

**FOLLOW-UP REPORT ON SUICIDE PREVENTION PRACTICES
WITHIN THE MASSACHUSETTS DEPARTMENT OF
CORRECTION**

by

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A. INTRODUCTION

The following is a summary of the observations, findings, and recommendations of Lindsay M. Hayes, Project Director of the National Center on Institutions and Alternatives, following the provision of short-term technical assistance to the Massachusetts Department of Correction (DOC). This writer previously consulted with the DOC in 2006-2007 following a rash of eight (8) inmate suicides during 2006, resulting in the report entitled *Technical Assistance Report on Suicide Prevention Practices Within the Massachusetts Department of Correction* in January 2007

As shown in Table 1 on page 3, although the suicide rate in the DOC declined in both 2007 and 2008, the agency again experienced a higher number of inmate suicides in 2009 and 2010 (the last suicide occurring in July 2010). Similar to its response in 2006, the DOC quickly began to examine the deaths through a previously established mortality review process, as well as review of various policy and procedural directives relating to suicide prevention that were previously revised pursuant to this writer's 2007 report. In order to more independently assess current practices, to include implementation of this writer's previous recommendations, as well as offer any appropriate additional recommendations for improving DOC suicide prevention policies and practices, then Commissioner Harold Clarke decided to again seek this writer's assistance.¹

¹Commissioner Clarke left his position in October 2010 and was replaced by Acting Commissioner Ronald T. Duval, and then most recently Acting Commissioner Luis S. Spencer.

In conducting the assessment, this writer toured various DOC facilities; met with and/or interviewed several correctional, medical, and mental health officials and staff from both DOC headquarters and individual prison facilities; interviewed numerous inmates; reviewed numerous documents [including all DOC and MHM, Inc.² (the mental health services provider) policies and procedures related to suicide prevention, screening/assessment protocols, and suicide prevention lesson plans/training curricula]; observed workshops for both the 8-hour pre-service and 2-hour annual suicide prevention training programs; and reviewed mortality review reports of 13 inmate suicides during 2009-2010. The toured facilities and tour dates are listed as follows:

- 1) Souza-Baranowski Correctional Center – Shirley (September 28, 2010)
- 2) Massachusetts Correctional Institution – Cedar Junction (September 29, 2010)
- 3) Old Colony Correctional Center – Bridgewater (November 9, 2010)
- 4) Massachusetts Correctional Institution – Framingham (November 11, 2010)
- 5) Massachusetts Correctional Institution – Concord (December 28, 2010)

As of February 7, 2011 the Massachusetts Department of Correction held approximately 11,222 inmates in 18 correctional facilities and other programs. Since 2007, the DOC has experienced 18 inmate suicides in its facilities, with more than 72 percent occurred during 2009-2010. As shown by Table 1, the suicide rate within the Massachusetts Department of Correction during the past 4 years was 39.8 deaths per 100,000 inmates. According to the most recent national data, the suicide rate in federal, state, and private prisons throughout the country during 2007 was 16 deaths per 100,000 prison inmates.³ As such, the suicide rate within the DOC was more than double the national average during this 4-year period.

²MHM, Inc. replaced UMASS Correctional Health (UMCH) as the mental health services provider in July 2007. UMCH still provides medical care for DOC inmates.

³Noonan, Margaret, E. (2010), *Deaths in Custody: State Prison Deaths, 2001-2007 - Statistical Tables*, Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

TABLE 1
INMATE SUICIDES AND AVERAGE DAILY POPULATION WITHIN THE
MASSACHUSETTS DEPARTMENT OF CORRECTION⁴
(2007 thru 2010)

<u>Year</u>	<u>Suicides</u>	<u>Average Daily Population</u>	<u>Rate</u>
2007	4	11,132	35.9
2008	1	11,723	8.5
2009	5	11,225	44.5
2010	8	11,135	71.8
2007-2010	18	45,215⁵	39.8

In addition, this writer reviewed mortality review reports of the 13 inmate suicides during 2009-2010. The following findings were noted in the reviewed cases:

- The inmate suicides were distributed amongst several medium and maximum security facilities: MCI - Norfolk (3); Souza-Baranowski Correctional Center (3), MCI - Framingham (2), Old Colony Correctional Center - (2), MCI - Concord (1), MCI - Shirley (1); and North Central Correctional Institution - Gardner (1).
- All of the suicides were by hanging and/or asphyxiation (one utilized a plastic bag) -- with anchoring devices including bunks, bars, shelf, sprinkler head, and ventilation grates;
- Most (9 of 13) of the suicides occurred in general population, with 2 in segregation and 2 in residential treatment units. [*Of note, this writer's previous review of 2006-2007 suicides found that most (5 of 10) occurred in segregation, with only one in general population*];
- Most of the victims had documented mental health histories, and 8 of 13 were currently on the mental health caseload; and
- The majority (11 of 13) of victims had documented histories of suicidal behavior, and 3 had been released from suicide

⁴Data provided by the Massachusetts Department of Correction.

⁵Population includes sentenced, pre-trial, and civilly-committed inmates, as well as Bridgewater State Hospital patients.

precautions (i.e., mental health watch) within 5, 7, and 19 days of their deaths.

It is important to note that while suicide rates in correctional facilities may appear interesting, they are not a primary measurement of the adequacy of a correctional system's suicide prevention program. As detailed in the following pages, the adequacy of a suicide prevention program can only be measured by a thorough review of suicide prevention practices (principally in the areas of training, identification/assessment, management, and emergency response), as well as review of any inmate suicides on a case-by-case basis.

Finally, it is noteworthy that several changes have occurred within the Massachusetts Department of Correction since release of the writer's report in 2007 that either directly or indirectly impact the provision of adequate suicide prevention practices. For example:

- In July 2007, MHM, Inc. replaced UMASS Correctional Health (UMCH) as the mental health services provider. UMCH continues to provide medical care for DOC inmates.
- Several treatment programs have been established to manage the needs of inmates with serious mental illness: a 15-bed Secure Treatment Program at Souza-Baranowski Correctional Center (opened in February 2008), a 32-bed Residential Treatment Unit was initially opened at Souza-Baranowski (in May 2008) then moved and expanded to 45 beds at Old Colony Correctional Center (in January 2010),⁶ a 10-bed Behavior Management Unit at MCI-Cedar Junction (opened in July 2010), a day treatment program at MCI-Framingham (opened in February 2008), and a 33-bed Intensive Treatment Unit (or crisis stabilization unit) at MCI-Framingham (not yet opened due to lack of funding for staff).
- MCI-Cedar Junction became the agency's reception and diagnostic center for male inmates in June 2009, with MCI-Concord converted from the reception center to strictly a medium security institution in June 2009, although it continues to house inmates

⁶Three other residential treatment units were in operation prior to 2007: a 60-bed unit at Old Colony Correctional Center, a 39-bed unit at North Central Correctional Center, and a 40-bed unit at MCI-Framingham. The OCCC program was expanded to 86 beds in January 2010.

under Massachusetts General Laws, Part IV, Title II, Chapter 276, Section 52a.

- Beginning in March 2010, Old Colony Correctional Center began to be converted into a facility almost exclusively housing male inmates with mental illness.
- Beginning in 2009, the state's declining economy resulted in budget cuts within the Department of Correction, including reductions in the contracts for medical services (with UMCH) and mental health services (with MHM), suspension of the DOC's annual in-service training academy from May 2009 to September 2010 (resulting in no annual suicide prevention and AED/CPR training for current employees during this 16-month period), and elimination of roll-call briefings at each facility.⁷

⁷Although routine roll-call briefings have been eliminated, a superintendent may still order a roll call briefing when necessary.

B. FINDINGS AND RECOMMENDATIONS

Detailed below is this writer's assessment of suicide prevention practices within the Massachusetts Department of Correction. It is formatted consistent with this writer's previous *Technical Assistance Report on Suicide Prevention Practices Within the Massachusetts Department of Correction* (2007) and according to eight (8) critical components of a suicide prevention policy: staff training, identification/screening, communication, housing, levels of supervision/management, intervention, reporting, and follow-up/morbidity-mortality review. This protocol was developed in accordance with both Standard 4-4373 of the American Correctional Association's *Standards for Adult Correctional Institutions* (2003) and Standard P-G-05 of the National Commission on Correctional Health Care's *Standards for Health Services in Prisons* (2008).⁸ Each section lists the status of recommendations from the 2007 report, summarizes current findings, and offers additional recommendations (if appropriate).

⁸American Correctional Association (2003), *Standards for Adult Correctional Institutions*, 4th Edition, Lanham, MD: Author; National Commission on Correctional Health Care (2008), *Standards for Health Services in Prisons*, Chicago, IL: Author.

1) **Staff Training**

All correctional, medical, and mental health staff should receive eight (8) hours of initial suicide prevention training, followed by two (2) hours of annual training. At a minimum, training should include avoiding negative attitudes to suicide prevention, prison suicide research, why correctional environments are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, components of the agency's suicide prevention policy, and liability issues associated with inmate suicide.

The key to any suicide prevention program is properly trained correctional staff, who form the backbone of any correctional system. Very few suicides are actually prevented by mental health, medical or other professional staff. Because suicides usually are attempted in inmate housing units, often during late evening hours and on weekends, they are generally outside the purview of program staff. Therefore, these incidents must be thwarted by correctional staff who have been trained in suicide prevention and are able to demonstrate an intuitive sense regarding the inmates under their care. Simply stated, correctional officers are often the only staff available 24 hours a day; thus they form the front line of defense in suicide prevention.

Both the American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC) standards stress the importance of training as a critical component to any suicide prevention program. ACA Standard 4-4084 requires that all correctional staff receive both initial and annual training in the "signs of suicide risk" and "suicide precautions;" while Standard 4-4373 requires that staff be trained in the implementation of the suicide prevention program. As stressed in NCCHC Standard P-G-05 -- "All staff

members who work with inmates are trained to recognize verbal and behavioral cues that indicate potential suicide, and how to respond appropriately. Initial and at least biennial training are provided, although annual training is highly recommended.”

2007 RECOMMENDATIONS: Several recommendations were previously offered to strengthen both the content and consistency of suicide prevention training within the Massachusetts Department of Correction.

