



# Report on Suicide Prevention and Response within the California Department of Corrections and Rehabilitation

**Conducted per Penal Code 2064.1  
October 1, 2019**



## Executive Summary

Suicide is reaching epidemic levels in many parts of the country and has steadily increased over the last four years in California's state prisons. In 2018, there were 166,333 unique offenders that spent at least one night incarcerated in the state prison system. Out of that population, 34 inmates committed suicide, each a separate tragedy the impact of which is incalculably devastating on family, friends, and the community. For the California Department of Corrections and Rehabilitation (CDCR), each and every suicide on its premises is one too many, and must be carefully examined for lessons and insights on how to prevent similar tragedies in the future.

Senate Bill 960 (Leyva) (Chapter 782, Statutes of 2018) added Penal Code Section 2064.1 to require CDCR to submit a report to the Legislature on or before October 1 of each year, to "include, among other things, descriptions of progress toward meeting the department's goals related to the completion of suicide risk evaluations, progress toward completion of 72 hour treatment plans, and progress in identifying and implementing initiatives that are designed to reduce risk factors associated with suicide." The bill requires the report to be posted on the Department's Internet Web site.

Over the last 30 years, CDCR has dedicated tens of millions of dollars to developing a robust suicide prevention program employing nationally established best practices and a comprehensive system of quality mental health care for inmates that few other state correctional systems can boast of. In 1990, CDCR had no formal suicide prevention program whatsoever and mental health services were available only at a handful of institutions. Now, CDCR provides *all* CDCR staff members suicide prevention training every year, ensures all potential first responders to suicides in progress are trained in emergency procedures and life-saving skills such as cardiopulmonary resuscitation and basic life support, extensively trains CDCR's talented and dedicated mental health clinicians in suicide risk assessment and risk management, has systems in place for identifying inmates at risk of suicide and referring them to proper care, provides special care for inmates who are placed in administrative segregation settings, and regularly offers inmates suicide prevention information through videos, pamphlets, and institutional suicide prevention events.

Although there is more work to be done, CDCR now has a comprehensive system of suicide risk evaluations, treatment plans, and suicide prevention in place. Moreover, CDCR does not stand alone in addressing the problem of suicide. Since 1995, CDCR has spent over \$100 million to fund the operations of the *Coleman* Special Master appointed by the federal court overseeing CDCR's mental health care system (the *Coleman* court), the *Coleman* Special Master's team of experts, consultants, and attorneys, as well as the attorneys of the Prison Law Office and the law firm Rosen, Bien, Galvan and Grunfeld LLP, working closely with them to develop and implement policies on suicide prevention and response. CDCR has further implemented dozens of recommendations from



three separate audit reports by the *Coleman* Special Master's suicide prevention expert since 2015. Many of the policies and procedures aimed at suicide prevention and response have been mandated by the federal court overseeing CDCR's mental health care system, and are compiled in the court-ordered Mental Health Services Delivery System Program Guide. The State pays the *Coleman* Special Master Matthew Lopes, his team at the law firm Pannone Lopes Devereaux & O'Gara LLC, the Prison Law Office, and Rosen Bien Galvan & Grunfeld LLP to monitor this Program Guide for compliance.

This report is structured to correspond directly to the requirements outlined in the legislation, including: the completion of suicide risk evaluations; the completion of timely treatment plans for patients in crisis; ensuring staff are trained in suicide prevention and response; the Department's progress in adopting and monitoring recommendations made by the *Coleman* Special Master; identifying and reducing risk factors in CDCR associated with suicide; and improving a system of notifications in the event of self-inflicted harm.

Progress toward each of these items is discussed at length in this report. The following is a summary of the findings:

Suicide Risk Evaluations: While the Department conducts more than 5,000 suicide risk evaluations per month, it struggles to complete them with consistently high quality. Suicide Risk evaluations occur, per policy, whenever an inmate expresses suicidal ideation, makes threats, or makes a suicide attempt, at a number of key evaluation points, and during known higher risk times for the patient. To address the ongoing challenge of completing these evaluations at a consistent high quality, the Department is in the process of revising its Suicide Risk Assessment and Self-Harm Evaluation form and providing specialized training to clinicians.

Treatment Plans: While the Department is more than 90 percent successful in completing treatment plans within 72 hours of admission to a Mental Health Crisis Bed, it is working to ensure that the treatment plans meet quality standards set by the Statewide Mental Health Program through improved training and the use of quality improvement tools and audits.

Training: The Department has a broad catalogue of suicide prevention and response training. The Department is more than 90 percent compliant in providing annual training for employees overall. This average, however, reflects very high rates of compliance among custody staff, whereas compliance by medical and mental health staff needs improvement.

Adopting Recommendations: Compliance with the *Coleman* Special Master's recommendations is a continuously evolving effort. The *Coleman* Special Master's initial suicide audit from 2014 included 32 recommendations, most of which have been addressed and implemented or which are the subject of current policy development and physical plant improvements. The expert is currently conducting his fourth re-audit of CDCR's suicide prevention program. Each successive audit has



raised new issues or concerns that the Department has adopted in addition to the suicide prevention expert's previous recommendations, as described more fully in the report.

Notification: The Department continues to seek out initiatives, best practices, and innovative solutions to enhance suicide prevention, and is working towards a next-of-kin notification system that is responsive to the gravity and tragedy of suicide and suicide attempts, but that also recognizes and honors the right of patients to medical privacy.

Identifying and Implementing Initiatives: Inmates, family members, and advocates including the Inmate Family Council and the Inmate Advisory Committee have provided valuable insights into the stressors that affect incarcerated individuals. Mental health and custodial staff have collaborated to reduce these stressors where possible. Additionally, CDCR invited a formerly incarcerated individual to present at an annual conference for CDCR staff related to suicide prevention and response. He spoke of his time incarcerated in CDCR institutions, of his suicide attempts, and his insights into how inmates can be helped in times of crisis. The Department has also identified specific points when incarcerated people are at increased risk, including: upon arrival at the reception center, after parole suitability hearings, and when facing new charges or civil commitment. The Department is also analyzing serious suicide attempts for ways to improve prevention, including providing training regarding cultural factors, when assessing suicidality.

While outside the scope of this report, CDCR remains committed to transforming the culture inside institutions through staff training and wellness efforts to improve the interaction between staff and inmates and we believe that could help suicide prevention efforts. Proposition 57 reinforced the Department's rehabilitation mission giving staff greater purpose to impact positively the prison environment. The Department has over 3,800 self-help programs, with 3,200 of those qualifying for Rehabilitative Achievement Credits. The Department has also launched a new literacy initiative and expanded face-to-face college to all institutions. Greater opportunities for earning credits have motivated many inmates to participate in programs to earn their release back to their homes and loved ones. Many of these programs have also helped to reduce social isolation.

Changes to case law and to the California Constitution have also resulted in more inmates going before the Board of Parole Hearings for parole suitability hearings, and many inmates serving life sentences have been released and are now programming successfully in the community. The Department is in the process of changing regulations to allow formerly incarcerated individuals greater ability to enter CDCR institutions to share their lived experiences with those still inside prison walls. Most meaningfully, the Department has radically decreased the number of individuals housed in restricted housing environments. Lastly, CDCR is in the process of reforming the inmate appeals system, so that inmates have a meaningful ability to redress any concern or adverse effect, which should help to reduce feelings of hopelessness or disempowerment. In the context of these



changes, many inmates report a greater feeling of hope, which is a protective factor against suicidality.

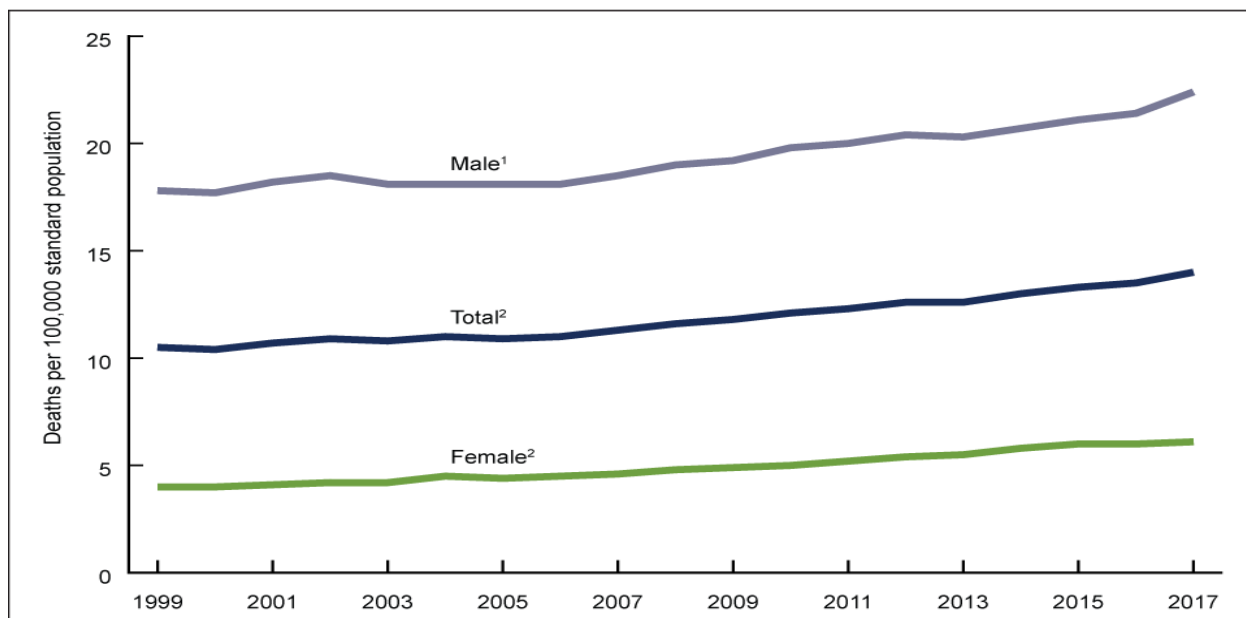
This first iteration of this annual report has proven helpful to the Department to identify where progress needs to be made and areas that require more innovation and thinking outside of the box. The Department looks forward to documenting its improvements annually to the Legislature and respectfully submits this report for consideration.



