	38.2%	5.4%
New Lisbon Correctional Institution	41.2%	5.7%
Oshkosh Correctional Institution	45.5%	12.3%
Racine Correctional Institution	44.4%	3.8%
Racine Youthful Offender Correctional Facility	49.5%	2.7%
Redgranite Correctional Institution	39.9%	7.1%
Stanley Correctional Institution (SCI)	35.2%	3.5%
TOTAL	**41.4%**	**6.0%**

Within the nine male medium-security facilities, 41.4% of the total population was on the mental health caseload and 6.0% were designated as SMI.

Table 12: Mental Health and SMI Population Percentage by Minimum/Male-Facility

FACILITIES	% of Population on the Mental Health Caseload	% of Population with SMI
Chippewa Valley Treatment Facility	44.7%	3.8%
Oakhill Correctional Institution	30.7%	5.3%
Prairie Du Chien Correctional Institution	26.4%	0.2%
Sturtevant Transitional Facility	23.6%	2.0%
TOTAL	**32.4%**	**3.4%**

Within the four male minimum-security facilities, 32.4% of the total population was on the mental health caseload and 3.4% were designated as SMI.

Table 13: Mental Health and SMI Population Percentage

FACILITIES	% of Population on the Mental Health Caseload	% of Population with SMI
Black River Correctional Center	9.2%	0.0%
Drug Abuse Correctional Center	3.0%	0.0%
Felmers O. Chaney Correctional Center	4.6%	0.0%
Flambeau Correctional Center	0.0%	0.0%
Gordon Correctional Center	0.0%	0.0%
John C. Burke Correctional Center	25.8%	2.1%
Kenosha Correctional Center	6.8%	0.8%
Marshall E. Sherrer Correctional Center	5.3%	0.0%
McNaughton Correctional Center	0.8%	0.0%
Oregon Correctional Center	3.0%	0.0%
Sanger B. Powers Correctional Center	9.4%	0.9%
St. Croix Correctional Center	0.0%	0.0%
Thompson Correctional Center	3.2%	0.8%
Winnebago Correctional Center	12.8%	2.1%
TOTAL	**8.1%**	**0.7%**

Within the fourteen male centers, 8.1% of the population was on the mental health caseload and 0.7% were designated as SMI.

Table 14: Mental Health and SMI Population Percentage by Minimum/Women-Facility

FACILITIES	% of Population on the Mental Health Caseload	% of Population with SMI
Milwaukee Women's Correctional Center	83.8%	10.5%
Robert E. Ellsworth Correctional Center	83.2%	12.9%
TOTAL	**83.3%**	**12.5%**

Within the two women's minimum-security centers, 83.3% of the total population was on the mental health caseload, and 12.5% were designated as SMI.

The following table lists the percentage of individuals who were designated as SMI and separates the MH-2As and MH-2Bs:

Table 15: SMI Population Separated by MH-1, MH-2A, and MH-2B

		SMI		SMI Total
	MH-1	MH-2A	MH-2B	
All Mental Health Caseload	84.8%	14.4%	0.8%	**15.2%**

Most individuals designated as SMI had the MH-2A classification. Whereas 15.2% of the total mental health caseload was designated as SMI, only 0.8% had an MH-2B classification.

Table 16: SMI Population Separated by Gender, MH-1, MH-2A, and MH-2B

All Mental Health Caseload		SMI		SMI Total	Grand Total
Gender	MH-1	MH-2A	MH-2B		
Female	77.8%	18.7%	3.5%	22.2%	100.0%
Male	85.8%	13.7%	0.4%	14.2%	100.0%
Grand Total	**84.8%**	**14.4%**	**0.8%**	**15.2%**	**100.0%**

Taken as a whole, with nearly half of all incarcerated individuals being on the mental health caseload – except the majority classified as MH-1, which requires only two clinical contacts per year – a statewide review is indicated. The goal will be to increase clinical contact with those in

need to establish positive therapeutic relationships between patients and clinicians, prevent clinical decompensation, and improve the overall safety and security of the entire system. Specific recommendations are made in the Mental Health Classification System and Levels of Care section and the Mental Health Practices recommendations sections at the end of this report.

Mental Health Classification System and Levels of Care

WIDOC's current mental health classification system only partially achieves the goals of identifying clinical acuity, establishing the minimum frequency of mental health contact, and creating a common language for staff to understand the specific needs of each individual.

The current classification system has several challenges but, most significantly, it does not indicate an individual's acuity level. For example, an individual designated as SMI who is responsive to treatment may present without any acute symptoms, while another individual with the same diagnosis and mental health classification may experience acute symptoms requiring intensive intervention. The current system also has the same frequency of mental health contact requirements and does not communicate the significant differences in clinical presentation between these individuals.

The ideal application of a mental health classification system should be used to identify (1) clinical acuity, (2) the minimal frequency of mental health contact, (3) the minimal frequency between treatment plan updates, and (4) the level of care placement based on clinical acuity. The system should be dynamic and allow for rapidly changing mental health classification designation based on the individual's current presentation. It is common for correctional systems to have the number denote the acuity level, which can change over time, and a lettered subcode to identify long-term issues.

The following is an example of a mental health classification system designed specifically for the WIDOC system and based on best practices from other jurisdictions:

- **MH-0**—Patients who have no history of mental health issues and are not receiving mental health treatment.
    - These individuals shall *not* be regularly monitored by mental health staff but may request mental health services in accordance with the HNR protocols.
    - The mental health score may be increased when clinically indicated based on the treating clinician's assessment of the individual's current functioning.
- **MH-1**—Patients who received mental health treatment in the past but currently have no mental health needs and have demonstrated behavioral or psychological stability for at least six months.

  - These individuals are not regularly monitored by mental health staff but may request mental health services.
  - The mental health score may be increased when clinically indicated based on the clinician's assessment of the individual's functioning.
  - Individuals with a reported suicide attempt are classified as MH-1 or greater.
- **MH-2**—Patients with well-controlled symptoms who are behaviorally stable without significant functional impairment and currently have more minimal or situational mental health needs requiring outpatient treatment.
  - Seen for individual sessions by a primary therapist / qualified mental health professional (QMHP) a minimum of every 90 days.
  - If prescribed medication, receives a session with the psychiatric provider a minimum of every 90 days or sooner, as clinically indicated.
  - Updated treatment plan annually or for significant changes.
- **MH-3**—Patients with symptoms that are not well controlled who are behaviorally stable with some impairment in functioning and have more ongoing mental health needs requiring outpatient treatment.
  - Seen for individual sessions by a primary therapist / QMHP a minimum of every 30 days.
  - If prescribed medication, a session with a psychiatric provider a minimum of every 90 days or sooner, as clinically indicated.
  - Updated treatment plan every six months or for significant changes.
- **MH-4**—Patients with severe symptoms that cannot be managed on an outpatient basis and require placement in some form of mental health treatment unit.
  - Seen for individual sessions by a primary therapist / QMHP every 14 days.
  - If prescribed medication, a session with a psychiatric provider a minimum of every 30 days or sooner, as clinically indicated.
  - Updated treatment plan monthly or for significant changes.
  - Timely access to care through verbal request.
  - Group psychotherapy and group psycho-educational services on the unit.
- **MH-5**—Patients with severe symptoms that require an inpatient level of care at WRC.

The use of a letter subcode for individual factors other than acuity is also recommended. Subcodes may change throughout one's course of treatment but typically remain static and are

useful for mental health, operational, and healthcare staff to identify and understand long-term and chronic issues for the individual. An example subcode system designed for WIDOC:

- **Subcode A:** The individual is designated SMI.
- **Subcode B:** The individual is actively prescribed psychotropic medication.
- **Subcode C:** The individual has had psychotropic medications discontinued and requires follow-up by a mental health professional for a minimum of six months (once every 90 days) to ensure stability over time before removing the subcode.
- **Subcode D:** The individual has a history of self-injurious behaviors and/or a suicide attempt.

By using subcodes, the system can also adopt new subcodes to improve communication. An example would be adding an "E" subcode for those receiving MAT.

If this model is adopted, Falcon will work with WIDOC behavioral health leadership to outline diagnostic and functional criteria for each level and subcode to inform training, implementation, treatment, quality improvement, and monitoring expectations.

Definition of Serious Mental Illness

Designating individuals as SMI in correctional settings accomplishes multiple goals. As in the community, the SMI designation identifies those most likely to present with acute behavioral health needs. The SMI designation also identifies those with a chronic mental illness that may be stable but intermittently presents with acute symptoms. In addition to improving awareness, this designation can help prevent staff from creating situations that may exacerbate symptoms of mental illness, particularly placement in restrictive housing or other isolated settings. As a best practice, the definition of SMI in correctional settings should contain both (1) a list of diagnoses that result in an 'automatic' designation as SMI and (2) a list of other diagnoses or other conditions that may meet the definition of SMI if the individual is experiencing acute symptoms resulting in functional impairment.

WIDOC's definition of SMI accomplishes these goals with the following breakdown:

- **MH-2A** – PIOC has a current diagnosis of, or is in remission from, the following conditions: Schizophrenia, Delusional Disorder, Schizophreniform Disorder, Schizoaffective Disorder, Other Specified (and Unspecified) Schizophrenia Spectrum and Other Psychotic Disorder, Major Depressive Disorder, Bipolar I Disorder, and Bipolar II Disorder. MH-2A also includes inmates with current or recent symptoms of the following conditions: Brief Psychotic Disorder, Substance / Medication-Induced Psychotic Disorder, head injury or other neurological impairments that result in

behavioral or emotional dyscontrol, chronic and persistent mood or anxiety disorders, and other conditions that lead to significant functional disability.

- **MH-2B** – PIOC has a primary personality disorder that is severe, accompanied by significant functional impairment and subject to periodic decompensation (i.e., depression or suicidality). If PIOC has stable behavior for two years, the code may be reassessed. Excluded from MH-2B classification are PIOC who have a primary diagnosis of Antisocial Personality Disorder and whose behavior is primarily the result of targeted goals rather than impairment from diagnosed mental illness.

While WIDOC's definition of SMI identifies individuals who have acute mental health needs, this does not automatically prevent the individual from being placed in situations that could exacerbate their underlying mental health condition, such as placement in restrictive housing. The distribution of those designated as SMI (as discussed in the Understanding the Mental Health Population Served section above) across the male and female facilities also raises concern about the accuracy of the designation. The Mental Health Practices section at the end of this report provides recommendations for improvement.

Suicide Watch Practices

According to the WIDOC Suicide Prevention Policy, any staff member can initiate a suicide watch, even if mental health staff are unavailable. If non-PSU staff places an individual in clinical observation, a security supervisor must inform PSU staff. Observation typically occurs in restrictive housing, which houses approximately 4% of the total DAI population. Suicide watch procedures include 15-minute checks and constant watch, consistent with national correctional healthcare standards. PSU staff may also direct observations to take place at five-minute or 10-minute intervals. Recent trends within DAI indicate a significant increase in the number of suicide watches placements with a reported increase from 1,200–1,500 per year to approximately 2,500 in 2024.

PSU staff manage discharge from clinical observation and determine property access during observation, starting from a standard list that can be adjusted based on clinical judgment. This list, however, is very limiting and includes a "security mat or mattress" that was observed to be inadequate for most individuals placed on suicide precautions. Observations are documented either on paper or through electronic systems, though the system is inconsistent statewide. Efforts are underway to implement a standardized tracking tool, such as Guard1, to streamline documentation and oversight.

Data presented during the workshop showed that 59 individuals died by suicide over the past 15 years, an average of four deaths by suicide per year. While most occur in single cells, deaths by suicide occurred across security levels and mental health classifications, including several by individuals with no mental health diagnosis. After each completed suicide, a Committee on

Inmate/Youth Deaths (COIYD) completes a mortality review, including a full review of the case, and makes recommendations based on the findings.

The Falcon Team has several recommendations related to suicide precautions, particularly removing clinical observation placements from restrictive housing units and individualizing the overall conditions for each individual requirement this clinical intervention. These recommendations are included in the Next Steps in Restrictive Housing and Mental Health Practices sections of this report. Also, see the next section, Targeted Interventions for Individuals Placed on Suicide Precautions, for additional recommendations.

Targeted Interventions for Individuals Placed on Suicide Precautions

Determining the specific reason(s) an incarcerated individual is found to need suicide precautions forms the foundation of identifying targeted and effective treatment interventions. Targeted treatment may include behavioral, psychiatric, medical, or correctional interventions, and most likely some combination of these.

In correctional settings, an additional issue is the limited provision of a trauma-informed, therapeutic environment for those at elevated risk of suicide or self-harm. When individuals are identified as being at risk, unnecessarily restrictive practices are often used, such as locking the individual in a "hardened" cell without access to personal clothing, recreation, books, visits, and other activities that can often increase behavioral stability in non-correctional settings. Oftentimes, correctional practices may be accompanied by a "watch and wait" approach in which behavioral health intervention is limited to one-time-per-day observations and mental status exams with no individualized treatment. As a result, the individual may often experience feelings of isolation, shame, anger, and boredom, all of which can decrease treatment engagement, lead to regressive behaviors, and exacerbate, rather than reduce suicide risk.