- 1) It is strongly recommended that the DOC increase the **pre-service** suicide prevention training from 2 to 8 hours. At a minimum, the revised training program should include much of information currently offered in the *Suicide Prevention: Risks, Roles and Responses for Massachusetts Correctional Staff* training curriculum, with additional emphasis placed on avoiding negative attitudes to suicide prevention, updated statistics and case studies on inmate suicides within the Massachusetts DOC, identifying suicidal inmates despite the denial of risk, dealing with manipulative inmates, components of the DOC/UMCH suicide prevention policies, and liability issues associated with inmate suicide.
- 2) It is strongly recommended that *all* correctional, medical, and mental health staff complete the 8-hour pre-service suicide prevention training program, either at the Correction Training Academy or respective agency.
- 3) It is strongly recommended that DOC and UMCH officials ensure that all personnel (i.e., correctional, medical, and mental health) receive a consistent and uniform 2-hour block of suicide prevention training on a yearly basis. At a minimum, the annual 2-hour training program should include a review of predisposing factors to suicide, warning signs and symptoms, negative attitudes to suicide prevention, identifying suicidal inmates despite the denial of risk, and review of changes in the DOC/UMCH’s suicide prevention policies. It is also recommended that the training program include general discussion on any inmate suicides and/or serious attempts occurring within the previous year. Material from 1) the current *Suicide Prevention: Risks, Roles and Responses for Massachusetts Correctional Staff* from 1999, 2) 36-PowerPoint slide presentation entitled “In-Service Training Program – Suicide

Prevention Review,” and 3) computer lab-based program entitled “In-Service 2005 – Suicide Prevention for Massachusetts Correctional Staff” could be utilized in developing this revised in-service program. Finally, it is strongly recommended that the in-service suicide prevention training program for correctional, medical and mental health staff be integrated, not separate and overlapping, as currently administered. Interdisciplinary training would prove to be more efficient and insightful.

- 4) It is strongly recommended that both DOC and UMCH suicide prevention policies be revised to include a richer description of the requirements for both pre-service and annual in-service suicide prevention. Much of the inconsistency found in both the length and content of in-service training at the toured facilities could be corrected with policy revisions that specified the required length and description of the training programs.

CURRENT FINDINGS: All correctional, medical, and mental health personal working within the Massachusetts Department of Correction continue to be required to complete both pre-service and annual in-service training in suicide prevention. Pursuant to the above recommendations, the DOC agreed to expand its pre-service training program from 2 to 8 hours in length. The issue of suicide prevention training is currently addressed in both DOC and MHM policies. For example, DOC Policy 216.25 (Suicide Prevention and Intervention) requires that:

“All correctional, medical, and mental health staff who work directly with inmates shall receive a minimum of eight (8) hours of Pre-Service Suicide Prevention Training, followed by a minimum of two (2) hours of annual In-Service Training to include “Mock Drill - Responding to a Suicide Attempt” training at each institution.

At a minimum, the eight hour (8) Pre-service Training shall include, prison suicide research, why correctional environments are conducive to suicidal behavior, recognition of signs and symptoms and risk factors of suicide, mental health disorders, high risk behaviors of incarceration, avoiding negative attitudes in suicide prevention, communication and referral protocols, suicide precautions/mental health watches, intervention techniques, emergency response to a suicide attempt, liability issues associated

with suicide prevention, and components of the medical/mental health service provider policies.

At a minimum, the two-hour (2) In-Service Training shall include a review of pre-service content standards, changes in the medical/mental health service provider suicide prevention policies, and include general discussion on any recent suicides and/or attempts occurring within the previous year.

MHM has a similar description of the training requirements in its suicide prevention policy (No. 53.00).

Pre-Service Training

The DOC's Division of Staff Development originally revised the pre-service training curricula in March 2007, and it continues to be updated on a regular basis. Review of the current pre-service curriculum, entitled "Suicide Prevention, Intervention, and Response," found that it contained recent statistics on DOC inmate suicides; signs, symptoms, and risk factors for mental illness and suicidal behavior; communication between correctional, medical, mental health staff; active listening between staff and inmate; role-playing; and emergency response. The curriculum contains most, but not all, of this writer's 2007 recommendations. For example, the topics of "avoiding negative attitudes in suicide prevention," "identifying suicidal inmates despite the denial of risk," "dealing with manipulative inmates," and "liability issues associated with suicide prevention" are not in the current pre-service curriculum. This information is also not contained within the 43-slide PowerPoint presentation for the pre-service program.

This writer attended an 8-hour pre-service suicide prevention workshop on February 17, 2011. The workshop, attended by approximately 15 new employees, was co-facilitated by both a

training academy and MHM staff member. Most of the above lesson plan was presented during the session. Recent statistics on DOC inmate suicides was presented first, followed by a lecture of the common warning signs and symptoms, possible precipitating factors in suicide, and several role-playing skits regarding interacting with problematic and/or potentially suicidal inmates were presented. Participants also broke out into five small groups and each group discussed a case study of an inmate suicide. Each group would then report back to the larger group with its findings. The role playing and case study formats allowed participants to recognize and review common signs, symptoms, and risk factors for mental illness and suicidal behavior, as well as appropriate communication techniques. This format also allowed for greater audience participation. Some time was also spent on the proper emergency response to a suicide attempt by hanging. Overall, the workshop was very good and the trainers did an excellent job in facilitating the session.

In-Service Training

The DOC's Division of Staff Development originally revised its in-service training curricula in March 2007, and it continues to be updated on a regular basis. Review of the current in-service curriculum ("Recognizing Mental Illnesses and Suicide Prevention and Intervention") found that it was a condensed version of the pre-service curriculum and contained recent statistics on DOC inmate suicides; signs, symptoms, and risk factors for mental illness and suicidal behavior; communication between correctional, medical, mental health staff and the inmate; emergency response; and liability. The curriculum is quite thorough.

Although all new employees have completed the 8-hour suicide prevention training program since March 2007, *the annual in-service program was suspended for 16 months from May 2009 thru September 2010 due to budget cuts within the agency.*

Since the in-service program was reinstated, suicide prevention workshops have occurred on a regular basis. This writer attended a 2-hour in-service suicide prevention workshop on January 14, 2011. The workshop, attended by approximately 30 correctional officers, was co-facilitated by both a training academy and MHM staff member.⁹ Most, but not all, of the lesson plan was presented during the session. Recent statistics on DOC inmate suicides was presented first, followed by participants breaking out into four groups and each group discussed a case study of a recent inmate suicide. Similar to the pre-service workshop, each group would then report back to the larger group with its findings. This case study format allowed participants to recognize and review common signs, symptoms, and risk factors for mental illness and suicidal behavior, as well as appropriate communication techniques. This format also allowed for greater audience participation. Time did not allow for adequate discussion of both emergency responses and liability issues. Overall, the workshop was very good and the trainers did an excellent job in facilitating the session.

It should also be noted that MHM has provided additional suicide prevention training to its mental health staff. In September 2009, MHM sponsored a full-day workshop on suicide prevention at Bridgewater State College that was attended by approximately 70 percent of its employees. The training included instruction for conducting suicide risk assessments, treatment

⁹Medical staff from UMCH and other employees are also required to complete the in-service training program and normally attend the workshop on another day.

intervention with suicidal inmates, review of policies, morbidity and mortality reviews, debriefing inmates following a sentinel event, and use of therapeutic restraints. In addition, MHM has provided targeted training to individual facility staff as a result of mortality review recommendations. This writer reviewed MHM's "Assessment of Suicide Risk in Corrections" lesson plan and found it to be excellent.

In conclusion, all correctional, medical, and mental health personnel working within the Massachusetts Department of Corrections have received suicide prevention training during the course of their careers. Although the annual in-service program was suspended for 16 months from May 2009 thru September 2010 during a time that saw a surge of inmate suicides within the agency, the DOC and MHM have worked hard to implement this writer's previous recommendations and maintain a viable suicide prevention training program.

NEW RECOMMENDATIONS: A few recommendations are offered to strengthen both the content and consistency of suicide prevention training within the Massachusetts Department of Correction. *First*, it is strongly recommended that the section on "Emergency Response" be removed from both the pre-service and in-service lesson plans. Although included in this writer's 2007 recommendations, the topic is already adequately discussed in other training programs (professional rescuer and first aid, mock drill training, etc.). In addition, the pre-service curriculum should include the following topics from this writer's previous recommendations: "avoiding negative attitudes in suicide prevention," "identifying suicidal inmates despite the denial of risk," "dealing with manipulative inmates," and "liability issues associated with suicide prevention." (The topic of liability could perhaps best be included in the

discussion of case study reviews during both the pre-service and in-service training workshops.) Finally, the PowerPoint slides should more closely resemble the revised lesson plans.

Second, it is strongly recommended that MHM repeat its full-day workshop (previously conducted in September 2009) for all clinical staff on an annual basis, with special emphasis on suicide risk assessments and treatment planning.

2) Identification/Screening

Intake screening for suicide risk must take place immediately upon confinement and prior to housing assignment. This process may be contained within the medical screening form or as a separate form, and must include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; transporting officer(s) believes inmate is currently at risk. The intake screening process should include procedures for referral to mental health and/or medical personnel. Any inmate assigned to a special housing unit should receive a written assessment for suicide risk by mental health staff upon admission.

Identification/screening is also critical to a correctional system's suicide prevention efforts. An inmate can attempt suicide at any point during incarceration -- beginning immediately following reception and continuing through a stressful aspect of confinement. Although there is disagreement within the psychiatric and medical communities as to which factors are most predictive of suicide in general, research in the area of jail and prison suicides has identified a number of characteristics that are strongly related to suicide, including: intoxication, emotional state, family history of suicide, recent significant loss, limited prior incarceration, lack of social support system, psychiatric history, and various "stressors of confinement."¹⁰ Most importantly, prior research has consistently reported that at least two thirds of all suicide victims communicate their intent some time prior to death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than

¹⁰Bonner, R. (1992), "Isolation, Seclusion, and Psychological Vulnerability as Risk Factors for Suicide Behind Bars," in R. Maris et. al. (Editors) *Assessment and Prediction of Suicide*, New York, NY: Guilford Press, 398-419.

those who have never made an attempt.¹¹ The key to identifying potentially suicidal behavior in inmates is through inquiry during both the intake screening/assessment phase, as well as other high-risk periods of incarceration. Finally, given the strong association between inmate suicide and special management (i.e., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit should receive a written assessment for suicide risk by mental health staff upon admission.

Both the ACA and NCCHC standards address the issue of assessing inmates assigned to segregation. According to ACA Standard 4-4400: "When an offender is transferred to segregation, health care personnel will be informed immediately and will provide assessment and review as indicated by the protocol as established by the health authority." NCCHC Standard P-E-09 states that "Upon notification that an inmate is placed in segregation, a qualified health care professional reviews the inmate's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation."

2007 RECOMMENDATIONS: A few recommendations were previously offered.

- 1) Consistent with current Old Colony Correctional Center practices, it is strongly recommended that DOC and UMCH explore the feasibility of formalizing into agency policy a requirement that medical staff briefly assess all inmates returning from court hearings.
- 2) In order to increase the availability of information regarding an inmate's suicide risk within the county correctional system, it is strongly recommended that the sending agency (e.g., county jail, etc.) and/or transporting personnel be required to complete and submit a brief discharge/transfer form to DOC booking/reception

¹¹Clark, D. and S.L. Horton-Deutsch (1992), "Assessment in Absentia: The Value of the Psychological Autopsy Method for Studying Antecedents of Suicide and Predicting Future Suicides," in R. Maris et. al. (Editors) *Assessment and Prediction of Suicide*, New York, NY: Guilford Press, 144-182.

staff documenting any immediate concerns about the newly arrived inmate. The form should be reviewed by the intake nurse and subsequently placed in the inmate's health care file. UMCH currently utilizes an "IntraSystem Transfer Form" to communicate the health care needs of inmates between DOC facilities. This is an excellent form and could be adapted for use by county jail personnel as a discharge and transfer form.