## Introduction

In the United States (US), 1.4 million suicide attempts were reported in 2017.<sup>1</sup> The rate of deaths by suicide in the US increased by one-third between 1999 to 2017, from less than 30,000 per year to over 47,000 per year. The current rate of suicides in the US is the highest rate in the country since the 1930s, during the Great Depression.

Figure 1. Age-adjusted suicide rates, by sex: United States, 1999–2017



<sup>1</sup>Stable trend from 1999 through 2006; significant increasing trend from 2006 through 2017,  $p < 0.001$ .

<sup>2</sup>Significant increasing trend from 1999 through 2017 with different rates of change over time,  $p < 0.001$ .

NOTES: Suicides are identified using *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes U03, X60–X84, and Y87.0. Age-adjusted death rates were calculated using the direct method and the 2000 U.S. standard population. Access data table for Figure 1 at:

[https://www.cdc.gov/nchs/data/databriefs/db330\\_table-508.pdf#1](https://www.cdc.gov/nchs/data/databriefs/db330_table-508.pdf#1).

SOURCE: NCHS. National Vital Statistics System. Mortality.

Suicide is a society-wide problem that has frustrated the efforts of federal, state, and local agencies to prevent suicides. Despite the implementation of a revised national strategy in 2012 for suicide prevention, suicide rates have continued to rise, with suicide rates increasing in most demographics by 30% since 2000 in the US. The increasing rate of suicide is seen in many different contexts. For example, multiple branches of the US military are struggling with rising suicide rates. In the early 2000's, a large increase in suicides occurred in the US military, with extensive suicide prevention efforts implemented by 2006. After a dip in rates, a troubling increase has been seen again in the US military, with rates in 2017 nearing or exceeding 30 suicides per 100,000 active military personnel in the Army, National Guard, and Marines.

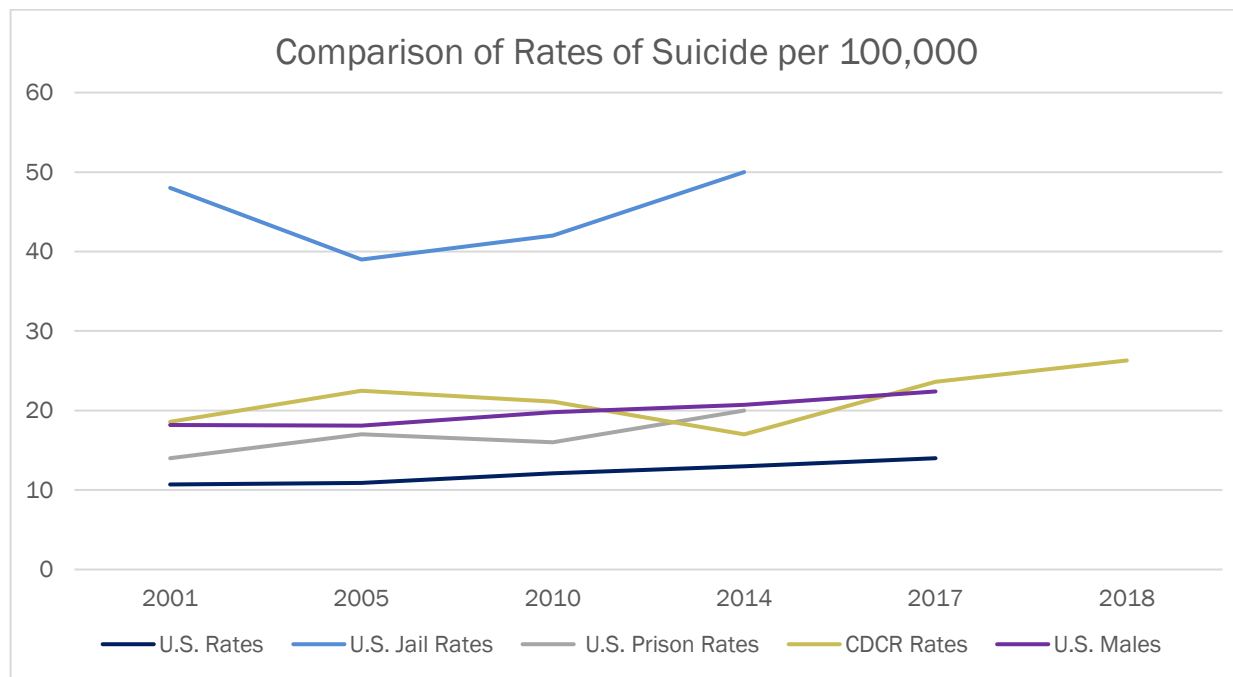
<sup>1</sup><https://afsp.org/about-suicide/suicide-statistics/>



This tragedy speaks to the difficulty of preventing such a complex issue as suicide, and parallels what CDCR has seen, with a rise in suicides despite extensive prevention efforts. In the US, suicide has long been more prevalent in jails than in prisons and there have been significant increases in the number of jail suicides in most recent years. The rate of suicide increased from 39 to 42 per 100,000 from 2005 to 2010 to rates reaching 50 per 100,000 in 2014 in US jails.<sup>2</sup>

The rate of suicide in US state prisons ranged from 14 per 100,000 to 17 per 100,000 from 1999 to 2013,<sup>3</sup> increasing in 2014 to 20 per 100,000 inmates. The Bureau of Justice Statistics has yet to publish information on state prisons for 2015 or subsequent years. The rates of suicide in the US and in US jails and prisons is found in Figure 2.

Figure 2: Rates of Suicide for the U.S., U.S. Males, and U.S. Jails and Prisons



In prison systems, suicide rates are multifactorial, with contributing factors that can include medical and mental health issues, court and sentencing issues, as well as those involving family, lack of purposeful activity, conditions of the specific prison environment, and the stress of adjusting to incarceration. In 1990, CDCR began tracking suicide frequency and suicide rates annually.<sup>4</sup> The

<sup>2</sup> <https://www.bjs.gov/content/pub/pdf/mlj0014st.pdf>

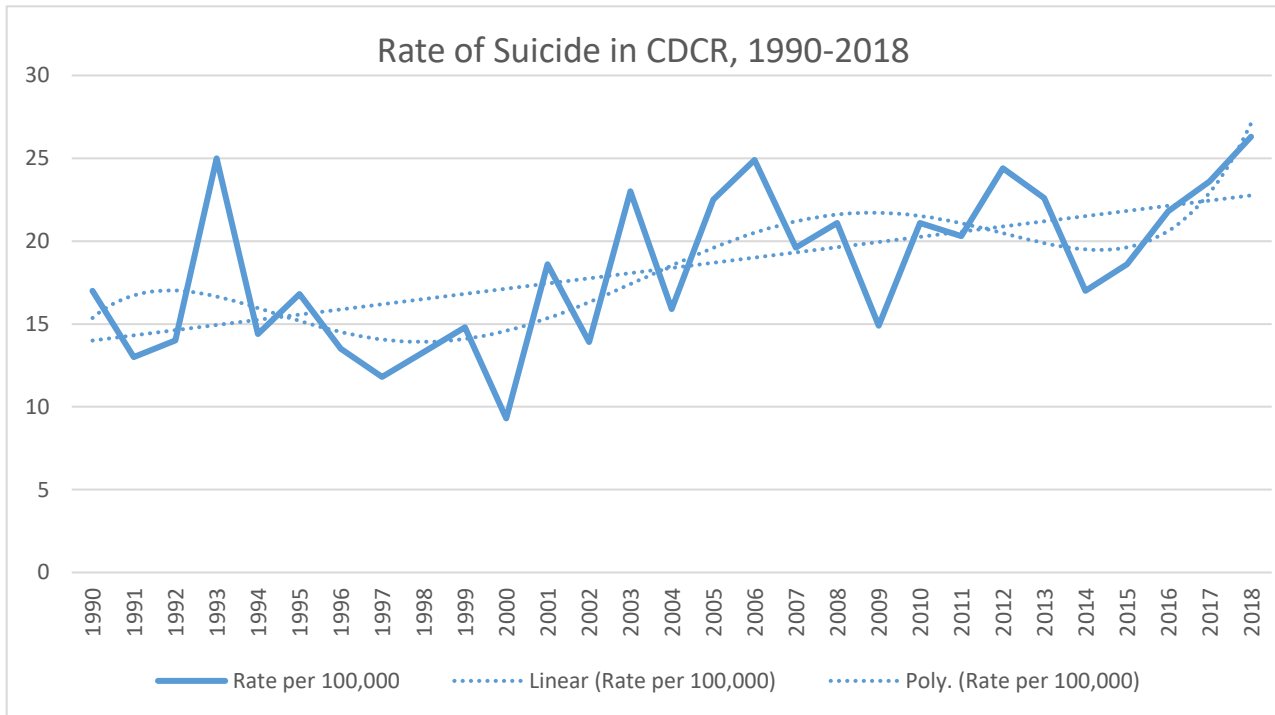
<sup>3</sup> Noonan, M. *Mortality in Local Jails and State Prisons, 2000-2013 – Statistical Tables*, August 2015, Website, U.S. Department of Justice, Bureau of Justice Statistics.

<sup>4</sup> <https://www.psychiatryadvisor.com/home/topics/suicide-and-self-harm/preventing-suicide-in-prison-inmates/>



annual rate of suicide for each year is shown below in Figure 3. The highest rate of suicide occurred in 2018, with 34 suicides, equating to a rate of 26.3<sup>5</sup> per 100,000.<sup>6</sup>

Figure 3: Rate of Suicide per 100,000 from 1990-2018, CDCR<sup>7</sup>



It is important to consider the efforts that have taken place in the past thirty years within the department in understanding suicides rates in the CDCR. Thirty years ago, there were minimal mental health or suicide prevention services for inmates in CDCR. The first psychiatric inpatient hospital beds available for CDCR inmates were opened in 1988. In 1990, CDCR had no formal suicide prevention program and mental health services were available only at a handful of institutions. The first formal statewide training in suicide prevention in the department occurred after a spike of suicides in 1993. The training was developed in 1994 and delivered in 1995 as a one-time requirement.

