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January 31, 1997

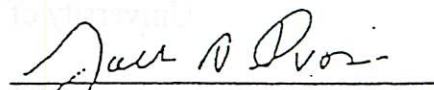
Robert C. Krekorian
Undersecretary
Commonwealth of Massachusetts
Executive Office of Public Safety
One Ashburton Place
Room 2133
Boston, MA 02108

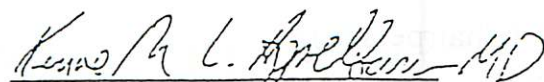
Dear Mr. Krekorian,

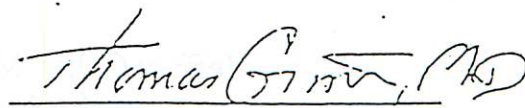
Please find our report on the psychiatric management of John Salvi.

Sincerely,


Jeffrey L. Geller, M.D., M.P.H.


Joel A. Dvoskin, Ph.D., ABPP


Kenneth Appelbaum, M.D.


Thomas Grisso, Ph.D.

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Enclosure



Report on the Psychiatric Management of John Salvi
in Massachusetts Department of Correction Facilities
1995-1996

Submitted to the Massachusetts Department
of Correction
by the
University of Massachusetts Medical Center
Department of Psychiatry
January 31, 1997

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EXECUTIVE SUMMARY

The Massachusetts Department of Correction (DOC) requested that the University of Massachusetts Medical Center Department of Psychiatry review the psychiatric management of John Salvi while he was an inmate in DOC facilities (1995-1996). During the first three weeks of January, 1997, a team of two psychiatrists and two psychologists reviewed DOC policies and procedures; staffing qualifications and schedules of mental health providers at the Massachusetts Correctional Institution-Concord (MCI-Concord) and the Massachusetts Correctional Institution-Cedar Junction (MCI-Cedar Junction); and all correctional and medical/psychiatric records of John Salvi. On January 21, 1997, the team toured those areas of MCI-Concord and MCI-Cedar Junction that had housed John Salvi, interviewed correction and mental health personnel who had had contact with John Salvi, and interviewed several of John Salvi's attorneys and relatives. Throughout this evaluation of the psychiatric management of John Salvi, the DOC was completely forthcoming in response to all requests made by the team, gave the team access to all areas and all personnel of DOC facilities that the team sought, and in every way possible facilitated this evaluation process.

The life and death of John Salvi present a number of difficult and confusing issues, not all of which we (the evaluation team) were able to successfully resolve during this review. Despite the differences of clinical opinion about Mr. Salvi's psychiatric diagnosis amongst those psychiatrists and psychologists who had evaluated him, in our opinion, Mr. Salvi suffered from some type of psychotic disorder. This psychosis, however, may not have been readily evident to many with whom he communicated.

During this review, we identified a number of ways in which the treatment and management of Mr. Salvi could have been improved. Before summarizing these, we first wish to address the question of whether these errors led to Mr. Salvi's death. The simple answer is that we will never know. It is clear that Mr. Salvi's suicide was well planned, probably for a long time. We also know that Mr. Salvi was guarded in his interactions and largely non-disclosive with clinicians. On the other hand, there were a few times when he appeared to accept the opportunity to interact with mental health professionals. Had such interaction been provided to a greater extent, this could have affected his mental status in a positive way.

Although findings in regard to Mr. Salvi's treatment and management focused primarily on his confinement in DOC facilities, our review covered the entire period from his detention in Norfolk County House of Correction until his death at MCI-Cedar Junction. Throughout Mr. Salvi's period of confinement we found instances where important clinical information was neither sought nor shared. Statements about suicidal ideation were not communicated to the people responsible for Mr. Salvi's safety at several points during his confinement.

Equally problematic is the issue of the adequacy of the psychiatric evaluation and treatment Mr. Salvi received within the DOC. From the time of his conviction until his death, Mr. Salvi was seen only once by a psychiatrist and even then primarily because this psychiatrist was "curious" about this famous new inmate. Though Mr. Salvi did receive some supportive counseling at MCI-Concord, upon his transfer to the more stressful maximum security

environment at MCI-Cedar Junction, Mr. Salvi was neither evaluated nor treated, with the exception of one contact that resulted in a brief and unsatisfactory clinical interaction.

More generally, in our opinion, the number of full-time equivalent psychiatrists within the DOC is far too low to meet the psychiatric needs of the inmate population. Prevalence data at MCI-Cedar Junction and around the country strongly suggest that many DOC inmates with mental illness are not receiving needed psychiatric treatment. We believe this is predominantly due to inadequate numbers of staff.

We were very positively impressed with the DOC policies and procedures and with the content of the suicide prevention training curriculum for correctional officers. However, we note that this training is offered for a total of only four hours, a period that is too short to cover the subject adequately. Further, all of the correctional officers we interviewed felt they did not have enough training in recognizing and managing the signs of emotional crisis, mental illness, or suicidal risks.

In large part, due to the limited level of psychiatric and mental health services available, staff of various disciplines have come to regard the threshold for mental health referral as very high. We were repeatedly told that only those inmates whose mental illnesses are obviously disruptive are likely to receive treatment. Many DOC personnel believe that the absence of an Axis I (DSM-IV) diagnosis was equivalent to a finding of no mental illness. For all of these reasons, inmates who suffer from depression, anxiety disorders, psychoses (like Mr. Salvi), and other serious psychiatric disorders--whether Axis I or Axis II--are unlikely to receive adequate treatment in prison.

The overriding impression at both MCI-Concord and MCI-Cedar Junction is that mental health services are provided with a greater sensitivity to staffing levels than to inmates' needs. Within this paradigm only "the most severely impaired" and "the most dangerous to themselves or others" can be served.

These observations have lead us to the following specific recommendations in the DOC Psychiatric Care and Treatment of John Salvi section of this report:

RECOMMENDATIONS

1. *Mental health screeners and evaluators at MCI-Concord need guidelines on the pursuit of relevant, outside mental health information (29).*
2. *Transfer of the maximally permissible mental health information from BSH to MCI-Concord should be routinized, especially regarding recommendations for care and treatment provided in BSH forensic evaluation reports (29).*
3. *Policies should be reviewed and modified regarding the communication of mental health information between mental health staff and non-mental health staff within a given DOC institution. Similarly, there should be clearly defined guidelines for non-*

mental health personnel to obtain consultation from mental health staff. Policies should be modified to open such communications to the full extent allowed by law. Each institution should establish periodic sharing of information between mental health services and other relevant offices (e.g., at MCI-Concord, between mental health services and classification officers) (29).

4. Policies should be developed and implemented that clearly identify the types of mental health information that may be communicated between clinical and correctional personnel within and between DOC facilities. These policies should maximize the types of information that may be shared to facilitate the treatment and/or safety of inmates, while recognizing the importance of confidentiality and privacy (33).
5. Guided by legal counsel, DOC should determine how much of the content of forensic evaluations at BSH can be routinely conveyed to mental health services at other DOC facilities, and should take steps to develop practices that maximize the amount of forensic evaluation information that can be shared relevant for mental health care and treatment (33).
6. DOC should consult with the Department of Mental Retardation to determine the level of need for the use of intelligence testing in the admission screening and evaluation process (34).
7. Policies and guidelines should be developed that lower the threshold for behavioral signs that will be considered sufficient to notify clinical staff concerning an inmate's need for attention by mental health services. Adherence to these guidelines should be monitored as a quality improvement indicator (34).
8. Psychiatric services to the prison system (excluding BSH) should be increased to include an absolute minimum of 9 FTE psychiatrists (36).
9. Staffing patterns for the services of psychiatrists should be modified to provide coverage, which is not currently adequate, for psychiatric services during times when psychiatrists are on holidays or on leave from their normal assignments (36).
10. Other recommendations in this report may require an increase in FTE positions for other mental health professionals as well (e.g., see the Lockdown section below on need for frequent mental health personnel visits to inmates in lockdown) (36).
11. Inmates in "lockdown" conditions, who are not currently open mental health cases, should be visited at least three times per week, if not daily, by mental health staff to provide monitoring of their mental condition and an opportunity for meaningful social contact and mental health counseling (38).
12. Mental Health Rounds at a frequency of not less than three times per week should also be put in place in the back segregation unit at MCI-Concord (38).

13. *Correctional staff should be provided more training than they now receive concerning the meanings of psychiatric diagnoses, recognizing signs of mental illness, and making decisions about referral for mental health services (39).*
14. *DOC should conduct a level of needs survey for mental health services at each of its facilities (39).*
15. *Explicit guidelines should be developed to determine when mental health practitioners should consult the psychiatrist and when mental health practitioners and psychiatrists should seek a second opinion from one of their peers or supervisors (40).*
16. *DOC should bring in an outside group to review the psychopharmacologic practices at its facilities and to review its facilities' formularies (40).*
17. *Inmates referred to MCI-Shirley for detoxification must be evaluated by the psychiatrist upon discharge from MCI-Shirley with an accompanying report to the DOC facility at which they will be imprisoned (40).*
18. *DOC should ensure compliance with the policy that only those who are licensed to prescribe medication in the Commonwealth of Massachusetts will make decisions about the discontinuation of medications at DOC facilities (41).*
19. *Inmates should be routinely questioned and assessed for the side effects of psychotropic medications no less than at the time of prescription and renewal (41).*
20. *DOC should assess the appropriateness of instituting group psychotherapies at any of its facilities where the modality is not in use (42).*
21. *DOC must have, at each of its secure facilities, a doctoral level psychologist (or equivalent) to provide clinical supervision (42).*
22. *DOC should consider the appropriateness of creating residential special needs treatment programs, e.g., mental health, dementia, head injured, within one or more of its secure institutions (42).*
23. *DOC should consider suicide to be a QI indicator, should maintain aggregate statistics on suicide, and should maintain an ongoing study of suicides in DOC facilities (43).*
24. *DOC must ensure C.O. access to trauma shears to cut down hanging inmates. This access must be regulated, safe, secure, and efficacious (43).*
25. *DOC should review the practices of its two non-discoverable mortality reviews for suicide deaths and other questionable psychiatric deaths: the peer review process at each facility and the DOC process for all facilities (43).*

Report on the Psychiatric Management of John Salvi in Massachusetts Department of Correction Facilities 1995-1996

At the request of the Massachusetts Department of Correction, the University of Massachusetts Medical Center Department of Psychiatry convened a team to evaluate the psychiatric management of John Salvi while Mr. Salvi was in the custody of the Department of Correction. The scope of work set forth for this consultation was:

- A review of the policies, procedures, guidelines, and related material that govern the practices of the Department of Correction concerning the confinement, care for, and treatment of prisoners with suspected mental disorders.
- A review of the Department of Correction's record of the confinement of John Salvi from the time of his initial entrance into any Department of Correction facility until his demise to ascertain whether the policies, procedures, guidelines, and related materials were appropriately executed in relationship to Mr. Salvi during his period of confinement.

EVALUATION TEAM

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Thomas Grisso, Ph.D., Professor of Psychiatry
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ABBREVIATIONS USED IN THIS REPORT

APA	American Psychiatric Association
BSH	Bridgewater State Hospital
CMS	Correctional Medical Services
C.O.	Correction Officer
CPS	Correctional Psychiatric Services
DOC	Massachusetts Department of Correction
DSM-IV	Diagnostic and Statistical Manual, Fourth Edition
HOC	House of Correction

LICSW	Licensed Independent Clinical Social Worker
MCI-Cedar Junction	Massachusetts Correctional Institution at Cedar Junction (aka Walpole)
MCI-Concord	Massachusetts Correctional Institution at Concord
NCCHC	National Commission on Correctional Health Care
REC	Recommendation
UMMC	University of Massachusetts Medical Center

DATA BASE

Documents Reviewed:

John Salvi

Norfolk County Intelligence and Disciplinary Reports, January 6, 1995 - March 30, 1995 and May 26, 1995 - March 18, 1996
 Bridgewater State Hospital, March 30, 1995 - May 26, 1995
 MCI-Concord, March 18, 1996 - July 23, 1996
 MCI-Cedar Junction, July 23, 1996 - November 29, 1996
 John Salvi Autopsy Report, November 29, 1996
 Statements and letters by inmates of MCI-Cedar Junction concerning John Salvi and directed to Attorney J.W. Carney, Jr.
 Letter to "Dear Sir" by a Correction Officer of MCI-Cedar Junction, December 6, 1996
 Writings of John Salvi, undated

Department of Correction

Curriculum Vitae and Work Schedule, Mental Health Staff, MCI-Concord
 Curriculum Vitae and Work Schedule, Mental Health Staff, MCI-Cedar Junction
 Names and Positions of Security Staff directly involved in confinement of John Salvi, MCI-Concord
 Names and Positions of Security Staff directly involved in confinement of John Salvi, MCI Cedar Junction
 Mental Health Audits, MCI-Cedar Junction, FY 95, 96, 97
 Department of Correction Division of Health Services and Correction Medical Services FY 1996 Contract and Correctional Medical Services subcontracts with Forensic Health Services Inc. and with Correctional Psychiatric Services, P.C.
 Correctional Medical Services Site Specific Policy and Procedure Manual for MCI Cedar Junction
 MCI-Cedar Junction Procedures for Department of Correction Policy for MCI Cedar Junction
 Correctional Medical Services Pharmacy Policies and Procedures
 Department of Correction Policies
 MCI-Concord Procedures for Department of Correction Policies
 Correctional Medical Services Site Specific Policy and Procedure Manual for MCI-Concord
 Department of Correction Training Plan for Suicide Prevention

