ANNUAL REPORT OF SUICIDES
IN THE
CALIFORNIA DEPARTMENT OF
CORRECTIONS AND REHABILITATION

JANUARY 1, 2016 TO DECEMBER 31, 2016

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EXECUTIVE SUMMARY

In 2016, twenty-seven inmates died by suicide in the California Department of Corrections and Rehabilitation (CDCR). This was an increase from 2014 and 2015, when 23 and 24 suicides occurred, respectively. During the twenty-year period spanning from 1997 to 2016, CDCR averaged 28.7 suicides per year. The rate of suicide in CDCR during 2016 was 21.0 suicide deaths per 100,000 inmates. The Bureau of Justice Statistics estimates the suicide rate among state prison inmates nationally was 21 per 100,000 in 2016.[1] The rate of suicide among adult males in the U.S. has climbed steadily since 1999, reaching a rate of 27.7 per 100,000 in 2016. The analogous rate for adult males in California in 2016 was 21.6 per 100,000.[2]

Suicides occurred in 14 CDCR institutions in 2016. Some trends from previous years are noted, including an increase in suicides in Latino/a inmates. Three age groups (35-44, and 55-64 and 65 and older) were overrepresented among CDCR suicide deaths in 2016 when compared to the comparable proportion of these groups in the overall CDCR population. Twenty-two (81%) of suicides occurred among inmates with violent offense histories. One-third of suicides occurred in segregated housing units[3] and 74% of suicides occurred in high-custody programs (Level III and Level IV). Eighty-five percent of inmates who died by suicide in 2016 were sentenced to 11 years or more. Eighty-one percent of the suicides in 2016 occurred in mental health population inmates, including fifteen (56%) suicides among Enhanced Outpatient Program (EOP) inmates and another seven (26%) in the Correctional Clinical Case Management System (CCCMS) population. Sixteen inmates who died by suicide in 2016 (59%) had been psychiatrically hospitalized during the year prior to their deaths. Seventy-eight percent of the inmates who died by suicide in 2016 had made one (19%) or more (59%) suicide attempts in their lives.

CDCR continues to focus on improving and expanding its suicide prevention practices. Although this report covers suicides that occurred in 2016, the lessons learned are still valuable today and the analysis of these deaths are an essential part of a robust suicide prevention system. CDCR is in the process of reporting on all suicides through calendar year 2019 by the end of 2020. A large number of initiatives that occurred in 2016 are continuing, are under development, or have been implemented in recent months by CDCR. The department continues to assess the effectiveness of these initiatives and to monitor the quality and their sustainability. During 2016, further implementation of a number of recommendations from the Office of the Special Master's

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

[2] Center for Disease Control's Web-based Inquiry Statistics Query and Reporting System (WISQARS) fatal injury data: www.cdc.gov/injury/wisqars/index.html. Accessed February 18, 2020.

[3] These include Administrative Segregation, Security Housing Units, Short-Term Restricted Housing, Long-Term Restricted Housing, Psychiatric Services Unites, and Condemned Housing.

(OSM) suicide prevention workgroup and the OSM's expert reviewer have been made, while the department prepared for the implementation of a new electronic health record and new SRE form.

Improvements in suicide prevention and response are categorized into three broad areas: clinical programs, training, and policy changes.

- Clinical program improvements
  - Initiation of a telepsychiatry program to augment on-site psychiatric services
  - Training groups of clinicians in a suicide-specific treatment model.[4]
- Training
  - Revision of the clinical mentoring program
  - Addition of "booster" training for mentors
- Policy and procedural changes
  - Revision and expansion of forms to document the evaluation of inmates during their first five days after discharge from psychiatric inpatient facilities
  - Updated requirements for custodial checks on these same patients for at least 24 hours after inpatient discharge;
  - Development of policies for short- and long-term restricted housing
  - Creation of a form to document the evaluation of non-mental health designated inmates following placement in security housing
  - Revised policy for privileges and property in Mental Health Crisis Beds
  - Establishment of a referral processes for Board of Prison Hearings commissioners and staff

These enhancements are meant to bolster a comprehensive, integrated system of suicide prevention and response.

Recommendations contained in this report include implementation of suicide-specific interventions for CDCR's mental health population, particularly for inmates in the EOP level of care, increased support for inmates after leaving psychiatric inpatient care, and improving suicide risk evaluations in light of the implementation of the Electronic Health Record System (EHRS).

[4] The Collaborative Assessment and Management of Suicidality (CAMS)

I. INTRODUCTION AND REVIEW OF FINDINGS

This report reviews the deaths by suicide of 27 CDCR inmates during 2016. The report is submitted as part of joint efforts by CDCR and the OSM with the goal to reduce the number of suicides within California's state prisons and is part of CDCR's compliance with court-ordered remediation specified by the Special Master as part of the continuing review in the matter of *Coleman v. Newsom* (case No. 2:90-cv-0520, U.S. District Court for the Eastern District of California).

The report provides a statistical description of the 2016 suicide deaths and trends, a discussion of ongoing prevention programs, targets for suicide prevention efforts, and recommendations for continued improvement. Additional detail is provided about suicide response efforts and implementation of quality improvement processes (QIP) and programs to prevent suicide. The department has produced an annual report of suicides most years since the early 2000s which is distributed to the *Coleman* parties and the experts in the Office of the Special Master (OSM).

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

SUICIDE DEFINITIONS AND TERMS USED

The Mental Health Services Delivery System (MHSDS) Program Guide, 2009 Revision, provides definitions of suicide and suicide attempts. Several terms used in the last full revision of the Program Guide are now considered obsolete within the field of suicidology and will not be used in this report. Specifically, the terms self-mutilation and suicide gesture are found in the MHSDS Program Guides, 2009 Revision. A less pejorative term, self-harm without intent to die, is used in this report and refers to self-harm for reasons other than death by suicide.

1. Suicide: An intentional self-injurious behavior that causes or leads to death.

2. Suicide Attempt: An intentional self-injurious behavior which is apparently designed to deliberately end one's life, and may require medical and/or custody intervention to reduce the likelihood of death or serious injury.

3. Suicidal Ideation: Thoughts of suicide or death, which can be specific or vague, and can include active thoughts of committing[5] [that is, dying by] suicide or the passive desire to be dead.

4. Suicidal Intent: The intention to deliberately end one's own life.

5. Self-injurious Behavior: A behavior that causes, or is likely to cause, physical self-injury.

REVIEW OF FINDINGS: CURRENT YEAR

There were 27 suicide deaths within CDCR in 2016. This represents an increase of three over the total in 2015. The suicide rate for CDCR in 2016 was 21 per 100,000, higher than the average rate of 18.1 per 100,000 for the 20 years 1996-2015. Figure 1 shows the rate (and trends over time) of inmate suicide deaths in the CDCR from 1990 through 2016.[6]

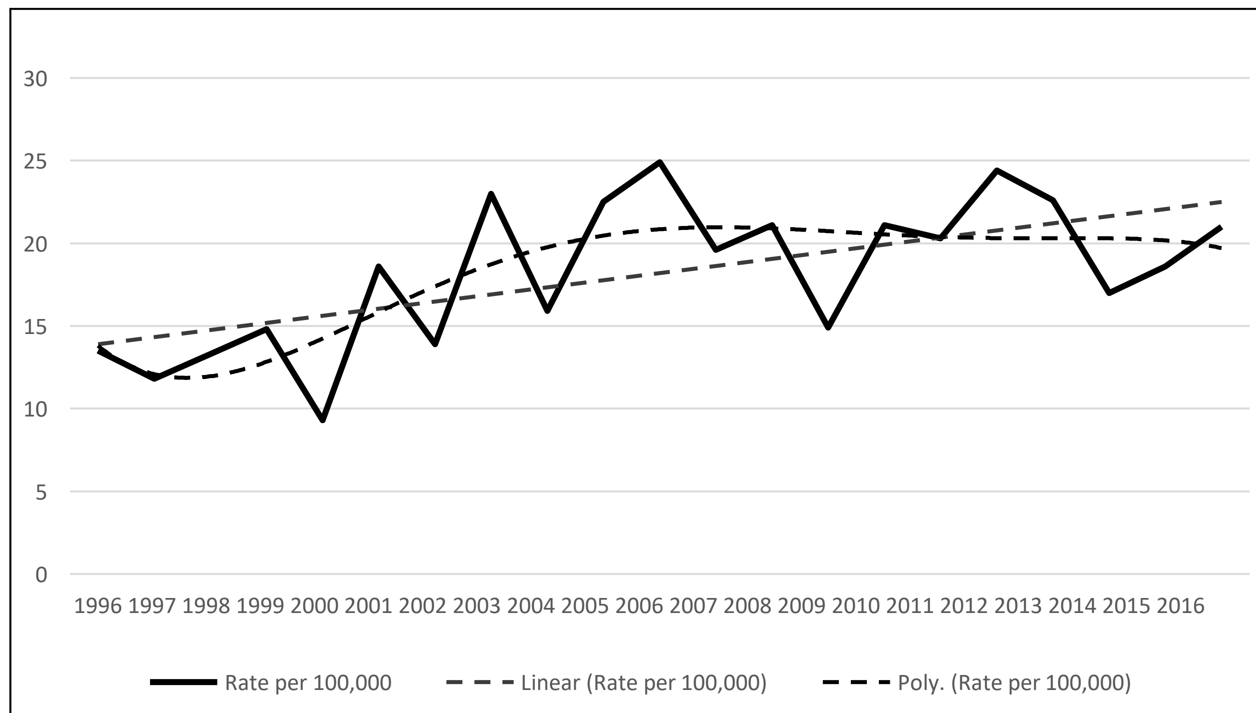

Figure 1. CDCR Rate of Suicide per 100,000 from 1996-2016

A linear trendline of suicides in CDCR institutions shows a rise since 1990. A polynomial trendline, reflects the downward slope in the late 1990s and early 2000s, an upward slope in the mid-1990s and between 2003 and 2013, a dip downward in 2014 to 2015, and a small rise in 2016.

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

[6] A discussion of data sources and calculations is contained in Appendix C, Methodology.

The rate of suicide in the CDCR has been at least 20 per 100,000 in 11 of the last 27 years. The rate of suicide in CDCR approached 25 per 100,000 on in 1993, 2006, and 2012, and was below 15 per 100,000 on six occasions, most recently in 2009. Table 1 presents the data in tabular form.

SOCIODEMOGRAPHIC FACTORS.

Although sociodemographic characteristics do not directly cause suicide, they are important risk factors with indirect effects.

Gender. In 2016, 24 men and 3 women died by suicide while in CDCR custody. The rate of suicides was 19.5 per 100,000 for men and 52 per 100,000 for women (Table 1). Three or more female inmates have died by suicide in CDCR only three times in the past 20 years.

Table 1. Annual Frequency and Rate of Suicide in the CDCR for 10 and 20 Years, by Gender and Total, 1997-2016

Year	Male			Female			Total		
	Population	Frequency	Rate	Population	Frequency	Rate	Population	Frequency	Rate
1997	141.669	18	12.7	10,837	0	0.0	152,506	18	11.8
1998	147,001	21	14.3	11,206	0	0.0	158,207	21	13.3
1999	150,581	24	15.9	11,483	0	0.0	162,064	24	14.8
2000	150,793	15	9.9	11,207	0	0.0	162,000	15	9.3
2001	150,785	29	19.2	10,712	1	9.3	161,497	30	18.6
2002	148,153	22	14.8	9,826	0	0.0	157,979	22	13.9
2003	150,851	37	24.5	10,080	0	0.0	160,931	37	23.0
2004	152,859	23	15.0	10,641	3	28.2	163,500	26	15.9
2005	153,323	37	24.1	10,856	0	0.0	164,179	37	22.5
2006	160,812	39	24.3	11,749	4	34.0	172,561	43	24.9
2007	161,424	33	20.4	11,888	1	8.4	173,312	34	19.6
2008	159,581	36	22.6	11,392	0	0.0	170,973	36	21.1
2009	156,805	25	15.9	11,027	0	0.0	167,832	25	14.9
2010	155,721	34	21.8	10,096	1	9.9	165,817	35	21.1
2011	152,803	33	21.6	9,565	0	0.0	162,368	33	20.3
2012	128,829	32	24.8	6,409	1	15.6	135,238	33	24.4
2013	126,992	29	22.8	5,919	1	16.9	132,911	30	22.6
2014	129,268	21	16.2	6,216	2	32.2	135,484	23	17.0
2015	123,268	22	17.8	5,632	2	35.5	128,900	24	18.6
2016	122,874	24	19.5	5,769	3	52.0	128,643	27	21.0
1997-2016	2,924,392	554	18.9	192,510	19	9.9	3,116,902	573	18.4

2007-2016	1,417,565	289	20.4	83,913	11	13.1	1,501,478	300	20.0

Race/Ethnicity. The racial and ethnic backgrounds of inmates who died by suicide in 2016 are presented in Table 2. In 2016 and for the second time in the previous decade, Hispanic inmates accounted for a higher proportion of suicides than Caucasian inmates (41% vs. 33%). Historically, Hispanic inmates have accounted for the second highest percentage of inmate suicides after Caucasian inmates. From 2006 through 2015 44% of all suicide deaths were by Caucasian inmates, 32% by Hispanic inmates, and the remaining 24% by African-American and Other inmates.

Table 2. Race/Ethnicity of Inmates Who Died by Suicides in the CDCR, 2016

Racial Group	Frequency	Percentage	Percentage of CDCR Population
African-American	4	15	29
Caucasian/European-American	9	33	22
Hispanic/Latino	11	41	43
Other[7]	3	11	7

Age. Table 3 shows age group suicide deaths in 2016, the percentage of suicides for each group, and the percentage of that age group within the total CDCR population. Three age groups (35-44, and 55-64 and 65 and older) were overrepresented among CDCR's suicide deaths in 2016 when compared to the proportion of these groups in the overall CDCR population. In the decade from 2007 through 2016, the average age of inmates in CDCR has increased from 37 to 39 years. In the same time period, the proportion of the CDCR population aged 55 and above has increased by 73%[8] and suicide deaths of this age group have trended upward from six percent in 2007 to greater than ten percent each year since 2011.

Table 3. Age Groups of Inmates Who Died by Suicide in the CDCR, 2016

Age Group	Frequency	Percentage	Percentage of CDCR Population
18-24	1	4	11
25-34	6	23	31
35-44	11	41	25
45-54	1	4	19
55-64	6	22	11
65 +	2	7	3

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

[8] The 55-and-older age group was the only group showing any increase in CDCR population between 2007 and 2016, due to the release of inmates less than 45 years of age after the 2011 enactment of AB109. Older inmates represent inmates with longer and life terms.

Marital Status. Marital status has been identified as a risk factor among prison inmates. Researchers in England found, in a large international sample of prison inmates, that married inmates were 1.5 times more likely to die by suicide than unmarried inmates.[9] In 2016, only six CDCR suicides (22%) occurred among married individuals, whereas 21 suicides (78%) occurred among separated or divorced, single, never-married or widowed inmates.

Education, Juvenile Criminal History, and Work History. In 2016, 21 inmates (78%) who died by suicide had less than a high school degree. Five inmates (19%) had a GED or had graduated from high school. One inmate had some college education. Eleven inmates (42%) had a history of gang involvement, though two of these inmates were gang dropouts at the time of their death. Fifteen (56%) had a history of juvenile arrest, with first arrests as early as age 12.

Most suicides occurred among inmates with limited employment history, typically in work classified as "unskilled labor" (48%) or no work history (11%). One inmate's work history was unknown. None of the suicides occurred among inmates in the Developmental Disability Program (DDP), and none had a documented history of special education.

Languages Spoken. In 2016, 21 inmates who died by suicide spoke only English. Six additional inmates (22%) were either monolingual Spanish (two) or bilingual in a language other than English (one bilingual Korean-English and three bilingual Spanish-English).

Health Factors. Six (22%) inmates who died by suicide in 2016 had serious and/or chronic medical problems. Of these, four inmates were treated for chronic pain, one had a seizure disorder, and one suffered from end-stage liver disease. In these cases, medical needs were determined to be adequately addressed according to nursing reviews. In one case, active medical diagnostic work was occurring at the time of the suicide (related to findings of blood in the inmate's stool).

Family Psychiatric History. In 2016, eleven of the inmates (41%) who died by suicide had reported a family history of mental illness. The most common person was the inmate's mother (eight cases), though several inmates reported having more than one affected family member. One inmate reported that his wife had died by suicide. One case had no record of the presence or absence of family mental illness.

Temporal Factors. Suicides occurred in the CDCR in ten of twelve months during 2016; no suicides occurred in February and August. Five suicides (19%) occurred in April and three suicides occurred in January, March, July, November, and December.

Another temporal factor is the time of day when suicides occur. In the CDCR, first watch is from 2200 hours to 0600 hours, second watch from 0600 hours to 1400 hours, and third watch is from 1400 hours to 2200 hours. In 2016, there were nine suicide deaths in each watch. From 2012

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[9] Fazel, S., Cartwright, J., Norman-Nott, A., Hawton, K. (2008). Suicide in prisoners: a systematic review of risk factors. *Journal of Clinical Psychiatry* 69(11), 172).

through 2016 there were no significant differences in the number of suicide deaths between the watches.

