
This bill will begin to rectify very serious safety and constitutional concerns identified by the U.S. Department of Justice (DOJ) after an investigation of the Department of Correction’s (DOC) suicide prevention and response practices. The legislation prohibits our prisons and jails from placing possibly suicidal prisoners in what is effectively solitary confinement, ensures all decisions made about the treatment of such prisoners are made by qualified mental health professionals, and removes officers from watching suicidal prisoners if the officers violate suicide prevention policies.

CURRENT SHORTCOMINGS

- Individuals with behavioral health needs are vastly overrepresented in the criminal justice system; 36% of males and 81% of females in Massachusetts’ prisons have open mental health cases. The trauma of the prison environment exacerbates symptoms of these conditions.
- Individuals at risk of suicide in our jails and prisons can spend months in solitary-like conditions.
- Per the DOJ report, correctional officers assigned to oversee mental health watch exhibited willful disregard for prisoner safety by falling asleep while watching suicidal prisoners, encouraging prisoners to engage in self-harm, and failing to stop instances of self-harm. In some instances these practices resulted in prisoner injury or death.

WHAT THIS BILL ACHIEVES

- Prohibit suicidal prisoners from being held in conditions of solitary confinement, and require transfer to a psychiatric hospital if needed behavioral health support cannot be safely provided by DOC after 24 hours under mental health watch.
- Mandate a written suicide prevention and suicide response policy for all state and county correctional facilities, and a mental health watch chain of command under qualified mental health professionals, not correctional staff.
- Require the provision of appropriate mental health treatment on an ongoing basis for all prisoners with mental health conditions, including those on mental health watch.
- Ban correctional officers from participating in suicide watch if they violate suicide safety protocols.
- Require independent review of all completed and attempted suicides and incidents of self-harm, along with recommendations for changes in protocol after each incident.

WHY THIS MATTERS

With passage of this bill, DOC can begin to rectify critical safety and constitutional concerns related to prisoners on mental health watch by implementing a more comprehensive mental health treatment plan, chain of command, and reporting practices.

For more information: Please contact Jessica Larochelle, MAMH Director of Public Policy and Government Relations jessicalarochelle@mamh.org | (617) 742-7452 x106