Quality Assurance Review, December 4, 1996
 Healthcare Quality Committee Minutes (MCI-Cedar Junction), FY 96 & 97
 Monthly Minutes of Director of Mental Health and Health Services Administrator meeting (MCI-Cedar Junction), FY 96 & 97
 Job Description for Psychiatrist (MCI-Cedar Junction)
 Job Description for Masters Level Clinician (MCI-Cedar Junction)
 Twelve Month Training Schedule for Mental Health Professionals (MCI-Cedar Junction), FY 97
 Copy of training material provided to C.O.'s on symptoms of mental illness and schedule of when they received this training (MCI-Cedar Junction), FY 96 & 97
 Copy of training material given to staff to train them to make mental health referral (MCI Cedar Junction)
 Correctional Medical Services: Psychiatric Staffing vs. Inmates on Psychotropic Medication
 MCI-Cedar Junction Mental Health Statistics, January, 1996 - December, 1996
 DOC Suicide Statistics, 1992-1996
 Modification to CMS Contract for FY 97 (Closing Cases), January 1997

Other

American Psychiatric Association: Psychiatric Services in Jails and Prisons (1989)
 National Commission on Correctional Health Care. Standards for Health Services in Prisons (1992)
 DiCataldo F, Greer A, Profit WE: Screening prison inmates for mental disorder: An examination of the relationship between mental disorder and prison adjustment. Bulletin of the American Academy of Psychiatry and Law, 23:573-585, 1995
 Cohen F, Dvoskin J: Inmates with mental disorders: A guide to law and practice. Mental and Physical Disability Law Reporter 16:339-346 and 462-470, 1992
 Videotape of Philip Resnick, M.D.'s, competency evaluation of John Salvi from Court TV

Tour:

We toured MCI-Concord and MCI-Cedar Junction on January 21, 1997, between 9:00 a.m. and 10:00 p.m. We visited:

- MCI-Concord: Health Service Unit; C-Building or NewLine; Building 9
- MCI-Cedar Junction: Modular Unit; Suffolk-1

Interviews:

As part of this evaluation, we interviewed:

MCI-Concord

William Coalter, Superintendent
 Elise Daigle, Health Service Administrator
 Lori Peasley, R.N.

C.O. Bailey, C-building
 Sergeant Silverio, C-building
 Captain Sampson, Dept. 9
 C.O. Douglas Adams, Dept. 9
 C.O. Chris Pouliout, Dept. 9
 Bruce Gelb, Director of Security
 Joseph Foley, Correction Program Officer 1
 Corbitt Campbell, M.D. (Psychiatrist)
 Howard Nalt, LICSW
 Jeffrey Vander Yacht, M.A.
 John Kehoe, LICSW
 Bernard Menendez, M.Ed., Director of Mental Health

MCI-Cedar Junction

Mark Powers, Deputy Superintendent
 Deacon John Manion
 Jeanne Kinsella, N.P.
 Sergeant Doug Adams
 C.O. Steve Perry
 C.O. Kevin O'Hearn
 Kevin Keiley, LICSW
 Richard Vinacco, Psy.D.
 Michele Santello, Correction Program Officer
 Maureen-McInnis, R.N.
 Robert D. McGuinness, Lt., Special Investigator to Superintendent

Bridgewater State Hospital

Frank DiCataldo, Ph.D.
 Joel Haycock, Ph.D.
 Rex Birkmire, M.D. (Psychiatrist)

Other

Jorge Veliz, M.D., Director of Correctional Psychiatric Services
 Terre Marshall, Vice President, Correctional Medical Services
 J.W. Carney, Jr., Attorney
 Charles W. Rankin, Attorney
 Anne-Marie Salvi, Mother
 Gerard Trudel, Maternal Uncle
 Prudence Baxter, M.D. (Psychiatrist)

REVIEW OF MENTAL HEALTH POLICIES AND PROCEDURES OF THE MASSACHUSETTS DEPARTMENT OF CORRECTION

We first provide an overview of the background documents we consulted in the review of the DOC policies and procedures—the American Psychiatric Association’s Psychiatric Services in Jails and Prisons and the National Commission on Correctional Health Care Standards. We then apply these and our observations to the specific policies and procedures of DOC.

Review of Background Documents

Summary of American Psychiatric Association (APA) Report and Guidelines. Unlike the National Commission on Correctional Health Care (NCCHC) Standards, the APA report and guidelines do not create a set of essential requirements that lend themselves to specific accreditation or audit. On the other hand, many believe them the clearest and best map currently available to a correctional system that wishes to provide an adequate system of mental health services.

The APA guidelines are philosophically centered around the concept of access to mental health services. They recognize the need for cost efficiency, and that inmates should receive all of the mental health care they require, but only the care they require. Especially relevant to the case of Mr. Salvi, the guidelines also recognize the need to respect competent refusals of mental health service.

Briefly, the APA guidelines include the following:

- Adequate staffing levels and access for all inmates to needed mental health evaluation and treatment
- Quality assurance and improvement plans and activities
- Accreditation
- Specialty education and training for providers
- Psychiatric input into facility training
- Liaison with academia
- Informed consent and treatment refusal policies
- Confidentiality
- Written policies
- Access to treatment, including receiving intake screening, referral, and mental health evaluations
- Crisis services to include training of correctional staff; 24-hour consultation by psychiatrists; 24-hour physician coverage; special housing; and safe, private areas for evaluation and treatment
- Treatment services to include acute, transitional, and outpatient care; chronic care; suicide prevention services; and transfer to inpatient hospital level of care when needed
- Treatment modalities to include milieu, psychotherapy, psychotropic medication, and seclusion/restraint when necessary under strictly observed protective guidelines
- Individual treatment plans
- 24-hour nursing coverage

- Appropriate transfer and discharge planning practices
- Administration by qualified mental health professionals, including psychiatric leadership, security training for clinicians, and clinical input into correctional decisions and practices

Summary of Relevant National Commission on Correctional Health Care (NCCHC)

Standards. As noted above, the NCCHC standards were specifically written for the purpose of allowing surveyors to assess and accredit systems and facilities. Thus, they are at once more specific, more basic, and less demanding than the APA guidelines. Further, NCCHC attends to mental health services only as a part of the overall facility medical and health services system. This is both a strength (i.e., it is important that mental health services be coordinated and cooperative with other medical services) and a weakness (i.e., there is far less attention to mental health issues than in the APA guidelines).

If one looks carefully at the NCCHC standards, few are totally irrelevant to mental health services. However, in the interest of focusing the scope of this inquiry, only those standards that deal more directly and specifically with mental health, or those that seem specifically relevant to Mr. Salvi's death, will be considered in this report. Those standards are:

- Manual of written policies and procedures, to include a policy for each NCCHC standard (P-04)
- Comprehensive quality improvement program (P-03)
- Privacy and confidentiality (P-06 and P-10)
- Communication concerning special needs patients (P-07)
- Family notification of emergencies (P-08)
- Mortality review (P-09)
- Grievance/complaint procedure (P-13)
- Credentials and job descriptions (P-18 and P-19)
- Adequate staffing levels (P-20)¹
- Orientation training and continuing education for health providers (P-21 and P-22)
- Training for correctional officers in identifying and referring problems (P-23)
- Prohibition of inmates providing health care services (P-25)
- Ability to transfer to inpatient hospital care when needed (P-29)
- Appropriate prescription of medications, including up to date formulary of medications and ability to order non-legend medications (P-30)
- Receiving screening to include mental health and suicide risk issues (P-31)
- Informing inmates on how to access and self-refer to mental health services (P-32)
- Health assessment (includes review of screening mental health related information) within 7 days (P-34)
- Mental health evaluation for all inmates within 14 days (P-35)
- Daily review of self-referrals and 5 day/week sick call (P-37 and P-38)
- Prohibition of standing orders (P-40)

¹ Despite its innocuous appearance as one among many standards, this single standard, requiring adequate staffing levels, is probably more important than all of the other standards combined in regard to mental health and suicide prevention services. It is, of course, not addressable merely by written staff plans, policy, and procedure.

- 24-hour emergency services (P-42)
- Daily health (including depression) evaluation of inmates in disciplinary segregation, and mental health evaluation within 24 hours for mental health service recipients placed in disciplinary segregation (P-43)
- Health evaluation 3 times per week for inmates in administrative segregation or protective custody (P-44)
- Counseling in preparation for release (P-45)
- Written policy and procedure, including an individual treatment plan, for all special needs (including special mental health needs) inmates (P-50)
- Infirmary includes physician on call 24 hours per day, supervision (daily) by registered nurse, and all inmates within sight or sound of health care staff (P-53)
- Suicide prevention plan and program includes identification, training for all inmate-contact staff, assessment by mental health professionals, monitoring of inmates identified as suicide risks, special housing, referral, communication, intervention when suicide attempt is in progress, notification of various actors, reporting and documentation, and mortality review (P-54)²
- Health care response to sexual assault (P-55)
- Health record (P-59)
- Confidentiality of health records and information (P-60 and P-61)
- Informed consent procedures (P-64)
- Right to refuse treatment (P-65)
- Careful and appropriate limitations on use of seclusion, restraint, or forced use of medication (P-66 and P-67)

Review of Specific DOC Mental Health Policies:

Overall, the entire package of DOC policies and procedures was extremely impressive. The policies and procedures have obviously been carefully drafted to meet each NCCHC standard. In many cases the policies and procedures significantly exceed any standard or legal requirement of which we are aware. For these, DOC deserves praise.

Unfortunately, this review necessarily focuses on areas in which we believe change would be beneficial. Thus, it undoubtedly presents a more negative picture than is deserved. Therefore, we reiterate what we said at the outset: DOC has generated an excellent set of policies and procedures.

We also understand that policies and procedures alone do not create adequate mental health care or suicide prevention. They must be carried out in a competent and professional manner, by an adequate number of well-trained and appropriately educated staff. This review of written policies does not, therefore, assess their implementation. That occurs in the later sections of this report.

² Suicide prevention guidelines are further explained in NCCHC Guidelines Appendix M.

Please note that in reviewing these policies and procedures, special attention was paid to issues that may have been specifically relevant to the death of John Salvi by suicide. Nevertheless, since the DOC, in requesting this review, was also interested in recommendations regarding prevention of future suicides and the overall provision of mental health care in Massachusetts prisons, the following assessment includes a broad array of suggestions and recommendations regarding policies and procedures. Those listed in boldfaced type should be regarded as essential or mandatory.

In specific regard to Bridgewater State Hospital (BSH), it is inappropriate to apply only NCCHC standards to this institution which purports to be an inpatient psychiatric hospital. For such settings, the customary standard for accreditation is the Joint Commission on Healthcare Organizations (JCAHO), and we strongly recommend that consideration be given to seeking JCAHO accreditation for BSH as soon as possible. For this reason, we limited our review of BSH policies and procedures to a cursory one, though DOC clearly has attempted to structure them to meet NCCHC standards.

In regards to MCI-Concord and MCI-Cedar Junction, we have cited specific DOC policies and procedures and specific MCI-Concord policies and procedures. MCI-Cedar Junction policies and procedures are not distinctly different from these. Recommendations should be applied to both institutions, and, in fact, to all DOC prisons.

- MDOC 3.06 Pharmacy and Therapeutics Committee - This policy does not discuss how to order non-formulary medications, or discuss criteria for addition or deletion of medications to the formulary.
- MDOC 5.00 through 5.02 - The policy on Comprehensive Quality Improvement (CQI) is too vague, and the mortality review policy does not spell out documentation and systematic follow-up of recommendations. Policy should cross reference 103 DOC 620, Death Procedures, which does spell out documentation requirements.
- MCI-C 12.00 - This policy on Emergency Medical Plan is impressive. Because the policy is extremely long and detailed, it would likely suffer from poor implementation in an actual emergency. To rectify this situation, DOC has thoughtfully and foresightedly included a simple and easy to use checklist of each actor's responsibilities, and included an annual drill. Our only recommendation is that the most likely first responder to an emergency is a correctional officer; thus we suggest adding a checklist of C.O. duties in the event of a medical emergency (e.g., who to call, in what order, whether to enter a cell without backup, etc.)
- MDOC 14.031 Infection Control Program - Add to the HIV/AIDS treatment policy a routine periodic review of mental status, due to the likelihood of reactive depression or dementia.
- MDOC 20.00 Staffing Levels - Staffing is more important than all of the policies and procedures put together. This staffing policy, though adequate, does not in any way

ensure that staffing itself is adequate. This will be assessed subsequently in our report.