CUSTODIAL AND CORRECTIONAL FACTORS

Institution at Time of Death. In 2016, suicide deaths occurred in 14 different institutions (Table 4). Historically, suicides are more frequent in institutions with significant mental health programs than in those without programs for more severely ill inmates. Suicides are also more frequent in higher security (Level III or Level IV) institutions than in lower security settings. In 2016 twenty-two suicides (82%) occurred in Level III and IV institutions.

Table 4. Suicides by Institution, 2016

Institution	Frequency	Security Level[10]	Mental Health Program?
Salinas Valley State Prison	4	III (1), IV (3)	Y
California Men's Colony	3	II (1), III (1), Unclassified (1)	Y
California State Prison, Sacramento	3	IV	Y
Kern Valley State Prison	3	IV	Y
California Correctional Institution	2	IV	Y
California Institution for Women	2	II (1), IV (1)	Y
California State Prison, Los Angeles County	2	IV	Y
Pleasant Valley State Prison	2	III (1), IV (1)	Y
California Correctional Center	1	I/II	N
California Medical Facility	1	IV	Y
Central California Women's Facility	1	II	Y
Folsom State Prison	1	II	Y
North Kern State Prison	1	III	Y
Pelican Bay State Prison	1	IV	Y

Housing Type. Inmates alleged to be or found guilty of committing a disciplinary infraction are typically placed in segregated housing (Administrative Segregation and Security Housing Units). If found guilty, sanctions can include loss of time credits, loss of privileges, or other consequences. Inmates can also be placed in segregated housing at their own request for protection; indicating they may be in trouble with, or being threatened by, individuals or groups of inmates so

[10] Institutions often house inmates of different security levels; the listing here is the security level of the inmates who died by suicide at each site.

that the person feels his/her safety is in jeopardy. Conditions of confinement in segregated housing may result in significant distress for inmates. For some inmates, placement in segregated housing increases the risk of self-harm.

CDCR has implemented a number of policies and programs to increase mental health services and to reduce the risk of suicide in segregated housing. In 2015, CDCR developed Short-Term and Long-Term Restricted Housing (STRH/LTRH) units for inmates at the Correctional Clinical Case Management System (CCCMS) level. In previous years, specialized Administrative Segregation (ASU) "Hub" units and Psychiatric Services Units (PSU) for patients in the Enhanced Outpatient Program (EOP) were created. By the start of 2016, inmates in segregated housing units were to be checked by custodial officers every half-hour around the clock, using an electronic system called Guard One. The Guard One system requires officers to use an electronic "wand," officers" to record each time the inmate was checked throughout their stay in a segregated housing unit. At the end of 2016, the percentage of inmates housed in segregated housing was 3.7 percent, or roughly 5,000 inmates.

Other types of housing can also be associated with prison-related difficulties. Inmates entering CDCR with a new prison term or after having their parole revoked are housed in Reception Center (RC) institutions. Housing in a Sensitive Needs Yard (SNY) may indicate an inmate has an offense history that places them at some risk of harm from other inmates in the general population, such as being convicted of sexual offenses against children, that the inmate is perceived at risk from other inmates due to leaving a gang, or some other factor. Fewer inmates are housed in segregated housing units or SNY facilities than in general population settings. Table 5 lists the types of housing placements inmates were assigned to at the time of their deaths.

Time in Segregated Housing. Historically, a large number of suicides have occurred within the first few days of placement in administrative segregation. Upon arrival into administrative segregation, all inmates are placed into specially designed intake cells for 72 hours. In order to ensure the safety of patients newly placed in administrative segregation, objects that could be used as possible ligature anchors have been removed from these intake cells. In 2016, only one of the eight segregated housing suicides occurred within the first three days of placement and only two of the eight occurred within the first 10 days. In this case, the inmate was placed in an ASU EOP hub cell for six weeks prior to transfer to PSU. As the patient was new to PSU, this was considered a new instance of segregated housing placement.[11] The other suicide death within the first 10 days of segregated housing placement was placed in ASU for protective custody. He was in an intake cell for three days and then moved to a standard ASU cell.

[11] Inmates are not placed into intake cells when transferred to PSUs as they have previously been in segregated housing prior to PSU transfer.

Table 5. Suicides by Housing Type

Housing Type	Frequency	Percent
Administrative Segregation	5	19
Security Housing Unit	0	0
Condemned Housing	0	0
Psychiatric Services Units	1	4
Short-Term Restricted Housing	2	7
Long-Term Restricted Housing	0	0
Sensitive Needs Yard	3	11
Department of State Hospitals	0	0
Reception Center	0	0
Correctional Treatment Center	1	4
General Population	15	55

Offense Type. A common finding in prison and jail settings is a high proportion of suicides among inmates with violent commitment offenses; inmates incarcerated for a violent crime have a rate of suicide death more than twice the rate for those committed for non-violent crimes.[12] The commitment offenses of inmates who died by suicide in 2016 in CDCR are listed in Table 6. Notably, more than one-third of suicides (37%) occurred in individuals who had committed murder, with an additional 22% of suicides in individuals incarcerated for attempted murder. When combined with other violent crimes, 81% of suicides occurred among inmates with violent commitment offenses. The committed offenses of the remaining five inmates consists of: one case of Driving Under the Influence (DUI) with harm to others; three cases involved felons found in possession of firearms; and one case of burglary.

Table 6: Commitment Offense of Inmates Who Died by Suicide, 2016

Type of Offense	Frequency	Percentage
Violent offense		
Murder	**10**	**37**
Attempted Murder	**6**	**22**
Assault w/ Great Bodily Injury	**2**	**7**
Armed Robbery	**1**	**4**
Sex Offense	**3**	**11**
Violent Crimes Overall	**22**	**81**
Nonviolent offense		
DUI with injury/vehicular manslaughter	**1**	**4**
Burglary	**1**	**4**
Possession of a Firearm	**3**	**11**
Non-Violent Crimes Overall	**5**	**19**

[12] Mumola, C. (2005), Bureau of Justice Statistics, located at: http://www.bjs.gov/content/pub/pdf/ardus05.pdf

Security Level. Seventeen (63%) of CDCR suicide deaths in 2016 occurred in high security (Level IV) prisons while five (19%) occurred in Level III prisons. Table 7 shows the number of suicides by security classification level and compares 2016 with the five prior years and the 2016 statewide proportions of inmates housed at different security levels. As in previous years, the distribution of suicide deaths across the security levels was significantly different than the distribution of inmates across the security levels statewide.[13]

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

Table 7: Suicides by Security Level, 2016, 2011-2015, & Statewide Percent

	2016		2011-2015	Statewide
Security Level	Frequency	Percent	Percent	Percent
Level IV	17	63	51	19
Level III	5	19	22	19
Level II	4	14	16	27
Level I	0	0	3	8
Unclassified[14]	1	4	8	27

Table 8 shows that during 2016 the vast majority of suicides (85%) occurred among inmates with longer sentences (11 or more years) and various forms of life sentences (life term with or without the possibility of parole).

Table 8: Suicides by Sentence Length, 2016

Sentence Length	Frequency	Percentage
1-5 years	**3**	**11**
6-10 years	**1**	**4**
11-20 years	**8**	**30**
21+ years	**9**	**33**
Life w/ Possible Parole	**2**	**7**
Life w/o Possible Parole	**4**	**15**
Condemned	**0**	**0**

[13] Chi-Square = 36.54, df = 4, $p < .0001$
[14] Unclassified inmates are those who have not completed the classification process while at a CDCR reception facility or are unclassified for other reasons.

Table 9 shows categories of time spent in CDCR and the number (percentage) of inmates in each category. In 2016, there were no significant differences between the categories of time served by inmates who died by suicide.[15] The range of time served spanned from under two months to more than 28 years.

Table 10 shows the length of time remaining in sentences for those who died by suicide in 2016. There was nearly an even split between those with relatively short sentence, from a year to five years left to serve (41%) and those with lengthy sentences of 11 years or more or of indeterminate (life) sentences (49%). There were no suicides among inmates with six to ten years left to serve in 2016. The number of inmates that died by suicide with less than a year remaining on their sentence is striking (34%).

Table 9: Number of Inmates by Amount of Time Served at Time of Death, 2016

Amount of Time Served at Time of Death	Number of Inmates	Percentage
0-1 year	**6**	**22**
1-5 years	**7**	**26**
6-10 years	**3**	**11**
11-20 years	**7**	**26**
21+ years	**4**	**15**

Cell Occupancy. In 2016, 18 (67%) suicides occurred among inmates housed in designated single cells. Of these, two were cleared for double cell housing but remained in single cells. Of the remaining nine cases, two suicides occurred outside of cell (both by way of jumping from high tiers), one suicide occurred in a dorm setting (behind an inmate-made privacy screen), and six suicides occurred within double-person celled housing. Of the six suicide deaths of inmates in designated double-person cells, in two cases cellmates discovered the deceased inmate in the early morning; two inmates were discovered by cellmates upon returning to the cell from yard or work releases; and two inmates were not assigned a cellmate at the time of their death. Of the eight suicides occurring in segregated housing settings, all suicides occurred in single-person cells or within a solely occupied (at the time) double cell.

Table 10: Suicides in the CDCR by Time Left to Serve, 2016

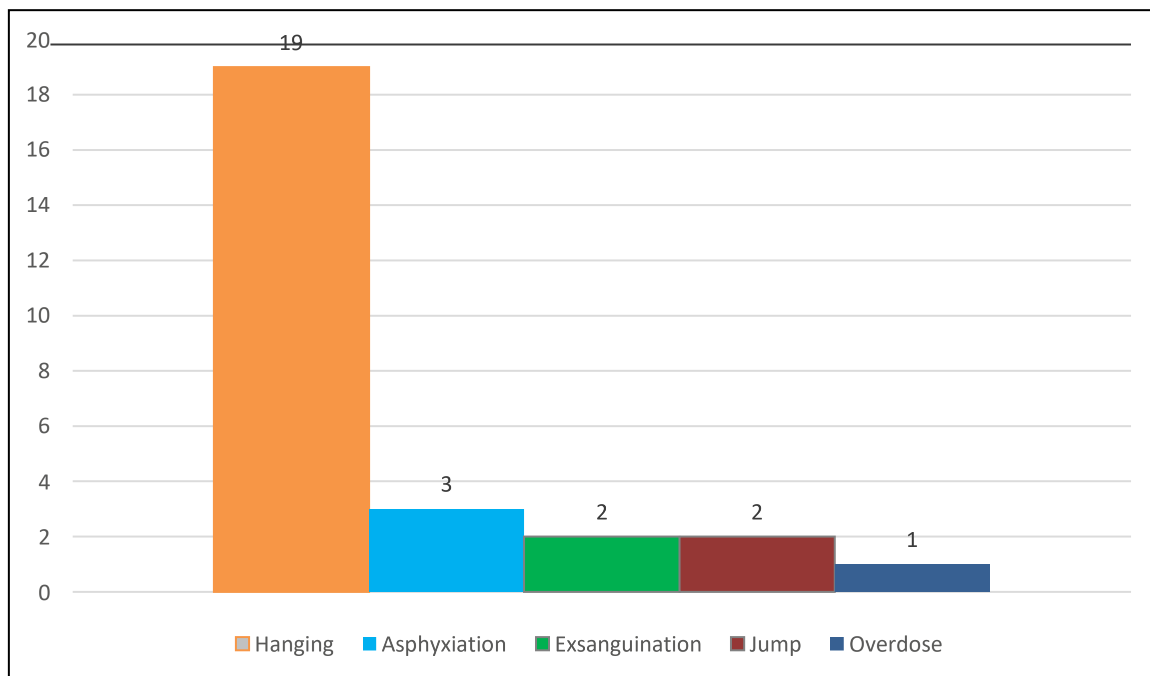
Suicides by Time Left to Serve	Frequency	Percentage
0-1 year	**9**	**34**
1-5 years	**2**	**8**
6-10 years	**0**	**0**
11-15 years	**3**	**11**
16+ years	**13**	**48**

[15] Chi-square "Goodness of Fit" statistic = 2.44 (df=4), p = 0.655

Job/School Assignment. The majorityof inmates (15 of 27, or 56%) who died by suicide in 2016 had not had a job assignment or educational placement during their current incarceration. The remaining 12 inmates were currently assigned a job or school placement or had an assignment earlier in their term.

Means or Method of Suicide. In 2016, asphyxiation by hanging was the primary means used by CDCR inmates to die by suicide. Inmates in most housing units have access to clothing, linens, and other materials (e.g. coaxial cables, shoelaces, earphone cables) that can be used for nooses, and ligature attachment points can be found in most cells.[16] As shown in Figure 2, nineteen of the twenty-seven suicides were by hanging (70%), a relatively low percentage compared to other years. For example, in 2015, 19 (83%) of suicides occurred by hanging. A similar method, asphyxiation, accounted for an additional three suicides (11%) in 2016. Of the remaining five inmate suicides two died by exsanguination, two jumped from a high tier, and there was one intentional drug overdose.

Figure 2. Method of Suicide, 2016



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

MENTAL HEALTH FACTORS

Mental Health Level of Care. Twenty-two (82%) of the suicides that occurred in 2016 were by inmates in the Mental Health Service Delivery System (MHSDS).[17] (see Table 11.) Mental health patients continue to be overrepresented in the year's suicides, a pattern that is typical in correctional and community settings.

In 2016, more than half of all of suicides occurred among inmates receiving treatment at the EOP level of care at the time of their death and another quarter were at the CCCMS level of care. Only five (18%) suicides in 2016 occurred among inmates without current involvement in the MHSDS. Of these five, two had never been participants in the MHSDS, one had a short stay in an inpatient setting within the month prior to his death, one had been at the lowest level of mental care until several weeks prior to his death, and one had a distant history of mental health care in CDCR.

Mental Health Treatment Prior to Incarceration. In 2016, 18 (67%) of the inmates who died by suicide had a history of mental health treatment prior to incarceration. Four additional inmates appeared to have their first involvement with mental health services after arrival into CDCR custody.

Table 11: Suicides in the CDCR by MHSDS Participation, 2016

MHSDS Level of Care at Time of Death	Frequency	Percentage
CCCMS	**7**	**26**
EOP	**15**	**56**
MHCB	**0**	**0**
APP/ICF	**0**	**0**
Any MHSDS LOC	**22**	**82**

Screening Upon Arrival at CDCR. Upon entrance to CDCR from county jails, inmates are screened for mental health service needs. Fifteen of the 27 (56%) inmates who died by suicide in 2016 were identified as possibly having significant mental health needs during initial screening. After mental health evaluations, 12 of the 15 (80%) were diagnosed with mental health conditions qualifying them for MHSDS services.

[17] The MHSDS is divided into levels of care with increasing intensity of treatment: Correctional Clinical Case Management (CCCMS), Enhanced Outpatient Program (EOP), Mental Health Crisis Bed (MHCB), Acute Psychiatric Program (APP), and Intermediate Care Facility (ICF). CCCMS and EOP are outpatient programs while MHCB, APP, and ICF are licensed, in-patient programs.

Involuntary Psychiatric Medication Orders. A small percentage of CDCR inmates are placed on involuntary psychiatric medication orders per Penal Code section 2602[18] due to severe mental illness and poor compliance with prescribed medications. In 2016, five of 27 inmates (18.5%) who died by suicide were subject to an involuntary psychiatric medication order at the time of death. 17 inmates (63%) were prescribed psychiatric medications at the time of death, including the five subject to involuntary psychiatric medication orders. In five of the 17 cases (29%), issues with medication compliance were raised during the suicide case reviews.

History of Psychiatric Inpatient Admissions in CDCR. In 2016, 16 inmates (59%) who died by suicide had at least one admission to a MHCB or other inpatient hospitalization in the year before their deaths.

Psychiatric Diagnoses. The frequency of mental health diagnoses of individuals who died by suicide in 2016 are summarized in Table 12. Because multiple mental health diagnoses are the rule rather than an exception, total frequency of diagnoses in Table 12 exceeds the number of suicides in the period. Additionally, some inmate suicides in 2016 involved individuals with some history of substance use or abuse. However, the diagnoses in Table 12 include substance use disorder *only* if formally reported as a diagnosis. All diagnoses are based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

Table 12. Mental Health Diagnoses of Inmates Who Died by Suicide in the CDCR, 2016

Diagnostic Category	Frequency	Percentage
Any DSM-5 Disorder	22	82
Any Mood Disorder	13	48
Major Depressive Disorder	8	30
Depressive Disorder NOS	3	11
Bipolar I Disorder	1	4
Mood Disorder NOS	1	4
Any Psychotic Disorders	8	30
Schizophrenia	3	11
Schizoaffective Disorder	4	15
Psychotic Disorder NOS	1	4
Anxiety Disorder	1	4
Personality Disorders	7	26
Substance Abuse or Dependence	7	26

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

When present, mood disorders and psychotic disorders were listed as the primary diagnosis of record. Of the individuals diagnosed with DSM-5 mental health disorders, the most common category of disorder was mood disorders, followed by psychotic disorders. Additionally, seven individuals were diagnosed with a personality disorder or substance use disorder, either in addition to a major mental illness or as a primary diagnosis; and 22 inmates were noted to have had a history of substance use problems, though only seven were diagnosed with a substance use disorder.

