Annual Report on Suicide Prevention and Response Within the California Department of Corrections and Rehabilitation

Conducted per Penal Code 2064.1
October 1, 2020

Executive Summary

Each suicide in prison is an incalculably devastating tragedy that takes a profound toll on family and friends separated from their loved ones by distance and incarceration. Each suicide also significantly impacts staff and other inmates within the California Department of Corrections and Rehabilitation (CDCR).

This report, submitted pursuant to Penal Code section 2064.1, provides information about suicide prevention initiatives and progress made during the calendar year 2019.

In recent years, suicide has reached epidemic levels in many parts of the country. It has similarly increased over the last five years in California's state prisons. In 2019, there were 162,451 unique offenders who spent at least one night incarcerated in the state prison system. Out of that population, 38 individuals committed suicide. Each and every suicide within the Department 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, Statues 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, the Department 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 patients with which few other state correctional systems can compare. In 1990, the Department 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 the Department's talented and dedicated mental health clinicians in suicide risk assessment and risk management, has robust systems in place for identifying individuals at risk of suicide and referring them to proper care, provides specialized care for individuals who are placed in higher-risk administrative segregation settings, and regularly offers individuals suicide prevention information through videos, pamphlets, and institutional suicide prevention events.

 A number of other governmental and private entities work closely with the Department to address the problem of suicide. Since 1995, CDCR has funded the operations of the *Coleman*

Special Master, who is appointed by the federal district court in the Eastern District of California (the *Coleman* court). The Special Master monitors CDCR's mental health care system. The Special Master's team of dozens of experts, consultants, and attorneys, as well as the numerous attorneys of the Prison Law Office and the law firm Rosen, Bien, Galvan and Grunfeld LLP, work closely with all parties to develop and implement policies on suicide prevention and response. The Department has further implemented dozens of recommendations from five separate audit reports by the Special Master's suicide prevention expert since 2015. Many of the policies and procedures aimed at suicide prevention and response are compiled in the court-ordered Mental Health Services Delivery System Program Guide.

This report is structured to correspond directly to the requirements outlined in Penal Code section 2064.1, 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 the Department associated with suicide; and improving a system of notifications in the event of self-inflicted harm. While an updated report is expected to be filed by the Special Master's court expert for institutional visits conducted in 2018 and 2019, such a report was not filed at the time of the drafting of this report.[1]

Progress in implementing each of the Penal Code requirements is discussed at length in this report. The following is a summary of the findings:

Suicide Risk Evaluations: In 2019, Department clinicians conducted more than 7,500 suicide risk evaluations per month. This total includes evaluations completed in compliance with the Program Guide requirements plus those completed by clinicians based on perceived clinical need. In 2019 program clinicians completed 47% more suicide risk evaluations than were required by the mental health program's business rules.

Each risk evaluation is a complex undertaking that requires clinicians to make important judgments despite uncertainty. According to the Department's policy, risk evaluations occur whenever an individual 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 consistently high quality, the Department has performed system-wide training, has revised the form used by clinicians to document these risk evaluations, and has provided specialized training to clinicians on Safety Planning Intervention.

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[1] The report of the Fourth Re-Audit along with recommendations by the Special Master was filed in late September 2020, too late for a discussion of its findings in this report. One significant finding of the Special Master's Report on His Expert's Fourth Re-Audit is that the Department has fully or partially implemented 12 of the 29 remaining recommendations.

Treatment Plans: The Department is more than 90% successful in completing treatment plans within 72 hours of admission to a Mental Health Crisis Bed unit. It continues its efforts 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. By the end of 2019, more than 90% of employees had completed their annual training. This average reflects high rates of compliance among all staff, with substantial improvement from 2018 among medical and mental health staff.

Court Recommendations Agreed to and Adopted by the Department: Compliance with the *Coleman* Special Master's recommendations is a continuously evolving effort. The *Coleman* Special Master's initial suicide audit from 2015 included 32 recommendations, which have been addressed and implemented or which are the subject of current policy development and physical plant improvements.[2] The parties later agreed to remove three recommendations. Each successive re-audit has raised new issues or concerns that the Department continues to address, and each resolution builds upon the suicide prevention expert's previous recommendations, which are described more fully in this report.

The Department has reached almost total compliance with a number of the Special Master's recommendations: for example, 17 of 18 Mental Health Crisis Bed units have been retrofitted for suicide safety and all institutions have demonstrated greater than 90% compliance with the Department's 30-minute welfare check policy in administrative segregation units, at least 90% compliance with annual suicide prevention training, and admissions to MHCB units within 24 hours.

Next-of-Kin Notification: The Department is working towards an updated next-of-kin notification process that is responsive to the gravity and tragedy of suicide and serious suicide attempts and that also recognizes and honors the right of individuals to medical privacy. The Department continues to seek out initiatives, best practices, and innovative solutions to enhance suicide prevention.

Departmental Initiatives: In addition to initiatives taken in cooperation with the *Coleman* parties, the Department has undertaken numerous suicide prevention projects. Individuals incarcerated in CDCR, their family members, and advocates, including the Inmate Family Council and the Inmate Advisory Committee,[3] have provided valuable insights regarding the stressors that affect

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[2] Three additional recommendations were later removed from the list.

3 The Inmate Family Councils are representatives of family members of the incarcerated who meet regularly with institutional staff to support connects between incarcerated individuals and their families through improved communication, shared information, issue identification, and problem resolution. Inmate Advisory Councils are groups of elected individuals who meet regularly with institutional staff about institutional issues.

incarcerated persons. Mental health and custodial staff have collaborated to reduce these stressors where possible. The Department has identified specific points in time when incarcerated individuals are at increased risk, including: arrival at a reception center, after parole suitability hearings, the 90 days after discharge from inpatient psychiatric settings, and when facing new charges or civil commitment. The Department is also analyzing serious suicide attempts for ways to improve prevention.

Changes to case law and to the California Constitution have also resulted in more incarcerated persons appearing before the Board of Parole Hearings for parole suitability hearings. Many who had been serving life sentences have been released and are now programming successfully in the community. The Department has changed its regulations to allow the formerly incarcerated greater ability to enter CDCR institutions in order 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 administrative segregation environments. Lastly, CDCR has implemented changes in the appeals system for the incarcerated, so there is the opportunity to raise issues outside of the adult institutions and in a more timely fashion, which may help to reduce feelings of hopelessness or disempowerment.

The first iteration of this annual report proved helpful to the Department and the State of California in identifying areas where progress needs to be made and areas that require more innovative thinking to address the needs of those who are most vulnerable. This 2019 report will provide an update on the progress the Department has made in those areas in 2019. The Department looks forward to documenting its improvements annually to the Legislature.

