REPORT OF SUICIDES IN THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

JANUARY 1, 2017, TO DECEMBER 31, 2019

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EXECUTIVE SUMMARY

In the period of January 1, 2017, through December 31, 2019, 102 inmates (98 men and 4 women) died by suicide while in California Department of Corrections and Rehabilitation (CDCR) custody. This continued a concerning upward trend in suicides in CDCR institutions that began in 2014. During the three years covered by this report the Department averaged 34 suicides per years while in the previous ten years the average was thirty per year.

The rate of suicide in CDCR during 2017 to 2019 was 26 per 100,000 inmates (23 per 100,000 in 2017; 26 per 100,000 in 2018; and 30 per 100,000 in 2019). The rate of suicide for an adult male in California has climbed steadily since 2000 when it was 19 per 100,000 to 23 per 100,000 in 2018.[1] The most recent suicide rate for state prison inmates was 21 per 100,000 in 2016.[2]

Suicides occurred in 25 of 35 CDCR-administered institutions and one out-of-state facility during 2017 through 2019. Inmates aged 25-55 comprised a higher proportion of suicides than in 2016, while the proportion of deaths of the youngest and oldest inmates were either equal to or less than their proportions in the CDCR population as a whole. In 2017 and 2018, Hispanic inmates were half of each year's total, continuing a worrisome trend of increasing Hispanic suicides. Over the three years of this report, deaths of Hispanic inmates were 43% of all inmate suicides. Seventy-five percent of suicides over the three years were by inmates requiring the highest levels of security in the prisons, with 88% having been convicted of a violent crime, higher than the overall proportion of CDCR inmates convicted of a violent crime. This is a long-standing trend among suicide decedents. Long sentences and having many years remaining to serve continued to be prominent markers for suicide risk during 2017 through 2019. Suicides occurring in segregated housing comprised 35% or less of suicides in each of the three years, continuing an encouraging trend of lower number of suicides in these higher-risk settings.

CDCR continues to focus on improving and expanding its suicide prevention practices. A large number of initiatives are continuing, are under development, or have been implemented in the three years covered by this report. The department continues to assess the effectiveness of these initiatives and monitor their quality and sustainability. During the three years covered by this report, further implementation of a number of recommendations from the Office of the Special Master's (OSM) suicide prevention workgroup and the OSM's expert reviewer have been made.

Although suicide case reviews and the resulting findings have spurred many changes in suicide prevention, the department also uses the analysis of historical data, internal audits, improvements suggested by research by community researchers, and policy initiatives from other such as the U.S. Department of Veterans Affairs and other large healthcare systems. A number of specific key areas have emerged from both the suicide case review process and other sources.

1. **Lessons from Suicide Case Reviews:** Almost two-thirds of quality improvement plans (QIPs) from suicide case reviews in the period covered by this report indicated a need to improve mental health services, specifically suicide risk evaluation and treatment planning. To address these deficiencies the statewide mental health program (SMHP) implemented improvements to the electronic health record to improve documentation of suicide risk.

[1] Center for Disease Control, Web-based Inquiry Statistics Query and Reporting System (WISQARS): www.cdc.gov/wisqars/index.html. Accessed on December 12, 2020.

[2] Carson, E.A. and Cowhig, M.P. (February 2020). *Mortality in State and Federal Prisons, 2001-2016 – Statistical Tables*, Report NCJ 251920. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Washington, DC. Available at: https://www.bjs.gov/index.cfm?ty=pbdetail&iid=6766

Audits of the quality of risk assessments conducted in the report period suggest the difficulty of achieving consistent and durable change in this area. Other areas identified by QIPs include monitoring of inmates in segregated housing, nursing observation procedures, and better identification of the need for referrals of inmates who need more intensive mental health treatment.

2. **Reception Center Inmates**: The results of multiple QIPs and analysis of historical trends have shown that the transition from county jails to state prison can be highly stressful and increase the risk of suicide attempts particularly for individuals with long sentences or certain high visibility offenses. From 2017 through 2019, eleven newly arrived Reception Center inmates died by suicide. The department is working to improve the ability of reception center mental health programs to obtain records from county jails and other agencies to improve continuity of care and to better evaluate newly arrived inmates' mental health needs.
3. **Suicides of EOP inmates**: Community researchers, CDCR data, and case reviews have consistently noted that inmates with serious and chronic mental illness have higher long-term suicide risk than other groups of inmates. CDCR's Enhanced Outpatient Programs (EOP) house the system's most chronically mentally ill inmates, often chronically suicidal and with multiple suicide attempts. More than one-third of the 102 suicides during 2017 to 2019 were by EOP inmates. EOP programs offer considerable treatment services, such as weekly contacts with primary clinicians and a minimum of 10 hours of group treatment per week. All staff working with EOP patients need to recognize the risk inherent in this group. The SMHP has instituted increased training in case formulation, risk assessment, and treatment planning to improve outcomes with these patients.
4. **Reducing Single Cell Occupancy**: Research on the origins of suicidal behavior suggest that interpersonal connections and social support can provide a buffer against the despair and distress inherent in suicidal crises. For prison inmates, having a cellmate can be such a buffer and reduce suicide risk. From 2017 through 2019, 75 of the 102 inmates who killed themselves were eligible for a cellmate or were on single-cell status. Not all inmates can be safely housed with other inmates. However, a move to strategically place inmates in two-person cells with compatible cellmates in high-risk populations (e.g., Level III and IV EOP inmates and mental health inmates in segregated housing) stands to have protective benefit.
5. **Follow-up after Psychiatric Hospitalization**: The days and weeks after discharge from psychiatric hospitalization is a high-risk period for suicide. This is particularly true when the individual was hospitalized after attempting suicide[3] and for those diagnosed with schizophrenia or bipolar disorder,[4] a major group among CDCR suicide decedents. In response, CDCR has implemented a number of policies and procedures for inpatient discharges, such as five-day follow-up and Mental Health Crisis Bed (MHCB) discharge custody-check procedures that provide additional observations and mental health contacts, audits of discharge risk assessments and treatment plans. The SMHP Inpatient Referral Unit has also instituted case conferences for treatment teams to discuss difficult cases.

[3] Chung, Ryan, & Hadzi-Pavlovic. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis, *JAMA Psychiatry*, 74, 694-702

[4] Tidemalm, Langstrom, Lichtenstein, & Runeson. (2008). Risk of suicide after suicide attempt according to coexisting psychiatric disorder: Swedish cohort study with long-term follow-up. *British Medical Journal*, 337

6. **Suicide Attempt History**: Most CDCR inmates who kill themselves have at least one prior suicide attempt, with the majority having made multiple past suicide attempts. The lifetime risk of death by suicide increases with a single attempt and much more so after a second attempt; for both psychiatric and non-psychiatric samples. The SMHP is implementing a training program that targets high risk patients with a suicide-specific treatment – the Collaborative Assessment and Management of Suicidality (CAMS). The treatment focuses on psychological pain and distress and includes patient ratings of what most fuels suicidal desire for them and what has historically contributed to a wish to die by suicide, while challenging this wish for death with considerations of making life worth living.
7. **Focus on Common Precipitants of Suicide**: Inmates who killed themselves during this report period shared a number of common precipitants or drivers of suicide: the symptoms of severe mental illness, loss of social support and interpersonal connectedness, and in-prison stressors such as interpersonal safety concerns or new criminal charges. Case reviews suggest that clinicians often underestimate the impact of in-prison stressors when added to the risk bestowed of major mental illness in causing psychological pain. Risk assessment and suicide prevention trainings should continue to integrate the findings of suicide case reviews. Programs should foster interpersonal and prosocial contacts that can bolster an inmate's will to live, give more meaning to their life in confinement, and decrease situational distress and despair. Group activities such as group therapy, occupational and recreational therapy, and school and job placements are environments that can enhance interpersonal relatedness.
8. **Hispanic Suicides**: The proportion of suicides among Hispanic inmates appears to be on the rise. During 2017-2019 Hispanic inmate suicides comprised 41% of total CDCR suicides, a much larger proportion than other ethnic/racial groups. This proportion was higher than in the two previous three-year periods when Hispanic suicides accounted for only thirty and thirty-three percent, respectively, of all suicides. This increase has outpaced the increase in the overall proportion of Hispanic CDCR inmates which increased only 4.4% from 2011 through 2019.

In late 2018, the department completed the implementation of a system-wide electronic health record system (EHRS). As part of this implementation, the Statewide Mental Health Program redesigned the suicide risk evaluation documentation and rolled out new training on risk assessment, mentoring of clinicians in risk assessment, and a new safety planning intervention as part of the evaluation process.

New and ongoing improvements in suicide prevention and response can be categorized into three broad areas: clinical programs, training, and policy changes.

- Clinical and rehabilitative program improvements
  - Telepsychiatry visits grew significantly – providing services to institutions that are the most difficult hiring sites.
  - Continued training in the "Collaborative Assessment and Management of Suicidality" – a suicide-specific treatment model suicidal inmates.
  - Based on a U.S. Department of Veterans Affairs initiative for suicidal individuals, CDCR added a "Safety Planning Intervention" to its standard suicide risk evaluations to improve treatment planning in suicidal crises.
  - Documentation of suicide risk evaluations were improved with new assessments and a more integrated format in the EHRS.

  - Using a model from the community, the department created and implemented cross-disciplinary Crisis Intervention Teams in 22 institutions that respond to inmate crises and reduce expensive inpatient hospitalizations.
  - To improve treatment and address an increase in female inmate suicides, the department created domestic violence programs at a women's institution, along with substance abuse programs and better access to mental health services for other inmates.
  - The state has initiated programs that allow inmates to shorten their sentences by earning Milestone and Rehabilitative Achievement Credits by participation in rehabilitation programs.
- Training
  - Additional training for risk assessment mentors and increasing their training time
  - Improvements and updating of on-the-job suicide prevention training
  - Improvements in suicide prevention training at the cadet academy
  - Improved tracking of training allowing management to increase compliance with training requirements
  - Improvements to the training of suicide risk evaluation mentors
  - Training on the Safety Planning Intervention, a new module in the EHRS
  - Updating of the standard "seven-hour" suicide risk evaluation training for clinicians
  - Training for suicide prevention tools within the electronic health record system
- Policy and procedural changes
  - Updated and implemented the follow-up procedures for when inmates return from inpatient psychiatric settings, a period of high risk for self-harm and suicide.
  - Improvements in how inmates are processed into institutions when they return from court dates in the counties
  - Continued work on obtaining timely county jail records for newly-arrived inmates
  - Implementation of a standardized "cut-down" kit for all institutions
  - Distribution of electronic "entertainment" devices in segregated housing to combat boredom and stress
  - Improvements in the assessment of self-harm incidents by providing more complete counting rules and integrating the rules into the EHRS
  - Creation of mental health programs for those inmates at CIW who are not participating in the CDCR mental health program
  - Creation of a Reception Center work group to develop new programs for newly arrived inmates

In addition to these initiatives, the SMHP has actively participated with the OSM and his experts to translate their recommendations into policies and procedures to improve the overall suicide prevention program.

These enhancements are meant to add to the department's comprehensive, integrated system of suicide prevention and response.

INTRODUCTION AND REVIEW OF FINDINGS

This report reviews the deaths by suicide of 102 CDCR inmates during the years of 2017 through 2019. The report is submitted as part of CDCR's determined effort to reduce the number of suicides within California's prisons, as well as CDCR's compliance with court-ordered remediation in the matter of *Coleman v. Newsom* (case No. 2:90-cv-0520, U.S. District Court for the Eastern District of California).

The report provides a statistical description of the 2017-2019 suicides and trends, a discussion of ongoing prevention programs, targets for suicide prevention efforts, and recommendations for continued improvement. Additional detail is provided about suicide response efforts and implementation of quality improvement processes (QIP) and programs to prevent suicide. The department has produced an annual report of suicides most years since 1998, which is distributed to the *Coleman* parties and the Office of the Special Master (OSM).

The primary source of data for this report are the suicide case reviews completed by staff of the SMHP who are trained in conducting these reviews. Additional data is obtained from CDCR's Office of Research, the California Correctional Health Care System's (CCHCS) Death Review Committee (DRC) reports, information from prior annual suicide reports, and publicly available information regarding suicide rates in community and incarcerated settings. Suicide case review reports were independently reviewed by senior clinical staff of the SMHP to assess trends in data or in qualitative findings.[5]

SUICIDE DEFINITIONS AND TERMS USED

The Mental Health Services Delivery System (MHSDS) Program Guide, 2018 Revision, provides definitions of suicide and suicide attempts. Several terms used in the last full revision of the Program Guide are now considered obsolete within the field of suicidology and will not be used in this report. Specifically, the terms "self-mutilation" and "suicide gesture" are found in the MHSDS Program Guides, 2018 Revision; however, a less-pejorative term, "non-suicidal self-injury" or NSSI, is used in this report and refers to self-harm for reasons other than death by suicide.

1. Suicide: An intentional self-injurious behavior that causes or leads to death.
2. Suicide Attempt: An intentional self-injurious behavior which is apparently designed to deliberately end one's life and may require medical and/or custody intervention to reduce the likelihood of death or serious injury.
3. Suicidal Ideation: Thoughts of suicide or death, which can be specific or vague, and can include active thoughts of committing[6] (that is, dying by) suicide or the passive desire to be dead.
4. Suicidal Intent: The intention to deliberately end one's own life.
5. Self-injurious Behavior: A behavior that causes, or is likely to cause, physical self-injury.

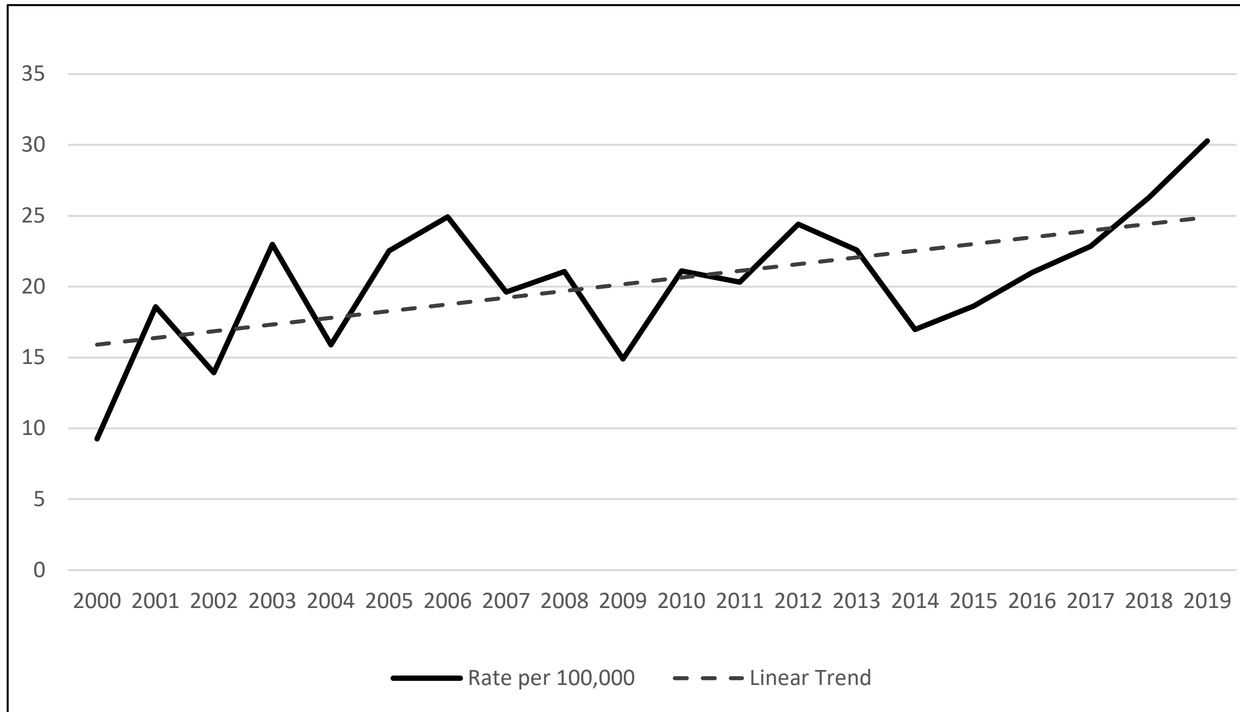
[5] Pursuant to CCHCS and CDCR policy, individual case reviews are not included in this report for patient privacy reasons. The *Coleman* Special Master and Plaintiffs receive CDCR's complete Suicide Case Reviews and have access to the records of each inmate who committed suicide.

[6] The term" 'committing" is not used by current suicidal experts, as the term implies some sort of success in carrying out a pledge or obligation. The favored term is straightforward — "died by suicide."

REVIEW OF FINDINGS: 2017-2019

The aggregate annual suicide rate in CDCR for the period 2017 through 2019 was 26.4 deaths per 100,000 inmates. The rate increased each year in the period – from 22.8 in 2017 to 30.3 in 2019. This was a continuation of the increase in rates since 2014, when the rate was 17.0 per 100,000 inmates.[7] Figure 1 shows the annual rate of suicide in CDCR since 2000. The dotted line represents the overall trend in rates in the last 20 years.

Figure 1. CDCR Suicide Rate (Deaths per 100,000), 2000-2019



The rate of suicide in CDCR institutions has been at least 20 per 100,000 in 12 of the last 20 years. The rate of suicide in CDCR fluctuated in the teens during the 1990s as CDCR's inmate population increased statewide. Since the passage of Assembly Bill 109, "Public Safety Realignment Act," in 2011, the statewide inmate population for CDCR has decreased by about 23 percent. However, the proportion of the inmate population with mental illness has increased, and with that increase, so has the suicide rate. The annual number of suicides peaked at 43 in 2006, when the system's population was over 170,000 inmates, then continued to decrease in subsequent years to 23 in 2014, and then has risen again in each year since. Table 1 shows the male, female, and overall frequency and rates of suicide in CDCR for each year since 2000.

1. SOCIODEMOGRAPHIC FACTORS. Sociodemographic characteristics do not directly cause suicide, but they are important risk factors with indirect effects.

Gender. During 2017, 2018, and 2019, 98 men and four women died by suicide while in CDCR custody. The rate of suicide was 26.6 per 100,000 for men and 22.8 per 100,000 for women (Table 1). The four female inmate suicides were a decrease of three from the seven who died by suicide in the period 2014 through 2016.

[7] A presentation and discussion of data sources and calculations is contained in Appendix B, Data Sources and Methods

Table 1. Annual Frequency and Rate of Suicide in CDCR, by Gender and Total, 2000-2019

Year	Male			Female			Total		
	Population	Frequency	Rate	Population	Frequency	Rate	Population	Frequency	Rate
2000	150,793	15	9.9	11,207	0	0.0	162,000	15	9.3
2001	150,785	29	19.2	10,712	1	9.3	161,497	30	18.6
2002	148,153	22	14.8	9,826	0	0.0	157,979	22	13.9
2003	150,851	37	24.5	10,080	0	0.0	160,931	37	23.0
2004	152,859	23	15.0	10,641	3	28.2	163,500	26	15.9
2005	153,323	37	24.1	10,856	0	0.0	164,179	37	22.5
2006	160,812	39	24.3	11,749	4	34.0	172,561	43	24.9
2007	161,424	33	20.4	11,888	1	8.4	173,312	34	19.6
2008	159,581	36	22.6	11,392	0	0.0	170,973	36	21.1
2009	156,805	25	15.9	11,027	0	0.0	167,832	25	14.9
2010	155,721	34	21.8	10,096	1	9.9	165,817	35	21.1
2011	152,803	33	21.6	9,565	0	0.0	162,368	33	20.3
2012	128,829	32	24.8	6,409	1	15.6	135,238	33	24.4
2013	126,992	29	22.8	5,919	1	16.9	132,911	30	22.6
2014	129,268	21	16.2	6,216	2	32.2	135,484	23	17.0
2015	123,268	22	17.8	5,632	2	35.5	128,900	24	18.6
2016	122,874	24	19.5	5,769	3	52.0	128,643	27	21.0
2017	125,289	28	22.3	5,971	2	33.5	131,260	30	22.8
2018	123,511	33	26.7	5,906	1	17.0	129,417	34	26.3
2019	119,781	37	30.9	5,691	1	17.6	125,472	38	30.3
2000-2019	2,853,722	589	20.6	176,552	23	13.0	3,030,274	612	20.2
2010-2019	1,308,336	293	22.4	67,174	14	20.8	1,375,510	307	22.3

Race/Ethnicity. The racial and ethnic backgrounds of inmates who died by suicide in 2017 through 2019 are presented in Table 2. For the three years covered by this report, Hispanic inmates comprised the largest proportion of suicides, with 42 inmates (41%) dying by suicide. During this period, 29 White inmates (28%) died by suicide, while 15 Black inmates (14%) and 16 inmates (16%) of other racial/ethnic backgrounds died by suicide. When compared to the population proportions of ethnic/racial groups in CDCR (Table 2), there were fewer Black suicides and more suicides of "Other" racial/ethnic" groups than would be expected during the three years.

