Corrective Action Plan
Addressing Recommendations from the Follow-up Report on Suicide Prevention Practices within the Massachusetts Department of Correction
March 14, 2011

During the first half of 2010, the Department of Correction experienced an increased incidence of suicide within our correctional facilities at a rate four times greater than the national average. Per previously established protocols, all inmate deaths were examined through the mortality review process and all policies and procedural directives relating to suicide prevention were reviewed and in some cases modified. In order to more independently assess our current practices related to suicide prevention, the decision was made to call upon the services of Lindsay Hayes, a nationally recognized expert in the field of jail, prison and juvenile suicide, who was already under contract as a consultant to the department, and had provided a technical assistance report on suicide prevention to the department in February 2007.

An initial meeting was held between then Commissioner Harold Clarke and Mr. Hayes on August 6, 2010, to discuss the overall scope of the review being requested. In order to comprehensively assess suicide prevention policies and practices within a correctional system, Mr. Hayes uses an eight-point checklist that he developed and has utilized in his review of other systems throughout the country. The checklist consists of the following areas:

1. Training: Assess the scope, content and duration of suicide prevention training offered to correctional, medical and mental health staff.
2. Identification and Screening: Assess the process by which inmates are initially identified and assessed for suicide risk upon entry and throughout confinement; to include referrals for further assessment
3. Communication: Assess the process by which the identification, referral and management of suicidal inmates is communicated among correctional, medical and mental health staff; to include communication mechanisms between the prison system and outside agencies.
4. Housing: Conduct physical plant tours to assess the extent of suicide-resistant, protrusion-free housing for at risk inmates.
5. Levels of Supervision: Assess levels of suicide risk and frequency of supervision for suicidal inmates; to include decision making responsibility for authorizing, upgrading, downgrading and discontinuing suicide precautions; to include assessment of any other supervision management tools, (e.g., closed circuit television, observation protocols, restraints, etc.)
6. Intervention: Assess the scope and level of response from correctional, medical and mental health staff following a suicide attempt; to include assessment of staff training in standard first aid and cardiopulmonary resuscitation.
7. Reporting: Assess process by which officials, other outside agencies and family members are notified of an inmate suicide; to include requirements of report writing from all staff involved in the incident.

8. Follow-up/Mortality Review: Assess scope and content of any administrative and/or clinical review process following an inmate suicide or serious attempt requiring hospitalization; to include quality assurance and mortality reviews, critical incident stress debriefing, etc.

As part of his system-wide assessment, Mr. Hayes requested several documents for review including: current suicide prevention policies for both the DOC and MHM, Code 99 policies, the 562 policy, program descriptions/handbooks for the Secure Treatment Program, Behavior Management Unit, Residential Treatment Unit programs, MHM staffing patterns over the course of the current contract, current pre-service and annual in-service suicide prevention training curricula and the completed mortality reviews of all the 2009 and 2010 inmate suicides.

An integral part of the system-wide assessment conducted by Mr. Hayes included on-site tours of our correctional facilities where he interviewed senior institutional administration for the DOC, MHM and UMCH as well as a large number of correctional officers, mental health clinicians and medical personnel. His on-site work included a record review of inmates currently or recently on suicide precautions and a physical plant review of the currently designated suicide-resistant cells. Mr. Hayes toured SBCC on September 28, 2010, MCI-CJ on September 29, 2010, OCCC on November 9, 2010, MCI-F on November 11, 2010 and MCI-Concord on December 28, 2010. Mr. Hayes also was allowed to observe the mortality review conducted on an inmate who recently had committed suicide. This mortality review occurred on August 12, 2010 at OCCC. Mr. Hayes additionally observed the 2-hour in-service training on suicide prevention on January 14, 2011 and the 8-hour pre-service training on suicide prevention on February 17, 2011.

Acting Commissioner Luis Spencer and members of the Department's Executive Staff have carefully reviewed and analyzed the 22 specific recommendation contained in the *Follow-up Report on Suicide Prevention Practices within the Massachusetts Department of Correction* completed by Lindsay Hayes, dated February 18, 2011. These recommendations are broad in scope and will involve revising policies and training curricula, creating new forms and systems designed to improve communication, as well as making physical plant renovations to better allow the department the ability to safely manage inmates identified as being at increased risk for suicide. The department is committed to implementing all the recommendations that fall within the purview of the agency or its medical and mental health vendors, while other recommendations will require additional funding and/or cooperation for interested stakeholders.