Introduction

In the United States (U.S.) at large, one million suicide attempts were reported in 2018. The number of deaths by suicide in the U.S. increased by more than 60% between 1999 and 2018, from less than 30,000 per year to over 48,000 per year, while the overall U.S. population has grown by only 17%.[4] The current rate of suicides in the U.S. is the highest rate in the country since the 1930s, during the Great Depression.[5]

Figure 1 U.S. Adult Suicide Rates by Sex, 2000-2018*
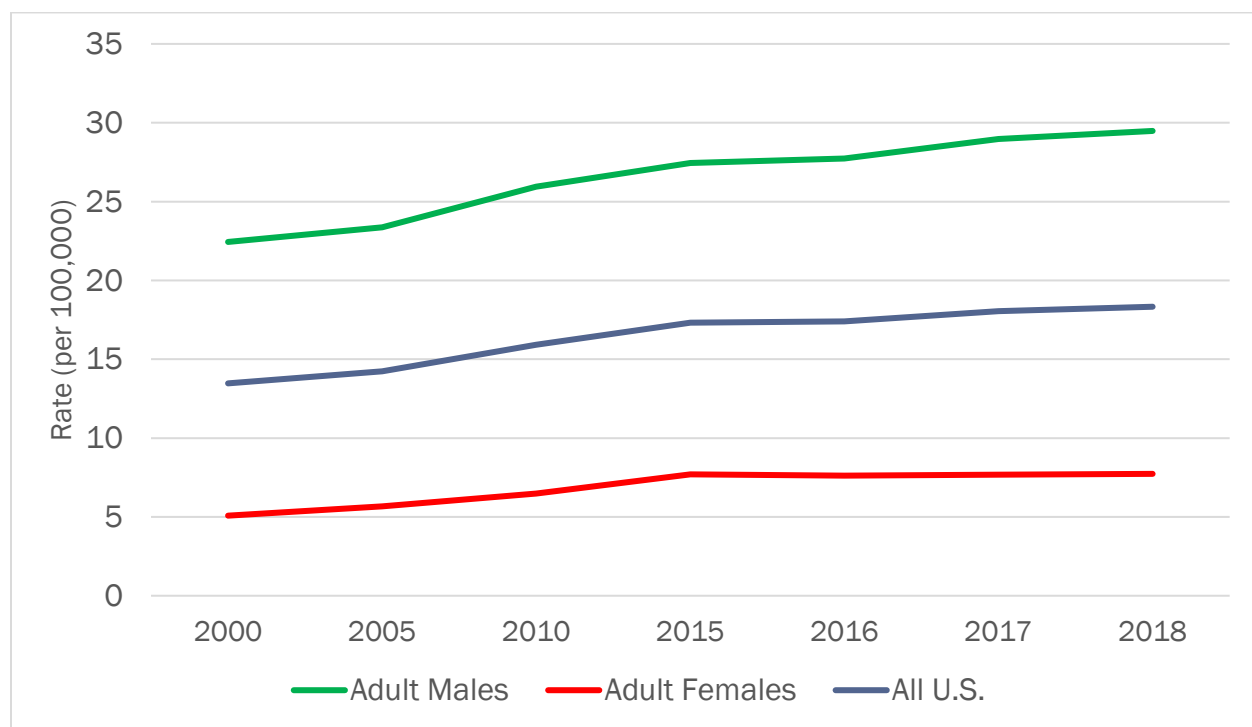
* Data accessed May 14, 2020 from CDC Web-based Injury Statistics Query and Reporting System (WISQARS), https://www.cdc.gov/injury/wisqars/fatal.html

Suicide prevention is a society-wide and complex public health problem that has frustrated the efforts of federal, state, and local agencies alike. Despite the implementation of a revised national strategy in 2012 for suicide prevention,[6] suicide rates have continued to rise, with suicide rates increasing in most demographic groups in the US by 30% since 2000.

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[4] Suicide rates for large samples are standardized as the number of deaths per 100,000, calculated by dividing the annual number of suicides by the annual population multiplied by 100,000.
[5] Drapeau, C. W., & McIntosh, J. L. (for the American Association of Suicidology). (2020). *U.S.A. suicide: 2018 Official final data.* Washington, DC: American Association of Suicidology, dated February 12, 2020, downloaded from http://www.suicidology.org.
[6]https://store.samhsa.gov/product/National-Strategy-for-Suicide-Prevention-Implementation-Assessment-Report/sma17-5051

The increasing rate of suicide occurs in many different contexts. For example, multiple branches of the US military are struggling with rising suicide rates. In the early 2000s, a large increase in suicides occurred in the US military. Extensive suicide prevention efforts were implemented in response. The suicide rate in 2018 for active duty soldiers, seamen, marines, and air force personnel was 24.8 per 100,000 and even higher for National Guard personnel.[7]

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 U.S., suicide has long been more prevalent in jails than in prisons and there have been significant increases in the number of suicides in jails in most recent years. Among those detained in U.S. jails the rate of suicide increased from 39 per 100,000 in 2005 to 42 per 100,000 in 2010. It reached 52 per 100,000 in 2015 before dropping in 2016 to 46 per 100,000.[8]

The rate of suicide for those incarcerated in all state prisons nationwide ranged from 14 per 100,000 to 21 per 100,000 from 2000 to 2016.[9] The rates of suicide among adult males in the U.S. and those in jails and prisons are shown in Figure 2.

Figure 2. Comparison of Suicide Rates*
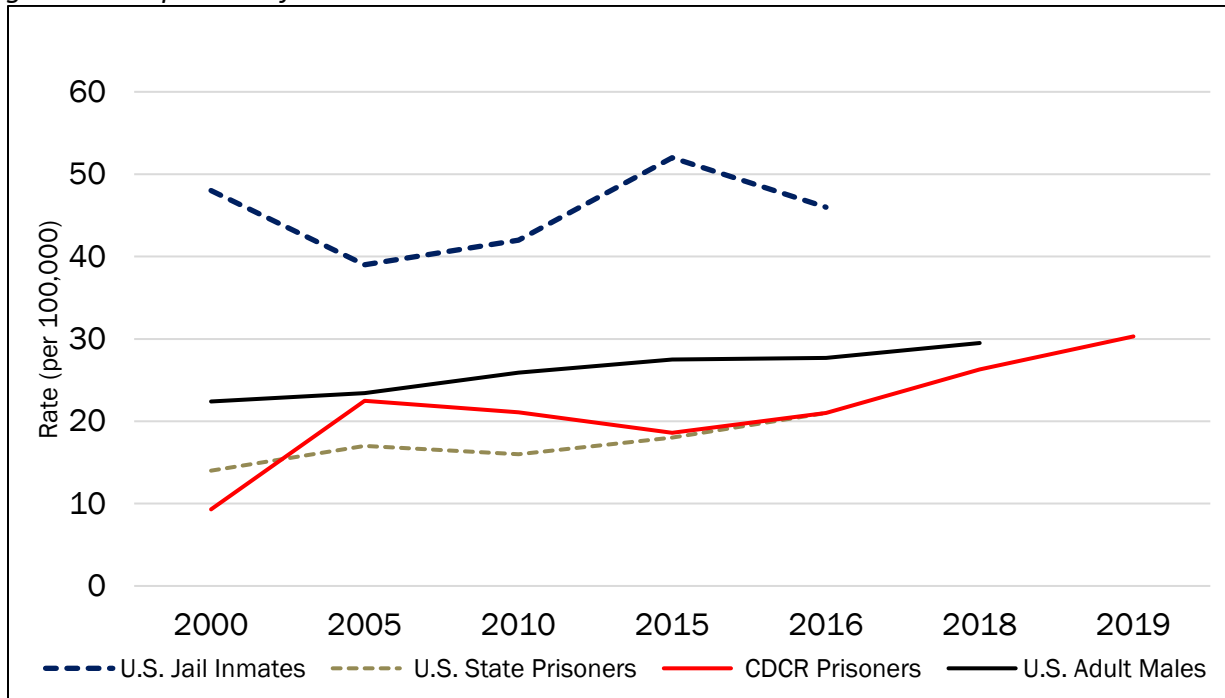
* *Most recent data from Bureau of Justice Statistics, CDCR, and WISQARS.*

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[7] Annual Suicide Report, Department of Defense, Undersecretary of Defense for Personnel and Readiness, Washington, DC, September 2019.
[8] *Mortality in Local Jails, 2000-2016 – Statistical Tables* (NCJ 251921, Bureau of Justice Statistics, February 2020)
[9] *Mortality in State and Federal Prisons, 2000-2016 – Statistical Tables* (NCJ 251920, Bureau of Justice Statistics, February, 2020)