<sup>5</sup> One death in 2018 is under additional review. The outcome of the review, which will determine whether or it was a suicide vs. accidental death could impact the rate of suicides reported in this report. If determined not to be a suicide, the number of suicides for 2018 would change to 33 suicides and a suicide rate of 25.5 per 100,000.

<sup>6</sup> Suicide rates for large samples are standardly summarized as the number per 100,000, calculated by dividing the number of suicides by the total size of the population times 100,000. The CDCR rate of suicide uses the mid-year inclusive CDCR inmate population (in state and out-of-state totals on June 30 of each year).

<sup>7</sup> A linear trend line is most appropriate when data increases or decreases at a steady rate, whereas a polynomial trend line is used when data fluctuates over data or time points, as in this case.





In 1995, a federal court found that the mental health system operated by CDCR was unconstitutional. The court found that prison officials were deliberately indifferent to systemic deficiencies in inmates' mental healthcare, including inadequate screenings, understaffing, delays in access to care, deficiencies in medication management and involuntary medication, inadequacy of medical records, inadequately trained staff, and improper housing of mentally ill inmates in administrative segregation. The federal court further found that CDCR had designed an adequate suicide prevention program and had taken many of the steps necessary to implement that program; however, the Court also found that the suicide program had not yet been fully implemented. The court ordered that new policies and protocols be developed, and ordered that a special master be appointed to monitor compliance with the courts-orders. On December 11, 1995, the court appointed the first *Coleman* Special Master.

Since that time, CDCR has spent significant resources working with the federal court's Special Master, his suicide prevention expert, and the attorneys representing the *Coleman* class members (Prison Law Office and Rosen, Bien, Galvan and Grunfeld, LLP) to develop and fully implement policies to improve CDCR's suicide prevention program as well as millions of dollars to build and update prisons to provide suicide resistant housing for inmates at risk of suicide. Federal court oversight of those efforts continue with the *Coleman* Special Master's expert conducting comprehensive audits of the suicide prevention efforts at individual prisons and reporting his findings to the federal court following each audit.

Although there is more work to be done, CDCR now has in place a comprehensive system of suicide risk evaluations, treatment plans, and suicide prevention. As explained above, since the 1990's, CDCR has made significant improvements in development of its Statewide Mental Health Services Delivery System. With respect to suicide, these improvements include new and enhanced suicide prevention training for all CDCR staff, specialized emergency procedures training for all potential first responders to suicides in progress, and training for mental health clinicians on suicide risk assessment and risk management. Additionally, CDCR is providing inmates with a range of mental health services and has created a referral procedure for inmate evaluations, including procedures for protecting inmates during particularly vulnerable periods. CDCR also has implemented suicide screening procedures and provides inmates with suicide prevention information through videos, pamphlets, and institutional suicide prevention events.



### Progress toward meeting the department's goals related to the completion of suicide risk evaluations in a sufficient manner.

It is the Department's goal to ensure that suicide risk evaluations are completed accurately, timely and in a sufficient manner. The Suicide Risk Assessment and Self-Harm Evaluation (SRASHE) is composed of a standardized measure of suicide risk assessment, the Columbia-Suicide Severity Rating Scale<sup>8</sup>, a review of the inmate's history of self-harm, and an interview regarding risk and protective factors. The SRASHE is used to evaluate an inmate's risk of suicide, resulting in a formulation of suicide risk and a risk management strategy for the case. A SRASHE is administered, per policy, whenever an inmate expresses suicidal ideation, makes threats, or makes a suicide attempt. In addition, the SRASHE is administered, by policy, at a number of key evaluation points and during known higher risk times for the patient.

#### SRASHE Revisions

Mental health clinicians at CDCR institutions complete approximately 5,000 SRASHEs per month, with 60,800 completed in 2018. The importance of the accuracy of these assessments and the ability of clinicians to formulate risk, and to create appropriate risk management strategies based on these assessments, is critical.

In an effort to improve the completion and quality of suicide risk evaluations, CDCR released revisions to the SRASHE form in May and December of 2018. These were the first two of four phases of revision. The third and fourth revision phases are currently being tested by CDCR and are anticipated to be released in the spring of 2020.

#### SRASHE Audits Using the Chart Audit Tool

The Statewide Mental Health Program (SMHP) developed a standardized method for evaluating the quality of a number of key mental health documents, this method is called the Chart Audit Tool (CAT). The CAT is conducted on numerous documents on a quarterly basis, with results available to the mental health leadership at institutions, at regional mental health sites, and at headquarters. One document that is audited is the SRASHE. The quality of a selection of SRASHEs is audited quarterly. Each CDCR mental health clinician is audited at least twice per year regarding SRASHE completion and quality. The criteria used in this audit were listed in the 2017 report of the California State Auditor (CSA).<sup>9</sup> The first quarterly CAT audit of the Suicide Risk Evaluation (SRE) form (now the SRASHE) occurred in the third quarter of 2013. Since the beginning of 2017, the pass rate has fluctuated between 61% and 72%, as shown in Table 1 below.

<sup>8</sup> The Columbia Suicide Severity Rating Scale is a suicidal ideation and behavior rating scale created by researchers at Columbia University, University of Pennsylvania, University of Pittsburgh and New York University to evaluate suicide risk.

<sup>9</sup> <https://www.auditor.ca.gov/pdfs/reports/2016-131.pdf; page 23>



Table 1. Results of CAT SRE and/or SRASHE Audits, 2017-2019<sup>10</sup>

<i>Time Period</i>	<i>Pass Rate</i>
2017 Quarter 1	70%
2017 Quarter 2	72%
2017 Quarter 3	66%
2017 Quarter 4	62%
2018 Quarter 1	63%
2018 Quarter 2	61%
2018 Quarter 3	70%
2018 Quarter 4	72%
2019 Quarter 1	66%
2019 Quarter 2	67%

The CAT questions pertaining to suicide prevention have been modified to be more consistent with the revisions to the SRASHE, particularly as it relates to the Safety Planning Intervention (SPI) initiative discussed further on page 16 of this report. Additionally, the revised questions will better assess the quality of the SRASHE documentation, in contrast to previous process-focused questions assessing whether or not the SRASHE had all of the items completed without looking at the content of the documentation.

Live SRASHE Training

In May and June of 2019, a departmental expert provided a live Training for Trainers (T4T) course on the SRASHE to selected staff members within each institution. The T4T focused on improving the quality and accuracy of suicide risk evaluations. These staff will deliver training to all clinicians at their respective institutions by the end of 2019. CDCR will assess the value of the live training in

<sup>10</sup> 2019 data from Performance Report run 9/10/19



improving the quality of the SRASHEs by comparing SRASHE CAT passing rates before and after the training is implemented.

**Description of progress toward meeting the department's goals related to the completion of 72 hour treatment plans in a sufficient manner.**

It is the department's goal to ensure that the 72-hour treatment plans are completed in Mental Health Crisis Bed (MHCB) settings as required. Treatment plans establish the goals and interventions inmates receive at all levels of need for mental health services. Inmates who are found to be in crisis are transferred to a MHCB, where an evaluation and initial treatment plan is developed within 24 hours of admission<sup>11</sup>. By policy, a full treatment plan must be completed within 72 hours of admission.<sup>12</sup> The 72-hour treatment plan is discussed in the patient's Interdisciplinary Treatment Team (IDTT) meeting in the MHCB, which the patient attends. The IDTT is composed of, at a minimum, the patient's assigned psychiatrist and primary clinician (typically a psychologist), a member of the MHCB unit nursing staff, and a correctional counselor. The IDTT members are responsible for ensuring that the treatment plan created is within timelines and meets the quality standards set by the department.

In 2017, the CSA Report cited the completion and quality of the 72-hour treatment plans in the MHCB as a chief concern. The CSA noted several incidents where sections of the 72-hour treatment plans were left blank, and reported several other deficiencies. Those deficiencies were: inadequate treatment methods; including a lack of information on the frequency of interventions and who was responsible for the intervention; poor post-discharge follow-up plans; poor treatment goals or goals without measurable outcomes; and missing documentation of medication dosage and frequency. To remedy these concerns, a number of efforts have been made.

- Training to Improve the Quality of 72-hour IDTTs: CDCR expends considerable resources in training appropriate IDTT processes and treatment planning quality, with quarterly audits conducted both in person by CDCR Regional Mental Health teams and in quarterly CAT documentation audits. New training<sup>13</sup> designed to improve the quality of 72-hour IDTTs is under development with an anticipated implementation date in the spring of 2020. This new training has been drafted to emphasize the importance of the treatment plan to MHCB supervisors and clinicians, and will be given only to MHCB staff members. It focuses on the role of the 72-hour IDTT conference in suicide prevention efforts and crisis resolution, while reinforcing good treatment team practice and quality treatment planning documentation. The new training is meant to complement existing IDTT process training.

<sup>11</sup> MHSDS Program Guide page 12-5-11

<sup>12</sup> MHSDS Program Guide page 12-5-12

<sup>13</sup> Other IDTT Trainings currently exist, such as "IDTT: An overview of the clinical thinking and process," a 7-hour training for treatment planning for all levels of care.



- Continuous Quality Improvement (CQI) and CQI Tool (CQIT): CDCR has developed a sustainable CQI process, including regional oversight of compliance indicators and requirements for corrective action.

As the CQI process continues to develop, Regional Mental Health staff are assisting institutions in developing their own oversight using standardized audits and their existing quality improvement program. A major instrument used in this process of standardized CQI audits is called the CQI Tool, or CQIT. The CQIT contains detailed audit instructions and process for evaluating IDTT meetings. The CQIT has questions related to observing how the IDTT interacts with the patient, discusses intake information, evaluates that effective communication is established, provides case formulation information, discusses diagnosis, reviews the rationale for the prescribed medication (by the psychiatrist), and questions the patient in an open-ended manner regarding their input into the treatment plan and understanding of the plan. The CQIT auditor is also asked to rate the participation of the correctional counselor, the skill of the IDTT leader to engage all participants and encourage discussion, and rates whether measurable treatment goals are established and discussed. The discussion of a possible need for a higher level of care is also an audited component of the CQIT. Finally, the 72-hour IDTT audit rates the discussion of levels of observation, a justification of the level of observation chosen, and the discussion of discharge plans.