- 3) It is strongly recommended that the Q5 Inquiry section of CJIS be updated each time an inmate is placed on mental health watch for suicide risk (regardless of whether or not actual injury occurs), and that booking/admission staff and medical personnel access both the "Medical/Mental Health Section" and "Mental Health Watch" screen of IMS to determine if the newly arrived inmate was on a mental health watch during a previous DOC confinement.
- 4) Consistent with previous mortality review recommendations, it is strongly recommended that the DOC, in conjunction with UMCH, develop effective alternative placement options for those inmates suffering from severe and persistent mental illness, but whose behavioral difficulties and security needs require more strict containment than can be afforded in general population. (In beginning to address this problem, mental health personnel must be regularly invited participants in the institution's segregation review meetings.) *This issue should be among the highest priorities facing the DOC in its efforts to improve suicide prevention practices within the agency.*¹²

CURRENT FINDINGS: The DOC, UMCH, and MHM continue to have very good intake screening and assessment procedures to identify potentially suicidal inmates, but these procedures are still in need of slight revision. Upon admission, booking/admissions staff access the statewide Criminal Justice Information System (CJIS) to perform a "Q-5 Inquiry" on each inmate admitted into the DOC. Positive results of inmates who have a history of suicide "attempts or threatens"¹³ in a correctional facility, county jail, or police lockup within the Commonwealth of Massachusetts are recorded in the DOC's computerized Inmate Management

¹²As previously noted on page 4 of this report, the DOC has established and/or expanded several residential treatment programs for inmates with serious mental illness since 2007.

¹³See *Massachusetts General Laws*, Chapter 40, Section 36A.

System (IMS) and referred to medical staff for further assessment. In addition, all inmates receive basic intake screening (via the "Medical History and Screening" form) by medical staff upon admission into one of the DOC's reception centers (MCI-Cedar Junction or MCI-Framingham). The form contains pertinent questions regarding mental health and potential suicide risk. Within 14 days of admission, all inmates are subsequently administered a "Mental Health Initial Appraisal" by mental health staff. The evaluation contains inquiry regarding suicide risk.

Further, all inmates placed in segregation are given an "Initial Segregation Assessment" by medical staff to determine whether existing medical and/or mental health problems contraindicate the housing placement. This form contains the same lines of inquiry regarding suicide risk that is found on the "Medical History and Screening" form. Inmates with a history of mental illness and/or are considered "open" mental health cases are assessed by mental health staff within 24 hours or the next business day. Inmates remaining in segregation beyond 30 days are assessed by mental health staff via the "Mental Health Status Update" form which is completed during the initial 30 days and then every 90 days.

Finally, however, this writer continued to find a few areas of concern regarding the screening and assessment process. *First*, the DOC has continued to struggle (as most state correctional agencies do throughout the country) with realistically being able to re-screen all inmates following their return from a court proceeding. The agency has convened a Suicide Prevention Committee to explore the feasibility of designing a system that can identify inmates at high risk for an adverse reaction to a legal proceeding. *Second*, the DOC reception centers

(MCI-Cedar Junction or MCI-Framingham), as well as MCI-Concord [the recipient of 52(a) pre-trial inmates] continue to receive few, if any, medical and mental health records from county jurisdictions regarding the inmate's adjustment and possible suicide risk within the county jail, nor even a simple transfer summary sheet.

The problem is particularly acute at MCI-Concord which houses approximately 300 pre-trial male inmates (held under Massachusetts General Laws, Part IV, Title II, Chapter 276, Section 52a). Most of these inmates come from the counties of Middlesex, Suffolk, and Worcester. The DOC knows very little about them when they arrive. Tragically, MCI-Concord experienced a recent pre-trial inmate suicide in which the facility did not receive any information from the sending jurisdiction.¹⁴ This has been a persistent problem for many years and DOC officials have previously met with the Massachusetts Sheriffs Association in an attempt to improve communication between the agency and county jurisdictions. As a result, a transfer summary form was introduced to the counties by the DOC. Few counties, however, have chosen to utilize the form. It is simply inexcusable for any county jurisdiction to not utilize professional courtesy in providing basic security, medical, and mental health information regarding an inmate they are transferring to state custody.

Third, as cited in the 2007 report, although a "Q5 Inquiry" is performed upon admission, neither booking/admission staff or medical personnel access the IMS to determine if the inmate was at risk for suicide and on suicide precautions (mental health watch) during a prior DOC confinement. This information is available in both the "Medical/Mental Health Section" and "Mental Health Watch" screen of IMS but, according to both correctional and medical personnel

¹⁴It remains unknown as to whether any received information would have changed the outcome in the case.

who were interviewed, is not accessed on a routine basis. In addition, when an inmate is placed on a mental health watch for suicidal behavior, that information is not routinely entered into the Q5 Inquiry section of CJIS unless a suicide attempt has occurred. Therefore, upon intake into the DOC, neither booking/admission staff or medical personnel assessing the inmate are always aware as to whether the inmate has a prior history of being on mental health watch within the DOC. It should be noted that, in response to this writer's 2007 recommendations, DOC officials previously met with the executive director of the Criminal History Systems Board (that administers the Q5 database) in an attempt to revise the criteria. As a result, inmates on mental health watch were then required to be entered into the database. However, the system is imperfect and this writer found that inmates placed on mental health watch are not always entered into the database. As recommended in 2007, a simple solution to this problem would be for booking/admission staff or medical personnel to access the "Medical/Mental Health Section" and "Mental Health Watch" screens of IMS during the intake process to verify the inmate's prior mental health watch status.

Fourth, this writer noted that, with one exception, neither DOC or MHM has guidelines related to mental health referrals (e.g., responses based upon emergent, urgent or routine issues). At MCI-Concord, mental health staff have devised an un-written four-level staging system: 1) immediate (requiring an immediate response), 2) new lockup (for inmates referred to segregation and requiring a brief assessment within 30 minutes to 24 hours), 3) more urgent (requiring a response within 24 to 36 hours), and 4) routine (requiring a response within two weeks). This writer would argue that a two-week response to a routine mental health request appears insufficient and outside the standard of care in prison systems throughout the country. This

writer was also informed that, throughout the system, each facility has a mental health triage clinician who reviews each sick call request and brings the requests to a daily treatment team meeting for disposition. How soon the request will be responded is then decided on a case-by-case basis.

NEW RECOMMENDATIONS: A few recommendations are offered. *First*, the Massachusetts Sheriffs Association is an independent state agency within the Commonwealth of Massachusetts. One of its responsibilities is to foster better communication among other like state agencies, e.g., the Department of Correction. The Massachusetts Sheriffs Association's budget is controlled by the Governor's office. The DOC has attempted, without success, to gain the cooperation of the Massachusetts Sheriffs Association and its member counties to fully cooperate in completing transfer summary forms on inmates transferred to the DOC. Because many of these counties have not taken this issue seriously and hundreds of inmates enter the DOC annually without sufficient transfer information from county jurisdictions, it is strongly recommended that the Governor's Office now require that the Massachusetts Sheriffs Association require its member counties to fully cooperate with the DOC's request to forward pertinent transfer summary information whenever an inmate is transferred from county to state custody.

Second, it is strongly recommended that, in addition to initiating a Q5 inquiry of the CJIS, the booking/admission staff and medical personnel access both the "Medical/Mental Health Section" and "Mental Health Watch" screen of the IMS to determine if the newly arrived

inmate was on a mental health watch during a previous DOC confinement. DOC and UMCH policies should be revised accordingly.

Third, it is strongly recommended that MHM develop a standardized protocol for responding to mental health referrals throughout the DOC. Generally accepted definitions and time frames are: Emergency (requiring an immediate response), Urgent (requiring non-immediate response within the same day), and Routine (requiring a response within five business days).

3) Communication

Procedures that enhance communication at three levels: 1) between the sending institution/transporting officer(s) and correctional staff; 2) between and among staff (including medical and mental health personnel); and 3) between staff and the suicidal inmate.

Certain signs exhibited by the inmate can often foretell a possible suicide and, if detected and communicated to others, can prevent such an incident. There are essentially three levels of communication in preventing inmate suicides: 1) between the sending institution/transporting officer and correctional staff; 2) between and among staff (including mental health and medical personnel); and 3) between staff and the suicidal inmate. Further, because inmates can become suicidal at any point in their incarceration, correctional staff must maintain awareness, share information and make appropriate referrals to mental health and medical staff.

2007 RECOMMENDATIONS: A few recommendations were previously offered.

- 1) It is strongly recommended that DOC and UMCH embark upon a quality assurance process to audit selective security files and health care charts on a regular basis and take corrective action when appropriate. Initially, it is suggested that the files of inmates on the Mental Health Risk List be selected for audit.
- 2) It is strongly recommended that the process for developing and maintaining inmates on the Mental Health Risk List be revised collaboratively by DOC and UMCH. In order for the List to be effective, selected inmates must receive increased attention from both mental health and correctional personnel. If the sole criteria remains that inmates are maintained on the list when they are determined to be "at risk to themselves or others because of mental illness," then those inmates should be observed more frequently by correctional staff (e.g., at documented 30-minute intervals) and assessed more frequently by mental health staff (e.g., at least three times per week). In addition, inmates on the List should be stronger candidates to be excluded from designation to segregation. Simply stated, if there is increased concern regarding

an inmate, then DOC and UMCH must demonstrate increased attention to that inmate.

CURRENT FINDINGS: As stated in the 2007 report, effective communication between correctional, medical, and mental health staff is not an issue that can be easily written as a policy directive, and is often dealt with more effectively through recurring training sessions and shift briefings. Although shift briefings (roll call) have been eliminated due to budget cuts within the agency, each superintendent continues to meet with the mental health director of the facility on a daily basis. These meetings typically occur during the superintendent's daily meetings with other management staff and inmates of mutual concern are discussed. A superintendent may still order a roll call briefing whenever necessary and an inmate's placement on a mental health watch is discussed during the superintendent's daily meetings. The DOC's previous practice of maintaining a "Mental Health Risk List" at each facility has been discarded because it was not being utilized very effectively.

Further, correctional and medical/mental health personnel continue to communicate through various established forms, including, but not limited to, the "Intrasystem Transfer Form," "Referral to Mental Health," and the Health Status Report." As previously stated, mental health staff meets together during daily treatment team meetings to discuss inmates currently on mental health watches, as well as to triage mental health referrals.

Finally, although inadequate communication was not the proximate cause of any of the recent 2009-2010 inmate suicides, there were lapses in communication found in several cases. For example, In the suicide of Case No. 1, the inmate had been a patient at Bridgewater State

Hospital (BSH) for several years prior to his transfer back to the DOC prison. A subsequent mortality review found there was a lack of communication to assist in the transition process and the review panel recommended that the DOC and MHM collaborate in developing a policy regarding the appropriateness of case conferences between BSH and the designated facility for returning patients/inmates. In the suicide of Case No. 2, the inmate was on the mental health caseload and when he was temporarily housed in segregation to serve a disciplinary sanction, the mental health clinician assigned there was not familiar with the case. A subsequent mortality review panel recommended that the primary care clinician be notified during the daily treatment team meeting when their client is assigned to segregation and provide an assessment when appropriate. In the suicide of Case No. 3, the inmate had written a letter to his mother approximately three months prior to his death allegedly threatening suicide. The mother then called the prison expressing concern for her son. Although various prison staff conversed with the inmate regarding the letter, mental health staff were never notified. A mental health clinician only found out about the telephone call (and subsequently assessed the inmate) after they reviewed an incident report generated about the incident. In the suicide of Case No. 4, the inmate was recently returned to the prison from the BSH without a copy of the 18(a) evaluation or other pertinent outside medical records. A subsequent mortality review panel recommended that the BSH medical director and MHM director of clinical programs revise existing policy to specify the records required to be forwarded with the patient upon BSH transfer.