Each recommendation has been addressed with Product, Responsible Staff, Timelines, and Cost. Timelines have been designated as Immediate being that which will be accomplished within ten days; Short Term within sixty days; Intermediate less than six months and Long Term more than six months. The recommendations are addressed in the order in which Mr. Hayes presented them in his report. The detailed plan for full corrective action and implementation follows:

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.

Product:	**Revised curricula for both the pre-service and in-service suicide prevention training removing the section on emergency response, and reinstating sections on 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. PowerPoint slides will also be modified to more closely resemble the revised lesson plan.**
Responsible Party:	**Division of Staff Development** **Health Services Division**
Timeline:	**Short-Term**
Cost:	**Neutral**
Comments:	**Collaboration between the Division of Staff Development and the Health Services Division is already underway to revise the suicide prevention lesson plans. The Health Services Division will also work with MHM to ensure that those staff responsible for providing the suicide prevention training will be trained on how to present the new material.**

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.

Product: **Annual provision of Suicide Risk Assessment Training by MHM to all contractual clinical staff**

Responsible Party: **MHM**
Health Services Division

Timeline: **Intermediate**

Cost: **Neutral**

Comments: **MHM has committed to providing this training on an annual basis to all clinical mental health staff. The Health Services division will coordinate with the Division of Staff Development and MHM to set aside time and space for this training. Preliminary plans are to offer this training next in September 2011.**

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.

Product: **A. Letter to Undersecretary McCroom**
B. Proposed Memorandum of Understanding
C: Proposed Legislation

Responsible Party: **A: Commissioner's Office**
B: Health services Division/Legal Division
C: Commissioner's Office

Timeline: **A. Immediate**
B. Short-Term
C. Intermediate

Cost: **Neutral**

Comments: **A: A letter will be drafted to Undersecretary McCroom asking for her assistance in engaging the Sheriff's Association in a discussion pertaining to the communication of pertinent medical and mental health issues of inmate's/detainees transferring from the counties to the department's custody.**
B. Proposed Memorandum of Understanding will seek to require that medical and mental health information will be shared between the Department and the counties. The MOU, which already has already been drafted, needs to be reviewed and amended as deemed necessary.
C. Proposed legislation has already been drafted to require this sharing of information. Inquiries shall be made into the status of this proposed legislation.

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.

Product: **A. Memo reinforcing existing policy**
B. Study of existing practices related to the communication between mental health staff and the designated CJIS operator of an inmate's need for a mental health watch related to a threat or an action of self-injury

Responsible Party: **A. Deputy Commissioner of Prisons**
B. Deputy Commissioner of Prisons

Timeline: **A. Immediate**
B. Short-Term

Cost: **A. Neutral**
B. Neutral

Comments: **A. Policy 103 DOC 401.01 G. 1. already specifies the following actions be taken by the booking officer:** *Before generating a new commitment number, booking staff shall conduct a search on the IMS Inmates Pending*

Identification screen for prior commitments. If prior commitments are found, the most recent one shall be selected and copied to the current record utilizing the "copy prior record" button. When records are copied in this manner, the inmate shall still be interviewed and the screens updated as necessary in accordance with 401.01 (2) (A).

Note: Use of the "copy prior record" function populates IMS screens with information from the inmates' prior commitment. For inmates that a "full copy" is possible, booking staff shall review the "Suicide Query" screen, "Mental Health Watch" screen, and the "Mental Health/Substance Abuse" screen. For inmates that only a "partial copy" of records is possible, booking staff shall review the "Suicide Query" screen and "Mental Health/Substance Abuse" screen. If evidence of past mental health issues are found as part of this review (i.e., Q5 entries, past mental health watches, suicidal ideation), booking staff shall contact the shift commander.

During business hours, the shift commander shall notify the director of security and contact the director of mental health to determine appropriate placement and/or need for action or follow-up. During non-business hours, the shift commander shall contact the facility duty officer and the on-call mental health clinician.

B. Every time an inmate is placed on a mental health watch because they have either threatened or engaged in an act of self-harm should result in an entry into CJIS as a positive Q5 event. A system-wide assessment needs to be undertaken to ensure this practice is being uniformly conducted at all institutions.

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).

Product:	**A. A separate sick-call slip for mental health requests that has the ability to specify the urgency of an inmate's request for mental health services and tracks follow-up care and disposition.** **B. MHM and DOC policies**
Responsible Party:	**A. MHM** **B. MHM/Health Services Division**
Timeline:	**Short-Term**
Cost:	**Neutral**
Comments:	**MHM has already begun drafting a mental health specific sick call request form utilizing feedback from their clinical operations department. Policies will be created specifying the use of this new form and the triage timeline requirements. Additionally, clinical staff will be trained on the use of this new form and the triage process.**

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.