Table 2. *Race/Ethnicity of Inmates Who Died by Suicides in the CDCR, 2017-2019*

Racial/Ethnic Group	Frequency (Percent)				CDCR Population 2017-2019
	2017	2018	2019	2017-2019	
Black	6 (20)	1 (3)	8 (21)	15 (14)	28%
Hispanic	14 (47)	17 (50)	11 (29)	42 (41)	44%
White	7 (23)	9 (27)	13 (34)	29 (28)	21%
Other[8]	3 (10)	7 (21)	6 (16)	16 (16)	7%

Age. Table 3 shows annual age group suicides for 2017 through 2019, the percentage of suicides in each group, and the percentage of that age group within the total CDCR population over the three years. The percentage of age group suicides in 2017 through 2019 did not significantly differ from the overall age group percentages of the CDCR population during the report period.

Table 3. *Age Groups of Inmates Who Died by Suicide in the CDCR, 2017-2019*

Age Group	Frequency (Percent)				CDCR Population 2017-2019
	2017	2018	2019	2017-2019	
18-24	5 (17)	3 (9)	1 (3)	9 (9)	9%
25-34	11 (37)	11 (32)	10 (26)	32 (32)	31%
35-44	11 (37)	9 (27)	15 (40)	35 (34)	26%
45-54	2 (7)	8 (24)	9 (24)	19 (18)	18%
55+	1 (3)	3 (9)	3 (8)	7 (7)	16%

Marital Status. During 2017-2019, twelve inmates who died by suicide (12%) were married at the time of their deaths. The remaining inmates who died during the three years covered by this report were single, divorced, or widowed.

Education, Juvenile Criminal History, and Work History. During the period covered by this report, 38 inmates (37%) of inmates who died by suicide had less than a high school education. Twenty-six (25%) had a General Education Diploma (GED) and 20 (20%) had graduated from high school. Nine (9%) had some college experience, and information about education was unknown about the remaining seven. Five inmates had reported participating in Special Education classes, and one inmate who died during this period was a participant in the Developmental Disability Program at the DD1 level. The DD1 designation is assigned when individuals require minor prompting or coaching for activities of daily living that may impact the individual's ability to adapt to the prison environment.

Among the inmates who died by suicide between 2017 and 2019, sixty-one (60%) had a

[8] One Japanese-Filipino male, one Korean female, and one Native American male

history of crime while juveniles. Fifty-one (50%) of the suicide decedents in this period had some work experience outside of CDCR, although for most, the employment was sporadic and involved unskilled labor. Fewer than ten had reported job histories lasting five or more years. One inmate reported professional employment and seventeen reported skilled employment outside CDCR.

Languages Spoken. Ninety-four inmates (92%) were either primary or secondary English-speakers. Two additional inmates were Spanish-only speakers, four spoke other languages, and information about the remaining two was unknown.

Health Factors. Prison inmates are known to have higher rates of both chronic medical conditions and infectious diseases than members of the community at large.[9] Medical conditions can increase the risk of suicide-related thinking and behavior.[10]

Fifteen inmates who died by suicide (15%) during 2017 through 2019 were identified as having chronic medical conditions. One inmate had the sequelae of a helicopter crash during the Vietnam War, while another had only partial functioning in one shoulder. Others had chronic conditions, such as gastroesophageal reflux disease, diabetes mellitus, polycystic kidney disease, hearing impairment, and hepatitis C infection; however, there was no identifiable pattern of medical conditions tied to suicide. In addition, a number of suicide decedents were reported to have chronic pain or other painful conditions. None of these conditions were identified by reviewers as the proximal causes of the individual's suicide, but as noted, medical problems, especially when intertwined with mental disorders can increase the risk of suicide-related thoughts and behaviors.

Temporal Factors. Over the three years between 2017 through 2019, suicides occurred in all months of the year. They ranged from nine in August 2019 to zero in February 2017 and July 2019. The average in any one month was 2.8, and the median was three suicides per month. Although there was substantial variation in monthly frequency of suicide, there were no statistically significant differences between the months of the year.

Thirty (29%) of suicides in 2017-2019 occurred during the holiday/winter months of November, December, and January. Historically, many suicides have occurred in late spring and early summer. But during the three years covered by this report, just 18% of all suicides occurred in the months of May, June, and July.

Another temporal factor is the time of day when suicides occur. In CDCR institutions, there are three basic work shifts or watches during a 24-hour period. These shifts or watches identified as first, second, and third watch. First watch is from 2200 hours to 0600 hours, second watch from 0600 hours to 1400 hours, and third watch from 1400 hours to 2200 hours. During the three years between 2017 through 2019, there were 26 suicides (26%) discovered during first watch, 38 (37%) during second watch, and 38 (37%) during third watch.[11]

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[9] Maruschak, L.M. & Berzofsky, M. (2016). "Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12." Report NCJ 251920. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Washington, DC. Available at: https://www.bjs.gov/pub/pdf/mpsfpji1112.pdf.

[10] Moscicki, E. (2014). "Suicidal Behaviors among Adults." In Nock, M.K. (Ed.), *The Oxford handbook of suicide and self-injury* (pp. 82-112). Oxford University Press. DOI:10.1093/oxfordhb/9780195388565.001.0001

[11] CDCR notes the time of discovery of an inmate who has made a suicide attempt and the time of death. The elapsed time between the suicide attempt itself and the time of death can be minutes, hours, or days, depending on several factors: manner of death (poisoning, hanging, laceration, etc.), how soon the discovery is made, life-saving efforts, and subsequent medical treatment. The actual time of death is noted as when a physician declares the individual deceased

CUSTODIAL AND CORRECTIONAL FACTORS

Institution at Time of Death. Between 2017 and 2019, suicides occurred in 25 in-state institutions, plus one in an out-of-state facility located in Arizona (Table 4). Historically, suicides are more frequent in institutions with significant mental health programs than in those without those programs. Suicides are also more frequent in higher security (Level III or Level IV) institutions than in lower security settings. During 2017 through 2019, sixty-one suicides (60%) occurred in Level III and IV institutions.

Housing Type. Inmates in CDCR are housed in a variety of physical settings, from dormitory settings with up to 200 inmates to the most common type, celled housing, which houses one or two inmates.

Segregated Housing. Inmates alleged to be or found guilty of committing a disciplinary infraction are typically placed in segregated housing (Administrative Segregation and Security Housing Units). If found guilty, sanctions can include loss of time credits, loss of privileges, or other consequences. Inmates can also be placed in segregated housing at their own request for protection. They may believe they are being threatened by individuals or groups of inmates and their safety is in jeopardy. For the three years covered by this report, the percentage of total CDCR population housed in segregated housing was on average 3.7%, or about 4,567 inmates each year.[12]

The units and cells in these units are often physically similar to other housing units. But the regulations and routines of segregated housing restrict an inmate's movements and privileges, which may affect an inmate's mental status and functioning. The conditions of confinement in segregated housing may result in significant distress for some inmates, and for others, placement in segregated housing increases the risk of self-harm.

CDCR has implemented a number of policies and programs to increase mental health services and to reduce the risk of suicide in segregated housing. In the early 2000s, the department created specialized Administrative Segregation Unit (ASU) "Hub" units and Psychiatric Services Units (PSU) for patients in the Enhanced Outpatient Program (EOP). In 2015, CDCR developed the Short-Term and Long-Term Restricted Housing (STRH/LTRH) units for inmates at the Correctional Clinical Case Management System (CCCMS) level. These units correspond to the ASU and Security Housing Units, respectively.

During 2017 through 2019, thirty-two (31%) inmates died by suicide while housed in CDCR segregated housing units (SHUs). Of these, 22 were participants in the MHSDS – nine at the CCCMS level of care and 13 at the EOP level of care. Three inmates died while housed in condemned housing, none of whom were participants in the MHSDS at the time of their deaths.

Other types of housing can also be associated with prison-related difficulties. Inmates entering CDCR with a new prison term or whose parole has been revoked are housed in Reception Center institutions. During the period covered by this report, eleven inmates died in Reception Centers. Table 5 lists the types of housing placements inmates were assigned to at the time of their deaths.

[12] For the purpose of this report, segregated housing includes ASU, STRH, LTRH, ASU Hubs, SHU, PSU, and Condemned housing.

Table 4. Suicides by Institution, 2017-2019, with Available Mental Health Programs

Institution	Unclas-sified	Level I/II	Level III	Level IV	Mental Health Program Available
California State Prison, Sacramento			1	11	CCCMS, EOP, EOP-ASU, PSU, MHCB
California State Prison, Corcoran				9	CCCMS, EOP, EOP-ASU, MHCB
California State Prison, Los Angeles County		1	1	6	CCCMS, EOP, EOP-ASU, MHCB
Deuel Vocational Institution	5	1	1	1	CCCMS
Kern Valley State Prison			1	7	CCCMS, EOP, MHCB
Mule Creek State Prison		2	1	3	CCCMS, EOP, EOP-ASU, MHCB
California Correctional Inst.		1	2	2	CCCMS
California Medical Facility		2		3	CCCMS, EOP,EOP-ASU, MHCB, PIP
Richard J. Donovan Correctional Facility			3	2	CCCMS, EOP, EOP-ASU, MHCB
San Quentin State Prison	1			4	CCCMS, EOP, MHCB, Condemned PIP
Salinas Valley State Prison		1		4	CCCMS, EOP, MHCB, PIP
Wasco State Prison	2		1	1	CCCMS, MHCB
Correctional Training Facility		2		1	CCCMS
High Desert State Prison			1	2	CCCMS, MHCB
California Health Care Facility				2	CCCMS, EOP, EOP-ASU, MHCB, PIP
California Institution for Women		2			CCCMS, EOP, EOP-ASU, PSU, MHCB, PIP
California State Prison, Solano		1	1		CCCMS, MHCB
Central California Women's Facility	1			1	CCCMS, EOP, EOP-ASU, MHCB
North Kern State Prison	1		1		CCCMS, MHCB
California Correctional Center		1			No Mental Health
California Institution for Men		1			CCCMS, MHCB
California Men's Colony		1			CCCMS, EOP, EOP-ASU, MHCB
California Substance Abuse Treatment Facility					CCCMS, EOP, MHCB
Pelican Bay State Prison				1	CCCMS, MHCB
Pleasant Valley State Prison				1	CCCMS, MHCB
California Out-of-State Correctional Facility			1		No Mental Health
Total (percent)	10 (10%)	16 (16%)	15 (15%)	61 (60%)	

Time in Segregated Housing. Historically, a significant number of CDCR suicides have occurred in segregated housing units. In 2007, the department began a program to retrofit a number of ASU cells as "intake" cells. These cells have physical modifications, which include removing ligature attachment sites to increase the safety of the cells. Inmates entering ASU are temporarily assigned to these cells for at least 72 hours before transitioning to regular ASU housing. This initial period in ASU or STRH may be very stressful for some inmates, especially those who are in mental health treatment. Alternatively, extended stays (greater than 30 days) can also lead to a deterioration of an inmate's mental well-being.[13] During the three years covered by this report, six inmates died within the first 48 hours of being housed in ASU. Two of these were housed in non-retrofitted cells in violation of policy, and four were appropriately housed.

Table 5. Housing Types, 2017-2019

	Frequency (Percent)		
Housing Type	2017	2018	2019
Administrative Segregation	10 (33)	4 (12)	6 (16)
Condemned Housing	0 (0)	2 (6)	1 (3)
Psychiatric Services Units	1 (3)	0 (0)	5 (13)
Short-Term Restricted Housing	0 (0)	2 (6)	1 (3)
Acute/ICF and PIP	0 (0)	1 (3)	1 (3)
Reception Centers	6 (20)	2 (6)	3 (8)
CTC/MHCB	2 (7)	1 (3)	0 (0)
General Population	11 (37)	22 (65)	21 (55)

Offense Type. A common finding in prison and jail settings is a high proportion of suicides among inmates with violent commitment offenses; inmates incarcerated for a violent crime have a rate of suicide death, more than twice the rate for those committed for non-violent crimes.[14] The primary commitment offenses of inmates who died by suicide between 2017 and 2019 are listed in Table 6.[15] Notably, 31 (30%) of 102 suicide decedents during 2017 through 2019 had committed murder, fifty percent more than the system-wide average for those three years. Overall, 88% of suicide decedents in the period covered by this report were incarcerated for a violent crime against a person, which is higher than the overall average proportion of inmates in CDCR for these types of crimes.

Security Level. Sixty of 102 (59%) suicide decedents were at the highest security classification in CDCR (Level IV). In comparison, only 24% of CDCR inmates were at that level over the three years covered by this report. As can be seen in Table 7, half or more of suicide decedents in each of the three years were at Level IV security level. Whereas over three-quarters of CDCR inmates are at Level III and below, only 42 (41%) of suicide decedents were at Level III and below, including ten inmates who had yet to be classified at the time of their deaths.

[13] Haney, C. (2018). Restricting the use of solitary confinement. *Annual Review of Criminology, 1.* 285-310. https://doi.org/10.1146/annurev-criminol-032317-092326
[14] Mumola, C. (2005), Bureau of Justice Statistics, located at: http://www.bjs.gov/content/pub/pdf/ardus05.pdf
[15] Most inmates are charged and found guilty of multiple charges. The charges in Table 6 are the primary charges as noted by suicide case reviewers.

Table 6. Commitment Offenses, 2017-2019

Type of Offense	Frequency (Percent) 2017	2018	2019	CDCR Population 2017-2019
Violent Crimes				
Murder	6 (20)	12 (35)	13 (34)	20%
Attempted Murder	1 (14)	3 (9)	5 (13)	
Assault	7 (23)	1 (3)	5 (13)	25%
Robbery	4 (13)	6 (18)	6 (16)	16%
Carjacking	3 (10)			
Corporal Injury to Another	2 (7)	1(3)	2 (6)	
Elder Abuse with Injury		1 (3)		
Sex Offense	2 (7)	7 (21)	3 (8))	15%
Total Violent Crimes	25 (83)	31 (91)	34 (90)	76%
Non-Violent Crimes				
Burglary	1 (3)		1 (3)	7%
Auto Theft	1 (3)		2 (6)	2%
Resisting Arrest	1 (3)			
Evading a Peace Officer	1 (3)	1 (3)	1 (3)	
Arson		1 (3)		
Possession of a Firearm	1 (3)	1 (3)		
Total Non-Violent Crimes	5 (17)	3 (9)	4 (11)	10%

Sentence Length. Another variable unique to suicides in correctional settings is sentence length: total length of sentence; how much time an inmate has served prior to a suicide death; and how much time an inmate had left to serve in prison at the time of their death. These variables are captured in Tables 8, 9, and 10.

Table 7. *Security Level, 2017-2019*

Security Level	Frequency (Percent) 2017	2018	2019	2017-2019	CDCR Population 2017-2019
Level IV	16 (53)	20 (59)	24 (63)	60 (59)	24%
Level III	5 (17)	6 (18)	5 (13)	16 (16)	17%
Level II	2 (7)	5 (15)	5 (13)	12 (12)	44%
Level I	2 (7)	1 (3)	1 (3)	4 (4)	10%
Unclassified[16]	5 (17)	2 (6)	3 (8)	10 (10)	6%

Length of sentence can have implications for the mental state of inmates at the beginning of their prison term. Table 8 presents data about the sentences of inmates who died by suicide during 2017-2019. During the three years covered by this report, 51 (50%) inmates who died by suicide had sentences of greater than 10 years or a life sentence without the possibility of parole (LWOP).

[16] Unclassified inmates are those who have not completed the classification process while at a CDCR reception facility or are unclassified for other reasons

If inmates with indeterminate sentences (N = 22) and those condemned to death (N = 3) are added to this group, 75% of inmates who died by suicide in these three years were serving long sentences.

Table 8. Sentence Length, 2017-2019

	Number of Inmates (Percentage)			
Sentence Length	2017	2018	2019	2017-2019
1-5 years	7 (23)	4 (12)	1 (3)	12 (12)
6-10 years	6 (20)	3 (9)	5 (13)	14 (14)
11-20 years	3 (10)	4 (12)	5 (13)	12 (12)
21+ years	9 (30)	9 (26)	10 (26)	28 (28)
Life w/ Possible Parole	5 (17)	7 (21)	10 (26)	22 (22)
Life w/out Parole	0 (0)	5 (15)	6 (16)	11 (11)
Condemned	0 (0)	2 (6)	1 (3)	3 (3)

Table 9 shows time spent in CDCR by inmates who have died by suicide. During 2017-2019, the amount of time served at the time of death ranged from several days to more than 25 years. Just over one-quarter of inmates who died by suicide during the three-year span had served less than one year at the time of their death. On the opposite end of the range, five inmates had been incarcerated for over 20 years by the time of their death.

Table 9. Time Served at Time of Death, 2017-2019

	Number of Inmates (Percentage)			
Time Served	2017	2018	2019	2017-2019
0-1 year	14 (47)	7 (21)	5 (13)	26 (26)
1-5 years	9 (30)	9 (26)	12 (32)	30 (29)
6-10 years	3 (10)	6 (18)	7 (18)	16 (16)
11-20 years	4 (13)	10 (29)	11 (29)	25 (24)
21+ years	0 (0)	2 (6)	3 (8)	5 (5)

Table 10 shows the length of time remaining in sentences for those who died by suicide during 2017 to 2019. Fifteen percent of inmates who died during 2017 to 2019 had one year or less left to serve at the time of their death. Just under one-third (N = 31) had between a year and 10 years left to serve, while the remaining 56 (55%) had more than ten years left to serve at the time of their deaths.

Table 10. Time Left to Serve, 2017-2019

Suicide Deaths by	Frequency (Percent)			
Time Left to Serve	2017	2018	2019	2017-2019
0-1 year	8 (27)	3 (9)	4 (11)	15 (15)
1-5 years	6 (20)	5 (15)	7 (18)	18 (18)
6-10 years	2 (7)	6 (18)	5 (13)	13 (13)
11-15 years	1 (3)	4 (12)	5 (13)	10 (10)
16+ years	13 (43)	16 (47)	17 (45)	46 (45)

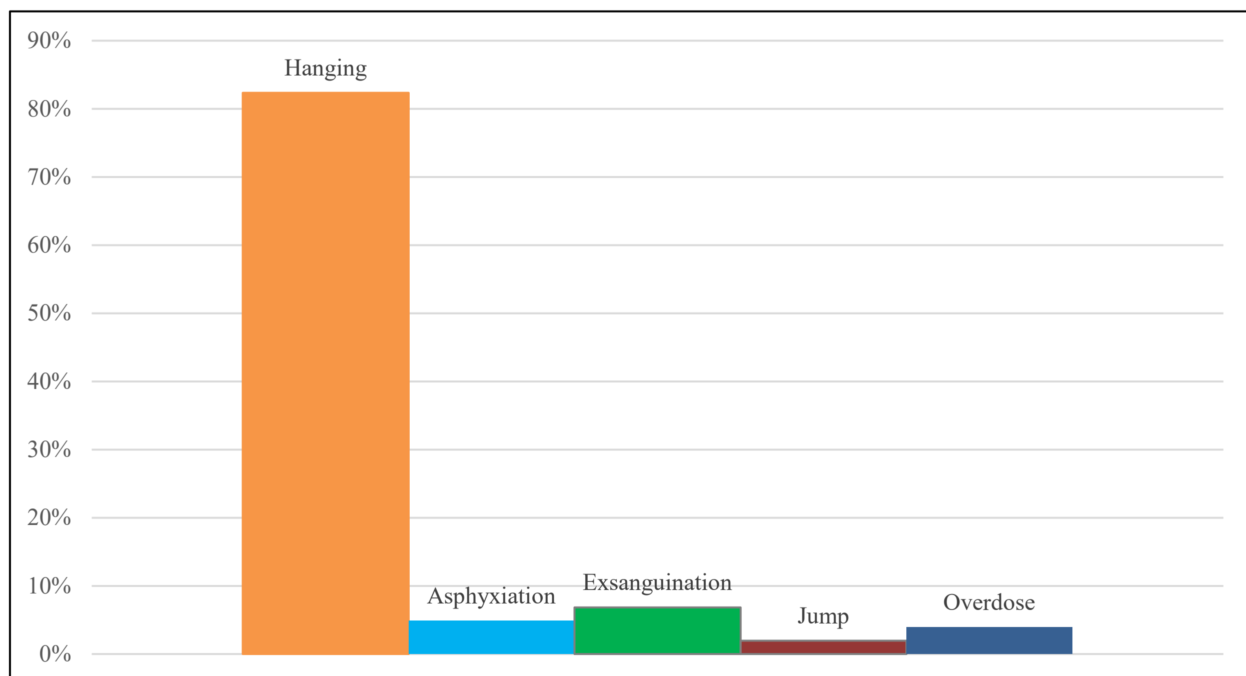
Cell Occupancy. It is typical for inmates to attempt suicide when they are alone in their assigned housing. They may be alone because they have not been assigned a cellmate, they are assigned a single cell, they are in single-cell designated housing (Correctional Treatment Center,

or CTC; Mental Health Crisis Bed, or MHCB; or ASU/STRH intake cells), or their cellmate is out of the cell. During 2017 to 2019, 93 (91%) of suicide decedents were alone in a cell at the time of their death. Fourteen inmates (14%) who died by suicide were assigned a cellmate and made their fatal suicide attempt while the cellmate was elsewhere. Five inmates died by suicide while their cellmates were present – two by hanging, two by poisoning/overdose, and one by laceration and exsanguination. Two inmates jumped to their deaths – one from a high tier and the other from the roof of a housing unit. Finally, two inmates died in dormitory settings.