- MDOC 22.00 Continuing Education for Qualified Health Service Personnel - The policy of 40 hours of inservice training annually is excellent, but it must be followed and should be considered the minimum acceptable training.
- MDOC 31.00 Receiving Screening - While we applaud the receiving screening process, we have two suggestions: First add several additional questions regarding mental health history, including any history of needing or receiving mental health services, especially during prior incarcerations; and second, add more explicit directions regarding how many “yes” responses require a referral. If any such response gets referred, one would simply add that instruction to the policy.
- MCI-C 35.00 Mental Health Evaluation - Which form is used for this “within 14 day” mental health assessment? There are two very different forms following this policy, with the same title (Mental Health Evaluation) and no form number to differentiate them. One is a one-page form and the other is a four-page form. This should be clarified. Further, the one-page form is clearly too brief for adequate documentation of a mental illness or psychiatric crisis. Do they use the short form for a finding of “no mental illness” and the longer form when there is something to document? This should be reviewed and perhaps clarified. More importantly, however, we should like to point out that very few correctional institutions conduct and document mental health evaluations of every newly admitted inmate, especially not within fourteen days of arrival. This, despite the fact that NCCHC deems it an “essential” standard. If indeed this policy were to be carried out by DOC as written, then DOC would have achieved a commendable level of mental health assessment.
- MCI-C 35.01 Comprehensive Mental Health Assessment and Treatment Plans - We certainly applaud the requirement that every member of the active caseload receive a treatment plan (though the policy would profit from a definition of active caseload membership). We also agree this requirement should not kick in for brief, one-shot crisis visits, to avoid drowning the staff in paperwork. However, we do not believe that an annual review of treatment plans in long-term cases is acceptable, and would recommend that it be changed to every three months for the first year (for new cases) and every six months thereafter.
- MDOC 35.02 Inmate Refusal of a Mental Health Evaluation - This policy is squarely relevant to the case of Mr. Salvi, who refused, at least at times, to cooperate with mental health evaluations. This policy strikes an excellent balance between protection and respect for the person’s autonomy. It requires refusal to be responded to first as a clinical matter, and only legally as a last resort. It also encourages the seeking of other sources of information that might assist the clinician in reaching a conclusion as to the inmate’s dangerousness, mental health need, and competence. In addition, however, the policy

should require repeated, respectful attempts to gain inmate's consent for evaluation and/or treatment.

- MCI-C/NCC 41.00 Continuity of Care - This policy again represents a level of service to which most correctional systems only aspire to. If it is followed as written, we would again applaud DOC for its adherence to this policy.
 - MCI-C 43.01 Mental Health Evaluation of Inmates in Segregation - This policy, regarding mental health "rounds" on segregation, meets NCCHC standards. However, in order to catch emerging problems more quickly and to prevent some emotional crises in segregation, we recommend that these rounds be made on each business day, or at least three times per week.
 - MDOC 47.00 Exercise - Depending upon the inmate's mental status and location (e.g., residential mental health treatment setting), inmates (especially those with mental illness) may well require more than three hours per week of exercise.
 - MDOC 50.02 Special Needs Treatment Plans - This policy, like the one on staffing, has a brevity that belies its profound importance. It requires that all clinically indicated mental health services are available to inmates with serious mental illness, and in a very real sense implicates the entire mental health treatment program and staffing. For this reason, its adequacy can only be assessed by its implementation—see discussion in next section of this report.
 - MDOC 54.00 Suicide Prevention - This policy is of course especially relevant to Mr. Salvi's death by reported suicide. Significant here is the need to clarify the duty of a correctional officer in the event of a hanging. Some facilities have had different rules under different supervisors on the issue of whether or not an officer, without backup, should enter a cell to cut down an inmate who appears to be hanging. The logic in prohibiting officers from entering cells without back-up is that inmates might use an apparent hanging as a ruse to overpower an officer who is trying to help. This is a very difficult issue, and one which exposes a possible conflict between the safety of officers and that of the suicidal inmate. DOC can decide this either way, but there must be one consistent, unambiguous, and well-known rule for staff to follow.
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- MDOC 54.01 Suicide Prevention - Page 3, Section 4-a, is somewhat ambiguous. Thus, we may have misunderstood its intent, and if so it simply needs clarification. If we read it correctly, however, we strongly suggest that it be changed. In contradistinction to the policy as written, inmates who are suicidal should not be automatically segregated into a stripped cell. In fact, to do so may well exacerbate the depression that led to the suicidal feelings in the first place. It is important to note that all suicidal individuals have some degree of ambivalence about their wish to die, and it is of the utmost importance that inmates feel free to inform staff of their depressed and suicidal feelings and intentions if interventions are to be successfully made. If the response to real suicidal ideation is

perceived by inmates as punitive, then inmates will become far less likely to tell staff when they are sincerely fearful of killing themselves. Above all, decisions should be clinically made on a case-by-case basis with as many options as possible available to the clinical team.

- MDOC 54.01 Suicide Prevention - In regard to suicide watches, we are pleased to see that the frequency of such watches is to be determined by clinicians. However, the form only lists constant, 15-minute, and 30-minute watches as available choices. Because constant watches are so staff intensive and therefore expensive, clinical staff will be implicitly or explicitly discouraged from their use. And 15-minute watches are too far apart for inmates who are actively suicidal. The emerging presumptive standard for suicide watches is becoming five, instead of fifteen minutes.³ And clinicians need to be allowed to use their clinical judgment in deciding which watch is appropriate for each inmate and circumstance.
- MDOC 54.02 Mental Health Watch - Similarly, mental health watches need to include more choices for clinicians, and will need to vary depending on the correctional and/or treatment setting.
- MDOC 60.00 Confidentiality and Storage of Health Records - While we strongly support the concept of confidential medical records, it should be made clear that correctional officers may appropriately be considered part of the treatment team for certain inmates in certain situations. Officers who are not aware of the treatment goals may inadvertently interfere with their accomplishment. Also, the observations of officers in such settings are often the most important and accurate information available to the rest of the treatment team. In short, such officers may be analogous to psychiatric technicians in inpatient units. These appear to be quite relevant in Mr. Salvi's case. Similarly, and also quite relevant to Mr. Salvi's case, other care providers such as chaplains should be explicitly included as members of the mental health treatment team (at the discretion of the treatment team leader) whenever they have regular contact with an inmate.
- MDOC 60.02 Confidentiality of Medical Records - Similarly, the superintendent ought not to have to ask for information that relates to the essential functions and safety of the prison, especially security-related information such as planned escapes, etc. Such information should be immediately given to the superintendent or other appropriate officials (e.g., watch commander). We are quite sure this is the practice at DOC, but the policy ought to reflect it. Further, it is always honest and wise to tell inmates upon arrival that there are various exceptions to the confidentiality of their medical and mental health records and information.

³ There are cost effective ways to achieve this level of supervision of suicidal inmates. For example, if more than one inmate requires a segregated suicide watch, as long as all such inmates are housed contiguously, one officer can provide a very effective watch on an every-minute basis. Or, if several inmates are dangerous only to themselves, one officer can prove each and all of them with constant observation in a dormitory setting.

- MDOC 60.03 Duty to Warn and Protect - In general, we very much liked this policy. However, we would suggest revision of procedure A(5), which requires the clinician to notify the identified victim if it is believed that there is a clear and present danger. Most states have shied away from mandatory actions in favor of policies (and even statutes) that permit clinicians to violate confidentiality and use their best judgment about how best to protect. For example, there are cases where a warning might increase the danger by encouraging the intended victim to "strike first." It is best to use consultation and good judgment, along with complete documentation, before deciding which actions to take. Obviously, this policy must be compatible with Massachusetts statutes and court decisions. It should be reviewed with these in mind.
- MCI-C/NCC 61.01 Parameters of Confidentiality - We strongly disagree with the language contained in the introductory paragraph and Item #1 under "procedure." This list of exceptions to confidentiality is not exhaustive. For example, if a judge subpoenas the record absent any of the above circumstances, it will be divulged. It is impossible to list prospectively all of the potential exceptions to confidentiality, and it is important to avoid making over broad promises that may not be kept. For this reason, we recommend that inmates be promised discretion rather than confidentiality, and told that there are several circumstances under which information may be shared, "including but not necessarily limited to" the list contained in this section.
- MDOC 64.00 Informed Consent - This policy does not explain the procedure to be followed when an inmate (e.g., a psychotic or retarded inmate) is not able to understand the medical procedure being proposed, or is otherwise unable to give informed consent. (If this is covered elsewhere, this policy simply needs a reference to that other policy). This issue is not solved by the health care proxy policy, because that action would also require the inmate to be competent at the time of execution of the proxy.
- MDOC 65.00 Right to Refuse Treatment - As noted above, this policy is strongly relevant to the case of Mr. Salvi, who was disinclined to receive mental health services. This policy appears to balance the protective and autonomy concerns which are often in conflict. In each case, however, it is important to assess three issues: 1) Is the inmate competent to refuse treatment, or should he have been referred for a court ordered or court oversighted treatment? 2) Is there any reason to believe that a mentally ill inmate presents enough potential danger to self or others that would justify some action to overcome the inmate's treatment and evaluation refusal? and 3) Is this an emergency such that treatment can and should be provided absent informed consent?
- MDOC 65.02 Court Ordered Medical Treatment - This policy, like the one reviewed immediately above, is directly relevant to Mr. Salvi. The problem with this policy is that it makes no provision for an incompetent person who does not have a life-threatening medical condition. In most states, for example, a person who will lose a leg if he does not receive treatment and who refuses treatment for it in a state of florid psychosis, will likely

be found incompetent and a treatment guardian appointed. Since this is true in Massachusetts, a similar policy for inmates is necessary.

- MDOC 66.00 Therapeutic Seclusion - As noted above, this policy is quite worrisome. If, in practice, the most common watch ordered is constant observation, then we have no problem. But we suspect otherwise. Especially in circumstances where more than one inmate is deemed to be suicidal, it becomes extremely costly to put each inmate on a constant observation watch. Our concern is that clinicians may be implicitly or explicitly discouraged from ordering such watches due to their expense or inconvenience to custody staff. In that event, the next most frequent watch listed would be every 15 minutes, which is not frequent enough. We suggest adding other options, such as every minute (which allows one officer to very closely watch multiple contiguous cells), every five minutes, and every ten minutes. This will allow clinicians to safely and cost-effectively utilize their clinical judgment.
- DOC 650 Mental Health Services - We found this very brief policy confusing; it is the only policy in the DOC policies set mentioning mental health services. In light of the extremely clear, detailed and lengthy health care policies we reviewed, we were at a loss to understand why custody staff would have such an incomplete and brief policy. For example, this policy does not mention training correctional staff in how to recognize the signs of impending psychiatric crisis, yet such training is clearly spelled out in DOC 23.00. We suspect this policy may be a holdover from bygone days, perhaps before these services were contracted out. In any event, we suggest the brief policy be replaced by the more complete CMS policies wherever applicable.
- New Policy - We understand the following has been recently added (January, 1997) to the Correctional Medical Services contract for FY 97:

"Eligibility for Mental Health Services:

1. All inmates are eligible for mental health services under this agreement based upon demonstrated clinical need. It is the purpose of the mental health program to provide, through a range of services as described within this agreement, support and treatment for those inmates suffering from major mental illness as well as other mental health or mental retardation needs, based upon priority of need and availability of resources. For the purpose of service priority, provision of care must start with the most severely impaired inmates, the most dangerous to themselves or others, and those who evidence an inability to function independently within the correctional environment. In all of these instances, the existence of a mental disorder as classified in the APA Diagnostic and Statistical Manual is required for service eligibility, however, it is the degree of dysfunction, ability to adapt and potential for responsiveness to and cooperation with treatment which serves as the primary criteria for eligibility. Treatment decisions can and should be based upon diagnosis, however, with the priority of service to those inmates with the highest level of need being those who pose an imminent risk to themselves or others and/or inability to care for self.

2. No mental health case will be closed without documentation of a clinical consultation with a supervisor or senior clinical consultant.
3. The Division of Health Services will be provided with a report which lists all mental health cases that are closed during the preceding month. This information shall accompany the other required reports."

We strongly endorse the policy that the closing of cases requires clinical consultation. This consultation must be with an individual adequately trained and credentialed to supply such consultation. This policy should be formalized in DOC and institution specific policies and procedures.

We have great reservations about the language specifying which inmates are eligible for mental health services. Mental health services need to be available to all inmates with serious mental illnesses (e.g., psychosis, significant mood or anxiety disorders, mental retardation, or dementia). Assigning priority to inmates who "pose an imminent risk to themselves or others and/or inability to care for self" must not result in neglecting the needs of other seriously ill, but not imminently at risk, inmates. In conjunction with this policy, education must occur around identifying not only the most severely impaired and dangerous inmates but all inmates who have severe emotional, intellectual, and/or behavioral problems such as hallucinations, suicidal and/or homicidal thinking, severe thought disorganization, or bizarre behavior.

Further, we are concerned that language stating that priority is to be given to inmates with greater *potential for responsiveness and cooperation* may mean that those most in need but most reluctant to engage in treatment will not receive treatment. The ascertainment of need must be the priority; recalcitrance to engage in treatment must be viewed as a clinical issue, not a policy-based reason to refrain from delivering treatment.

PORTRAIT OF JOHN SALVI

Mr. Salvi's History Prior to Arrest and Incarceration:

John Salvi was born in Salem, Massachusetts on March 2, 1972, the only child of John and Anne Marie Salvi. The family lived in Ipswich, Massachusetts until 1982 when they moved to Naples, Florida. Mr. Salvi's childhood development, medical history, and social history were unremarkable. He and his family belonged to the Catholic Church and attended services during his childhood.

After graduating from Naples High School in 1990, Mr. Salvi attended Edison College in Naples, Florida for one year, without graduating. He had jobs as a carpenter, construction worker, and hairstylist, eventually enrolling in a cosmetology school in New Hampshire. He never married, did not serve in the military, and had no criminal history before the incident that led to this incarceration.

Mr. Salvi had no history of mental health evaluation or treatment prior to his arrest. Although he described himself as a "social drinker," he reportedly did not abuse alcohol or other substances.