In prison systems, suicide deaths have multiple contributing factors that can include longstanding medical and mental health issues, court and sentencing issues, issues involving family, lack of purposeful activity, conditions of the specific prison environment, and the stress of adjusting to incarceration.[10] In 1990, CDCR began tracking the annual suicide frequency and rate. The annual rate of suicide for each year is shown below in Figure 3. The highest rate of suicide occurred in 2019, with 38 suicides, equating to a rate of 30.3 per 100,000.[11]

Figure 3. Rate of Suicide in CDCR, 1990-2019
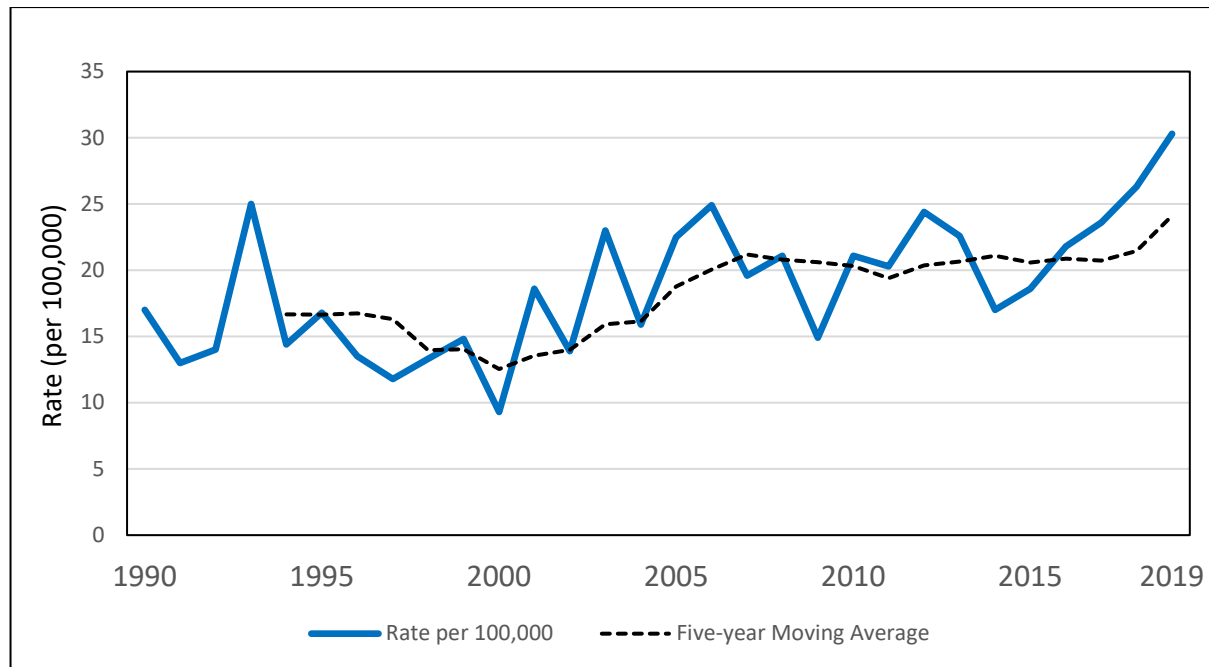
It is important to consider the prevention efforts the department has undertaken in the past three decades. Thirty years ago, there were minimal mental health or suicide prevention services for incarcerated individuals in CDCR. The first psychiatric inpatient hospital beds available for CDCR patients were opened in 1988. The first suicide prevention program was developed in 1990, but mental health services were available at only 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.

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 patients' mental health care, including inadequate screenings, understaffing, delays

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[10] https://www.psychiatryadvisor.com/home/topics/suicide-and-self-harm/preventing-suicide-in-prison-inmates/
[11] The CDCR suicide rate uses the annual June 30 CDCR population.

in access to care, deficiencies in medication management and involuntary medication, inadequacy of medical records, inadequately trained staff, and improper housing of the mentally ill in administrative segregation. While the federal court further found that CDCR had designed an adequate suicide prevention program, the court found that the suicide prevention and response 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 court's orders. In December 1995, the court appointed the first *Coleman* Special Master.

Since that time, CDCR has expended significant resources working with the federal court's Special Master, the Special Master's team of suicide prevention experts, and the attorneys representing the *Coleman* class members (the Prison Law Office and Rosen, Bien, Galvan and Grunfeld, LLP) to develop and fully implement policies to improve the Department's suicide prevention program. Federal court oversight of those efforts continues with the *Coleman* Special Master's expert conducting four comprehensive audits of the suicide prevention efforts at individual prisons and reporting his findings to the federal court following each audit. The most recent audit was conducted from November 2018 through December 2019.

CDCR has in place a comprehensive system for suicide risk screening and evaluation, treatment planning, and suicide prevention and remains committed to continuing to work and improve upon what is already in place. As explained above, since the 1990s, the Department has made significant improvements in the development of its Statewide Mental Health Services Delivery System. With respect to suicide prevention and response, these improvements include new and enhanced suicide prevention training for all staff, specialized emergency procedures training for all potential first responders to suicide attempts in progress, and training for mental health clinicians on suicide risk assessment and risk management. Additionally, the Department provides patients with a range of mental health services and has created a referral procedure for mental health evaluations, including procedures for protecting individuals during particularly vulnerable periods. The Department has implemented suicide screening procedures and provides the prison population with suicide prevention information through videos, pamphlets, and institutional suicide prevention events.

Progress toward completing adequate suicide risk evaluations.

It is CDCR's goal to ensure that suicide risk evaluations are completed accurately and timely, and are adequate and appropriate. The Suicide Risk Assessment and Self-Harm Evaluation (SRASHE), a set of electronic forms in the Electronic Healthcare Record System, is the primary way that suicide risk evaluations are documented in the record. It is composed of 1) a standardized set of questions about suicide-related ideation and behavior – the Columbia-Suicide Severity Rating Scale;[12] 2) a review of the individual's history of self-harm; 3) a checklist of risk and protective factors and warning signs; 4) a risk formulation and its justification; and 5) a safety plan,[13] if appropriate. Under the Department's policies, a suicide risk evaluation is conducted whenever any individual expresses suicidal ideation, makes threats, or makes a suicide attempt; at a number of key evaluation points; and during known high risk times.

Risk Evaluation Form Revisions

Mental health clinicians at CDCR institutions complete more than 5,100 risk evaluation forms per month, with almost 61,800 completed in 2019. 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, the Department released revisions to the form in 2018. The final revisions were completed and tested in 2019 and placed in the Electronic Health Record System in July 2019. The new version of the form includes a safety planning tool/intervention that flows directly from the clinician's justification of risk.

Risk Evaluation Audits Using the Chart Audit Tool

The Statewide Mental Health Program uses a standardized audit method—the Chart Audit Tool—for evaluating the quality of a number of key mental health documents. Audits are conducted on numerous documents on a quarterly basis, with results available to the mental health leadership at institutions, to regional mental health administrators, and at statewide headquarters. Each quarter the quality of a selection of risk evaluation forms are audited. Each mental health clinician is audited at least twice per year for risk evaluation form completion and quality. The criteria used in this audit were listed in the 2017 report of the California State Auditor (CSA).[14] The first quarterly audit of the risk evaluation form occurred in the third quarter of 2013. Since the beginning of 2017, the pass rate has fluctuated between 52% and 72%, as shown in Figure 4 below

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[12] See: https://cssrs.columbia.edu/
[13] A suicide "safety plan" is a series of individualized and concrete statements that are developed in collaboration with a patient to lower the risk of suicide attempt in the near-term.
[14] See: https://www.auditor.ca.gov/pdfs/reports/2016-131.pdf; page 23

(Figure 4 does not include data for 2019 Q3 and Q4. Suspension of the chart audit due to changes in the audit questions required review and updating of the process). Common reasons for a risk evaluation form to fail an audit include poor justification of suicide risk, under estimation of suicide risk, and non-individualized treatment planning.