Job/School Assignment. Twenty-nine inmates (28%) of the 102 inmates who died by suicide between 2017 and 2019 had a job, school, or other assignment at some point during their incarceration in CDCR.

Means or Method of Suicide. As in most years, during the three years 2017 through 2019, asphyxiation by ligature, or hanging, was the primary means used by CDCR inmates to die by suicide. Inmates in most housing units have access to clothing, linens, and other materials (e.g., coaxial cables, shoelaces, earphone cables) that can be used for nooses, and ligature attachment points can be found in most cells.[17] As shown in Figure 2, 84 of the 102 suicides (83%) were by ligature hanging.

Figure 2. Method of Suicide, 2017-2019



MENTAL HEALTH FACTORS

Mental Health Level of Care. The MHSDS is divided into levels of care with increasing intensity of treatment. In addition to EOP and CCCMS, which are out-patient programs, psychiatric inpatient programs are include Mental Health Crisis Bed (MHCB), Acute and Intermediate Psychiatric Programs (PIP); these latter three are licensed, in-patient programs.

Unsurprisingly, mental health patients are overrepresented in the suicides covered by this

[17] Inmates deemed at elevated risk for self-harm have their clothing and belongings restricted, particularly when in inpatient psychiatric housing or while awaiting transfer to such settings.

report, a pattern that is typical in both correctional and community settings. Specifically, seventy (69%) of the suicide decedents during 2017 through 2019 were participants in the MHSDS at the time of their deaths (see Table 11).

Table 11. *Suicides in CDCR by MHSDS Participation, 2017-2019*

MHSDS Level of Care at Time of Death	Frequency	Percent of All Suicide Deaths
CCCMS	31	30
EOP	36	35
MHCB	3	3
Any MHSDS LOC	70	69

During 2017-2019, thirty-six (35%) of suicide decedents were at the EOP level of care while thirty-one (30%) were at the CCCMS level of care. Three inmates died by suicide while housed in in-patient MHCB settings.

Thirty-two inmates (31%) were not in the MHSDS at the time of their deaths. Five inmates had been discharged from the CCCMS LOC within the previous year. The most recent discharge was 26 days prior to death. Eighteen inmate decedents had no record of treatment in the MHSDS during incarceration. Three inmates had been participants in the MHSDS seven or more years prior to their deaths. An additional six inmates had no MHSDS designator because they died during Reception Center processing. However, of the six, four had a documented history of mental health treatment either in county jail or in the community.

Mental Health Treatment Prior to Incarceration. Fifty-eight inmates (57%) of inmates who died by suicide from 2017 through 2019 reported some history of mental health treatment in the community.

Screening Upon Arrival at CDCR. All inmates are administered a brief mental health screening questionnaire upon their initial arrival into CDCR. The screening casts a relatively wide net in order to identify inmates who need further evaluation. Those who screen positive are provided a fuller mental health evaluation within 18 days.

Of the 102 inmates who died by suicide during 2017 through 2019, reception center screening and initial mental health evaluation data is available for 45.[18] In 2017 and 2018, data is available for 41 of the 64 suicide decedents. Of those with available data, 28 (68%) screened positive and were referred for further evaluation. Of these 28, 24 (86%) were found eligible for participation in the MHSDS after the full evaluation. Of the 38 inmates who died by suicide in 2019, four had information about reception center screening and evaluation within a year of their death. According to records compiled by the case reviewers, three inmates screened positive, and of those, none were placed into the MHSDS upon further evaluation.

Psychiatric Medication. Of the 70 inmates who were receiving mental health treatment at the time of their deaths, 65 (93%) were prescribed psychiatric medications as part of their treatment. Suicide case reviewers noted that medication compliance (either outright refusal or

[18] Data is not available for the others because 1) they entered more than ten years ago when CDCR used paper charts and these charts are archived; 2) they entered more than a year before their death and review criteria have been changed; or 3) data was not available due to the change to electronic records

intermittent adherence) was an issue in 14 (22%) of the mental health cases.

A small percentage of CDCR inmates are placed on involuntary psychiatric medication orders per Penal Code section 2602 due to severe mental illness and poor compliance with prescribed medications.[19] In the three years covered by this report and of those who were prescribed psychiatric medication, seven inmates (11%) were subject to an involuntary psychiatric medication order at the time of death.

History of Admissions to CDCR Psychiatric Inpatient Programs. Of the 70 inmates who were in mental health treatment at the time of their deaths, thirty-three (47%) had been hospitalized for psychiatric treatment in the year before their deaths. An additional 20 inmates (29%) had a psychiatric inpatient admission at some point in their CDCR incarceration. One inmate was not in the MHSDS at the time of his death but had been psychiatrically hospitalized three months prior to his death.

For the 33 inmates psychiatrically hospitalized in the year prior to their deaths, most (N=24, 73%) were admitted to MHCB units. The median length of stay was ten days and the average was 12 days. The remaining nine inmates had been admitted to the department's longer-term inpatient psychiatric programs, which transitioned from Department of State Hospitals (DSH) administration to CDCR administration on July 1, 2017. The average length of stay in inpatient psychiatric care for these nine inmates was 135 days, with a range of 29 days to 265.

For inmates who were discharged from either MHCB or psychiatric inpatient units, the average length of time from their discharge to their death was 63 days, but the median time to death was just 14 days. The time between inpatient discharge to death ranged from zero days to 349 days.

Psychiatric Diagnoses. The mental health diagnoses of individuals who died by suicide during the three years between 2017 and 2019 are summarized in Table 12. Seventy-five (74%) of the 102 inmate deaths reviewed for this report had mental health diagnoses.[20] The remaining 27 inmates were not participants in the MHSDS at the time of their death or had been discharged from the MHSDS more than six months prior to their death. Although many inmates use and abuse alcohol and illegal substances while incarcerated, substance and alcohol use diagnoses in Table 12 are included *only* when formally reported as a diagnosis in the medical record. All diagnoses are based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V).

When present, mood disorders and psychotic disorders were counted as the primary diagnosis of record. Of the individuals diagnosed with DSM-V mental health disorders, the most common category of disorder was mood disorders (47% of decedents), followed by alcohol and substance use disorders (42%), and psychotic (33%) disorders. Additionally, 23 individuals (31%) were diagnosed with a personality disorder, either in addition to a major mental illness or as a

[19] Penal Code § 2602 provides for the involuntary administration of psychiatric medication if a psychiatrist determines that an inmate suffers from a "serious mental disorder" and "as a result of that disorder, the inmate is gravely disabled and does not have the capacity to refuse treatment with psychiatric medications or is a danger to self or others." Inmates are entitled to a hearing and the psychiatrist must certify that alternative methods of treatment "are unlikely to meet the needs of the patient."

[20] Four inmates were not participants in the MHSDS or had not been given a diagnosis at a Reception Center at the times of their deaths. Three inmates' diagnoses are included in the tally because their diagnoses were given within six months of their deaths. The fourth inmate's diagnosis was noted by a reviewer to have been given by a Board of Parole Hearings (BPH) examiner, and the fifth inmate's diagnosis was derived from jail mental health records since he had not yet been seen for a full Reception Center mental health evaluation at the time of his death.

primary diagnosis. Twenty-two inmates (22%) were noted to have had a history of substance use problems, though only seven were diagnosed with a substance use disorder.

Table 12. Mental Health Diagnoses of 75 Suicide Decedents, 2017-2019

Diagnostic Category	Frequency	Percent of Suicide Decedents with Diagnosis
Any DSM-5 Disorder	135	
Any Mood Disorder	35	47
Major Depressive Disorder	19	25
Depressive Disorder NOS	2	3
Bipolar Disorder	7	9
Mood Disorder NOS	7	9
Any Psychotic Disorders	25	33
Schizophrenia/Schizoaffective Disorders	19	25
Psychotic Disorder NOS	6	8
Anxiety Disorder	3	4
Adjustment Disorder	14	19
Post-Traumatic Stress Disorder	3	4
Personality Disorders	23	31
Alcohol Abuse or Dependence	5	7
Any Substance Abuse or Dependence	26	35
Other Diagnoses	1	1

SUICIDE ATTEMPT HISTORY

Sixty-six (65%) of the 102 suicide decedents had at least one documented prior suicide attempt either while in CDCR custody or elsewhere. This is roughly comparable to the totals in 2015 (67%) and 2016 (74%). Of these, 22 (35%) had made one documented attempt, 21 (32%) made two attempts, and 23 (35%) had made three or more suicide attempts. Of those who had at least three prior suicide attempts, two had multiple incidents of self-harm since the beginning of 2017. One had over 30 incidents and the other 20. The finding that 44 inmates (43% of suicide decedents in the three years covered by this report) had two or more attempts is significant, since "multiple attempters," as a group have high chronic risk of suicide.[21]

Suicide Precipitants and Behavior. Individuals who die by suicide often experience significant interpersonal or life events in the weeks or months prior to death. These events are often identified as "precipitating" events that play a role in triggering an individual's decision to end their life. Additionally, individuals can be "driven" to suicidal thinking and/or behavior by mental processes such as the symptoms of a mental disorder, negative life events, or a collection of psychosocial stressors.[22] The frequency and percentage of total precipitants or drivers of suicides listed or suspected by CDCR suicide reviewers in the suicide case review reports are presented in

[21] Rudd, M.D., Joiner, T. & Rajab, M.H. (1996). Relationships among suicide ideators, attempters, and multiple attempters in a young-adult sample. *Journal of Abnormal Psychology*, *105*, 541-550.
[22] Tucker, R.P., Crowley, K.J., Davidson, C.L. & Gutierrez, P.M. (2015). Risk factors, warning signs, and drivers of suicide: What are they, how do they differ, and why does it matter? *Suicide Life-Threatening Behavior 45*, 679-689.

Table 13. In many cases, the precipitants or drivers were not entirely clear or definitively established. Rather, those identified by suicide case reviewers should be considered clinically presumptive about each inmate's idiosyncratic reasons for ending their life, based on available records and information reviewed posthumously.

Rarely can one precipitant or driver be identified as the sole reason someone killed themselves. More often, there are multiple precursors that accumulate on top of pre-existing vulnerabilities. Reviewers identified 161 separate precipitants and drivers among the 102 suicides. The frequency of precipitants and drivers is greater than the total number of suicides, as nearly all suicide case reviews identified more than one precursor. Mental health symptoms (52%) were the most frequent precipitant or driver found in suicides occurring during 2017 through 2019, similar to previous years. Almost one-third of suicide decedents in this period had losses of social support that reviewers associated with the timing of their death. Of these, reviewers found that 30 had conflicts or losses of external support, while three had conflicts or losses of within-prison social supports.

Of the 102 inmates who died by suicide during 2017 to 2019, twenty-seven (27%) left suicide notes. This is higher than the rate (one in six) found in community samples,[23] but lower than the 37% found among 2016 suicide decedents and the 2015 rate of 29%.

The interpersonal culture of prison may include coercion and threats of outright violence.[24] Thus, the general category of "safety concerns" figured prominently in a number of suicides during 2017 to 2019. These concerns can center on prison gang issues, threats based on a commitment offense (particularly sex crimes), gambling or drug debts, intellectual disability status, or simply physical size. Reviewers identified 27 (27%) instances where the record suggested that safety concerns were a precipitant or driver to an inmate's suicide death. Medical illness, chronic pain, and medical disability were found to contribute to nine suicides (9%) in this period. The category "refusals and discontinuation of psychiatric medications or poor compliance with medications" was noted in only two cases in 2017-2019 compared to five case in 2016 and none in 2015. Conversely, the number of suicides triggered by new charges or disciplinary actions, in-prison disruptions, BPH issues, and anniversary dates increased between 2017 and 2019 to 16 (16%) compared to 2016 and 2015.

Many inmates, because of lifestyle, developmental vulnerabilities (e.g., childhood adversity), criminal background, and medical co-morbidities, may enter prison already bringing with them an increased risk for suicide-related thinking and behavior. But each year, a number of inmate suicides appear to have no proximal precipitating factors or triggers for death. In 2017-2019, five inmates (5%) who died by suicide did not appear to reviewers to have any proximal cause of death.

[23] See Gelder, Mayou, and Geddes (2005). "Incidence of note-leaving remains constant despite increasing suicide rates." *Psychiatry and Clinical Neurosciences,* 4(1). And also: Cerel, J., Moore, M., Brown, et al. (2014). "Who leaves suicide notes? A six-year population-based study." *Suicide and Life-Threatening Behavior 45*(3), 326-334. https://dx.doi.org/10.1111/sltb.12131

[24] See e.g. Toch, H. & Adams, K. (2002). *Acting Out: Maladaptive Behavior in Confinement*. American Psychological Association, Washington, DC.

Table 13 Suspected Precipitants/Drivers of Suicide in CDCR, 2017-2019

Precipitant Category	Frequency	Percentage of Decedents with Precipitant or Driver
Mental health symptoms, e.g. anxiety, psychosis, depression	53	52
Conflict or losses of external supports, such as family or spouse	36	35
Safety concerns, drug debts, fears of victimization	27	26
Medical illness and/or pain issues; medical disability	9	9
Active substance use	8	8
Disruption in prison 'program;' e.g., transfer between facilities, cellmate change, loss of single cell housing	7	7
Receipt of new charges, convictions, disciplinary actions, or added time in prison	6	6
Anxiety about parole	4	4
Fatigue with the length of incarceration; "tired of prison life"	3	3
Conflict or losses of within prison supports	3	3
Receipt of or anticipation of negative outcomes with the Board of Prison Hearings	2	2
Refusals and discontinuation of psychiatric medications or poor compliance with medications	2	2
Holidays or anniversaries of losses, crimes, etc.	1	1

REVIEW OF FINDINGS: CURRENT YEAR VS. PRIOR YEARS

COMPARISON OF SUICIDE RATE IN 2017-2019 AND PRIOR YEARS

In the three years covered by this report, the rate of suicide death within CDCR was 23 per 100,000 in 2017, 26 per 100,000 in 2018, and 30 per 100,000 in 2019 – a continued increase since 2014, when the rate was 17 per 100,000. In the five-year period between 2012 and 2016, the rate of suicide was 21 per 100,000 inmates. The rate during 2007 to 2011 was 19 per 100,000.

Table 14 shows the rate and frequency of suicide in CDCR for both genders and total inmate population for 2000 through 2019. The total number of suicides annually over the period has ranged from a low of 15 in 2000 to a high of 43 in 2006, while the rate has been as low as 9 per 100,000 in 2000 and as high as 30 per 100,000 in 2019.

Historically, there are fewer suicides among the CDCR female population than the male population. In the past three years, there were four female suicides compared to seven in the preceding three years. Because the absolute numbers of female suicides and the CDCR female inmate population has fluctuated over the past twenty years, the rate fluctuations have tended to be more extreme than for male inmates. For instance, the rate of suicide in 2006 when the female inmate population approached 12,000 was 34 per 100,000 with four suicides, while in 2016, when there were three suicides in the female inmate population, the rate was 52 per 100,000 with a population of less than half that of 2006.

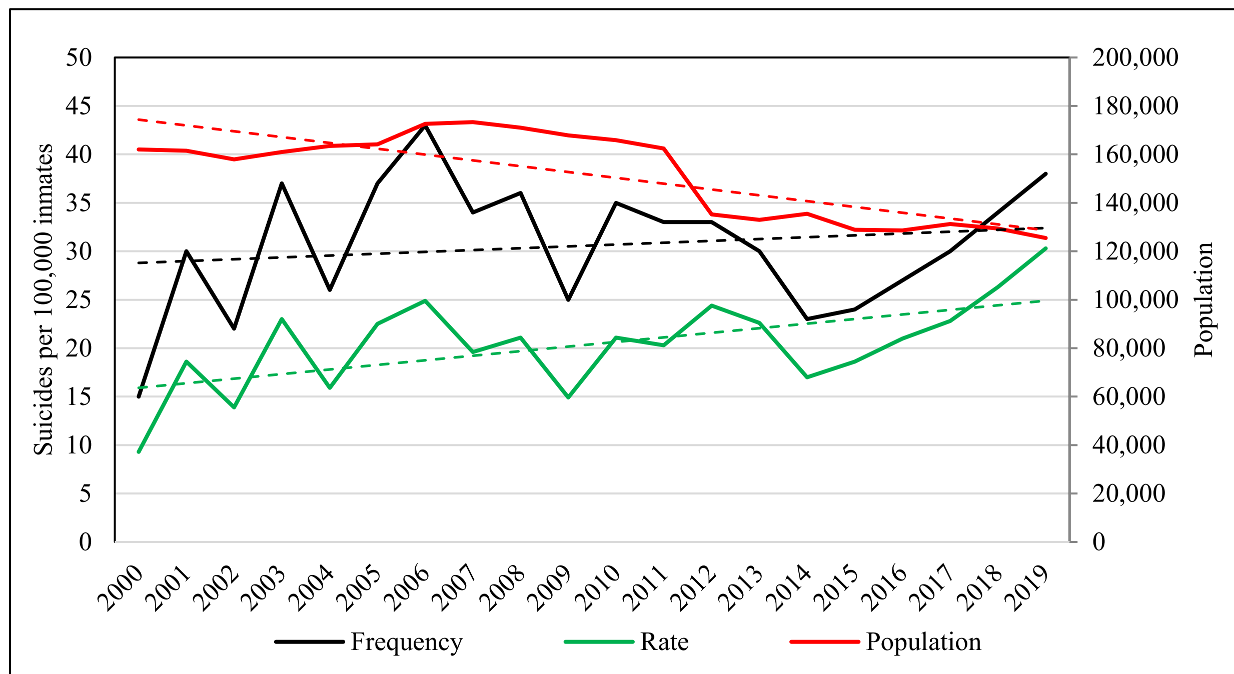
Over the 20 years covered between 2000 and 2019, the variability in the number female suicide has been lower than for males, while the variability in suicide rate has been higher because of a smaller population and small numbers. Male suicides have fluctuated from 15 in 2000 to 39 in 2006, while female suicides have ranged from zero in most years to four in 2006. Although there were nine suicides of female inmates in 2000-2009, there were 14 in 2010-2019.

Figure 3 shows the twenty-year trends in the CDCR inmate population, frequency of suicides, and the suicide rate. Year-to-year fluctuations in the number of suicides predominated in the first decade of the century and then dropped as the prison population declined after the 2011 enactment of Public Safety Realignment. Although the CDCR population has continued to drop, the number of suicides has climbed from a low of 23 in 2014 to 38 in 2019.