At least since the summer of 1994, Mr. Salvi began contacting "pro-life" groups regarding his interest in working to stop abortion. Around that time, he allegedly began to plan the murders for which he was convicted. On October 11, 1994, he bought a .22 caliber Ruger rifle, later modified into an "assaultive type of weapon" with a collapsible stock, expanded capacity ammunition magazines and hollow point bullets. On December 29, 1994, witnesses observed him practicing rapid firing, including at "point blank range," at a firing range in Salisbury, Massachusetts.

On December 30, 1994, at about 10:00 a.m., Mr. Salvi entered the Planned Parenthood Clinic in Brookline, Massachusetts carrying his rifle inside a duffel bag. Taking his rifle out of the bag, he pointed it through the reception window and shot to death the receptionist, Shannon Lowney. Before leaving the Planned Parenthood Clinic, he shot "at least" three other people "multiple" times. He then went to Preterm Clinic, on Beacon Street in Brookline, where he shot one employee twice and killed the receptionist, Leanne Nichols, by shooting her "a minimum of nine times." He also shot a security guard "multiple times" in the hands and arm when the guard exchanged fire with him. Mr. Salvi then fled from the Preterm Clinic, firing at bystanders as he left.

On the morning of December 31, 1994, Mr. Salvi showed up at the Hillcrest Clinic, another women's clinic, in Norfolk, Virginia. Using the same rifle, he sprayed the lobby of the clinic with .22 caliber rounds. Police officers arrested him as he drove away from the scene. Sometime after his arrest, Mr. Salvi was returned to Massachusetts for trial on charges including first degree murder.

Mr. Salvi's Functioning, Management, and Mental Health Treatment After Arrest and Incarceration:

Initial confinement at Norfolk County Correctional Center. After his return from Virginia to Massachusetts, Mr. Salvi was held at the Norfolk County Correctional Center. Initially, Mr. Salvi appears to have been held in the medical unit. On January 24, 1995, correctional officials received a "Classification Appeal Form" on which Mr. Salvi wrote, "I seek companionship with other inmates. In medical I am all alone, conditions are adequate however I am unhappy here."

On January 25, 1995, when approached by a correctional officer with his evening meal, Mr. Salvi "leaped from his bed and rushed toward" the correctional officer knocking the food to the floor. Mr. Salvi told the correctional officer, "I didn't feel like getting out of bed." He refused to clean up the food, and became "unresponsive" to further questioning.

A February 1, 1995, "Intelligence Report" of "inappropriate behavior" gives the following description of Mr. Salvi who was observed leaning against the wall in his cell at about 7:45 p.m.: "[Mr.] Salvi had an elastic band firmly placed around the head of his penis. Attached to that

elastic was a chain of elastics with a plastic food container hanging at the end of it. Inside of the plastic container there was a wet rag." When questioned about his behavior, Mr. Salvi explained that "he was performing an experiment that he had read about in a book."

Confinement at Bridgewater State Hospital. Norfolk Superior Court committed Mr. Salvi to Bridgewater State Hospital (BSH) for twenty days on March 30, 1995, for evaluation of competence to stand trial under the provisions of Massachusetts General Laws Chapter 123, Section 15(b). Joel Haycock, Ph.D., Director of Forensic Services at BSH, conducted the evaluation, and requested and received a twenty-day extension of the evaluation until May 8, 1995. The Court continued the case to May 26, 1995, and Mr. Salvi remained at BSH until that date.

During his stay at BSH, Mr. Salvi got involved in at least five fights with other inmates and threw a cup of juice at a unit sergeant on one occasion. He refused many meals because "the food's not good enough," but he did eat food that he purchased in the canteen. Although the record describes him as "guarded" and having "blunted" affect, Mr. Salvi repeatedly denied feeling depressed or suicidal with the exception of statements made to Dr. Haycock noted below. His "problem list" indicates "mild paranoia," and his attending psychiatrist, Rex Birkmire, M.D., wrote that he "seemed to stare through this interviewer at times." On April 27, 1995, Dr. Birkmire records Mr. Salvi as saying that he wears glasses for his "protection." The meaning of this statement is not explored. Dr. Birkmire described Mr. Salvi as "eccentric" and socially isolative, but not hallucinating, delusional or disorganized in his thinking. Mr. Salvi did not receive psychotropic medications at BSH. On May 11, 1995, however, he asked a medication nurse for some "ups." The record does not elaborate on this incident other than assessing it as an "inappropriate request." The BSH record does not include a discharge summary or a discharge diagnosis by Dr. Birkmire, but Dr. Birkmire believes Mr. Salvi had a Schizotypal Personality Disorder.

Dr. Haycock conducted seven interviews with Mr. Salvi for a total of eleven hours. He wrote a forty-three page competence to stand trial report and a twelve page updated competence to stand trial report. Dr. Haycock described Mr. Salvi as "vigilant" with a "flattened" affect and no sense of humor. He walked with "a stiff and rigid posture that lacked flexibility and fluidity," and he "often maintained a fixed and vacant stare and he held his head in a stationary position with minimal movement." He "volunteered little information," spoke in a "monotone," answered questions only after "long" pauses, and his "associational process was loose and sometimes difficult to follow." He also had "an obsessional preoccupation with his meals, their nutritional content and balance." He would not answer questions about whether he heard voices, but he did not act like he was hallucinating. Dr. Haycock reported "no obvious signs of frank psychosis" noted by any of the clinicians at BSH. He diagnosed Mr. Salvi as having a Schizotypal Personality Disorder based on "his sometimes vague, circumstantial, overelaborate, and stereotyped speech; his odd thinking; his suspiciousness and paranoid ideation; his inappropriate and constricted affective; his sometimes peculiar or eccentric behavior; his apparent lack of close friends or confidants other than relatives."

During an interview with Dr. Haycock, Mr. Salvi discussed his wish for the death penalty if convicted. He described the death penalty as "the sanest solution to an insane environment," explaining that he would prefer death to "prison life." He stated, "I've given it some thought." Dr. Haycock describes this discussion on Page 22 of his forty-three page report, but does not directly address issues of potential suicidality in the "Need for Care and Treatment" or "Discussion" sections at the end of the report or in his "Updated" report.

Staff at BSH, including Dr. Haycock, did not have records from Norfolk County Correctional Center during their evaluation of Mr. Salvi. For example, Dr. Haycock did not know about the incident of bizarre behavior on February 1st.

Frank DiCataldo, Ph.D., the psychologist who did psychological testing on Mr. Salvi at BSH, confirmed the absence of records from the Norfolk County Correctional Center during Mr. Salvi's evaluation at BSH. Dr. DiCataldo believes that Mr. Salvi's involvement in fights was not atypical for patients at BSH. Dr. DiCataldo felt surprised when he learned about Mr. Salvi's suicide. Mental health staff at MCI-Concord and MCI-Cedar Junction never contacted Dr. DiCataldo about Mr. Salvi's BSH evaluation.

During our interview with Dr. Haycock, we asked if he felt surprised when he heard that Mr. Salvi had committed suicide. He responded, "Among the persons I evaluated, I was probably the least surprised. The timing of it remains a mystery to me." Dr. Haycock explained that in his opinion at least four issues bore upon the "time line" within which Mr. Salvi might attempt to take his own life. These included the progress of his appeal; the waning of outside interest in his ideas; the possible loss of outside support for him, especially if he began to be seen as "a psychiatric case"; and the risk of continuing problems getting along with other inmates.

Subsequent confinement at Norfolk County Correctional Center after completion of BSH commitment. Mr. Salvi had behavioral problems and at least three fights with other inmates after his return to the Norfolk County Correctional Center from BSH. According to a July 7, 1995, "Intelligence Report" by Capt. Alfred B. Wood, Jr., for about a week before the first fight Mr. Salvi "frequently" had been "banging on the wall between the cells and yelling in the vent." On the day of the fight, he kicked a basketball at another inmate in the yard and then kicked the other inmate three times, grabbed the other inmate around the neck from behind, and pulled the other inmate to the ground and punched him. The report states that Mr. Salvi "kept yelling racial statements and used the word Nigger several times, which was creating a major disturbance." The report continues, "Salvi disobeyed 8 direct orders to go into the dayroom and two additional orders to quiet down....had to be physically moved to his cell where he continued racial slurs."

On July 21, 1995, Mr. Salvi reportedly stabbed another inmate with a pencil." On August 10, 1995, he was observed "throwing punches" at a cell mate. He refused a correctional officer's order to stop, and he "struggle[d]" with the officer.

On March 6, 1996, correctional officers "found pieces of a broken clock next to [Salvi's] bunk....[and] a razor under an envelope box next to Salvi's bunk."

Records from the Norfolk County Correctional Center do not document the alleged incidents described below in which Mr. Salvi was found with a noose around his neck.

Confinement at MCI-Concord. On entry to MCI-Concord a few hours after his sentencing on March 18, 1996, Mr. Salvi was placed on D-9, the prison segregation unit. He remained in segregation through most of his stay at MCI-Concord. The primary stated reason for this appears to have been the high-profile nature of his case.

On the day of his arrival at MCI-Concord, Mr. Salvi was seen for a "partial evaluation" in a holding cell by Howard Nalt, LICSW, and for a mental health screening in D-9 by Jeffrey J. Vander Yacht, M.A. Mr. Nalt did not do a mental status examination, but he did note that Mr. Salvi "had no intention of harming himself." On interview with us, he described Mr. Salvi as "very isolative" and someone who "didn't quite fit in." He does not feel surprised by the suicide because he "thought at some point depression might set in." Mr. Vander Yacht did not have any outside records available at the time of the screening and had no information regarding prior suicidal statements or behavior. He noted that Mr. Salvi "denied current auditory/visual hallucinations, but was vague about whether he had experienced such symptoms in the past." Mr. Salvi also "commented that he is 'very concerned about certain social issues,'" but he would not elaborate on the meaning of this statement. Although Mr. Vander Yacht saw Mr. Salvi as "anxious....guarded....[and] evasive....," he did not describe symptoms of psychosis, mood disorder, or suicidal thinking. Mr. Salvi "inquired how to contact M[ental] H[ealth] services if needed," and Mr. Vander Yacht recommended "daily check-in by crisis clinician to monitor adjustment, and to obtain diagnostic clarification, if possible."

A follow-up contact with Joanne Rodman, LICSW, at 10:00 a.m. on March 19, 1996, found Mr. Salvi "lying in bed with blanket up to neck," but with "no mood or thought disorder apparent at this time." Later that afternoon, Bernard Menendez, M.Ed., had his initial clinical contact with Mr. Salvi and wrote, "There was significant latency to his responses and he had some difficulty understanding simple concepts, frequently asking the same question twice." Mr. Menendez also wrote an earlier note on March 19th after speaking with Dr. Haycock who conveyed the diagnosis of "Schizotypal Personality Disorder, an Axis II disorder....[and] pointed out that the course of Mr. Salvi's disorder has been very stable and he has presented with no significant changes since the time of his arrest in January of 1995." The note goes on to say that the staff at BSH had considered and rejected the possibility of mental retardation. Mr. Menendez does not recall any mention of suicide potential during his conversation with Dr. Haycock, but Dr. Haycock believes that they "briefly touched on" this issue.

Mr. Salvi's only contact with a psychiatrist after his sentencing occurred on March 21, 1996, when Corbitt Campbell, M.D., saw him. Even this contact would not have happened except for Dr. Campbell's feeling "curious" about Mr. Salvi's notoriety. Mental health staff involved with Mr. Salvi had not requested a consultation from Dr. Campbell. Dr. Campbell found no active symptoms and no need for medications.

On March 25, 1996, John Kehoe, LICSW, met with Mr. Salvi at the request of correctional officers. Mr. Salvi was upset about the failure to transfer some of his funds from

Norfolk County Correctional Center to MCI-Concord. Other than a "blunted affect" Mr. Kehoe saw no psychopathology, and Mr. Salvi "denied" suicidal thoughts.

J. W. Carney, Jr., Mr. Salvi's attorney, sent a letter dated March 25, 1996, to Edward Foley, Deputy Superintendent at MCI-Concord. In this letter, Mr. Carney expresses the following concerns about his client's mental state:

"John had a number of problems at the Dedham Jail that required frequent intervention by the mental health staff, including instances of his being found with a noose around his neck in December and using industrial cleaners to wash himself. In addition, his significant mental illness (schizophrenia) led to him be [sic] indiscriminate in making inappropriate comments to other inmates, often unintentionally provoking them. I urge you to consider an 18(a) evaluation in order to obtain a thorough assessment of John's suitability for a prison environment before a serious incident occurs."

Mr. Carney asked Mr. Foley to have Bernard Menendez, M.Ed., mental health service director, contact Drs. David Bear and Prudence Baxter, two psychiatrists who had frequent contact with Mr. Salvi during the previous three months.

Although informed of Mr. Carney's recommendations, Mr. Menendez and other mental health staff did not contact Drs. Bear or Baxter. They also did not contact staff at the Norfolk County Correctional Center. Mr. Menendez informed us that he thought about asking Mr. Salvi to sign a release allowing them to speak with the clinicians at Norfolk Correctional Center. He didn't follow through, however, because he believed Mr. Salvi was so guarded that the request "would drive a wedge" between them and impair their therapeutic alliance.