Figure 4. Percent of Mental Health Clinicians Passing CAT Audit, 2017-2019
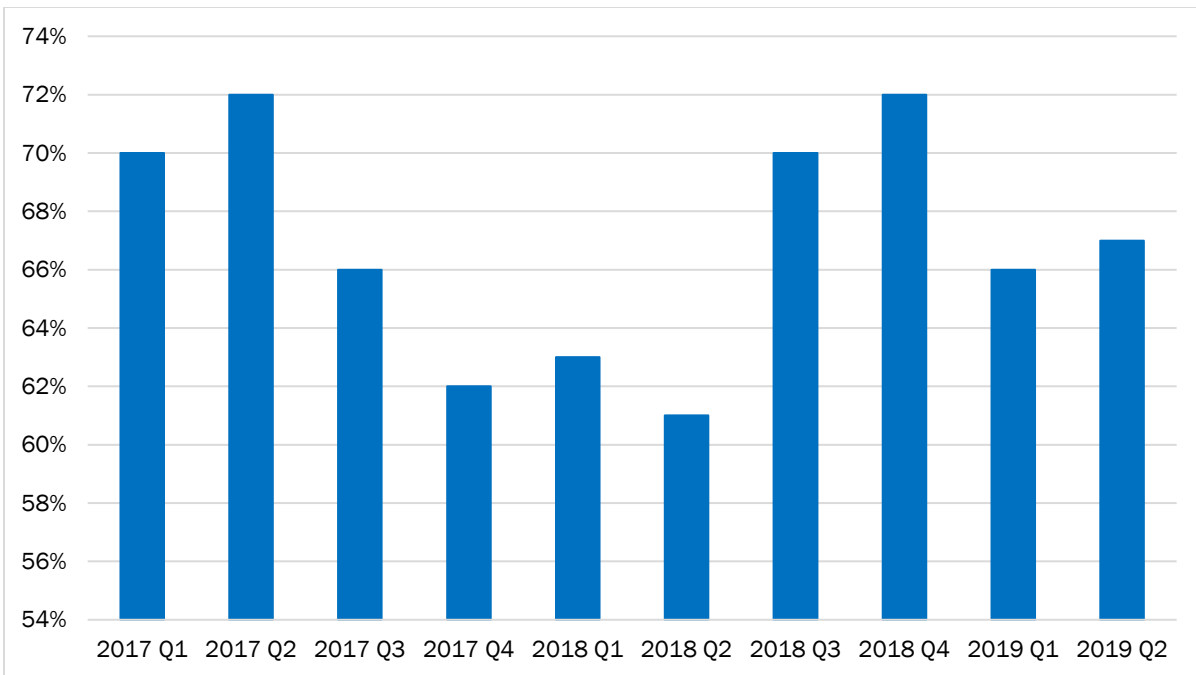
The audit questions pertaining to suicide prevention have been modified to be more consistent with the revisions to the form, particularly regarding the Safety Planning Intervention (SPI) initiative discussed further on page 20 of this report. Additionally, the revised questions will better assess the quality of the risk evaluation documentation, in contrast to previous process-focused questions that merely assessed whether all items on the form were completed without looking at the content of the documentation. A copy of the new audit questions for the risk evaluation form is found in the Appendix to this report.

Live SRASHE Training

In May and June 2019, a departmental expert provided a live Training-for-Trainers course on risk evaluation documentation to selected staff members within each institution. The course 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. The Department is in the process of assessing the value of the live training in improving the quality of the suicide risk evaluations by comparing chart audit passing rates before and after the training was implemented.

<div style="background-color:#1F3864; color:white; padding:4px;">Progress toward completing 72-hour treatment plans in a sufficient manner.</div>

It is the Department's goal to ensure that a full treatment plan in Mental Health Crisis Bed (MHCB) units is completed for all patients as required (within 72 hours). [15] Treatment plans establish the goals and interventions patients receive at all levels of need for mental health services. Patients in crisis are transferred to a MHCB unit, where an evaluation and initial treatment plan is developed within 24 hours of admission.[16] The 72-hour treatment plan is discussed in the patient's Interdisciplinary Treatment Team meeting in the MHCB unit, which the patient attends. Treatment teams are 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 team 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 MHCB units 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 included: 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 deficiencies, the Department undertook the following efforts:

- <u>Training to Improve the Quality of 72-hour Treatment Plans</u>: CDCR expends considerable resources to train for appropriate treatment team processes and treatment planning quality. Quarterly audits are conducted both in person by Regional Mental Health teams and in quarterly chart documentation audits. New training[17] designed to improve the quality of 72-hour treatment planning has been developed and been delivered in all institutions that have Mental Health Crisis Bed units. This new training emphasizes the importance of the treatment plan to MHCB supervisors and clinicians and will be provided to MHCB staff members and supervisors. The training focuses on the role of the 72-hour treatment planning conference in suicide prevention and crisis resolution, and reinforces good treatment team practice and high quality documentation. The new training is meant to complement existing treatment team process training.

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[15] MHSDS Program Guide page 12-5-12
[16] MHSDS Program Guide page 12-5-11
[17] Other IDTT Trainings currently exist, such as "IDTT: An overview of the clinical thinking and process," a seven-hour training for treatment planning for all levels of care.

- Audits of Treatment Plans: MHCB treatment plan audits are required for both the 72-hour and the discharge treatment plans. Results of chart audits are monitored by regional and institutional mental health supervisors and managers. Audits ask about 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 among team members and with the patient; 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. Audits are conducted by clinical supervisors or senior psychologists who oversee the programs. Auditors use findings to provide feedback to staff and develop plans to improve documentation. Audit items can be revised periodically based on departmental priorities or due to changes to treatment planning forms. Revisions to the MHCB treatment team audit are currently in process and under review by the *Coleman* litigation parties.

Table 1 below shows that audit results related to quality of MHCB treatment planning documentation fluctuated widely during 2018 and 2019, ranging from 57% to 84% of MHCB treatment plans complying with all audit criteria.[18] The Department has set a standard for institutions to pass 85% of audited treatment planning documents. Institutions that have pass rates under 85% are required to develop and implement corrective action plans 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 corrective action plans are sent to Regional Mental Health leadership each month. Institutions may also set Performance Improvement Work Plans to prioritize treatment plan quality through the site's Quality Management Committee. Since performance has not substantially improved in the most recent reporting period, the Statewide Mental Health Program is evaluating further methods for improving quality of MHCB treatment plans and ensuring compliance with statewide standards.

Table 1: Results of MHCB IDTT Audits, 2018-2019[19]

Time Period	Pass Rate	Number of Audits Conducted
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

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[18] Due to the COVID=19 emergency, CAT audits were halted in Q2 2020.
[19] Performance Report "Treatment Plans with Satisfactory Documentation" data extracted July 1, 2020

2019 Quarter 3	65%	253
2019 Quarter 4	71%	264

- Timeliness of MHCB Master Treatment Plans: The timeliness of MHCB Master Treatment Plans is tracked by the Performance Report, a tool used for quality management purposes. Timeliness is defined by policy as whether a treatment planning session has occurred within 72 hours of admission, for initial treatment plans, and within seven days since the initial treatment planning session for routine treatment plans. In 2019, the overall timeliness of treatment plans completed by MHCB treatment teams was at least 95%. 24,948 MHCB treatment team sessions were conducted, with 12,821 Initial or 72-hour, and 12,127 Routine treatment plans completed. As shown in Table 2, timeliness of routine treatment plans in MCHBs, including discharge treatment plans, was 98% or higher in each quarter of 2019. The compliance for initial treatment plans ranged from 91% to 93% in each quarter of 2019.[20]

Table 2. Timeliness of MHCB IDTTs, 2018 through 2019

Time Period	Initial IDTTs	Routine IDTTs	Total
2018 Quarter 1	89%	98%	94%
2018 Quarter 2	92%	99%	96%
2018 Quarter 3	90%	98%	94%
2018 Quarter 4	91%	99%	95%
2019 Quarter 1	93%	98%	95%
2019 Quarter 2	91%	98%	95%
2019 Quarter 3	93%	98%	96%
2019 Quarter 4	93%	99%	96%

Progress toward ensuring that all required staff receive training related to suicide prevention and response.