Table 14. Annual Frequency & Rate of Suicide in CDCR, by Gender & Total, 2000-2019

Year	Male			Female			Total		
	Population	Frequency	Rate	Population	Frequency	Rate	Population	Frequency	Rate
2000	150,793	15	9.9	11,207	0	0.0	162,000	15	9.3
2001	150,785	29	19.2	10,712	1	9.3	161,497	30	18.6
2002	148,153	22	14.8	9,826	0	0.0	157,979	22	13.9
2003	150,851	37	24.5	10,080	0	0.0	160,931	37	23.0
2004	152,859	23	15.0	10,641	3	28.2	163,500	26	15.9
2005	153,323	37	24.1	10,856	0	0.0	164,179	37	22.5
2006	160,812	39	24.3	11,749	4	34.0	172,561	43	24.9
2007	161,424	33	20.4	11,888	1	8.4	173,312	34	19.6
2008	159,581	36	22.6	11,392	0	0.0	170,973	36	21.1
2009	156,805	25	15.9	11,027	0	0.0	167,832	25	14.9
2010	155,721	34	21.8	10,096	1	9.9	165,817	35	21.1
2011	152,803	33	21.6	9,565	0	0.0	162,368	33	20.3
2012	128,829	32	24.8	6,409	1	15.6	135,238	33	24.4
2013	126,992	29	22.8	5,919	1	16.9	132,911	30	22.6
2014	129,268	21	16.2	6,216	2	32.2	135,484	23	17.0
2015	123,268	22	17.8	5,632	2	35.5	128,900	24	18.6
2016	122,874	24	19.5	5,769	3	52.0	128,643	27	21.0
2017	125,289	28	22.3	5,971	2	33.5	131,260	30	22.8
2018	123,511	33	26.7	5,906	1	17.0	129,417	34	26.3
2019	119,781	37	30.9	5,691	1	17.6	125,472	38	30.3
2000-2019	2,853,722	589	20.6	176,552	23	13.0	3,030,274	612	20.2
2010-2019	1,308,336	293	22.4	67,174	14	20.8	1,375,510	307	22.3

Figure 3. CDCR Suicide Frequency, Rate, and Population, with Trends, 2000-2019



SUICIDES BY INSTITUTION, 2017-2019, AND 10-YEAR AVERAGE

Whereas Figure 3 presents suicides across CDCR as a whole (including out-of-state facilities, fire camps, community correctional facilities, and prisons), the frequency of suicides by institution is less variable. Institutions vary in the number of patients in the institution's mental health program, the mental health mission of the facility, the predominance of violent offenders at the site, and the total number of inmates at the institution. These are just some of the factors that contribute variance to *where* suicides occur. Fluctuations can occur in the number of suicides at an institution in any given year due to cluster effects,[25] changes in the use or mental health mission of the institution, and other factors. There are also subsets of suicides that occur during or upon transfer of an inmate from one institution to another, further complicating the interpretation of *why* suicides occur at certain institutions more frequently than others.

Table 15 presents the number of suicides in each institution during 2017-2019 and the average for each institution for the period 2007-2016. The table includes all CDCR institutions in California, private contract facilities in and outside of California, and programs run by the Department of State Hospitals. The inclusion of ten years of data allows the 2017 through 2019 data to be compared to averages over a significant period of time.

The range of suicides during the decade before 2017 was, on average for all facilities, 0.0 to per year, and the average for the three years of this report was 0.0 to 4.0 suicides deaths per year. The range for the three years 2017-2019 was zero to 12 suicides.[26] Four institutions (California City Correctional Facility, Chuckawalla Valley State Prison, Ironwood State Prison, and Valley State Prison for Women) had zero suicides during the decade before this report period. Thirteen institutions had no suicides from 2017 through 2019.[27]

Sixteen prisons averaged at least two suicides per year in the 10 years before 2017. Of these 16, one (Folsom State Prison) had none in the three years of this report, and three (California Men's Colony, California Institution for Men, and Pleasant Valley State Prison) had only one each in the same period. Ten of the remaining 12 prisons had significant Level IV and/or EOP mental health programs and continued to average from one per year (California Training Facility) to over four per year (California State Prison, Sacramento)

[25] Clusters of suicides can occur temporally or by location. See: Hawton, K., Linsell, L., Adeniji, T., Sariaslan, A., and Fazel, S. (2014). "Self-harm in prisons in England and Wales: An epidemiological study of prevalence, risk factors, clustering, and subsequent suicide." *Lancet, 383*. http://dx.doi.org/10.1016/ S0140-6736(13)62571-4

[26] The average has been adjusted to take into account that some institutions were not open for the full 15 years (COCF 10 years, CHCF 2.3 years, KVSP 10 years, VSPW 11 years, VSP 4 years).

[27] The thirteen were: California City Correctional Facility, Ironwood State Prison, Chuckawalla State Prison, Centinela State Prison, California Rehabilitation Center, Valley State Prison and its successor, Valley State Prison for Women, Calipatria State Prison, private Community Correctional Facilities, Sierra Conservation Center, Avenal State Prison, Folsom State Prison, inpatient psychiatric programs at the Department of State Hospitals, and CDCR inpatient psychiatric programs.

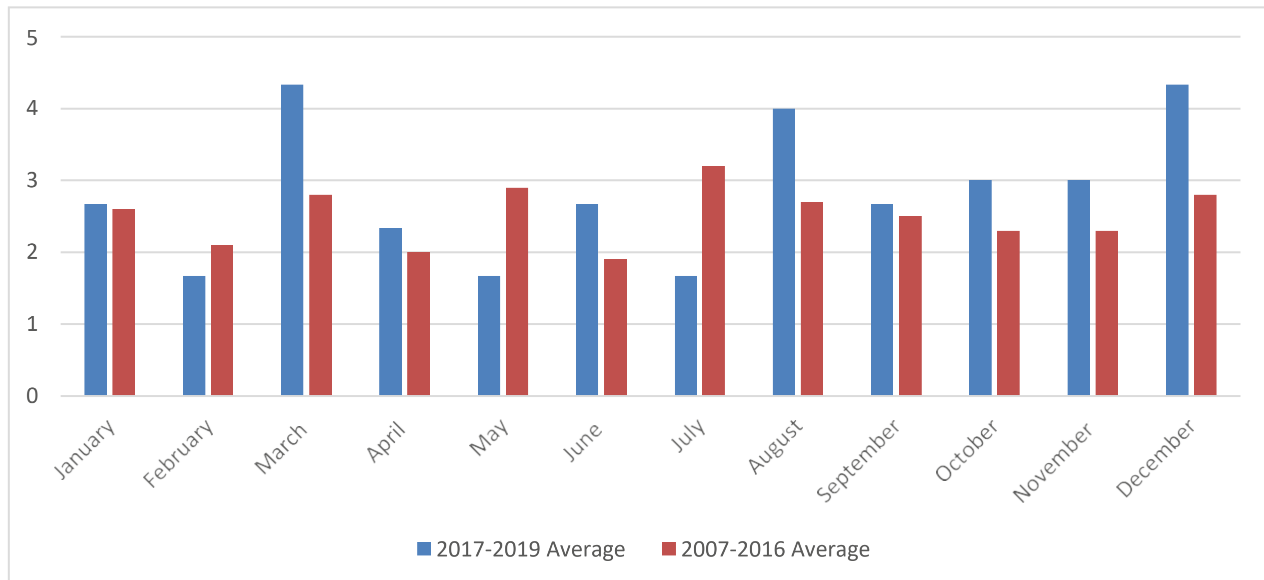
Table 15. Suicides in CDCR Institutions, 2017-2019 and 10-Year Average

Institution	2017	2018	2019	10-Year Adjusted Average
California City Correctional Facility				0.0
Chuckawalla Valley State Prison				0.0
Ironwood State Prison				0.0
Valley State Prison for Women (2007-2012)				0.0
Centinela State Prison				0.2
California Rehabilitation Center				0.2
Valley State Prison (2013-2016)				0.3
Calipatria State Prison				0.4
California Correctional Center	1			0.4
Community Correctional Facilities				0.4
Sierra Conservation Camp				0.4
Central California Women's Facility	1	1		0.6
California State Prison, Solano	1	1		0.6
California Health Care Facility (2013-2016)		1	1	0.6
Avenal State Prison				0.8
California Out-of-State Correctional Facility		1		0.8
Dept. of State Hospitals/Psychiatric Inpatient				1.0
Wasco State Prison	4			1.2
North Kern State Prison			2	1.4
California Institution for Women	1		1	1.6
Pelican Bay State Prison	1			1.6
Substance Abuse Treatment Facility			1	1.6
California Training Facility		2	1	1.8
California Institution for Men			1	2.0
California State Prison, Corcoran	2	3	4	2.0
Mule Creek State Prison	2	2	2	2.0
Pleasant Valley State Prison			1	2.0
California Medical Facility	2		3	2.2
Deuel Vocational Institution	4	1	3	2.4
High Desert State Prison		2	1	2.4
Kern Valley State Prison	1	5	2	2.4
RJ Donovan Correctional Facility	1	4		2.4
Folsom State Prison				3.0
California State Prison, Los Angeles County	4	2	2	3.0
California Correctional Institution	1	2	2	3.2
California State Prison, Sacramento	1	2	9	3.2
California Men's Colony		1		3.6
San Quentin State Prison	2	2	1	4.2
Salinas Valley State Prison	1	2	1	4.6
System Wide Totals	30	34	38	30.0

SUICIDES BY MONTH: CURRENT YEAR AND 10-YEAR AVERAGE

As shown in Figure 4, for the three years covered by this report, seven months (March, April, June, August, October, November, and December) exceeded the ten-year average number of suicides while three months (February, May, and July) had fewer suicides, on average, than the 2007-2016 monthly average. January and September's monthly averages were little different from the ten-year average. There were no significant differences in frequencies of monthly suicides across the year when compared to a random distribution or the ten-year average.

Figure 4. Monthly Suicide Frequency, 2017-2019 and 2007-2016 Averages



SOCIODEMOGRAPHIC FACTORS

Ethnicity/Racial. Figure 5 shows the percentage of suicides among CDCR's ethnic/racial groups over the ten-year period of 2010 through 2019. The proportion of White inmates, long the majority of inmate suicides, has begun to decline over the decade including the three years of this report. On average, during the five years 2010-2014, White inmates comprised the largest group of suicides (44%), but Hispanic inmate suicides appear to be on the rise. During 2017-2019 Hispanic inmate suicides comprised 43% of total CDCR suicides, a much larger proportion than other ethnic/racial groups. This proportion was higher than in the two previous three-year periods when Hispanic suicides accounted for only thirty (2014-2016) and thirty-three percent (2011-2013) of all suicides. This increase has outpaced the increase in the overall proportion of Hispanic CDCR inmates which increased only 4.4% from 2011 through 2019.

Age at Time of Suicide. In the decade from 2010 through 2019, the average age of inmates in CDCR has increased from 38 years to just over 40 years. In the same time period, the proportion of CDCR inmates older than 55 years of age has increased 110%, from eight percent in 2010 to 16.6 percent in 2019, while the population of inmates younger than 45 years of age has shrunk by 6.1%. During the ten years 2010-2019 62% of all suicide deaths were among inmates 25-44 years of age. During 2017 to 2019, 67% of suicides were among inmates aged 25-44 years of age.

Figure 5. Annual Percentage of Suicides by Ethnicity/Race, 2010-2019

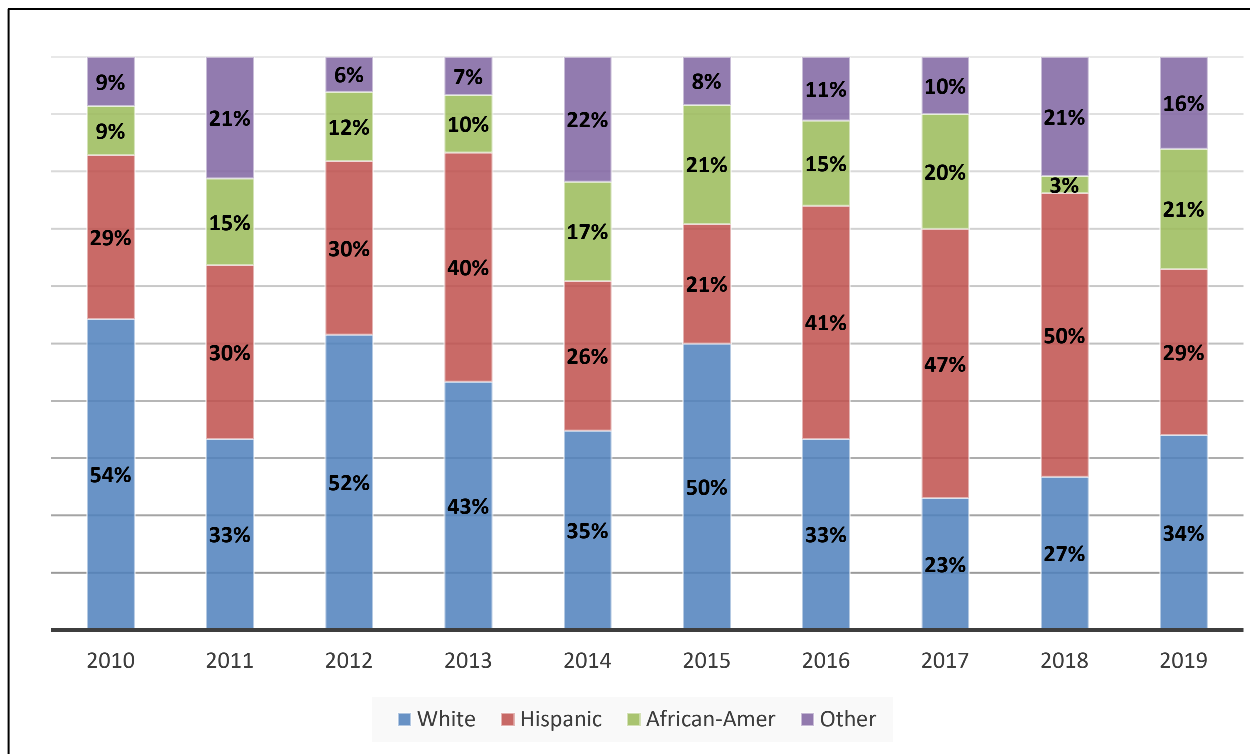
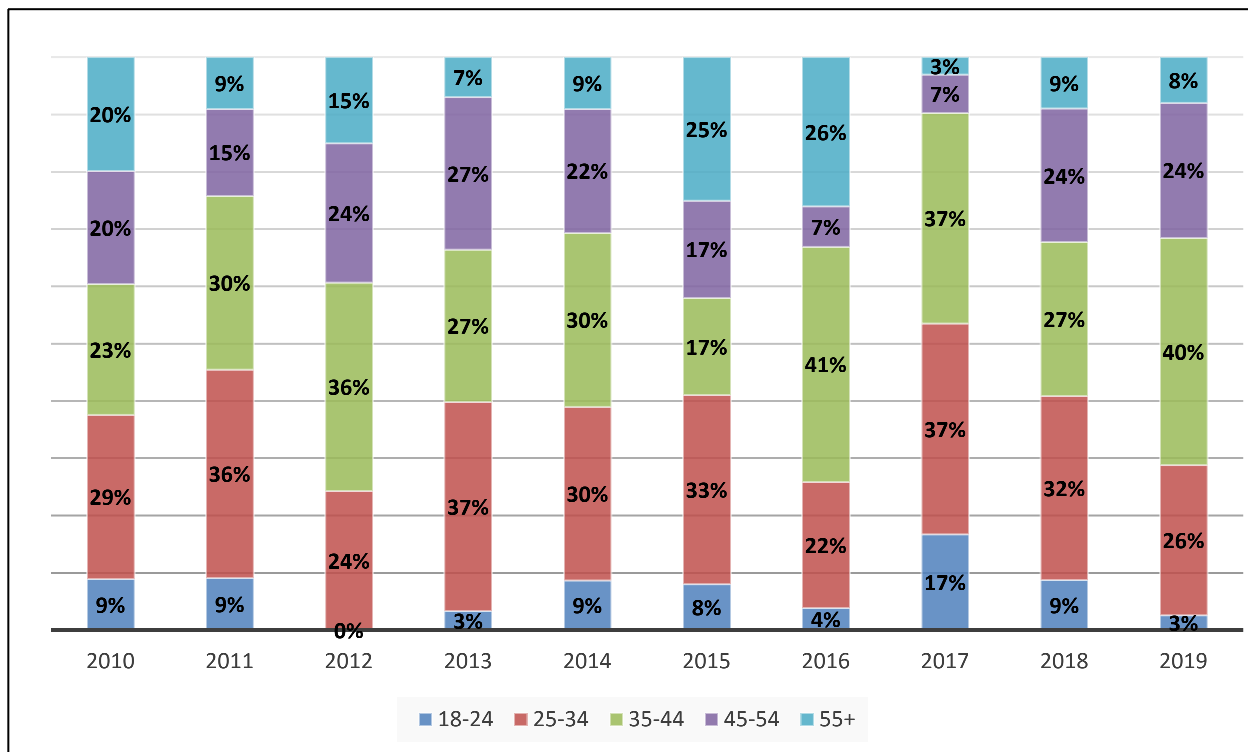


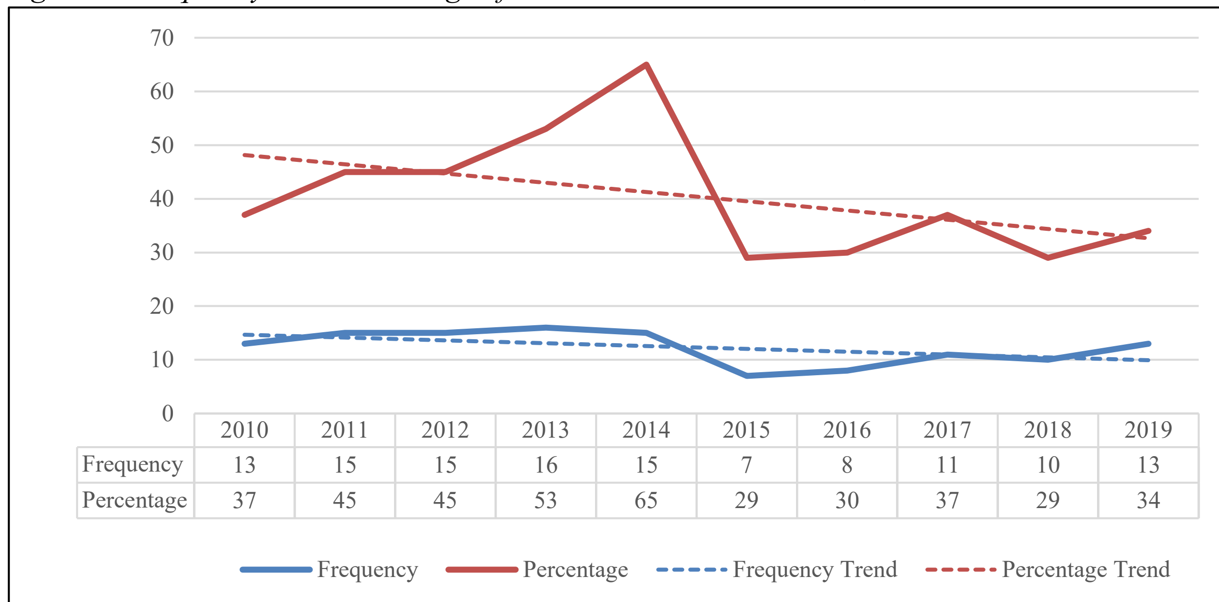
Figure 6. Annual Percentage of Suicides by Age Group, 2010-2019



SUICIDES BY HOUSING TYPE

Historically, in both CDCR and in national studies, segregated housing units have been a high-risk setting for suicide, particularly when inmates are housed alone.[28] During 2017 through 2019, suicides in segregated housing accounted for 41% (N = 30) of the total suicides. On average, 3.6% of CDCR inmates were assigned to segregated housing during this time. Suicide rates for segregated housing are generally higher than the rest of CDCR because of the small number of beds and the proportion of suicides that occur in those units. Figure 7 shows the annual number and percentage of total CDCR suicides that occurred in segregated housing from 2000 through 2019. The annual total of suicides in segregated housing has trended downward over the last ten years, although the trend in the last five years has been slightly upward. The percentage of all suicides that occurred in segregated housing also showed a slight decrease over the decade.