SUICIDE ATTEMPT HISTORY

In 2016, twenty (74%) of the inmates who died by suicide had at least one prior suicide attempt. Of these, 14 (52%) had made prior suicide attempts while incarcerated in CDCR. Five had made a single suicide attempt in CDCR and nine had made multiple attempts (with a range of two to twenty prior attempts) during incarceration. Thirteen inmates had reported at least one suicide attempt while in the community. Ten of these reported multiple attempts in the community. The finding of seventeen inmates (63%) within "multiple attempters*,*" a term indicating the presence of 2 or more suicide attempts with the intent to die, is significant as this is a group with known high chronic risk of suicide.[19] Implications of this finding are discussed later in this report.

Suicide Precipitants and Behavior. In 2016, ten (37%) inmates who died by suicide wrote suicide notes. This is higher than the rate (one in six) found in community samples.[20] More than one-quarter of the 2016 suicide deaths occurred among inmates who reported having no interpersonal supports, while another inmate was reported as having a very limited interpersonal support system. Almost three-quarters endorsed having two or more social supports during their most recent mental health or suicide risk evaluations. One inmate who died by suicide was believed to have feigned distress or suicidality.

Individuals who die by suicide often experience significant interpersonal or life events in the weeks or months prior to death. These events are often identified as "precipitating" events that play a role in triggering an individual's decision to end their life. The frequency and percentage of total precipitants to suicides listed or suspected by Mental Health Suicide Reviewers (MHSR) in their suicide case review reports are presented in Table 13. In many cases, the precipitants were not entirely clear or definitively established. Rather, the precipitants identified by suicide case reviewers should be considered clinically presumptive about each inmate's idiosyncratic reasons for ending their life, based on available records and information reviewed posthumously.

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[19] Rudd, Joiner, & Rajab (1996). Relationships among suicide ideators, attempters, and multiple attempters in a young-adult sample. *Journal of Abnormal Psychology*, *105*, 541-550; And also: Horon, McManus, Schmollinger, Barr, & Jiminez (2013). A study of the use and interpretation of standardized suicide risk assessment measures within a psychiatrically hospitalized correctional population. *Suicide and Life-Threatening Behavior*, *43* (1): 17-38.

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

The precipitants listed in suicide case review reports can be divided roughly into sixteen categories, with ten categories contributing to more than one suicide. The frequency of precipitants is greater than the total number of suicides, as nearly all suicide case reviews listed more than one hypothesized precipitant. Mental health symptoms were the most frequent precipitant found in suicides occurring in 2016, whereas this category was only the fourth most frequent precipitant identified in 2015. The category "discontinued psychiatric medications or poor compliance with medications" was noted in five case in 2016, compared to none in 2015. Conversely, the number of suicide deaths triggered by new charges or disciplinary actions, safety concerns, in-prison disruptions, and holidays declined in 2016 compared to 2015. Inmates diagnosed with major mental illness were more common in the group that died by suicide in 2016 compared to 2015.

Table 13. Suspected Precipitants to Suicides in the CDCR, 2016

Precipitant Category	Frequency	Percentage
Mental health symptoms, e.g. anxiety, psychosis, depression	14	23
Conflict or losses of external supports, such as family or spouse	8	13
Receipt of new charges, convictions, disciplinary actions, or added time in prison	7	11
Medical illness and/or pain issues; medical disability	7	11
Safety concerns, drug debts, fears of victimization	5	8
Refusals and discontinuation of psychiatric medications or poor compliance with medications	5	8
Receipt of or anticipation of negative outcomes with the Board of Prison Hearings	3	5
Active substance use	3	5
Fatigue with the length of incarceration; "tired of prison life"	2	3
Conflict or losses of within prison supports	2	3
Disruption in prison 'program;' e.g., transfer between facilities, cellmate change, loss of single cell housing	1	2
Loss of parole to the community (e.g., due to added sentence, finding of MDO or SVP)	1	2
Holidays or anniversaries of losses, crimes, etc.	1	2
Language barriers/inability to communicate distress	1	2
Anxiety about parole	1	2
Pressures to produce illegal drugs or to commit other crimes	1	2

Precipitant Category	Frequency	Percentage
TOTAL	62	100

An additional way to look at precipitating factors for suicide death occurring in the CDCR in 2016 is on a case-by-case basis. Table 14 contains the list of precipitants for each case. As is apparent, the majority of inmates had multiple potential triggers for the action, and the combination of precipitants in each case varied widely.

Table 14. Individual Precipitants for Suicides within the CDCR, 2016

Case	Precipitants Noted
A	Anniversary of instant offense; refused psychiatric medications; asked to be taken off pain medications; wrote about bizarre delusions involving custody erasing his memory, having bullets in his head, etc.
B	Argued with cellmate, an intimate partner, the night before the death; pending BPH hearing; anxiety about paroling
C	Suicide note suggested feelings of loss related to ex-spouse and familial deaths; received Rules Violation Report (RVR) which precluded transfer and with expected impact of BPH hearing
D	Alleged discord with cellmates in dorm; pressure to distribute illegal drugs; current personal substance use
E	Medical symptoms; frustration with language barrier/inability to express medical symptoms; exacerbation of mental health symptoms; no contact with family
F	Received call from spouse ending their marriage
G	Methamphetamine intoxication; told of death of family dog
H	Significant psychotic and depressive symptoms
I	The suicide occurred two days after transfer to PSU for a staff battery
J	Likelihood of additional sentencing for in-custody assault and weapons possession; complaints of having no family contact
K	Safety concerns related to a drug debt; placed in ASU for fighting, potentially for the purposes of safety (removal from general population)
L	Cell phone confiscated; lost hope regarding a petition for a pardon; possible medical concern (blood in stool)
M	Safety concerns – requested protective custody due to nature of offense
N	Expressed fear for his family due to threats from a prison gang and engaged in violence in order to be placed in ASU “for personal safety”
O	Psychotic agitation related to discontinuation of a long-acting injectable antipsychotic medication; beliefs of needing “to bleed out to release my sister’s soul from hell”
P	Pending District Attorney referral; struggles with depression, anxiety, and substance abuse; possible safety concerns related to gang affiliation
Q	PTSD symptoms and depressive symptoms; discontinued medication

Case	Precipitants Noted
R	Recurrent nightmares/insomnia, depression, and thoughts to join deceased daughter; news that spouse did not want to cohabit following parole
S	Fatigue with incarceration (facing life sentences in two states); increasing medical problems
T	Persistent delusional beliefs of having a deadly disease or heart problem; psychiatric medication discontinued
U	Attended preliminary court hearing and was charged with murder over an in-cell homicide (suicide occurred hours later)
V	Paranoia and hallucinations; taunting by other inmates who urged self-harm; discontinuation/refusal of psychiatric medications
W	Ongoing desire to die with depression and psychosis; did not want to have a cellmate
X	Severe mental illness; treated for several serious chronic medical conditions; length of incarceration
Y	Depression heightened by guilt; confrontation by family on how the commitment offense had impacted family functioning
Z	Receipt of distressing letters from mother and erroneous reports of her death; anxiety, depression and guilt regarding crime (with nightmares and related hallucinations)
AA	Distress and remorse over reviewing crime reports in anticipation of a BPH hearing; increased anxiety and paranoia that staff was "playing trickery" to cause a bad BPH hearing; discontinued medications

C. REVIEW OF FINDINGS: CURRENT YEAR VS. PRIOR YEARS

1. COMPARISON OF SUICIDE RATE IN CURRENT AND PRIOR YEARS

In 2016, the suicide rate within CDCR was 21.0 per 100,000 – an increase over the previous two years when the rate was 17.0 and 18.6, respectively. There were three more suicides in 2016 than in 2015. During the ten-year period from 2006 to 2015, the rate of suicide within CDCR was 20.5 per 100,000.

Table 15 shows the rate and frequency of suicide within CDCR for both genders and total inmate population for the 20 years 1997-2016. The frequency of suicides over the period has ranged from a low of 15 in 2000 to a high of 43 in 2006, while the rate has been as low as 9.3 per 100,000 in 2000 and as high as 24.9 in 2006.

As noted above, the rate of suicide in female inmates fluctuates considerably compared to a relatively stable rate in male inmates. In 11 of the past 20 years, there were no female suicides. The number of suicides in female institutions has ranged from zero to four within that time period; with three occurring in 2016. There appears to be a trend present over the last five years (2012-

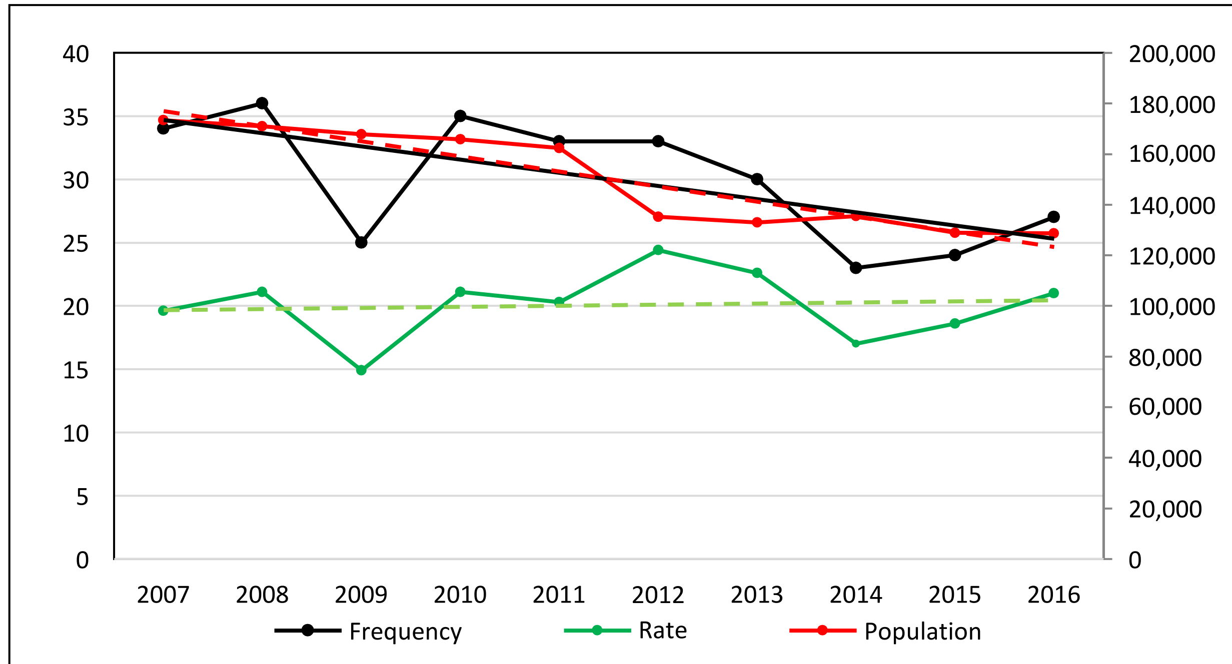
2016), with at least one female inmate suicide per year, whereas female inmate suicides were absent in three of the five prior years (2007-2011).

Table 15. Annual Frequency and Rate of Suicide in the CDCR, by Gender and Total, 1997-2016

Year	Male			Female			Total		
	Population	Freq	Rate	Population	Freq	Rate	Population	Freq	Rate
1997	141,669	18	12.7	10,837	0	0.0	152,506	18	11.8
1998	147,001	21	14.3	11,206	0	0.0	158,207	21	13.3
1999	150,581	24	15.9	11,483	0	0.0	162,064	24	14.8
2000	150,793	15	9.9	11,207	0	0.0	162,000	15	9.3
2001	150,785	29	19.2	10,712	1	9.3	161,497	30	18.6
2002	148,153	22	14.8	9,826	0	0.0	157,979	22	13.9
2003	150,851	37	24.5	10,080	0	0.0	160,931	37	23.0
2004	152,859	23	15.0	10,641	3	28.2	163,500	26	15.9
2005	153,323	37	24.1	10,856	0	0.0	164,179	37	22.5
2006	160,812	39	24.3	11,749	4	34.0	172,561	43	24.9
2007	161,424	33	20.4	11,888	1	8.4	173,312	34	19.6
2008	159,581	36	22.6	11,392	0	0.0	170,973	36	21.1
2009	156,805	25	15.9	11,027	0	0.0	167,832	25	14.9
2010	155,721	34	21.8	10,096	1	9.9	165,817	35	21.1
2011	152,803	33	21.6	9,565	0	0.0	162,368	33	20.3
2012	128,829	32	24.8	6,409	1	15.6	135,238	33	24.4
2013	126,992	29	22.8	5,919	1	16.9	132,911	30	22.6
2014	129,268	21	16.2	6,216	2	32.2	135,484	23	17.0
2015	123,268	22	17.8	5,632	2	35.5	128,900	24	18.6
2016	122,874	24	19.5	5,769	3	52.0	128,643	27	21.0
1997-2016	2,924,392	554	18.9	192,510	19	9.9	3,116,902	573	18.4
2007-2016	1,417,565	289	20.3	83,913	11	13.1	1,501,478	300	20.0

Figure 3 shows that while the frequency of suicide has trended downward over the period 2007-2016, the suicide rate trend has remained almost unchanged. This is best explained by the almost identical declining trends in population and frequency as seen in Figure 3.

Figure 3. CDCR Suicide Rate, Frequency, and Population with Trends, 2007-2016



2. SUICIDES BY INSTITUTION, CURRENT YEAR VS. 15-YEAR AVERAGE

Whereas Figure 3 presents suicide deaths across the CDCR as a whole (including out-of-state facilities, fire camps, community correctional facilities, and prisons); the frequency of suicides by institution is less variable. Institutions can vary by the number of patients in the institution's mental health program, the mental health mission of the facility, the predominance of violent offenders at the site, and the total number of inmates at the institution are just some of the factors that contribute variance to *where* suicides occur. Fluctuations can occur in the number of suicides at an institution in given years due to cluster effects,[21] changes in the use or mental health mission of the institution, and other factors. There are also subsets of suicides that occur during or upon transfer of an inmate from one institution to another, further complicating the interpretation of *why* suicides occur at certain institutions more frequently than others.

Table 16 presents the number of suicides in each institution during 2016, the total for each institution for the period 2001-2015, and the average number of suicides in each institution during that period. The inclusion of 15 years of data allows current year data to be compared to averages over a significant period of time. The range of suicides, on average, for all facilities (including psychiatric programs at CMF and SVSP) was 0.0 to 2.2 per year, and the average for all institutions

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

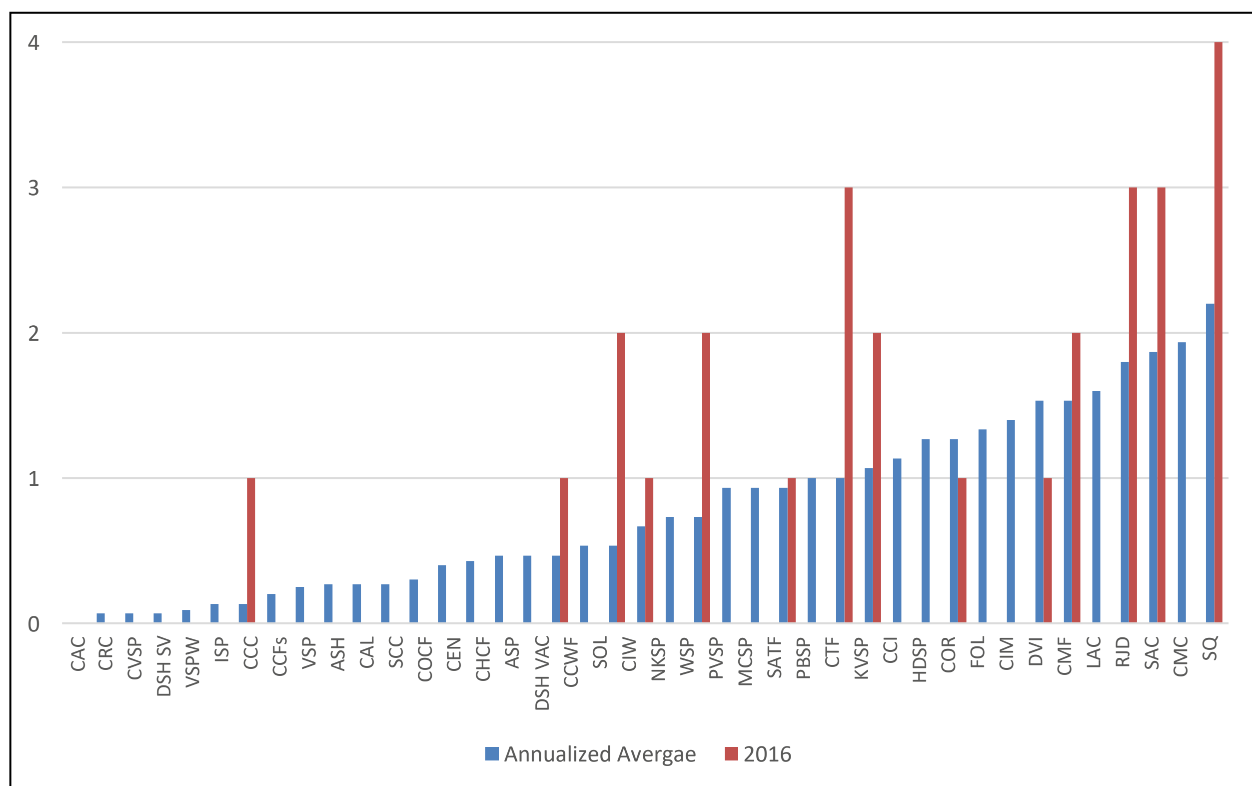
Table 16. Suicide by CDCR Institution, 2016 and 2001-2015 Average