In conclusion, because it contains many moving parts, effective communication is the most challenging component of suicide prevention. For the most part, the DOC, UMCH, and MHM have effective policies, but policies alone do not guarantee effective communication. As

previously stated in the 2007 report, the most effective way to correct deficiencies in the area of communication is to regularly audit security files and health care charts before a sentinel event occurs. As noted above, this writer previously recommended that the DOC and mental health provider embark upon a quality assurance process to audit selective security files and health care charts on a regular basis and take corrective action when appropriate. As will be discussed in more detail on pages 56-58 of this report, neither the DOC or MHM currently have the sufficient staffing necessary to maintain a quality assurance program that regularly audits security files and health care charts.

NEW RECOMMENDATIONS: None

4) **Housing**

Isolation should be avoided. Whenever possible, house in general population, mental health unit, or medical infirmary, located in close proximity to staff. Inmates should be housed in suicide-resistant, protrusion-free cells. Removal of an inmate's clothing (excluding belts and shoelaces), as well as use of physical restraints (e.g. restraint chairs/boards, straitjackets, leather straps, etc.) and cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is physically engaging in self-destructive behavior.

In determining the most appropriate location to house a suicidal inmate, there is often the tendency for correctional officials in general to physically isolate and restrain the individual. These responses may be more convenient for staff, but they are detrimental to the inmate. The use of isolation not only escalates the inmate's sense of alienation, but also further serves to remove the individual from proper staff supervision. National correctional standards stress that, to every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located in close proximity to staff.

Of course, housing a suicidal inmate in a general population unit when their security level prohibits such assignment raises a difficult issue. The result, of course, will be the assignment of the suicidal inmate to a housing unit commensurate with their security level. Within a correctional system, this assignment might be a "special housing" unit, e.g., restrictive housing, disciplinary confinement, administrative segregation, etc., However, to every extent possible, such inmates should be housed in suicide-resistant, protrusion-free cells. Further, cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), removal of clothing

(excluding belts and shoelaces), as well as the use of physical restraints (e.g., restraint chairs/boards, straitjackets, leather straps, etc.) should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is physically engaging in self-destructive behavior. Housing assignments should not be based on decisions that heighten depersonalizing aspects of incarceration, but on the ability to maximize staff interaction with inmates.

2007 RECOMMENDATIONS: Several recommendations were previously offered.

- 1) It is strongly recommended that the DOC ensure that all cells designated to house suicidal inmates are as reasonably "suicide-resistant" as possible. For example, wall and ceiling ventilation grates should contain holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch; clothing hooks should be removed; gaps between window bars and glass should be closed; and bed rails and bunk holes should be removed. This writer's complete recommended guidelines for removing obvious cell protrusions can be found in Appendix A.
- 2) It is strongly recommended that the DOC work collaboratively with UMCH to completely revamp the use of the Health Services Unit for suicide precautions. The revised policy should include, but not be limited to, the following procedures:
 - The removal of an inmate's clothing and issuance of safety garment shall be commensurate with the level of suicide risk as determined by mental health staff;
 - All inmates on suicide precautions shall be allowed all routine privileges (e.g., family visits, telephone calls, recreation, etc.) unless the inmate has lost those privileges as a result of a disciplinary sanction;
 - All inmates on suicide precautions shall have unimpeded access to their attorneys at any time;
 - All inmates on suicide precautions shall have shower access commensurate with their security level; and
 - To every extent possible, mental health staff should avoid conducting daily assessments through the food slot of the inmate's cell door. In addition, prior to

discharging an inmate from suicide precautions, the inmate must be provided with an out-of-cell mental health assessment.

- 3) It is strongly recommended that the clinical decision regarding placement of an inmate on any level of suicide precautions should not be dictated by the availability of bed space and staff; rather it should be based upon the specific needs of the identified suicidal inmate. As such, the DOC should ensure that it provides sufficient staff to the HSU and any other unit housing suicidal inmates to ensure proper observation at constant or 15-minute intervals, as well as to allow adequate out-of-cell time for the inmate. In addition, placement and length of stay on suicide precautions should be based solely upon the clinical judgment of mental health staff, and DOC officials and staff should refrain from interfering with, and/or unduly influencing, that judgment.
- 4) Given the increase in suicides in the HSUs, it is strongly recommended that correctional staff conduct documented observation at 15-minute intervals within these units.
- 5) It is strongly recommended that no inmate (regardless of their mental status) should receive a punitive sanction (i.e., disciplinary report) based solely upon self-injurious behavior.
- 6) Given the increase in the number of "open" mental health cases within the DOC during the past several years, it is strongly recommended that additional suicide-resistant cells be identified for the housing of suicidal inmates. *These cells need not be necessarily located in the HSUs.*
- 7) It is strongly recommended that the DOC work collaboratively with UMCH to create a transitional housing unit and/or step-down process following an inmate's discharge from mental health watch in the HSU. On a trial basis, it might be beneficial to identify beds in the DOC's residential treatment units to begin this initiative.

CURRENT FINDINGS: The DOC's Division of Resource Management was responsible for implementing this writer's recommendation regarding "suicide-resistant" housing for inmates identified as suicidal and placed on mental health watch status. Significant funds were allocated to complete the project, and most of the renovation was devoted to replacing

ventilation grates with smaller holes to thwart their use as an anchoring device in a hanging attempt. To date, all inmates on mental health watch status are said to be housed in suicide-resistant housing. This writer re-toured five correctional facilities and found the following:

- At Souza-Baranowski Correctional Center, four (4) cells in the Health Services Unit (HSU) are designated for mental health watches, as well as four (4) “backside” cells. Each cell is as suicide-resistant as is reasonably possible. However, the backside cells are problematic because they do not contain any bunks. On a restricted basis, mental health watches also occur in designated cells within the Special Management Unit. These cells, however, contain numerous protrusions and, because of these hazards, suicidal inmates are supervised under constant observation by correctional staff (at considerable expense to the DOC).
- At MCI-Cedar Junction, any of the 13 HSU cells can be utilized for mental health watch, as well as four (4) cells in the Departmental Disciplinary Unit and four (4) cells in the Behavior Management Unit.¹⁵ All designated cells in these units were found to be as suicide-resistant as is reasonably possible.
- At Old Colony Correctional Center, four (4) cells in the Health Services Unit (HSU) are designated for mental health watches. Each cell is as suicide-resistant as is reasonably possible. On a restricted basis, mental health watches also occur in designated cells within the Special Management Unit (segregation). These segregation cells, however, contain numerous protrusions and, because of these hazards, suicidal inmates are supervised under constant observation by correctional staff (at considerable expense to the DOC). With its recent conversion to housing a high percentage of inmates with mental illness, OCCC officials are well aware that there are currently an inadequate number of cells designed to house suicidal inmates. Although the OCCC superintendent would like to renovate up to 15 cells on one of the RTU units to house inmates on mental health watch, the DOC currently lacks sufficient funding to renovate the cells to become suicide-resistant.
- At MCI – Framingham, several cells in the HSU and first floor cells in the Close Custody Unit (CCU) are designated for mental

¹⁵It should be noted that this writer’s 2007 tour of both MCI-Cedar Junction and MCI-Framingham found that the HSUs were loud and filthy, with a foul smell permeating the units. The atmosphere was certainly not conducive to housing and managing suicidal and other vulnerable mentally ill inmates. During a re-tour in September and November 2010, both units were very much improved.

health watches. With the exception of hazardous bunk holes found in each cell, the CCU cells are as suicide-resistant as is reasonably possible. The HSU cells, however, continue to be hazardous, containing old restraint beds with protrusions, floors with tile that can be removed and utilized for cutting oneself, and old ventilation grates. It should also be noted that a 33-bed Intensive Treatment Unit (or crisis stabilization unit) has been constructed within a previously vacated building. The housing unit was constructed to house inmates on mental health watch and contains state-of-the-art furnishings, including fiberglass double bunks, recessed sprinkler heads, and safe ventilation grates with small holes. Each cell is as suicide-resistant as is reasonably possible. Unfortunately, the unit remains closed due to lack of funding for correctional, medical, and mental health staff.

- At MCI – Concord, two (2) of the eight (8) cells in the Health Services Unit (HSU) are designated for mental health watches and are as suicide-resistant as is reasonably possible. The other six (6) HSU cells are utilized as overflow for mental health watches, but contain regular bunks with hazardous bunk holes and bracketed stools that could be utilized as an anchoring device in a hanging attempt. On a restricted basis, mental health watches also occur in designated cells within the Special Management Unit (segregation). These segregation cells, however, contain numerous protrusions and, because of these hazards, suicidal inmates are supervised under constant observation by correctional staff (at considerable expense to the DOC).

In addition, pursuant to this writer's 2007 recommendations, both DOC and MHM policies have been revised to specifically require that removal of an inmate's clothing and issuance of a safety garment shall be commensurate with the level of suicide risk as determined by mental health staff; mental health watch inmates shall be allowed all routine privileges (e.g., family and attorney visits, telephone calls, showers, recreation, etc.) unless the inmate has lost those privileges as a result of a disciplinary sanction; and to every extent possible, mental health staff should avoid conducting daily assessments through the food slot of the inmate's cell door. In addition, prior to discharging an inmate from suicide precautions, the inmate must be provided with an out-of-cell mental health assessment.

These recommendations had been borne out of a concern that management of suicidal inmates on mental health watch was overly restrictive and seemingly punitive. Confining a suicidal inmate to their cell for 24 hours a day only enhanced isolation and was anti-therapeutic. Under these conditions, it was also difficult, if not impossible, to accurately gauge the source of an inmate's suicidal ideation. Take, for example, the almost daily scenario of a clinician interviewing an inmate on mental health watch in the HSU. The inmate has been in the cell for a few days, dressed in a safety garment. He has not been out of the cell, not allowed to shower, not allowed a telephone call, or visit from his family or attorney. The clinician asks "Are you suicidal?" Given the circumstances he finds himself in, the likelihood of an inmate answering affirmatively to that question, the result of which will be his continued placement under these conditions was highly questionable.