CDCR has a number of suicide prevention and response trainings, some of which are required for all staff members and some that are 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 and to update staff members about their responsibilities in these areas.

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[20] Performance Report "Timely IDTTs" data extracted on July 1, 2020.

The Department has efforts underway to improve how staff training is tracked. 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 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 which is accessible to the statewide mental health program and Division of Adult Institutions for compliance tracking.

Revisions to existing in-service training curricula were completed and adopted by the Department's Office of Training and Professional Development in late 2019. Subsequently, live training for new in-service training facilitators was conducted in all regions in December 2019 and January 2020.

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 offices at institutions via the use of compliance tracking logs. Lists of non-compliant staff are sent to the supervisors of each discipline. Training offices are asked to send the compliance figures for their institutions each October, giving institutional medical executives 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 are provided additional suicide prevention and response trainings. Compliance with required cardiopulmonary resuscitation and Basic Life Support classes is also tracked for potential first responders (custody and nursing), psychiatrists, and psychiatric nurse practitioners.[21]

In 2015, the Statewide Mental Health Program 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 training unit keeps record of institutional compliance with mandatory suicide risk assessment and evaluation training and all suicide prevention and response training. For non-in-service training, such as classes specific to mental health suicide risk evaluation training, compliance lists are maintained at the institution and information entered into a local tracking log. Copies of tracking logs are sent to and maintained by the training unit who reviews institutional compliance and alerts regional and institutional staff to follow up on

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

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.

The Department 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 institutions. In its 2017 report, the CSA identified variable attendance at this training between disciplines, with custodial attendance percentages often above those of mental health and other health care personnel. Improved compliance with this training is noted within all staff disciplines, as reflected in Table 3 below. In 2019, 40,368 staff members were required to take this training: 26,681 custody staff and 13,687 health care staff.[22] Ten institutions had attendance percentages below 90% in 2019.

In an effort to ensure that medical and mental health program staff comply with annual training requirements, Headquarters and Regional Mental Health staff track compliance and send updates and reminders to Chief Executive Officers, Wardens, Chief Nursing Executives, and Chiefs of Mental Health. These institutional leaders are responsible for ensuring that their staff are attending required training. In late 2019 the CCHCS issued an update to Regional Healthcare Executives regarding suicide training mandates.

Table 3. In-Service Training Compliance, Suicide Prevention, 2019

Attendance at Crisis Intervention and Suicide Prevention Training	2018 Compliance	2019 Compliance
All Staff Members	91%	90%
Custodial Staff	96%	93%
Medical/Dental/Nursing Staff	75%	90%
Mental Health Staff	81%	91%
Non-Health Care CCHCS staff	n/a	87%

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 is mandatory and tracked for compliance, as shown in Table 4. 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

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[22] Data on custodial staff is from Division of Adult Institutions. Data for CCHCS and SMHP staff are from CCHCS Staff Development Unit. Health care staff include mental health, medical, nursing, ancillary, and administrative staff and does not include staff on long-term leave (n=481).

working with suicidal patients. Several of these courses have Continuing Education Units (CEUs) available as well.

Table 4. 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)	6

For required mental health training in suicide prevention, compliance figures for 2017-2019 are shown in Table 5. In 2019, the Department introduced a comprehensive Safety Planning Initiative training to address ongoing concerns related to deficient safety planning found in both internal and external audits of suicide risk assessments. Additionally, CDCR updated and delivered the seven-hour Suicide Risk Evaluation course in 2019. Institutions are required to train newly hired mental health clinicians within 90 days on the topic of suicide prevention and institutional mental health leadership is responsible for tracking completion of required training within this period.

Table 5. Mental Health Staff Compliance in Required Suicide Risk Training[23]

Training Name	2017 Compliance	2018 Compliance	2019 Compliance
Suicide Risk Evaluation & SRASHE	89%	92%	69% (June 2019) 94% (Dec. 2019)

[23] Data received from SMHP Mental Health Training Unit on May 9, 2019. Suicide risk evaluation training was suspended in mid-2019 for revision of the lesson plans and curriculum to include revisions to the SRASHE and the Safety Planning Intervention.

Suicide Risk Evaluation Initial/Advanced Mentoring	77%	92%	89% (Dec. 2019)
Safety Planning & Safety Planning Intervention	87%	84%	77% (June 2019) 95% (Dec. 2019)
Differential Diagnosis in Complex Cases	91%	91%	88%

> Progress in implementing the recommendations made by the *Coleman* 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 federal 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 the court ordered the Department to implement.[24] In 2017 three of the recommendations were withdrawn.[25] Since 2015, CDCR has worked to implement the remaining 29 recommendations and continues to meet with the *Coleman* Special Master's experts to discuss the Department's progress.

Mr. Hayes began auditing the suicide prevention practices of all CDCR institutions in November 2013. He completed his first audit in July 2014 and offered 32 recommendations. Mr. Hayes re-audited practices at 18 institutions in 2015,[26] submitting a report in January 2016. Mr. Hayes re-audited 23 institutions in 2016, reporting these results in September 2017.[27] An additional audit was conducted by Mr. Hayes between May 2017 and February 2018, with a report issued in November 2018.[28] The 2017 audit and 2018 reports contained audits of 18 institutions. Mr. Hayes most recent tour covered 20 prisons visited between November 2018 and December 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 partially or fully implemented many of the 29 recommendations made by Mr. Hayes. In addition, the introduction of the EHRS from August 2016 through October 2017 created challenges and required new solutions to issues previously raised. For issues identified as part of the Hayes audits, Corrective Action Plans (CAPs)

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[24] 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.
[25] Electronic Court Filing (ECF) 5762, Filed January 25, 2018; ORDER regarding the second re-audit.
[26] ECF 5396, Filed 1/13/16, A re-audit and update on suicide prevention practices in the prisons of CDCR
[27] ECF 5672, Filed 9/7/17, A re-audit and update on suicide prevention practices in the prisons of CDCR
[28] ECF 5994, Filed 11/5/18, ibid

were written and then monitored. The status of CAPs related to Mr. Hayes' findings are categorized and described below.[29] CAPs for each issue are developed depending on the unique character of each institution and may include one or more of the following solutions: physical plant modifications (e.g. administrative segregation cell retrofits; doors in reception areas), training and/or retraining of staff (e.g. monitoring of patients in MHCB units; policy updates (e.g. safety planning intervention revisions), or even statewide initiatives (e.g. updating screens in the electronic health record system).

- Initial Health Screening and Receiving and Release (R&R) Environment: CAPs related to the clarity of questions on the intake screening form were completed by the end of 2018. The most recent audit found continued problems with issues related to confidentiality and privacy in the screening environment. Specific CAPs have been developed for each institution that were noted in Mr. Hayes' report.

- Psychiatric Technician (PT) Practices: In 2017, Mr. Hayes' report of his Second Re-Audit found that PTs at three institutions did not meet standards for administrative segregation rounds. CAPs were developed, and in his 2018 Third Re-Audit report, Mr. Hayes found that 35 institutions had adequate PT rounding practices. A process of ongoing fidelity checks of PT rounding was in place at each site under the supervision of the Chief Nursing Executives but continues to require improvement.