Institution	2016 Frequency	2001-2015 Total	2001-2015 Average
California City Correctional Facility	0	0	0.00
California Rehabilitation Center	0	1	0.07
Chuckawalla Valley State Prison	0	1	0.07
Department of State Hospitals-Salinas Valley	0	1	0.07
Ironwood State Prison	0	1	0.09
Valley State Prison for Women	0	2	0.13
California Correctional Center	1	2	0.13
Community Correctional Facilities	0	3	0.20
Valley State Prison	0	1	0.25
Atascadero State Hospital	0	4	0.27
Calipatria State Prison	0	4	0.27
Sierra Conservation Center	0	4	0.27
California Out-of-State Correctional Facilities	0	3	0.30
Centinela State Prison	0	6	0.40
California Health Care Facility	0	1	0.43
Avenal State Prison	0	7	0.47
Department of State Hospitals-Vacaville	0	7	0.47
Central California Women's Facility	1	7	0.47
California State Prison, Solano	0	8	0.53
California Institution for Women	2	8	0.53
North Kern State Prison	1	10	0.67
Wasco State Prison	0	11	0.73
Pleasant Valley State Prison	2	11	0.73
Mule Creek State Prison	0	14	0.93
Substance Abuse Treatment Facility	0	14	0.93
Pelican Bay State Prison	1	14	0.93
California Training Facility	0	15	1.00
Kern Valley State Prison	3	10	1.00
California Correctional Institution	2	16	1.07
High Desert State Prison	0	17	1.13
California State Prison, Corcoran	0	19	1.27
Folsom State Prison	1	19	1.27
California Institution for Men	0	20	1.33
Deuel Vocational Institute	0	21	1.40
California Medical Facility	1	23	1.53
California State Prison, Los Angeles County	2	23	1.53
RJ Donovan Correctional Facility	0	24	1.60
California State Prison, Sacramento	3	27	1.80
California Men's Colony	3	28	1.87
San Quentin State Prison	0	29	1.93
Salinas Valley State Prison	4	33	2.20
Total	**27**	**469**	**30.4**

from 2001-2015 was 34 suicides per year.[22]

Another way to view institutional data is to plot the number of suicides at an institution during one year compared to the annualized average of suicides for that institution. This can help to pinpoint institutions that are experiencing a spike in suicides and conversely, those institutions that have fewer suicides than their long-term average. Focusing prevention efforts to institutions that are not improving over time may help to reduce the overall burden of suicide in the system. Figure 4 shows 2016 suicide frequency by institution compared to their adjusted 15-year average.

Figure 4. Institutional Suicides Compared to Long-term Average, 2016 and 2001-2015

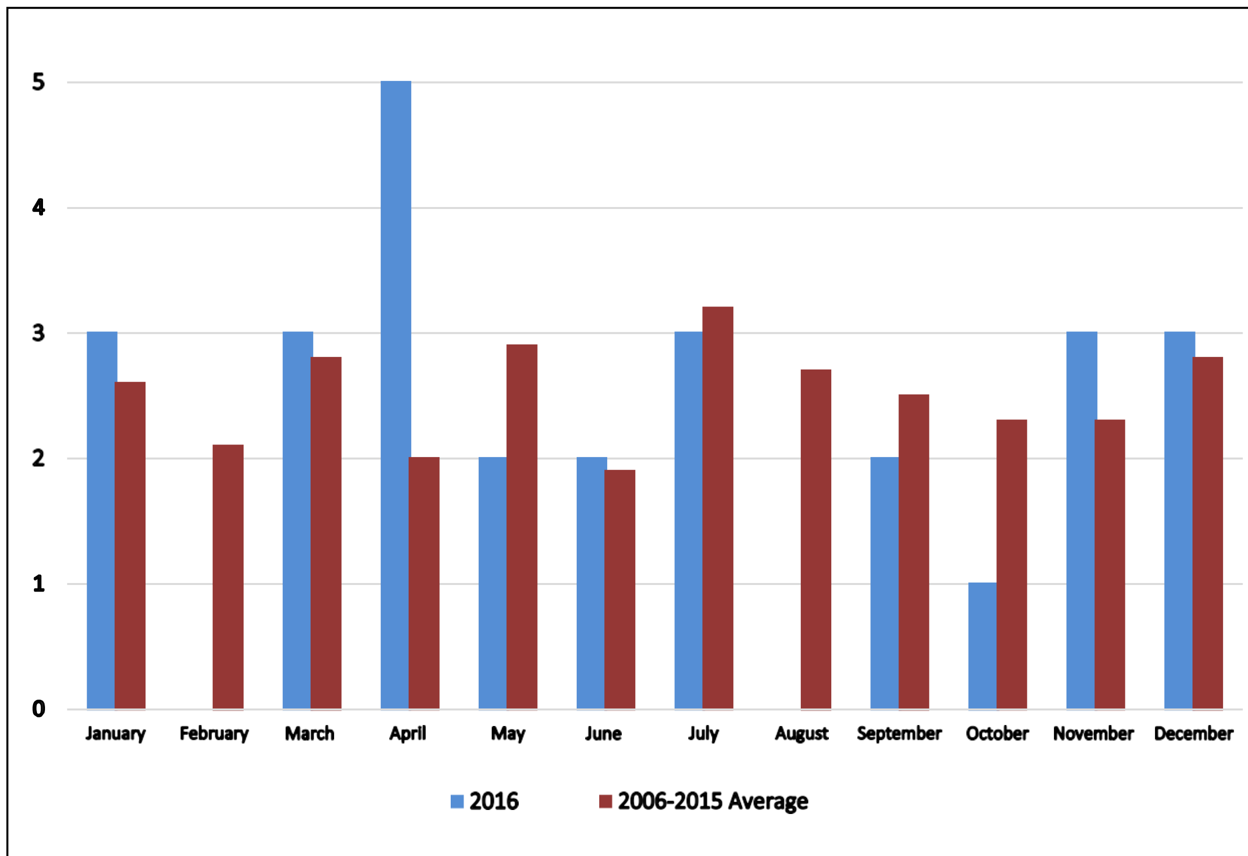


3. SUICIDES BY MONTH, CURRENT YEAR AND 10-YEAR AVERAGE

As shown in Figure 5, April had the most suicides in 2016. February and August had no suicide deaths. The frequency of suicide deaths in a specific month can vary widely within and between individual years but when averaged over a longer period the differences even out. Over the ten-year period ending in 2016, there were an average of 2.5 suicide deaths per month.

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

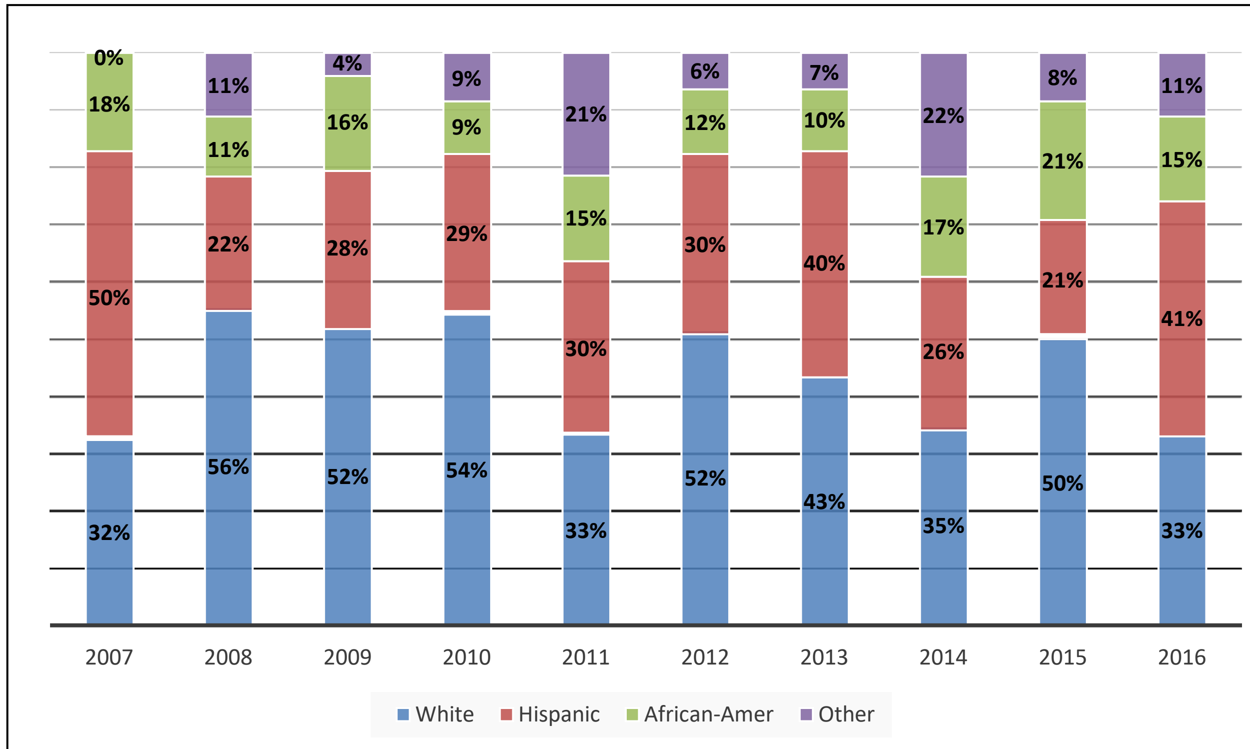
Figure 5. CDCR Suicide Frequency by Month, 2016 and 2007-2016 Average



4. SOCIODEMOGRAPHIC FACTORS

Ethnicity/Racial. Figure 6 shows the percentage of suicide deaths among CDCR's ethnic/racial divisions over the ten-year period 2007-2016. Caucasians comprised the largest group of suicide deaths over the ten-year period (44%), although in the last five years Caucasians have been in the majority only two years. Suicides among Hispanic inmates were the second largest group, accounting for 41% of the suicides in 2016 and 32% over the ten year period. The annual number of suicide deaths among Hispanic inmates fluctuated during the decade and surpassed the number of suicides in other racial group in 2007 and 2016. The frequency of suicide in the African-American and Other racial/ethnic groups (denoting a mixture of Asian, Pacific Islander, Native American, and other racial backgrounds) has generally been stable over the period. Of note, only one Native American died by suicide during the 10-year period.

Figure 6. Annual Percentage of Suicide Deaths by Ethnicity/Race, 2007-2016



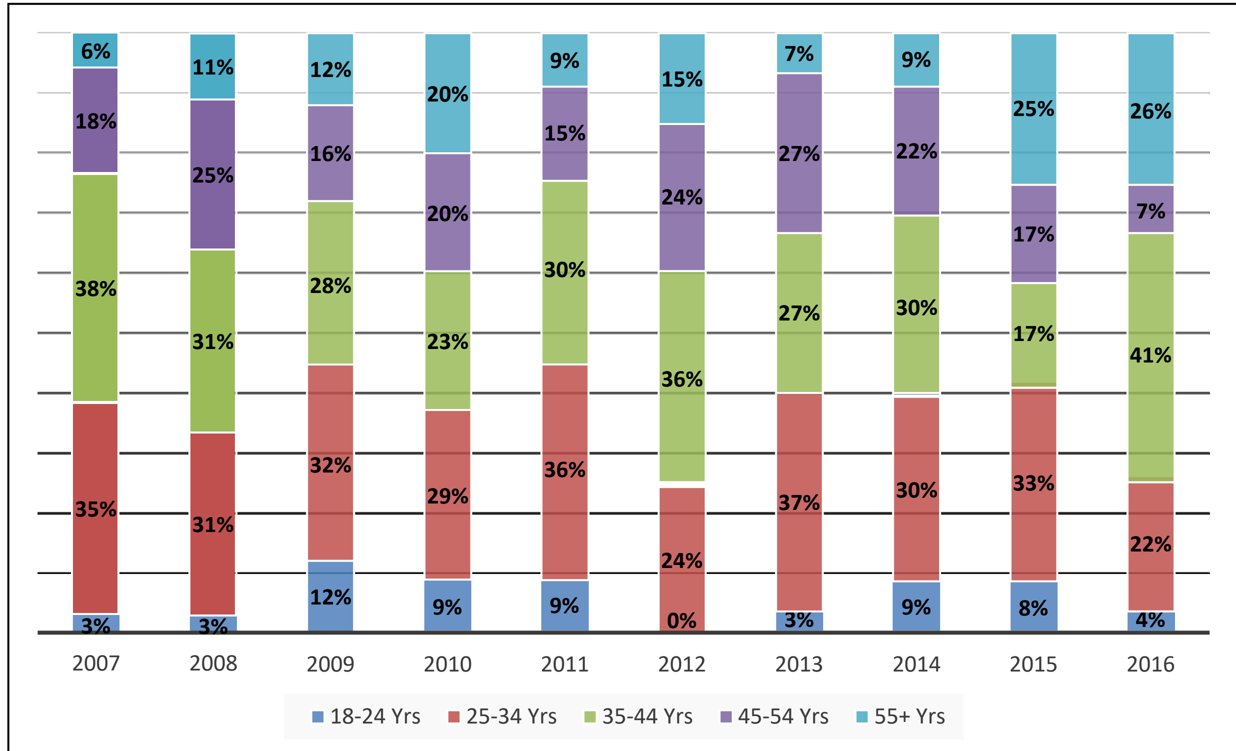
Age at Time of Suicide. The age of those who died by suicide between 2007 and 2016 is divided into five age brackets, shown in Figure 7 below. In most years, the largest percentage of suicides in any age group is among individuals aged 25-34. The exceptions to this general finding occurred in 2012 and 2016, when a higher proportion of suicides occurred among inmates aged 35-44 years. A trend of older suicides (over age 55) was noted in 2015, and this age group was again overrepresented in 2016.

5. SUICIDES BY HOUSING TYPE

Historically in CDCR and in national studies, segregated housing units have been a high-risk setting for suicide, particularly when inmates are housed alone.[23] In CDCR, segregated housing includes ASU, SHU, STRH, LTRH, PSU, and units for condemned inmates. During 2016, eight (30%) of the 27 suicide deaths occurred in segregated housing settings. For reference, approximately 3.7% of CDCR inmates were assigned to segregated housing at the end of 2016.[24] Suicide rates for segregated housing are generally higher than the rest of CDCR because of the small number of beds and the proportion of suicide deaths that occur in those units.

Figure 7. Annual Percentage of Suicide Deaths by Age Group, 2007-2016

[23] *Id.* and also Reeves, R., and Tamburello, A. (2014). Single Cells, Segregated Housing, and Suicide in the New Jersey Department of Corrections. Journal of the American Academy of Psychiatry and Law 42(4), 484-88.
[24] Data provided by the CDCR Office of Research.

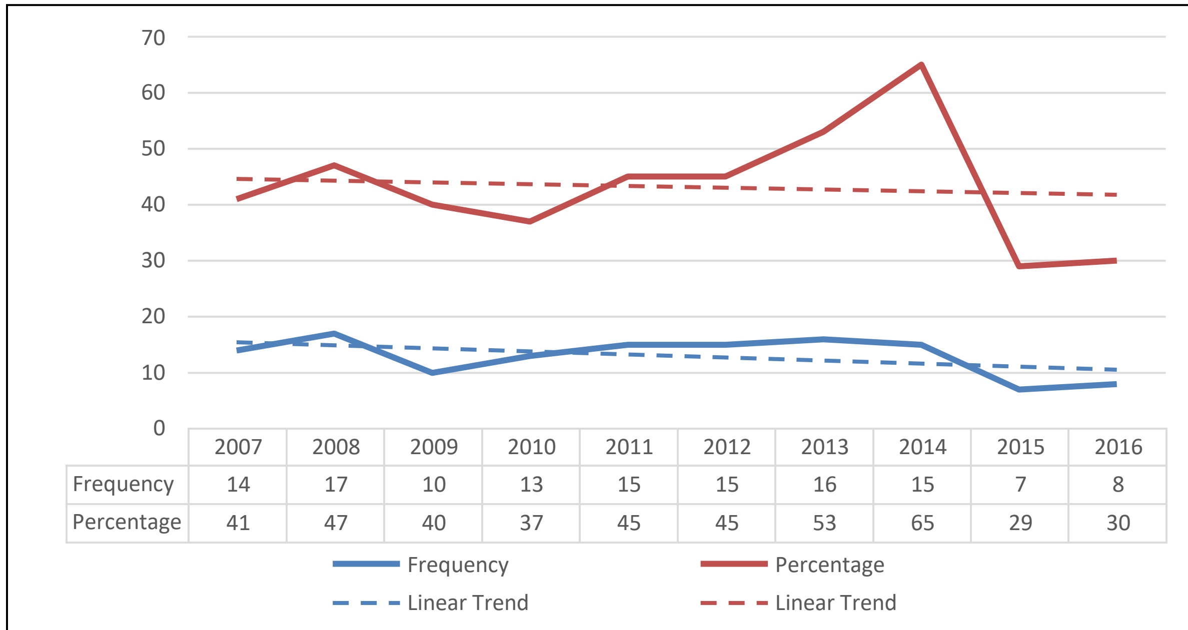


The annual total of suicide deaths in segregated housing had a slight downward trend from 2007 through 2016. The percentage of all suicide deaths that occurred in segregated housing also showed a slight decrease over the decade. Figure 8 below summarizes this information. Programs and policy changes directed at segregated housing began in earnest in 2007 and have continued in the ten years since. These changes mirrored the decreased use of segregated housing since that time.