Although these directives were revised to ensure that mental health staff took a more active role and decisions were individually-based, this writer still has some concerns about the mental health watch practices in the recently toured facilities. Although a prior concern that correctional staff were primarily driving these practices has been somewhat abated, and mental health staff are now more directly involved in managing mental health watches, this writer sensed that practices have not appreciably changed. For example, although the issue of clothing removal is to be determined commensurate with the individual level of risk, almost all suicidal inmates (regardless of risk level) are still stripped of their clothing and issued safety smocks. Although mental health staff are responsible for completing Mental Health Watch Sheets that are taped to each cell door, these sheets invariably will indicate that visits, non-legal telephone calls,

and recreation are prohibited. No justification of these decisions can be found in the inmates' progress notes.

Many inmates interviewed by this writer complained about these restrictions. The level of discontent was most apparent at MCI-Framingham.¹⁶ Most women complained that the conditions of mental health watch were punitive and they were often reluctant to express their suicidal ideation to staff because it meant being locked down on the HSU in a smock. Once housed on mental health watch, they were reluctant to be escorted out of the cell for an assessment in the HSU interview room because they were cold in the smock and often were confined to the therapeutic module (or cage) in the interview room. Although both correctional and mental health personnel suggested to this writer that the therapeutic module was rarely utilized, a review of medical charts confirmed that the device was used in the majority of cases. These complaints also appeared more credible when considered in the context that all interviewed female inmates were either current or former residents of the RTU, and were extremely complimentary of that program and staff.

With regard to other 2007 recommendations, DOC policies were revised and additional correctional staff posted in the HSUs to ensure that 15-minute rounds are conducted at all times. In addition, a DOC directive was issued to prohibit any inmate (regardless of their mental status) from receiving a punitive sanction (i.e., disciplinary report) based solely upon self-injurious behavior.

¹⁶The discontent is also apparently felt by male inmates. In this writer's review of one medical file, the inmate (Case No. 5) reported to the mental health clinician "that being on mental health watch only added to stress as he was not able to deal with legal work and family issues."

NEW RECOMMENDATIONS: *First*, it is strongly recommended that the DOC's Division of Resource Management re-inspect all cells designated for mental health watch to ensure they are suicide-resistant, most notably, the HSU cells at MCI-Framingham and bunk holes and bracketed stools in HSU cells at MCI-Concord.

Second, it is strongly recommended that any inmate on mental health watch be housed in a cell that contains a safe bunk. Therefore, suicide-resistant bunks should be installed in the "backside" cells of the HSU at Souza-Baranowski Correctional Center.

Third, with Old Colony Correctional Center's recent conversion to housing a high percentage of inmates with mental illness, it is strongly recommended that the DOC seek additional funding to renovate up to 15 cells in one of the RTU units to house inmates on mental health watch. As an alternative, the DOC should seek additional funding to create an Intensive Treatment Unit for male inmates who are in need of mental health watch and/or close monitoring due to acute mental health issues and/or chronic behavior management issues.

Fourth, it is strongly recommended that the DOC seek additional funding to staff and open the Intensive Treatment Unit at MCI-Framingham.

Fifth, it is strongly recommended that the DOC determine the cost it is incurring by utilizing correctional officers to provide constant observation of inmates on mental health watch in Special Management Units not designated to be suicide-resistant. Most of these inmates are not at high risk for suicide and would not require constant observation if they were housed in

suicide-resistant cells. If the costs of providing constant observation to these lower risk inmates exceeds the cost of renovating a cell to make it suicide-resistant, the DOC should seek the necessary funding to renovate these cells.

Sixth, should the DOC decide to seek additional funding to renovate a designated number of Special Management Unit cells for mental health watches, it is strongly recommended that the DOC and MHM avoid transferring inmates with serious and/or persistent mental illness to these SMU cells.

Seventh, it is strongly recommended that, to avoid its potential for misuse, the DOC remove the therapeutic module (or cage) from the HSU interview room at MCI-Framingham.

Eighth, it is strongly recommended that the DOC and MHM conduct a quality assurance audit of mental health watch practices to determine if restrictions are individualized on a case-by-case basis and fully justified in writing within each inmate's medical chart. The audit should also determine the percentage of mental health assessments that are conducted outside the cell in a private and confidential interview room.

5) Levels of Supervision/Management

Two levels of supervision are generally recommended for suicidal inmates -- *close observation* and *constant observation*. *Close Observation* is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 15 minutes. *Constant Observation* is reserved for the inmate who is actively suicidal, either by threatening or engaging in self-injury. This inmate should be observed by a staff member on a continuous, uninterrupted basis. Other supervision aids (e.g., closed circuit television, inmate companions/watchers, etc.) can be utilized as a supplement to, but never as a substitute for, these observation levels. Suicidal inmates should be assessed by a qualified mental health professional (or medical staff in their absence) on a daily basis. Treatment planning is provided to all inmates placed on suicide precautions for longer than 24 hours.

Experience has shown that prompt, effective emergency medical service can save lives. Research indicates that the overwhelming majority of suicide attempts in custody is by hanging. Medical experts warn that brain damage from asphyxiation can occur within four minutes, with death often resulting within five to six minutes. In inmate suicide attempts, the promptness of the response is often driven by the level of supervision afforded the inmate. Both the ACA and NCCHC standards address *levels of supervision*, although the degree of specificity varies. ACA Standard 4-4257 vaguely requires that "suicidal inmates are under continuing observation," while NCCHC Standard P-G-05 requires physical observation ranging from "constant supervision" to "every 15 minutes or more frequently if necessary."

In addition, the component of "Levels of Supervision/Management" encompasses the overall management of the inmate on suicide precautions and includes the appropriate level of observation, timely and comprehensive suicide risk assessments, downgrading the level of observation following a period of stability, and providing periodic follow-up assessments (pursuant to an individualized treatment plan) following discharge from suicide precautions.

2007 RECOMMENDATIONS: Several recommendations were previously offered.

- 1) It is strongly recommended that both the DOC and UMCH suicide prevention policies be revised to include a better description of the type of behavior and/or circumstances that necessitates a specific level of observation. A proposed revision is offered as follows:
 - ***Close Observation*** is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of self-destructive behavior and would be considered a low risk for suicide. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 15 minutes, and should be documented as it occurs.
 - ***Constant Observation*** is reserved for the inmate who is actively suicidal, either by threatening or engaging in self-injury and would be considered a high risk for suicide. This inmate should be observed by a staff member on a continuous, uninterrupted basis. The observation should be documented at 15-minute intervals.
- 2) It is strongly recommended that reference to 30-minute observation for suicidal inmates be deleted from DOC Policy 650.07. While this level of observation would be appropriate for an inmate discharged from suicide precautions and transferred to a transitional housing unit, it is not appropriate for an inmate in suicidal crisis in the HSU.

- 3) The DOC should ensure all facilities are utilizing the "Correction Officer Observation Check Sheet" (DOC 650, Attachment B-4) that does not contain pre-printed 15-minute time intervals. In addition, a "Mental Health Watch Form" (DOC 650, Attachment C), completed by the assigned mental health clinician, should be attached to the door of each cell housing a suicidal inmate. The report provides a daily listing of the inmate's level of observation, and personal items and privileges that are allowed/prohibited. It is also strongly recommended that the DOC develop and enforce a policy that prohibits its officers from allowing inmates on suicide precautions to cover their heads with blankets or other bedding.
- 4) It is strongly recommended that correctional officers conduct documented 30-minute rounds of all special housing units, including residential treatment units. As previously recommended, documented 15-minute rounds should be conducted in the Health Services Units. In addition, to ensure compliance with these directives, it is strongly recommended that DOC officials conduct more frequent audits (via review of closed circuit telephone monitors) of these units, as well as the segregation units.
- 5) It is strongly recommended that UMCH revise its suicide prevention policy to ensure that an inmate is not discharged from suicide precautions until their case was reviewed during the daily clinical team meeting. In addition, an inmate placed on constant observation should always be downgraded to close (i.e., 15-minute) observation for a reasonable period of time prior to being discharged from suicide precautions. Further, progress notes regarding inmates on suicide precautions should always reflect a thorough suicide risk assessment and justification for a particular level of observation. UMCH should embark upon a quality assurance process to audit selective health care charts on a regular basis and take corrective action when appropriate.
- 6) In order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health staff until their release from DOC custody. As such, unless an inmate's individual treatment plan directs otherwise or they are on the Mental Health Risk List and receive recommended visits from mental health personnel three times per week, it is recommended that the current reassessment schedule following discharge from suicide precautions be revised as follows: daily for 5 days, once a week for 2 weeks, and then once a month until release from the DOC custody.

- 7) It is strongly recommended that administrative or security watches should not be utilized in cases in which staff is concerned enough about an inmate's behavior that increased observation is necessary. These inmates, regardless of their diagnoses, should be placed on mental health watch. And as previously stated, these mental health watches need not necessarily be conducted in the HSUs.

CURRENT FINDINGS: Pursuant to the above recommendations, the DOC revised its suicide prevention policy (No. 103 DOC 650) to include the exact descriptions of both *constant observation* and *close observation* as listed above. In addition, reference to 30-minute observation for suicidal inmates was deleted from the policy and that level of observation is no longer utilized. The "Correction Officer Observation Check Sheet" no longer contains pre-printed 15-minute time intervals, and "Mental Health Watch Forms" are completed by the assigned mental health clinician and attached to the door of each cell housing a suicidal inmate. The Deputy Commissioner of the Prison Division issued a directive to all superintendents that prohibited officers from allowing inmates on suicide precautions to cover their heads with blankets or other bedding. This writer found only an occasional incident during the recent tours whereby an inmate on mental health watch was completely unobservable under their blanket or bedding. In addition to conducting 15-minute rounds in the HSUs, correctional officers are now conducting 30-minute rounds in RTUs and SMUs.¹⁷ The DOC has been auditing compliance with this directive since 2007 and reported substantial compliance on most occasions. It should also be noted that medical staff continue make daily rounds in segregation units, whereas mental health staff conduct cell-to-cell segregation rounds three times a week. These continue to be very good practices.

¹⁷It should be noted that, in response to an increase in self-injurious behavior at MCI-Framingham in July 2009, the superintendent ordered that correctional officers conduct at least 30-minute rounds of all housing units in the facility. In addition, the OCCC superintendant ordered 15-minute rounds in both RTUs during the overnight shift. It would be cost-prohibitive to require expansion of these directive to non-special housing units system-wide.

Further, DOC and MHM policies have been revised to ensure that an inmate is not discharged from the mental health watch until their case was reviewed during the daily treatment team meeting. In addition, an inmate placed on constant observation is always downgraded to close observation for a reasonable period of time prior to being discharged from suicide precautions. The policies require that progress notes regarding inmates on mental health watch reflect a thorough suicide risk assessment and justification for a particular level of observation. All inmates discharged from mental health watch receive regularly scheduled follow-up assessments by mental health staff within three (3) days of discharge, and then again within seven (7) days. (Although this writer had recommended a more aggressive follow-up schedule of daily assessments for 5 days, then once a week for 2 weeks, and then once a month until release from the DOC custody, the adopted schedule by the DOC and MHM is consistent with the standard of care.) Finally, as previously recommended, "administrative or security watches" are not utilized in lieu of mental health watch for a potentially suicidal inmate.