- Retrofitted Cells in MHCB Units: In 2018, Mr. Hayes reported that three institutions did not meet all specifications for retrofitted cells in their respective MHCB units. Retrofitting was completed at all three institutions by January 31, 2019. 17 of 18 audited institutions are compliant with this requirement.

- Use of Suicide Resistant Cells for Those Newly Admitted to Administrative Segregation: Individuals 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 individual.

    CAPs have been developed for seven institutions to create additional retrofitted cells, ensuring that all currently identified new intake cells are suicide-resistant, and reinforcing the requirement that those newly placed in Administrative Segregation should not be placed in non-intake cells when intake cells are available.

    In addition, the Department has identified 145 existing Administrative Segregation intake cells in 17 institutions that will be further retrofitted to provide additional ligature resistance. The design drawings for this work are being completed in phases and are anticipated to be fully

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[29] Ordering of items corresponds to Mr. Hayes' most recent re-audit.

completed by the end of 2020. The actual modifications of cells will occur on a phased basis and are estimated to be completed by December 31, 2021. In addition to the 145 noted above, the 2020 Budget Act includes funds to convert 64 existing Administrative Segregation cells in 14 institutions to intake cells. Design efforts for these conversions are underway.

- MHCB Practices for Observation Status, Clothing, and Privileges: Three issues related to MHCB unit 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 and again in 2018, institutions were found to have documented inaccurately the times when nursing observations occurred of suicidal patients. The EHRS was modified in 2018 to trigger staggered observation rounding, with nursing staff trained on this adjustment by way of a statewide webinar. Regional teams continue to audit the suicide observation practices in MHCB units across the state and the court's expert recommends that each of the dozen "chronically deficient" institutions complete a review of observation orders and engage the local nursing leadership in this effort.

  - Regarding 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 unit 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.[30] The appropriate issuance of property to patients while on suicide precautions was added as a regional auditing item and is an audit item included in CQIT.

  - Regarding 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 patients 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 regular quality management auditing of MHCB units. Institutional CAPs were developed for six units where improvements were not found in 2018. During 2019 three of these institutions item showed improvement on this issue.

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[30] Memorandum dated 6/1/2018, Reminder-Level of Observation for Patients in Mental Health Crisis Beds

- **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 2019. The Department continues to audit and re-audit this indicator in all institutions.

- **Mental Health Referrals and Suicide Risk Evaluations**: In his 2018 audit of institutions Mr. Hayes found a compliance rate of 74% for the 23 institutions audited, which is below the expected rate of 90% compliance. Seven institutions remain below 90% compliance with 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 21.

  Between May 1, 2019 and February 29, 2020, the rate of compliance for timely completion of SRASHEs after an emergent referral for suicidal ideation or self-injurious behavior, or at the time of discharge from alternative housing was above 90% in the aggregate for all 20 institutions in the most recent OSM re-audit.

- **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 Statewide Mental Health Program Training Unit and with monitoring compliance within institutional suicide prevention programs. Institutions which did not meet training compliance standards were instructed to develop internal correctional action plans. In 2018, compliance had improved in required suicide risk evaluation trainings, with only two institutions not meeting the 90% benchmark. By the end of 2019, compliance in the 35 institutions was over 90%.

- **Safety Planning for Suicidal Individuals**: 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 supervisory[31] monitoring of all safety plans written as part of suicide risk evaluations at the time of discharge from MHCB. These reviews are designed to ensure that MHCB discharge safety plans are of good quality, reflect consultation with receiving treatment teams when indicated, and help to ensure risk management efforts are described effectively. With the transition to an updated safety planning intervention as part of suicide risk evaluations in late 2019, the statewide mental health program issued guidance to the field in March 2020 that detailed the criteria for auditing of suicide risk evaluations completed at the time of discharge from MHCB units statewide.

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[31] While MHCB program supervisors are the most likely reviewers of discharge safety plans, at times a qualified designee, such as a SPR FIT coordinator or covering Sr. Psychologist, Supervisor or Specialist may act as a reviewer.

As noted in the 2018 report, the safety planning intervention is a widely disseminated approach to follow-up care for suicidal individuals and is being adopted as an intervention with CDCR patients at a moderate or high acute risk of suicide.

The recently implemented SPI process and training are still gaining traction in the institutions. The statewide mental health program has audited the safety planning intervention and anticipates that further modifications will be necessary to improve the adequacy of the process. The original SPI process was initiated based on conceptual and research work in the community (particularly the Veterans Administration). The transition from community application of this intervention (often in emergency departments) has been difficult and the intervention as currently implemented requires more evaluation and revision to make it "fit" in the correctional environment.

- <u>MHCB and Alternative Housing Discharge - Efficacy of Custody Welfare Checks and Five-Day Follow-Up</u>: When patients are discharged from either Alternative Housing or MHCB units, custody officers in housing units must make welfare checks every half-hour for at least 24 hours. After the first 24 hours, a mental health clinician must evaluate the patient and notify the housing officers about the patient's adjustment to the unit. This process can re-occur at 24-hour intervals up to 72-hours. Additionally, when a patient is discharged from either Alternative Housing or MHCB units, 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 previous audits 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 corrective action plan 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 action plans 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-checks, with significant improvement noted. In early 2020, discussions were begun about modifications to the CDCR 7497 form and the necessary training.

- <u>Local Suicide Prevention Programs</u>: In February 2018 and in response to a court order,[32] the statewide mental health program issued a memorandum outlining enhancements for local Suicide Prevention and Response Focused Improvement Teams (SPR FIT).[33] These enhancements

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[32] ECF No. 5762 at 3.
[33] Memorandum dated 2/2/18, "Enhancements to the Suicide Prevention and Response Focused Improvement Teams," is found in Attachment A.

were intended to improve oversight of training of staff, monitoring of audits, data gathering, review of serious self-harm incidents, establishment of a high-risk management program, and improve reporting by local suicide prevention programs.

Mr. Hayes observed local SPR FIT meetings at institutions in 2017 and 2018, and in 2019 reviewed policies and practices in response to the changes instituted in 2018. The re-audit focused on compliance with aspects of the 2018 memorandum for local SPR FITs, including quorum requirements, presence of a written local operating procedure (LOP) for the SPR FIT, the review of serious self-harm incidents, and the presence of policies for high risk patients.

- Continuous Quality Improvement (CQI): The Department, in consultation with Mr. Hayes and the *Coleman* Special Master, has agreed to monitor nineteen 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 comprehensive. A self-audit guidebook containing the items was distributed to institutions. The CQIT is currently being revised in consultation with the *Coleman* Special Master.

- Suicide Prevention Training: Mr. Hayes attended selected in-service training annual suicide prevention classes held within audited institutions. He opined that the course content was too much for a 2-hour class, yet still did not include important topics. Mr. Hayes made recommendations for course content that have been integrated into a revised training. The updated training has been reviewed by Mr. Hayes and was implemented in all institutions as of the beginning of 2020.

- Reception Center Suicides: This item was raised in 2018; specifically, there were a cluster of suicides in Reception Center institutions during the year. Reception Centers are prisons where individuals committed to the Department are received from county jails for initial processing. Some of the issues identified as impacting suicide prevention in reception 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 statewide mental health program is drafting a memorandum providing direction to reception center mental health clinicians regarding expectations for obtaining and reviewing jail records for newly received individuals.

    The Transitional Help and Rehabilitation in a Violence-Free Environment (THRIVE) program is under development. The Division of Rehabilitative Programs (DRP) has been working with subject matter experts within CDCR to develop an orientation for offenders in reception

centers. DRP's goal is to place modules and video content on eReaders that will be checked out to offenders. 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 statewide mental health program 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.