6. PRESENCE OF CELLMATE IN SEGREGATED HOUSING

In 2016, all inmates who died by suicide while in segregated housing units were housed alone. Two of the inmates had been cleared to have a cellmate while in segregated housing, but in both cases no other inmate had been placed in the cell. This percentage is consistent with prior years. The percentage of suicides in segregated housing units by inmates housed alone was 100% in 2010, 86% in 2011, 91% in 2012, 100% in 2013, 86% in 2014, and 89% in 2015.

Figure 8. Frequency and Percentage of Suicide within Segregated Housing, 2007-2016

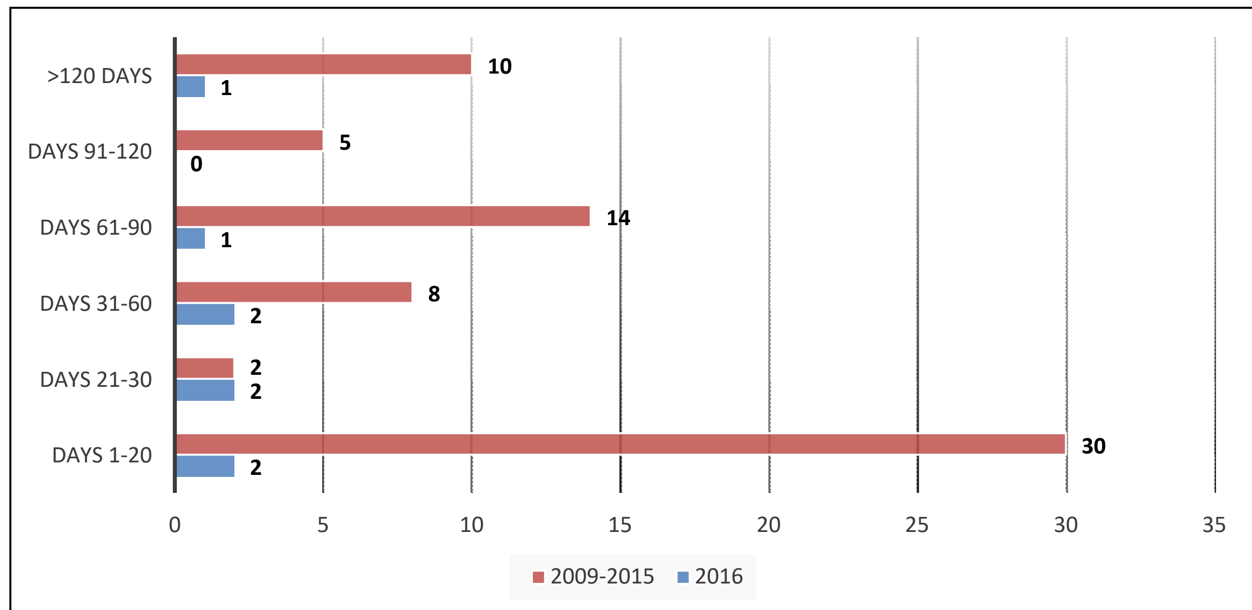


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Frequency	14	17	10	13	15	15	16	15	7	8
Percentage	41	47	40	37	45	45	53	65	29	30

7. TIME IN SEGREGATED HOUSING PRIOR TO DEATH

Data on the number of days between segregated housing placement and deaths by suicide has been tracked since 2009. Over this seven-year period between 2009 and 2015, suicides tended to occur shortly after placement, particularly in the first 72 hours after placement and overall within the first 20 days of placement. As noted earlier, the proportion of suicides soon after placement in segregated housing was lower in 2016 (Figure 9).

Figure 9. Time in Segregated Housing Prior to Suicide, 2009-2015 and 2016



8. METHOD OF SUICIDE

Ligature hanging has been the predominant method of suicide death over the long-run in CDCR. In 2016 twenty (77%) of suicide deaths were by hanging. In the ten years ending in 2016 the percentage of suicide deaths by hanging was 82% with a range from 74% in 2007 to 94% in 2011. In the same period, poisoning/overdose, laceration with exsanguination, and asphyxiation each accounted for five percent of suicide deaths and other methods (jumping and water intoxication) accounted for the remaining three percent.

9. INVOLVEMENT WITH MENTAL HEALTH SERVICES

Although suicide is commonly associated with significant mental health problems, [25] individuals without a mental health diagnosis and inmates with no prior identified mental health needs can also die by suicide. Inmates can avoid mental health services by choice, such as by denying symptoms on screening or by masking symptoms in order to be discharged from the MHSDS. It is not uncommon for suicidal inmates to distrust mental health clinicians when contemplating suicide, concerned that clinicians may remove a valued option (death) should life so dictate. The SMHP has had a number of initiatives over the years that target inmates who do not participate in the MHSDS, and screens all inmates, regardless of MHSDS status, at a variety of points during their incarceration. Table 17 lists the numbers of suicides at each level of MHSDS involvement from 2007 through 2016.

Table 17. Frequency of Suicide by MHSDS Level of Care, 2007-2016

Year	CCCMS	EOP	In-Patient	% of Total
2007	17	5	3	74
2008	9	9	0	50
2009	11	8	0	76
2010	12	8	0	57
2011	10	13	0	69
2012	12	5	1	55
2013	9	6	1	53
2014	12	9	1	96
2015	9	5	0	58
2016	7	15	0	81
Total	**108**	**83**	**6**	**66**

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

10. SUICIDE RATES - MENTAL HEALTH VS. NON MENTAL HEALTH

Table 18 shows the annual suicide rates of MHSDS inmates, non-MHSDS inmates, and total CDCR populations from 2006 through 2015 and in 2016. [26] The ten-year rate of suicide for MHSDS inmates is more than five times the rate for inmates not included in the MHSDS. The trend of higher rates of suicide in those in MHSDS was magnified in 2016, as the rate for non-MHSDS inmates was only 5.5 per 100,000.

Table 18. Suicide Rates of Mental Health, Non-Mental Health, and Total CDCR Populations, 2006-2015 and 2016

Year	MHSDS Inmates	Non-MH Inmates	Total Rate
2006	**61.9**	**16.5**	**25.1**
2007	**75.4**	**6.5**	**19.8**
2008	**51.6**	**13.6**	**21.6**
2009	**53.3**	**4.8**	**15.5**
2010	**53.9**	**12.5**	**22.3**
2011	**61.9**	**8.8**	**20.3**
2012	**53.6**	**16.0**	**25.9**
2013	**46.4**	**15.5**	**24.1**
2014	**56.3**	**2.2**	**18.2**
2015	**40.4**	**9.8**	**18.6**
2006-15 Average	**55.3**	**10.7**	**21.3**
2016	**58.3**	**5.5**	**21.0**

Note: The population data in this table was derived from Health Care Population Oversight Program (HCPOP) reports which may differ from OOR estimates because of differences in methods and time of collection.

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

Examination of suicide rates across state prison systems allows comparisons between analogous systems, e.g. large systems with many units and comparable populations. Variables that can contribute to different suicide rates in different prison systems include, but are not limited to, how the prison system operates, the structure and quality of prison's mental health system, differences in the system's administrative and statutory standpoint, different demographics, and availability and quality of suicide prevention programs. With this caveat in mind, the next sections

[26] This information was derived from the Health Care Placement Oversight Programs (HCPOP) monthly trends reports. The population totals vary slightly from other referenced population totals within this report, as the data from HCPOP is collected at different points of time and utilizes total population averages.

will explore comparisons between the CDCR, estimates of other U.S. state prison systems, and community estimates.

1. CDCR SUICIDE RATE VERSUS OTHER STATE PRISON RATES.

In 2016, CDCR ranked 16th compared to other U.S. state prison suicide rates. Table 19 presents each state's 2016 prison suicide rate, its ranking (highest to lowest), the ranking of each state's prison population, and the adult suicide rate in the state. CDCR's total population of almost 125,000 inmates in 2016 was exceeded only by Texas, which had a prison population of over 163,000 inmates but a state prison suicide rate of 17 deaths per 100,000. Of the top ten states by prison population nationally, only New York with a prison population of just over 50,000 inmates had a higher suicide rate.

Table 19. State Prison Suicide Rates, and Rankings of the States' Prison Suicide Rates, Prison Population, and Adult Suicide Rate, 2016[27]

State	Prison Suicide Rate (deaths per 100,000)	U.S. Ranking		
		Prison Suicide Rate	Prison Population	Adult Suicide Rate
Utah	43	1	39	6
Rhode Island	40	2	46	43
Montana	35	3	44	2
Alaska	33	4	42	1
Massachusetts	30	5	33	48
Hawaii	29	6	40	42
New Hampshire	29	7	45	19
Vermont	29	8	50	17
South Dakota	28	9	43	11
Delaware	27	10	38	41
Idaho	27	11	35	7
New Mexico	24	12	37	4
Connecticut	23	13	29	45
Nebraska	22	14	41	39
New York	22	15	6	49
California	20	16	2	44
Oklahoma	20	17	17	8
Wisconsin	20	18	19	29
Arkansas	19	19	27	12
Colorado	19	20	23	9
Iowa	19	21	34	32

[27] See Appendix for data sources for this table.

State	Prison Suicide Rate (deaths per 100,000)	U.S. Ranking		
		Prison Suicide Rate	Prison Population	Adult Suicide Rate
Maryland	19	22	22	47
Wyoming	19	23	48	3
Arizona	17	24	9	14
Illinois	17	25	8	45
Indiana	17	26	18	25
Nevada	17	27	30	5
Texas	17	28	1	40
Kansas	16	29	32	18
Michigan	16	30	10	36
Minnesota	16	31	31	37
Oregon	16	32	28	16
Pennsylvania	16	33	7	27
Tennessee	16	34	16	21
Mississippi	15	35	25	38
North Dakota	14	36	49	15
Ohio	14	37	5	31
South Carolina	14	38	21	22
Washington	14	39	26	26
Missouri	13	40	14	13
New Jersey	13	41	24	50
Maine	12	42	47	24
Georgia	11	43	4	33
Louisiana	11	44	13	30
Florida	9	45	3	28
Virginia	10	45	11	34
Kentucky	8	47	20	20
North Carolina	8	48	12	35
West Virginia	8	49	36	10
Alabama	7	50	15	23

Another way of displaying the comparison data is presented in Figure 10 below. Each state is represented by a bubble and the size of the bubble represents the size of the state's prison population. On the vertical axis is prison suicide rate, and on the horizontal axis is adult male suicide rate. Bubbles are colored for the ten states with the highest prison populations. The dotted line represents the average of the state suicide rate and the state prison suicide rate. As can be seen, it is generally true that state prison suicide rates rise gradually compared to the overall state adult suicide rate.

California (in red), which has a prison population second only to Texas (in blue), lies at the average for state prison suicides (which the Bureau of Justice Statistics estimates as 21 per 100,000 inmates) while Texas lies just below it. California ranks 16th in prison suicide rate compared to other states, yet lies well below most states in adult male suicide rate, ranking 44th.

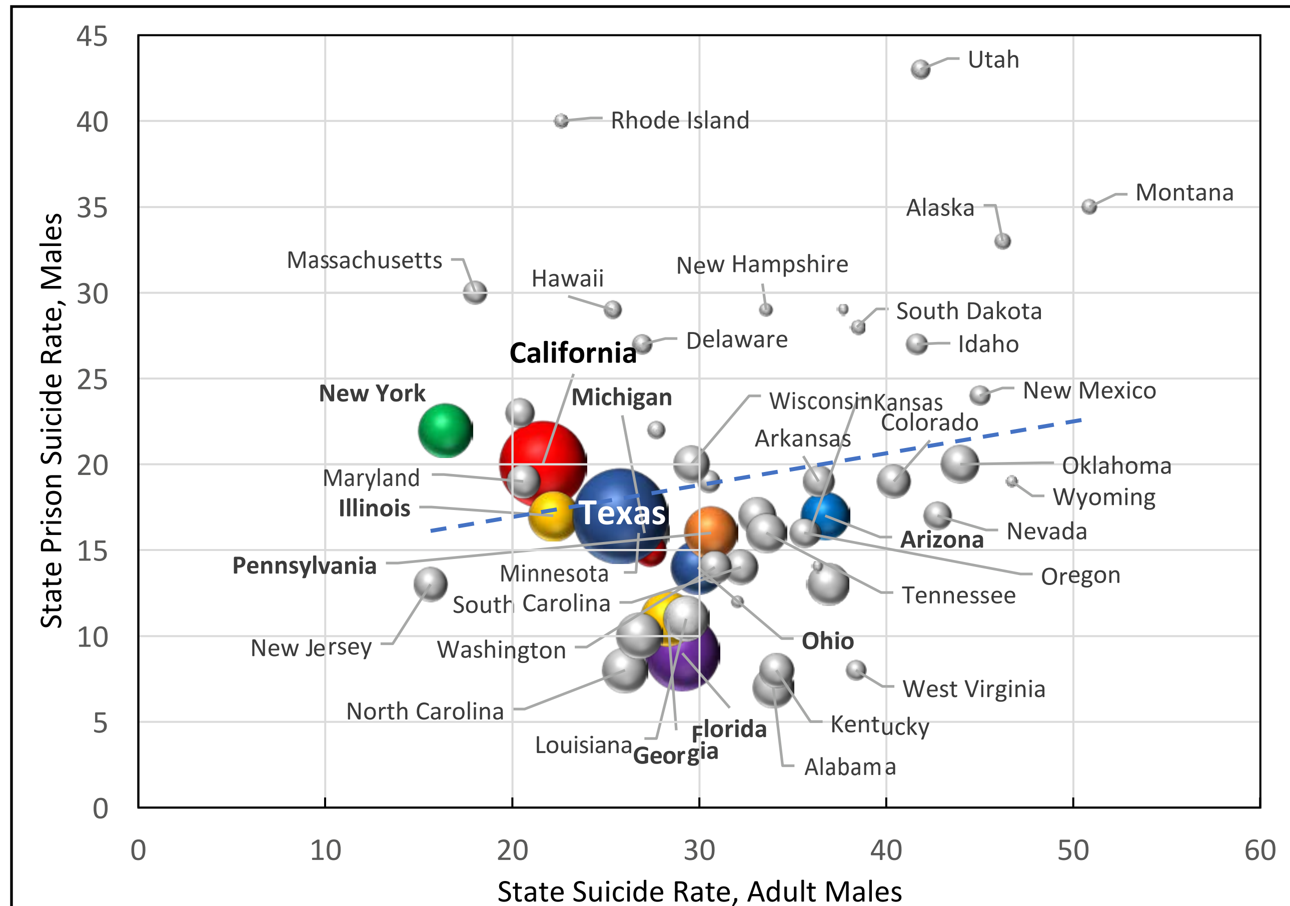


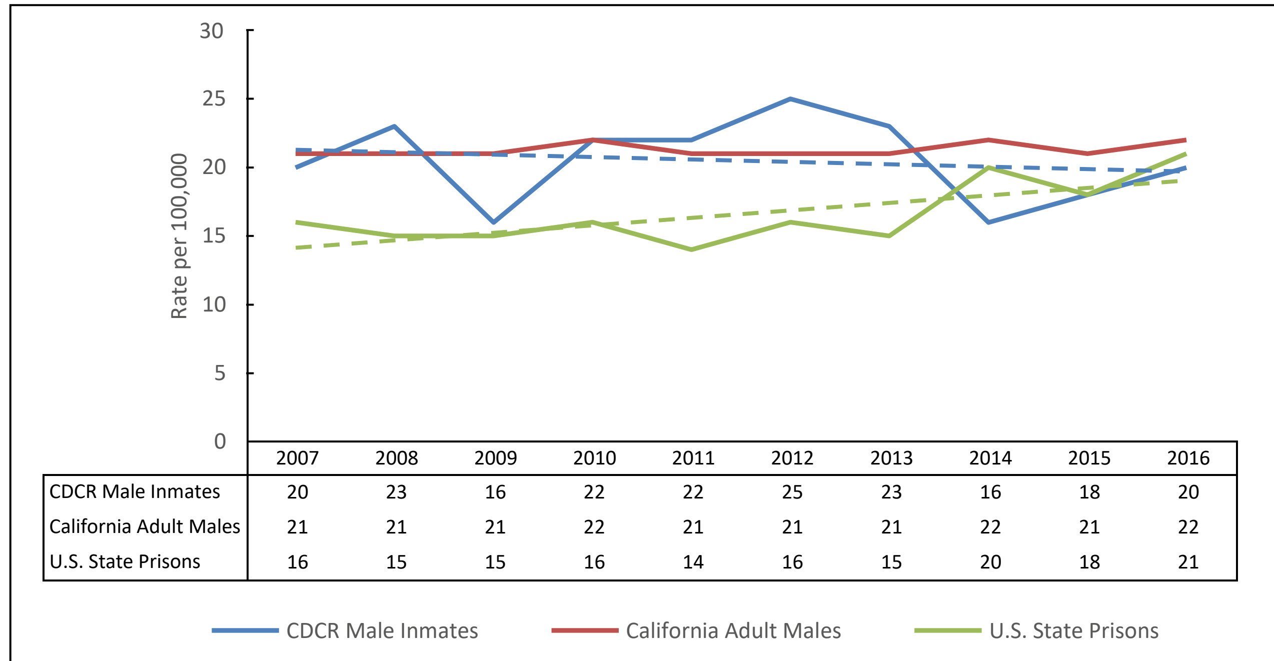
Figure 10. *State Prison Suicide Rate, State Suicide Rate, and State Prison Populations, 2016 (Males Only) (some state labels omitted)*

2. CDCR RATES VERSUS U.S. AND CALIFORNIA COMMUNITY RATES

The rate of suicide among adults in the United States rose more than 25% between 1999 and 2018, with suicide attempts rising by more than 30% from 2001 to 2018. Historically, California has had lower suicide rates than the nation as a whole in most demographic groups. Whereas adult males nationally had a suicide rate of 27.7 per 100,000 in 2016, California's rate was only 21.6. Figure 11 shows the rate of suicides among adult males within CDCR (similar to prisons nationwide, for which 95% of suicide deaths are among male inmates), California adult males, and state prison suicide rates nationally as compiled by the Bureau of Justice Statistics. While the trends in rates for California adult males and male inmates in the CDCR have been essentially flat

over the decade 2007-2016 (dotted line), the rate for prison inmates in the U.S. appears to be increasing.