Although the DOC and MHM have accepted each of this writer's previous recommendations and memorialized them into policy, there are concerns about adequate practices in a few areas. First, when reviewing medical files of inmates on mental health watch, this writer observed several instances in which progress notes were not sufficiently descriptive of either a suicide risk assessment or justification for a particular level of observation. For example, in Case No. 6, the inmate was placed on mental health watch after stating "I'm feeling suicidal, what are you going to do about it." The following day, he refused to cooperate with mental health staff's assessment and remained on mental health watch. On the third day, the

inmate was discharged from mental health watch, but there was no progress note in the file to justify the discontinuation of suicide precautions. In Case No. 7, the inmate was placed on constant observation following a suicide attempt by hanging. Although there was documentation in the medical file to suggest his case was reviewed by the treatment team the following day and his status was downgraded to 15-minute checks (close observation), there was no progress note in the file to justify the downgrade in status. In Case No. 8, the inmate was placed on constant observation after engaging in head banging. There were no progress notes found in the file for the following two days, and no documentation to justify downgrading the observation status to 15-minute checks (close observation) on the third day.

This writer, however, also reviewed several medical files that documented excellent clinical judgment by mental health staff. For example, in Case No. 9, the inmate with a significant mental health history was provided with a mental health evaluation two days following arrival at the facility. He denied any current suicidal ideation (as he had during intake screening the previous day), but reported self-injurious behavior four weeks earlier, as well as periodic auditory hallucinations. The inmate requested that his psychotropic medication be restarted. The inmate appeared anxious, high strung, and complained of stomach discomfort. Despite a denial of any current suicidal ideation, the clinician decided to place the inmate on mental health watch. The inmate was successfully discharged from suicide precautions approximately one week later.

This excellent judgment is contrasted with the disposition in a case several months earlier in the same facility with an inmate displaying similar risk factors as found in Case No. 9. In

Case No. 10, the inmate entered the facility and denied any current suicidal ideation during the intake screening process. He was, however, under the influence of alcohol and placed on a detoxification protocol by medical staff. Several days later, the inmate submitted a sick call request form to speak with mental health staff about his stress and anxiety. This complaint was followed by a second sick call request six days later complaining again about anxiety, as well as depression, panic attacks, and sleeping problems. The inmate was finally assessed by a mental health clinician and he denied any current suicidal ideation, but further explained his anxiety (“feel like lump in throat, butterflies in stomach, constant shaking”) and depression (“can’t sleep, persuasive thoughts of victim in his case....worried victim may not come out of coma”). He also reported a prior history of taking psychotropic medication. A mental health evaluation was completed and indicated a provisional diagnosis of Mood Disorder. The inmate was not placed on mental health watch.¹⁸ He committed suicide the following day.

Treatment Planning

There were also concerns about treatment planning of those inmates on and released from mental health watch from the reviewed medical files. NCCHC standards (P-G-02), as well as other national correctional standards, require that a treatment plan “should describe signs, symptoms, and the circumstances in which risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided, and the actions the patient or staff can take if suicidal thoughts do occur.” According to current DOC and MHM policies, an “Initial Mental Health Treatment Plan” is developed for an inmate within 30 days of placement on the mental health caseload. The plan is reviewed (and revised accordingly) every three months on a “Mental Health

¹⁸As stated in 103 DOC 650.07, “an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed on close observation.”

Treatment Plan Review” form during the first year, and every six months thereafter. Although not explicitly described in either DOC or MHM suicide prevention policies, inmates on mental health watch should have treatment plans developed to decrease the symptoms of their suicidal behavior. In fact, MHM’s “Assessment of Suicide Risk in Corrections” lesson plan specifically addresses treatment planning for suicidal inmates and emphasizes that the “plan” section of the DAP (Description, Assessment, and Plan)-formatted progress note should “spell out what you’re doing to decrease risk.” The same lesson plan also cites the requirement for a “crisis treatment plan” and “intervention and specific strategies and services implemented to address the underlying reasons for the inmate’s suicide risk must be documented.”

Despite these directives, this writer found numerous examples of either inadequate documentation of treatment planning or no plans at all for suicidal inmates. In Case No. 11, the inmate received an initial treatment plan with “depression” listed as a problem area and the primary care clinician scheduled to meet with the inmate twice a month. The inmate was not seen by mental health staff for approximately a month and then only seen when he was placed on mental health watch following self-injurious behavior.

In Case No. 12, the inmate was initially placed on 15-minute checks (close observation) for suicidal threats. When his threat level increased, he was moved to constant observation. On the third day, his level was reduced to close observation and there was a very well documented progress note to justify the downgrade status. The following day, however, the “plan” section of the DAP-formatted progress note read: “Discontinue 15-minute MHW, follow-up scheduled per protocol. I/M is an open mental health case. PCC to f/u per protocol. I/M indicates

understanding of how to access routine/crisis MH services.” This, of course, is not a treatment plan designed to “spell out what you’re doing to decrease risk,” (as cited in MHM lesson plan), but rather a recitation of required procedures. Most “plan” sections of the DAP-formatted progress notes had similar language. Two days later, this same inmate was again placed on a mental health watch and the clinician wrote that “client will be followed up with per his treatment plan.” Yet, this inmate had no treatment plan for suicidal behavior. In addition, adequate strategies to address suicidal behavior were also either absent or lacking in most Initial Mental Health Treatment Plans and Mental Health Treatment Plan Review forms in this and other reviewed files.

In Case No. 4, the inmate had a long history of mental illness and self-injurious/suicidal behavior within the DOC. He was on mental health watch on multiple occasions. The inmate also had multiple commitments to Bridgewater State Hospital. Upon one recent return from the hospital, a Comprehensive Mental Health Evaluation and Treatment Plan was completed. In the treatment plan section, the clinician wrote - Goals: “decrease self-injurious behavior,” Modality: “1:1 with PCC, groups when available,” Frequency: “2-4 times per month,” Target Date: “on-going.” He was subsequently transferred to a residential treatment unit, but his mental health further deteriorated and he was sent back to Bridgewater State Hospital. A few weeks later, the inmate was placed on mental health watch for self-injurious behavior at the hospital. He was later returned to the residential treatment unit. An Initial Mental Health Treatment Plan was developed by a clinician. Incredibly, the treatment plan did not make any reference to self-injurious behavior and/or suicidal ideation. Two weeks later, the inmate swallowed a razor blade and was placed on mental health watch for several days. He was seen by his primary care

clinician approximately one week later. The inmate subsequently committed suicide the following month and there was no documentation that he had been seen by a clinician during the last month of his life.

Finally, as stated in the beginning of this report, three inmate suicides during 2009-2010 occurred within 5, 7 and 19 days following their releases from suicide precautions (i.e., mental health watches. The close proximity of these deaths from mental health watch release may be related to the adequacy of follow-up and treatment planning in each case.

NEW RECOMMENDATIONS: This writer would offer several recommendations. *First*, it is strongly recommended that the DOC and MHM conduct a quality assurance audit of mental health watch practices to ensure that progress notes are sufficiently descriptive of either a suicide risk assessment or justification for a particular level of observation.

Second, it is strongly recommended that MHM consider creating a suicide risk assessment form to assist its clinicians in documenting the assessment of suicidal inmates. If adapted, the suicide risk assessment form should include a brief mental status exam, listing of chronic and acute risk factors, listing of any protective factors, level of suicide risk (e.g., low, medium, or high), and treatment plan. At a minimum, the assessment form should be utilized during the initial assessment of risk that justifies an inmate's placement on mental health watch, as well as when the clinician determines that the inmate no longer is in need of a mental health watch.

Third, it is strongly recommended that both DOC and MHM policies be revised to require a treatment plan for inmates on mental health watch to describe signs, symptoms, and the circumstances in which risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided, and the actions the patient or staff can take if suicidal thoughts do occur.

Fourth, as previously offered on page 14 of this report, it is strongly recommended that MHM repeat its full-day workshop (previously conducted in September 2009) on an annual basis for all clinical staff, with special emphasis on suicide risk assessments and treatment planning.

Fifth, this writer's review of medical charts of inmates on mental health watch found they were cluttered with numerous Correction Officer Observation Check Sheets. While it is important for the inmate's primary care clinician to review the observation sheets as part of the daily assessment process, it appears unnecessary and cumbersome to store the sheets in the medical file. At MCI-Framingham, the observation sheets are reviewed for accuracy by the deputy superintendent and stored in a security file. This is a reasonable practice and should be replicated in other facilities.

6) Intervention

A facility's policy regarding intervention should be threefold: 1) all staff who come into contact with inmates should be trained in standard first aid and cardiopulmonary resuscitation (CPR); 2) any staff member who discovers an inmate attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin standard first aid and/or CPR; and 3) staff should never presume that the inmate is dead, but rather initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, all housing units should contain a first aid kit, pocket mask or mouth shield, Ambu bag, and rescue tool (to quickly cut through fibrous material). All staff should be trained in the use of the emergency equipment. Finally, in an effort to ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training for all staff.

Following a suicide attempt, the degree and promptness of intervention provided by staff often foretells whether the victim will survive. Although both ACA and NCCHC standards address the issue of intervention, neither are elaborative in offering specific protocols. For example, ACA Standard 4-4389 requires that -- "Correctional and health care personnel are trained to respond to health-related situations within a four-minute response time. The training program...includes the following: recognition of signs and symptoms, and knowledge of action required in potential emergency situations; administration of basic first aid and certification in cardiopulmonary resuscitation (CPR)..." NCCHC Standard P-G-05 states -- "Intervention: There are procedures addressing how to handle a suicide attempt in progress, including appropriate first-aid measures."

2007 RECOMMENDATIONS: Several recommendations were previously offered.

- 1) Both DOC and UMCH policies should be slightly revised to better ensure a proper response of both correctional and medical personnel to a suicide attempt. At a minimum, policies should reiterate that CPR should be initiated immediately (on a flat, hard surface) and the victim should not be carried away from the cellblock area during the emergency. This writer's complete recommended guidelines for intervention following a suicide attempt can be found in Appendix A.
- 2) It is strongly recommended that the DOC ensure that *all* housing units contain an emergency response bag that includes a first aid kit; pocket mask, face shield, or Ambu-bag; latex gloves; and emergency rescue tool. All staff who come into regular contact with inmates should know the location of this emergency response bag and be trained in its use.
- 3) It is strongly recommended that the health services administrator at each facility ensure that all equipment utilized in the response to medical emergencies (e.g., Code 99 bags, code cart, oxygen tank, AED, etc.) is inspected and in proper working order on a daily basis.
- 4) It is strongly recommended that the DOC review and revise its "mock drill" training at each facility to ensure that correctional and medical staff review specific instructions regarding the proper role in responding to suicide attempts and providing first aid/CPR. The mock drill training should occur on an annual basis for all correctional and medical personnel.