Product:	**Review existing proposal for the Intensive Treatment Unit at MCI-Framingham**
Responsible Party:	**Commissioner's Office**

Timeline: **Intermediate**

Cost: **Final cost yet to be determined**

Comments: **A review of the existing proposal is required to determine the feasibility of operating the unit as initially envisioned. Much of the renovation to the ITU has already been completed, however renovations to the windows in the cells still need to be completed and the IPS offices must be moved to create program space. Additional security, medical, mental health and administrative staff are also required to operate this unit.**

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.

Product: **A. Cost assessment of correctional officer overtime related to the provision of providing constant mental watch coverage for inmates who only require that level of observation due to the lack of suicide resistant cells.**
B. Report of review of cost estimates for renovating cells in designated SMU's to create additional suicide-resistant cells.

Responsible Party: **A. Director of Administrative Services**
B. Division of Resource Management

Timeline: **A. Short-Term**
B. Short-Term

Cost: **A. Neutral (costs to be determined)**
B. Neutral (costs to be determined)

Comments: **A. A cost assessment of overtime related to constant correctional officer coverage for mental health watches where that level of coverage is**

only required because of the lack of suicide resistant watch cells will be critical in helping to determine the most cost effective manner to move forward as an agency
B. A review will identify preferred cells for renovation, the renovations required and the total cost. At the completion of the report further discussions will be necessary to determine the efficacy of renovating the cells vs. providing overtime.

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.

Product: **DOC Policy**

Responsible Party: **Health Services Division**

Timeline: **Intermediate (pending outcome of recommendation #7)**

Cost: **Neutral**

Comments: **Mental health watches should be conducted first and foremost in the cells designated for mental health watch that have been certified using the checklist provided by Mr. Hayes as being suicide resistant. If the decision is made to create additional suicide resistant cells in designated SMU's, policy language will be added to 103 DOC 650 specifying that these cells should not routinely be used for mental heath watches for inmates designated as having a serious mental illness, as capacity dictates, or as clinically indicated.**

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.

Product: **A. Removal of the cage from the Health Services Unit at MCI-Framingham**

B. MCI-Framingham site specific policy

Responsible Party: **A. Deputy Commissioner Prisons**
Superintendent MCI-Framingham
B. Superintendent MCI-Framingham

Timeline: **A. Short-Term**
B. Short-term

Cost: **Neutral**

Comments: **The cage shall be removed and site specific policies will be developed to indicate under what security conditions inmates will be evaluated while on a mental health watch.**

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.

Product: **Audit tool**

Responsible Party: **Health Services Division**

Timeline: **Intermediate**

Cost: **Neutral**

Comments: **A first draft of a specially designated audit tool for the review of mental health watch practices has already been developed. The tool needs to be revised in relation to subsequent Hayes report recommendations, piloted, revised again if necessary and than fully implemented with regularly scheduled audits.**

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.

Product: **Report of review of suicide resistant, designated mental health watch cells**

Responsible Party: **Division of Resource Management**

Timeline: **Short-Term**

Cost: **There may be costs for the necessary renovations of these cells that will be determined in the report.**

Comments: **Division of Resource Management will commission this report.**

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.

Product: **Cost assessment for the installation of Safe Bunks in designated suicide resistant cells.**

Responsible Party: **Division of resource Management**

Timeline: **Short-Term**

Cost: **Neutral (costs to be determined)**

Comments: **The number of safe bunks required needs to be determined with a cost estimate completed. Additional funds will need to be sought.**

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.

Product: **Needs Assessment**

Responsible Party: **Division of Resource Management**
Health Services Division

Timeline: **Long-Term**

Cost: **Neutral (costs to be determined)**

Comments: **A final determination regarding the ultimate placement of the Secure Residential Treatment Unit needs to be rendered at which point an assessment into the mental health watch cell needs and physical plant renovations required at the affected institutions will be conducted. The creation of an Intensive Treatment Unit for males will be considered at this time.**

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.

Product: **Audit tool**

Responsible Party: **Health Services Division/MHM**

Timeline: **Intermediate**

Cost: **Neutral**

Comments: **A first draft of a specially designated audit tool for the review of mental health watch practices has already been developed. The tool needs to be revised in relation to subsequent Hayes report recommendations, piloted, revised again if necessary and than fully implemented with regularly scheduled audits.**

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.