While these practices are typically well intended in the service of suicide prevention, best practices call for placement in the least restrictive setting to balance safety and unintended negative impacts. These best practices include an emphasis on programming and out-of-cell interactions.[10] Within WIDOC, as with many other correction departments, 'suicide-resistant' or 'safety' cells are used for patients identified as at risk for suicide or self-harm, with no regard for the specific and individualized cause(s) of the patient's distress. While these locations are designed to minimize the individual's ability to engage in self-injurious and suicidal behaviors, placement in such settings does not guarantee safety, nor does it constitute the active interventions needed to reduce risk and increase resiliency. These would include more than

[10] Pieper, S. (2022, July 20). 4 innovative approaches to inmate suicide prevention. *Lexipol*. https://www.lexipol.com/resources/blog/4-innovative-approaches-to-inmate-suicide-prevention/

daily rounds and eyes-on observation with a shift to meaningful out-of-cell time, as well as individualized reassessment, treatment, and programming.

Patient-specific behavioral, psychiatric, or medical interventions are usually needed to decrease an individual's risk for suicide or self-harm. In other cases, correctional interventions, such as housing or classification changes, are essential to decrease or eliminate an individual's risk for suicide or self-harm. The key principle: the assessment identifies potential motivations for suicide risk and self-injury without negative judgments about those who may be motivated by what is often referred to as 'secondary gain.'

Placement of a patient in a suicide-resistant cell or room due to acute risk must be accompanied as soon as possible by intensive and active interventions aimed at mitigating such risk and limiting the need for restrictive and/or intrusive interventions. The Falcon Team's review of suicide prevention "gown or safety smock" practices across the country shows that some jurisdictions rely heavily on their use while others have moved away from this practice and use them on an individualized basis. It is recommended that whenever an individual is placed on suicide watch, a comprehensive analysis of the causes for such placement is conducted. Once the specific cause(s) for placement are identified, targeted interventions to address the root cause(s) of that placement can be implemented.

In correctional settings, individuals may be placed on suicide watch for various reasons including, but not limited to, the following:

- The individual is actively suicidal.
- The individual is engaging in chronic and recurrent non-suicidal self-injury (NSSI).
- The individual is engaging in calculated but intermittent self-injurious behavior, often lethal self-injury with a predetermined goal (e.g., obtaining pain medications, etc.).
- The individual is engaging in intermittent self-injurious behavior due to environmental or situational reasons (e.g., gang threats, debts, etc.).
- The individual is engaging in self-injurious behavior secondary to experiencing extreme distress due to withdrawal symptoms.

Considerations for Understanding Individual Needs of Those Placed on Suicide Watch

A two-step process is recommended for optimal understanding of risk factors and populations placed on suicide precautions within WIDOC.

First, a continuous quality improvement (CQI) analysis should be conducted to identify the reasons why individuals are placed on watch at each facility. To conduct this analysis, those administering suicide assessments (PSU staff) should complete a data collection form indicating

the reasons the individual has been placed on watch. At a minimum, the following data should be collected:

- **Description:** Overview of the reason(s) the individual was placed on suicide precautions (including those listed above).
- **Ideation:** Description and frequency of suicide or other self-injury thoughts.
- **Self-Injury:** Description, frequency, and severity of engaging in self-harm.
- **Purpose of Suicide Precautions:** The general purpose for placement on suicide precautions.
- **Targeted Interventions:** The interventions used to address the underlying reason the individual was placed on suicide precautions.

This data should be collected over an extended period of time (e.g., 180 days) and then analyzed by CQI staff. The results will inform the department's strategy for addressing suicide risk and those who are placed on suicide precautions for other reasons. Based on the outcomes of these studies, more specific policies, clinical guidelines, and training should be developed to assist clinical staff in providing individually tailored and targeted interventions for individuals placed on suicide precautions. Interventions, including the determination of whether to place an individual on suicide precautions, should match the individual etiology that led to the placement.

Mental Health Input to Disciplinary Process and Restrictive Housing Practices

A review of WIDOC policies and discussions with staff indicate that while there is a formal process for mental health staff input into the disciplinary process, several improvements can be made. The policy governing the *Psychology Input for Security Decisions form (DOC-3509)* does not require mental health staff to conduct a formal evaluation and complete the form in certain circumstances, but rather, it is at the request of the security director or designee. In the ideal disciplinary practice, an assessment would include a record review and face-to-face contact with a clinician prior to a disciplinary hearing or any discipline being imposed for incarcerated individuals meeting certain criteria (i.e., designated as SMI or behavior resulting in disciplinary action, which could be the result of an underlying mental health issue).

The mental health consultation requires a specialized and timely assessment, with consideration of:

1. The individual's capacity to participate in the disciplinary proceeding.
2. The role that mental illness may have contributed to the behavior that resulted in the disciplinary charge.

3. Whether the delivery of discipline is likely to exacerbate symptoms of a mental illness (e.g., placement in restrictive housing).

The primary goals of the consultation are to:

1. Verify that patients have the capacity to participate in the disciplinary hearing.
2. Identify situations in which the individual engaged in rule-breaking behavior directly as a result of mental illness symptoms.
3. Identify those patients who may experience significant deterioration of their mental health following the standard type of discipline, particularly placement in restrictive housing.

Finally, in cases when the mental health professional determines that the individual has the capacity to participate in the disciplinary process, the mental health professional should provide input into which types of sanctions, if any, would have the least negative impact on the individual's mental health. For example, if the individual experiences depression and anxiety, and their connection with family through weekly phone calls helps to alleviate these symptoms, the mental health professional would recommend that these phone calls are not to be removed. This process is adopted in many prison systems and, when incorporated into a multidisciplinary framework, often results in more comprehensive and informed decision-making during the disciplinary process. This process, also in line with nationwide best practices, can be found in the N*CCHC Mental Health Standard on Segregated Inmates (MH-E-07),*[11] which notes, "On notification that an inmate is placed in segregation, mental health staff reviews the inmate's mental health record to determine whether existing mental health needs contraindicate the placement or require accommodation." These practices consider and appreciate the role of severe mental illness in behavior and the overall trend of reducing segregation for the SMI.[12]

Currently, there is not an ability to determine how often this input is considered and how often disciplinary sanctions are either dismissed or modified as a result of mental health input. This process should therefore be formally monitored through the CQI program, and staff should consistently collect and analyze the following data:

- Number of mental health evaluations related to the disciplinary process.

[11] Standards for mental health services in correctional facilities. (2015). Retrieved from https://www.ncchc.org/mental- health-2/

[12] Maszak-Prato, S & Graham, L (2022). Reducing the use of segregation for people with serious mental illness. *The Prison Journal 102*(3) 283-303. https:///doi.org/10.1177/00328855221095519

- Timeliness of mental health evaluations related to the disciplinary process.
- Number of instances in which the individual was deemed not to have the capacity to participate in the disciplinary process.
    - Number of instances where the disciplinary process was paused or dismissed as a result.
- Number of instances in which the individual was determined to have engaged in the rule-breaking behavior directly as a result of symptoms of mental illness.
    - Number of instances in which the disciplinary process resulted in the charge being dismissed due to mental illness.
- Number of instances in which mental health professionals provided recommendations for alternative sanctions.
    - Number of instances these recommendations for alternative sanctions were implemented.
- Number and percent of instances in which a dismissal or alternative to discipline occurred secondary to concerns about deterioration of mental health.
- Number and percent of individuals designated as SMI receiving discipline to include restrictive housing as a sanction.

Individualized Behavior Management Plans

The Falcon Team reviewed WIDOC's policy on BMPs, *DAI Policy: 500.70.30: Chapter 500 Health Services, Subject: Behavior Management Plans*. The current policy requires BMPs to be conducted when an individual designated as SMI incurs disciplinary separation or administrative confinement. It was reported that approximately 20 to 30 BMPs are in place at each maximum-security facility, and it was estimated that, there are currently between 100 and 150 BMPs in place statewide. There is currently no tracking of data to measure the efficacy of these plans.

The following section details the ideal use of BMPs in a correctional department.

Chronically disruptive individuals present both treatment and management challenges to correctional, mental health, and medical staff. Disruptive individuals display a heterogeneous set of behaviors that can endanger themselves (e.g., self-injury, suicide threats) and others (e.g., assaultive behavior) and threaten the safety, security, and long-term stability of the

correctional facilities in which they reside.[13] While only a small group of individuals engage in these types of repetitive behavior, such episodes may result in the use of force by corrections staff (e.g., forced cell removal). This is often followed by placement in restrictive settings, or back and forth between disciplinary and psychiatric units, or between correctional institutions and outside hospitals. While these interventions may temporarily limit the behavior, they do not address the motivations and reinforcement that led to their occurrence and may, in fact, reinforce the disruptive behavior in some instances.[14]

BMPs, sometimes referred to as Behavior Treatment Plans (BTP), use a structured sequence of incentives to reinforce positive behavior change and reduce identified problem behaviors.[15] Additional interventions used in BMPs include patient psychoeducation and cognitive-behavioral interventions, including skills training and consistent staff communication with the patient. BMPs are developed through a multidisciplinary collaboration led by independently licensed mental health professionals. It is recommended that staff complete specialized training in functional assessment, principles of learning, and ethical issues related to behavioral interventions before developing BMPs. Behavior management strategies have been shown to reduce self-injury (and resulting medical interventions) at both an individual and group level.[16]

The intent of these behavioral interventions is to help incarcerated individuals achieve their highest level of functioning while simultaneously holding the patient accountable for problematic behaviors. To identify which interventions are most likely to succeed, BMPs are most effective when they are strength-based, transparent, and involve collaboration with the incarcerated individual.

BMPs do not replace safety/crisis interventions or the disciplinary process. Crisis interventions, such as suicide precautions, must be determined by a specific assessment of the patient's immediate safety and treatment needs during the crisis and cannot be dictated ahead of time.

---

[13] Helfand, SJ. "Managing Disruptive Offenders: A Behavioral Perspective." In Correctional Mental Health: From Theory to Best Practice. Thomas J. Fagan, Ph.D., Robert K. Ax, Ph.D. ED Sage Publications, 2011. pp 309-326.

[14] Ibid.

[15] Helfand, S. J., Sampl, S., Trestman, R. L. (2010). Managing the disruptive or aggressive inmate. In C. L. Scott (ed.), Handbook of correctional mental health, 2nd ed. Washington DC: American Psychiatric Publishing.

[16] Andrade, J.T., et al. (2014). Developing the evidence base for reducing chronic inmate self-injury: Outcome measures for behavior management. Corrections Today, 76, 30-35.

The development and implementation of BMPs are consistent with the recommendations of the Behavioral Analyst Certification Board's 2020 *Ethics Code for Behavior Analysts.*[17]

All BMPs require a comprehensive data-gathering and functional assessment of the individual's problem behavior before appropriate interventions can be developed. This step involves carefully identifying the specific problem behaviors to be extinguished and the prosocial replacement behaviors to be reinforced. Target behaviors should be described in objective, non-judgmental, and behavioral terms, so that all stakeholders recognize and agree when these behaviors are occurring.

Completing a functional assessment of concerning behaviors requires a chronology of the problematic behaviors, their antecedents, and their consequences. Data collected must include warning signs, triggers, conditions under which the behaviors are more likely to appear, conditions under which the behaviors are less likely to appear, the sequence of problematic behaviors as they unfold, and consequences of the behavior that appears to be reinforcing. The development of detailed antecedent-behavior-consequence chains assists in reaching viable hypotheses on the function of problematic behaviors. When behaviors are difficult to change, it is likely that they fulfill more than one function. Alternative hypotheses to the identified function(s) should be explored. The diagnostic review should be completed during this step so that all possible contributors to the targeted problem behaviors are identified.

In most cases, a reliable and potentially sustainable response to a BMP requires up to six months following implementation. Although adjustments to a BMP can be made before that time, well-developed BMPs anticipate a range of problem behaviors and positive behavioral responses. Absent unanticipated developments, well-developed BMPs are typically not altered in the first three months of implementation except when the multidisciplinary team and incarcerated individual review the plan's progress and reach a consensus on a modification. Prior to implementation, all stakeholders, including representatives from security, administration, behavioral health, and medical services, should review and approve the plan, noting each component their department will be responsible for. All stakeholders, including the patient, should be oriented to the expectations and long-term nature of the behavioral interventions.

Regarding the current use of BMPs for individuals designated as SMI who are in restrictive housing settings, SMI individuals should be automatically diverted from such placements (as described in the Restrictive Housing section), rather than receiving a BMP. BMPs should be

[17] Ethics code for behavior analysts. (2022, January 1). Retrieved from Ethics Code for Behavior Analysts (bacb.com)

reserved for those situations described above. The result will be significantly fewer, but much more comprehensive and focused, BMPs throughout WIDOC.

Behavior Management Unit

In Falcon's experience, Behavior Management Units (BMUs) can be effective in eliminating repetitive problematic behaviors for individuals who do not respond to the traditional structure. With staff training and the assurance of a collaborative and flexible approach to specific individual needs, WIDOC can experience a significant reduction in problematic behaviors. Such a program could be implemented at the BMU at Waupun, which was closed due to COVID and re-opened earlier in 2025. The following paragraphs provide an overview of such a program.