CURRENT FINDINGS: Most, but not all, of this writer's previous recommendations appear to be currently in operation. For example, DOC revised its Code 99 Emergency Response Guidelines (formerly No. 103 DOC 622 and currently entitled 103 DOC 562), most recently in June 2010. The 2010 revised guidelines provide better clarity of both medical and correctional staff responsibilities, requirements for "mock drill" training, and contents of the Code 99 emergency "red bag" brought to the scene by medical staff. The guidelines now provide specificity on the minimum number of personnel required to be present prior to opening a cell

door during a presumed medical emergency: In a special management unit, “when the decision to enter a cell has been made by the shift commander, there shall be at least three (3) staff members present when the door opens. One of these staff members shall be of supervisory rank, if at all possible.”¹⁹ In general population units, “when there is no apparent threat to staff to enter the cell, during the 7x3 and 3x11 shifts, the first officer on the scene shall initiate a Code 99 response and enter the cell to initiate first responder responsibilities. On the 11x7 shift, there should be at least 2 officers present before entering the cell.” These are reasonable procedures.

Although this writer observed various emergency response equipment (first aid kit, pocket mask, and cut-down shears, etc.) in the toured housing units, the Code 99 guidelines still do not specify that all housing units or control stations contain an emergency response bag that includes a first aid kit; pocket mask, face shield, or Ambu-bag; latex gloves; and emergency rescue tool. This is a separate requirement to that of the more fully equipped Code 99 emergency red bag brought to the scene by medical staff.

With regard to training, as previously noted, the DOC’s annual in-service program was suspended for 16 months from May 2009 thru September 2010 due to budget cuts within the agency. Although all correctional officers had received initial first aid and cardiopulmonary resuscitation (CPR) training upon employment and up through May 2009, no recurring emergency medical response training was provided during this 16-month period.

In addition, all DOC employees received classroom instruction regarding the implementation of the revised Code 99 Emergency Response Guidelines in the summer of 2010.

¹⁹When entering a double-cell in a special management unit, five (5) officers are required.

“Mock Drill” training was also started at that time, but in one toured facility, only a small percentage a correctional staff had received the training as of December 2010.

Finally, this writer reviewed mortality review reports of the 13 inmate suicides during 2009-2010. Similar to findings detailed in this writer’s 2007 Report, problematic emergency responses were found in 10 of the 13 recent cases. Problems included the following:

- Delayed response in cell entry²⁰
- Delayed arrival of medical staff; as well as their arrival without Code 99 equipment
- Delayed initiation of CPR while staff searched for emergency equipment
- Delayed emergency 911 call
- Malfunctioning equipment (Ambu-bag; portable oxygen tank; dull medical shears)
- Improper CPR (wrong technique for chest compressions; CPR initiated on bed rather than hard surface of floor)

It should be noted that all but one of the inmate suicides occurred before revision of the Code 99 Emergency Response Guidelines, as well as initiation of mock drill training.

NEW RECOMMENDATIONS: This writer would repeat two recommendations from the earlier report. *First*, although emergency equipment was found in each housing that was toured, it is strongly recommended that the Code 99 Emergency Response Guidelines (103 DOC 562) be revised to specify that all housing units or control stations contain an emergency response bag that includes a first aid kit; pocket mask, face shield, or Ambu-bag; latex gloves; and emergency rescue tool. (This is a separate requirement to that of the more fully equipped Code 99 emergency red bag brought to the scene by medical staff.) *Second*, it is strongly

²⁰Correctional standards require a minimum emergency response time of four (4) minutes, see Section 4389 of American Correctional Association’s *Standards for Adult Correctional Institutions*.

recommended that the DOC expedite completion of all annual mock drill training for both correctional and medical staff.

7) **Reporting**

In the event of a suicide attempt or suicide, all appropriate correctional officials should be notified through the chain of command. Following the incident, the victim's family should be immediately notified, as well as appropriate outside authorities. All staff who came into contact with the victim prior to the incident should be required to submit a statement as to their full knowledge of the inmate and incident.

CURRENT FINDINGS: The reporting requirements following an inmate suicide are detailed in DOC Policies 622.02, 622.03, and 650.07. Although this writer did not have an opportunity to review all of the required notifications and documentation in the recent inmate suicides, in the material that was reviewed, all reporting procedures seemed to have been appropriately followed.

RECOMMENDATIONS: None

8) **Follow-up/Morbidity-Mortality Review**

Every completed suicide, as well as serious suicide attempt (i.e., requiring hospitalization), should be examined by a morbidity or mortality review. (If resources permit, clinical review through a psychological autopsy is also recommended.) The review, separate and apart from other formal investigations that may be required to determine the cause of serious injury or death, should include: 1) review of the circumstances surrounding the incident; 2) review of procedures relevant to the incident; 3) review of all relevant training received by involved staff; 4) review of pertinent medical and mental health services/reports involving the victim; 5) review of any possible precipitating factors that may have caused the victim to attempt or commit suicide; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. Further, all staff involved in the incident should participate in each process, as well as offered critical incident stress debriefing.

Experience has demonstrated that many correctional systems have reduced the likelihood of future suicides by critically reviewing the circumstances surrounding instances as they occur. While all deaths are investigated either internally or by outside agencies to ensure impartiality, these investigations are normally limited to determining the cause of death and whether there was any criminal wrongdoing. *The primary focus of a morbidity-mortality review should be two-fold: What happened in the case under review and what can be learned to help prevent future incidents?* To be successful, the morbidity-mortality review team must be multidisciplinary and include representatives of both line and management level staff from the corrections, medical and mental health divisions.

2007 RECOMMENDATIONS: One recommendation was previously offered.

- 1) It is strongly recommended that in order to ensure that all mortality review recommendations are processed in a timely manner, a "corrective action plan" (CAP) should be developed in response to

each recommendation. Each CAP should include, but not be limited to, the following: 1) the recommendation, 2) whether it has been accepted or rejected by the DOC Commissioner and UMCH program medical director (or their designees), 3) the corrective action, 4) target date for completion, 5) completion date, and 6) the mechanism for periodically monitoring continued compliance. In addition, it is suggested that the recommendations contained within this report be subject to the corrective action format described above.

CURRENT FINDINGS: The DOC continues to have both excellent policies and practices regarding the mortality review process following an inmate suicide. In many ways, the mortality review process continues to represent the strength of the DOC-MHM suicide prevention program. Per policy, the death is investigated by the agency's Office of Investigative Services. The DOC Commissioner also normally designates a "Departmental Medical Investigation Team" to investigate the death. The team is comprised of at least one individual from the Office of Investigative Services (OIS) and either the Health Services Division (HSD)'s Director of Behavioral Health or a Regional Administrator. The team reports almost immediately to the facility which sustained the death to begin its investigations. The OIS investigation results in a report to the Commissioner. A copy is forwarded to the Quality Assurance Mortality Review Committee. The HSD investigation results in an extensive written narrative that is discussed by the Committee during the Quality Assurance Mortality Review.

In most cases, Quality Assurance Mortality Review Committee tries to meet within 30 days of the inmate suicide. The Committee is comprised of both participants and observers, and includes representatives from HSD headquarters, an independent psychiatric consultant, representatives from MHM and UMCH, and the facility superintendent or designee. The process is now chaired by the DOC Director of Quality Improvement. Interviewed staff may be those

correctional, medical, and mental health personnel who were involved in the care and custody of the inmate, as well as those who responded to the emergency. A report of the mortality review is completed and recommendations, if any, for corrective action are offered.

In order to better coordinate and integrate various competing investigative reviews of a death, the Committee made the following recommendation during a recent mortality review meeting: “systemic action items that arise out of morbidity and mortality reviews conducted by the contractual medical and mental health services providers as well as investigations of suicides conducted by the Office of Investigative Services be incorporated as part of unified performance improvement activities that are implemented as a consequence to Performance Improvement Mortality Review/Psychological Autopsy meetings.” This is an excellent recommendation that should be implemented for future reviews.

This writer reviewed the Quality Assurance Mortality Review reports on 13 inmate suicides occurring in 2009-2010. In each case, the reviews were very comprehensive and insightful, and the recommendations were thoughtful and directly on-point. With that said, one area of concern still remained. Similar to concerns found during the earlier review, several mortality reviews conducted in 2009 contained recommendations with either vague and/or unrealistic narrative that made it difficult to determine whether (and when) corrective action would be instituted.

Beginning in March 2010, the mortality review format became tighter and consistent with this writer’s above 2007 recommendation. For example, the process, now entitled “Performance

Improvement: Mortality Review/Psychological Autopsy,” is broken into the following sections: Incident, Autopsy/Toxicology Findings, Criminal History, Institutional Adjustment/Functioning, Mental Health History, Medical History, Precipitating Events, Pre-Suicidal Functioning, Issues for Review, Recommendations, and Review and Signatures.

With regard to the Recommendations section, guidelines for the process state that “All recommendations shall be realistic, achievable, objective, and measurable. Check to be sure that the selected measurable provide data that will permit objective assessment of the effectiveness of the action. Consider whether pilot testing of a planned improvement should be conducted. Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where and how the improvements will be implemented.” Following each recommendation of the mortality review template, a “Responsible Person(s),” “Progress to Date,” and “Outcome Measure” are listed. Finally, under the Review and Signature sections, the Assistant Deputy Commissioner of Clinical Services is now required to review and sign the mortality review report, better ensuring the recommendations will be implemented. These are all excellent revisions that should better ensure full implementation of committee recommendations.

Quality Assurance

According to the Health Services Division (HSD), prior to the 2009, the division routinely audited medical records as part of an effort to determine contractual compliance by the health services providers. Beginning in 2009, focus of these chart reviews changed to a philosophy that was focused on quality assurance (QA) and quality improvement (QI) rather than

strict contract compliance. Auditing tools and clinical guidelines were developed, and staff from the HSD were able to audit all 18 DOC facilities. MHM also has QA/QI capabilities, although it would appear their auditing tool had recently focused upon the quantity of services rather than the quality of services.²¹

This writer was informed that the Health Services Division QA/QI team is comprised of three staff: the director of quality improvement, director of behavioral health, and a regional administrator. (Other facility-based staff are recruited when necessary.) However, all three members of the team have multiple other responsibilities within the Health Services Division, and none of the positions are exclusively dedicated to QA/QI. In addition, MHM had assigned a full-time staff member to the quality improvement process. Unfortunately due to budget cuts, this MHM position was lost in September 2010. In addition, MHM has lost and/or reassigned several supervisory positions, creating a challenge to provide adequate clinical supervision over line clinicians.

It would be this writer's opinion that many of the case examples of poor documentation and/or justification for certain decisions cited in this report would normally be identified and corrected by a robust quality assurance program. In addition, many of the other deficiencies raised in this report would normally be identified during an on-going quality assurance process, and systemic "slipping back" from good practices could normally be avoided with more than simply a once a year on-site review. Finally, within many of the "outcome measure" sections of

²¹See MGT of America (2008), *A Presentation to the Massachusetts Department of Correction for the Comprehensive Operations Assessment*, which stated that "The contract compliance audit tool does not contain the flexibility to actually monitor the quality of services delivered and the decision-making process on a case-by-case basis. All services are monitored based on a yes/no quantitative measure."

the 2010 mortality reviews, the narrative stated that “DOC Health Services Division will conduct an audit” to resolve the issue. Given the findings in this report, and the necessary corrective action and targeted QI audits that lie ahead, it is difficult to imagine how the currently staffed Health Care Division will be able to adequately maintain quality assurance of suicide prevention in the long-term, let alone monitor other vital areas of health services within the department.