Dr. Baxter confirmed to us that no one from correctional mental health contacted her regarding Mr. Salvi. Had they done so she would have told them about Mr. Salvi's "preoccupation" with concerns about Catholics and Freemasons, continuous writing and rewriting of statements about these concerns, and obsessive computing of the amounts of money people would need for mortgages and other purposes. He had difficulty letting go of these concerns and focusing on other issues. She considered him to have an unspecified psychotic disorder.

Mr. Menendez did see Mr. Salvi for scheduled mental health sessions on March 26, April 5, April 11, April 18, April 24, and May 15 of 1996. At the first session, Mr. Salvi "declined to discuss the reported noose that was found in his cell at the Norfolk County Jail but denied current suicidality." The notes mostly address mundane issues of Mr. Salvi's adjustment to prison life and do not mention any serious psychopathology. During the last couple of contacts, Mr. Salvi complained of "boredom" and "having little to occupy his time." All notes conclude with the assessment, "stable, not at risk at this time." On May 15, 1996, Mr. Menendez closed the case, ending further scheduled follow-up.

Mr. Salvi's "Initial Classification Report" dated May 1, 1996, by Joseph Foley, Case Worker, states "Subject has no suicide history....He suffers from at least one Psychological Disorder, however has never been diagnosed with any MH illness." The report also notes, "He

considers himself as a religious messenger," but it does not explore the meaning of this statement. Mr. Foley explained to us that he understood Mr. Salvi to have a "mental health disorder," not a "mental health illness." Mr. Foley has not had training in mental health issues and could not clearly explain what he meant by these terms or how they differed. Although he had spoken with the case manager on Mr. Salvi's unit at the Norfolk County Correctional Center, he does not recall any mention of an incident with a noose or other suicidal behavior. Norfolk records available to MCI-Concord also did not include the required report of a suicide attempt, the so-called "Q-5" report, involving the incident with the noose.

Mr. Salvi had a final unscheduled contact with a mental health clinician at MCI-Concord on July 11, 1996. He had been out of the segregation unit and housed in the general population apparently for only a few days when he got into a fight with another inmate. According to his "Disciplinary Report," Officer Michael Rawnsley "witnessed inmate John Salvi, throw a bat at, run at, and kick [another] inmate....while both were playing in a league softball game." Mr. Salvi stated "the inmate was being rude and making comments so he kicked him." Because of the fight, Mr. Salvi was returned to the D-9 segregation unit. Social worker Howard Nalt saw him on July 11, 1996, for the required mental health screening of inmates sent to segregation. Mr. Salvi "admitted to kicking other inmate because he was not playing properly." Mr. Nalt's note describes Mr. Salvi as "logical," "variable" in his mood and affect, "somewhat distant," and having "no suicidal ideation reported." Mr. Nalt assessed him as "not at risk" and needing no follow-up.

Confinement at MCI-Cedar Junction. Mr. Salvi was transferred from MCI-Concord to MCI-Cedar Junction on July 23, 1996. In accordance with policy and procedure at MCI-Cedar Junction, he was housed on a unit where inmates are confined singly in their cells 22.5 to 23 hours a day. Inmates come out of their cells in small groups for sixty to ninety minutes during which they may shower, make phone calls, or take recreation. All new arrivals at MCI-Cedar Junction remain in this mostly locked-down status for stated reasons of institutional safety until they earn with good behavior their way onto a unit that allows them more time out of their cells. Even then, transfer to a more open unit may be delayed pending availability of a cell. Mr. Salvi remained in this locked-down, isolated status for his entire confinement at MCI-Cedar Junction.

According to Richard Vinacco, Psy.D., former Director of Mental Health Services at MCI-Cedar Junction, a chart review of Mr. Salvi took place sometime after his arrival at MCI-Cedar Junction. Warren Stearns, a "senior clinician" who has since retired, conducted the review and found no evidence of a major mental illness. Mr. Menendez from MCI-Concord said that he called Dr. Vinacco the day after Mr. Salvi's transfer to MCI-Cedar Junction, but Dr. Vinacco has no recollection of this phone call or any other contact with mental health staff at MCI-Cedar Junction regarding Mr. Salvi. As a result of the chart review, Mr. Salvi's case remained closed and he had no scheduled contacts with mental health staff at MCI-Cedar Junction.

Although Mr. Salvi did not have planned contacts with mental health staff, Deacon John Manion met with him about every other week for a total of about twelve times at MCI-Cedar Junction. Deacon Manion told us that Mr. Salvi "rambled," was "not very communicative," had strange ideas about religion, and would often go off on a tangent. Deacon Manion saw Mr. Salvi

as clearly mentally disturbed, but he did not make a referral to mental health because he saw no evidence of dangerousness.

On September 16, 1996, Mr. Salvi was written up in a Disciplinary Report after "arguing over the shower....pushing" and getting into a fight with another inmate. A correctional officer who we interviewed attributed the fight to Mr. Salvi's unfamiliarity with prison etiquette. Apparently, he began using a shower that the other inmate had "reserved" by hanging his towel on the adjacent cloths hook. When the other inmate returned and demanded to use the shower, Mr. Salvi refused to comply.

On October 24, 1996, about one month before his death, Mr. Salvi had his first and only contact with a mental health clinician at MCI-Cedar Junction. At 10:00 a.m. he had an appointment with Jeanne Kinsella, a nurse practitioner, for evaluation of a "cold sore and resolving URI [upper respiratory infection]." He complained of "problems sleeping and 'tension'" leading Ms. Kinsella to refer him to mental health for "stress/tension/anxiety." She recalls him as "quiet, guarded," and looking "suspicious." Getting him to answer questions was "like pulling teeth."

Kevin Keiley, LICSW, saw Mr. Salvi at 11:05 a.m. on October 24, 1996. He recorded and recalls this as a "self-referral," although it occurred an hour after Ms. Kinsella's referral. Mr. Salvi complained of "stress related to loss of privileges (phone and canteen) from fight two weeks ago and theft of property." Although he had been sleeping twelve hours a day, he "requested tranquilizers to block out prison." He expressed an interest in moving to a unit where he would be allowed to "participate in more activities (work and recreation)." He appeared "guarded" but denied depression, suicidal thoughts, or psychotic symptoms. Mr. Keiley told him that tranquilizers and follow-up were "not indicated," told him ways "to occupy time constructively," and explained how to contact mental health if he had a "crisis."

Additional information obtained from Mr. Salvi's attorneys and family. Mr. Carney met with Mr. Salvi about thirty times before and during the trial. He described Mr. Salvi as "disoriented" and concerned only with "conspiracies involving Freemasons, the Ku Klux Klan, Mafia, and British Petroleum." He often had a "vacant stare," but was "very good at repeating back what others told him" without actual understanding. He told Mr. Carney that staff at the Norfolk jail were trying to poison him, and he asked Mr. Carney to get a chemical analysis on a piece of ham that he had saved from one of his meals. Mr. Carney related his concerns about Mr. Salvi's mental state to Edward Foley at MCI-Concord, and Mr. Foley reportedly told Mr. Carney that someone would contact Dr. Bear and Dr. Baxter.

Mr. Carney also sent us copies of letters allegedly from four inmates and an anonymous corrections officer at MCI-Cedar Junction describing abuse and mistreatment of Mr. Salvi by staff and other inmates.

Attorney Charles Rankin and his partner Jamie Sultan were appointed to represent Mr. Salvi for his appeal. Attorney Rankin described Mr. Salvi as "essentially in another world" and unable to give "an intelligent response."

Mrs. Salvi described her son as "almost in a trance" and his condition as deteriorating to the point that she had to repeat things to him "louder and louder and slower and slower." He told her that people were trying to poison him, and he would eat only sealed food. She expressed her concerns to prison officials during three visits to MCI-Cedar Junction at the end of October and early November 1996. She also received letters from her son with suicidal themes in them about six weeks before his death. Although she told Attorney Rankin about these letters, neither of them discussed the letters with prison officials.

Gerard Trudel, Mr. Salvi's uncle, described his nephew as a "normal" boy who was not overly religious when growing up. He appeared to be doing well until near the end of his life when he "physically looked worse and worse" and began to just "stare off." Mr. Trudel saw his nephew on Thanksgiving day, three days before his death. For the first time, Mr. Salvi showed some emotion and questioned his own sanity. He told his uncle, "I am trying to stay sane."

Mr. Salvi's writing samples sent to his mother in September and October, 1996. We reviewed copies of twenty-two handwritten pages of Mr. Salvi's writings. These included two pages of instructions to his mother for an "epitaph" for his "tomb-grave stone" and to send copies of his writings to Dom Dimaggio for possible publication, and to Pope John Paul II and Cardinal Bernard Law. The remainder of the writings consisted of often rambling, incoherent statements lacking in syntax. These included six pages, each labeled at top "Thoughts Justifying Non-Christian Attitude. Anti Christ Manifesto - Thoughts During Nero Drunken Disputes with Similar of Augustus Caesar Then Name Dear Eating Half Christian" and another fourteen pages each labeled at the top "Pro-Action Pro-Verb Pro-Action Pro-Verb Pro-Action Pro-Verbs Pro-Actions." The latter fourteen pages took the form primarily of a catechism. Illustrative examples of his writings include the following:

"A wise prophet causing prosperity will probably be a-one success. We are-will be the cause regarding education process learning being easier, we will experience less difficulty learning-comprehending due to artificial insemination process used-to be use too propagate geniuses. We do breed-propagate geniuses, we will breed-propagate geniuses justifying reason due too fact we are-will be smart, too be the cause regarding our descendants-heirs being more capable. We are the cause; we will be the cause regarding our descendants transition from uneducated infants to educated professionals the cause regarding transition being easier. We will be the cause regarding better easier life, big question how difficult is the mean geniuses life, small question what is definition of word mean? We are a warring cause due to just decisions beneficial-benefiting us."

"Question: Are you comprehension regarding rules pertaining to spending limits compared to needed production associated with printing money less being incarcerated?"

Answer: Yes....

Question: Do you comprehend reasons justifying punishing the destroyer of unifying families being our species with authority-permission-order from President Prime Minister Caesar or equivalent here or there of too execute mission then after executing mission

permitted by President etc. too commit suicide reason too not be incarcerated by foreign governments-peoples?

Answer: Yes."

These writings also included a detailed description of a method for cutting into a vein, inserting a tube, and blowing air into the tube to cause a "massive stroke." In another passage, Mr. Salvi poses the question, "Did you ever experience suffocation then being suffocated?" He writes in response, "Yes, during my probably fourteenth year living I did request my cousin too tie me then suffocate me using a plastic bag and elastic during sufficient time too allow myself too be unconscious."

Circumstances of Mr. Salvi's Death:

At about 6:05 a.m. on November 29, 1996, Sergeant Douglas Adams was doing the hourly rounds on the Suffolk-1 unit at MCI-Cedar Junction. Mr. Salvi was housed in Cell #16, the first cell on the second tier. During his last rounds at about 5:05 a.m., Sergeant Adams reported he had seen Mr. Salvi on his bunk and noticed nothing unusual. He now observed Mr. Salvi on the floor lying spread eagle on his back. His arms were at a ninety degree angle from his body with his left hand tied to the bottom of the grill at the front of the cell and his right hand tied to something at the back of the cell. His head was under his bed and his feet under the small "desk" in the cell. He had a clear trash barrel bag over his head.

Lucille Landry, LPN, was doing medication rounds on the Suffolk-1 unit when she heard Sergeant Adams shouting Mr. Salvi's name. She came over to assist and observed Mr. Salvi as described above with all of his extremities tied with shoe laces. The plastic bag was also tied around Mr. Salvi's neck with shoe laces.

According to Sergeant Adams, policy required he and Ms. Landry to wait for help before entering the cell, and Mr. Salvi remained unresponsive during this time. They got into the cell after about four minutes had passed. Sergeant Adams used a knife to cut Mr. Salvi loose, and Ms. Landry ripped open the plastic bag only to find a white cloth "securely wrapped over his mouth." She removed the cloth, but attempts to resuscitate Mr. Salvi were unsuccessful.

Lieutenant Robert McGuinness, Special Investigator to the Superintendent showed us a reconstruction of the ligatures that Mr. Salvi had used to bind himself. Each of these consisted of about six shoelaces tied in series. He also showed us papers, apparently in Mr. Salvi's handwriting, found in his cell after his death. These included pages of detailed, step by step instructions describing his method of suicide. The instructions contained the precise manner and sequence of binding and suffocating himself, including the use of slip knots. Also with the papers were two handmade devices for puncturing veins and blowing air into them, along with his handwritten instructions for their use as a suicide method.

Impressions:

In our opinion, the information available to us indicates that Mr. Salvi suffered from a psychotic disorder. We base this opinion on the following findings:

1. Mr. Salvi's "blunted" affect (i.e., a severely reduced intensity in emotional expressiveness).
2. Mr. Salvi's generally "guarded" demeanor, suggesting suspiciousness and distrust, if not frank paranoia.
3. Mr. Salvi's social isolation and withdrawal.
4. Mr. Salvi's apparently paranoid, delusional concerns about being poisoned as suggested by the following:
 - a. Refusal of many meals and extensive purchasing of food in canteens at BSH and in prison;
 - b. Informing his mother that people were trying to poison him, causing him to prefer only "sealed" food;
 - c. Reported statements to Attorney Carney that the Norfolk County Correctional Center was trying to poison him, and Mr. Salvi's request that Attorney Carney get a chemical analysis on a piece of ham that Mr. Salvi had saved.
5. Mr. Salvi's evasive responses to clinicians, including Dr. Haycock and Mr. Vander Yacht, regarding any history of hearing voices, suggesting that he did experience auditory hallucinations.
6. Mr. Salvi's assaultive and bizarre behavior while incarcerated, including hanging a wet rag, plastic container and chain of elastic bands from his penis.
7. Mr. Salvi's often perseverative, rambling, and disorganized thinking noted by some observers and present in his writings.
8. The above findings appear to represent a deterioration in functioning for Mr. Salvi. He had no reported history of psychiatric disturbance prior to the time leading up to and following his crime.