BMUs have been designed and implemented as an alternative to restrictive housing placement for individuals with SMI and a severe personality disorder.[18] The goal of BMU placement should be to focus resources on helping individuals achieve their highest level of functioning, developing alternative coping skills, and facilitating a safe return to the general population. In some cases, the goal will be preparation for reentry into the community at the end of their sentence.

An effective BMU utilizes an integrated approach that involves the close collaboration of mental health, medical, classification, and security professionals. Individuals progress through several program phases based on adherence to program rules and behavioral stability. Programming is based on cognitive/behavioral treatment modalities as well as behavior chain analyses. When an individual is assigned to a BMU, all disciplinary sanctions should be suspended if safety permits, so the individual can participate and benefit fully from the BMU program.

Phase System

The phase system is the basis for the program. Advancement from one phase to the next is determined by clearly defined time frames. All BMU participants should be scheduled for a set amount of out-of-cell structured and unstructured time, typically at least 10 to 15 hours each week. Structured programming time includes mental health programming, education, activity groups, and other available programming. Unstructured time includes recreation, visits, and other activities, also for at least 10 to 15 hours per week. Unstructured time should not include time for showers or other essential activities. When an individual is admitted to the BMU, the

[18] Mental Health Units as Alternatives to Segregation: It Can Be Done.

treatment team determines the phase that is most appropriate based on the individual's clinical presentation and recent behavior.

Incentive Program

An incentive system runs parallel to the phase system and provides individualized incentives to each program participant. Incentives are a proven method for increasing pro-social behavior and reducing problematic (target) behaviors. The incentive system provides BMU participants with the opportunity to earn incentive points that may be redeemed for items on a regularly scheduled basis. Incentive points – are earned when an individual engages in pro-social behavior. Incentive 'items' may be purchased weekly through the incentive point system and are deducted at the time the individual receives the incentive. The consequences for engaging in problematic behavior should be immediate. The advancement from one phase to the next is determined by the time frames detailed in the unit phase system. The following is an example of an incentive program for consideration:

- **Daily Incentive Points:** An individual may earn daily incentive points each week based on the individual's daily performance. An individual who follows institutional rules and regulations, as evidenced by not receiving a disciplinary report, will earn one incentive point for the day.
- **Structured Activity Points:** Structured activity or treatment points are earned based on attendance without disruptive outbursts at all out-of-cell structured activities. An individual may earn one point for each hour of attendance at scheduled programming, which includes both group and individual programming. An individual with an unexcused absence, who asks to leave before the group ends, or who is escorted out of the group due to disruptive behavior, would not earn a treatment point.
- **Unstructured Activity Points:** Unstructured activity points are earned based on attendance without disruptive outbursts during out-of-cell unstructured activity. An individual may earn one point for each hour attending the scheduled out-of-cell unstructured activity. An individual with an unexcused absence, who asks to leave before the out-of-cell unstructured activity ends, or who is escorted out of the activity due to disruptive behavior, would not earn a point.

Each week, participants use their points to select certain items, which individualize incentives beyond the pre-determined movement through the phase system.

The Behavioral Health Unit (BHU), at WCI, still in its infancy is designed to incorporate best practices in correctional mental health care, including individualized treatment planning, multidisciplinary care teams, and structured therapeutic programming. In addition to its current use, this unit could be used for individuals designated MH-2B who incur placement in restrictive housing could be immediately transferred to the BHU as an alternative. This unit would be

based on the principles outlined in this section of the report, which are specifically designed to meet the needs of individuals who meet criteria for the current MH-2B classification.

Summary of Workshop and Site Visit Discussions with Staff Related to Mental Health

The following section summarizes information on issues gleaned from staff during the mental health workshops and facility visits.

One of the most notable developments was the centralization of mental health supervision under the Bureau of Health Services. This shift has reportedly improved oversight and consistency across institutions.

Reception and intake processes for new admissions are broadly structured and effective in screening for acute medical and mental health needs. However, lack of electronic health record (EHR) integration with referring facilities and inconsistent transfer summaries often result in delays initiating or continuing care, such as the need for psychotropic medication that is not self-reported by the patient.

Mental health services were described as strained, with approximately 10,000 individuals across WIDOC facilities classified as needing mental healthcare (approximately 46% of the total population including 43% of the male population and 90% of the female population). This is a rate much higher than what is seen in other state departments of correction. Access to mental healthcare can be challenging due to physical space constraints, lack of escorts for movement, and a system that assigns caseloads by housing unit rather than clinical need. The use of the MH-1 classification is overinclusive, resulting in an unsustainable number of individuals requiring mental health contact every six months, which interferes with more intensive care needed for higher-acuity patients.

Suicide prevention remains a pressing concern, with clinical observation placements rising to approximately 2,500 annually, a significant increase. While the current system lacks electronic tracking for observation rounds, the Guard1 system at all sites was scheduled to begin in July 2025, providing an electronic method to track and verify that rounds are completed.

Another identified concern for those on suicide precautions is that observation cells are typically in restrictive housing units, which is problematic for the individual needing such placement, as well as for the staff and incarcerated individuals working and housed in restrictive housing. Additionally, individuals on observation status are not allowed therapeutic items, visits, phone calls, or recreation.

The expansion of the MAT and MOUD programs were deemed very successful. The system has implemented Vivitrol and long-acting buprenorphine injections. Staff have credited effective messaging and interdisciplinary staff training for their acceptance and support of these

important initiatives. These programs have likely reduced contraband and overdoses, resulting in buy-in from custody staff and leadership. However, sustainability remains a concern, as many of the positions and initiatives are grant-funded and may not survive without long-term legislative support/financial investment.

For female incarcerated individuals, staff at TCI reported several successful initiatives including the use of trauma-informed approaches, doula programs for pregnant women, and family visitation initiatives. A significant challenge for the female population is the high incidence of placement on the mental health caseload, with 95% of incarcerated women at TCI being on the mental health caseload. Additionally, restrictive housing for women lacks sufficient group programming, despite policies that require out-of-cell programming for SMI individuals.

The SRTU program is being expanded to offer a structured, therapeutic environment for individuals with SMI, incorporating multidisciplinary meetings and tailored programming.

Most facilities reported having developed unofficial units 'organically' to address the needs of the population. In some cases, the units were designed for individuals with intellectual disabilities, while others are less specific. But the need for a more organized set of mental health units was consistently reported. These should, include specific admission and discharge criteria, a centralized approval process for admission and discharge, and centralized data reporting and tracking.

BMPs are required by policy for certain mental health classifications under certain conditions. BMPs are individualized, reviewed monthly, and designed to be collaborative, including input from the incarcerated individual. As with other important interventions, there is no centralized system for tracking BMPs or monitoring compliance, and programming tied to these plans is currently lacking. Security staff participation in BMP development is also reportedly inconsistent due to other obligations, which undermine BMP's interdisciplinary nature. BMPs are discussed in the Individualized Behavior Management Plans section of this report, including specific recommendations for overall BMP process improvement.

High rates of substance use and mental illness among individuals placed in restrictive housing was noted, often contributing to a "revolving door" for this population. Expanding MAT and MOUD services to this population may be helpful in addressing this issue.

As with other disciplines, workshops and facility visits reveal a mental health system in transition—progressing toward greater coordination, oversight, and patient-centered care. The Mental Health Practices section at the end of this report incorporates what was learned through the mental health workshops, site visits, policy and data reviews, and discussions with incarcerated individuals.

F. Medical

Access to Care

Legal Framework and Standards

Ensuring access to healthcare for individuals in a correctional facility requires a multifaceted approach that includes, but is not limited to, the availability of medical services and quality care. In the United States, the Eighth Amendment prohibits cruel and unusual punishment, and the Supreme Court has interpreted this to require prisons to provide the incarcerated population with access to constitutionally required medical care (*Estelle v. Gamble*, 429 U.S. 97, 1976).[19] The Fourth Circuit Court of the U.S. then granted the same constitutional protections to individuals with mental illness in the case of *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977).[20] Similar standards are applicable in many jurisdictions around the world, where the provision of healthcare in prisons is regarded as a fundamental human right.

Types of Healthcare Services

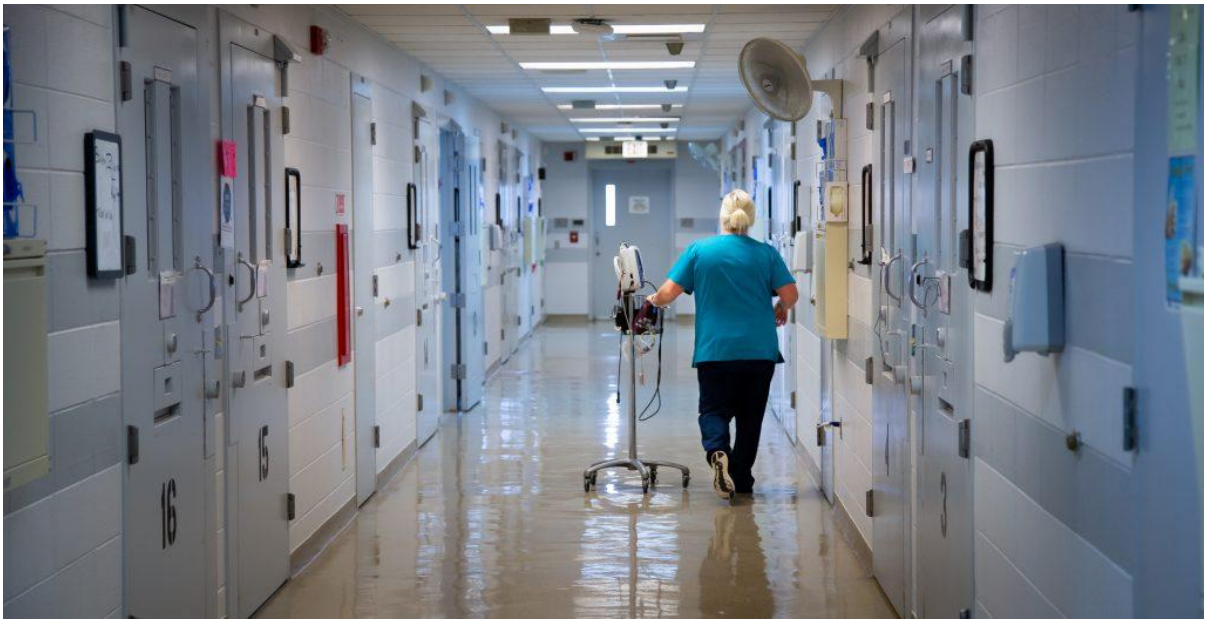
Incarcerated individuals require routine healthcare, including treatment for acute illness and chronic conditions, nutrition, preventive care, dental care, and health education. Due to the rising prevalence of mental health issues today among incarcerated populations, psychiatric care, counseling, and substance abuse treatment also fall within the scope of meeting the patient's overall healthcare needs. WIDOC provides various healthcare services, including managing medical emergencies and complex health conditions, as well as specialized services like on-site dialysis and physical therapy. WIDOC also participates in innovative healthcare initiatives, such as initiating a MAT program, demonstrating the department is commitment to meeting and exceeding minimum healthcare and community standards.

[19] https://supreme.justia.com/cases/federal/us/429/97/

[20] https://www.casemine.com/judgement/us/591494c9add7b049345c3013

Challenges and Barriers

WIDOC faces ongoing challenges, including staffing shortages and limited availability of community resources, both of which can affect the delivery of healthcare services. Ensuring continuity of care for individuals with chronic illnesses and those transitioning into and out of correctional facilities has long been recognized as a complex and critical undertaking. Despite obstacles, WIDOC's Bureau of Health Services is committed to further developing and implementing strategies to address challenges and enhance access to care, as timely access to care is essential for meeting individual's needs, protecting their rights, supporting rehabilitation, and easing reentry into the community, thereby strengthening public health and safety.



Intake Receiving Screening

Upon arrival at WIDOC, access to care begins with a thorough intake process, mandated by *DAI Policy 500.30.49 Initial Health Assessment*, which aligns with national standards calling for physical examination, medical classification, health education, and referral for chronic disease management services. This process includes a comprehensive receiving screening conducted by qualified healthcare and mental health professionals. It is arguably the most essential process in the overall care of the incarcerated individual. The intake process occurs at DCI for males and TCI for females. Between April 2024 and March 2025, 7,194 males and 878 females were admitted to DCI and TCI.

Requesting Care

DAI Policy 500.30.11: Daily Handling of Non-Emergency Requests for Health Care, allows incarcerated individuals to submit verbal or written healthcare requests daily, which are collected and triaged by qualified healthcare professionals within 24 hours. Requests are prioritized based on symptoms, with face-to-face evaluations conducted by a registered nurse in a clinical setting, if needed, and documented in the health record. For non-emergency issues, routine sick calls are scheduled at least five days a week at facilities with adequate staffing, with referrals to advanced care providers (ACPs), who have prescriptive authority, made after two unresolved sick call visits for the same complaint, ensuring timely and confidential care. This policy aligns with national standards calling for timely action on patient requests for medical attention.

In high-security units, where movement is more restricted and medical appointments require escort by uniformed security staff, scheduling and coordination between healthcare and security teams can affect the timing of responses to medical requests. These logistical factors may contribute to the number of medical concerns reported through the inmate complaint system.