As previously stated, the mortality review process continues to represent the strength of the suicide prevention program, much of it attributable to the efforts of this three-member QA/QI team. Yet despite the efforts of the HSD and MHM in this area, the current staff resources available for quality assurance and quality improvement appear woefully inadequate within the DOC.

NEW RECOMMENDATIONS: This writer would offer two recommendations. *First*, it is strongly recommended that “target date for completion” and “actual completion date” be added to the Recommendation sections of future “Performance Improvement: Mortality Review/Psychological Autopsy” documents. *Second*, it is strongly recommended that the DOC seek funding for dedicated staff positions for the Health Services Division’s quality assurance and quality improvement program. The MHM quality improvement staff position should also be reinstated. *It is imperative that these positions be funded in order for both the DOC and MHM quality assurance staff to more regularly visit facilities and avoid slipping back from good suicide prevention practices.*

C. SUMMARY OF RECOMMENDATIONS

Staff Training

- 1) It is strongly recommended that the section on "Emergency Response" be removed from both the pre-service and in-service lesson plans. Although included in this writer's 2007 recommendations, the topic is already adequately discussed in other training programs (professional rescuer and first aid, mock drill training, etc.). In addition, the pre-service curriculum should include the following topics from this writer's previous recommendations: "avoiding negative attitudes in suicide prevention," "identifying suicidal inmates despite the denial of risk," "dealing with manipulative inmates," and "liability issues associated with suicide prevention." (The topic of liability could perhaps be best included in the discussion of case study reviews during both the pre-service and in-service training workshops.) Finally, the PowerPoint slides should more closely resemble the revised lesson plans.
- 2) It is strongly recommended that MHM repeat its full-day workshop (previously conducted in September 2009) for all clinical staff on an annual basis, with special emphasis on suicide risk assessments and treatment planning.

Identification/Screening

- 3) It is strongly recommended that the Governor's Office now require that the Massachusetts Sheriffs Association require its member counties to fully cooperate with the DOC's request to forward pertinent transfer summary information whenever an inmate is transferred from county to state custody.
- 4) It is strongly recommended that, in addition to initiating a Q5 inquiry of the CJIS, the booking/admission staff and medical personnel access both the "Medical/Mental Health Section" and "Mental Health Watch" screen of the IMS to determine if the newly arrived inmate was on a mental health watch during a previous DOC confinement. DOC and UMCH policies should be revised accordingly.
- 5) It is strongly recommended that MHM develop a standardized protocol for responding to mental health referrals throughout the DOC. Generally accepted definitions and time frames are: Emergency (requiring an immediate response), Urgent (requiring non-immediate response within the same day), and Routine (requiring a response within five business days).

Communication

None

Housing

- 6) It is strongly recommended that the DOC seek additional funding to staff and open the Intensive Treatment Unit at MCI-Framingham.
- 7) It is strongly recommended that the DOC determine the cost it is incurring by utilizing correctional officers to provide constant observation to inmates on mental health watch in Special Management Units not designated to be suicide-resistant. Most of these inmates are not at high risk for suicide and would not require constant observation if they were housed in suicide-resistant cells. If the costs of providing constant observation to these lower risk inmates exceeds the cost of renovating a cell to make it suicide-resistant, the DOC should seek the necessary funding to renovate these cells.
- 8) Should the DOC decide to seek additional funding to renovate a designated number of Special Management Unit cells for mental health watches, it is strongly recommended that the DOC and MHM avoid transferring inmates with serious and/or persistent mental illness to these SMU cells.
- 9) It is strongly recommended that, to avoid its potential for misuse, the DOC remove the therapeutic module (or cage) from the HSU interview room at MCI-Framingham.
- 10) It is strongly recommended that the DOC and MHM conduct a quality assurance audit of mental health watch practices to determine if restrictions are individualized on a case-by-case basis and full justified in writing within each inmate's medical chart. The audit should also determine the percentage of mental health assessments that are conducted outside the cell in a private and confidential interview room.
- 11) It is strongly recommended that the DOC's Division of Resource Management re-inspect all cells designated for mental health watch to ensure they are suicide-resistant, most notably, the HSU cells at MCI-Framingham and bunk holes and bracketed stools in HSU cells at MCI-Concord.
- 12) It is strongly recommended that any inmate on mental health watch be housed in a cell that contains a safe bunk. Therefore, suicide-resistant bunks should be installed in the "backside" cells of the HSU at Souza-Baranowski Correctional Center.
- 13) With Old Colony Correctional Center's recent conversion to housing a high percentage of inmates with mental illness, it is strongly recommended that the DOC seek additional funding to renovate up to 15 cells in one of the RTU units to house inmates on mental health watch. As an alternative, the DOC should seek additional funding to create an Intensive Treatment Unit for male inmates who are

in need of mental health watch and/or close monitoring due to acute mental health issues and/or chronic behavior management issues.

Levels of Supervision/Management

- 14) It is strongly recommended that the DOC and MHM conduct a quality assurance audit of mental health watch practices to ensure that progress notes are sufficiently descriptive of either a suicide risk assessment or justification for a particular level of observation.
- 15) It is strongly recommended that MHM consider creating a suicide risk assessment form to assist its clinicians in documenting the assessment of suicidal inmates. If adapted, the suicide risk assessment form should include a brief mental status exam, listing of chronic and acute risk factors, listing of any protective factors, level of suicide risk (e.g., low, medium, or high), and treatment plan. At a minimum, the assessment form should be utilized during the initial assessment of risk that justifies an inmate's placement on mental health watch, as well as when the clinician determines that the inmate no longer is in need of a mental health watch.
- 16) It is strongly recommended that both DOC and MHM policies be revised to require a treatment plan for inmates on mental health watch to describe signs, symptoms, and the circumstances in which risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided, and the actions the patient or staff can take if suicidal thoughts do occur.
- 17) As previously offered on page 14 of this report, it is strongly recommended that MHM repeat its full-day workshop (previously conducted in September 2009) on an annual basis for all clinical staff, with special emphasis on suicide risk assessments and treatment planning.
- 18) This writer's review of medical charts of inmates on mental health watch found they were cluttered with numerous Correction Officer Observation Check Sheets. While it is important for the inmate's primary care clinician to review the observation sheets as part of the daily assessment process, it appears unnecessary and cumbersome to store the sheets in the medical file. At MCI-Framingham, the observation sheets are reviewed for accuracy by the deputy superintendent and stored in a security file. This is a reasonable practice and should be replicated in other facilities.

Intervention

- 19) It is strongly recommended that the Code 99 Emergency Response Guidelines (103 DOC 562) be revised to specify that all housing units or control stations contain an emergency response bag that includes a first aid kit; pocket mask, face shield, or Ambu-bag; latex gloves; and emergency rescue tool. (This is a separate

requirement to that of the more fully equipped Code 99 emergency red bag brought to the scene by medical staff.)

- 20) It is strongly recommended that the DOC expedite completion of all annual mock drill training for both correctional and medical staff.

Reporting

None

Follow-up/Morbidity-Mortality Review

- 21) It is strongly recommended that “target date for completion” and “actual completion date” be added to the Recommendation sections of future “Performance Improvement: Mortality Review/Psychological Autopsy” documents.
- 22) It is strongly recommended that the DOC seek funding for dedicated staff positions for the Health Services Division’s quality assurance and quality improvement program. The MHM quality improvement staff position should also be reinstated. *It is imperative that these positions be funded in order for both the DOC and MHM quality assurance staff to more regularly visit facilities and avoid slipping back from good suicide prevention practices.*

D. CONCLUSION

It is hoped that this follow-up assessment, as well as the recommendations contained within this report, will be of assistance to the Massachusetts Department of Correction. Similar to the initial assessment in 2006-2007, this writer again met numerous DOC and MHM officials and supervisors, as well as officers and clinicians, who were genuinely concerned about inmate suicide and committed to taking whatever actions were necessary to reduce the opportunity for such tragedy in the future.

Many changes have occurred since this writer's initial assessment four years ago. A new mental health provider has arrived, the reception and diagnostic center for male inmates has been relocated, one facility has been converted to almost exclusively house male offenders with mental illness, and residential treatment programs to manage the needs of inmates with serious mental illness have greatly expanded. These changes have had, or will have, an impact on the provision of suicide prevention practices within the DOC.

It should be noted that the offering of new recommendations in this report, as well as a restatement of several prior recommendations, should not be interpreted to mean that the DOC and its health care providers are not providing adequate suicide prevention programming and/or failed to heed the previous advice and recommendations of this writer. On the contrary, in either whole or in large part, the Department of Correction and MHM had previously accepted and implemented all 29 of this writer's 2007 recommendations. This writer did find that some of the recommendations previously implemented by the DOC and its providers have slipped back from good practices in certain areas, the cause of which is likely attributable to budget cuts and an

under-funded quality assurance program. With that said, the DOC and MHM continue to manage a good suicide prevention program and the issues they continue to struggle with are similarly experienced by other state correctional systems throughout the country.

Limited discussion about budget reductions to the DOC and its health care providers has been expressed in this report for the simple reason that suicide prevention is a multifaceted issue. There can be many reasons why a correctional system sustains a rash of suicides and, other than the previously cited problematic emergency medical responses found in most of the incidents, there were few common threads to these deaths. And even if the emergency responses had been error-free, many of these deaths might still have not been preventable. Budget reductions probably did not directly cause any of these suicides, but they have perhaps had an impact on the ability to provide seamless health care services to the inmate population. Less health care staff and higher caseloads can affect a clinician's ability to thoroughly review medical charts, provide appropriate documentation for decision-making, and have time for quality follow-up and treatment planning with patients recently discharged from mental health watch. Job uncertainty can also effect morale and contribute to staff burn-out.

Finally, with that said, some additional funding is vital to the DOC's suicide prevention program and reduction of inmate suicides in the future. This report contains a few recommendations for the DOC to seek additional funding for quality assurance staff positions, as well as the staffing of an intensive treatment unit for female inmates and conversion of additional "suicide-resistant" mental health watch beds for male inmates. In addition, it is critically

important that annual in-service training in the areas of suicide prevention, first aid, and CPR never be cut or suspended again in the future.

In conclusion, this writer would be remiss by not extending sincere appreciation to Luis S. Spencer, current Acting DOC Commissioner, as well as former Acting Commissioner Ronald Duyal and former Commissioner Harold Clarke. Special thanks goes to Veronica Madden, DOC Deputy Commissioner for Classification, Programs, and Re-Entry; Lawrence Weiner, DOC Director of Behavior Health; Katherine O'Neill, Health Services Division/Regional Administrator; and Joel Andrade, PhD., MHM Director of Clinical Services in Massachusetts. These four individuals, particularly Lawrence Weiner, provided much needed assistance in scheduling the tours and interviews, fulfilling document requests, and providing valuable insight to this assessment. Without the total candor, cooperation and assistance from these individuals, as well as from all correctional, medical, and mental health personnel that were interviewed, this writer would not have been able to complete this technical assistance assignment.

Respectfully Submitted By:

Lindsay M. Hayes

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