Figure 11. Suicide Rates of CDCR Male Inmates, Adult Males in California, and U.S. State Prison Inmates, 2007-2016



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
CDCR Male Inmates	20	23	16	22	22	25	23	16	18	20
California Adult Males	21	21	21	22	21	21	21	22	21	22
U.S. State Prisons	16	15	15	16	14	16	15	20	18	21

E. SUMMARY REVIEW OF FINDINGS AND TRENDS

Twenty-seven inmates died by suicide within CDCR in 2016 for an annual rate of 21.0 deaths per 100,000. The rate of CDCR suicides was equal to the average rate of all U.S. state prison systems combined. Rates of suicide, particularly for males, have increased significantly over the past decade in the U.S. This trend was echoed in the nation's prison systems, and was more predominant in male prison systems. Adult males in California had higher suicide rates than male inmates within CDCR from 2014 to 2016, whereas their rates were equal to or lower than male CDCR inmates from 2010 to 2013.

A few trends are noted in the years leading to and including 2016. First, in the past twenty years the number of female inmate suicide deaths has been rising. From 1997 to 2001, there was one female inmate suicide death. From 2002 through 2006, there were seven, and from 2007 through 2011, there were two; but from 2012 through 2016, there were nine. Second, the number of Hispanic inmates who died by suicide increased in the last decade and for the first time surpassed the number of white inmates who died by suicide in 2007 and 2016. Although the suicide rates of Hispanic inmates remain well below those for white inmates, for the decade ending in

2016 they are one-third higher than the rate for adult Hispanic males in California.[28] Third, a decline in the frequency of suicides in segregated housing units continued in 2016. Fourth, inmates who are placed in the MHSDS continue to have considerably higher rates of suicide than other inmates.

The increase in female inmate suicide deaths is concerning. As noted in the 2016 California State Auditor report,[29] the closing of one female prison along with issues of domestic violence in interpersonal relationships and drug involvement may have accounted for some of the increase in suicide deaths and attempts, particularly at CIW.

The increase in Hispanic inmate suicides in the last year may signal an increased risk for this significant population. What is troubling is that this increase runs against the grain of Hispanic suicide rates in the community, which have been historically low compared to other ethnic and racial groups.

The decline in suicide deaths in 2015 and 2016 of inmates housed in segregated settings may reflect both the decreasing percentage of the inmate population housed in such settings and efforts implemented to improve safety from suicide in these settings.

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

For the 27 inmates who died by suicide in 2016 in CDCR, important individual risk factors are:

- Older age (above 55 years of age)
- History of violent commitment offense
- Housed alone at the time of fatal suicide attempt
- Non-married status
- Mental health treatment particularly at the EOP level of care
- Two or more serious suicide attempts
- Recent (12 month) psychiatric hospitalization, and
- Serious medical problems including chronic pain

From an institutional and systems standpoint, the following factors are important takeaways:

- Segregated housing continues to impart risk over and above that of the individual inmate

[28] Rate for Hispanic males in California, 2007-2016 was 10.8 per 100,000. Data from WISQARS accessed on June 23, 2020.

[29] California State Auditor. (2016). Report on the CDCR's Policies, Procedures, and Practices for Suicide Prevention and Reduction, Report No. 2016-131. State of California, Sacramento, CA.

- High security housing (Level IV institutions) aggregate a number of individual risk factors, especially when combined with significant numbers of seriously mentally ill inmates

The reasons for suicide by individuals in CDCR remain individualistic and complex, with most suicide reviewers identifying multiple precipitants (or triggers) for suicide. In 2016, suicide deaths frequently corresponded with increasing mental health symptoms, followed by conflict or losses of external supports, receipt of new charges, convictions, disciplinary actions, or added time in prison, medical illness, disability, and/or pain issues, safety concerns, drug debts, and fears of victimization, and refusal of and discontinuation of psychiatric medications or poor compliance with medications.

II. RESPONSE TO SUICIDE AND SUICIDE ATTEMPTS

A. INSTITUTIONAL REPORTING OF SELF-HARM INCIDENTS

Since 2013, the SMHP has collected data on self-harm incidents across all institutions. Prior to 2013, there was no centralized collection and aggregation of data. By the end of 2016, the system had evolved and individual institutions reported all incidents of self-harm via data entry screens on a SharePoint website. Information for each incident included intent to die, medical severity, disposition, method, and lethality.[1]

Incidents of self-harm in CDCR are reviewed by custody, nursing, and mental health staff. When a suicide attempt results in serious bodily injury,[2] the incident is additionally documented by custody staff members using CDCR Form 837 – Serious Incident Report. The Suicide Prevention Response Focus Improvement Team (SPR FIT) coordinator may discuss the event with housing officers, treating clinicians, or others to help derive the intention of the inmate and details of the incident. Monthly SPR FIT Committee meetings include discussions of trends, prevention efforts, and action steps to take in response to self-harm incidents.

Created in early 2016, a self-harm On Demand report allows local mental health leadership to monitor, track, and respond to incidents within a facility. The self-harm data is also a management tool for regional and headquarters staff, allowing them to note and focus on areas of need.

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

B. INSTITUTIONAL RESPONSE AND REPORTING OF SUICIDE DEATHS

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

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[1] See the Data Sources and Methods appendix for more information about self-harm data collection and reporting.

[2] Title 15, Sec. 3000: "Serious bodily injury (SBI) means a serious impairment of physical condition, including, but not limited to the following: loss of consciousness; concussion; bone fracture; protracted loss or impairment of function of any bodily member or organ; a wound requiring extensive suturing; and serious disfigurement."

Officers are trained in basic life support and emergency response procedures, including bringing "cut-down" kits to the scene of a suicide in progress.[3] Custody officers continue to render life saving measures until relieved by health care personnel. Officers then assist health care staff, including institutional responders and paramedics, in transporting the patient to the institution's Triage and Treatment Area (TTA) and/or ambulance. In cases in which emergency interventions are not successful, the watch commander or senior custody officer is notified of the death and in turn notifies the Warden or the AOD.[4] A CDCR Form 837 – Serious Incident Report, is completed in the event of all suicide deaths.

The institution's Chief Medical Executive, or physician designee, makes a report of the death by suicide within eight hours of the event. Medical information is provided in the CDCR Form 7229A – *Initial Inmate Death Report*. This form, once completed, is distributed internally, to the county coroner's office, and to the California Correctional Health Care System (CCHCS) Death Review Coordinator at headquarters. A separate form is completed by institutional mental health staff, CDCR Form MH-7229B – *Inmate Suicide*. The MH-7229B form is typically completed by the institutional SPR FIT Coordinator and contains information on the inmate's prior suicide attempts, the results of recent suicide risk evaluations, and whether the inmate had been considered at high risk for suicide.[5] The completed MH-7229B form is retained at the facility and a copy of the form is sent to the SMHP. Once received, SMHP support staff ensures the suicide is entered into a log, reports the event to nursing leadership, and alerts the SMHP Suicide Response Coordinator to the event. The process described above will change once the EHRS implementation has been completed.

C. REPORTING A SUICIDE TO STAKEHOLDERS

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

D. DETERMINATION OF UNKNOWN CAUSES OF DEATH.

When deaths of indeterminate cause occur in a CDCR institution, the cases are classified as "Unknown Deaths." These cases receive special attention until the cause and manner of death is determined, particularly when suicidal intent needs to be determined in a timely fashion. In the event that a death notification lists the cause of death as unknown or undetermined, the SMHP tracks the case until the death is classified. On some occasions, the cause and manner of death is

[3] MHSDS Program Guides, 2009 Revision, pages 12-10-21 to 12-10-23
[4] MHSDS Program Guides, 2009 Revision, pages 12-10-24
[5] *Id.*

classified quickly by institutional medical review. In other cases, the cause of death remains undetermined pending the receipt of autopsy or toxicology results. In such cases, the CCHCS Death Review Committee (DRC) will investigate the death and produce an initial cause of death as well as a final cause and manner of death determination. In the meantime, the SMHP communicates with the institution and with the DRC about these cases until the cause and manner of death is finalized. A member of the SMHP also sits on the DRC to ensure all unknown deaths are reviewed and, when applicable, that the possibility of suicide has been closely and objectively considered. The SMHP member of the DRC may discuss unknown or undetermined death with the headquarters SPR FIT committee, particularly when a history of suicide attempts is present or if there's some suspicion an overdose was intentional, rather than accidental.

The following guidelines for suicide reviewers were used in 2016 to determine unknown deaths:

Reviewer Guidelines for Determination of Unknown Deaths

1. Review the method of death to determine if there may have been an alternative reason (other than suicide) for the behavior (e.g., autoerotic asphyxiation, confusion and inability to form intent, purposeful intoxication, etc.).
2. If an overdose on substances, is it reasonable the substance (illicit or prescribed) may have been used in an attempt to become intoxicated? (e.g., Tylenol is not likely to be used to become intoxicated; Klonopin may be).
3. Review recent mental health history and any past history of suicide attempts/self-harm behavior (check self-harm log). Did the inmate:
    - Voice suicidal ideation (including conditional suicidal ideation)?
    - Have admissions to a MHCB unit?
    - Engage in self-harm behavior?
    - Have a history of depression or mood disturbance?
    - Have a history of psychosis?
4. Review substance abuse history.
    - What substances were used?
    - Have there been any past overdoses?
        - If yes, what did the inmate say about them at the time?
    - What substance abuse treatment was offered?
    - How recent are reports of current use?
5. Review recent custodial information.
    - Was the inmate facing criminal charges?
    - Did the inmate lose an appeal?
    - Did the inmate have any recent losses?
    - Was there any bad news readily apparent?
6. Review medical information for the presence of:
    - Chronic pain
    - Terminal illness

7. Was there a suicide note or a note that could be construed as such?

E. SELF-HARM INCIDENTS, INCLUDING SUICIDE ATTEMPTS.

Self-harm among prison inmates is a serious problem. A 2011 study collected data on self-harm from 39 state and federal prison systems in the United States. The study's authors found that "in the average prison system less than 2% of inmates per year engaged in self-injurious behavior. …"[6] Most systems surveyed reported that these types of incidents are at least somewhat disruptive to facility operations and consumed significant mental health resources.[7]

In CDCR in 2016, the self-harm data collection system reported 3,185 incidents of self-harm by 1,710 unique individuals (1.3% of CDCR population at mid-year).[8] Twenty-seven (0.9%) of reported incidents resulted in death (suicides) and 659 (21%) were considered suicide attempts (self-harm with intent to die). There were 2,206 (69%) reported incidents of non-suicidal self-injury (NSSI) and for the remaining 293 (9%) self-harm incidents the intent was classified as unknown. Table 20 presents data about self-harm incidents.

Table 20. Self-harm Incidents by Intent, Level of Care, and Medical Severity, 2016, (excluding incidents with unknown intent)

	No Intent to Die				Intent to Die				
Level of Care	No Injury	Minor	Moderate	Severe	No Injury	Minor	Moderate	Severe	Death
ACUTE	10	30	8	2	2	2	2	1	
CCCMS	79	169	54	17	23	48	39	33	7
EOP	179	438	171	38	57	112	87	31	15
GP	19	29	15	9	7	7	10	5	5
ICF	9	24	8				1	1	
MHCB	279	504	96	16	48	85	46	8	
UN		3			2	1	1		
Totals	575	1197	352	82	139	255	186	79	27

Two-hundred sixty-five suicide attempts (40%) had moderate or severe medical consequences ("serious" attempts) and comprised 8.3% of all self-harm incidents. Of the inmates who made a serious suicide attempt, 118 (45%) were at the EOP level of care, 72 (27%) were at the CCCMS level of care, 59 (22%) were among psychiatric inpatients, and the remaining 16 (6%) were either not in the MHSDS or were Reception Center inmates. Seventeen inmates made two or

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

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

[8] These figures are possibly an undercount. As the self-harm data collection system was implemented there was probably a lag in reporting as institutional staff became accustomed to the process. In addition, there may have been incidents of self-harm that individuals did not disclose or were hidden from staff.

three serious attempts during 2016. The most common methods used to attempt suicide were hanging, laceration, or ingestion.

More than two-thirds of the reported incidents of self-harm in 2016 (2,206) were classified as NSSI. Of the 2,206 such incidents, 434 (20%) were classified as moderate or severe in medical severity. The most common methods of NSSI were laceration and ingestion/insertion. Almost half of the laceration were classed as No Apparent or Minor Injury. Of the ingestion/insertion injuries, 58% were classed as No Apparent or Minor Injury. Overall, 97% of the individual inmates who self-harmed were participants in the CDCR mental health system, with two-thirds at the CCCMS or EOP level of care.

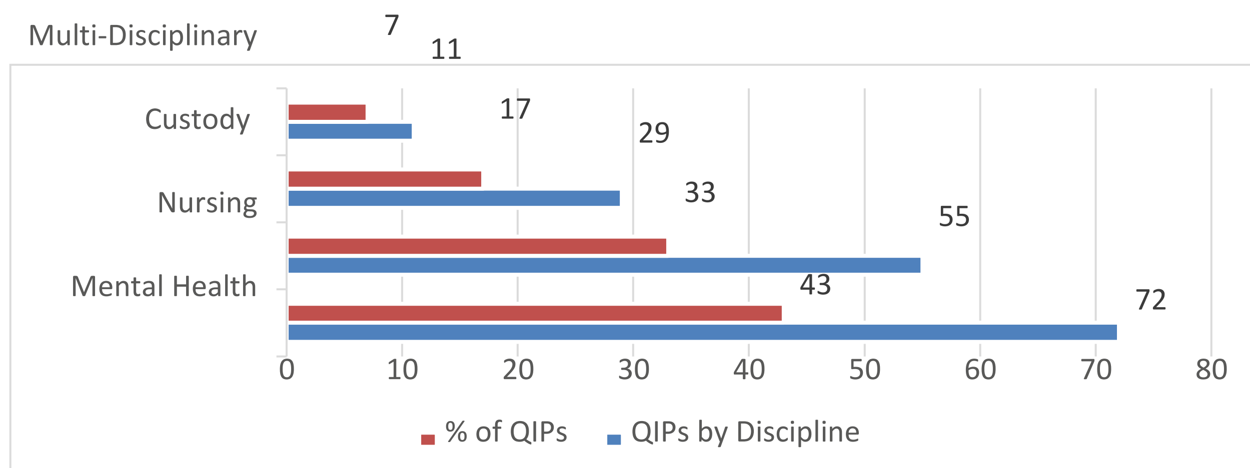
F. DETERMINATION AND TRACKING OF QUALITY IMPROVEMENT PLANS.

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

In 2016, 167 QIPs were generated for 27 Suicide Case Reviews, an average of approximately six QIPs per suicide review. Figure 12 shows the number of 2016 QIPs by discipline. The largest number of QIPs are directed to Mental Health leadership, followed by Nursing, and then Custody. A number of QIPs were directed to either multiple disciplines within a facility or to the DHCS (Headquarters) SPR FIT for a multidisciplinary, statewide improvement plan.

The specific reasons for individual QIPs are presented in the individual case review section in Section III, along with a summary of actions taken in response. The actions taken by the DHCS SPR FIT in response to QIPs are in Section IV.