Primary Care Services

The primary care services provided by WIDOC are designed to meet community standards, offering comprehensive care for incarcerated individuals. The process begins with thorough intake screenings, which address acute and chronic medical, dental, and mental health conditions. The care team, including registered nurses, physicians, nurse practitioners, and physician assistants, delivers routine health maintenance, treatment for illnesses, and specialized services.

Chronic Care

Chronic care services refer to healthcare and support provided to individuals with chronic diseases or long-term health conditions. The main goal of these services is to manage symptoms, improve the quality of life, prevent disease progression, and reduce the need for acute care interventions. Chronic diseases include conditions such as diabetes, heart disease, respiratory diseases, arthritis, and mental health disorders, among others.

DAI Policy 500.30.55, Patient with Chronic Disease Services and Other Special Needs requires that patients with chronic diseases, significant health conditions, or disabilities receive continuous, multidisciplinary care that follows evidence-based standards. This policy aligns with chronic care clinic standards, calling for protocols used to identify and manage chronic conditions and special needs. The Bureau of Health Services medical director develops and annually approves chronic disease management guidelines, ensuring alignment with national clinical standards for conditions like asthma, cardiovascular disease, diabetes, and others. ACPs

create individualized treatment plans when a condition is identified, updated as needed, and documented in the HCR. The HCR tracks disease control, monitoring frequency, patient condition, diagnostic testing, therapeutic regimens, and any protocol deviations. Chronic conditions are listed in the HCR problem list, with notations for resolved conditions. The Bureau of Health Services medical director or designee conducts periodic audits to ensure compliance and recommend improvements.

WIDOC's chronic care policies are well-defined, with opportunities to further strengthen consistent implementation and target staff training in standardized care protocols, chronic disease management, and documentation practices. By offering competitive compensation to better recruit and retain skilled nursing staff, and by expanding cross-facility nursing support, the organization can promote consistent procedures and enable nursing supervisors to focus on advancing CQI functions while other nursing staff provide direct patient care.

Acute Care

Any incarcerated individual in need of care requiring a face-to-face encounter will be seen within 24 hours of receipt of the health care request (*DAI Policy 500.30.11 Daily Handling of Non-Emergency Requests for Health Care*). Most healthcare needs can be handled at the facility, but there are some barriers to receiving care, as noted below. If necessary, the patient may be referred off-site for specialty or hospital care. Additionally, there are infirmary units at DCI, TCI, and Oak Hill Correctional Institution (*DAI Policy 500.30.08*). This level of care is appropriate for patients with chronic or complex conditions requiring daily monitoring, medication, therapy, or assistance with daily activities, needing skilled or frequent nursing beyond what general population facilities can safely provide, but not requiring acute hospital care.

Staffing challenges and space constraints can affect the delivery of on-site care. Despite a substantial decrease in vacancy rates, some uniformed and non-uniformed staff have misused leave—including excessive use of unanticipated sick leave, call-ins, and intermittent FMLA—which places operational strain on the system. Notably, overtime increased as vacancy rates declined. In July 2025, the agency implemented revised policies aimed at addressing this issue.

At certain sites, limited treatment rooms and outdated facilities require providers and space to be available simultaneously, while shared spaces necessitate advanced scheduling that can disrupt workflows. Exploring options to reimagine and redesign existing spaces—potentially through the creation of flexible, multipurpose treatment areas—could improve utilization, reduce scheduling conflicts, and enhance access to care, though such changes would likely require additional funding and time to implement.

Specialty Care Services

DAI Policy 500.30.02 Specialty Consultations requires all sites to develop procedures for specialty care, including specialists, emergency services, and inpatient services to ensure continuity of services when those providers make recommendations.

Specialty care refers to advanced medical treatment delivered by professionals with specialized training in specific fields of medicine, beyond the scope of primary care providers. Specialty care includes areas such as cardiology, oncology, neurology, orthopedics, endocrinology, gastroenterology, pulmonology, and dermatology. Across the country, healthcare systems face a shortage of specialized providers due to population growth, an aging demographic, increased demand for services, and challenges in recruiting and retaining healthcare workers. Providing specialty care for incarcerated individuals presents additional obstacles, as community providers may hesitate to treat this population due to concerns about safety, legal risks, biases, or stigma. Coordinating care for these patients is complex, particularly for off-site appointments, which require extensive planning to ensure quality medical care as well as security.

WIDOC has implemented several robust on-site specialty programs, including dialysis and physical therapy, to enhance healthcare delivery. Dialysis services are available at DCI and FLCI, though utilization varies. Physical therapy is provided at multiple facilities, including Dodge, Taycheedah, Fox Lake, Waupun, and John Burke, with most programs staffed by limited-term equivalent (LTE) therapists. These on-site programs reduce the need for off-site medical transport, alleviating pressure on security staff and minimizing safety risks. Having on-site services also decreases healthcare costs and potential litigation by addressing medical needs proactively.

Timely access to specialty care is important and WIDOC continues to explore ways to strengthen this area across the system. While vacancy rates for security staff have decreased, frequent call-ins can still affect coverage and limit the ability to schedule and complete off-site specialty appointments, and a limited number of vehicles equipped for medical transport can further constrain capacity. An aging population adds to the demand for specialty care and the number of off-site visits required. As the organization does not employ specialty care providers, it relies on referrals to external providers and is actively assessing opportunities to improve coordination. Potential strategies include conducting a system-wide analysis of vehicles currently equipped, or capable of being equipped, for off-site appointment medical transports, analyzing staffing schedules to ensure coverage is aligned with mission priorities and population care needs, and reviewing weekly specialty appointment data by facility to inform long-term budget planning and guide resource allocation.

Long-Term Care and Palliative Units

WIDOC provides long-term and palliative care, as outlined in *DAI Policy 500.00.010 Long Term Care Unit*. The Long-Term Care unit at Oshkosh has 17 beds, including three dedicated palliative care beds, and 24/7 nursing coverage to support patients needing assistance with activities of daily living or end-of-life.

The WIDOC aging resident population increases the need for skilled nursing and protected environments. Exploring the expansion of specialized housing units, including repurposing existing spaces can help safeguard vulnerable individuals, preserve infirmary beds for acute care, and enhance overall facility safety, while acknowledging that investments in facility modifications, specialized equipment, and staffing may be required.

Emergency Services

Timely response to medical emergencies can significantly improve patient outcomes. *DAI Policy 300.00.59 Emergency Services CPR and AED Use* specifies that all DAI facilities will provide 24-hour emergency medical, dental, and mental health services. In life-threatening situations, staff administer emergency care. Non-life-threatening cases receive first aid for stabilization. Emergency equipment, including automated external defibrillators (AEDs), oxygen, and blood sugar monitors, is maintained and checked regularly. Staff receive annual training in CPR, AED, and first aid to manage emergencies.

Infectious Disease Prevention

DAI Policy 500.60.01 Infection Prevention and Control Program details the comprehensive program encompassing surveillance, prevention, communication, and management of communicable diseases. This policy calls for each WIDOC facility to maintain a written exposure control plan that is compliant with Occupational Safety and Health Association (OSHA) standards, reviewed annually by the Health Authority, ACP, and Health and Safety Committee. Infection control policies must be accessible, with a clear reporting structure to communicate issues to key stakeholders, including the nursing coordinator, Bureau of Health Services Administration, and local public health departments. Facilities ensure annual staff training, adherence to standard precautions, and proper decontamination of instruments, sharps, and biohazardous waste. Patients with communicable diseases receive community referrals upon release, and a designated health and sanitation officer oversees training for handling bio-hazardous materials. The Health and Safety Committee meets monthly to review sanitation inspections, infection control concerns, and environmental safety, ensuring equipment maintenance, clean units, and accessible sharps disposal to prevent disease transmission. This policy meets national correctional healthcare standards for infection prevention and control.

Dental Services

A strong dental program in prisons is essential for maintaining overall health for incarcerated individuals, as poor oral health can cause pain, infections, and serious medical issues like heart disease. It also helps meet legal requirements to provide necessary care and support rehabilitation. Effective dental care also reduces strain on medical staff by preventing emergencies.

WIDOC dental services policies (*DAI Policy 500.40.06 Routine Dental Treatments* and *500.40.05 Preventive Dental Hygiene Services*) emphasize routine and preventive dental care. Routine dental services are elective and provided only after urgent and essential needs are addressed. Oral examinations include an intake screening within seven days by a trained healthcare professional, followed by a dentist-conducted examination within 30 days, including bitewing and panoramic radiographs unless recent ones exist. Periodic exams are based on request. Restorative treatments are limited to basic procedures like fillings, excluding cosmetic treatments, crowns, bridges, implants, or veneers. Oral surgery is limited to medically necessary procedures, with informed consent required, and complex cases are referred to DOC oral surgeons or off-site providers.

WIDOC currently has a substantial dental backlog due to dentist and dental assistant vacancies. Recruitment for dental positions is challenging because of pay discrepancies between community and correctional dentistry positions. In order to decrease the waitlists, BHS has employed strategies to include cross coverage of facilities by FTE dentists and dental supervisors and have deployed dentists to help with coverage at facilities, other than their own, to assist with the waitlists.

Medication Services and Management

Medication Assisted Treatment

WIDOCs MAT using buprenorphine and Vivitrol was authorized with *DAI Policy 500.80.29 Medically Supervised Withdrawal and Treatment* and became available at MSDF starting in December 2024 with funding through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant. MAT begins with screening for opioid use when the individual

arrives. Individuals already on buprenorphine tablets can continue the medication in the injectable form to minimize diversion risks.

The program is designed to integrate evidence-based interventions, such as the "Thinking for a Change" curriculum and cognitive-behavioral therapy (CBT), alongside personalized counseling to support recovery. A dedicated team, including a peer support specialist with prior incarceration experience, facilitates care coordination and release planning, ensuring a "warm handoff" to community providers for continuity of care post-release. The program also collaborates with the DCC to maintain treatment consistency after release, particularly for those with substance use disorder (SUD) diagnoses.

The benefits of the MAT program at MSDF are significant. Since its implementation, the facility has reported a notable decrease in contraband and no overdoses. The comprehensive training of 400 DOC staff members, including nursing, security, and wardens, has fostered widespread buy-in and effective implementation. The program's integration with evidence-based therapies and the inclusion of a peer support specialist enhances patient engagement and trust, particularly for release planning. Collaboration with external entities, such as SAMHSA, and internal initiatives to develop SUD programs further strengthen the program's foundation, making it a model for other WIDOC facilities, with wardens at other sites expressing interest in adopting similar initiatives.

The MAT program has delivered significant benefits for individuals with substance use disorders and remains a treatment component of the WIDOC's care strategy. Sustaining and expanding the program will require navigating the legislative budget process for staffing resources, securing consistent funding beyond the current federal SAMHSA grant, and pursuing opportunities to integrate evidence-based programming across facilities.

In general, the Falcon Team recommends expanding MAT services to improve treatment outcomes and to improve safety throughout the department, as realized at MSDF.

Pharmacy Services

Pharmacy services are critical to WIDOC's medical operations, supporting timely access to medications following intake screenings and medical encounters at all hours.

The current model includes central pharmacy operations and partnerships with local pharmacies to ensure after-hours and emergency access, particularly in rural areas where shipping is required. Building on this foundation, the organization could examine extending central pharmacy hours to evenings and weekends, using staggered shifts within existing staffing levels, to further support same-day medication processing. Additional potential solutions include implementing overnight delivery from the central pharmacy to all facilities to reduce reliance on external pharmacies, minimizing staff travel, and lower shipping expenses,

as well as contracting with a correctional pharmacy to explore potential cost savings while enhancing efficiency and supporting consistent care delivery.

Medication Administration

WIDOC has developed robust policies for medication administration, recognizing that a best practice is for medical professionals to dispense medications. Currently the process is hindered by the reliance on security staff to administer certain medications. Medications requiring staff administration, specifically medication that cannot be classified as Keep on Person (KOP), are best dispensed by healthcare staff to ensure compliance, monitor side effects, and provide patient education, as these interactions enhance adherence and prevent decompensation in conditions like diabetes and mental illness. While security staff is provided with some basic training on medication delivery (*DAI Policy 500.80.08, Medication Delivery and Training – Security*), the security staff's limited clinical training can increase the risk for negative outcomes and compromise the quality of care. WIDOC has formally requested resources to transition all medication administration to healthcare staff, including during the most recent budget cycle, but these requests have not been approved through the legislative process. WIDOC will continue to advocate for and request the resources needed to align with best practices and further strengthen patient safety, clinical oversight, and treatment adherence.

Continuity of Care

Medical Records/EHR

The Cerner EHR, implemented in 2018, has significantly advanced WIDOC's ability to manage patient information and support clinical operations. As with any technology platform, it continues to evolve, and the organization is committed to pursuing enhancements that improve consistency and reporting capacity. Recognizing that technology is essential to operations across the entire agency, WIDOC has, in several recent budget cycles, requested additional IT staffing to better support system development and implementation. While these requests have not been approved through the legislative process, continued careful prioritization of IT project requests is recommended. Recent process improvements have expedited system access for new staff; however, the agency's training resources for the EHR are far more limited than those available in comparable state agencies, such as the DHS.