- Audits of Treatment Plans: Similar to how the CAT is conducted on the quality of suicide risk evaluations every quarter, clinician documentation of treatment planning is audited regularly through the CAT. Treatment planning audits are required within all CDCR mental health programs, including both the 72-hour and discharge MHCB IDTT treatment plans. Results of CAT audits are monitored by regional and institutional mental health supervisors and managers. CAT audits cover 15 questions, including items such as whether a summary of mental health symptoms and treatment is present, if the diagnosis and clinical summary are consistent with the problems found, whether medications are listed that target symptoms, if the goals and interventions include individualized, measurable objectives, if progress was discussed, if there is a meaningful discussion of a discharge plan or future treatment needs, if the rationale for the level of care is sound, and whether the plan is updated to reflect current functioning. Chart audits are to be conducted by the clinical supervisors or senior specialist who oversee their programs. Auditors use audit findings to provide staff feedback and develop plans for the program to improve documentation. CAT items can be revised periodically based on departmental priorities or due to changes made to treatment planning forms.

Table 2 below demonstrates that CAT audit results related to quality of MHCB treatment planning documentation fluctuated rather significantly between quarters of 2018, ranging from 63% to 84% of MHCB treatment plans meeting all audit criteria. CDCR has set a standard for institutions to pass 85% of audited IDTT documents. This standard was approached in quarter one of 2018, with poorer performance in subsequent quarters. To address these deficiencies, institutions that have pass



rates under 85% are required to develop and implement Corrective Action Plans (CAPS) to remedy the quality of their documentation for all audits that are included in the statewide performance improvement priorities. Currently, quality of suicide risk evaluations is included as one of the priorities, and CAPS are sent to Regional Mental Health leadership each month. These plans are then discussed at the monthly headquarters mental health quality management subcommittee. Institutions may also set Performance Improvement Work Plans (PIWP) to prioritize IDTT quality through the site’s Quality Management Committee.

Table 2: Results of MHC B IDTT Audits, 2018<sup>14</sup>

Time Period	Pass Rate	Number of Audits Conducted <sup>15</sup>
2018 Quarter 1	84%	223
2018 Quarter 2	71%	226
2018 Quarter 3	75%	297
2018 Quarter 4	63%	267
2019 Quarter 1	57%	267
2019 Quarter 2	62%	273

- Timeliness of MHC B Master Treatment Plans:** The timeliness of MHC B Master Treatment Plans is tracked by the Performance Report, a tool used for quality management purposes. The Performance Report tracks timeliness of all treatment plans in the MHC B. In general, the overall timeliness of treatment plans completed by MHC B IDTTs ranges from 94% to 96% compliance. Timeliness is defined by policy as whether the IDTT occurred within 72 hours of admission, for initial IDTTs, and within seven days since the initial IDTT for routine IDTTs. In the first six months of 2019, 17,052 MHC B IDTTs were conducted, with 8,070 Initial or 72-hour treatment plans completed and 8,982 Routine treatment plans completed. Thus far in 2019, the timeliness for initial treatment plans at the 72-hour MHC B IDTTs has ranged from 91%-93%.<sup>16</sup> As shown in Table 3, timeliness of routine treatment plans by MCHB IDTTs, which in the MHC B includes discharge treatment plans, ranges from 98%-99%. The compliance for initial treatment plans at the 72-hour MHC B IDTTs ranges from 89%-92%. In 2018, 21,108 MHC B IDTTs were conducted, with 9,877 Initial or 72-hour treatment plans completed and 11,231 Routine treatment plans completed.<sup>17</sup>

<sup>14</sup> Data from SQL query (Kanban 66760) on 5/23/2019, Performance report variable *Treatment Plans with Satisfactory Score*; data for Q1-Q2 of 2019 run 9/10/19

<sup>15</sup> Number of treatment plan audits for MHC B admissions in 2018; data validated via comparison of performance report on 5/23/19 and data analysis completed on 7/9/19; 2019 data run 9/10/19

<sup>16</sup> MHSDS Program Guide, page 12-5-12

<sup>17</sup> Data based on completed IDTT appointments while housed in MHC B; data run 7/9/19



Table 3. Timeliness of MHCB IDTTs, 2018

Time Period	Overall IDTTs occurring on time	Initial IDTTs occurring on time	Routine IDTTs occurring on time.
2018 Quarter 1	94%	89%	98%
2018 Quarter 2	96%	92%	99%
2018 Quarter 3	94%	90%	98%
2018 Quarter 4	95%	91%	99%
2019 Quarter 1	95%	93%	98%
2019 Quarter 2	95%	91%	98%

**Description of the department’s efforts to ensure that all required staff receive training related to suicide prevention and response.**

CDCR has a number of suicide prevention and response trainings that are required for either all staff members or for specific disciplines. Some suicide prevention training is meant to be provided over a brief period, such as training on a new procedure or an updated form. Other suicide prevention training is meant to be ongoing, used both as a way for new employees to learn suicide prevention and response practices, or to update staff members about their responsibilities in these areas.

A number of efforts are underway to improve how training is tracked for employees of CDCR. These efforts range from granular, institution-specific generation of compliance data and tracking, with supervisors expected to ensure compliance of staff members in completing training, to broad efforts to adopt sophisticated training compliance tools using the 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.

When individual employees are non-compliant with required training, several routes can be taken to identify and remedy the lack of compliance. Non-compliance is identified by In-Service Training (IST) offices at institutions via the use of compliance tracking logs. Lists of non-compliant staff are sent to the supervisors of each discipline. IST offices are asked to send the compliance figures for their institutions each October, giving institutional CEOs and Wardens an opportunity to schedule non-compliant custody, medical, and mental health staff members in required training before the end of the year.

In addition to the annual training given to all disciplines and new employees, custodial officers and nursing staff members are provided additional suicide prevention and response trainings. Required cardiopulmonary resuscitation (CPR) and Basic Life Support (BLS) classes are also tracked for



compliance for potential first responders (custody and nursing), psychiatrists, and psychiatric nurse practitioners.<sup>18</sup>

In 2015, the SMHP created a specialized Training Unit for the purposes of tracking training compliance, developing new clinical training when needed, and revising existing training as needed. The SMHP Training Unit keeps record of institutional compliance with mandatory suicide risk assessment and evaluation training and all suicide prevention and response training. For non-IST training, such as classes specific to mental health suicide risk evaluation training, compliance lists are held at the institution, with information entered into a tracking log. Copies of tracking logs are sent to and maintained by the SMHP Training unit who reviews institutional compliance and alerts regional and institutional staff to follow up on compliance. For training held within the LMS system, compliance data is automatically tabulated and both individual staff members and their managers are alerted to any non-compliance issues. Compliance with mandatory training is also an issue reviewed at an employee’s probationary and/or annual evaluations.

CDCR provides a broad training in suicide prevention and response to all employees upon their initial hiring and annually thereafter. Suicide Prevention training is provided through the In-Service Training departments at all CDCR institutions. In its 2017 report, CSA identified that attendance at this training had variable attendance between disciplines, with custodial attendance percentages often above that of mental health and other health care personnel. Improved compliance with this training is noted within all staff disciplines, as reflected in table 4 below. In 2017, 37,470 staff members were required to take this training, including 28,200 custody staff, 2,190 mental health staff, and 7,060 nursing staff. In 2018, 36,077 staff members were required to take this training, including 27,418 custody staff, 2,054 mental health staff, and 6,605 health care staff.

Table 4. In-Service Training Compliance, Suicide Prevention, 2017-2018

<b>Attendance at Crisis Intervention and Suicide Prevention</b>	<b>2017 Compliance</b>	<b>2018 Compliance</b>
All Staff Members	89%	91%
Custodial Staff	95%	96%
Medical/Dental/Nursing Staff	69%	75%
Mental Health Staff	72%	81%

In an effort to ensure that medical and mental health program staff comply with annual training requirements, SMHP and Regional Mental Health offices track compliance and send compliance updates and reminders to Chief Executive Officers, Wardens, Chief Nursing Executives, and Chiefs

<sup>18</sup> Memorandum dated 12/3/18, *Psychiatry and Psychiatric Nurse Practitioners Basic Life Support Certification*, tracking occurs through the Credentialing and Privileging Support Unit.





of Mental Health. These institutional leaders are responsible to ensure that their staff are attending required training.

Mental health clinicians receive a significant number of additional tailored suicide risk evaluation and risk management classes as a requirement of employment. For mental health staff, the training related to suicide prevention that is mandatory and tracked for compliance is found in Table 5. Several additional training courses are available to CDCR clinicians as optional trainings. These courses provide mental health clinicians with opportunities to enhance skills when evaluating or working with suicidal patients. Several of these courses have Continuing Education Units (CEUs) available as well.

Table 5. Required Suicide Prevention Training, Mental Health Staff

Required Training Name	Staff Required	Hours Required
Suicide Risk Evaluation	Mental health clinicians who complete evaluations	7
Columbia-Suicide Severity Rating Scale	Mental health clinicians who complete evaluations	2
Suicide Risk Evaluation Initial Mentoring	Mental health clinicians who have been selected to mentor other clinicians	2
Suicide Risk Evaluation Advanced Mentoring	Mental health clinicians who have been selected to mentor other clinicians	2
Safety Planning	Mental health clinicians who complete suicide risk evaluations	2
Differential Diagnosis in Complex Cases	Mental health clinicians; optional for psychiatrists	2.5
Safety Planning Intervention	All mental health clinicians (includes psychiatry) <i>Begins mid-year 2019; replaces Safety Planning</i>	6

For required mental health training in suicide prevention, compliance figures for 2017 and 2018 are shown below in Table 6. The training Safety Planning was discontinued in 2018 pending the roll out of the more comprehensive SPI training, which likely explains the decrease in compliance percentage for the Safety Planning course. Training in the 7-hour Suicide Risk Evaluation course was also paused during the third quarter of 2018, pending the implementation of the revised class. Additionally, although institutions track compliance of mental health staff in completing the Columbia-Suicide Severity Rating Scale training, compliance on this training was not made a tracking metric by the Mental Health Training Unit and therefore is not included in Table 6.