Figure 12. Frequency and Percentage of QIPs Generated from Suicide Case Reviews by Discipline, 2016



G. DETERMINATION OF PREVENTABLE AND/OR FORESEEABLE SUICIDES

Reviews of whether deaths by suicide were preventable or foreseeable are completed by the CDCR's Statewide Mental Health Program's Suicide Case Review Committee (SCRC) upon completion of the Suicide Case Review teleconference on each case. The SCRC in 2016 was comprised of members of the CDCR Statewide Mental Health Program, DAI's Mental Health Compliance Team (MHCT), Nursing Executives and/or their designees, members of the CDCR Office of Legal Affairs, and medical personnel (as needed). In addition, subject matter experts from the Office of the Special Master attended Suicide Case Reviews and participated in teleconference discussions of foreseeability and preventability with the SCRC immediately following each Suicide Case Review. The OSM's experts gave opinions on the determinations made, though they were not considered "voting members" of the SCRC. The SCRC determined that in 2016, 13 of the 27 suicides were foreseeable and 22 of the 27 suicides might have been preventable had some additional information been gathered or some additional interventions undertaken.[9]

The following definitions of *foreseeable* and *preventable* were used in 2016 SCRC reviews.

Foreseeable: A "foreseeable" suicide is one which, based upon available information reasonably known, is reasonably anticipated based upon the presence of a substantial or high risk for a suicide attempt which would require reasonable clinical, custodial, or administrative intervention. Foreseeability is assessed by determining the adequacy and accuracy of how suicide risk was evaluated. Assessment of the degree of risk may be high, moderate, or low to none. In contrast to a high and immediately detectable risk, a "moderate risk" of suicide, indicates a more

[9] These definitions do not apply the legal standards for causation or deliberate indifference. For these reasons, the use of these definitions in this report should not be confused in any way with legal concepts of causation or foreseeability, nor do they determine personal or systemic culpability. Causation and foreseeability are legal terms of art, and must demonstrate that something caused or produced some effect, or had a quality of being reasonably anticipated, respectively. *Black's Law Dictionary* 249, 721 (9th ed. 2009). Determinations of personal or organizational culpability with respect to causation or foreseeability of suicide prevention are governed by the deliberate indifference standard ("a prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety….") *Farmer v. Brennan,* 511 U.S. 825, 837 (1994). This not only requires awareness "of facts from which the inference could be drawn that a substantial risk of serious harm exists," but that such an inference is also drawn. *Id.* The development, implementation, and continued improvement of the suicide prevention system is necessarily contrary to any disregard for excessive risks to an inmate's health or safety with respect to suicidality, and meets the constitutional requirement to create a reasonable measures to prevent inmate suicide as a necessary component of any correctional mental-health system. *Balla v. Idaho State Bd. Corr.,* 595 F. Supp. 1558, 1577 (D. Idaho 1984) (citing to standards of minimally adequate care for mental health in *Ruiz v. Estelle,* 503 F. Supp. 1265 (S.D. Tex.1980 *aff'd in part, rev'd in part on other grounds)*. The Eighth Amendment does not allow a deliberate-indifference finding based merely on a difference of medical opinion about appropriate treatment. *Estelle v. Gamble,* 429 U.S. 97, 107 (1976); *Cano v. Taylor*, 739 F.3d 1214 (9th Cir. 2014). Thus, "where suicidal tendencies are discovered and preventative measures taken, the question is only whether the measures taken were so inadequate as to be deliberately indifferent to the risk." *Rellegert ex rel. Rellegert v. Cape Girardeau County,* Mo., 924 F.2d 794, 796 (8th Cir. 1991).

ambiguous set of circumstances that requires significant clinical judgment based on adequate training, as well as a timely assessment, to determine the level of risk in the most appropriate manner and relevant interventions to prevent suicide.

Preventable: A "preventable" suicide is one in which it is probable that, had some additional information been gathered or some additional interventions undertaken, as required by existing policy, the suicide would not have occurred. Preventability is assessed by determining whether risk management and/or suicide prevention policies and procedures, local operating procedures and the requirements set forth in the Program Guide were followed adequately. Suicides that may have been preventable include not only cases in which additional information might have been gathered or additional interventions undertaken, but also cases involving issues with emergency response by custody and clinical staff.

However, the 2016 definitions were distilled from longer definitions previously adopted by the Special Master's experts. The definitions used by the SCRC in 2016 were shortened for the purpose of facilitating discussion of the foreseeability and preventability of a suicide. The longer definitions, as used in the Special Master's reports are::[10]

> The terms "foreseeable" and "preventable" are used in this report… They describe the adequacy and implications of CDCR suicide prevention policies and procedures, staff training and supervision, clinical judgments, and utilization of clinical and custodial alternatives to reduce the likelihood of completed suicides.
>
> The term "foreseeable" refers to those cases in which available information about an inmate indicates the presence of substantial or high risk for suicide, and requires reasonable clinical, custodial, and/or administrative intervention(s). Assessment of the degree of risk may be high, moderate, or low to none. This is an important component in determining foreseeability. In contrast to a high and immediately detectable risk, a "moderate risk" of suicide indicates a more ambiguous set of circumstances that requires significant clinical judgment based on adequate training, as well as a timely assessment, to determine the level of risk in the most appropriate manner and relevant interventions to prevent suicide. Interventions may include but are not limited to changes in clinical level of care, placement on suicide precautions or suicide watch, and changes in housing including utilization of safe cells and transfers to higher levels of care, as well as clinically appropriate treatment and management services which may include but not be limited to increased contacts/assessments by mental health professionals, medication management review and changes, other therapeutic interventions and measures, and/or changes in level of care, including short-term changes such as utilization of MHCBs and/or longer term level-of-care changes including transfer to DSH programs.

[10] Retrieved from Report on Suicides Completed in the California Department of Corrections and Rehabilitation, January 1, 2014-December 31, 2014, Kerry Hughes, M.D. Filed 03/29/2016.

> Individuals evaluated as a "low risk," "no risk," or "negligible risk" may continue to require some degree of clinical and custodial monitoring and subsequent evaluation with appropriate treatment and management by clinical staff of the potential for self-injury and/or suicidal ideation or activity.
>
> The term "preventable" refers to those cases in which the likelihood of completed suicide might have been reduced substantially had some additional information been gathered and/or some additional intervention(s) undertaken, usually as required by existing policy, reflected in the Program Guide and/or local operating procedures. Suicides that may have been preventable include not only cases in which additional information might have been gathered or additional interventions undertaken, but also cases involving issues with emergency response by custody and clinical staff. The emergency response is reviewed not only by DCHCS mental health staff but also by DCHCS medical staff as part of the death review summary process, as well as by this reviewer.

CDCR acknowledges slight differences between the Special Master's definitions and those used by the SCRC in 2016. CDCR agreed to a request by the *Coleman* plaintiffs to re-review the 2016 suicides using the Special Master's definitions. The Special Master's experts concurred with this request. After meeting and conferring with the Special Master's experts, it was agreed that all cases *not* previously found as both foreseeable and preventable by the SCRC would be reviewed again using the Special Master's definition. As twelve cases had originally been found as both foreseeable and preventable, fifteen cases remained for re-review.

Based on the differences between definitions, a re-review of the determinations of foreseeability and preventability were undertaken. The author of the 2016 Annual Report on Suicides in CDCR attended SCRs and post-call SCRC discussions of foreseeability and preventability, being a voting member of this committee. The author also compiled the original committee findings of foreseeability and preventability on each case. The author then re-reviewed all 15 cases using the Special Master's definition. In cases where the finding of foreseeability and preventability fall outside of the scope of a licensed mental health professional (this author), consultation was made with custodial, nursing, and/or psychiatry representatives as to matters of appropriate discipline practice and adherence to within-discipline policies and procedures. Special attention was given to re-evaluating each case based on the official OSM definition of foreseeable and preventable. As a result of this re-review, two additional cases were found to meet criteria for foreseeability. That is, two cases that were previously determined to be *not* foreseeable were changed to foreseeable when using the Special Master's definition. Accordingly, 15 of the 27 suicides were foreseeable and 22 of the 27 suicides might have been preventable had some additional information been gathered or some additional interventions undertaken.[11]

[11] Again, these definitions do not apply the legal standards for causation or deliberate indifference. For these reasons, the use of these definitions in this report do not constitute any admission of causation, fault, or liability.

H. AUDITS OF SUICIDE CASE REVIEW QUALITY

The DHCS Quality Management Unit audits all Suicide Case Reviews (SCR) on the presence or absence of 15 elements. Overall, in 2016, SCRs were at least 96% compliant in all but two of the 15 audit categories (Table 21). An exception was in the review of most recent Suicide Risk Evaluations (SRE) (70%). Six SCRs did not comment on *all* aspects of the most recent SREs. For example, the reviewer discussed risk factors but did not provide an analysis of the adequacy of risk formulation. The other item with a lower completion rate was in the review of emergency response (82%). Emergency response timelines were reported by nursing and custody in all SCRs, but in four cases reviewers did not specifically state that the emergency response was adequate, though this appears to be the case in each occasion.

Table 21. Results of Quality Audits, 2016 Suicide Case Review Reports

Audit Item	Present	Absent	% Present
1. Does the Executive Summary describe the means of death, the emergency response taken, and the MH LOC of the patient?	23	1	96
2. Are the sources for the SCR identified?	24	0	100
3. Are substance abuse issues reported, if applicable?	24	0	100
4. Does the Institutional Functioning section include information on institutional behavior, including disciplinary history?	24	0	100
5. Does the Mental Health History review the adequacy of mental health care and screening?	24	0	100
6. Are medical concerns discussed (e.g., chronic pain, terminal illness) or is the absence of medical conditions noted?	24	0	100
7. Is the quality of the most recent SREs (past year) reviewed, with comment on risk level, safety planning, and risk and protective factors?	14	6 (4 N/A)	70
8. Does the Suicide History section review all prior attempts, as applicable?	24	0	100
9. Are significant pre-suicide events discussed (e.g., receipt of bad news or existence of a safety concern)?	23	1	96
10. Was a risk formulation offered specific as to why the person was vulnerable to suicide?	24	0	100
11. Does the review comment on the adequacy of the emergency response?	18	4 (2 N/A)	82
12. Are all violations of policy and breaches of standards of care in mental health, medical, and nursing addressed in the reviewer's concerns, if applicable?	24	0	100
13. Were custody policies followed? If not, were violations noted in the report?	23	0 (1 N/A)	100
14. Were all concerns raised by reviewers (custody, nursing, and mental health) represented in Quality Improvement Plan recommendations?	24	0	100
15. Were the Quality Improvement Plan recommendations adequate to address the concerns? (e.g., QIP should not simply say conduct an inquiry and report findings).	23	1	96
Total	339	13	96

I. TIMELINESS OF SUICIDE CASE REVIEWS AND SUICIDE REPORTS

The process of responding to suicides, completing reviews, writing and editing reports, tracking QIP compliance, and so on, is complex. Timelines for each step in suicide response are specified in the MHSDS Program Guides, 2009 Revision. Internal deadlines have also been developed to ensure timelines for each step of the suicide response process are met. The number of days specified for each step in suicide response, for both Program Guide and internal deadlines, are shown in Table 22.

Table 22. Suicide Case Review Deadlines (calculated from date of death or for internal deadlines from previous step)

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

In reviewing the timeliness of the reporting and review process for 2016 suicides:

- Assignment of the suicide reviewer was completed within timeframe in all 27 cases.
- Review team (mental health and custody) site visits were completed within seven days in 18 of the 27 (67%) cases. Delays ranged from one to five days.
- Original suicide reports were generally completed within 25 to 40 days after the death.
- Twenty of twenty-seven drafts (74%) of suicide reports were sent to the OSM by day 40. The remaining seven cases had delays ranging from one to 19 days.
- All reports were available at the time of SCR meetings.
- Seventeen of 27 (63%) SCR meetings were held on time. Ten SCR meetings were late, with a range of seven to sixteen days.

After suicide reports are reviewed at the SCR meeting, final edits are made and a finished report is due at institutions within 60 days after the date of death. Timeline compliance becomes more difficult at this step. None of the 2016 reports were finalized and sent to institutions by the 60-day mark. Delays at this step can affect the ability of institutions and other recipients of QIPs to complete QIPs by the prescribed deadline (150 days after the death). Despite delays, in 11 cases QIP response timelines were met. QIP responses also require review and approval, with a report of QIP implementation due to the OSM by 180 days after the suicide.

The final processing of reports and QIPs after SCR meetings was the largest source of delays in 2016. Because the reports require routing through various levels of leadership and a number of departments (including separate routing through mental health, nursing and custody) delays are possible. The DHCS SPR FIT were to explore further ways to expedite review processes for implementation during the 2017 calendar year.

III. FINDINGS IN INDIVIDUAL CASE REVIEWS

A. INTRODUCTION TO INDIVIDUAL CASE REVIEWS

The presentation of suicide rates, demographic variables, custodial, and mental health characteristics of the year's suicide deaths provides a sense of data trends, comparisons between correctional systems, and so forth. These rates and numbers give us an aggregated, or *macro,* look at causes and contributors to suicide and to variables that require monitoring. The data presented in prior sections has implications for practice within CDCR and will be reviewed in the conclusion to this report.

Individual case reviews, on the other hand, represent a *micro* look at the idiosyncratic, often multi-determined reasons why an individual takes his or her own life. The sources of distress noted in the cases below range from a response to gang threats to an inmate's family to the vagaries of severe medical and mental illness to grief over the loss of lovers and loved ones. No two cases are alike.

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

B. COMMONALITIES IN INDIVIDUAL CASE REVIEWS

Tables 23 and 24 list fourteen variables that have been found to be common to many suicide deaths and that are often prioritized for review. For the purpose of confidentiality, the inmates' names in both tables have been replaced with letters from the alphabet. The columns present elements of a suicide review. The adequacy of each element as determined by the suicide case reviewer is given in each cell (if applicable). Narrative comments are given after each table.

Note that four elements (inadequacy of risk assessment, poor treatment planning, problems with custody or nursing rounds, and issues with the emergency response) usually result in a QIP being generated. Other elements of cases may or may not result in QIPs depending on the severity of deviation from policy and procedure, how directly the element is related to the suicide death, and other issues tangential to the suicide. In SCR reports, reviewers *may* comment on what was done well within an institution and *may* state areas where policy was correctly followed. However, these comments are not required as it is assumed staff members follow policy and will act

professionally in their work with inmates. In contrast, reviewers *must* identify any and all departures from policy or from standards of care by creating formal QIPs applicable to each identified issue. Reviewers may also point to clinical, medical or custodial practices that could be improved either at an institutional level or throughout all institutions; these practice suggestions can be addressed through QIP processes as well. Institutional responses to QIPs are sent to the SMHP and DAI leadership for review. If a QIP response is inadequate, the SMHP and the DAI will request clarification, additional development, or implementation of the QIP. QIPs are not considered final until approved at the headquarters level.

Table 23 lists qualitative judgments of staff performance in suicide cases. A "No" answer can mean anything from a singular error in the treatment or care of the patient to a pattern of poor care, whereas a "Yes" finding reflects actions and behaviors that were consistently professional and adequate. Column A shows that 16 out of 25 (64%) cases had problems with at least one SRE. Problems include: overall quality concerns; poor documentation of risk factors; problems with risk formulation; and failure to complete suicide risk evaluations when they were required by clinical standards or policies. Problems in documentation, risk formulation, or failure to complete a SRE can lead to errors in risk management. Thus, Column B shows 72% of applicable cases had inadequate risk management practices, including 3 cases that had been judged to have adequate risk assessment. In the 3 cases of adequate SRE without subsequent adequate risk management, other factors were present. In Case R, clinicians accurately documented the high chronic risk for suicide present in the case but did not recognize the need for a higher level of care. In Case T, suicide risk was evaluated well, but increasing somatic symptoms were perhaps understandably not viewed as a matter of suicide risk. In Case U, adequate SREs were conducted. However, a nursing staff member did not report or refer urgent issues such as medication refusal and complaints of worsening depression.

The lack of quality in SREs impacts mental health treatment planning (Table 23, Column C). If risk for suicide is underestimated or the issues that drive suicidal motivation are not recognized then treatment planning will be inadequate because of the inability to address key interventions or risk management needs. In 2016, 23 of 27 (85%) cases had treatment plans created for an inmate. Only five of the 23 cases (22%) were judged to have had adequate treatment planning. Issues included how inmate treatment refusals were addressed, the overall quality of the treatment plan, poor concordance between the plan and subsequent progress reports, the lack of adequate treatment planning at time of discharge from inpatient treatment, and decisions to discontinue psychiatric medications despite ongoing symptoms or treatment refusal.