Figure 7. Frequency and Percentage of Suicides in ASU and STRH, 2010-2019



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Frequency	13	15	15	16	15	7	8	11	10	13
Percentage	37	45	45	53	65	29	30	37	29	34

CELLMATES IN SEGREGATED HOUSING

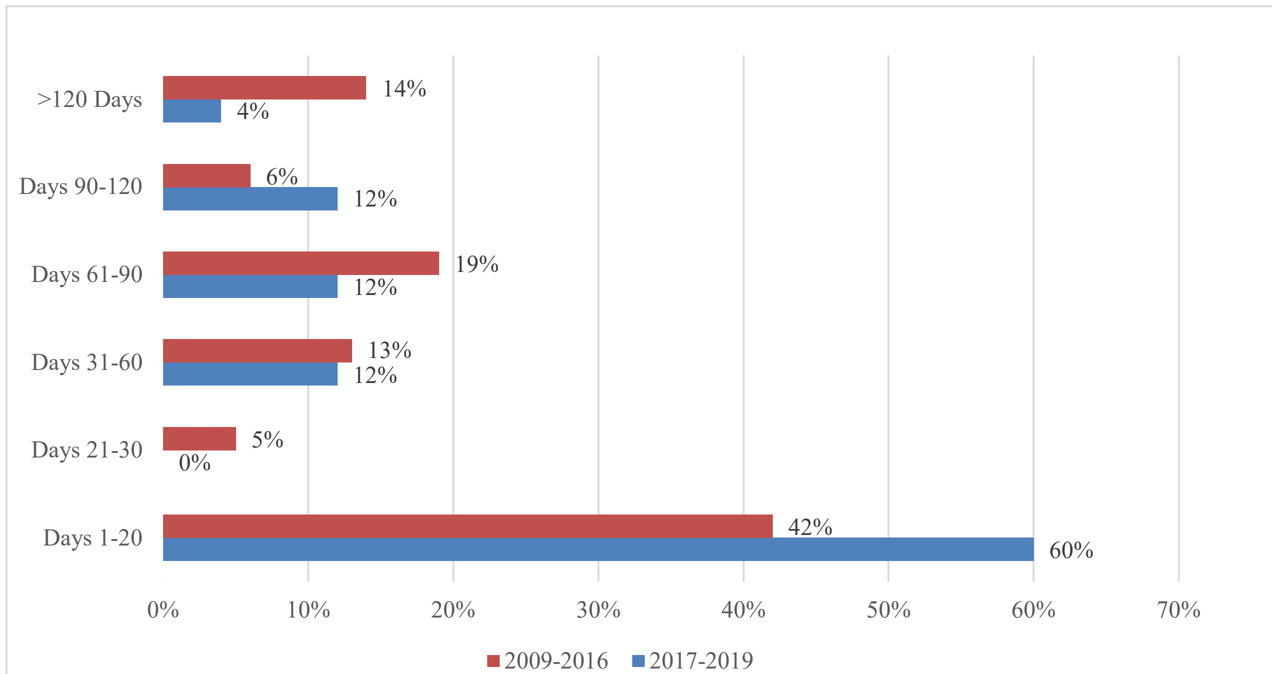
During 2017-2019, all inmates who died by suicide while in segregated housing units were housed alone. This is consistent with prior years. The percentage of suicides by inmates housed alone in segregated housing units in the five years prior to this report period ranged from 86% to 100%.

TIME IN ADMINISTRATIVE SEGREGATION UNITS PRIOR TO DEATH

Data on the number of days between ASU placement and suicide deaths has been tracked since 2009. Over the eight-year period between 2009 and 2016, suicides tended to occur shortly after placement, particularly in the first 72 hours after placement, and overall within the first 20 days of placement. During 2017 to 2019, 60% of the 25 ASU suicides occurred within the first 20 days of housing. One inmate died after more than 290 days in ASU (Figure 9).

[28] *Id.* and also Reeves, R., and Tamburello, A. (2014). "Single Cells, Segregated Housing, and Suicide in the New Jersey Department of Corrections." *Journal of the American Academy of Psychiatry and Law* 42(4), 484-88.

Figure 8. Time in Segregation Prior to Suicide, 2009-2016 and 2017-2019



METHOD OF SUICIDE

Asphyxiation by ligature hanging has been the predominant method of suicide death for many years in CDCR. Between 2007 and 2016, 82% of suicides were by hanging. For the three years of this report 83% of suicides were by this method. Other methods of suicide (laceration with exsanguination, poisoning (overdose), and jumping) have been present most years but individually have never accounted for more than 10% of suicides in a year.

MENTAL HEALTH SERVICES

Although suicide is commonly associated with significant mental health problems[29] individuals without a mental health diagnosis and those with no prior identified mental health needs can also die by suicide. In prison settings, inmates can avoid mental health services by choice, such as by denying symptoms on screening or by masking symptoms so they can be discharged from the MHSDS. It is not uncommon for suicidal inmates to distrust mental health clinicians when contemplating suicide, concerned that clinicians may remove a valued option (death) should life so dictate.

The SMHP has implemented a number of initiatives over the years that target inmates who do not participate in the MHSDS, and screens all inmates for suicidal thinking and behavior, regardless of MHSDS status, at a variety of points during their incarceration. Table 16 lists the numbers of suicides at each level of MHSDS involvement during the decade 2010 through 2019. As shown, the proportion of MHSDS inmates varies from year to year but on average about two-thirds of suicides are among the mental health population.

[29] For a recent review see: Chesney, E., Goodwin, G., Fazel, S. (2014). "Risks of all-cause and suicide mortality in mental disorders: A meta-review." *World Psychiatry: Official journal of the World Psychiatric Association 13*(2), 153. https://dx.doi.org/10.1002/wps.20128

Table 16. Frequency of Suicide by MHSDS Level of Care and Percent Total Annual Suicides, 2010-2019

Year	CCCMS	EOP	In-Patient	% of Total Suicide Deaths
2010	12	8	0	57%
2011	10	13	0	70%
2012	12	5	1	55%
2013	9	6	1	53%
2014	12	9	1	96%
2015	9	5	0	58%
2016	7	15	0	82%
2017	8	10	2	67%
2018	12	10	1	68%
2019	11	16	0	71%
Total	102	97	6	67%

MENTAL HEALTH VS. NON-MENTAL HEALTH - SUICIDE RATES

Table 17 shows the annual suicide rates of MHSDS inmates, non-MHSDS inmates, and total CDCR populations from 2010 through 2019.[30] The ten-year rate of suicide for MHSDS inmates is more than five times the rate for inmates not included in the MHSDS, a reflection of the close association of mental disorders with suicide death.

Table 17. Suicide Rates of Mental Health, Non-Mental Health, & Total CDCR Populations, 2010-2019

Year	MHSDS Inmates	Non-MH Inmates	Total Rate
2010	53.9	12.5	22.3
2011	61.9	8.8	20.3
2012	53.6	16.0	25.9
2013	46.4	15.5	24.1
2014	56.3	2.2	18.2
2015	40.4	9.8	18.6
2016	58.3	5.5	21.0
2017	51.9	10.8	23.0
2018	60.9	12.0	26.3
2019	74.7	12.5	30.3
10-Year Average	55.8	10.7	23.0

Note: The population data in this table was derived from Health Care Population Oversight Program (HCPOP) reports.

[30] This information was obtained from the CCHCS Health Care Placement Oversight Programs (HCPOP) monthly trends reports and the CDCR Office of Research Data Points series. The population totals vary slightly from other referenced population totals within this report, as the data from HCPOP is collected at different points of time and utilizes total population average

REVIEW OF FINDINGS: COMPARISON OF CDCR SUICIDE RATES TO OTHER SYSTEMS

CDCR SUICIDE RATE VERSUS OTHER STATE PRISON RATES [31]

The most recent estimates of state prison suicide rates published by the Bureau of Justice Statistics are for the years 2001 through 2016 before the timeframe of this report. Without national data for 2017 through 2019 meaningful comparisons are not possible.[32]

CDCR RATES VERSUS U.S. AND CALIFORNIA COMMUNITY RATES

The appropriate community comparison for California inmate suicide rates is to California men 18 years of age and older. Data is available for 2017 and 2018 and show that adult men in California had a suicide rate of 21.9 in 2017 and 22.5 in 2018.[33] CDCR's suicide rate in 2017 was 23.0 and in 2018 was 26.3.

[31] For a discussion of the challenges of such comparisons see Appendix B: Data Sources and Methods section at the end of this report.
[32] The *Plata* Three-Judge panel recognized in 2011 that state-by-state comparisons are of "limited value" when they fail to "control for demographics of each state's inmate population." ECF No. 3641 at 88.
[33] CDC Fatal injury data accessed on December 12, 2020: https://webappa.cdc.gov/sasweb/ncipc/mortrate.html

SUMMARY REVIEW OF FINDINGS AND TRENDS

One-hundred two inmates died by suicide in CDCR custody during the three years (2017- 2019) covered in this report. The rate of CDCR suicide increased to just over 30 per 100,000 in 2019 with 38 suicides. Rates of suicide, particularly for males, have increased significantly over the past decade in the U.S. This trend was echoed in the nation's prison systems. CDCR suicide rates were higher than rates for adult males in California in 2017 and 2018.

Over the three years of this report and compared to previous years:

- The number of suicides in the system continued the upward trend that started in 2014.
- Female suicides in the last three years were less frequent than in the preceding three years, totaling only four during the period.
- Hispanic suicides continued to rise, comprising 50% of suicides in 2017 and 2019.
- Inmates aged 35-44 years comprised a larger proportion of suicides than of the total CDCR population. The numbers of suicides by the youngest and oldest inmates remained low.
- Mental health patients, inmates with violent commitment offenses, and those who resided in high security settings predominated, comprising over 50% of all suicides.
- Suicides in segregated settings comprised less than one-third of all suicides, with ASU/STRH comprising only 23% of total suicides over the three years, compared to 34% in the preceding three-year period.
- As in the past, inmates who died by suicide during 2017-2019 generally suffered from significant mental illnesses (mostly major mood disorders), had suffered losses in social connectedness in the year or two prior to their deaths, and many also expressed safety concerns.
- The suicide report review process, which suffered significant delays in the last decade, has improved and the number of case reviews with significant delays has been reduced.
- Case reviews continue to find problems with adequate risk assessment by clinicians, poor treatment planning, and delivery of mental health services.

The increase in the proportion of Hispanic inmate suicides in the last five years may signal an increased risk for this significant population. What is troubling is that this increase runs counter to the rates of suicide in the Hispanic community, which historically have been lower than other ethnic and racial groups.[34]

The continued lower levels of suicides in ASU/STRH are possibly a reflection of lowered populations in that housing type. The number of suicides early in ASU/STRH stays continues to be a concern and highlights the need for increased vigilance by all staff.

Finally, the high rate of suicide death among the mental health population in CDCR is a continued reflection of the primacy of mental health issues that are associated with suicide.

Overall, inmates who died by suicide in 2017-2019 in CDCR, continued to have a number of important individual risk factors, including:

- History of violent commitment offense
- Housed alone at the time of fatal suicide attempt

[34] See Suicide Prevention and Resource Center: https://www.sprc.org/populations/hispanics-latinos.

- Non-married status
- Symptoms of serious mental illness and substance abuse
- Mental health treatment particularly at the EOP level of care
- Two or more serious suicide attempts
- Recent psychiatric hospitalization

Institutionally and from a systems standpoint, high security housing (Level IV institutions) with EOP treatment programs continue to aggregate a number of individual risk factors, especially when combined with significant numbers of seriously mentally ill inmates

Suicide by individuals in CDCR custody remain individualistic and complex, with most suicide reviewers identifying multiple precipitants (or triggers) for suicide. In the three years spanning 2017 to 2019, suicides frequently corresponded with increasing mental health symptoms, followed by conflict or losses of external supports, and safety concerns, drug debts, and fears of victimization.

RESPONSE TO SUICIDE AND SUICIDE ATTEMPTS

INSTITUTIONAL REPORTING OF SELF-HARM INCIDENTS

Since 2013, the SMHP has collected data on self-harm incidents across all institutions. Prior to 2013, there was no centralized collection and aggregation of data. By the end of 2016, a system was established to have information for each incident reported, including intent to die, injury severity, disposition, method, and lethality.[35]

Incidents of self-harm in CDCR are reviewed by custody, nursing, and mental health staff. When a suicide attempt results in serious bodily injury,[36] the incident is additionally documented by custody staff members using CDCR Form 837, "Serious Incident Report." The Suicide Prevention Response Focus Improvement Team (SPR-FIT) coordinator may discuss the event with housing officers, treating clinicians, or others to help ascertain the intention of the inmate and details of the incident. Monthly SPR-FIT Committee meetings include discussions of trends, prevention efforts, and action steps to take in response to self-harm incidents.

In 2016, the SMHP began electronic collection of self-harm data. With the advent of the EHRS in 2017 this data was aggregated and made available to clinicians and mental health leadership via a computerized report. The data is also a management tool for regional and headquarters staff, allowing them to note and focus on areas of need.

Suicide attempts documented via the CDCR Form 837 are reported by custody staff via the Daily Briefing Report (DBR) and the Administrative Officer of the Day (AOD) report. The information is sent to the CDCR's Division of Adult Institutions (DAI) and forwarded to Mental Health Headquarters. When a serious suicide attempt results in a death at a later date, the administrative reports are updated and the DAI Mental Health Compliance Team is notified of the death by suicide.

INSTITUTIONAL RESPONSE AND REPORTING OF SUICIDES

By policy and training, correctional officers who discover a suicide attempt in progress are to sound an alarm and initiate life-saving measures. In such circumstances, emergency medical interventions are continued until the individual's condition is medically stabilized or they are pronounced deceased by a qualified physician. In the meantime, a call to 911 is to occur immediately.

Officers are trained in basic life support and emergency response procedures, including bringing "cut-down" kits to the scene of a suicide in progress.[37] Custody officers continue to render life-saving measures until relieved by health care personnel. Officers then assist health care staff, including institutional responders and paramedics, in transporting the patient to the institution's Triage and Treatment Area (TTA) and/or ambulance. In cases in which emergency interventions are not successful, the watch commander or senior custody officer is notified of the death and in turn notifies the Warden or the AOD.[38] The CDCR Form 837, "Serious Incident Report," is completed in the event of all suicides.

[35] See the Appendix B: Data Sources and Methods for more information about self-harm data collection and reporting.
[36] Title 15, Sec. 3000: "Serious bodily injury (SBI) means a serious impairment of physical condition, including, but not limited to the following: loss of consciousness; concussion; bone fracture; protracted loss or impairment of function of any bodily member or organ; a wound requiring extensive suturing; and serious disfigurement."
[37] MHSDS Program Guides, 20018 Revision, Chapter 10
[38] Prior to the implementation of the EHRS in 2017 much of this information was collected via paper forms.

The institution's Chief Medical Executive, or physician designee, makes a report of the death by suicide within eight hours of the event. Medical information is displayed in the EHRS. Institutional mental health staff, typically the institutional SPR-FIT Coordinator, electronically provide information on the inmate's prior suicide attempts, the results of recent suicide risk evaluations, and whether the inmate had been considered at high risk for suicide. Once notified, SMHP support staff enter the information into a log, report the event to nursing leadership, and alert the SMHP Suicide Response Coordinator to the event.

REPORTING A SUICIDE TO STAKEHOLDERS

When an inmate dies by suicide, members of the SMHP complete a formal notification process. First, a death notification is sent to the OSM with details of the death. Second, a summary of the suicide is sent to the Deputy Director for Mental Health, the Director of Health Care Services, the Undersecretary of Health Care Services, and to the Governor's Office. The Public Information Officer at the institution provides any local notifications or reports regarding the death, including notifying the next of kin of the suicide.

DETERMINATION OF UNKNOWN CAUSES OF DEATH.

When a death occurs in CDCR for which there is no obvious cause, it is classified as an "Unknown Death." These cases receive special attention until the cause and manner of death is determined, particularly when suicidal intent needs to be determined in a timely fashion and/or is unclear. In the event that a death notification lists the cause of death as unknown or undetermined, the SMHP tracks the case until the death is classified. In some instances, the cause and manner of death is quickly classified by institutional medical review. In other cases, the cause of death remains undetermined pending the receipt of autopsy or toxicology results. In such cases, the CCHCS Death Review Committee (DRC) will investigate the death and produce an initial cause of death as well as a final cause and manner of death determination. In the meantime, the SMHP communicates with the institution and with the DRC about these cases until the cause and manner of death is finalized. A member of the SMHP also sits on the DRC to ensure all unknown deaths are reviewed and, when applicable, that the possibility of suicide has been closelyand objectively considered. The SMHP member of the DRC may discuss unknown or undetermined death with the headquarters SPR-FIT committee, particularly when a history of suicide attempts is present or if there's some suspicion an overdose was intentional, rather than accidental.

The following guidelines for suicide reviewers are used to determine unknown deaths:

Reviewer Guidelines for Determination of Unknown Deaths

1. Review the method of death to determine if there may have been an alternative reason (other than suicide) for the behavior (e.g., autoerotic asphyxiation, confusion and inability to form intent, purposeful intoxication, etc.).
2. If an overdose on substances, is it reasonable that the substance (illicit or prescribed) may have been used in an attempt to become intoxicated? (e.g., Tylenol is not likely to be used to become intoxicated; Klonopin may be).
3. Review recent mental health history and any past history of suicide attempts/self-harm behavior (check self-harm log). Did the inmate:
    - Voice suicidal ideation (including conditional suicidal ideation)?
    - Have admissions to a MHCB unit?

- Engage in self-harm behavior?
- Have a history of depression or mood disturbance?
- Have a history of psychosis?

4. Review substance abuse history.
   - What substances were used?
   - Have there been any past overdoses?
     - If yes, what did the inmate say about them at the time?
   - What substance abuse treatment was offered?
   - How recent are reports of current use?
5. Review recent custodial information.
   - Was the inmate facing criminal charges?
   - Did the inmate lose an appeal?
   - Did the inmate have any recent losses?
   - Was there any "bad news" readily apparent?
6. Review medical information for the presence of:
   - Chronic pain
   - Terminal illness
7. Was there a suicide note or a note that could be construed as such?

SELF-HARM INCIDENTS, INCLUDING SUICIDE ATTEMPTS.

Self-harm among prison inmates is a serious problem. A 2011 national survey collected data from 39 state and federal prison systems in the United States. The study's authors found that "in the average prison system less than 2% of inmates per year engaged in self-injurious behavior. …"[39] Most systems surveyed reported that these types of incidents are at least somewhat disruptive to facility operations and consumed significant mental health resources.[40]

In CDCR, in the three years spanning 2017 to 2019, the self-harm data collection system reported 14,402 separate incidents of self-harm by 5,491 unique individuals.[41] The majority of these incidents resulted in no injury or minor injury. The vast majority of incidents of self-harm during 2017 to 2019 (11,195, or 78% of all reported incidents of self-harm during the three-year period) were non-suicidal. However, two-thousand six hundred seventy (18%) were considered suicide attempts (self-harm with intent to die), of which 102 (0.7% of total incidents and 4% of all incidents with intent) resulted in death (suicides). Table 19 presents data about self-harm incidents during 2017-2019.

The vast majority of incidents of self-harm during the 2017-2019 period were non-suicidal. These 11,195 incidents comprised 78% of all reported incidents of self-harm. For the remaining 537 (4%) self-harm incidents, the intent was classified as unknown.