Product: **Suicide risk assessment tool for assessment of inmates presenting at risk for suicide/self-harm**

Responsible Party: **MHM**

Timeline: **Short-Term**

Cost: **Neutral**

Comments: **MHM has completed a template of a Crisis Treatment Plan inclusive of all the data requested within both recommendations 14 and 15 that will serve as both a suicide risk assessment and a treatment plan for inmates requiring a mental health watch. This form has been sent to their clinical operation division for feedback and revisions. Once completed, the form will be piloted, revised as necessary and than fully implemented. Both DOC and MHM policies will be revised to reflect the required use of this form.**

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.

Product: **A. Crisis Treatment Plan for Mental Health Watch**
B. DOC/MHM Policies

Responsible Party: **MHM/Health Services Division**

Timeline: **Short-Term**

Cost: **Neutral**

Comments: **MHM has completed a template of the Crisis Treatment Plan inclusive of all the data requested within both recommendations 14 and**

15. This form has been sent to their clinical operation division for feedback and revisions. Once completed, the form will be piloted, revised as necessary and than fully implemented. Both DOC and MHM policies will be revised to reflect the required use of this form.

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.

Product: **Annual provision of Suicide Risk Assessment Training by MHM to all contractual clinical staff**

Responsible Party: **MHM**
Health Services Division

Timeline: **Intermediate**

Cost: **Neutral**

Comments: **MHM has committed to providing this training on an annual basis to all clinical mental health staff. The Health Services division will coordinate with the Division of Staff Development and MHM to set aside time and space for this training. Preliminary plans are to offer this training next in September 2011.**

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.

Product: **Memo from the Deputy Commissioner of Prisons to each facility informing them that from this point forward, Correction Officer Observation Check Sheets shall be maintained outside of the inmate's medical record and shall be maintained**

in a separate file by each facilities Deputy of Classification

Responsible Party: **Deputy of Prisons**

Timeline: **Immediate**

Cost: **Neutral**

Comments: **The Deputy of Prisons shall issue a memo.**

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.)

Product: **A. Assessment of blue bags/rescue equipment**
B. Policy revision

Responsible Party: **Deputy Commissioner of Prisons**

Timeline: **Short-Term**

Cost: **Cost to be determined by assessment**

Comments: **The Deputy Commissioner of Prison shall ensure that a review of the rescue equipment/blue bags on each unit is conducted to ensure that all the materials included within this recommendation are present. He shall also ensure that language is included within policy 103 DOC 562 requiring that all housing units contain this equipment.**

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

Product: **A. Annual record of Mock drill training**
B. Intranet based distribution of all mock drill debriefings

Responsible Party: **A. Deputy Commissioner of Prisons**
B. Deputy Commissioner of Prisons

Timeline: **A. Long-Term**
B. Intermediate

Cost: **A. Neutral**
B. Neutral

Comments: **A. Policy requires that code 99 drills and specifically responding to a hanging victim, are conducted on each shift quarterly. While all security personnel are required to attend the 562 training, it is operationally impossible to ensure that all security staff participates in a mock drill.**
B. A debriefing of all Code 99 mock drills will be provided through the intranet and all correctional officers will be required to read this as part of their post orders. In this manner, critical information and lessons learned can be universally disseminated.

Reporting

None

Follow-up/Morbidity-Mortality Review

21) It is strongly recommended that "target date for completion" and "actual completion date" to added to the Recommendation sections of future "Performance Improvement: Mortality Review/Psychological Autopsy" documents.

Product: **Mortality Review recommendation follow-up template**

Responsible Party: **Health Services Division**

Timeline: **Immediate**

Cost: **Neutral**

Comments: **These categories will be added to the Mortality Review Template.**

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.*

Product:	**A. Regional Mental Health Administrators** **B. Establishment of MHM Central Office CQI Committee**
Responsible Party:	**A. Human Resources Division** **B. MHM**
Timeline:	**A. Intermediate** **B. Immediate**
Cost:	**A. Positions already exist in the matrix so it is cost neutral** **B. Neutral**
Comments:	**A. Two Regional Mental Health Administrators have been hired and are in the process of completing their Governor's background check.** **B. MHM has already established a central office CQI committee chaired by Maria Masotta, Psy.D., and Joel Andrade, Ph.D. System wide CQI projects are established and reviewed through monthly conference calls with all the site level mental health directors.**