A number of initiatives have been developed and implemented to reduce the time needed to move patients in crisis from their current location to an MHCB.

- Use of Alternative Housing for Suicidal Individuals: Patients housed in Alternative Housing are to be transferred to MHCB units within 24 hours unless their referrals to MHCBs are rescinded. In 2019 compliance with transfer from Alternative Housing was at or above 99%.

- 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 6, and as a result of continued improvements to the process, improved compliance is anticipated for 2020.

Table 6: Compliance with Timely Admissions to MHCB, 2017-2019[34]

Mid-Year Date	Percent Compliance
June 30, 2017	56%
June 30, 2018	90%
June 30, 2019	98%

- Improving Transfer Timelines for Female Patients: The Department has established an additional unlicensed MHCB unit for female patients that has dramatically decreased the number of female patients waiting over 24 hours for transfer. This unit, at the California Institution for Women, provides additional beds and allows 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, Acute Psychiatric Program, and MHCB. The existence of flex units ensures no one inpatient

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[34] Data per Mental Health Performance Report, Timely Admission to MHCB Indicator.

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. A more detailed plan is expected to be completed after an in-person space survey at each location to determine the number of beds that can be designated as Acute/ICF based on treatment space.

- 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 practices, medical clearance procedures, and communication between centralized population management staff and local classification representatives at institutions. These changes were implemented in 2018, along with institutional self-monitoring strategies. In the last two years CDCR has been successful meeting the timelines for transfer. Progress in meeting referral timelines by policy are noted in Table 6.

> **Progress in identifying and implementing initiatives 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 the incarcerated population and/or their family or loved ones, 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 healthcare 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.

All individuals housed in CDCR, patients and non-patients alike, are important sources of information about the issues affecting them as a group, what external stressors may be contributing to the development of suicidal thoughts and/or behavior in some individuals, and what they find helpful to reduce the risk for suicide. Individuals incarcerated in CDCR may tell custody officers, nurses, or other staff members about certain stressors, such as peers who are in danger from other peers. Individuals 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 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. SMHP staff attend the annual AAS conference and have given presentations and trainings for correctional staff from across the country.

Reviews of suicide deaths and attempts 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 efforts derived from findings from suicide reviews and investigations of suicide attempts in 2019:

- Development of support teams for institutions with a high number of suicides and self-harm.
- Psychiatric Inpatient Program and MHCB unit discharge workgroup.
- Revision of Suicide Prevention in-service and Basic Correctional Officer Academy training.
- Revision of the seven-hour suicide risk evaluation training.
- Begin revision of mentoring policy and procedure.
- Drafting Psychiatric Inpatient Program suicide prevention policy.
- Creation of Psychiatric Inpatient Program suicide prevention program coordinator positions.
- Supervisory review of discharge suicide risk evaluation forms.
- Regional oversight and reporting process for suicide case review quality improvement plans.
- Creation and authorization of regional suicide prevention coordinator positions.
- Communication processes in the Psychiatric Inpatient Programs to improve patients' ability to program in safe environments.

CDCR established a requirement for institutional suicide prevention program coordinators 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. The RCA initiative has been on hold since late 2019 for further planning and coordination between the statewide mental health program and federal Receiver's medical team. Institutions are still required to review incidents of serious self-harm on a semi-annual basis.

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. The various quality management activities monitor many institutional functions, highlighting when programs are underperforming, and leading to innovation in determining how quality can be improved.

Currently, Mental Health Quality Management 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 Quality Management portal contains, for example, information on conducting Performance Improvement Work Plans, the Root Cause Analysis process, 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 updated and reported daily. Compliance rates can be compared between institutions and can be addressed by regional resources, as well as institutional leadership. The Performance Report is updated regularly to reflect changes in program requirements.

This robust mental health quality management 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 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 practices and as ways 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, Chief Executive Officers at institutions meet with institutional quality management staff members and with other executives 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.

The statewide mental health program and the federal Receiver's medical staff jointly administer a healthcare data warehouse to house information and analyze system-wide data. The warehouse is a repository for data from the electronic health record system and other health care databases. The warehouse is linked with the Department's Strategic Offender Management System (SOMS), the custodial data system. This wealth of data is then aggregated and disseminated for quality improvement purposes. The use of informatics allows mental health leadership to look at "big picture" items, sharing this information with other stakeholders (e.g., custody leadership).

Access to this large cache of data has allowed the statewide mental health program to engage in novel analytic strategies, such as machine learning and other advanced statistical methods, to investigate clinical processes. 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.

The Department in collaboration with the federal Receiver's medical staff have implemented numerous ways in which staff members and institutions can inform others 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 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 the statewide QM committee to familiarize successful improvements to other institutions and regions. The full list of 2019-2022 Statewide Performance Improvement Plan is available online and includes substance abuse treatment and the impact of violence on the CDCR patient population – including trends of self-harm acts such as ingestion and insertion, two categories of self-injury with high prevalence among patients who suffer from serious mental illness.

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 CCHCS 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[35] include:

o   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 25% increase in discharge custody checks from baseline measurement to post-project implementation at the California State Prison - Sacramento.

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[35] http://cchcssites/dept/QI/default.aspx

o 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.

o 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.

o Improving transfer of Correctional Clinical Case Management System[36] patients from Reception Centers to mainline institutions. This project was implemented at North Kern State Prison during 2019. The project identified a number of inflection points where improvements can be made. The project resulted in minor improvements in transfer times, in part due to uncontrollable issues such as quarantined buildings that impact timely processing of transfers of these patients.

o A project to improve completion of suicide case reviews within policy-designated timeframes. The project identified competing demands made on reviewers and recommended a variety of methods to improve the time to completion. The project is ongoing.

Inpatient Discharge Work Group: Recognizing that the risk of suicide is elevated in the period after a patient discharges from psychiatric inpatient units, the statewide mental health program has been working to improve outcomes in this group. This is especially important since 20 suicide deaths in 2019 were among this population. The work group has met approximately 30 times. Among the recommendations are: post-discharge psychotherapeutic groups; better documentation of clinical needs and condition in the Master Treatment Plans; better processes to evaluate safety concerns and other custodial issues; and a better referral process for mental health teams to communicate needs to custody. In addition to this work group, a Lean Six Sigma project has been running parallel to this project.

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[36] The Correctional Clinical Case Management System is the lowest level of mental health care in the CDCR.

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 the American Association of Suicidology, groups of presentations made at the Suicide Summits, contact lists for institutional suicide prevention program coordinators and headquarters suicide prevention staff, resources for staff suicide prevention, and resources for the entire CDCR population (videos, pamphlets, and posters). The information sharing occurring on SharePoint sites is another way of disseminating best practice information.

The statewide mental health program has started to revise its intranet site with a best practices library. The library is 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.

Statewide Suicide Prevention Coordinator Conference Calls: In addition to monthly suicide prevention video conferences that can be viewed by all staff, Suicide Prevention Program coordinators from headquarters and from all institutions have held quarterly conference since 2014 to discuss issues impacting suicide prevention efforts statewide. These calls continued during 2019.

Leadership Meetings Related to Suicide Prevention: The statewide mental health program holds three Mental Health Leadership conferences and one three-day Suicide Prevention 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 2019, topics presented at the Suicide Summit included: dealing with veterans in the CDCR, Medication Assisted Treatment in CDCR; interventions after a suicide attempt; use of canine companions; reviewing trends in suicides; description of the CAMS treatment project; legal aspects of suicide risk assessment, female offenders research, religious services, and the use of meditation techniques with mental health patients. All presentations from the 2019 Suicide Summit are found in the Suicide Prevention SharePoint site.