Institutional tracking of the Columbia-Suicide Severity Rating Scale training, the new SPI course, and the revised 7-hour Suicide Risk Evaluation course will begin in the 2<sup>nd</sup> half of 2019. Finally, CDCR is a major employer of mental health clinicians, employing over 1600 psychiatrists, psychologists, and social workers. Institutions have 90 days to ensure newly hired mental health clinicians are compliant with required suicide prevention training, and institutional mental health leadership is responsible for tracking completion of required training within this period.

Table 6. Mental Health Staff Compliance in Required Suicide Risk Training<sup>19</sup>

Training Name	2017 Compliance	2018 Compliance
Suicide Risk Evaluation	89%	92%
Suicide Risk Evaluation Initial/Advanced Mentoring	77%	92%
Safety Planning	87%	84%
Differential Diagnosis in Complex Cases	91%	91%

Description of the department’s progress in implementing the recommendations made by the special master regarding inmate suicides and attempts, to include the results of any audits the department conducts, at the headquarters or regional level, as part of its planned audit process to measure the success of changes the department implements as a result of these recommendations.

On July 12, 2013, the *Coleman* court ordered CDCR, the *Coleman* Plaintiffs, and the Special Master to convene a Suicide Prevention Management Workgroup. The Special Master’s expert, Lindsay Hayes, made 32 recommendations related to suicide prevention practices in 2015, which were ordered to be implemented by the court that same year.<sup>20</sup> Three of those recommendations were later withdrawn in 2017.<sup>21</sup> Since 2015, CDCR has worked to implement the recommendations made by the workgroup and continues to meet with the *Coleman* Special Master’s experts to discuss progress on those recommendations.

<sup>19</sup> Data received from SMHP Mental Health Training Unit on May 9, 2019.

<sup>20</sup> Electronic Court Filing (ECF) 5259, Filed 1/14/15, An audit of suicide prevention practices in the prisons of CDCR; and ECF 5271, Filed February 3, 2015, ORDER regarding first Hayes audit.

<sup>21</sup> Electronic Document Filing (EDF) 5762, Filed January 25, 2018; ORDER regarding the second re-audit.



Lindsay Hayes, M.S., began auditing the suicide prevention practices of all CDCR institutions on November 12, 2013 as the Subject Matter Expert (SME) hired by the *Coleman* Special Master. He completed his first audit in July, 2014, and offered 32 recommendations. Mr. Hayes re-audited practices at 18 institutions in 2015,<sup>22</sup> submitting a report on January 13, 2016. Mr. Hayes re-audited 23 institutions in 2016, reporting these results on September 7, 2017.<sup>23</sup> An additional audit was conducted by Mr. Hayes between May 2017 and February 2018, with a report issued on November 5, 2018.<sup>24</sup> The 2017 audit and 2018 reports contained audits of 18 institutions "...which chronically struggled with their suicide prevention programs, as well as almost all prisons that contained MHCB units. (These institutions) undergo continued re-inspection." Mr. Hayes continues to audit suicide prevention practices in selected CDCR institutions in 2019.

As noted in the CSA report (page 51), CDCR has "...addressed the majority of the suicide expert's January 2015 report." Since the October 2015 summary of progress, CDCR has either substantially completed or implemented the recommendations made by Mr. Hayes. However, as audits continue to occur, additional items are identified that are specific to certain institutions. Furthermore, the introduction of the Electronic Health Record System (EHRS) occurred subsequent to Mr. Hayes' recommendations; this system was phased in between 2015 and October 2017. This both created new challenges and solutions to the issues raised previously. For all of these items, Corrective Action Plans (CAPs) were written and then monitored. The status of CAPs related to Mr. Hayes' recommendations in 2017 and 2018 are categorized and described below.

- Initial Health Screening and Receiving and Release Environment: Some intake forms included compound questions, making it difficult to know if a patient was, for example, expressing depression, suicidal thoughts, or both. Per recommendations by Mr. Hayes, these paper forms were modified. All CAPs in this area were completed by the end of 2018.
- Psychiatric Technician (PT) Practices: PTs at three institutions were found not to meet standards for administrative segregation rounds in 2017. CAPs were developed and the issues were not found during Mr. Hayes' 2018 audit. A process of ongoing fidelity checks of PT rounding was in place at each site under the supervision of the Chief Nursing Executives.
- Retrofitted Cells in MHCB Units: In 2018, Mr. Hayes reported that three institutions did not meet all specifications for retrofitted cells in the MHCB units. Retrofitting was completed at one institution on April 2, 2018, another on September 17, 2018, and the final unit was completed on January 31, 2019.

<sup>22</sup> ECF 5396, Filed 1/13/16, A re-audit and update on suicide prevention practices in the prisons of CDCR

<sup>23</sup> ECF 5672, Filed 9/7/17, A re-audit and update on suicide prevention practices in the prisons of CDCR

<sup>24</sup> ECF 5994, Filed 11/5/18, *ibid*



- Use of Suicide Resistant Cells for Newly Admitted Inmates in Administrative Segregation: Inmates placed in administrative segregation are to be housed in single-occupancy suicide resistant intake cells for the first 72 hours of their placement. They may occasionally need to be placed in non-intake cells, which is permissible, if housed with another inmate. Mr. Hayes reported problems with eight institutions in 2017 and ten institutions in 2018 related to either retaining inmates in intake cells for longer than 72 hours or placing some new arrivals in administrative segregation in non-intake cells. In the latter circumstance, intake cells were unavailable because other inmates were retained in intake cells longer than required. In response, in 2017, a survey was developed to adequately identify the number of intake cells needed within institutions and an auditing report was created for intake cell use. In 2018, each of the ten institutions identified as having problematic practices was required to file CAPs with headquarters. Both the 2017 and 2018 CAPs were completed by the end of 2018. Following the 2018 Hayes' review, additional CAPs were developed to add intake cell use to regular custody audits, which are monitored by institutional quality management committees. Additionally, the following initiatives have been undertaken:
  - Standardized methodology for monitoring and determining the appropriate number of intake cells by institution has been developed.
  - Existing cells have been retrofitted to increase the number available intake cells in identified institutions.
- MHCB Practices for Observation Status, Clothing, and Privileges: Three issues related to MHCB practices were identified: Problems with nursing documentation of observation of suicidal patients, errors in allowable property for patients, and the provision of out-of-cell activities and other privileges (e.g., access to a telephone).
  - In 2017, six institutions were found to have documented inaccurately the times when nursing observations occurred of suicidal inmates. Nursing supervisors were therefore tasked to conduct regular audits of observation practices and documentation of these observations. The issue was again seen in 2018; many institutions experienced difficulties adjusting to the documentation requirements for nursing observations for patients on suicide precaution. The EHRS was modified in 2018 to trigger staggered observation rounding, with nursing staff trained on this adjustment by way of a statewide webinar.
  - In regards to property issues, errors were noted during Mr. Hayes' audits whereby patients on suicide watch were issued full property, such as regular clothing, rather than a safety smock, or were found in safety smocks after being taken off suicide watch. To respond to this concern, MHCB staff received specific training on what is known as "patient issue", that is, the clothing and property allowance given to patients based on their assessed



suicide risk.<sup>25</sup> The appropriate issuance of property to inmates while on suicide precautions was added as a regional auditing item and is an audit item included in CQIT.

- In regards to the provision of out-of-cell activities and privileges, an instructive memorandum was released on February 14, 2017, with MHCB staff members trained on the policy. The memorandum detailed that inmates would attend out-of-cell activities consistent with their security level designation, with therapeutic recreational goals pursued, that telephone access would be given as consistent with policy, that non-contact visiting privileges would be considered whenever appropriate based on the patient's condition, and that all out-of-cell activity would be documented. Out-of-cell activities and privileges were also included as part of the CQIT auditing of MHCBs. Institutional CAPs were developed for units where improvements were not seen in 2018.
- 30-Minute Welfare Checks in Segregated Housing: Mr. Hayes recommended CAPs for any institution with a less than 90% compliance rate for 30-minute checks within segregated housing facilities. All institutions were found to meet or surpass this compliance rate in 2018.
- Suicide Risk Evaluation Trainings: In 2017, low training compliance rates were noted for mental health clinicians on the Suicide Risk Evaluation and Suicide Risk Evaluation Mentoring courses at eight audited facilities. To address this issue, all institutions were tasked with sending training compliance data to the SMHP Training Unit and with monitoring compliance within SPRFIT. Institutions who did not meet training compliance standards were instructed to develop internal CAPs. In 2018, compliance had improved in required suicide risk evaluation trainings, with only two institutions not meeting the 90% benchmark.
- Completion of Suicide Risk Assessments as Required: A number of institutions were below 90% compliance rates in their completion of suicide risk evaluations when required, such as for emergency mental health referrals or upon discharge from Alternative Housing, which is described in detail in page 19. SMHP and local SPRFIT committees began to monitor suicide risk evaluation compliance, and institutions who were out of compliance in this area developed internal CAPs. In 2018, the number of institutions who failed to meet compliance standards fell from twelve institutions to six institutions.
- Safety Planning for Suicidal Inmates: In both 2017 and 2018, Mr. Hayes noted difficulties with the quality of safety plans written within suicide risk evaluations. During discussions, CDCR and Mr. Hayes agreed to the supervisorial<sup>26</sup> monitoring of all safety plans written in suicide risk evaluations at the time of discharge from MHCB. The supervisory reviews were designed to ensure that MHCB

<sup>25</sup> Memorandum dated 6/1/2018, Reminder-Level of Observation for Patients in Mental Health Crisis Beds

<sup>26</sup> While MHCB program supervisors are the most likely reviewers of discharge safety plans, at times a qualified designee, such as a SPRFIT coordinator or covering Sr. Psychologist, Supervisor or Specialist may act as a reviewer.



discharge safety plans were of good quality, reflected consultation with receiving treatment teams when indicated, and helped to ensure risk management efforts were described effectively. Of note, the SMHP has reformatted safety plans using a SPI, with implementation by August 2019. Therefore, monitoring of compliance with the newly required SPI at MHCB discharge will be needed.