[39] Although two percent may appear small, across a national state prison population of more than 1.3 million inmates, two percent is more than 25,000 inmates who have self-harmed themselves

[40] Appelbaum, K., Savageau, J., Trestman, R., Metzner, J., & Baillargeon, J. (2011). A national survey of self- injurious behavior in American prisons. *Psychiatric Services 62*(3), 285. https://dx.doi.org/10.1176/ps.62.3.pss6203_0285

[41] Seventy-eight (0.5%) additional incidents had no data about intent and/or injury severity and were excluded from this analysis

Table 18. Self-harm Incidents by Intent, Mental Health Level of Care, and Medical Severity, 2017-2019 (excluding incidents with unknown intent)

	No Intent to Die					With Intent to Die				
Level of Care	No Injury	Minor	Moderate	Severe	Death	No Injury	Minor	Moderate	Severe	Death
ACUTE	130	293	79	2		13	27	12	4	1
CCCMS	1,045	1,247	352	45	2	205	235	200	70	31
EOP	1,377	2,269	620	79		287	341	379	106	35
GP	122	296	163	31		30	57	56	21	31
ICF	99	391	63	10		24	37	25	3	
MHCB	774	1,414	243	21		109	192	106	20	3
UN	11	15	1	1		5	2	1	1	1
Total	3,558	5,925	1,521	189	2	673	891	779	225	102

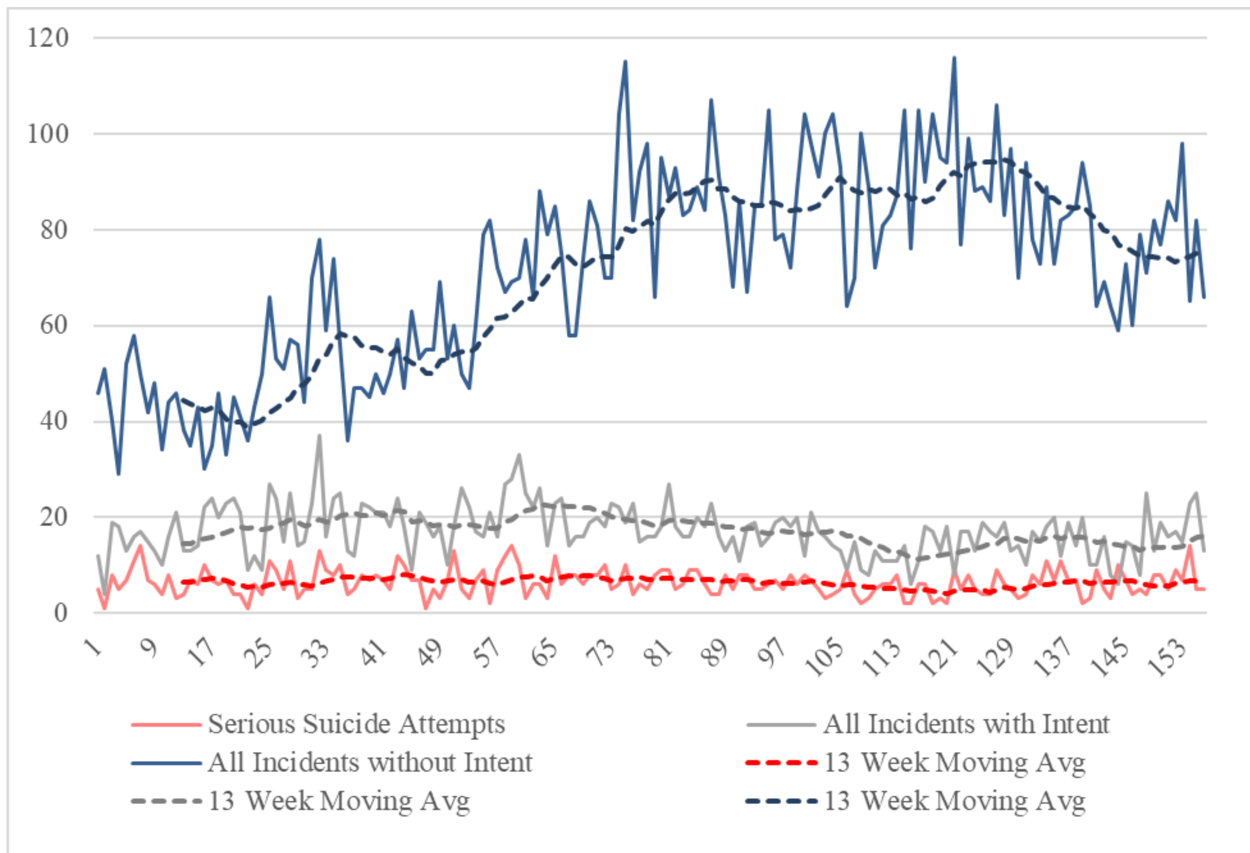
One-thousand-four suicide attempts (38%) had moderate or severe injury ("serious" attempts) and comprised seven percent of all self-harm incidents. Of the inmates who made a serious suicide attempt, 485 (48%) were at the EOP level of care, 270 (27%) were at the CCCMS level of care, 154 (15%) were among psychiatric inpatients, and the remaining 79 (8%) were either not in the MHSDS or were Reception Center inmates. Seventeen inmates made two or three serious attempts during 2016. The most common methods used to attempt suicide were hanging, laceration, or ingestion.

Of the 11,195 incidents of non-suicidal self-injury (NSSI), 1,710 (15%) were classified as moderate or severe in medical severity. The most common methods of NSSI were laceration (40%) and ingestion/insertion (21%). More than 85% of the NSSI lacerations were classed as "No Apparent or Minor Injury." Of the ingestion/insertion injuries, 80% were classed as "No Apparent or Minor Injury." Overall, 94% of the individual inmates with NSSI were participants in the CDCR mental health system, with 67% at the CCCMS or EOP level of care.

Figure 10 below shows the weekly frequency of self-harm incidents over the 156-week period during 2017 to 2019. Thirteen-week moving averages (dotted lines) are superimposed on the week-to-week frequencies to smooth out the extreme variability. Incidents of NSSI (blue line) predominated overall and rose from December 2017 (week 49) through December 2018 (week 104), peaked in the spring of 2019 (weeks 121 to 129) and then declined, although not to the 2017 levels.

The weekly frequency of self-harm incidents *with* intent to die (suicide attempts, gray line) ranged from a low of four in week 32 to a high of 37 in week 32. Serious suicide attempts – those with moderate or severe medical injury – remained at a low level throughout the three years. They ranged from one in three separate weeks in 2017 to three weeks (one each in 2017, 2018, and 2019) with 14 such incidents.

Figure 9. Weekly Number of Self-Harm Incidents in CDCR, 2017-2019



DETERMINATION AND TRACKING OF QUALITY IMPROVEMENT PLANS.

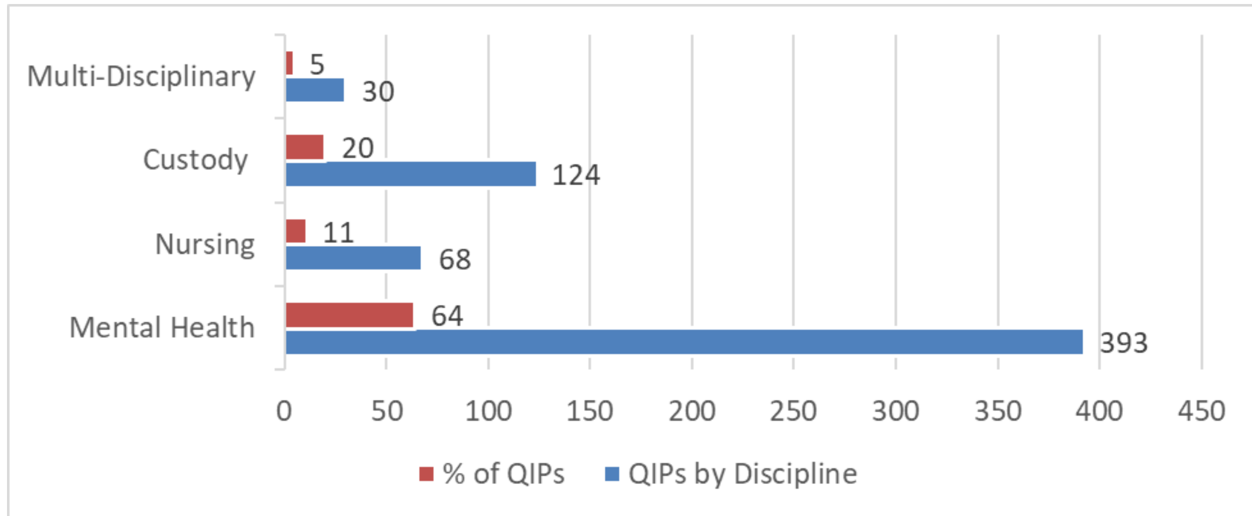
Each Suicide Case Review report may include formal Quality Improvement Plans (QIPs) as applicable to the case. QIPs are developed based on concerns or departures from policies and procedures identified by custody, nursing, medical, and mental health case reviewers. The plans are designed to remedy specific issues raised within each review, though in some cases the plans developed address statewide policy or prevention initiatives.

During 2017 through 2019, 615 QIPs were generated for 102 Suicide Case Reviews, an average of approximately six QIPs per suicide review. Figure 13 shows the number and percentage of QIPs during this time-frame by discipline. The largest number of QIPs are directed to Mental Health, followed by Nursing, and then Custody. A number of QIPs were directed to either multiple disciplines within a facility or to the DHCS (Headquarters) SPR-FIT for a multidisciplinary, statewide improvement plan.

QIPs focused on mental health services continued to predominate during the report period. Specifically, adequacy of suicide risk assessment, treatment planning, and the quality of mental health contacts were noted by reviewers on a majority of cases. Other issues that prompted a significant number of QIPs were nursing services, emergency response, delays in response to the emergency, and the adequacy of "wellness checks" in segregated housing.

The specific reasons for individual QIPs are presented in the individual case review section in the section on Findings in Individual Case Reviews, along with a summary of actions taken in response. The actions taken by the SMHP SPR-FIT in response to QIPs are in the section on suicide prevention initiatives, below.

Figure 10. Frequency and Percentage of QIPs Generated from Suicide Case Reviews by Discipline, 2017- 2019



AUDITS OF SUICIDE REVIEW QUALITY

Suicide case reviews are audited for the presence or absence of 15 elements considered necessary for an adequate review. The overall compliance with suicide review criteria for the years 2017 through 2019 was 96%. Only two categories fell below 90% compliance over the three years covered by this report: quality of the past-year's suicide risk assessments (71% compliance of 72 applicable reviews),[42] and description of past suicide attempts (87% compliance of 89 applicable reviews). Not all cases have all audit items, and so the number of applicable cases is often less than the number of total cases over the three years. The audit was completed by SMHP senior staff who do not write suicide case review reports but participate in the review of cases. Audit results are presented in Table 20.

[42] Suicide risk assessments are audited regularly for the presence of a number of requirements including: a review of past suicidal behavior, notation of risk/protective factors and warning signs, estimation of current risk and justification, and adequacy of safety planning.

Table 20. Results of Quality Audits, 2017-2019 Suicide Case Review Reports

Audit Item	Applicable Cases	Compliance
1. Does the Executive Summary describe the means of death, the emergency response taken, and the MH LOC of the patient?	102	100%
2. Are the sources for the SCR identified?	102	100%
3. Are substance abuse issues reported, if applicable?	97	95%
4. Does the Institutional Functioning section include information on institutional behavior, including disciplinary history?	101	99%
5. Does the Mental Health History review the adequacy of mental health care and screening?	99	97%
6. Are medical concerns discussed (e.g., chronic pain, terminal illness) or is the absence of medical conditions noted?	102	100%
7. Is the quality of the most recent suicide risk evaluations (past year) reviewed, with comment on risk level, safety planning, and risk and protective factors?	82	90%
8. Does the Suicide History section review all prior attempts, as applicable?	89	100%
9. Are significant pre-suicide events discussed (e.g., receipt of bad news or existence of a safety concern)?	101	99%
10. Was a risk formulation offered specific as to why the person was vulnerable to suicide?	100	99%
11. Does the review comment on the adequacy of the emergency response?	102	100%
12. Are all violations of policy and breaches of standards of care in mental health, medical, and nursing addressed in the reviewer's concerns, if applicable?	93	91%
13. Were custody policies followed? If not, were violations noted in the report?	100	98%
14. Were all concerns raised by reviewers (custody, nursing, and mental health) represented in Quality Improvement Plan recommendations?	93	91%
15. Were the Quality Improvement Plan recommendations adequate to address the concerns? (e.g., QIP should not simply say conduct an inquiry and report findings).	93	91%
Compliant Items/Total Items	1446/1508	96%

TIMELINESS OF SUICIDE CASE REVIEWS AND SUICIDE REPORTS

The process of responding to suicides, completing reviews, writing and editing reports, tracking QIP compliance, and so on, is complex. Timelines for each step of suicide response are specified in the MHSDS Program Guides, 2018 Revision. Internal deadlines have also been developed to ensure timelines for each step of the suicide response process are met. The number of days specified for each step of the response to a suicide, for both Program Guide and internal deadlines, are shown in Table 21.

Table 21. Suicide Case Review Deadlines (calculated from date of death or for internal deadlines from previous step)

Program Guide Deadlines		**Internal Deadlines**	
Assign suicide reviewer	Within 2 days		
Reviewer visits institution	Within 7 days		
Custody & Nursing Report due to MH reviewer	Within 22 days		
Suicide report received at HQ	Within 25 days		
		Report reviewed, edited, QIPs developed and sent to all case review participants with request for feedback from reviewers	7 days prior to case review (no later than day 40 after DOD)
Suicide Case Review	Within 45 days		
		Final report edits	Within 1-2 days
		Signed by MH Deputy Director	Within 1-2 days
		Signed by DAI	Within 3-5 days
Final suicide report to institution	Within 60 days		
QIPs completed at the Institution	Within 150/120 days (**See internal deadline that requires this sooner from institution)	***Please note*: this internal deadline is set for institutions to ensure SPR-FIT ability to comply with the Coleman deadline in the event that QIPs are inadequate and require amendment* QIPs completed and QIP report submitted to HQ	Within 45 days of institution's receipt of final report (no later than day 105 after DOD)
Institution's QIP Report completed and submitted to HQ	Within 150/120 days (**See internal deadline that requires this sooner from institution)		
		QIPs reviewed by committee	Within 10 days
		QIPs signed by MH Deputy Dir.	Within 1-2 days
		QIPs signed by DAI	Within 3-5 days
Implementation of QIP report sent to Special Master	Within 180 days		

In reviewing the timeliness of the reporting and review process for 2017-2019 suicides:

- Assignment of the suicide reviewer was completed within timeframe (two days) in 80 of 102 cases, and within four days in 95 of 102 cases.

- Review team (mental health and custody) site visits were completed within seven days in 32 of 102 cases. Delays ranged from one to fifty-five days.
- The median time for report submission by a reviewer (within 40 days of death) over the three years was 28 days after the death. Thirty-two reports (31%) were submitted thirty or more days after death.
- The median time for a report to be sent to the OSM was 29 days. Forty of 102 reports (39%) were sent more than forty days after the inmate's death.
- Sixty-two SCR meetings (61%) were held on time. Late meetings ranged from one to thirty-eight days late. Seventeen late reviews were held within 10 days of the scheduled date.

After suicide reports are reviewed at the SCR meeting, final edits are completed, and a finished report is due at institutions within 60 days after the date of death. Timeline compliance becomes more difficult at this step. None of the 2017 reports were finalized and sent to institutions by the 60-day mark. The median time for reports to be sent to institutions in 2017 was 91 days with a range of 64 to 157 days. In 2018, two reports were sent timely to institutions. The median time for sending the reports to the respective institutions in 2018 was 83 days, with a range of 40 to 143 days. In 2019, after changes were made to the routing process, 13 reports were sent to institutions within 60 days or less. The median in 2019 was 61 days with a range of 57 to 62 days.

Delays at this step can affect the ability of institutions and other recipients of QIPs to complete QIPs by the prescribed deadline (150 days after death for 2017 and 2018, and 120 days in 2019)[43]. Despite delays, only 16 reports were sent to the OSM late, with a range of one to 101 days late.

The final processing of reports and QIPs after SCR meetings was the largest source of delays in 2017 and 2018. Because the reports require routing through various levels of leadership and a number of departments (including separate routing through mental health, nursing, and custody) delays are possible. In 2017 22 of 30 (73%) reports were sent to the institutions overdue. In 2018 32 of 34 (94%) were sent overdue. In 2019, due to changes in timelines and internal changes in the SMHP only 12 of 38 (32%) reports were late being sent to institutions.

[43] The timeline for final resolution and reporting of QIPs changed in 2019 due to reinterpretation of the language in Chapter 10 of the 2018 Revision of the Program Guide.

FINDINGS IN INDIVIDUAL CASE REVIEWS

Quantitative views of suicides in CDCR provide a broad overview. These tables of rates and numbers give us an aggregated, or *macro,* look at correlates and causes to suicide and to variables that require monitoring. Individual case reviews, on the other hand, represent a detailed and individualized examination at the idiosyncratic, multi-determined reasons why an individual takes his or her own life. The sources of distress noted in the cases below range from a response to gang threats to an inmate's family, to the vagaries of severe medical and mental illness to grief over the loss of lovers and loved ones. No two cases are alike.

What cannot be overly idiosyncratic are the actions of staff members of all disciplines. These staff, as a whole, are responsible for preventing suicide. Suicide prevention in correctional settings is no small task. All CDCR staff must follow policy and procedure, show diligence and compassion in their work, and be professional in their day-to-day interactions and responsibilities. Individual case reviews thus speak not only to the idiosyncrasies of the suicidal patient but also to the actions and professionalism of staff leading up to a suicide, in reaction to a suicide in progress, and in response to the death.

COMMONALITIES IN INDIVIDUAL CASE REVIEWS

Table 22 lists nine variables reviewers have found to be common to many suicides and that are often prioritized for review. Each individual suicide decedent is assigned an alphabetical code to maintain anonymity. Most of these variables are systemic issues that cross disciplinary and professional lines. As can be seen in Table 22, many cases have many elements present and very few, in fact only 30 cases (29%), had either none or only one area of concern. Case reviews assess an inmate's care, functioning, and behavior in the year leading up to their death, and also evaluate the institutional response to the suicide attempt.

A number of the elements, when lacking or are of poor quality, almost always result in a reviewer recommending a QIP. Other elements of cases may or may not result in QIPs, depending on the severity of deviation from policy and procedure, how directly the element is related to the suicide death, and other issues tangential to the suicide. In SCR reports, reviewers *may* comment on what was done well within an institution and *may* state areas where policy was correctly followed. However, these comments are not required, as it is assumed staff members follow policy and will act professionally in their work with inmates. In contrast, reviewers *must* identify any and all departures from policy or from standards of care by creating formal QIPs applicable to each identified issue. Reviewers may also point to clinical, medical, or custodial practices that could be improved either at an institutional level or throughout all institutions; these practice suggestions can be addressed through QIP processes as well. Institutional responses to QIPs are sent to the SMHP and DAI leadership for review. If a QIP response is inadequate, the SMHP and DAI will request clarification, additional development, or implementation of the QIP. QIPs are not considered final until approved at the headquarters level.

An area of primary concern across all cases is the adequacy of suicide risk assessment and formulation, and subsequent management of that risk (Table 22, Column A). Not all inmates exhibit overt suicide risk, but the system is designed to detect risk and treat it accordingly. Table 22 shows that 59 (79%) of 75 applicable cases[44] had problems with at least one suicide risk

[44] Overall, 31 inmates were not participating in the MHSDS at the time of their deaths. Of these, four were evaluated for suicide risk at a point proximal to their death and a case reviewer found that evaluation or management of risk to be lacking.

evaluation or the clinical management of the assessed level of risk. Problems can include overall quality concerns; poor documentation of risk factors; problems with risk formulation; and failure to complete suicide risk evaluations when they were required by clinical standards or policies. Problems in documentation, risk formulation, or failure to complete a risk evaluation can lead to errors in risk management. Poor risk assessment leads directly to inadequate risk management, which may include levels of monitoring, safety planning, or follow-up with providers.

Poor quality mental health treatment planning (Column B) can affect an individual's ability to adequately program in the prison environment. Suicide risk assessment and formulation of risk is an important aspect of treatment planning. Additionally, if suicide risk is not recognized by clinicians and their team, then adequate management of that risk is not possible. Of the 71 cases of inmates who were participating in the MHSDS at the time of their deaths, plus two non-participants whose risk was inadequately evaluated, 48 (66%) were judged by case reviewers to have had inadequate treatment planning. Issues noted included poor discharge planning from inpatient settings, efforts to deal with poor treatment participation, and inadequate recognition of and efforts to deal with chronic suicidal ideation.

The quality of contacts with mental health staff (Table 22, Column C) can make a difference in outcomes for an inmate. Good quality interactions act as modelling of positive and prosocial interactions and increase the probability of changing behavior. On the other hand, poor quality or simply the lack of contacts can alienate an inmate from mental health treatment, lead to distrust of and distancing from mental health staff. In the period 2017 through 2019, reviewers found that 25 inmates who died by suicide (35% of MHSDS participants) had poor quality mental health contacts at some time in the period prior to their death.

Aspects of nursing practice (Column E) considered in suicide case reviews include nurse and licensed psychiatric technician (LPT) rounds and/or nursing observations when required for inmates in segregated housing settings, inpatient settings, and while a patient is on suicide watch or precautions either in alternative housing or in MHCB. Additionally, nursing documentation and knowledge of procedure during emergency response efforts are considered by reviewers. Typically, problems in any of these areas will yield a mention of concern and QIPs directed to the CCHCS DRC for corrective or proactive action. In the period 2017-2019, reviewers found deficiencies in nursing practices in 32 (31%) cases.

Custody checks (Column E) occur in all institutions for all inmates. For example, custody conducts "counts" several times each day and, per policy, for inmates in segregated housing, conducts one welfare check during each 30-minute period. In 12 cases during 2017 through2019, custody checks were judged as inadequate and not conducted per policy. As noted in Column H, in six of these cases, inmates were found with evidence of rigor mortis despite evidence of earlier security and wellness checks.

A prompt, vigorous, and timely emergency response can save a life. The response of custody, nursing, and health care staff is considered in ratings of emergency response (Column F). Reviewers wrote QIPs focused on emergency response in 51 (50%) of suicide death cases during 2017 through 2019. The large majority of these cases involved calling 911 or bringing the full "cut-down" kit to the incident scene.

A patient's refusal to participate in specific evaluations, interventions, such as prescribed psychiatric medications, or offered treatment can have severe impact on their functioning and the course of their mental illness. Fourteen (14%) of 72 applicable cases were found to have issues related to treatment refusal. The one non-MHSDS inmate for whom this was noted had been treated

at the all levels of care in CDCR for a number of years but adamantly denied the need for services, denied mental health symptoms, and generally refused to participate due to a delusional disorder. A treatment team acceded to his wishes to be discharged from the MHSDS one month before his death. In another case an inmate's order for involuntary medication had been allowed to lapse in part because of intractable side effects, and without the force of the legal order for medications, the inmate began refusing psychiatric medication and his conditioned worsened prior to his suicide death.