As reflected in the organization's recent strategic priorities (July 2025), enhancing onboarding processes is a key operational focus, aimed at ensuring staff are well-prepared to perform their roles effectively and to make full use of available systems and resources. Expanding training capacity would help ensure users can fully leverage EHR capabilities and promote consistency across facilities. WIDOC also recognizes that, while the system selected was a choice made in accordance with state procurement rules and regulations, and other products with more premium features were not financially feasible, it has made substantial progress since

implementation and continues to support quality care, with opportunities for targeted enhancements.

Utilization Management

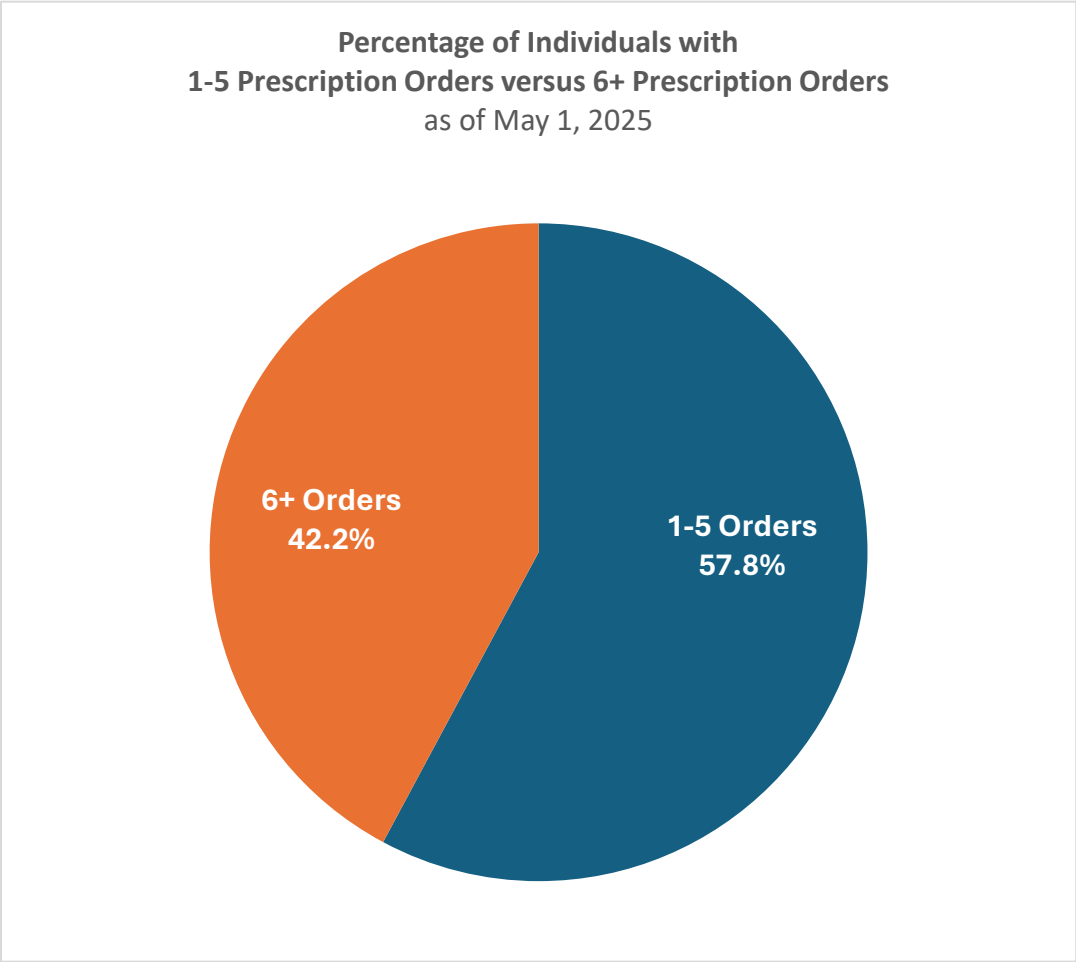
WIDOC does not have a utilization management process. Developing such a process would help strengthen care coordination, optimize services delivery, reduce unnecessary specialty referrals, and enhance operational efficiency, particularly in light of staffing capacity constraints and high referral volumes. A standardized utilization management program would provide clear guidelines to support in-house providers in assessing the necessity of specialty referrals and diagnostics, thereby reducing excessive off-site referrals. Combined with reporting mechanisms to track referrals, this approach would allow WIDOC to identify trends, address underlying factors and make data-informed decisions.

As part of this process, the organization should look to procure an evidence-based clinical decision support tool designed to determine the medical necessity and appropriateness of healthcare services, including inpatient admissions and outpatient procedures which would inform decisions regarding outside hospital transfers. The tool should provide evidence-based criteria to help guide utilization management, care transitions, and level-of-care determinations. Medical experts should routinely update the tool's criteria in line with best practices and with the most available data. The tool should allow for a nurse to review off-site requests, and if the request meets established criteria, the patient can be transferred. If not, the nurse consults with a medical director to make the most informed clinical decision. This process/tool can expediate cases that clearly meet criteria for an off-site transfer without utilizing on-call time.

Active Orders Data

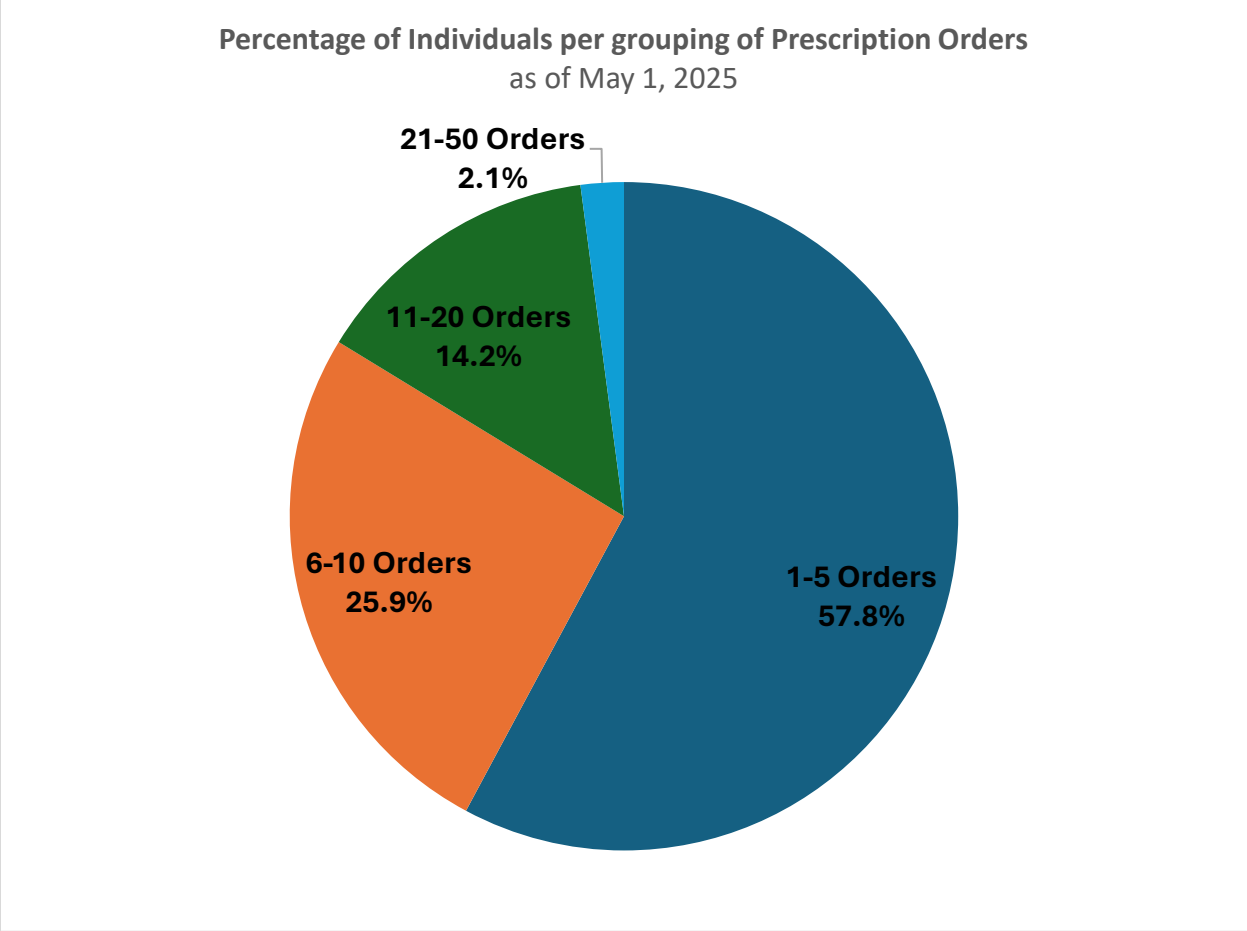
To evaluate prescribing practices, particularly polypharmacy, all prescriptions were analyzed. The following figure illustrates the percentage of incarcerated individuals prescribed (1) five or fewer prescriptions, and (2) those with six or more prescriptions.

Figure 4: Percentage of Individuals with 1-5 Prescription Orders versus 6+ Prescription Orders as of May 1, 2025



In all, 18,479 individuals within the WIDOC were prescribed some type of medication. At the time of this analysis there were 23,333 individuals within WIDOC DAI facilities, meaning that 79.2% of the entire DAI population is prescribed at least one medication. The total number of prescriptions was 112,264, showing that on average each individual prescribed medication is prescribed 6.01 medications.

Figure 5: Percentage of Individuals per grouping of Prescription Orders as of May 1, 2025



The previous figure illustrates the percentage of individuals prescribed between one and five medications, six to 10 medications, 11 to 20 medications, and between 21 and 50 medications.

These findings indicate that polypharmacy needs further study. Several specific recommendations are provided in the Medical Practices section of this report for individual medication practices and system-wide practices.

Summary of Workshop and Site Visit Discussions with Staff Related to Medical Issues

The following section summarizes information gleaned from staff on issues identified during the medical workshops and facility visits.

The study underscored the importance of aligning strategies that address immediate staffing needs with the long-term goal of developing a stable, high-performing and consistent healthcare workforce.

Approximately 35–40% of provider (physician and dentist) positions remain vacant, prompting a costly reliance on agency staff and diminishing continuity of care. In FY24, WIDOC paid $16,620,515.33 to agency staff to fill vacant positions. Through the first 12 pay periods of FY25, WIDOC paid agency staff a total of $8,035,386.30, which is on pace to surpass FY24.

While the recent addition of nurse educators, assistant psychology directors, and scheduling supervisors has been viewed positively, inadequate pay, limited professional incentives, and slow or ineffective human resource processes continue to undermine recruitment and retention efforts. One issue centered on the role of board certification for medical staff. While some leaders expressed initial resistance to requiring board certification, citing pressing staffing shortages, others emphasized the long-term value of board-certified physicians in stabilizing and professionalizing medical leadership. The lack of a pay differential for board-certified providers was noted as a barrier to attracting and retaining high-caliber medical professionals. This differential is consistent with mental health staff, as independent licensure is not required nor encouraged/incentivized with a higher salary.

Staff noted opportunities to strengthen chronic care management, particularly by promoting greater consistency across facilities and enhancing centralized oversight to help reduce variations in care. Staff noted that the training of providers on chronic care protocols was essential for supporting consistent treatment and reducing patient complaints. Staff highlighted an opportunity to enhance consistency in provider decision-making to reduce confusion, improve satisfaction, support patient trust, and decrease the likelihood of formal complaints.

Establishing clear clinical guidelines and providing training for physicians and nurses were proposed as strategies to foster more consistent decision-making and reduce the variability that leads to perceived inequities in care.

While most medical staff interviewed thought that the system collects all necessary data, they identified opportunities to strengthen data analysis. For example, reviewing grievances related to medication lapses and examining inhaler-use patterns could help identify systemic issues and guide target interventions. Discrepancies in the use of rescue versus maintenance inhalers, for instance, may highlight areas for improvement in chronic respiratory disease management. Staff felt that regularly reviewing such data and applying the findings could be used to drive quality improvement efforts.

Staff discussed opportunities to further leverage the Cerner EHR system. Optimizing features such as auto-scheduling and clinical flags could enhance continuity of care and reduce missed appointments. Standardizing EHR use across facilities would promote consistent access to and

management of patient information, thereby improving care coordination and documentation. The use of physical therapy was identified as an area of opportunity to enhance chronic pain management and reduce reliance on pharmacological interventions. Many facilities have the infrastructure for physical therapy, but these resources are underused. Staff recommended providing additional training for providers to effectively communicate the benefits of physical therapy to patients and to expand the use of physical therapy assistants to increase access to services. Staffing and retention were discussed extensively, with stable staffing being strongly correlated with better operational performance and care quality.

The practice of having correctional officers pass medications at the male facilities was a concern among medical personal at all facilities and a common theme in workshops. Staff identified long-term care capacity for individuals with conditions such as dementia as an important area for future planning. With an aging incarcerated population, proactively addressing long-term care needs is essential. One option could include expanding or repurposing existing facilities to meet these demands as part of the strategic planning process.

Another major theme was the opportunity to enhance consistency in medical practices and training. Onboarding processes could be further standardized, and EHR training expanded, to better equip staff for their roles.