SPI is a widely used and well researched approach to safety planning. SPI is being adopted as an intervention with patients found to be at a moderate or high acute risk of suicide. The evidenced-based approach selected is based on the safety planning work of Barbara Stanley and Greg Brown (2012).<sup>27</sup> Stanley et al. (2014)<sup>28</sup> described the process of a SPI as one which involves patients working with a clinician to develop a safety plan with the following steps:

- Identifying warning signs that indicate a crisis may be developing
  - Listing internal coping strategies that can be used independently
  - Listing external situations or supports that can provide distraction
  - Listing people who are available sources of support
  - Listing the names of staff members that can be contacted during a crisis
  - Taking steps to make the environment safe (means restriction)
  - Listing reminders of things that make life worth living
- MHCB and Alternative Housing Discharge and Efficacy of Custody Welfare Checks: When patients are discharged from either Alternative Housing or MHCB, custody officers in housing units must check on their welfare every half-hour for at least 24 hours. Following 24 hours, a mental health clinician must evaluate the patient and speak with the housing officers about the patient's adjustment to the unit. This process can re-occur at 24-hour intervals up to 72-hours. In both 2017 and 2018, Mr. Hayes noted problems with the documentation of 30-minute welfare checks, with such issues as clinicians discontinuing checks in less than 24 hours, custody conducting 60-minute checks instead of 30, and so forth. A CAP was developed in 2017 for all institutions not in compliance with the process or form, known as the Discharge Custody Check Sheet (CDCR 7497). These CAPs were used again in 2018 for any institution with less than 90% compliance in correct documentation. An automated report monitors the required daily follow-ups on these welfare-

<sup>27</sup> <https://www.sciencedirect.com/science/article/pii/S1077722911000630?via%3Dihub>

<sup>28</sup> <https://www.sciencedirect.com/science/article/pii/S1551714414001013>



checks, with significant improvement noted. This item is integrated within the draft CQIT suicide prevention self-monitoring tool and continues to be audited in 2019.

- MHCB and Alternative Housing Discharge and Efficacy of Five-Day Follow-Up: When patients are discharged from either Alternative Housing or MHCB, mental health clinicians must re-evaluate the patient daily, recording their assessment on a five-day follow-up form. The form requires clinicians to ask about suicidal thoughts, signs of distress, while instructing the clinician to review MHCB discharge documents, and to review and/or revise the patient’s safety plan. In 2017 and 2018, Mr. Hayes found the five-day follow-up forms completed adequately in most of the institutions he visited.
- Local SPRFITs: Mr. Hayes observed local SPRFIT meetings at institutions in 2017 and 2018, and/or reviewed the minutes from these meetings. In general, his impression was that meetings consisted of mostly quantitative reports, such as monitoring of training compliance and prevalence of self-harm incidents, with minimal discussion of qualitative elements relevant to institutional suicide prevention, or of progress on CAPs in place to remediate concerns raised by the his audits. In response, in 2018, a memorandum was issued designed to improve the structure of local SPRFITs to help them fulfill their mission.<sup>29</sup> Institutional SPRFIT meeting minutes are also provided to institutional and Headquarters Mental Health Quality Management Committees on an ongoing basis and an audit was revised to ensure compliance.
- Continuous Quality Improvement (CQI): CDCR, in consultation with Mr. Hayes and the *Coleman* Special Master, has agreed to monitor nineteen (19) suicide prevention audit items through a CQI process. In 2018, the Department worked with the *Coleman* Special Master on a final CQI report format. This format integrates suicide prevention audit findings with other CQI assessments, with the comprehensive group of findings detailed in a written report. The CQI tool, or CQIT, involves reviewers from multiple disciplines within each institution (e.g., custody, nursing, and mental health disciplines) to ensure that the audit is done comprehensively. A self-audit guidebook containing these items was distributed to institutions. The CQIT-SP is also undergoing revision, to include new items audited by the *Coleman* Special Master.
- Suicide Prevention Training: Mr. Hayes attended selected IST annual suicide prevention classes held within audited institutions. He opined that the course content was too large for a 2-hour class, yet missed important topics. Mr. Hayes made recommendations for course content that have been since integrated into a revised training. The revised training has been reviewed by Mr. Hayes. The training was sent to the Office of Training and Professional Development (OTPD) for review and will be implemented at institutions in early 2020. Mr. Hayes made similar observations while attending suicide prevention classes at the Training Academy at Galt, noting again the course

<sup>29</sup> Memorandum dated 2/2/18, “Enhancements to the Suicide Prevention and Response Focused Improvement Teams,” is found in Attachment A.



content was too large for this 2.5-hour class, yet missed important topics. Revisions to this course have been completed, with the revised class expanded to four hours. The class is currently under review by OTPD.

- Reception Center Suicides: Reception centers are prisons where inmates committed to the Department are received from county jails for initial processing. When a patient arrives at the reception center, each patient shall have a thorough initial health screening completed by a licensed health care staff. The patient is screened for medical and mental health needs and is evaluated for suicidal ideation. If the patient is identified as requiring mental health services they will be referred as clinically indicated. The issue of reception center suicides was raised in 2018, due to a cluster of suicides in reception center institutions during the year. Some of the issues identified as impacting suicide prevention in reception centers included inconsistent posting of suicide prevention posters and difficulties receiving jail mental health records in a timely manner. Regional Mental Health Compliance Teams are directed to inspect reception center institutions for suicide prevention posters on a routine basis. The SHMP is drafting a memorandum providing direction to reception center mental health clinicians regarding expectations for obtaining and reviewing jail records for newly received inmates. In addition, a Transitional Help and Rehabilitations in a Violence-Free Environment (THRIVE) program is under development. The THRIVE program consists of 12 training modules created by the Division of Rehabilitative Programs for reception center inmates, with each module containing short videos and pamphlets that provide new inmates information regarding available services, how submit requests, and “what you should know” about each area. The THRIVE program is still under development.
- Use of Alternative Housing for Suicidal Inmates: A number of initiatives have been developed and implemented to reduce the time needed to move patients in crisis from their current location to MHCB; this temporary housing is called Alternative Housing. Patients housed in Alternative Housing are to be transferred to MHCB units within 24 hours, unless their referrals to MHCBs are rescinded. In 2017, Mr. Hayes commented on the location of Alternative Housing cells, stating that some types of cells were more appropriate than other types. He asked SPRFIT committees to identify appropriate Alternative Housing cells within their institutions. In response, a policy was developed to re-enforce the Mental Health Program guide requirements for prioritization of certain types of cells, with some cells listed only when all other locations have been filled. A memorandum related to SPRFIT monitoring of Alternative Housing use was also distributed in early 2018. In 2018, Mr. Hayes noted that the majority of institutions (82%) were in compliance with transfer from Alternative Housing within 24 hours, while four institutions (18%) continued to have stays that, on average, surpassed the 24 hour mark.<sup>30</sup> In 2019, compliance with transfer from Alternative Housing was at 99% for quarters 1 and 2.<sup>31</sup>

<sup>30</sup> In response, institutional CAPs were written at each of the four institutions.

<sup>31</sup> Per Performance Report run 8/21/19, Indicator “Alternative Housing Stays”





- MHCB Transfer Timelines: CDCR has initiated several statewide initiatives for oversight and improvement of timelines for transfer from Alternative Housing to MHCB. A specific Quality Management report was developed to help ensure timely transfers. Assigned headquarters staff members in the Inpatient Referral Unit send out alerts, review missed transfer timelines, and ensure institutional action plans are developed to prevent future missed timelines. Barriers to timely transfer were identified and addressed through a number of actions impacting CDCR transportation staff practices, medical clearance procedures, and improved communication between centralized population management staff members and local classification representatives at institutions. This improvement is noted in Table 7.
- Improving Transfer Timelines for Female Patients: CDCR has established an additional unlicensed MHCB facility for female inmates that has dramatically decreased the number of female patients waiting over 24 hours for transfer. This unit, located at California Institution for Women (CIW), has had the desired impact of providing additional beds and allowing for compliance with mandated transfer timelines.
- Flex Units: Flex units are designed to adjust as needed between different levels of inpatient care. Three levels of inpatient care are available to meet patient needs: Intermediate Care Facility (ICF), Acute Psychiatric Program (APP), and MHCB. The existence of flex units ensures no one inpatient program has on-going problems with wait lists or delays in admissions. Thus, these units adjust to patient needs in order to address any possible wait time issue in MHCB. As of this date, this project is anticipated to be implemented by the end of 2019.
- Referral Timeline Alerts: In 2018, the Inpatient Referral Unit implemented alert systems that warned institutional Chiefs of Mental Health of pending deadlines regarding timely transfers of patients in Alternative Housing. A specific Quality Management report was also developed to help ensure timely transfers. Barriers to timely transfer were identified and addressed through a number of improvements in CDCR transportation staff practices, medical clearance procedures, and communication between centralized population management staff members and local classification representatives at institutions. These changes were implemented in 2018, along with institutional self-monitoring strategies. Progress in meeting referral timelines by policy are noted in Table 7.



Table 7: Compliance with Timely Admissions to MHCB, 2017-2019<sup>32</sup>

Mid-Year Date	Percentage of Compliance: Timely Admissions to MHCB
June 30, 2017	56%
June 30, 2018	90%
June 30, 2019	98%

The CSA report (page 52; table 7)<sup>33</sup> lists seven recommendations made by Mr. Hayes, the action taken in response to each recommendation, the dates the actions were taken, and whether monitoring and/or enforcement of the action was in place. Of the seven items, one was in progress and six were in place at the time of the report.<sup>34</sup> Each of the actions taken required follow-up monitoring and auditing. As noted by the CSA, an audit of suicide prevention items and on-going monitoring of compliance with changes to CDCR policy was necessary to ensure recommendations were being applied in a sustainable, proficient manner. CDCR’s audit, described to the CSA at the time, has since been drafted and finalized, with several institutions undergoing a formal audit of suicide prevention practices in 2018.