Psychiatry Trainings and Consultants: Psychiatrists and other interested staff are able to attend weekly Grand Rounds and earn Continuing Medical Education credits. Grand Rounds offer 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 illness, 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.

The statewide psychiatry program has a psychopharmacological consultant psychiatrist on staff available for consultation statewide. She also has access to additional consultation services with Department of State Hospital experts. Psychopharmacological approaches are important, as some psychiatric medications, for example, Clozapine[37] and Lithium,[38] are associated with lower suicide rates among vulnerable patients with particular diagnoses. In addition, psychopharmacological treatment itself lowers all causes of death (including suicidality) among patients with serious mental illness.[39] The expertise of the consulting 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 deaths from other causes. In the past two years, there have been an average of 28 consults per month from Department psychiatrists.

Beginning in 2018, CDCR implemented U.S. Substance Abuse and Mental Health Services Administration's evidenced-based *Illness Management and Recovery*[40] group curriculum to address co-occurring disorders in CDCR's Enhanced Outpatient Program population. In addition, at the end of 2019 Medication-Assisted Treatment (MAT) is available in all CDCR institutions, with medications such as buprenorphine, methadone, and naloxone available as treatment options. The most recent treatment statistics showed over 4,000 patients enrolled in MAT.[41]

Crisis Intervention Teams: The 2018 report to the Legislature noted the establishment of Crisis Intervention Teams (CIT) in CDCR institutions. These teams have been adapted through a partnership between mental health, nursing and custodial personnel to provide an interdisciplinary team to intervene in crisis situations. If an individual reports a desire to kill himself or herself, the team will evaluate the situation, identify sources of distress, attempt to resolve or mitigate the sources of distress at the point of service, and arrange follow-up (which may or may not include placement in an inpatient unit). If, for example, an individual 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 suicidal thoughts associated with interpersonal conflicts. These conflicts can create significant

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[37] Meltzer, 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

[38] 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

[39] 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

[40] https://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463

[41] Data accessed on June 8, 2020 from CCHCS Quality Management ISUDT Program Overview.

distress and can quickly develop into significant fears for one's safety. Whereas mental health clinicians may not be able to address safety concerns directly, they can work collaboratively with custody personnel who may be able to work out a reasonable solution, thus relieving the distress. The CITs help to problem-solve issues related to prison life that may not be directly related to a mental health issue.

The initial CITs were established at 22 institutions between late 2018 and early 2020. In that time, the teams had almost 7,600 contacts with individuals, an average of 422 each month. Thirty-seven percent (n = 2,801) of the contacts resulted in admission to a MHCB unit. Twenty-five percent (n = 1,887) were returned to their housing, eight percent (n = 621) were provided conflict resolution skills and returned to their housing unit, and eight percent (n = 644) were educated regarding a custody process. The resolution of the remaining 22% (n = 1,639) were a mix of referrals to mental health, housing changes, referrals to volunteer groups, custody consultations. Prior to the inception of these teams, it is likely that a much higher proportion of individuals with crisis issues would have been admitted to high-cost inpatient psychiatric beds around the state.

> **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 individual who commits an act of self-harm with the intent to die, while ensuring that it complies with federal laws designed to protect patients' medical records and other health information.

The Department collects and maintains notification lists, commonly referred to as Next of Kin designations. A CDCR Next-of-Kin form is completed regularly, and at least yearly, with all individuals who agree to do so. However, in order to provide protected personal healthcare information to a Next-of-Kin designee, the individual must also complete a health care Release of Information form, which allows a patient to designate an individual to receive protected health information for medical and mental health purposes.

The Department has assembled a high-level workgroup involving the statewide mental health program, the federal Receiver's medical staff, the Receiver's Privacy Officer, and attorneys from the Receiver's office and CDCR to investigate the following issues relevant to suicide attempt notifications:

1. Confidentiality and patient consent issues: Contacting next of kin is a complicated process involving both federal and state laws and regulations. There are overlapping requirements that the workgroup has had to work through.

2. Release of Information forms: The Department contemplates that changes to the standard health care Release of Information form will be necessary to allow notification of next of kin for serious suicide attempts.

3. Guidelines for self-harm incidents: The workgroup is establishing guidelines and criteria that would be utilized to notify family members in the event of a serious suicide attempt.

Responsibilities for notifications: A set of workflows for nursing, medical, mental health, and custody have been designed and is pending approval and incorporation into a policy memorandum. Implementation of the new policy and procedure is anticipated to occur in 2021.

APPENDIX

Automated Chart Audit Tool for SRASHE

6/12/2020   CAT7 - New Form

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Mental Health Survey - Suicide Evaluation/Prevention - Suicide Risk Evaluations That Meet Audit Criteria (Quarterly)

Institution: [_____ ▾]   Area: [_____ * ▾]   MHI: [_____ * ▾]

CDCR#: [_____ *]   Form Author: [_____]

Document Date: [_____ *] 🗓

❓

1. If patient refused SRASHE, did the clinician document the steps taken to encourage participation or increase the patient's ability to participate in the SRASHE?

- ☐ Yes
- ☐ No
- ☐ N/A

2. If History of Suicide Attempts was endorsed are details of previous attempt(s) provided? (If patient does not have history of Suicide Attempts, mark N/A.)

- ☐ Yes
- ☐ No
- ☐ N/A

3. Does the narrative of risk justification address the following? (check all that apply)

- ☐ Chronic Risk
- ☐ Acute Risk
- ☐ IS PATH WARM warning signs
- ☐ Protective factor

4. If the safety plan is required per policy, is a plan documented?

- ☐ Yes
- ☐ No
- ☐ N/A

5. Safety Plan audit:

    Step 1: Which of the following is true for step 1:

cchcssites/dept/MentalHealth/_layouts/FormServer.aspx?XsnLocation=http://cchcssites/dept/MentalHealth/CAT7/Forms/template.xsn&ClientInstalled=...   1/3

⭘ Collaboratively written to address modifiable risk, protective factors, and warning signs, specific and personalized

⭘ Documented but not collaboratively written to address modifiable risk, protective factors, and warning signs

⭘ Not documented but reason noted

⭘ None of the above

Step 2: Which of the following is true for step 2:

⭘ Collaboratively written to address modifiable risk, protective factors, and warning signs, specific and personalized

◯ Documented but not collaboratively written to address modifiable risk, protective factors, and warning signs

◯ Not documented but reason noted

◯ None of the above

Step 3: Which of the following is true for step 3:

⭘ Collaboratively written to address modifiable risk, protective factors, and warning signs, specific and personalized

◯ Documented but not collaboratively written to address modifiable risk, protective factors, and warning signs

◯ Not documented but reason noted

◯ None of the above

Step 4: Which of the following is true for step 4:

⭘ Collaboratively written to address modifiable risk, protective factors, and warning signs, specific and personalized

◯ Documented but not collaboratively written to address modifiable risk, protective factors, and warning signs

◯ Not documented but reason noted

◯ None of the above

Step 5: Which of the following is true for step 5:

⭘ Collaboratively written to address modifiable risk, protective factors, and warning signs, specific and personalized

◯ Documented but not collaboratively written to address modifiable risk, protective factors, and warning signs

◯ Not documented but reason noted

◯ None of the above

Step 6: Which of the following is true for step 6:

6/12/2020   CAT7 - New Form

○ Collaboratively written to address modifiable risk, protective factors, and warning signs, specific and personalized

○ Documented but not collaboratively written to address modifiable risk, protective factors, and warning signs

○ Not documented but reason noted

○ None of the above

Step 7: Which of the following is true for step 7:

○ Collaboratively written to address modifiable risk, protective factors, and warning signs, specific and personalized

○ Documented but not collaboratively written to address modifiable risk, protective factors, and warning signs

○ Not documented but reason noted

○ None of the above

Comment:

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