In contrast to our impressions, evaluators and treatment providers at BSH and at the prisons diagnosed Mr. Salvi as having, at the most, a Schizotypal Personality Disorder, a DSM-IV, Axis II personality disorder. The distinction between Axis II disorders and Axis I disorders, which include psychotic disorders such as the one we conclude Mr. Salvi suffered from, can be difficult to make and often require extensive longitudinal data. Reasonable clinicians can, and in this case did, disagree about diagnosis. We offer our opinion without the benefit of having personally interviewed Mr. Salvi but with the advantage of having relatively comprehensive access to his history and records. Unfortunately, many of the clinicians who treated Mr. Salvi during his incarceration did not have comparable access to his records and history. Some information was not available to them, and at times, some clinicians did not seek or share important information that was available.

In sum, the findings strongly suggest that Mr. Salvi had a psychotic disorder. Such disorders typically have their first acute episodes during adolescence or early adulthood. Mr.

Salvi's psychotic breakdown occurred in his early twenties. His guardedness, suspiciousness, limited communication, and social withdrawal made it difficult for some observers to detect his underlying paranoia and disturbed thinking. Lack of access to, along with failure to seek or share, some important information compounded the difficulty in fully assessing Mr. Salvi's mental condition. Finally, some correctional staff had a confused or incorrect understanding of psychiatric terminology and its significance, and some correctional and mental health staff unduly discounted Mr. Salvi's psychopathology because of the conclusion that he had a DSM-IV, Axis II disorder.

DOC'S PSYCHIATRIC CARE AND TREATMENT OF JOHN SALVI

In this section we review issues in the psychiatric management of John Salvi. For each issue, we first make recommendations and then provide the background data and rationale for the recommendation(s).

Transfer of Information:

REC: Mental health screeners and evaluators at MCI-Concord need guidelines on the pursuit of relevant, outside mental health information.

REC: Transfer of the maximally permissible mental health information from BSH to MCI-Concord should be routinized, especially regarding recommendations for care and treatment provided in BSH forensic evaluation reports.

REC: Policies should be reviewed and modified regarding the communication of mental health information between mental health staff and non-mental health staff within a given DOC institution. Similarly, there should be clearly defined guidelines for non-mental health personnel to obtain consultation from mental health staff. Policies should be modified to open such communications to the full extent allowed by law. Each institution should establish periodic sharing of information between mental health services and other relevant offices (e.g., at MCI-Concord, between mental health services and classification officers).

One of the most critical aspects of mental health screening and evaluation, as well as classification, is to be able to obtain adequate information about an inmate from other persons who have had contact with the inmate. During our investigation, we discovered many ways in which potentially important information existed about Mr. Salvi's past behaviors and clinical manifestations, but which was not known to various personnel because the information was not recorded, shared, or sought in ways that would have better informed those who made decisions about Mr. Salvi. These failures were found at three different interfaces: (a) *inter-system*--between the prison mental health system and other systems, (b) *inter-institutional*--between various institutions within the prison mental health system, and (c) *intra-institutional*--between personnel working within the same institution. Examples of short-comings in communication for each of these interfaces are discussed below, especially as they pertain to the case of Mr. Salvi.

Inter-System Communications. On record is a letter from Jay Carney (attorney for Mr. Salvi) to MCI-Concord at about the time Mr. Salvi was admitted to MCI-Concord. It urged MCI-Concord to contact two psychiatrists (Drs. Baxter and Bear) who had examined Mr. Salvi while he was at Norfolk House of Correction (while awaiting trial). The letter was known to the MCI-Concord classification officer. Yet no one at MCI-Concord tried to contact Drs. Baxter or Bear to inquire. Had they done so, they would have heard from Dr. Baxter that she believed that Mr. Salvi clearly had a psychotic disorder at the time that she examined him, and they would have received information from her about the nature of the reported "noose" found on Mr. Salvi while he was at MCI-Concord.

Whether the "noose" while at Norfolk House of Correction was a suicide attempt or merely a "manipulative gesture" by Mr. Salvi, it would have been important information for MCI-Concord to have. Norfolk HOC did not file a Q-5 report that would have alerted MCI-Concord to the incident, but MCI-Concord classification personnel and mental health personnel reported to us that they had heard about a "noose." A classification officer said that he had telephoned Norfolk HOC to obtain information about Mr. Salvi's behavior there, but did not specifically ask for information about the alleged "noose" (nor did Norfolk HOC offer any). One MCI-Concord mental health counselor said that he did not ask Norfolk HOC about it because he presumed that without a Q-5 notification, Norfolk personnel probably would have revealed such information to him only if it were released by Mr. Salvi's waiver of confidentiality.

It is difficult to understand why MCI-Concord staff would not take advantage of offers of additional mental health information from outside sources when it is made available to them. Moreover, while it is important to respect the right of inmates to confidentiality regarding certain information, it should not automatically be presumed that such concerns override the importance of obtaining information that is intended to protect inmates from harming themselves or others. In many cases--such as this one--voicing such concerns has a hollow sound, when it is quite possible that Mr. Salvi's attorney would have been of assistance in obtaining a waiver of confidentiality in order to obtain information from Norfolk HOC.

We are not aware of any existing policies that inhibit the inquiries that should have been made to outside sources. We also encountered no policies or guidelines that encouraged such inquiries. The latter should be developed.

Inter-Institutional Communications. Mr. Salvi spent considerable time at BSH while awaiting trial, partly for purposes of his forensic evaluation (for competence to stand trial). While at BSH, forensic examinees also receive mental health attention by a treatment team (separate from the forensic examination process), to the extent that they have mental health needs.

We noted that the very extensive BSH forensic report contained much information that was relevant to an assessment of Mr. Salvi's mental status, including suicide risk (e.g., that he had discussed with the examiner his desire to die rather than to have to serve a life sentence in prison). The forensic report, however, was not made available to MCI-Concord mental health or classification personnel, because by policy such "forensic" reports do not accompany the inmate to other DOC institutions. Further, it appears that no BSH discharge summary accompanies the

inmate who is transferred to other DOC institutions. Moreover, whatever information is transferred with the inmate does not provide a discharge diagnosis--or at least it did not do so in Mr. Salvi's case.

We were told that there is rarely any communication between the BSH treatment team and MCI-Concord mental health or classification personnel. In the present case, however, an MCI-Concord mental health counselor did talk to Dr. Haycock, the BSH forensic examiner in this case. The nature of what was communicated, however, is unclear, because MCI-Concord chart notes about that conversation do not correspond to Dr. Haycock's description of the main points that he conveyed, including at least a brief discussion of suicide risk.

The formulation and recording of a discharge diagnosis and a discharge summary are routine practices in virtually all psychiatric facilities, but apparently not at BSH. It is possible that discharge summaries are performed at BSH for inmates who are transferred there specifically for treatment, but not routinely when defendants are admitted primarily for the purpose of pretrial forensic evaluations. Why this would be so, however, is difficult to understand. Other inpatient forensic evaluation units in the Commonwealth (at Department of Mental Health facilities) routinely produce diagnostic and treatment summaries on defendants upon discharge.

Routine transfer of such summaries for inmates going from BSH to MCI-Concord could help to avoid the more haphazard way in which communications between these two institutions occurred in the present case. For example, the telephone conversation between MCI-Concord and BSH apparently never included any discussion of Mr. Salvi's notion--described to us as serious rather than a fleeting thought--that it would be better to die than to face life in prison.

Special attention is warranted to the intra-system use of mental health information contained in reports of forensic evaluations (wherein Mr. Salvi's preference for death over life in prison was discussed, but was never known to MCI-Concord personnel because they never saw the forensic report). M.G.L. Chapter 123, Section 15 describes legal standards for pretrial evaluations of competence to stand trial and criminal responsibility. Section 15(c) specifically requires that each of these evaluations address the forensic examinee's "need for care and treatment." Presumably the intention of this Section is to ensure that mentally disordered defendants receive the psychiatric care and treatment that they need, addressing their mental health and welfare beyond the legal questions of their competence and criminal responsibility. All such evaluations are performed by the Commonwealth's Designated Forensic Professionals, who have been especially trained to take this duty seriously, and these pretrial forensic evaluations usually contain excellent analyses of defendants' mental status and treatment needs. Among the matters routinely discussed in the Care and Treatment portion of these forensic evaluations is the defendant's risk of harm to self and others when the evaluation reveals such risk.

Nevertheless, we learned that BSH forensic evaluations are not made available to MCI-Concord for inmates who are transferred there after their trial process is concluded. Thus MCI-Concord does not have the benefit of this mental health information about the inmate. We are not lawyers, and we recognize that there may be questions of privilege to consider when determining policy in this matter. Yet in cases such as Mr. Salvi's, the BSH forensic reports had been entered

as evidence at a trial that had concluded; they were at that point a matter of public record, making it questionable that any privilege existed. Even if it did, it would seem worthwhile to determine whether the Care and Treatment sections of such reports could be transferred to MCI-Concord separate from the forensic portions of the report.

Intra-Institutional Communications. We learned that *within BSH*, little information exchange occurs between the defendant's treatment team and BSH forensic examiners about pretrial forensic examinees. Similarly, *within MCI-Concord*, we learned that mental health evaluators apparently do not see the classification report, and information provided to the classification officers by the mental health evaluators is often very limited. When classification officers have questions about mental health information that go beyond what has been provided to them, their access to mental health evaluators in order to gain further information or consultation apparently is quite limited. Comments were made by mental health clinicians at MCI-Concord, for example, that much of their mental health information was considered "confidential," not to be shared with classification officers.

We also learned of limited communications *within MCI-Cedar Junction* regarding inmates' mental status and mental health needs. For example, the chaplain who counseled Mr. Salvi in the months prior to his death felt constrained from mentioning to mental health personnel anything he learned about Mr. Salvi's disturbed and disorganized thinking. He felt it was proper to notify mental health services only if an inmate was clearly dangerous to himself or others. An MCI-Cedar Junction classification officer expressed confusion about the diagnosis that she had been given regarding Mr. Salvi, but said that she could not call mental health services to gain a better understanding of the diagnosis, because she believed that the information was considered "confidential."

Each DOC facility seemed to believe that it was important to maintain distance between its mental health services and other non-mental-health personnel. *While law might restrict the exchange of certain types of information, current practices may be over-estimating those restrictions. If so, this is done at a great cost, because it does not allow non-mental-health personnel to obtain and use mental health information accurately.*

For example, in the present instance, classification personnel at MCI-Concord had been told that Mr. Salvi had no "mental illness," but rather a "mental disorder" (Schizotypal Personality Disorder). Such a distinction was incomprehensible to classification officers with whom we talked. (Indeed, the difference is neither simple nor clear for clinical professionals; under Massachusetts' statutory definition of mental illness, for example, Schizotypal Personality Disorder could sometimes meet the definition of a "mental illness" for purposes of satisfying civil commitment criteria. For a further discussion, see the General Clinical Issues section of this report.) Faced with this issue, classification personnel had no ready access to consultation with mental health professionals in MCI-Concord to clarify the matter. Moreover, the bifurcation of functions in MCI-Concord does not allow mental health clinicians to check whether the information they do provide to classification officers is being interpreted and used accurately in the officers' classification reports. Clearly it is both inefficient and risky to segregate mental

health services and classification decision makers in this way, and steps should be taken to reduce their isolation from one another.

Confidentiality:

REC: Policies should be developed and implemented that clearly identify the types of mental health information that may be communicated between clinical and correctional personnel within and between DOC facilities. These policies should *maximize* the types of information that may be shared to facilitate the treatment and/or safety of inmates, while recognizing the importance of confidentiality and privacy.

REC: Guided by legal counsel, DOC should determine how much of the content of forensic evaluations at BSH can be routinely conveyed to mental health services at other DOC facilities, and should take steps to develop practices that *maximize* the amount of forensic evaluation information that can be shared relevant for mental health care and treatment.

As described in the previous section (Transfer of Information), mental health professionals and classification officers frequently explained that the flow of information between them was substantially and rigidly restricted by concerns for confidentiality of information about inmates. Confidentiality is an important principle because it furthers treatment objectives; inmates may feel more free to use mental health services if they know that the contents of their discussions with clinical staff are not routinely passed on to others.

However, in our opinion, clinicians should share clinical information with correctional and classification officers *whenever such sharing would facilitate the treatment or safety of an inmate*. Under those circumstances, recipients of the information would be held to the same standards of confidentiality as any member of the clinical staff.

Similarly, it is difficult to understand why information obtained by a mental health service in any DOC facility is not routinely made available to another mental health service in the DOC facility to which an inmate is being transferred. Confidentiality will place legal limits on the divulgence of such information to parties *outside* DOC. But mental health services in various DOC institutions arguably are not separate entities; they are units of a DOC mental health system, and transfer of medical information between those units is not unlike communications of information within a hospital for reasons of medical necessity and proper mental health care.