The November 11, 2018<sup>35</sup> filing by Mr. Hayes reports on his review and re-audit of 23 institutions from May 2017 to February 2018. Mr. Hayes noted in this report that CDCR had continued to work with the *Coleman* Special Master to revise the CQIT, coding items along with the EHRS. Mr. Hayes noted “progress at varying speeds” along the initiatives laid out for the department.

**Description of the department’s progress in identifying and implementing initiatives that are designed to reduce risk factors associated with suicide.**

There are many potential sources of information to consider in identifying initiatives for suicide prevention: the input and innovation of institutional staff and leadership, input from inmates and/or the family or loved ones of inmates, information from the field of Suicidology, the results of suicide reviews and reviews of serious incidents of self-harm, quality management reviews, the findings of the department’s informatics system and data warehouse, the dissemination of best practices at institutions, the practices of other agencies or states, the review of community or agency suicides or suicide attempts, insights from formal research on correctional populations, and the adoption and implementation of Crisis Intervention Teams.

<sup>32</sup> Data per Mental Health Performance Report, data pulled on 7/5/2019

<sup>33</sup><https://www.auditor.ca.gov/pdfs/reports/2016-131.pdf>

<sup>34</sup>*ibid*

<sup>35</sup> ECF 5994, Filed 11/5/18, The third re-audit and update on suicide prevention practices in the prisons of CDCR



Inmates and inmate-patients are important sources of information as to what issues are impinging upon them as a group, as to what external stresses may be contributing to self-harm thoughts in some individuals, and as to what they are finding helpful in reducing risk for suicide. Inmates may tell custody officers, nurses, or other staff members about certain stressors, such as peers who are in danger from other peers. Inmate-patients may be forthcoming in describing what issues or stressors are contributing to thoughts about suicide, identifying personal suicide risk factors that may have wide application.

The field of Suicidology is represented nationally by the American Association of Suicidology (AAS), with all major suicide prevention agencies being members or affiliates of the AAS. CDCR is a corporate member of AAS, meaning any staff member in CDCR may join the AAS without cost, gaining access to the association's research journal, *Suicide and Life-Threatening Behavior*, to informational webinars and libraries, and to discounted attendance fees at AAS events. CDCR staff are reminded how to join and/or access AAS materials routinely via videoconferences, with documents regarding how to join the AAS posted on the suicide prevention Share Point site. CDCR has sponsored presentations of papers and workshops at AAS conferences for a number of years and a number of CDCR employees attend the AAS conference annually.

Reviews of deaths by suicide and suicide attempts must inform the practice of suicide prevention. There are many examples of how reviews have led to innovation within CDCR, ranging from local institutional processes to statewide policy. The list provided here contains a sampling of recent efforts derived from findings from suicide reviews and investigations of suicide attempts:

- Creation of a Reception Center workgroup, focused on continuity of medical and psychiatric information from jails.
- Development of the THRIVE program.
- Discussion and incorporation of SPI.
- Design and re-design of suicide prevention posters and pamphlets, including posters designed by inmates.
- Formation of a workgroup to review reducing suicide following inpatient discharge.
- Formation of a workgroup to develop a process for investigating a peer support model for inmates.
- Provision of in-cell materials for inmates in segregated housing.
- Development of a training for Board of Prison Hearings (BPH) commissioners.
- Development of a mental health referral process for BPH commissions and evaluators.
- Development of a mental health referral process for county public defenders (when a CDCR inmate is facing new charges or civil proceedings).
- Exploration of ways to gather information on the outcome of court hearings and when an evaluation by mental health should occur..



- Review of when over-the-counter medications and keep-on-person medications should be restricted, developing a case-by-case process<sup>36</sup>.
- Development of a training on evaluating cultural factors when conducting suicide risk assessments.
- Creation of an emergency response workgroup to evaluate cut-down tools and create a standardized emergency response kit.

CDCR established a requirement for institutional SPRFITs to complete semi-annual, aggregate Root Cause Analyses (RCA) of serious suicide attempts. As many institutions struggled with this requirement, a different approach to reviews of serious suicide attempts is under discussion. A model similar to the self-harm reviews completed at the California State Prison, Sacramento mentioned in the CSA report<sup>37</sup> (page 61) is one of the templates for self-harm reviews that is under consideration.

There are many quality management processes occurring at institutions, as well as Patient Safety and Quality Management Committees at institutions. These institutional efforts are supported by regional healthcare, mental health, nursing, and custody staff members, as well as the California Correctional Health Care Services Quality Management (QM) units. The various quality management activities monitor many institutional functions, pointing out when programs are underperforming, and leading to innovation in determining how quality can be improved.

Currently, QM provides comprehensive management and executive reports, operational tools, resources for local committees and subcommittees, leadership tools and training, and best practice information to institutions. The QM portal contains, for example, information on conducting Performance Improvement Work Plans, Root Cause Analysis and Lean Six Sigma projects. Institutional leadership can review performance on a variety of metrics across units, programs, and facilities over periods of time, allowing leaders to adjust staffing, identify and address problems, and manage compliance issues. The Mental Health Performance Report, among other indicators, supplies metrics to mental health leadership regarding quality and compliance, including timeliness of transfers and required evaluations, the number of treatment hours received by patients at different levels of care, and so forth. The quality and timeliness of suicide risk evaluations, five-day follow-ups, treatment plans, inpatient discharges, outpatient appointments, and amount of treatment scheduled and completed is regularly reported and updated daily. Compliance rates can be compared between institutions and can be addressed by regional resources, as well as institutional leadership.

This robust QM structure and reporting capability has led to a natural process of information and best practices sharing. Institutional programs that are not meeting standards often reach out to

<sup>36</sup> CCHCS Memorandum dated 11/19/2014, Over the Counter Products Test Procedure—Clarification of Accessibility.

<sup>37</sup> <https://www.auditor.ca.gov/pdfs/reports/2016-131.pdf>



institutions that are meeting standards. Alternatively, regional staff members export what is working in one institution to other institutions in their region as a best practice and as a way to improve on a specific indicators. For example, institutions who were not meeting compliance standards regarding the completion of MHCB Discharge Custody Checks were assisted by regional staff by identifying high performing institutions. In addition, CEOs at varying institutions meet with institutional QM staff members and with other CEOs regularly, allowing for information to be passed from high-performing institutions to other sites. Best practices (discussed further below) can be highlighted in discussions within and between institutions.

CDCR Mental Health created a data warehouse to house information as a way to analyze system-wide data. This data is then disseminated for quality improvement purposes. The data warehouse includes large amounts of data drawn from various sources, including medical and custodial records, and information on self-harm events. The use of informatics allows mental health leadership to look at “big picture” items, sharing this information with other stakeholders (e.g., custody leadership).

Notably, the data warehouse has been used in an exploratory fashion to look at the major correlations of self-harm behavior. For example, survival curve analyses using the data warehouse have identified specific targets for suicide prevention efforts, such as the period of time following discharge from inpatient hospitalization. This information has contributed to such responses as a workgroup tasked with looking at recommendations pre- and post-discharge from PIP programs.

CCHCS has implemented a number of ways in which staff members and institutions can inform others of best practices or review best practices. Staff members at all levels are able to become involved in learning and using tools for performance improvement, with opportunities to inform institutional leadership and statewide leadership on specific projects or issues. Several methods are available to train staff in leadership skills, focused improvement projects, and projects that promote efficiency. In turn, each of these methods result in identifying best practices, with these best practices then available for dissemination.

Performance Improvement Work Plans: Performance Improvement Work Plans (PIWP) are a method used to identify quality improvement priorities, with both statewide and institutional PIWPs selected as a yearlong projects. Each PIWP selects a priority area, researches how to measure the area, proposes a measure or metric, evaluates a solution or quality improvement, and works with statewide QMC to familiarize successful improvements to other institutions and regions. A library of prior PIWPs is contained in the Quality Management portal, which is available to all CDCR and CCHCS staff. Sample PIWPs in 2018 focused on implementing a Complete Care Model, using multi-disciplinary daily “huddles” to discuss critical patient care needs, and a plan to improve the quality of suicide risk assessment evaluations.



Lean Six Sigma: Lean Six Sigma (L6S) is a leadership and management style that uses data to improve efficiency within complex systems. Completed L6S Green Belt and Black Belt projects are posted in the Quality Management portal, with links to project descriptions and presentations. Although L6S projects are institution specific, what is learned from each project is shared as a potential best practice, such that other institutions may benefit. A best practices link is currently under construction and will disseminate information from L6S projects. A selection of projects with the potential to reduce risk factors associated with suicide currently found in the L6S library<sup>38</sup> include:

- Improving the CDCR 7497 process: The CDCR 7497 records a process involving 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.
- Reducing psychiatrist prescribed medication refusals: This project was completed in 2017 on a group of Enhanced Outpatient Program (EOP) patients at the Substance Abuse Treatment Facility (SATF). A group of high medication refusers was identified with reasons for refusal analyzed. The project found that reasons for high refusers were multi-faceted and a collaborative response between institutional disciplines was needed to lower refusal rates. Medication refusal rates dropped from 33 per day to 8 per day over a two-week implementation period in August, 2017.
- 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 (CCI) 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 (CSP-LAC) 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.

<sup>38</sup> <http://cchcssites/dept/QI/default.aspx>



- Improving the quality of clinical summaries in mental health documentation: This project was implemented at Avenal State Prison (ASP) in 2018 and consisted of reviewing deficiencies in patient clinical summaries. A clinical summary template was created, which resulted in 85% fewer summaries rated as deficient. .

Suicide Prevention SharePoint Site: Like most SharePoint sites, the Suicide Prevention SharePoint allows users to share documents, post articles of interests, and share training materials. The site currently contains 315 research or clinical articles, archived suicide prevention slide shows from monthly instructional videoconference presentations (2011 to present), instructions on joining AAS, groups of presentations made at the 2018 Suicide Summit, contact lists for SPRFIT coordinators and HQ SPRFIT, resources for staff suicide prevention, and resources for inmates and inmate/patients (videos, pamphlets, and posters). The information sharing occurring on SharePoint sites is another way of disseminating best practice information.