As mentioned above, many providers lack board certification, and while some leaders do not view this as critical, others argue it contributes to unnecessary off-site referrals and inconsistent chronic care management. Opportunities also exist to strengthen chronic care documentation and follow-up practices by increasing the use of standardized templates and ensuring timely scheduling of follow-up appointments. Despite guidance being available, establishing clear accountability measures could help reinforce expectations and promote consistent care delivery.

Access to care continues to present challenges, especially in maximum-security settings where security staff levels can affect patient movement and the scheduling of off-site appointments. At some sites, officers are unavailable to escort patients to medical visits or medication distribution is impacted by the practice of relying on correctional staff to administer up to 80% of medications, including narcotics (as mentioned above). In some cases, tele-medicine and specialized in-house services have helped reduce the need for outside care.

These observations reflect a healthcare system in transition, and one evolving toward greater consistency, professionalism, and quality of care. Addressing these issues will require cross-disciplinary collaboration, strategic investments in staffing and technology, and a clear commitment to implementing evidence-informed practices across the WIDOC system.

G. Data Collection and System Monitoring

Effective data use in a correctional system depends on a coordinated bi-directional feedback loop for data collection, management, and reporting. Accurate data must be collected at the facility level in standardized, usable formats and relayed upward for analysis, oversight, and reporting. In turn, the results—such as system performance trends, emerging issues, and facility-level findings—must be communicated back to facilities to guide local decision-making and improvement. To support this cycle, databases should be integrated or interoperable, and both frontline staff and leadership must have timely access to current ("real-time") data.

WIDOC collects and consistently reports a substantial volume of data, and the agency has team members in multiple departments that are skilled in data management, reporting, and analytics. For example, the Research and Policy Unit maintains exemplary public-facing interactive dashboards covering multiple system domains, including detailed population trends, critical incidents, restricted housing placements and lengths of stay, and rehabilitative programming metrics. This level of frequent reporting, which replaced prior bi-annual reports, reflects a meaningful commitment to transparency and system oversight.

To capitalize on existing strengths and elevate the use of data to support strategic initiatives and continuous improvement, underlying barriers must be addressed, including inconsistent data collection practices and, in some cases, siloed databases and workflows.

Standardized policies and on-unit digital data collection systems are essential to advancing data collection beyond record-keeping. For example, all restricted housing units currently rely on paper forms to track out-of-cell time, which limits reporting to leadership and hinders feedback loops or data-informed decision-making. WIDOC should transition these units to an integrated electronic system that enables real-time logging, supports oversight, and produces analyzable data for system-wide evaluation. Similar policies and procedures are also needed to meaningfully track programming participation and outcomes at an individual- and system-level.

Integration of data across departments and units, including the Bureau of Health Services, is also essential, so relevant information is readily accessible to leadership to support data-driven decision-making and improvement initiatives. Where practical barriers exist, such as HIPAA-related limitations to healthcare data access, protocols should be established for the regular extraction and exchange of key data.

Many of Falcon's recommended changes and improvements will depend on continued data collection, but with more purposeful analysis and utilization. Additional discussion of data-related issues is included in the Data Management Recommendations section in this report, where specific considerations and recommendations are addressed in greater detail.

Section 3

Recommendations for Collaborative Change Model

Section 3: Recommendations for Collaborative Change Model

A. Overview of Collaborative Change Model

Falcon recommends utilizing a collaborative change model that aims to achieve the agency leadership's strategy by integrating guidance and sponsorship from WIDOC Executive Leadership with input and innovation from frontline staff, stakeholders, and the incarcerated population. This model fosters intentional communication and collaboration to ensure mutual understanding, appreciation, and effective implementation of change initiatives. The model also communicates an understanding that the goal of each initiative is to improve safety and health outcomes for all WIDOC staff and all incarcerated individuals living and working in WIDOC facilities.

The first step in this process is for the agency to align implementation efforts with its recently rolled-out strategic priorities by integrating operational priorities into divisional workplans. These efforts should be advanced through structured workgroups and, for a select subset, initially implemented at a limited number of designated sites, using an *Intentional Accountability Framework.* This is a collaboratively designed, structured approach emphasizing accountability, transparency, and consistency, but internally driven, to test and demonstrate the model. Each effort should be guided by clear objectives, measurable outcomes, deliverables, and timelines. Aligning this framework with the agency's strategic priorities will ensure consistency, avoid duplication, and provide a clear path for scaling successful practices across the system.

As part of the *Intentional Accountability Framework*, Falcon experts would conduct regular site visits and work alongside staff to assess progress, troubleshoot challenges, and directly contribute to implementation efforts. Beyond evaluating progress, this role would actively support the agency in developing and embedding quality assurance practices across agency leadership, ensuring the skills and structures are in place to sustain the model over time. This approach establishes a consistent rhythm of review, collaborative problem-solving, and accountability, while reinforcing engagement and strengthening capacity across the entire agency.

B. Overview of Collaborative Change Focus Areas

As part of this process, Falcon recommends the agency incorporate the focus areas listed below into its operational priorities and divisional workplans. Some of these areas may be advanced at designated sites under the *Intentional Accountability Framework*, while others will require agency-wide initiatives and oversight, and in some cases, efforts may involve both approaches.

- Bed Management
- Next Steps in Restrictive Housing
- Back-to-Basics in Correctional Practices
- Mental Health Practices
- Medical Practices
- Data Management
- Human Resources and Staffing (all disciplines)
- Investigations and Intelligence Practices

For each focus area, the following tables include: (1) the title of the focus area, (2) the recommended purpose, (3) top priorities, and (4) workstreams. Additional and specific recommendations to be considered during the implementation phase for each focus area are included in Appendix A. Recommendations are also provided and elaborated further in the Review of Existing Systems section of this report. All recommendations are made based on Falcon's overall review of the DAI system; however, we understand that the majority of recommendations will require funding, often requiring budget approval.

Table 17: Focus Area, Purpose, Priorities, and Workstreams

Bed Management
Purpose: This focus area aims to address gridlock and enhance the efficient movement of individuals between and within facilities. This is done by tackling operational bottlenecks that hinder appropriate and timely bed placement and implementing strategies to reconfigure existing capacity. This effort will involve coordination with experts in operations, mental health, medical, and classification.
Top Priorities • Optimize the new classification system implementation. • House all individuals at their appropriate classification level with no waitlists. • Implement site-specific specialty programs and population designations to enhance operational efficiency and advance the agency's mission and goals. • Strive to eliminate time delays for transferring individuals to appropriate security levels.
Recommended "Bed Management" Workstreams • Evaluation of Current Capacity: ○ Establish a process and conduct ongoing analysis to most effectively reconfigure bed capacity in ways that are responsive to evolving policy

Bed Management

priorities, broader state plans, and current conditions, while remaining firmly aligned with operational priorities.
    - Evaluate current staffing patterns and staff-to-resident ratios to develop standardized schedules and consistent staffing practices.
- Expanded Early Release Program (ERP):
    - Address staffing challenges to attract and retain qualified personnel.
    - Continue efforts to ensure that ERP participants are appropriately placed and have access to programming, maximize ERP utilization, and regularly review and update policy and suitability criteria to ensure alignment with the agency's mission.
    - Explore the feasibility of adding the ERP to additional facilities and increasing availability at current sites through added sessions, including evening and weekend hours.
- Appropriate Use of Maximum Custody Beds:
    - To reduce the risk of individuals being placed at higher custody levels due to conduct reports resulting from symptoms of a mental health condition, review and adjust current practices so that conduct reports are evaluated for this during classification reviews. This will help prevent the unnecessary use of maximum custody placements for individuals who could be safely housed in lower custody levels, thereby preserving higher-security beds for those who truly require them.
- Monitoring Classification Systems:
    - Continue to provide oversight to the implementation of the new classification system and systematically monitor outcomes to ensure it is applied consistently and supports ongoing improvements.

By addressing these critical areas, the Bed Management focus area aims to streamline operations, enhance mental health support mechanisms, and optimize resource allocation, contributing to the overall efficiency and well-being within the correctional system.

Next Steps in Restrictive Housing

Purpose: This focus area will build on recent initiatives to decrease the use of restrictive housing. Beyond decreasing the overall use of restrictive housing, this focus area will aim to improve the living conditions of those housed and working in these units, including increased out-of-cell time. This will require enhancing operational efficiency and mental health support.

Top Priorities

- Continue initiatives to limit the amount of time individuals remain in restrictive housing.
- Create alterative units for SMI individuals so they can automatically be diverted from restrictive housing.
- Implement a system so that all individuals in restrictive housing receive at least two hours of out-of-cell time per day, with increased opportunities at higher step levels, and their time is consistently tracked through a standardized, division-wide real-time system.
- Implement weekly multi-disciplinary review of all individuals in restrictive housing to review the status, programming, and needs of the individual (the current policy is every 30 days).
- Evolve facility spaces so that clinical observation rooms are transitioned out of restrictive housing and into more appropriate environments that support therapeutic care and patient safety.
- Reduce reliance on force and intermediary tools in managing behavior within restrictive housing units by increasing the use of de-escalation techniques.
- Conduct a comprehensive review of certified peer specialist utilization in restrictive housing units and expand their role to strengthen support services and promote positive adjustment.

Recommended "Next Steps" Workstreams

- Assessment and Improvement of Existing RHUs:
    - Improve overall conditions of those in restrictive housing to include at least two hours per day of recreation and/or programming, not including out-of-cell time for medical appointments, showers, or other necessary activities.
    - Ensure that all cells have a clear line of vision so officers conducting rounds can see each individual.
    - Evaluate overall facility layouts to identify areas that can be repurposed or evolved into mental health units and observation room placements to optimize space and resource use.

Next Steps in Restrictive Housing

- CQI on RHU Utilization - Develop CQI methodologies to continuously monitor and track all aspects of restrictive housing including the following:
    - Continue to track and monitor the overall number of individuals in restrictive housing, including length of time.
    - Monitor for the over-representation of certain groups receiving restrictive housing sanctions.
        - Track and analyze data specific to an individual's gender, age, and race/ethnicity,[21] as well as track and monitor differences in length of stay and frequency of dismissed charges across these variables.
    - Create a method for understanding the root causes of those who are repeatedly placed in restrictive housing and develop individualized plans for each person to address the causes of such placement. For example, if an individual is repeatedly placed in restrictive housing because she or he fears general population due to receiving threats, design a plan that includes working with the individual on a plan to identify locations they can be housed in general population and would feel safe. Alternatively, for someone who engages in frequent assaultive behavior, develop a plan that aims to understand the causes of aggression for the individual and implement strategies to decrease the individual's risk for violence, such as cognitive-behavioral therapy focusing on identifying the cause of the individual's anger.
- Alternatives for SMI Individuals:
    - Establish dedicated units as alternatives to placement in restrictive housing for individuals designated as SMI.
    - Design and implement separate units for MH-2As and MH-2Bs. For the unit designed for MH-2Bs, refer to the Behavior Management Unit section of this report as a guide.
    - Develop a process that automatically diverts individuals designated as SMI to these units.
- Suicide Observation Protocols:
    - Evolve facility spaces so that clinical observation rooms are transitioned out of restrictive housing and into more appropriate environments that support therapeutic care and patient safety.

[21] 2022 NCCHC committee on systemic racism open forums: Initial findings. (2023, March 31). Retrieved from https://www.ncchc.org/2022-ncchc-committee-on-systemic-racism-open-forums-initial-findings/

Next Steps in Restrictive Housing

- Modify conditions in observation cells, such as replacing small sleeping mats with suicide-resistant mattresses, removing concrete slabs to enable shifting away from restraints, and utilizing 1:1 observation rather than restraints when appropriate.

By concentrating on these initiatives, the Next Steps in Restrictive Housing focus area aims to minimize the reliance on restrictive housing, improve mental health outcomes, and create a more humane correctional environment.

Back-to-Basics in Correctional Practices

Purpose: This area focuses on training, monitoring, and ensuring accountability on basic security practices. A central deliverable will be the creation of a three-to-five-day operational training to equip personnel with foundational skills and reinforce consistent security practices across sites.

Top Priorities

- Improve overall security practices.
- Develop and implement three-to-five-day training for all staff reinforcing basic correctional practices, such as:
    - Searches
    - Entrance procedures
    - Rounds
    - Normative correctional practices (i.e., visits, communal meals)
    - Restraint practices
    - Restrictive housing out-of-cell time
    - Use of force
    - Incident reporting
    - Security Threat Group (STG) investigations
- Review and update statewide policies to improve security practices and consistency between facilities.
    - Modernize the FTO program to supplement academy instruction and strengthen on-the-job learning.
- Establish an Incident Reporting Review Team at the central office to review designated categories of incidents, follow up with sites to confirm whether investigations have been initiated, and determine when additional investigation is warranted.
- Enhance the current system-wide security audit process. Create a multi-disciplinary audit team at headquarters to conduct annual reviews of each facility to assess compliance with custody, medical, and mental health policies, ensure consistency across sites, and support continuous improvement. Recognizing that dedicated resources will be required, this effort may necessitate the reallocation of existing positions or inclusion in a future budget request.
- Ensure and enforce standardized statewide entrance procedures for all visitors, including professional visitors, law enforcement, and staff. Standards should cover areas such as metal detector usage, allowable items, and other security protocols to promote safety and consistency across facilities, supported by regular staff training,

Back-to-Basics in Correctional Practices

monitoring, and periodic review. This will reduce variability between sites, strengthen overall facility security, reinforce professionalism and visitor confidence in agency operations, and improve operational efficiency by minimizing confusion and exceptions.