As noted in the previous section, even some information obtained in the course of forensic evaluations at BSH (or Department of Mental Health inpatient forensic evaluation units) may be important for later care and treatment of an inmate, and exploration of the matter might reveal that use of such information in post-trial treatment of inmates is both lawful and ethical. Some issues surrounding this use of forensic evaluations might be satisfied by a policy that all forensic examinees will be informed, prior to participating in such evaluations, that information from such evaluations may be used not only in court (a warning they now receive), but also for purposes of mental health care while they are in the present or future custody of the DOC.

Screening and Referral:

REC: DOC should consult with the Department of Mental Retardation to determine the level of need for the use of intelligence testing in the admission screening and evaluation process.

REC: Policies and guidelines should be developed that lower the threshold for behavioral signs that will be considered sufficient to notify clinical staff concerning an inmate's need for attention by mental health services. Adherence to these guidelines should be monitored as a quality improvement indicator.

Mental health services in the facilities we reviewed included two mechanisms for identifying inmates' mental health needs: (a) *screening and evaluation* for mental health needs at admission (at MCI-Concord), and (b) *referral to mental health services* for inmates who are missed by the screening or who develop mental illness or emotional crises while imprisoned.

Admission Screening and Evaluation. There are two types of evaluations at admission: an *initial screening* within a day of admission to MCI-Concord, and a more substantial *mental health evaluation* within the next 14 days. Overall, mental health services at MCI-Concord pay careful attention to the issue of initial screening and evaluation of new inmates, apparently in order to meet the most specific NCCHC standards. In this regard, MCI-Concord seems to be doing a reasonably good job of timely mental health screening of new inmates.

Nevertheless, a few areas for improvement were identified in the screening and evaluation process at admission. First, as has already been discussed in the section on the Transfer of Information, there is a need for mental health evaluators to have better access to any clinically-relevant information that has arisen in the inmate's pre-trial incarceration. Also as noted in that section of this report, the Q-5 system that provides a computer database (accessible by MCI-Concord) on an inmate's suicide behaviors in other correctional settings is an excellent resource. But the fact that Norfolk HOC did not record one of these incidents for Mr. Salvi suggests that the system may need scrutiny. We were told that the incident did not result in a Q-5 report because it had been deemed to be a "manipulative" gesture rather than a suicide attempt. Yet "manipulative" gestures can lead to self-harm, and they may foretell a risk of future self-harm. Thus gestures are clinically relevant information that should be recorded and made available to clinicians who are responsible for the inmate's health and safety in future incarcerations.

Second, it was noted that a question was raised at admission to MCI-Concord about estimates of Mr. Salvi's intelligence, there having been conflicting estimates by various clinicians in his previous placements. With the benefit of hind-sight, we do not believe that Mr. Salvi had intellectual deficiencies. However, in other cases, such differences of clinical opinion may be more critical in identifying inmates with mental retardation. We note that no intelligence testing was done at MCI-Concord to resolve this issue in Mr. Salvi's case. If this represents typical practice in MCI-Concord's evaluation process, then consideration should be given to using such testing more frequently.

Referral. Referral for mental health services, when needs arise after screening and evaluation have been accomplished, occurs by inmate self-referral and through referral by correctional staff who identify an inmate's possible need for mental health services (e.g., psychoactive medication, counseling).

The MCI-Concord mental health staff described an extensive orientation that is given to all inmates, including information about how to access medical and mental health services. The purpose is to ensure that all inmates know how to gain access (that is, to make self-referrals) to medical and mental health services. Though we did not have the opportunity to observe this orientation, it is an excellent practice.

We learned that correctional staff typically seem to refer inmates to mental health services (or request such services for inmates) only when there is a very obvious need. There is a danger that their "threshold" for signaling the need for mental health services is too high. Several examples pointing to this conclusion can be offered.

The psychiatrist at MCI-Concord (Dr. Campbell) informed us that classification officers sometimes refer inmates to him for psychoactive medication. He noted that in the past year, he had found such inmates to be in need of medication every time that officers had made such a referral. This suggests that there are probably many inmates who are in need of medication who are not referred. We reach this conclusion because there are two kinds of errors that can be made in any such circumstances: missing the cases that truly need medication, and referring cases that do not need medication. Depending on where decision makers set their threshold for deciding that inmates are in need of medication, there will be more of one type of error than of the other. Since staff currently are making no errors of the second type (according to the psychiatrist, they are right every time that they refer for medication), they must be making a substantial number of errors of the first type (missing cases that do need medication). The solution is to somewhat lower the threshold for making such referrals. (See further discussion in the General Clinical Issues section.)

Similarly, correctional officers informed us that if an inmate develops a serious mental disorder, it is not likely to result in officers' requests for mental health attention to the inmate as long as the inmate is clean, quiet and obedient. "Bizarre behavior" is not likely to result in a referral as long as it is not disruptive. While subsequent evidence indicates that Mr. Salvi was suffering from serious thought disorder and manifested some unusual behaviors (see section The Portrait of John Salvi of this report), he did not attract enough attention to reach the relatively high threshold that staff typically use as signals for mental health services referral. Similarly, the chaplain who had frequent contact with Mr. Salvi clearly observed his disorganized thinking and confusion, yet decided not to bring this to the attention of clinical staff because he did not believe that this presented a clear and imminent danger of harm to Mr. Salvi.

Our belief that inmates are not referred for needed mental health services often enough is supported by the MCI-Cedar Junction Prison Mental Health Statistics Breakdown monthly reports. The total number of cases opened for the entire calendar year of 1996 at

MCI-Cedar Junction was 11.

We believe that disruptive behavior, uncleanliness, or serious suicide or homicide threat should not be the sole criteria for bringing inmates' mental health needs to the attention of clinical staff. Policy and guidelines should set a different and less extreme threshold.

Psychiatric and Other Mental Health Staffing:

REC: Psychiatric services to the prison system (excluding BSH) should be increased to include an absolute minimum of 9 FTE psychiatrists.

REC: Staffing patterns for the services of psychiatrists should be modified to provide coverage, which is not currently adequate, for psychiatric services during times when psychiatrists are on holidays or on leave from their normal assignments.

REC: Other recommendations in this report may require an increase in FTE positions for other mental health professionals as well (e.g., see the Lockdown section below on need for frequent mental health personnel visits to inmates in lockdown).

We examined the level of psychiatric staffing that is provided to meet the mental health needs of inmates. The primary need for psychiatrists' services focuses on prescribing and monitoring psychotropic medications, responding to special diagnostic questions, and dealing with psychiatric crisis situations.

We heard opinions of persons in clinical authority in DOC and CMS that the current level of psychiatric staffing--4.25 FTE psychiatrists--is adequate to manage the treatment of serious mental illness at MCI-Concord, MCI-Cedar Junction, and all other DOC facilities (except BSH). For the following reasons, we believe this number of psychiatrists is not adequate.

Excluding BSH, there are about 10,200 inmates in DOC prisons and for whom CMS through CPS is responsible for providing psychiatric care. The CMS contract with DOC provides for 4.25 FTE psychiatrists to meet this need. MCI-Framingham (approximately 500 inmates) and MCI-Concord (approximately 1200 inmates) each have 1 FTE psychiatrist assigned to them. The CMS contract provides for 0.3 FTE psychiatrists at MCI-Cedar Junction (about 800 inmates), and apparently a remainder of 2 FTE psychiatrists for 7,700 inmates in other facilities.

At MCI-Concord, the psychiatrist reported that he provides psychiatric care to about 10% of the inmate population (of about 1200). This yields a psychiatrist-patient ratio of about 1:120. The psychiatrist felt that this was an adequate ratio to meet current needs of MCI-Concord, but that any substantial increase beyond that (e.g., up to 1:150) would be too much for any psychiatrist to provide adequate care. We agree that a ratio of about one psychiatrist to 100-120 inmates/patients can usually provide adequate attention to diagnostic, medication, and crisis situations requiring a psychiatrist's special expertise, when offered in the context of services by other mental health professionals.

In contrast, at MCI-Cedar Junction, the average number of inmates on psychotropic medications is about 8% of the inmate population. With 0.3 FTE psychiatrists, this translates to a psychiatrist-patient ratio of about 1:200. We do not know the proportions of inmates among the 7,700 in other correctional facilities (excluding BSH) who receive psychiatric services. But their ratios of psychiatric coverage would be close to 1:400 with a 10% prevalence of serious mental disorder, and almost 1:200 if the prevalence were only half as much as in the other two facilities. We believe that these ratios are much too high to provide adequate care.

These figures do not tell the whole story regarding adequacy of coverage, however, because they do not take into account the fact that the proportions of inmates now receiving psychiatrists' services may not represent the number who are truly in need of services. When a system's psychiatric services are scarce, this often has the effect of reducing referrals by raising the threshold for identification of inmates who are in need of services.

For this reason, it is important to note a 1994 research study by DiCataldo and colleagues at MCI-Cedar Junction, "Screening Prison Inmates for Mental Disorder: An Examination of the Relationship Between Mental Disorder and Prison Adjustment." The study interviewed all inmates who were at MCI-Cedar Junction excluding those who were in administrative segregation or disciplinary units. About 9% of the population scored positively for Major Depression, 6% for Bipolar Disorder, and 6% for Schizophrenia. Some inmates may have scored positively on more than one of these. Therefore, in our opinion, the prevalence of major mental illness suggested by these figures is at least 9%, is almost certainly between 10-20%, and is best estimated at about 12-15% (excluding whatever prevalence exists in segregation units).

When these proportions are compared to those of inmates currently receiving psychotropic medication at MCI-Cedar Junction and MCI-Concord, they suggest that some inmates with serious mental illnesses are not receiving psychiatric care. This may be because they are simply not identified. Alternatively, they may be known to staff but not referred, due to psychiatric under-staffing that inhibits staff from making referrals for mentally ill inmates who do not manifest very troublesome behaviors.

Finally, we learned that some matters of coverage for psychiatric care presented a risk from inadequate to virtually no coverage or services. Currently, there appears to be inadequate provisions for coverage during times when psychiatrists are on holiday or other absences. As a result, CMS through CPS, is not meeting its contractual obligations to DOC. We noted also that Dr. Veliz, much to his credit, carries a beeper and is available 24 hours/day for seven days/week, and has not taken a vacation in three years, in his efforts to provide adequate coverage under the present arrangements of his contract. Current conditions also do not provide adequate backup for Dr. Veliz during his rare trips away from Massachusetts (during which he carries a national beeper). While his dedication is commendable, a mental health prison system should not be funded in a way that makes these practices necessary, because they run a high risk of danger to inmates and staff alike.

In summary, various observations point to the need for an increase in psychiatric coverage for diagnostic, medication, and crisis services in the Massachusetts prison system. We estimate that an absolute minimum of 9 FTE psychiatrists should be provided.

We offer no opinion concerning the absolute numbers of staffing for other mental health services (e.g., professionals providing other mental health classification, evaluation, and counseling services). These need to be augmented as well, however, in order to increase services described elsewhere in this report.

Physical Plant:

The focus of our review was predominantly the circumstances of Mr. Salvi's death, and secondarily any additional recommendations which emerged from that review that might decrease the chances of future suicides. While physical plant issues do relate to inmates' mental health and safety, we were not asked, nor did we attempt, to conduct a comprehensive survey of the physical plants at MCI-Concord or MCI-Cedar Junction.

Lockdown:

REC: Inmates in "lockdown" conditions, who are not currently open mental health cases, should be visited at least three times per week, if not daily, by mental health staff to provide monitoring of their mental condition and an opportunity for meaningful social contact and mental health counseling.

REC: Mental Health Rounds at a frequency of not less than three times per week should also be put in place in the back segregation unit at MCI-Concord.

At MCI-Cedar Junction, we noted that many inmates who are not officially deemed to be in segregation are nevertheless kept locked in their cells for 22.5 or 23 hours per day. "Lifers" such as Mr. Salvi, who are apparently placed at MCI-Cedar Junction and in such conditions routinely upon admission to prison, may experience this confinement as arbitrary and destructive of hope that they may one day adapt to prison. Most of the other residents of these units, we were told, are inmates who have committed very serious offenses (e.g., assaults on staff or gang leadership) that DOC officials believe justify their being held in such strict conditions of confinement. We make no judgment regarding the appropriateness of this level of confinement. Given the highly restrictive nature of this level of confinement, we recommend including mandatory periodic psychological evaluations, and more importantly the regular "rounds" that might help to identify and protect inmates who are becoming quietly despondent and suicidal in such conditions. It is, therefore, our strong recommendations that regular mental health rounds should be extended to all areas where inmates are locked down for the vast majority of their day (e.g., 22.5 or 23 hours per day).

Personal Effects:

We did not comprehensively review shakedown procedures and contraband rules. We did note that Mr. Salvi was able to keep plastic trash-can liners and perhaps six pairs of new shoelaces in his cell. Obviously, any general population cell has countless potentially lethal items that are perfectly appropriate and authorized. Prevention of suicide requires not that all such hazards are removed; but that staff are sensitive to materials available to those inmates who are identified as being at risk of suicide. Therefore, based on our interviews with staff, we suspect that the presence of these items in Mr. Salvi's cell was neither extraordinary nor evidence of poor C.O. performance. However, we would suggest that DOC officials review the policy concerning the relationship between inmates' mental status and inmates' personal effects in their cells.

Training:

REC: Correctional staff should be provided more training than they now receive concerning the meanings of psychiatric diagnoses, recognizing signs of mental illness, and making decisions about referral for mental health services.