Rigor mortis (Column H) is a condition of the body after death that involves stiffening of the musculature due to postmortem chemical reactions and indicates a person has been deceased for a period ranging from two to six hours.[45] In 2017 through 2019, ten inmates were reported in a state of rigor mortis at discovery. Eight of these inmates were housed in segregated settings, thus calling into question whether they had been monitored according to policy. These findings led to a number of QIPs and investigations. In the previous three-year period of 2014 through 2016, twelve inmates were found in rigor mortis.

During 2017-2019, reviewers noted that 14 inmates who died by suicide (19% of applicable cases) would have benefited from a higher level of mental health care than the level at which they were currently classified (Column I). A need for a higher level of care is also related to appropriate treatment planning, and in fact, 11 of these inmates also had deficiencies in treatment planning.

[45] https://en.wikipedia.org/wiki/Rigor_mortis

Table 22. Review Elements of 102 Suicides, 2017-2019

Inmate Code	Adequate Risk Assessment and/or Management	Adequate Treatment Planning	Good Quality Mental Health Contacts	Adequate Nursing Practice	Adequate Custody Checks	Adequate Emergency Response	Treatment Refusal Issues	Presence of Rigor Mortis	Need for Higher LOC
	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
A	N	N		N					
B									
C	N	N	N			N			
D		N	N	N		N			Y
E						N			
F					N	N		Y	
G	N	N		N		N			Y
H						N			
I	N					N			Y
J	N	N				N	Y		Y
K	N	N	N	N		N			Y
L				N	N	N	Y	Y	
M						N	Y		
N	N	N				N			Y
O	N	N	N				Y		
P	N	N				N			Y
Q	N				N		Y	Y	
R									
S	N	N	N			N			
T	N		N	N	N	N			
U									
V						N			
W									
X	N								
Y									
Z				N		N			
AA	N	N	N			N			
AB	N	N	N	N	N		Y		
AC	N	N	N	N	N				
AD						N			
AE									
AF	N	N		N			Y		
AG	N	N	N						
AH	N	N		N					
AI									
AJ	N	N			N			Y	
AK						N			
AL	N	N					Y		
AM									
AN	N	N							
AO	N	N							
AP						N			

Inmate Code	Adequate Risk Assessment and/or Management	Adequate Treatment Planning	Good Quality Mental Health Contacts	Adequate Nursing Practice	Adequate Custody Checks	Adequate Emergency Response	Treatment Refusal Issues	Presence of Rigor Mortis	Need for Higher LOC
AQ									
AR	N					N			
AS									
AT	N	N	N						
AU						N			
AV	N	N				N			Y
AW	N		N			N			
AX	N								
AY	N	N							
AZ	N	N		N		N	Y		
BA	N	N	N	N		N		Y	
BB	N		N	N		N			Y
BC						N			
BD	N							Y	
BE							Y		
BF	N	N	N	N		N			
BG									
BH	N			N		N			
BI					N	N			
BJ						N			
BK				N		N			
BL	N		N	N				Y	
BM						N			
BN	N	N		N			Y		
BO	N			N		N			
BP	N	N			N			Y	
BQ	N	N	N	N		N		Y	
BR	N								
BS	N	N							
BT									
BU	N	N				N			
BV		N					Y		
BW	N								Y
BX	N	N	N	N		N	Y		
BY									
BZ	N	N				N			Y
CB	N	N			N				
CC				N	N	N			
CA						N			
CD		N		N		N			
CE	N	N		N	N	N	Y	Y	
CF		N				N			
CG		N							
CH									
CJ	N	N	N						

Inmate Code	Adequate Risk Assessment and/or Management	Adequate Treatment Planning	Good Quality Mental Health Contacts	Adequate Nursing Practice	Adequate Custody Checks	Adequate Emergency Response Issues	Treatment Refusal	Presence of Rigor Mortis	Need for Higher LOC
CI	N	N	N	N					Y
CK									
CL	N	N							
CM	N	N	N	N					Y
CN						N			
CO	N	N	N			N			
CP	N	N	N	N		N			
CQ				N		N			
CR									
CS				N					
CT	N			N		N			
CU	N	N	N	N		N			Y
CV	N								
CW	N	N							
CX	N	N	N						

SUICIDE PREVENTION INITIATIVES, 2017-2019

The following section highlights suicide prevention initiatives CDCR has initiated during 2017 through 2019. Some of these initiatives are new programs, while others are improvements to existing programs.

Experts and researchers have identified key components that, for correctional systems to succeed in reducing the burden of suicidal thinking and behavior in their populations, need to be present as part of any comprehensive suicide prevention program.[46] These key components include: appropriate and effective screening occurring at various times and locations during incarceration; establishing referral processes; insuring that written policies and procedures for suicide prevention are maintained and updated as needed; and ensuring there are effective methods for evaluating proof of practice of existing and/or on-going suicide prevention programs and initiatives. A comprehensive suicide prevention program must have a commitment to staff training, with the provision of on-going training on suicide risk detection and referral for all correctional employees. In addition, training about the complexities and specifics of suicide risk evaluation, risk management, and intervention must be provided to mental health staff. Comprehensive programs also assure ready access to mental health services for inmates who request and/or are referred for these services, along with a variety of treatment options and levels. Suicide prevention materials must be readily provided for inmates and for those who interact with inmates (e.g., family members, work supervisors). Communication between disciplines and shifts must be prioritized, particularly regarding high-risk inmates.[47] Programs can also include population-based initiatives, including efforts to provide mental health services to all inmates and create a system-wide surveillance of self-harm to assist in planning and intervention.

The Department's has collaborated with and been reviewed by the OSM and the OSM's experts for many years. To assist the SMHP in pinpointing areas in need of suicide prevention improvement, one of the OSM's suicide experts has made four tours of selected CDCR institutions between 2017 and the end of 2019, and produced four reports about the CDCR's success or lack thereof in making improvements in the provision of its suicide prevention program. The information provided in the next section reviews advancements in CDCR's suicide prevention program during the years 2017 through 2019.

CDCR works diligently to ensure that a comprehensive suicide prevention program is in place. In the three years covered by this report, the SMHP has drawn on a variety of sources to develop and implement best practices in suicide prevention, including training, treatment, quality improvement, and informatics. In addition, the 102 suicide reviews completed in the period 2017-2019 have produced over 600 QIPS that have produced additional trainings, new clinical initiatives, and changes to policies and procedures that will improve the overall suicide prevention program of the Department.

TRAINING

- Between 2017 through 2019, during three rounds of training, approximately 150 CDCR clinicians across 20 institutions statewide were trained in the use of the Clinical

[46] Hayes, L.M. (2013). Suicide prevention in correctional settings: Reflections and next steps. *International Journal of Law and Psychiatry 36*, 188-194. See also Canning, R.D., and Dvoskin, J.A. (2016). Preventing suicide in detention and correctional facilities. In Wooldredge, J. and Smith, P. (Eds.) *The Oxford Handbook of Prisons and Imprisonment*. Oxford University Press: New York, NY. https://dx.doi.org/10.1093/oxfordhb/9780199948154.013.25

[47] *Preventing Suicide in Jails and Prisons*, World Health Organization, 2007

Assessment and Management of Suicidality (CAMS). CAMS is a cognitive-behavioral treatment targeted at suicidal behavior and thinking. Each clinician participated in the three-hour online webinar training provided by CAMS care, and then began using CAMS with selected inmate-patients who reported ongoing suicidal thinking or behavior. These clinicians participated in weekly case consultation calls for two months with other CDCR CAMS-trained clinician-participants and the CAMS trainer, based in Washington, D.C. The use of CAMS in the three training rounds has provided useful information about the benefits of CAMS with suicidal inmates, but its use has also pointed out various challenges of using CAMS within the correctional setting.

- Since 2013, the SMHP has used a seven-hour training in suicide risk assessment that all clinicians are required to complete once every two years. In the past three years, the course was updated and improved twice. It has been delivered in all institutions in the past year and continues to be a mainstay of training for clinicians.
- In May and June 2019, a departmental expert provided a live Training-for-Trainers (T4T) course on the Suicide Risk and Self-Harm Evaluation (SRASHE) to selected staff members within each institution. The T4T focused on improving the quality and accuracy of suicide risk evaluations. By the end of 2019, 94% of all mental health clinical staff had received the training. CDCR is in the process of assessing the value of the live training in improving the quality of the SRASHEs by comparing SRASHE Chart Audit Tool audit passing rates before and after the training is implemented.
- Additional measurement tools for use by clinicians that augment the standard suicide risk evaluation process are available in the EHRS. A four-hour training has been provided annually since 2017 to introduce these tools and give clinicians instructions for their use.
- Efforts have been underway to improve how suicide prevention training is tracked. Since 2017, the department has implemented a sophisticated training compliance system - the intra-departmental Learning Management System (LMS). The LMS is a computer-based teaching and tracking tool that provides online training, with options for offering recorded video and for requiring embedded knowledge checks. Each staff member is notified via email of the need to complete required trainings. The email includes a link to the LMS site. The LMS system automatically records information about training completion status that is accessible to the SMHP and DAI for compliance tracking. This system has been used in the past two years to track departmental compliance with ensuring both custody and clinical staff receive training in suicide prevention.
- Monthly suicide prevention system-wide videoconferences have been a staple of the SMHP's suicide prevention program since the early 2000s. Institutional SPR-FIT teams, Suicide Risk Evaluation mentors, and other institutional staff and mental health clinicians participate in the videoconference by viewing presentations in conference rooms using video conferencing connections or, when unable to attend in this manner, through phone lines. Lead by a senior clinician from headquarters, the suicide prevention videoconference is used to review suicides and trends in suicides within the department, to brief staff on new or revised policies and procedures, to notify staff of suicide prevention trainings and resources (e.g., membership in the American Association of Suicidology), to discuss findings from the court-appointed suicide prevention expert's tours of institutions, and to provide didactic trainings. The suicide prevention

videoconference is a continuing suicide prevention effort and has continued over the three years of this report.

- The standard suicide risk evaluation mentoring program has been revised in the past three years and training for the mentors themselves has been redesigned and implemented.
- Annual Suicide Summits, 2017 to 2019: Expanded to three days, the conference brought together leadership and staff from all parts of CDCR, including institutional chiefs of mental health, SPR-FIT coordinators, custody leadership, nursing leadership, and mental health headquarters staff. Presentations and discussions focused on self-harm definitions and the suicide attempt database; a review of SPR-FIT duties and best practices; a review of trends in suicide within the department; initiatives starting that month (including MHCB discharge checks and changes to five-day follow-up forms and ASU screening forms); a look at quality improvement processes and audit items; the use of psychiatric medications that are used to reduce risk to self; a review of court-appointed suicide prevention expert tour findings; and a number of small breakout group discussions and reports.

NOVEL CLINICAL INTERVENTIONS

- During 2018 to 2019, the SMHP developed a new intervention for suicidal inmates. Based on a model used in the Veterans Administration system, the Safety Planning Intervention was designed as the last step of the suicide risk assessment process, whereby a clinician after collecting various risk information and making a judgment of risk, works collaboratively with the patient to create a brief behavioral intervention that is tailored to the patient's individual needs and resources. This intervention was rolled out into the EHRS accompanied by a seven-hour training for all clinicians. Training for clinicians was implemented in 2019. It remains unclear at this point how effective this intervention will be and improvements are in the works.
- Modeled on successful programs from the community, CDCR established cross-disciplinary Crisis Intervention Teams (CIT) at 22 institutions between late 2018 and early 2020. These teams are called upon to intervene with inmates in crisis. Since their implementation, the teams have had almost 7,600 contacts with inmates, an average of 422 each month. Thirty-seven percent of the contacts resulted in admission of the inmate to a MHCB unit. Twenty-five percent were returned to their housing, eight percent were provided conflict-resolution skills and returned to their housing unit, and eight percent were given education about a custody process. The resolution of the remaining 22% of the CIT contacts included a mix of referrals to mental health, housing changes, referrals to volunteer groups, and custody consultations. Prior to the inception of these teams, it is likely that a much higher proportion of inmates with crisis issues would not have been able to have their immediate needs addressed and would have been admitted to high-cost inpatient psychiatric beds around the state.
- In response to the uptick in the number of suicides, self-harm events, and use of force incidents at the California Institution for Women in 2014 through 2016, the SMHP initiated a series of gender-specific programs to specifically target and reduce problems associated with domestic violence, combat high levels of substance abuse, and to provide mental health counseling resources to non-mental health inmates.

PHYSICAL PLANT IMPROVEMENTS

- Since the beginning of 2017, the department has completed a project to ensure all MHCB unit cells are safe and do not contain ligature attachment sites.
- Cut-down kits that contain emergency equipment used when a suicide attempt occurs have long been in use in housing units throughout the department. Over the last three years, policies and procedures were developed to standardize the equipment in these kits and make sure they are on-site in every housing unit in all institutions.

REHABILITATION PROGRAMS

- In 2017 and 2018, CDCR's Division of Rehabilitation (DRP) improved opportunities for inmates to earn Milestone and Rehabilitative Achievement Credits, which allow inmates' sentences to be reduced. This can have direct and indirect impacts on suicide prevention because it allows inmates to have more hope about being able to earn time off their sentence and reduce lengthy sentences.

IMPROVEMENTS TO CLINICAL AND CUSTODIAL TRANSITIONS

- In response to the more than ten suicides in Reception Center institutions in 2017, the department instituted a Reception Center work group to review policies and procedures in these institutions. One of the outcomes generated by the work group is a proposal to transfer inmates who are identified as needing mental health services to their assigned institutions within 30 days.
- A quality improvement project spearheaded a project that was implemented at North Kern State Prison during 2019 and 2020. The project identified a number of inflection points where improvements can be made. The project resulted in improvements in transfer times, in part due to uncontrollable issues such as quarantined buildings that impact timely processing of CCCMS transfers.
- Regional Mental Health Compliance Teams have been directed to inspect reception center institutions for suicide prevention posters on a routine basis. The SMHP has implemented a policy giving direction to reception center mental health clinicians regarding expectations for obtaining and reviewing jail records of newly received inmates.
- A new Reception Center program, the Transitional Help and Rehabilitation in a Violence-Free Environment (THRIVE) program is under development. DRP has been working with subject matter experts within the department to develop an orientation for newly arrived inmates. DRP's goal is to place modules and video content on eReader devices that can be loaned to inmates. The modules provide an overview of credit earning, rehabilitative programs, basic institutional rules, appeals process, disability policies and procedures, financial responsibilities, and family visiting. DRP has been working with SMHP to develop a module specifically informing offenders how to take care of their physical and mental health while in prison. The development of this module for the THRIVE program has been halted due to the COVID-19 emergency.
- The transition from an inpatient psychiatric setting to an inmate's usual housing can be a high-risk period. The SMHP's Inpatient Referral Unit (IRU), which manages inpatient psychiatric admissions and monitors discharges to institutions, has instituted consultation case conferences prior to discharge for patients with a history of serious self-harm. The

team has engaged institutions to monitor and discuss cases of inmates who move frequently between levels of care to determine the best location for long-term treatment. The IRU has also developed a discharge checklist for inpatient treatment teams that allows the regional mental health teams to have better oversight of discharges from these treatment units.

IMPROVEMENTS AND REVISIONS OF DOCUMENTATION

- The most recent version of the SMHP's suicide risk evaluation documentation, the SRASHE, was updated in 2018 and again in 2019 to better record suicide history and to include the recently implemented safety planning intervention.

STAFFING IMPROVEMENTS

- With the transition of Department of State Hospitals inpatient programs to CDCR administration on July 1, 2017, the CDCR inpatient programs have become more integrated with the SMHP suicide prevention programs. In October 2019, three senior psychologist positions were established and authorized for the Psychiatric In-patient Program (PIP) SPR-FIT coordinators. Two of the three authorized positions were filled by early 2020.

IMPROVEMENTS IN INMATE AND PATIENT ENVIRONMENTS

- Beginning in 2018, all inmates housed in segregated housing are issued a radio or electronic tablet with information built in about various programs and entertainment activities to "cut the boredom" in their housing. In February 2017, a joint memorandum from SMHP and DAI was issued that updated allowed out-of-cell activities and privileges for inmates who were patients in MHCB units. Prior to 2017, inmates in MHCB units had many restrictions on privileges, such as yard time, phone calls, etc., that made these environments akin to restrictive housing rather than therapeutic settings.

QUALITY IMPROVEMENT PROGRAM

- Lean Six Sigma is a leadership and management style that uses data to improve efficiency within complex systems. Projects focused on suicide prevention during the 2017-2019 period include:
    - Improving the CDCR 7497 process: The CDCR 7497 process involves recording custody checks and mental health evaluation following a patient's return from a psychiatric hospitalization. This project was completed in 2018 and resulted in a 75% decrease in failed discharge custody checks from baseline measurement to post-project implementation at the California State Prison, Sacramento.
    - Improving compliance with pre-placement screening for segregated housing intakes: A pre-placement screening form is used that includes direct questions about suicidal thoughts or behaviors. This project improved compliance rates at the California Correctional Institution from a baseline of 75% compliance to 99% compliance by improving notification of nursing of segregated housing arrivals, adding a checklist for new placements, updating local operating procedures, and clarifying the requirement to complete the screen with nursing staff.
    - Increasing timely completion of suicide risk assessment mentoring: This project took

place at the California State Prison, Los Angeles County, in 2018. At baseline, the average completion time of suicide risk evaluation mentoring for new staff or staff due renewal mentoring was 332 days "to complete a cycle of proctor/mentoring." Following development of a local operating procedure, the average time for completing mentoring was reduced to 36 days.

- Improving completion of suicide case reviews within policy-designated timeframe cutoffs. This project included efforts to document competing demands made on reviewers and recommendations for a variety of methods to improve the time to completion. The project is ongoing.

CONCLUSIONS

The numerous efforts undertaken by CDCR to reduce suicides, aided by consultation with the OSM and the initiative of the department's staff, are ongoing. While it may be impossible to ascertain just how many suicides were prevented during the three-year period 2017 through 2019, the continuing efforts and new initiatives for suicide prevention may have helped to prevent many suicides within CDCR. The department remains committed to a comprehensive system of suicide prevention and to response efforts that make a difference. Yet work remains to be done, and efforts are ongoing.

REPORT IMPLICATIONS AND FUTURE STEPS

The following implications are not intended as exhaustive but rather highlight findings from this report and ongoing concerns from previous reports.

1. **Lessons from Suicide Case Reviews:** One of the primary avenues for improvement of CDCR's suicide prevention program are the QIPs generated by suicide case reviews. Almost two-thirds of QIPs in the period covered by this report indicated a need to improve mental health services, particularly suicide risk evaluation and treatment planning. To address these deficiencies the SMHP implemented improvements to the EHRS to improve documentation of risk assessment. Additional requirements for mentoring of clinicians has been implemented along with "booster" training for mentors. Audits of the quality of risk assessments conducted in the report period suggest the difficulty of achieving consistent and durable change in this area. Less than three-quarters of audited assessments were adequate, prompting a redoubling of effort in this area. Other areas identified by QIPs include monitoring of inmates in segregated housing, nursing observation procedures, and better identification of the need for referrals of inmates who need more intensive mental health treatment.
2. **Reception Center Inmates**: The results of multiple QIPs and analysis of historical trends have shown that the transition from county jails to state prison can be highly stressful and increase the risk of suicide attempts, particularly for individuals with long sentences or certain high visibility offenses. From 2017 through 2019, eleven newly arrived Reception Center inmates died by suicide. The average length of time between entry and death was 56 days with a range of three to 104 days. The department continues to work on solutions to improve the efforts of reception center mental health programs to obtain records from outside agencies, particularly county jails, to improve continuity of care and allow Reception Center clinicians to better assess newly arrived inmates' mental health needs.
3. **Suicides of EOP inmates**: Community researchers, CDCR data, and QIPs have consistently noted that prison inmates with serious and chronic mental illness have higher suicide risk in the long term than other groups of inmates. CDCR's EOP programs house the system's most chronically mentally ill inmates, often chronically suicidal and with multiple suicide attempts. More than one-third (N=36) of the 102 suicides during 2017 to 2019 were by EOP inmates. EOP programs offer considerable treatment services, such as weekly contacts with primary clinicians and a minimum of 10 hours of group treatment per week. All disciplines working with EOP patients should recognize the risk inherent in this group. For example, EOP mental health clinicians should be attuned to and able to monitor individual risks and provide suicide-specific treatment interventions, while custody and nursing (e.g., LPTs) should have particular awareness during safety checks and rounds with

EOP inmates. These considerations are even more crucial in EOP inmates in Level III and Level IV housing whose histories of violence suggests elevated suicide risk.