Recommended "Back-to-Basics" Workstreams

- Internal Security Audit Checklist:
  - Build on the existing internal security audit checklist to strengthen its effectiveness, ensuring consistent implementation across facilities and incorporating clear feedback mechanisms for continuous improvement.
- Universal STG Assessment at Intake:
  - Strengthen intake processes by building on current practices to ensure universal STG interviews are conducted, supporting more consistently and accurate identification of STG affiliations.
- Use-of-Force Equipment Standards:
  - Enhance the accountability and training standards for staff handling use-of-force equipment, including tasers, Oleoresin Capsicum (OC) spray, etc.
- Body Camera Standardization:
  - Continue expanding and standardizing the use of body-worn cameras, as resources permit, to strengthen transparency, accountability, staff safety, and policy compliance. Current federal grant support provides an opportunity to further this effort, enhance incident review, and build the foundation for broader implementation across facilities.
- Incident Review Improvements:
  - Strengthen the incident review process by streamlining how incidents requiring formal investigation are confirmed, tracked, and closed out in coordination with facility leadership. Ensure findings are used not only to implement corrective actions but also to foster a culture of learning.
- Academy Training Protocols:
  - Continue the ongoing comprehensive review of the training curriculum for new staff, building on current efforts to update both content and delivery methods to reflect adult-learning models and best practices. These enhancements, aligned with the agency's strategic priorities around onboarding and training, will further strengthen staff preparedness, support professional development, and ensure greater consistency across facilities. Centralized training plays a key role in achieving this consistency, while

Back-to-Basics in Correctional Practices

decentralized, site-based training risks variability in quality and content. Advancing a centralized approach will help improve long-term retention and reinforce system-wide standards.

- Supervision and Performance Reviews:
  - Leverage existing performance evaluation policies to provide more frequent, individualized feedback and skill development discussions during the first six months of employment. Emphasize the importance of using the full performance rating scale to accurately reflect strengths, areas for growth, and opportunities for development, rather than defaulting to uniformly high ratings. This approach reinforces a culture of accountability, supports professional growth, and ensures evaluations are meaningful and constructive.
- Enhanced Communication Training:
  - As part of the ongoing curriculum review, make communication training a core component, emphasizing scenario-based practice in engagement, de-escalation, and other evidence-informed approaches. Strengthened communication skills benefit staff by enhancing safety and confidence while also reducing grievances and reliance on force, ultimately fostering more constructive interactions with the incarcerated population.
  - Consider reinstituting training on Motivational Interviewing.
- Mental Health Integration:
  - Better integrate mental health expertise into operational and disciplinary processes by ensuring staff have the tools, training, and consultation needed to distinguish mental health symptoms from behavioral issues. This approach supports fair decision-making, reduces unnecessary disciplinary actions, and promotes safer, more effective management of individuals with mental health needs..

The Back-to-Basics Focus Area aims to foster a culture of accountability, compliance, and effectiveness while prioritizing the mental well-being of those in correctional environments.

Mental Health Practices

Purpose: This focus area is dedicated to enhancing mental health care throughout WIDOC, ensuring that individuals receive appropriate assessment, treatment, and proactive intervention by updating policies, practices, and procedures.

Top Priorities

- Review and align the Mental Health Classification System with current standards to improve consistency in needs identification, placement, and services.
- Increase the frequency of contact for those with clinical needs to strengthen engagement, support stabilization, and reduce reliance on restrictive interventions.
- Decrease caseloads by reviewing MH-1s who are seen every six months and no longer require such infrequent contacts.
- Develop alternatives to RHU placement for individuals designated SMI (as described in the Next Steps in Restrictive Housing section of this report).
- Develop residential treatment units across the system to support individuals with short-term behavioral and adjustment needs, as well as those with long-term chronic conditions. These units should be accessible at maximum- and medium-security facilities and coordinated through a centralized referral process led by the statewide mental health director. Establishing these units will require evolving existing spaces, careful planning, and ensuring staff receive appropriate training to support effective implementation and sustainability.
- Adhere to using SRTU beds exclusively for SRTU-designated patients, maintaining their intended purpose and reinforcing treatment integrity.

Recommended "Mental Health" Workstreams

- Behavioral Intervention and Training:
  - Strengthen staff capacity through training and support to implement care plans that incorporate evidence-based strategies for effectively managing individuals who engage in severe self-injury.
- Suicide Prevention and Crisis Response:
  - Strengthen protocols to balance safety with humane care, improving timely clinical access and using targeted interventions to reduce the frequency and duration of suicide precautions.
- Mental Health Classification System:
  - Refine the Mental Health Classification system to more accurately reflect clinical acuity and reclassify individuals as appropriate under the updated

Mental Health Practices
system. Adjust the frequency of clinical contact to be responsive to each individual's assessed needs. The Mental Health Practices focus area is a system-wide effort to improve mental health services within DAI facilities, focusing on proactive care, humane treatment, and long-term recovery pathways rather than crisis-driven management.

Medical Practices

Purpose: This focus area will enhance comprehensive medical care throughout WIDOC, ensuring clinical team effectiveness, establishing a patient-centered chronic care model, and expanding specialty bed capacity so that individuals receive effective treatment, proactive interventions, and access to specialized care.

Top Priorities

- Improve the chronic care model and implement utilization management.
- Implement an off-site transfer approval process.
- Improve prescribing practices, including reducing polypharmacy.
- Transition medication administration from correctional officers to nursing or trained medical technicians.

Recommended "Medical Practices" Workstreams

- Excellence and Innovation in the Clinical Team:
  - Optimize clinical staffing by evaluating which roles require additional full-time staffing versus external support, streamlining hiring,[22] and aligning pay incentives.
  - Standardize high-performing models, best practices, and training across all sites to reduce variability while boosting quality and job satisfaction.
- Patient-Centered Medical Home (PCMH) for Chronic Care:
  - Establish a structured, industry-standard model for managing chronic care, ensuring consistent and high-quality treatment despite staffing challenges.
  - Adopt a utilization management system that gives clear, evidence-based guidelines to improve efficiencies.
- Specialty Bed Capacity:
  - Expand and optimize access to specialty beds, including those for long-term and palliative care.
  - Identify current gaps and develop scalable strategies so that patients with complex needs receive the specialized care they require.

[22] The Medical Practices Focus Area is heavily dependent on improved hiring and staffing practices as recommended within the HR & Staffing work group.

Data Management

Purpose: This focus area aims to expand and improve upon the department's collection, use, and impact of its rich data resources.

Top Priority Outcomes

- Improve overall data collection, analysis, and reporting.
- Create and oversee the implementation of a centralized tracking system for restrictive housing out-of-cell time.
  - Structured time (i.e., groups, programs)
  - Unstructured time (i.e., recreation)
- Improve or develop centralized tracking systems for the following:
  - Inmate Complaints and responses (consider utilizing tablets)
  - Use-of-force incidents
  - Investigations
  - Medical population
  - Mental health population
  - Utilization Management

Recommended "Data Management" Workstreams

- Data Asset Management Capabilities:
  - Expand and refine existing capabilities to further leverage rich data sources, including reports, analytics, metrics, and indicators supported by more effective tools and user experiences. Build new capacities where needed, recognizing additional IT staff resources will be required to support these efforts.
- Data Collection within Work Processes:
  - Identify and implement updated processes to capture data in line with work activities, replacing outdated or redundant methods where appropriate, in order to limit administrative burden while increasing the visibility of critical indicators, metrics, and quality characteristics.
- Rhythms of Review:
  - Assess, revise, and right-size organizational rhythms to review key metrics and indicators, which provide critical insight, foster discussion, and elevate leadership across the agency. These rhythms are intended to provide clarity and accountability to staff at all levels of the agency by maintaining

Data Management	
	transparency throughout the system while encouraging local leadership and decision-making.

Human Resources and Staffing (all disciplines)

Purpose: This focus area aims to streamline processes and address challenges in recruitment, retention, and resource allocation across statewide human resources operations.

Top Priorities

- Refine hiring practices to attract qualified candidates more effectively and ensure alignment with organizational needs.
- Promote salary structures that are competitive across disciplines and aligned with workforce needs.
- Establish licensure requirements for clinical positions.
- Expand opportunities to incentivize licensure and board certification, including salary adjustments for staff who achieve independent licensure or board certification.
- Align job titles with those commonly used in the community, particularly for mental health positions, to promote clarity and consistency in recruitment.
- Expand upon current internship programs.
- Improve the attendance policies to decrease misuse of sick leave.
- Address issues related to the misuse of FMLA.

Recommended "HR and Staffing" Workstreams

- Assessment of Current Hiring Protocols:
  - Review and refine hiring processes to attract and select well-qualified candidates efficiently, with continued emphasis on thorough background and security checks to safeguard workforce integrity.
  - Improve position titles to better match community titles.
- Consistently list available, open positions with their locations.
- Development of Recruitment Strategies:
  - Create targeted recruitment initiatives to attract highly qualified professionals for clinical, leadership, and specialized positions, fostering a well-rounded and talented workforce.
- Address Pay Disparity and Promotion Issues:
  - Continue to review and resolve pay disparity concerns, particularly in areas where pay discrepancies disincentivize the pursuit of promotions.
  - Refine promotion processes to strengthen fairness and transparency.
- Retention Programs:
  - Strengthen existing retention programs to enhance employee satisfaction, support engagement, and sustain a resilient and committed workforce.

Human Resources and Staffing (all disciplines)

- Mental Health Hiring and Leadership:
  - Employ independently licensed master's-level clinicians for clinical and supervisory positions that align with community standards.
- Change position titles to be more consistent with the community. For example, change the "Psychiatric Services Unit" to the "Mental Health Department" or the "Behavioral Health Department." Also, change psychological associate to QMHP to recruit both master's level (LCSWs and LPCs) and doctoral level independently licensed staff.
- Overtime:
  - Examine the use of forced overtime and staff rotation practices, including the impact of sick leave and FMLA usage on avoiding mandatory overtime.
- Sick Leave Policy Review:
  - Cap unscheduled call-ins annually to maintain both employee support and operational effectiveness.
- FMLA Use:
  - Federal FMLA policies should be adhered to; however, addressing the issue of FMLA overuse remains a priority for improvement.

By focusing on these initiatives, the goals are to improve key strategies, protocols, and processes in the HR framework that supports the organization's mission and adapts to evolving demands.

Investigations and Intelligence Practices

Purpose: This focus area aims to enhance processes and address challenges in investigations, monitoring, and resource allocation across intelligence operations.

Top Priorities

- Advance proactive practices in intelligence monitoring and staff investigations to prevent issues before they occur.
- Establish a centralized review process to promote consistency in the management of specific tiers of incidents.
- Strengthen the consistency and timeliness of staff investigations by partnering with external investigative experts to provide training.
- Activate and refine the centralized investigations database to enhance efficiency, usability, and cross-agency data sharing.
- Establish realistic timeframes for investigations and HR follow-up processes, making policy adjustments as needed to support implementation.
- Conduct parallel (contemporaneous) investigations with law enforcement, prioritizing administrative-disciplinary findings while avoiding transactional-immunity risks.

Recommended "Investigations and Intelligence" Workstreams

- Assessment of Current Investigation Protocols:
  - Strengthen the statewide investigation process by evaluating opportunities to improve efficiency, thoroughness, and timeliness.
  - Analyze workloads, to maintain manageable ratios (currently 7.5 investigations per investigator).
- Interview and Records Management:
  - Reinforce standardized interview procedures to ensure Internal Affairs Officers (IAOs) and facility/unit investigators apply consistent formats and content guidelines.
  - Explore alternatives to transcribing all interviews by focusing on formal disciplinary cases.
  - Track all investigations centrally regardless of severity or complexity.
- Bottleneck Reduction Strategies:
  - Identify and address bottlenecks in investigation reviews to streamline case progression and resolution.
  - Set the expectation for interviews to be conducted face-to-face, with video used only in rare circumstances when in-person is not feasible.

Investigations and Intelligence Practices

- Proactive Monitoring and Investigation Framework:
  - Conduct annual staff monitoring through background checks to support agency integrity.
  - Standardize intelligence functions through an agency-wide intelligence unit, replacing fragmented site-based assignments.
  - Create a system to flag for leadership when staff are associated with multiple investigations, regardless of outcome, to support proactive oversight.

By focusing on these initiatives, the *Investigations and Intelligence Practices* focus area seeks to create a resilient, proactive Intelligence framework that supports organizational objectives while ensuring efficiency and accountability.