The Mortality Review of Mr. Salvi's death indicates that training will be provided for chaplains in recognizing and responding to mental illness in inmates to whom they minister. This is commendable, and we identified several other needs for training.

All of the correctional officers we interviewed felt that they did not have enough training in recognizing mental illness in inmates and in making decisions about referring inmates for mental health services. One officer expressed difficulty in recognizing clinical depression in contrast to the emotional effects of prison itself. A Correction Program Officer noted that he/she often must write down clinical information or diagnoses in reports (as provided by mental health evaluators) without having been provided training that would allow him/her to understand the information (e.g., diagnosis) and its implications.

Therefore, there is a need for correctional staff to receive more training than currently is provided, on the meanings of psychiatric diagnoses, recognizing signs of mental illness (not only signs of suicide risk); and decision making about referral for mental health services.

Other Clinical Issues:

Level of Need

REC: DOC should conduct a level of needs survey for mental health services at each of its facilities.

There are several indicators that the psychiatric and other mental health services at MCI-Cedar Junction are not serving all inmates in need of mental health services, even if those services are to be prioritized to the most needy and/or the most potentially dangerous on the basis of mental illness. The study by DiCataldo, Greer, and Profit, discussed above, is a screening of

prison inmates for mental disorders that was actually done at MCI-Cedar Junction. The findings by this group serve in marked contrast to the mental health services being provided at MCI-Cedar Junction as documented in the monthly Prison Mental Health Statistics breakdown for MCI-Cedar Junction.

The inadequacy of mental health services to inmates is repeatedly reported by MCI C.O.'s. Many C.O.'s informed us they thought there were inmates who were equally or more mentally ill than those receiving services, who were not receiving services. In the C.O.'s own language, "lots of other inmates are crazy." Further, it is noteworthy that while Deacon John Manion thought John Salvi was severely mentally ill, or in his own language, "not a full shilling" and "not playing with a full deck", Deacon Manion was not surprised that John Salvi was going without any psychiatric or mental health services whatsoever.

Consultation Threshold

REC: Explicit guidelines should be developed to determine when mental health practitioners should consult the psychiatrist and when mental health practitioners and psychiatrists should seek a second opinion from one of their peers or supervisors.

While the psychiatrist is often the most fully trained of the mental health providers at each DOC facility, he or she appears to be significantly underutilized as a repository of expertise. It is astounding that Dr. Campbell reports he is asked to assist in a differential diagnosis only approximately 12 times per year.

As previously noted, prior to a recent change in the CMS contract, cases could be closed without consultation with clinical supervisors. We strongly endorse the discontinuance of this practice.

Finally, since no DOC facility has more than one psychiatrist, each psychiatrist works clinically without peers. There needs to be a system established where psychiatrists can consult one another around difficult cases such as diagnostic dilemmas, psychopharmacologic treatment refractoriness, or otherwise difficult to manage cases.

Psychopharmacology

REC: DOC should bring in an outside group to review the psychopharmacologic practices at its facilities and to review its facilities' formularies.

REC: Inmates referred to MCI-Shirley for detoxification must be evaluated by the psychiatrist upon discharge from MCI-Shirley with an accompanying report to the DOC facility at which they will be imprisoned.

REC: DOC should ensure compliance with the policy that only those who are licensed to prescribe medication in the Commonwealth of Massachusetts will make decisions about the discontinuation of medications at DOC facilities.

REC: Inmates should be routinely questioned and assessed for the side effects of psychotropic medications no less than at the time of prescription and renewal.

While John Salvi was not taking any psychiatric medications, the issue of psychopharmacologic practices did come up during this review. Of greatest concern to us was the use (or more accurately the non-use) of benzodiazepines. While we are well aware of the concerns about using potentially addictive medications in the inmate population, the categorical jettisoning of these medications is not an acceptable standard of care. Dr. Campbell, at MCI-Cedar Junction, indicated to us, "I believe benzodiazepines are quite unnecessary. There is no Axis I diagnosis that cannot be treated without benzodiazepines." By this, Dr. Campbell was also indicating to us that he saw no need to ever use psychiatric medications with Axis II diagnoses. Further, while the benzodiazepines are not used, non-benzodiazepine alternatives are also absent from the formulary, e.g., buspirone, hydroxyzine.

DOC might ask an outside group to conduct an examination of the psychopharmacologic practices and the formularies at DOC facilities.

It is our understanding that when an inmate arrives at MCI-Concord who is taking benzodiazepines, he is immediately sent to MCI-Shirley for detoxification. Upon return to MCI-Concord, under current practices, the inmate is simply put into population with no psychiatric evaluation. Having just been removed from medications that he may have been taking for a long time, it is essential that the inmate be evaluated by a psychiatrist for the necessity of alternative medications. This must occur at MCI-Shirley prior to the inmate's return to MCI-Concord with a report to the psychiatrist at MCI-Concord.

Under current practice, when an inmate with a psychiatric disorder is screened upon admission to MCI-Concord, one or more than one of the psychiatric medications that he is taking may be discontinued by the mental health professional who is doing the intake. Since in most instances this mental health professional, if not licensed to prescribe medication in the Commonwealth of Massachusetts, this practice should be discontinued immediately. In all cases, the decision as to whether or not a psychiatric medication should be continued or discontinued must be made by a psychiatrist or at least by a physician licensed to practice medicine in Massachusetts.

We strongly support the current practice at MCI-Concord of having no special medication line for psychiatric medications. The LPN administering medication, however, has neither the opportunity nor the time to evaluate inmates for side effects from medication. The frequency of contact with the psychiatrist must be sufficient to allow adequate monitoring of side effects from medication. All other health professionals should be kept up-to-date about new psychiatric medications and their side effects. While the medical (non-psychiatric) nurses at MCI-Concord reported that they had had good training about psychiatric medication, there is no indication they are receiving continuing education about psychiatric medication. This is particularly important as the last few years has seen a rapid flow of new psychotropic medications into general use. Many

of these medications are quite unlike those previously used and come with their own side effect profiles.

Psychotherapies

REC: DOC should assess the appropriateness of instituting group psychotherapies at any of its facilities where the modality is not in use.

While inmates are receiving one-to-one psychotherapy/counseling (although as we've indicated we think the number of inmates receiving this therapeutic modality is insufficient), none, at least at MCI-Cedar Junction, are receiving group therapy. Groups are a cost effective way to deliver services and we believe that there are many inmates with mental illness who would benefit from such services. Although we recognize that constituting psychotherapy groups could be difficult because of problems mixing inmates from different cell block units and because of changes in inmates' cell block units as inmates get housing reassignments within the facility, we recommend that DOC consider instituting group psychotherapies to the extent possible.

Clinical Supervision/Leadership

REC: DOC must have, at each of its secure facilities, a doctoral level psychologist (or equivalent) to provide clinical supervision.

While clinical supervision is being provided at MCI-Concord and MCI-Cedar Junction, it is not, at this time, being provided by a doctoral level psychologist. The level of training of the individuals that are providing this supervision is inadequate and the clinical supervisory process is beyond their area of expertise.

Mental Health Housing/Residential Care

REC: DOC should consider the appropriateness of creating residential special needs treatment programs, e.g., mental health, dementia, head injured, within one or more of its secure institutions.

It is our understanding that at neither MCI-Concord nor MCI-Cedar Junction is there any segregation of inmates into a housing unit which could be focused on a special needs population. Although BSH likely meets some of this need for male inmates, there may be inmates who would benefit from availability of residential level care that falls between that available at BSH and in general population. This is certainly done in other states and is worth visiting in Massachusetts. One of us (JG) was a member of the UMMC group that evaluated MCI-Frammingham at the behest of DOC, and MCI-Frammingham comes much closer to using this model than either MCI-Concord or MCI-Cedar Junction. DOC should itself evaluate the effectiveness of some of the interventions that have been made at MCI-Frammingham and consider adopting them at MCI-Concord and MCI-Cedar Junction.

Limitations of Scope of General Clinical Review

We wanted to underscore that while we have attended to general clinical issues in this section, these issues are limited to those that specifically touch on the case of John Salvi. This is not an overview of all psychiatric services within DOC facilities. Major issues of importance were not included such as substance abuse, mental illness induced danger to others, mental retardation, dual diagnosis, and sexual offenders, as examples.

Suicide Issues in General:

REC: DOC should consider suicide to be a QI indicator, should maintain aggregate statistics on suicide, and should maintain an ongoing study of suicides in DOC facilities.

REC: DOC must ensure C.O. access to trauma shears to cut down hanging inmates. This access must be regulated, safe, secure, and efficacious.

While we have made many specific recommendations in relationship to suicide in Massachusetts prisons, as reflected by the John Salvi case, we wanted to address two other areas that relate to suicide in general.

Between January 1, 1992, and December 31, 1996, there have been 17 suicides in DOC facilities (including Bridgewater State Hospital). Three of these 17 have been at MCI-Cedar Junction, one each in 1992, 1994, and 1996. From what we were told, there is no ongoing study of suicides in DOC facilities. We suggest DOC maintain a data base on suicides at DOC facilities and conduct an ongoing study of suicides in DOC facilities. Joel Haycock, Ph.D, could assist in this project as he indicated to us that he has studied every Massachusetts prison suicide. It is noteworthy, however, that apparently there has been no communication between Dr. Haycock and DOC regarding any of his findings.

MCI-Cedar Junction has a policy that requires an officer who finds an inmate hanging to wait for back-up before entering a cell. This is common policy in correctional institutions due to the risk of an inmate feigning suicide in order to compromise security. When an officer finds a hanging inmate, should he be required to cut down an inmate, he must obtain a sharp object, i.e., trauma shears, in order to do so. MCI-Cedar Junction has no effective, safe, secure access to the appropriate equipment to allow officers to accomplish this task in a timely fashion.

Mortality Review:

REC: DOC should review the practices of its two non-discoverable mortality reviews for suicide deaths and other questionable psychiatric deaths: the peer review process at each facility and the DOC process for all facilities.

There is very little indication that after the death of John Salvi, a mortality review process was done by the mental health staff at MCI-Concord where he had received most of his mental health services. Not only should something comparable to a peer review process be convened,

but the mental health providers must review not only the medical record, but also the custody file. It is noteworthy that Bernard Menendez informed us that after John Salvi's death, he reviewed only the medical record and not the custody file.

CONCLUSIONS

The main conclusions to our evaluation of the psychiatric management of John Salvi by the DOC are:

- The policies and procedures of the DOC and its facilities, MCI-Concord and MCI-Cedar Junction are excellent. They meet, and in many cases exceed national standards. There are, nonetheless, modifications to the mental health policies, and the policies governing suicide in particular, that require attention.
- The psychiatric staffing of DOC facilities by Correctional Medical Services (CMS), through its subcontractor Correctional Psychiatric Services (CPS), is inadequate in that
 - ◆ CMS through CPS is not meeting its current contractual obligations to DOC
 - ◆ The number of psychiatrists contracted for must be increased to reasonably meet the needs of the DOC inmate population
- The other mental health staffing of DOC facilities by CMS is inadequate in that
 - ◆ The number of mental health professionals needs augmentation to meet the needs of the DOC inmate population
 - ◆ The clinical supervision of mental health professionals must be improved to appropriately meet the needs of the DOC inmate population
- The inadequate numbers and inadequate supervision of psychiatrists and other mental health providers at DOC facilities means that some inmates do not receive sufficient or adequate
 - ◆ Evaluation
 - * differential diagnosis
 - * risk assessment
 - ◆ Triage
 - ◆ Psychopharmacologic treatment
 - ◆ Psychotherapeutic treatment
- The current training of correctional officers should be improved to more effectively allow them to identify and refer inmates who may need mental health services.
- The numbers of psychiatrists and other mental health professionals and the training level of correctional officers combines to create a system where only those inmates who are mentally ill and disruptive receive attention. Inmates who are quiescently mentally ill, but may be at equal or even greater risk to themselves or others than their disruptive peers, go mostly unnoticed and unserved.

- DOC's interpretation of statutes and common law of Massachusetts, and the resulting policies and procedures of DOC concerning confidentiality and the exchange of information about psychiatric care and treatment, unduly constricts the ability of DOC to effectively serve its inmates. Specifically, communication was insufficient in frequency and inadequate in content when it did occur
 - ◆ between outside sources and DOC
 - ◆ between DOC facilities
 - ◆ within each DOC facility between
 - * forensic evaluation and psychiatric treatment staffs (BSH)
 - * correctional and mental health staffs
 - * correctional and chaplaincy staffs
 - * chaplaincy and mental health staffs

- Had the DOC demonstrated none of the deficiencies noted above, John Salvi may well have been a successful suicide anyway. This is because
 - ◆ John Salvi had a subtle psychotic disorder that was difficult to diagnose, particularly because Mr. Salvi withheld information from many individuals with whom he interacted
 - ◆ John Salvi refused mental health services when offered, stating he had no mental illness
 - ◆ John Salvi was intent on suicide, planned his suicide carefully over a prolonged period, and executed his suicide according to his plan

As the result of these findings, we have made twenty-five recommendations to DOC aimed at improving the mental health services at DOC facilities. DOC has striven to achieve state of the art mental health services at its facilities and has made significant movements in that direction over the past several years. But much remains to be done. Our recommendations are aimed at furthering the DOC's efforts to create a system of psychiatric services that will decrease the future morbidity and mortality of the inmate population of DOC.