4. **Strategic cell occupancy**: Research on the origins of suicidal behavior suggest that interpersonal connections reduce the risk of suicide attempts. For prison inmates, having a cellmate can be a buffer against increased depression and despair. From 2017 through 2019, 75 of the 102 inmates who killed themselves were eligible for a cellmate or were on single-cell status. Not all inmates can be safely housed with other inmates. However, a move to strategically place inmates in two-person cells with compatible cellmates in high-risk populations (e.g., Level III and IV EOP inmates and mental health inmates in segregated housing) stands to have protective benefit.
5. **Follow-up after Psychiatric Hospitalization**: The days and weeks after discharge from psychiatric hospitalization is a high-risk period for suicide. This is particularly true when the individual was hospitalized after attempting suicide[48] and for those diagnosed with schizophrenia or bipolar disorder,[49] a major group among CDCR suicide decedents. Of inmates receiving mental health treatment at the time of their deaths between 2017 and 2019, almost half (47%) had been hospitalized for psychiatric treatment in the year before their deaths. In response, CDCR has implemented a number of policies and procedures for inpatient discharges, such as five-day follow-up and MHCB discharge custody-check procedures that provide additional observations and mental health contacts, audits of discharge risk assessments and treatment plans. The SMHP IRU has also instituted case conferences for treatment teams to discuss difficult cases.
6. **Suicide Attempt History**: As was noted in this report and in previous CDCR Annual Reports on Suicide, most deaths by suicide in CDCR occur among individuals with at least one prior suicide attempt, with the majority having made multiple past suicide attempts. The lifetime risk of death by suicide increases with a single attempt and much more so after a second attempt; for both psychiatric and non-psychiatric samples. The SMHP is continuing to implement a targeted treatment program – CAMS – with chronically high risk patients. As noted, CAMS is an empirically-tested, targeted intervention that is specific to suicide risk. The treatment focuses on psychological pain and distress and includes patient ratings of what most fuels suicidal desire for them and what has historically contributed to a wish to die by suicide, while challenging this wish for death with considerations of making life worth living.
7. **Focus on Common Precipitants of Suicide**: The most common precipitants noted in this report: mental health symptoms, loss of social support and interpersonal connectedness, and in-prison stresses such as safety or enemy concerns, victimization fears, gang pressures, or new charges have been prominent in the last ten years or more. Results of suicide reviews continue to suggest that clinicians often underestimate the impact of in-prison stressors when they add to the risk bestowed of major mental illness in causing psychological pain and thus, duress that can lead to suicide. Suicide risk assessment and suicide prevention trainings should continue to integrate the findings of suicide case reviews, such as these common precipitants to suicide within CDCR. Additionally, programs at all levels and in all settings should foster interpersonal and prosocial contacts

[48] Chung, Ryan, & Hadzi-Pavlovic. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis, *JAMA Psychiatry*, 74, 694-702

[49] Tidemalm, Langstrom, Lichtenstein, & Runeson. (2008). Risk of suicide after suicide attempt according to coexisting psychiatric disorder: Swedish cohort study with long-term follow-up. *British Medical Journal*, 337

that can bolster an inmate's will to live, give more meaning to their life in confinement, and decrease situational distress and despair. Group activities such as group therapy, occupational and recreational therapy, and school and job placements are environments that can enhance interpersonal relatedness, a known buffer against suicidal thinking.

8. **Hispanic Suicides**: The proportion of suicides among Hispanic inmates appears to be on the rise. During 2017-2019 Hispanic inmate suicides comprised 42% of total CDCR suicides, a much larger proportion than other ethnic/racial groups. This proportion was higher than in the two previous three-year periods when Hispanic suicides accounted for only thirty and thirty-three percent, respectively, of all suicides. This increase has outpaced the increase in the overall proportion of Hispanic CDCR inmates which increased only 4.4% from 2011 through 2019.

APPENDIX A: SUICIDE RESPONSE PROCEDURES

Reporting of a suicide to stakeholders: When an inmate dies by suicide, members of the SMHP complete two formal notification processes. First, a death notification is written and sent to the OSM and contains details of the suicide. Second, a summary of the suicide is composed and sent to the Deputy Director of the SMHP and the Undersecretary of the DHCS as well as the Governor's office. The Public Information Officer at the institution is assigned with any local notifications or reports regarding the death, including notifying the next of kin of the suicide.

Institutional internal review process: The internal process for reviewing suicides at CDCR institutions includes reviews by mental health, custody, and nursing/medical personnel employed at that site. The reviews are conducted first within disciplines and then within joint institutional reviews, such as during SPR-FIT and emergency medical response committee meetings.

Each CDCR institution has a SPR-FIT committee, with a Senior Psychologist Specialist assigned to coordinate local prevention and response efforts. The institution's SPR-FIT is established and maintained by the Mental Health Program subcommittee, with both committees being part of local Quality Management Committee.[45] Each institutional SPR-FIT is responsible for monitoring and tracking all self-harm events, ensuring that appropriate treatment and follow-up interventions occur. When deaths by suicide occur, the local SPR-FIT coordinator is required to notify the SMHP, to provide assistance to mental health, custody, and nursing suicide reviewers, and to ensure the implementation of QIPs resulting from the suicide review.[46]

External review processes: CDCR's response to suicides includes external reviews by nursing, medical, custody, and mental health staff. Within three days of the suicide, headquarters reviewers from each discipline are assigned to review the case. The role of each discipline's review is discussed separately below, but these disciplines collaborate with each other during the suicide review process, sharing initial findings, conducting reviews together, etc.

Trained custody and mental health reviewers conduct an on-site visit together within seven days of a suicide. Reviewers inspect the deceased's property, listen to recorded phone calls, check trust account records, and talk with the institutional Investigative Services Unit (ISU). Reviewers evaluate emergency response actions and review the medical and mental health services rendered in the case, if applicable. Reviewers will also talk with officers, clinicians, work or school supervisors, and cellmates who may have known the patient. Reviewers may gather information from other sources as well, e.g. interviews of family members. After thorough chart review, reports are generated by each discipline, with a combined report, the Suicide Report, distributed and discussed in the Suicide Case Review.

SCR meetings review findings in the case within and across disciplines while sharing information with institutional leadership. The Suicide Report contains QIPs that are presented at the SCR; these plans cross disciplines as well. Nursing, medical, and mental health disciplines additionally have peer review bodies that are able to review staff performance when indicated. The external review process is completed when all QIPs have been successfully implemented or resolved in the case.

DAI Mental Health Compliance Team (MHCT) reviews: The reviews completed by DAI's MHCT focus on the performance of custody staff members related to the suicide. The MHCT

[45] MHSDS Program Guides, 2018 Revision, pages 12-10-2 to 12-10-4
[46] *Id*

member reviews custody documentation and institutional records (i.e., SOMS). The MHCT member's role is to determine whether departmental suicide prevention practices and policies were followed by custody staff involved in the case. The MHCT reviewer, for example, evaluates whether custody officers followed procedure during the emergency response, how quickly the response was called once the suicide attempt was discovered, and whether all custody staff responding to the incident had received required training (e.g., in CPR) within set timelines (e.g., annually). The context of the suicide may necessitate additional review items. Most notably, if the individual was in a segregated housing unit at the time of the suicide, the MHCT reviewer will evaluate performance on tasks such as timeliness and quality of welfare checks, as specified by policy, whether inmates new to an ASU were placed in intake cells, and so forth. The MHCT reviewer also constructs a timeline for the emergency response and for significant events leading up to the suicide. Finally, the MHCT reviewer will document any concerns noted and will recommend corrective action/QIPs.

Nursing reviews: At the same time as a suicide is reviewed by DAI's MHCT, a Nurse Consultant Program Reviewer (NCPR) is assigned by a Headquarters Chief Nurse Executive. The NCPR does not make an on-site visit, but reviews all health care record documentation as to the quality of nursing care in the case. LPT practice is also covered within the nursing review. The NCPR and mental health case reviewer frequently consult on cases during the review period.

The NCPR generates a Nursing Death Review Summary (NDRS). The NDRS lists the primary cause of death, notes whether coexisting conditions were present prior to the death, summarizes medical history, reports what medications and medical treatment the patient was receiving, and documents significant events that occurred medically for the patient prior to and at the time of discovery. The NCPR determines if nursing standards of care were met within the emergency response to the suicide and whether nursing standards of care were met in the overall medical care of the patient prior to the time of death.

CCHCS Death Review Committee: The CCHCS Death Review Committee reviews all causes of inmate mortality within CDCR. When a suicide occurs, the Death Review Committee assigns a physician to serve as the medical reviewer. This physician works with the NCPR to examine all aspects of health care received by the patient and will yield an opinion as to the cause of death. As needed, the SMHP reviewer may also consult with the CCHCS physician reviewer. The physician and NCPR produce a Combined Death Review Summary (CDRS) on each case. The CDRS contains both an administrative review and a clinical mortality review of the case. In cases of suicide, the suicide report (discussed below) is reviewed by the Death Review Committee and addends or is integrated with the CDRS.[47] The findings of the NDRS and CDRS are then considered by the CCHCS Death Review Committee for corrective actions on either an institutional or individual basis.

Statewide Mental Health Program (SMHP) reviews: Simultaneous to custody, medical, and nursing reviews, a trained member of the SMHP is assigned to review each suicide. The assigned Mental Health Suicide Reviewer, typically a Senior Psychologist Specialist, is tasked with completing a Suicide Case Review. The Mental Health Suicide Reviewer schedules an on-site visit with the institution and is accompanied by the custody reviewer. The site-visit is conducted within seven calendar days of the death. The site review consists of an inspection of the location of the suicide and of the means used in the death, an inspection of the deceased's personal property, and

[47] CCHCS Health Care Department Operating Manual (HCDOM), Sec. 1.2.10

interviews of inmates, officers, medical, or mental health staff members who knew, interacted with, and/or treated the deceased. The deceased's property is inspected to see if there is any information present related to the suicide, such as a suicide note, letters to the inmate informing he/she of bad news, and other information associated the death. Interviews focus on behavior and statements made in the days prior to the suicide, with questions about anything the deceased may have said about being distressed or suicidal in past days, weeks, or months. Photographs of the scene at the time of death and photographs of the autopsy are also made available. Phone records, trust accounts, toxicology reports, and other sources of information are also made available. The Mental Health Suicide Reviewer may contact family members of the deceased to gain additional information about the individual's state of mind, statements made prior to the suicide, etc.

In addition to the on-site review, the Mental Health Suicide Reviewer reviews extensive documentation from medical and custodial files. The focus of the Mental Health Suicide Reviewer will vary based on the factors in the case, though all relevant information is reviewed in each case. In some cases, the review will concentrate on mental health treatment received while at CDCR; in others, on the quality of suicide risk assessment and in yet others, on the presence or absence of distress when an inmate is placed in administrative segregation, and so on. SMHP psychiatry staff review the psychiatric care and consult with the Mental Health Suicide Reviewer. The Mental Health Suicide Reviewer will review information from each of the institutions where the deceased resided and will look at whether mental health policy and procedure was followed at each setting.

Determination and tracking of QIPs: Each Suicide Case Review report may include formal QIPs as applicable to the case. QIPs are developed based on the concerns raised by custody, nursing, medical, or mental health case reviewers. QIPs may represent areas of deviation from policy or procedure, departures from standards of care, or systemic issues that require examination, modification, or innovation. QIPs may be written for any discipline and can focus on the specific institution where the suicide occurred. Occasionally a QIP will request that an institution's warden determine whether a formal investigation take place involving one or more aspects of a death. If systemic issues are identified, the QIP can be directed to the SMHP SPR-FIT, a team that can address statewide policies and practices. The DCHS SPR-FIT team includes representatives from nursing, custody, legal, mental health, and mental health quality management. This representation allows the team to review issues and find solutions in a manner that is inclusive of disciplines and effective in addressing problems.

Suicide Case Review meetings are held by teleconference so that staff from the institution can attend. During the meeting, the case reviewer will read sections of the Suicide Report. The Suicide Case Review Committee (SCRC) is made up of members of the CDCR SMHP, DAI MHCT, Nursing Executives, CDCR's Office of Legal Affairs, and medical personnel (as needed). The SCRC also discusses the QIPs raised within the Suicide Case Review with the institution. Institutional staff can respond to or clarify concerns raised in the report, can raise additional concerns, or can discuss ways of meeting the requirements of QIPs. Since late 2015, experts from the OSM are present by phone, and having reviewed the draft report, may raise additional concerns or issues. QIPs can also be written as pending concerns that need to be addressed if a fact or finding awaits further information, such as awaiting the results of a coroner's report to determine the time of death.

Audits of Suicide Case Review Quality: The DHCS Quality Management Unit audits all Suicide Case Reviews for fifteen items. The Suicide Case Reviews are scored with required elements marked present or absent.

APPENDIX B: DATA SOURCES AND METHODS

Data Sources. Rates of suicide are calculated using data from the SMHP and the CDCR Office of Research. CDCR population data varies slightly by source and counting rules. The Office of Research maintains and publishes weekly and monthly population reports.

The SMHP is notified of deaths throughout the CDCR system, including institutions/camps, in-state contract beds (California City Correctional Facility and privately-run community correctional facilities), and Department of State Hospital facilities. Until the spring of 2019, the department also housed inmates in privately-run facilities in Arizona. The SMHP investigated and produced reports on suicides in these facilities and counted the populations of these facilities when calculating suicide rates.

The figures for mental health and non-mental health populations in the body of this report were obtained from the monthly trends report of the Health Care Placement Oversight Program (HCPOP) and the CDCR Office of Research. Over the years, the Office of Research has also published a variety of reports about inmate characteristics. Most recently these statistics have been aggregated in an annual report entitled, "Data Points." Figures in the tables indicating statewide proportions of age, ethnicity/race, mental health level of care, and security level were calculated using the population figures in the OOR Data Points 2018 publication and directly from the Office of Research via their "Data Concierge Service."[50]

The SMHP suicide prevention program maintains a series of databases for tracking and reporting purposes. Custodial and individual characteristics of inmates who die by suicide are collected by suicide reviewers as part of their review. Data collected by reviewers is aggregated and is the source for many of the report's tables in the sections on custodial and mental health characteristics.

Beginning with the implementation of EHRS in 2016, data about self-harm incidents has been collected via a Self-Harm PowerForm, computer screens that allow staff to enter information about the incident. The aggregated data is used to produce an On Demand report, first available in 2016, that is available as part of the mental health program's quality management reporting. Definitions of self-harm are taken, in part, from the Centers for Disease Control and Prevention's (CDC) Self- Directed Violence Program.

Self-harm data from 2017-2019 was inspected for accuracy. Of the 14,402 incidents entered into the database, less than one percent were found to be in error. These errors were investigated and the most likely explanation for the errors data entry mistakes. These reports were not used as part of this report.

The data for rates of suicide for the United States and California, was downloaded from the fatal injury data section of the CDC's Web-based Injury Statistics and Query Reporting System (WISQARS)[51] which allows the user to filter for a variety of demographic variables.

Methods. Rates of suicide are calculated on an annual basis and standardized by the number per 100,000 to make comparisons between large samples and populations. When the number of deaths is small (twenty or less), the rates are not considered reliable, become overly sensitive and lead to "large, but meaningless increases or decreases." Although this report provides rates for groups of

[50] See https://www.cdcr.ca.gov/research/offender-outcomes-characteristics/offender-data-points
[51] See https://webappa.cdc.gov/sasweb/ncipc/mortrate.html

less than twenty (female suicides in particular) readers are cautioned to not over-interpret these findings.

Best practices dictate that mortality rates are calculated using the population at risk in the denominator.[52] Because prison populations can fluctuate over a 12-month period, choice of time-point is important. Bureau of Justice Statistics mortality reports for state prisoners have used mid-year prison system populations[53] and more recently end-of-year prison system populations including inmates held in private facilities.[54] CDCR annual reports of suicides as well as those of the experts from the OSM have most often used the mid-year total population as the denominator for rate calculations. Other experts have used the total of inmates in institutions and fire camps in the denominator, which neglects more than 5,000 inmates under CDCR jurisdiction. Table 23 presents how differences in choice of denominator can produce different estimates of the annual CDCR suicide rate.

Table 23. Suicide Rates by Choice of Population at Risk, 2019[55]

CDCR Monthly Population Report	Suicides	Population at Risk	Suicide Rate
Total Inmate Population, June 30, 2019	38	125,472	30.2
Institutions/Camps Only, June 30, 2019	38	117,682	32.3
Total Inmate Population, Dec. 31, 2019	38	124,027	30.9
Institutions/Camps Only, Dec. 31, 2019	38	117,393	32.4

Another concern is how best to make comparisons with other prison systems, as has been presented in previous reports. These comparisons are not been included in this report for several reasons. The federal Bureau of Justice Statistics collects, aggregates, and publishes data on state prison suicides. The most recent compilation was published in 2020 and included mortality rates for a variety of causes of deaths including suicide for the years 2001 through 2016.[56] Because the national data is not available for the years since 2016, no comparisons have been made in this report.

Second, when comparing state prison systems, demographics are important. The Three-Judge Panel pointed out in 2011 that state-by-state comparisons are of “limited value” when they fail to “control for demographics of each state’s inmate population.”[57] Suicide rates vary by age and racial/ethnic group. For example, in the community Hispanic suicide rates are lower than for Whites. Similarly, suicide rates for older individuals are higher than corresponding rates for younger individuals. [58] Hispanic inmates comprise over 40% of CDCR’s population, while in states

[52] See Siegel, J. S., & Swanson, D. A. (Eds.). (2004). *The methods and materials of demography* (2nd ed., p. 269). San Diego, CA: Elsevier Academic Press.
[53] Mumola, C. (2005). Suicide and homicide in state prisons and local jails. Report NCJ 210036. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Washington, DC.
[54] Carson, E.A. & Cowhig, M.P. (2020) Mortality in state and federal prisons, 2001-2016 – statistical tables. Report NCJ 251920. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Washington, DC.
[55] Reports are available from the CDCR Office of Research: https://cdcr.ca.gov/research/population-reports-2/
[56] Carson, E.A. & Cowhig, M.P. (2020) Mortality in state and federal prisons, 2001-2016 – statistical tables. Report NCJ 251920. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Washington, DC.
[57] *Coleman v Newsom*, ECF 3641 at 88.
[58] See e.g. https://suicidology.org/wp-content/uploads/2020/02/2018datapgsv2_Final.pdf

with large prison systems such as Florida or New York, the proportion of Hispanic inmates is much smaller.[59] Demographic data on individual state prison systems and suicide deaths is not easily obtainable, and has been reported by the BJS only as aggregate figures in their presentation of the causes of death or in aggregate reports of all state inmates. The ability to fully calculate and make meaningful comparisons with other states is thus limited. It is worth noting that over the years that CDCR and the OSM have been producing annual reports on suicide, these types of fine-grained analyses have not been presented.

Finally, rate calculations can fluctuate more widely for female inmates than the rate for men (see Table 1), as the female population is one-twentieth of the male population (5,691 vs. 119,781 in 2019). To illustrate, 2017 and 2018 had remarkably similar female inmate populations (5,971 and 5,906) and yet because there was one less suicide in 2018 than in 2017 (one vs. two), the rate of suicide in 2018 was 36% less. Also, in 2018, for instance, a decline of one suicide in male inmate deaths would have lowered the rate from 26.7 to 25.9, a difference of three percent. This illustrates the impact that population size has on mortality rates, particularly when the number of deaths is small.

Because population estimates can vary by sampling method and time of collection, 95% confidence intervals have been calculated for CDCR suicide rates for the five years ending in 2019 (Table C2).[60] Standard errors are measures of uncertainty associated with the estimates of death rates and are used to calculate confidence intervals, a measure of the range of certainty for the rate. The size of these measures depends on the number of deaths (numerator) and the base populations (denominator). Large numbers of deaths and large base population lead to greater certainty in estimating age-adjusted death rates.

Table 24. Annual Crude Suicide Rate and 95% Confidence Intervals, 2015-2019

Year	CDCR Population	Number of Suicides	Crude Rate	95% Confidence Interval
2015	128,900	24	18.6	12.5 – 27.7
2016	128,643	27	21.0	14.4 – 30.5
2017	131,260	30	22.8	16.0 – 32.6
2018	129,417	34	26.3	18.8 – 36.7
2019	125,472	38	30.3	22.1 – 41.6

[59] See, e.g.: http://www.dc.state.fl.us/pub/annual/1819/FDC_AR2018-19.pdf and https://doccs.ny.gov/system/files/documents/2019/09/Under%20Custody%20Report%202018.pdf

[60] Confidence intervals were calculated using the CDC's OpenEpi software – Score (Wilson) method. See: http://www.openepi.com/Menu/OE_Menu.htm

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