Section 4

Appendices

Section 4: Appendices

Appendix A: Additional Recommendations

Appendix A includes additional and specific recommendations to be considered during the implementation phase for each focus area. The following table includes these additional recommendations:

Next Steps in Restrictive Housing
Additional recommendations to consider for implementation are as follows: • Improve cleanliness and remove all graffiti. • Implement consistent use of tablets. • Ensure that programming is incentivized by limiting use of tablets to non-program and non-recreation times. • Expand substance use and criminal thinking programming and incentivize participation.
Back-to-Basics in Correctional Practices
Additional recommendations to consider for implementation are as follows: • Consider removing razors at facilities or units where there are high rates of misuse (i.e., using razors to engage in self-harm), and replace them with electric razors. • Implement independent policy mapping to enhance organizational systems and processes.
Mental Health Practices
Additional recommendations to consider for implementation are as follows: • Expand the use of clozapine when clinically appropriate for patients who could benefit from treating resistant psychosis and reducing the risk of self-harm or assaultive behaviors.   ○ Consider leveraging the recent change in Risk Evaluation and Mitigation Strategy (REMS) requirements to simplify pharmacy practices and safely increase access to and utilization for appropriate patients. • Add “dementia” to the *Mental Health Clearance Form* for minimum-security transfers.
Medical Practices
Additional recommendations to consider for implementation are as follows:

- Improve management of chronic medical conditions by elevating a position in chronic care and utilizing telehealth to alleviate the burden on on-site staff.
- Address reported tension between nurses and physicians by clarifying roles, supporting each discipline, and implementing consistent practices across sites.
- Address waitlists for physical therapy.
- Address job function inconsistencies in the Americans with Disabilities Act (ADA) coordinator role (education supervisor).
- Create standardized workflows in Cerner for clinical processes with clear quality metrics in such areas as chronic care clinics, pain management, and sick calls, which can supplant the multiple workflows providers currently select. It is likely that this will require time-limited, health-information management support from the vendor or contractor to access the required expertise with Cerner.
- Consider the following based on Falcon's review of prescribing practices:
    - Acetaminophen aspirin caffeine ("Excedrin migraine") is often abused for the caffeine and risks acetaminophen overdose. High risk of analgesic withdrawal headaches perpetuates the belief that it is working when it is creating the withdrawal headaches. Recommend taking it off formulary.
    - Albuterol: Spacer orders were only about a third of the orders for albuterol, suggesting it is an area for improvement. If a spacer is not used, most of the albuterol puff is wasted. Utilize the asthma chronic care clinical guideline.
    - Amphetamines are being prescribed at a higher-than-expected rate despite non-formulary status. Consider a CQI study to determine where there are higher rates of prescribing amphetamines and review records on the clinical indication. Once data is available, provide education/training, require specific documentation describing clinical indication, and continue to track data for areas that require improvement.
    - Calcium carbonate (Tums) briefly lowers stomach acidity, but the stomach compensates for it by making it more acidic later. It is not a good chronic medication for peptic ulcer. Famotidine is more effective both for symptom control and for preventing ulcers or bleeding. Consider removing calcium carbonate as a PRN for dyspepsia but maintain it for calcium supplementation for those with risk factors for osteoporosis.
    - Diphenhydramine, trazodone, and mirtazapine appear to be widely used for sleep. Consider taking them off formulary for a period, approving only for specific indications (i.e., diagnosed allergy conditions, treatment-resistant depression, or SSRI intolerance, respectively, to clarify indications).

- Ibuprofen and acetaminophen: High numbers of prescriptions suggest the use of sick call to obtain over-the-counter medications. Consider alternatives.
- Multivitamins are often requested but seldom medically necessary. Consider removing them from the formulary.
- Omeprazole: High number of orders suggests overuse. Chronic omeprazole is not associated with better outcomes than H2 blockers. However, it is associated with osteoporosis and pneumonia risk. It is common for patients to have omeprazole started in the hospital for gastrointestinal prophylaxis post-op or while in intensive care, and then it is commonly not re-evaluated and discontinued. Consider restricting access.
- Tricyclic antidepressants: Consider change to non-formulary status based on their high overdose risk and the presence of inexpensive, safer alternatives. Or consider keeping only the lowest dose form of amitriptyline (25mg) and eliminate the others, as the preferred agent for neuropathic pain.
- Topical emollients (including ointment and petrolatum): Often misused for various reasons. High numbers of prescriptions suggest over prescribing. Consider restricting access. Generic versions of Lubriderm are more effective for treating significant ichthyosis and less prone to misuse.
- Compare the Wisconsin Medicaid formulary to the DOC formulary to ensure that the same brands of certain high-cost medications are used by both agencies (e.g., biologics).

Human Resources and Staffing (all disciplines)

Additional recommendations to consider for implementation are as follows:

- Streamline recruitment and onboarding processes.
  - Improve the application process to simplify online platforms.
  - Clarify job postings (e.g., full-time versus part-time).
  - Hire a full-time dedicated recruiter.
  - Standardize onboarding across facilities by providing comprehensive training on chronic care protocols.
- Enhance compensation and incentives:
  - Conduct a wage analysis to identify regional and custody-level disparities, advocating for wage modifications or differentials for maximum custody settings, geographic areas with large health centers, and off-hour shifts.
  - Provide salary increases when staff receive their independent licensure or board certification (medical and mental health).
  - Consider ways to provide tuition reimbursement.

- Expand educational partnerships and professional development.
    - Build on the Nurse Externship Program's growth (from two to ten students) by partnering with universities for clinical rotations, preceptorships, and residency programs to expand the pipeline of qualified nurses and providers.
- Advocate for legislative support.
    - Seek legislative funding to increase the number of permanent positions, align the Bureau of Health Services pay with DHS rates, and support infrastructure for chronic care units. This would reduce dependence on costly agency staff and competition with regional health centers, ensuring sustainable staffing for facilities like Dodge and Taycheedah, where chronic-care demands are high.
- Change the staff requirement that all custody staff be sergeants at (centers) minimum-security facilities.
- Establish uniform standards for assigning specialty roles, ensuring that the same position titles are consistently used across facilities and not varying by site and update position descriptions accordingly.
- Establish a dedicated intelligence unit with a centralized reporting structure to ensure consistency, coordination, and accountability in intelligence functions.
- Invest in the 'social worker' positions as staff responsibilities in these positions significantly improve case management.
    - Consider changing the title of this position from *social worker* to *correctional counselor, correctional program specialist,* or something similar because there is no requirement for individuals to have a degree in social work. This change will also help in recruiting clinical social workers as the title "licensed clinical social worker" (LCSW) can be used and advertised by the mental health department for independently licensed clinical and supervisory positions.

Appendix B: Background Information for Staff Training Initiatives

Perceptions of Correctional Culture and Staff Recruitment Efforts

The perception of a correctional work environment can significantly impact the ability to attract and retain employees. Correctional staff work in an environment that exposes them to significant safety concerns, including dealing with violent individuals, altercations, and possibly dangerous situations. If the perception of safety is low, potential candidates may be discouraged from applying for opportunities, and current employees may seek work elsewhere. Moreover, constant exposure to undesirable experiences, such as witnessing violence or dealing with challenging incarcerated individuals, can cause employees stress, anxiety, and burnout. Employees who view their work environment as extremely stressful or unsupportive will inevitably leave, making it harder to retain talented people.

One suggestion to help change the stigma is to consider adopting a public awareness campaign to enhance the public perception of those who work in correctional settings. These campaigns can help educate the public about WIDOC's mission, vision, and goals, which include public safety, public health, rehabilitation, individual health and mental health outcomes, and reentry into the community.

Identifying how staff safety is significantly improved through initiatives such as reducing the number of individuals in restrictive housing, reducing the length of time individuals are housed in restrictive housing, and increasing programming, such as job training and education, should be integrated into these initiatives. This important focus is embedded in all of the recommendations provided in this report.

Training in the Rehabilitative Aspect of Corrections

A recent quasi-experimental study[23] examined the effect of pre-service academy training on the rehabilitative and custodial orientations of newly hired correctional officers toward incarcerated individuals. Based on the results, it appears that pre-service training academies could have a tremendous impact on the outcomes of professional orientations for recently hired correctional officers. The researchers concluded, "Our results suggest training academies may be an effective vehicle for changing Correctional Officers' orientations towards rehabilitation. State governments should take heed and consider whether training regimens should include a greater emphasis on rehabilitation." The officers' rehabilitative orientations were impacted by the supplementary hours of specialized training they completed throughout

[23] Burton, A. L., Jonson, C. L., Barnes, J. C., Miller, W. T., Burton, V. S. (2022). Training as an opportunity for change: A pretest–posttest study of pre-service Correctional Officer orientations. *Journal of Experimental Criminology.* https://doi.org/10.1007/s11292-022-09544-8

their basic academy training. The transformation to rehabilitative orientations was observed in officers who completed the eight hours of rehabilitation training. The results suggest that training academies could function as a viable means to improve the rehabilitation-focused viewpoints of newly hired correctional officers.

Appendix C - Data Gathering and Review

Falcon initiated the study with a discovery phase, issuing an initial data request followed by supplemental data requests to WIDOC's Research and Policy Department and WIDOC administration. WIDOC provided substantial documentation and continued to provide data when Falcon experts requested additional details. Requested items included:

WIDOC

1. Current and past court orders affecting WIDOC.
2. Current and past executive orders affecting WIDOC.
3. Wisconsin laws governing the DOC's operations pertaining to care and custody.
4. Ongoing or settled litigation pertaining to the delivery of healthcare, behavioral health care, restrictive housing, or other applicable topics.
5. Audit outcomes of external reviews of WIDOC.

WIDOC Administration

1. Organizational chart for WIDOC.
2. Current strategic plan for WIDOC.
3. Current operating budget.
4. List of, and recent communications with, community advocacy groups that interact with the department.
5. Any staffing analysis studies or reviews conducted for custody, medical, behavioral health, and substance use staff, either system-wide or by facility.
6. Reports and audits results produced as a result of Healthcare Services oversight and monitoring and tracking related to closed and ongoing corrective action plans that may have resulted.
7. List of WIDOC-specific acronyms and program references.
8. Documents or policies concerning WIDOC's communication strategy.
9. List of Training Academy curriculum for both pre-service and current in-service training.
10. List of curriculum offerings for supervisors and managers.
11. Any recent communications from headquarters to agency staff, including memos or other types of written or verbal communications.
12. Information and data related to out-of-cell tracking and programming within restrictive housing units.

13. Classification manual and tools (and any documents related to the recently updated tool and work done with NIC).
14. Statutes, regulations, and policies pertaining to early release options and reentry services.

WIDOC Facility Information

1. Organizational chart and leadership information for each facility.
2. Listing and/or mapping of all WIDOC facilities.
3. Description of each facility's mission.
4. Documents describing facility layout and custody levels.
5. Programs available by facility.
6. Special population units by facility, including mission and admission criteria.
7. Orientation materials and/or handbook for incarcerated individuals.
8. Most recent two accreditation reports from the American Correctional Association, NCCHC, or any other accrediting or regulatory agencies, if applicable.
9. Most recent PREA audits.
10. Staffing metrics, including vacancy rates, for each facility.
11. Number of staff in all classes eligible for retirement within the next three years.

Healthcare (including physical health, mental health, addiction services, pharmaceutical, and ancillary healthcare services):

1. Current controlling documents pertaining to the provision of on-site healthcare services, including any and all medical, behavioral health, substance use disorder, pharmaceutical, and ancillary healthcare services delivered to incarcerated persons.
2. Organizational chart for all healthcare services.
3. Staffing matrix and job descriptions for providers of healthcare services, current staffing plan and schedule, and vacancy rates, system-wide and by facility.
4. Formulary for pharmacy services.
5. All health services delivery and outcome data by month, quarter, or year, as currently collected and reported.
6. Quality improvement manual, guidelines, calendars, or any other documents and forms that guide the implementation and monitoring of a CQI program.

7. Data tracking and outcomes related to quality improvement initiatives, studies, and corrective action plans at the facility level.
8. Requirements for peer review and reports by discipline, as available.
9. Patient demographics and statistics (i.e., gender, race, age, custody level, sentence, etc.).
10. Current demographics and statistics specific to the juvenile/youthful offenders.
11. Current demographics and statistics specific to the geriatric population.
12. Health services reports over the last two years, including current caseload data for those diagnosed with chronic medical conditions.
13. Health services reports over the last two years, including current mental health caseload data such as all individuals on the mental health caseload (including MH classification level), individuals prescribed psychotropic medication, individuals with an SMI, and individuals receiving MAT.
14. Utilization statistics related to inpatient hospitalization by facility.
15. Documentation directing the grievance process and related grievance data and reports by facility and system-wide, as available.
16. Incident data pertaining to self-harm and suicide.
17. Incident data pertaining to staff assaults and inmate-on-inmate assaults.
18. Data for last six years concerning in-custody deaths.
19. Facility-specific data related to disciplinary infractions and applied sanctions.
20. Mortality review reports for all deaths since 2018.
21. Psychological autopsies for all deaths by suicide since 2018.
22. Relevant clinical forms:
    a. Intake screening
    b. Suicide risk assessment
    c. Referral for assessment
    d. Mental health evaluation
    e. Initial psychiatric evaluation
    f. Treatment plan
    g. Restrictive housing placement and review

h. Individual and group therapy documentation
i. Triage and referral forms
j. Other forms as applicable

The Falcon Team reviewed these materials in weekly internal meetings, engaging WIDOC administration for clarification, and ensuring a thorough understanding of WIDOC's operational processes.