Statewide SPRFIT Coordinator Conference Calls: In addition to monthly suicide prevention video conferences that can be viewed by all staff, SPRFIT Coordinators from headquarters and from all institutions hold conference calls at least quarterly to discuss issues impacting suicide prevention efforts statewide. In 2017 and 2018, topics discussed during these conference calls included improving inpatient discharge custody checks, managing risk when inmates are out to court, conducting root cause analyses on incidents of self-harm, findings from research on suicide prevention, creating a SPRFIT onboarding manual, and refining self-harm determinations and data entry.

Leadership Meetings Related to Suicide Prevention: SMHP holds three Mental Health Leadership conferences and one three day Suicide Summit conference annually. Mental Health Leadership conferences are meant to disseminate best practice information in a variety of areas, including suicide prevention. The Suicide Summit is focused more specifically on advancements within the department as to policy, procedure, best practices, innovations, and interventions to improve suicide prevention and response. In 2018, topics presented at the Suicide Summit included: addressing suicide risk factors among transgendered inmates; using the Multiple Interactive Learning Objectives (MILO) simulator system<sup>39</sup> to train staff members in responding to suicidal patients; learning the history of suicide prevention; reviewing trends in suicides; addressing suicide risk in female institutions; training on the role of the custody Mental Health Compliance Teams; providing updates on the work of the Inpatient Referral Unit and on the suicide-related components of the Chart Audit Tool; and seeing the impact of a suicide prevention week at a women's facility, CIW. In addition, the impact of the national opioid epidemic on corrections was presented by an addiction psychiatrist. Finally, a former CDCR inmate spoke of his time in incarceration, his suicide attempt while incarcerated, and his

<sup>39</sup> <https://www.govtech.com/products/Californias-Prisons-Have-New-Training-Software.html>



insights into how inmates can be helped during times of crisis. All presentations from the 2018 Suicide Summit are found in the Suicide Prevention SharePoint site.

Best Practices Library: SMHP has started to revise its intranet site with a best practices library. The library will be available to all CDCR intranet users. Once created, existing documents from other sites that are not readily available to all users will be added to the library in archival fashion, such as best practice information from the Suicide Prevention SharePoint site.

Psychiatry Trainings and Consultants: Psychiatrists and other interested staff are able to attend weekly Grand Rounds and obtain Continuing Medical Education (CME) for attending. Grand Rounds offers presentations from academic and forensic psychiatrists, and is broadcast throughout the state using video-conferencing technology. Much of the content of the series is related to psychopharmacology and psychiatric disease states, but there is also a lecture series on forensics and the assessment of suicidality. These educational sessions encourage the use of evidence-based best practices in forensic settings.

In collaboration with the Department of State Hospitals (DSH), a psychopharmacology specialist consults with CDCR psychiatrists regarding treating patients with very challenging psychiatric presentations, including those who are suicidal. Staff psychiatrists at institutions are able to send patient referrals to this consultant who will evaluate the case, utilizing chart review or in person. Psychopharmacological approaches are important as multiple medications are known to decrease suicidality in vulnerable patients with particular diagnoses, for example, Clozapine<sup>40</sup> and Lithium.<sup>41</sup> In addition, psychopharmacological treatment itself lowers all causes of mortality (which includes suicidality) in patients with serious mental illness.<sup>42</sup> The expertise of our psychopharmacology psychiatrist, and her relationship with and ability to consult with nationally renowned experts, supports CDCR psychiatrists, helps patients to improve, and ultimately helps to decrease suicidality and all-cause mortality. Her consultations have been well received.

Another source for potential initiatives are findings from the community related to suicide, both in relationship to emerging or trending risk factors, but also developments in treatment and outreach strategies. Although most opioid overdoses are accidental, rather than intentional, the need to modify correctional practice for inmate/patient safety reasons is apparent. Beginning in 2018, CDCR implemented Substance Abuse and Mental Health Services Administration's evidenced-

40Meltzer, H., et al. (2003) Clozapine Treatment for Suicidality in Schizophrenia, Archives of General Psychiatry, 60(1):82-91. doi:10.1001/archpsyc.60.1.82

41 Lewitzka, U., et al. (2015). The suicide prevention effect of lithium: more than 20 years of evidence. International Journal of Bipolar Disorders, 3: 15. <https://doi.org/10.1186/s40345-015-0032-2>

42 Tiihonen, J., et al. (2009). 11-year follow-up of mortality in patients with schizophrenia: a population-based cohort study. The Lancet, 374, 620-627. DOI:10.1016/S0140- 6736(09)60742-X





based *Illness Management and Recovery*<sup>43</sup> group curriculum to address co-occurring disorders in CDCR's EOP population. In addition, Medication-Assisted Treatment is now available in several institutions, with medications such as buprenorphine, methadone, and naloxone available as treatment options.<sup>44</sup> Another option, Substance Use Disorders Treatment (SUDT),<sup>45</sup> is a 5-month treatment program held 5 days per week for 3.25 hours per day in various institutions. The SUDT program is held as an educational class by a vendor agency, and covers risk and resiliency factors, relapse prevention, how substance use disorders impact families and loved ones, and the effect of substance use disorders on related health and behavior problems. The class also provides information on life skills essential for substance abuse recovery, such as stress management, relaxation, spirituality, assertiveness, and refusal skills. This program is used as a link to community reentry services.<sup>46</sup>

A recent innovation in CDCR emerging from community models is the establishment of a number of Crisis Intervention Teams (CIT) at institutions with large mental health missions. In CDCR, CITs are adapted to the setting of incarceration, though a partnership between mental health, nursing and custodial personnel. Within CDCR, the establishment of CITs attests to the fact that people have crises for a variety of reasons, some related to medical care, some to conflicts with others, some based on mental illness, or other reasons. CITs thus have a combination of custody, nursing, and mental health personnel to intervene in crisis situations. If an inmate reports to someone a desire to kill themselves, the CIT will evaluate the inmate, identify the sources of distress, attempt to resolve or mitigate these sources of distress at the point of service, and arrange follow-up (which may or may not include placement in a MHCB). If, for example, an inmate is distressed by a perceived lack of medical attention, the presence of a nurse may help to clear any misunderstanding. A relatively common example of the value of a CIT is an inmate who reports suicidal thoughts, with the trigger or motivation to these thoughts being conflicts with other inmates. These conflicts can be very distressing and can quickly develop into significant fears for one's safety. Whereas mental health clinicians may not be able to address safety concerns directly, when meeting with the patient, they can work collaboratively with custody personnel who may be able to work out a reasonable solution, thus relieving the inmate's distress.

The establishment of CITs potentially meets the needs of CDCR inmates in a better way than the typical mental health evaluation. As many suicides and suicide attempts occur in prison settings due to safety concerns, distress over conflicts with other inmates, and pressures

<sup>43</sup> <https://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463>

<sup>44</sup> <https://cchcs.ca.gov/wp-content/uploads/sites/60/2018/04/MAT-AnnualReport-2018.pdf>

<sup>45</sup> <https://westcarecalifornia.wordpress.com/2019/01/03/a-story-by-paul-sudt-program-participant-at-sierra-conservation-center/>

<sup>46</sup> <https://www.cdcr.ca.gov/adult-operations/fops/reentry-services/>



related to the realities of incarceration,<sup>47</sup> the CITs serve to problem solve issues related to prison life that may not be directly related to a mental health issue.

Description of the department's efforts and progress to expand upon its process of notification pursuant to Section 5022, including expansion of those notifications in cases of suicide attempts when deemed appropriate by the department, and when inmates have consented to allow release of that information.

CDCR is committed to expanding the process for notifying next of kin, to include events involving an inmate who commits an act of self-harm with the intent to die, while ensuring that it complies with federal laws designed to provide privacy standards to protect patients' medical records and other health information.

CDCR collects and maintained notification lists, commonly referred to as next of kin designations. The form is completed regularly, and at least yearly, with all inmates who agree to do so. However, the inmate must also complete a Release of Information (ROI) form, which allows a patient to designate an individual to receive protected health information for medical and mental health purposes.

CDCR has assembled a high-level workgroup to investigate the following issues relevant to suicide attempt notifications:

1. Confidentiality and patient consent issues: Contacting next of kin may be complicated by issues related to whether the inmate has completed a Release of Information (ROI), particularly if the notification is to be made by a physician or mental health clinician. Release of health information can be construed as a violation of the Health Insurance Portability and Accountability Act of 1996 if personal medical information is disclosed without the patient's consent.<sup>48</sup>
2. Release of Information forms: CDCR is reviewing whether the current release of information form used by the department is adequate for suicide attempts. The use of a 'blanket' ROI form may not conform to privacy laws.
3. Guidelines for self-harm incidents: The department is working on establishing guidelines and criteria that would be utilized to notify family members of a possible suicide attempt.

<sup>47</sup> Dear, et al., 2008. Ten years of research into self-harm in the Western Australian Prison System: Where to Next? *Psychiatry, Psychology, & Law*, 15 (3), 469-481.

<sup>48</sup> <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2013.301845>



4. Responsibilities for notifications: The responsibility of notification is under discussion. The expansion of circumstances for notification will require that existing roles and responsibilities for these notifications be considered.

CDCR is currently finalizing its review of departmental efforts to expand notification procedures when suicide attempts occur. The effort will require changes to notification lists and consent procedures, revision of forms for these procedures, finalization of decisions regarding what behavioral threshold is used for reporting suicide attempts to next of kin, regulation changes, and staff training.

### Conclusion

Each suicide in prison is a loss of life that takes a profound toll on people separated from their loved ones by distance and incarceration. Each suicide also affects the staff and other inmates in the prison. The number of suicides in CDCR is far too high, and the Department takes seriously its obligation to prevent and respond to suicide. There is a particular need to focus on inmates identified as being at enhanced risk, including those entering segregated housing and those with mental health problems. The six areas listed in Senate Bill 960 highlight the scope and the challenge of suicide prevention in the correctional setting. CDCR has taken many actions to address the issues raised by these benchmarks and yet there is still much room for improvement. Great thought and consideration has been and will be given to the areas where the Department still falls short. We look forward to reporting advancement in next year's report.