Table 23. Findings of Individual Case Reviews, part 1

	A	B	C	D	E	F	G	H
Inmate	Suicide Risk Adequately Assessed?	Adequate Suicide Risk Management?	Adequate Treatment Plan?	Good Quality Mental Health Contacts?	Adequate Nursing Practice?	Adequate Custody Checks?	Adequate Emergency Response?	Treatment Refusal?
A	N	N	N	N	Y	Y	Y	Y[12]
B	N	N	N	N	Y	Y	Y	Y
C	N[13]	N	N/A	N/A	N[14]	Y	N	Y[15]
D	N[16]	N	N	N	Y[17]	Y	N[18]	Y[19]
E	N	N	N	N[20]	N[21]	Y	Y[22]	Y
F	Y	Y	Y	Y	N[23]	Y	N	N
G	Y	Y	Y	Y	Y[24]	Y	Y[25]	N
H	N	N	N	N	N[26]	Y	N[27]	Y
I	N	N	Y	N	N[28]	Y	Y	N[29]
J	Y[30]	Y	Y	Y	Y	Y	Y	N
K	N/A	N/A	N/A	N/A	N	Y	N[31]	N
L	N[32]	N	N[33]	N[34]	Y	Y	N	Y
M	N[35]	N	N	N	N	Y	N[36]	N
N	N[37]	N	N[38]	N	Y	N[39]	N	Y
O	N[40]	N[41]	N[42]	Y/N[43]	N[44]	N	N	N
P	Y	Y[45]	N	N	N[46]	Y	N	N
Q	N	N	N	N	Y	Y	Y	Y
R	Y	N	N	Y	Y	Y	N	Y
S	N/A	N/A	N/A	N/A	N	Y	N	N/A
T	Y	N[47]	N[48]	N[49]	Y	Y	Y	Y[50]
U	Y	N[51]	N/A	Y	N	Y	N	N/A
V	N	N	N	Y[52]	N	N[53]	N[54]	N/A
W	N	N	N	N	N	Y	N	N
X	N	N	N	N	N	Y	N	N
Y	N	Y	N	N	N	Y	N	N
Z	Y	Y	N	Y	N	Y	Y	Y[55]
AA	Y	Y	Y	Y	Y	N[56]	Y	Y[57]
Total 'N' (Pct)	**16 (64)**	**18 (72)**	**18 (75)**	**15.5 (65)**	**16 (59)**	**4 (15)**	**17 (63)**	**13 (Yes) (54)**

[12] Off psychiatric medications in last 6-7 months pre-suicide.
[13] Suicide risk was assessed on an urgent basis as the inmate was seen "shaking, crying, distraught." Though the risk assessment completed did not generate a concern, risk formulation appeared poor and no risk management plan was developed.
[14] Based on a failure to notify 911.
[15] Inmate declined placement in CCCMS.
[16] Absence of evaluation despite treatment goal to monitor suicidal ideation
[17] A faulty AED was noted in the review, but all other nursing practice reviewed was adequate
[18] The cut-down kit was not brought to the scene as required by policy
[19] Frequent medication refusal
[20] A number of contacts in the MHCB and at discharge did not use an interpreter
[21] Failure to refer following refusal of PC 2602 medications
[22] Though an RN administered an IV prior to a physician's order, the act was done in an attempt to save the patient's life

Eight cases (33% of applicable cases) were rated as having good quality mental health contacts (Column D). In these cases the majority of clinical contacts were positive and in line with professional expectations. For the 16 cases (65%) without good quality contacts, at least one clinical contact was substandard, such as when poor documentation was present or when patient treatment refusals were not addressed. In one case, inconsistent interpreter use was noted, and in another, refusals were not considered within higher level of care considerations. The quality of mental health contacts was rated as not applicable in three cases where there were few or no evaluations beyond mental health screening.

Aspects of nursing practice (Column E) considered in suicide case reviews include nurse and Licensed Psychiatric Technician (LPT) rounds and/or nursing observations when required for inmates in segregated housing settings, inpatient settings, and while a patient is on suicide watch or precautions either in alternative housing or in MHCB. Additionally, nursing documentation and knowledge of procedure during emergency response efforts are considered in reviews. Typically,

[23] Four nursing QIPs noted
[24] One deviation in emergency response was noted, though the act was done in an attempt to save the patient's life
[25] *ibid*
[26] Based on a delay by nursing in activating 911 at the time of discovery
[27] *ibid*
[28] Based on quality of PT rounds
[29] Some notation of group refusal found, though described as cooperative and participatory in most documentation.
[30] Case J was assessed many times. The majority of suicide risk evaluations concluded high chronic risk, which is appropriate, and no QIPs were written for the quality of completed SREs.
[31] Based on the lack of a full cut-down kit being brought to the scene after discovery
[32] QIP written on last SRE
[33] QIP written on last treatment plan
[34] Mostly refused contacts
[35] A lack of a discharge SRE was noted 4-5 months before the death
[36] Based on nursing concerns, including gap between initiation of CPR and providing oxygen and applying AED
[37] At MHCB discharge
[38] QIP written on repeated refusals not being addressed in treatment plan
[39] Found in rigor mortis despite Guard 1 checks
[40] Upon inpatient discharge
[41] Allowed to purchase razors, although no ability to restrict razors in setting noted.
[42] Related to discharge plan from APP
[43] Adequate contacts noted upon arrival to EOP; poor contacts noted at APP
[44] Related to emergency response
[45] Assumed at low acute risk
[46] Based on nursing QIP for not assessing an inmate when referring to mental health
[47] A pattern of increasing distress over somatic symptoms did not lead to risk management changes
[48] Based on psychiatric medication discontinuation
[49] Based on poor quality psychiatry documentation and primarily cell-side contacts
[50] Commonly declined groups and confidential contacts
[51] Nursing/PT staff did not refer for an urgent mental health evaluation or note medication refusal
[52] High frequency of contacts
[53] Based on window covering obstructing view
[54] Based on possible delay in detecting the inmate's suicide in progress due to obstructed view
[55] Inconsistent refusals of medication
[56] Found in rigor mortis despite two checks in the 90 minutes before discovery
[57] At times

problems in any of these areas will yield a mention of concern and QIPs directed to the CCHCS DRC for corrective or proactive action. In 2016, eleven cases (41%) had no nursing QIPs or the concerns noted were judged as minor or non-contributory. In 16 cases (59%), a failure, or delay, in calling 911 was noted in several cases, along with other emergency response problems. In several cases, a failure to notify mental health staff as required by policy were found, ranging from a failure to notify psychiatry of involuntary medication refusal to a failure to notify mental health about a refusal to participate in daily rounds. Other concerns were noted about the quality of LPT rounds and, in some cases, a lack of nursing assessment before referring a patient to mental health.

Custody checks (Column F) occur in all institutions for all inmates. For example, custody conducts "counts" several times each day and is mandated by policy to conduct one welfare check during each 30-minute period while an inmate is housed in ASU. In four of 27 cases (15%) custody checks were rated as inadequate and not conducted per policy. Three inmates were found in a state of rigor mortis despite documentation of earlier security and wellness checks. In the fourth case, an inmate in ASU was allowed to maintain a window covering which at least partially obstructed officer's view during custody checks.

The response of custody, nursing, and health care staff is considered in ratings of emergency response (Column G). In 17 cases (63%), the majority of concerns related to delays in calling 911 and issues with bringing incomplete cut-down kits to the incident site. In two cases, staff performed heroic acts that did not follow policy (e.g., not waiting to put on personal protective gear). In 1 case, an issue with timely AED and oxygen placement following the initiation of CPR was noted. In another case, delays in emergency response were noted as the inmate could not be seen (due to a window covering). As discussed below, significant practical and policy work was completed in 2016 which clarified that any staff member can call 911. In ten cases (37%), no issues with emergency response were noted

Issues of patient refusal to participate in specific evaluations, interventions, such as, prescribed psychiatric medications, or of offered treatment were cited in 13 of 24 applicable cases (54%). In these cases, a number of individual reasons for refusal were noted, ranging from inmates who refused to participate in any mental health programming, to varying periods of medication refusal, to safety concerns and associated refusal of leaving one's cell. In a number of these cases, reviewers recommended QIPs to address patient refusal and to promote treatment planning when a patient refuses to come out of cell for confidential contacts. The problem of patients not wanting to be seen talking to mental health, yet needing these services, is a difficult dilemma for clinicians and their programs. In other cases, refusal of medications or groups due to mental illness symptoms were addressed as QIPs regarding staff communication and the need to consider a higher level of care.

Table 24 lists five additional variables commonly mentioned in SCRs and that are noted in the case reviews in Appendix A.

Rigor mortis (Table 24, Column A) is a condition of the body postmortem that indicates a person has been deceased for at least four hours.[58] In 2016, seven individual inmates were reported in a state of rigor mortis at discovery. By comparison, four cases were found in rigor mortis in 2014 and only one in 2015. This led to several QIPs during the year.

The method used for each suicide is listed in Table 24, Column B. As in prior years and in other prison systems, hanging and/or asphyxiation is the most common method of suicide used by inmates. In 2016, 22 of the 27 suicide deaths (82%) were by asphyxiation or hanging. Two deaths were by exsanguination secondary to laceration, two by jumping, and one intentional poisoning. Hanging is a highly accessible means for inmates, is highly lethal, and is difficult for an individual to abort once started.[59] Almost three-quarters of inmates who died by suicide in 2016 had at least one prior suicide attempt as shown in Table 24, Column C.

In 2016, reviewers judged that more intensive risk management was needed in 12 cases (44%) (Table 24, Column D). Of these cases, a need for a higher level of care were related to issues such as refusing mental health programming or medications and, most commonly, exhibiting signs of psychiatric deterioration. A few cases were more idiopathic. For instance, Inmate W made suicidal statements on several occasions and was referred for inpatient once which was later rescinded. In another case, Inmate U was about to be transferred to a triage area but died by hanging prior to being escorted to the area.

Housing status and whether a cellmate was present or not at the time of the death is shown in Column E. In 23 of 27 cases (85%), the deceased had either been in a single cell at the time of the suicide or the inmate was housed alone in a two-person cell. There were four cases in which a cellmate was either present or assigned at the time of death. In two cases the cellmate was elsewhere at the time of the suicide. In another, the cellmate was present but asleep. In the final instance, the inmate had placed coverings around the cell that blocked the view of others in a multi-person cell, which cellmates assumed was for privacy purposes (e.g., to use a bathroom or change clothing).

[58] https://en.wikipedia.org/wiki/Rigor_mortis
[59] https://www.hsph.harvard.edu/means-matter/means-matter/case-fatality/

Table 24. Findings of Individual Case Reviews, part 2

	A	B	C	D	E
Inmate	Presence of Rigor Mortis?	Method Used	No. of Prior Attempts	Higher LOC Indicated?	Housing Status/ Cellmate Present?
A	N	Hanging	4	Y	SNY/N
B	Y	Hanging	11	Y	EOP/Y[60]
C	N	Asphyxiation	1[61]	Y[62]	ML/Y[63]
D	N	Hanging	3[64]	Y[65]	ML/Y
E	N	Hanging	5[66]	Y	ML EOP/N
F	N	Hanging	2	N	ML EOP/Y[67]
G	N	Hanging	2	N	ML EOP/N
H	N	Overdose[68]	2	Y	ML EOP/N
I	N	Hanging	2[69]	N	PSU/N
J	N	Hanging	6[70]	N	ML EOP/N
K	N	Hanging	0	N	ASU/N
L	N	Hanging	1	N	ML/N
M	N	Hanging	2	N	ASU/N
N	Y	Asphyxiation	0	N	STRH/N
O	Y	Exsanguination	18	N	EOP GP/N
P	N	Hanging	0	N	ASU/N
Q	N	Hanging	3-4	Y	STRH/N
R	N	Hanging	6	Y	EOP SCU/N
S	N	Jumping	0	N	ML/N
T	Y	Hanging	3	Y	ML EOP/N
U	N	Hanging	0	Y[71]	ASU/N
V	N	Hanging	3	Y	ASU/N
W	N	Jumping/ Starvation	5	Y	ML EOP/N
X	Y	Asphyxiation	7	N	SNY/N
Y	Y	Exsanguination	0	N	SNY/N
Z	N	Asphyxiation	0	N	SHU/N
AA	Y	Asphyxiation	1	N	ML EOP/N

[60] Inmate B's cellmate was asleep at the time of hanging
[61] The attempt was reported to have occurred in 2014 while Inmate C was in the CDCR but was interrupted by a cellmate. There were no records of this incident in medical or custodial files.
[62] Inmate C refused to be placed in MHSDS and was not seen as requiring involuntary MH treatment.
[63] Cellmate was out of the cell/out to yard at the time of the incident
[64] An additional attempt was interrupted before the attempt occurred
[65] Based on medication refusal; the patient denied suicidal intent at most recent interviews.
[66] A sixth attempt was noted but not corroborated.
[67] Inmate F's cellmate returned to the cell to find him hanging
[68] Tricyclic antidepressants not prescribed to the inmate were used for this overdose
[69] At times, Inmate I denied intent to die in his first attempt
[70] Inmate J had several acts with unclear intention but with some medical injury (e.g., sutures needed) or with staff interruption (e.g., found in possession of a noose or hoarded pills). The rating of six attempts here are those that are most likely to have had intent. Inmate J NSSI by cutting "about 16 times."
[71] An evaluation was to be held in the TTA; transfer to the TTA was pending at the time of death

IV. SUICIDE PREVENTION INITIATIVES DURING 2016

A. INTRODUCTION

The development and implementation of QIPs is one part of the CDCR's comprehensive suicide prevention strategy. Suicide prevention plans occur too late for the deceased, but seek to correct problems and offer training and prevention plans that may contribute to decreasing the risk of suicide in the CDCR.

There are many additional aspects of a comprehensive suicide prevention strategy.[72] Such a strategy includes ensuring a solid screening process occurs at various points of incarceration, establishing referral processes, insuring written procedures and policies for suicide prevention are maintained and updated as needed, and there are effective methods for evaluating proof of practice of existing and/or on-going suicide prevention programs and initiatives. A comprehensive suicide prevention program must have a commitment to staff training, with the provision of on-going training on suicide risk detection and referral for all correctional employees. In addition, training about the complexities and specifics of SRE, risk management, and intervention must be provided to mental health staff. Comprehensive programs also assure ready access to mental health services for inmates who request and/or are referred for these services, along with a variety of care options and levels. Suicide prevention materials must be readily provided for inmates and for those who interact with inmates (e.g., family members, work supervisors). Communication between disciplines and shifts must be prioritized, particularly regarding high risk inmates.[73] Programs can also include population-based initiatives, including efforts to provide mental health services to all inmates and create a system-wide surveillance of self-harm to assist in planning and intervention.

CDCR has worked diligently to ensure that a comprehensive suicide prevention program is in place. This effort has been shared with and reviewed by the OSM and the OSM's experts for many years. The information provided in the next section reviews advancements in CDCR's suicide prevention program during the 2016 calendar year.

[72] Hayes, L.M. (2013). Suicide prevention in correctional settings: Reflections and next steps. *International Journal of Law and Psychiatry 36*, 188-194. See also Canning, R.D., and Dvoskin, J.A. (2016). Preventing suicide in detention and correctional facilities. In Wooldredge, J. and Smith, P. Eds. *The Oxford Handbook of Prisons and Imprisonment*. Oxford University Press: New York, NY. https://dx.doi.org/10.1093/oxfordhb/9780199948154.013.25
[73] *Preventing Suicide in Jails and Prisons*, World Health Organization, 2007

B. SUICIDE PREVENTION INITIATIVES DEVELOPED/ IMPLEMENTED DURING THE REPORTING YEAR

Numerous initiatives were either under development at the close of 2016 or had been implemented during the year. Each initiative is described below with notation of the status of the project on December 31, 2016.

- **New Five-Day Follow-Up Form**: Research in the community has shown that the period immediately after discharge from inpatient psychiatric hospitalization is an extremely high risk time.[74] The Five-Day Follow-Up Form (CDCR MH-7230-B) is used to ensure clinical contacts with inmates returning from inpatient settings in cases when they were admitted as a danger to self. The new form contains several structured, suicide-specific questions to ensure clinicians and psychiatric technicians ask about suicidal thoughts, desire, and intention. The revised form also requires mental health clinicians to complete a safety/treatment plan with the patient. The new form was approved by the end of 2015. Unions representing the employees affected were noticed. The form was readied for distribution and materials for Training for Trainers were prepared and delivered by webinar in January, February, and May, 2016. Training for Trainers materials were co-taught by mental health and nursing staff. The form was released for use on June 10, 2016.

- **ASU Post-Placement Screening Questionnaire**: For many years the department used the Reception Center mental health screening questionnaire (commonly called the "31-Item Screener") to screen for mental health needs among non-MHSDS inmates re-housed into ASU. Recognizing that this measure may not have been an effective tool to detect new ASU inmates with elevated distress and suicide risk, the SMHP undertook a project to determine if a better screening tool could be developed. The result was a proposal to use a combination of two standardized measures available in the public domain to measure heightened distress and suicide ideation and recent suicide-related behavior.

  The new ASU Post-Placement Screening Questionnaire is a brief measure (12 to 13 items) administered by a LPTs within 72 hours of an inmate being rehoused in ASU. The screening questionnaire has set scoring rules that, once scored, guide the psychiatric technician regarding whether a referral to mental health is indicated, and if so, to what degree of urgency. Inmates who refuse the screen are to be referred to mental health on an urgent (24-hour) basis. The new form (CDCR MH-7790) was routed and approved by all required committees by the end of 2015. Involved unions were noticed. The form was

[74] See e.g.: Qin, P., & Nordentoft, M. (2005). Suicide risk in relation to psychiatric hospitalization. *Archives of General Psychiatry 62*; 427. Hunt, I., Kapur, N., Webb, R., Robinson, J., Burns, J., Shaw, J., and Appleby, L. (2008). Suicide in recently discharged psychiatric patients: a case-control study. *Psychological Medicine 39*(3), 443-449. https://dx.doi.org/10.1017/s0033291708003644; Bickley, H., Hunt, I., Windfuhr, K., Shaw, J., Appleby, L., and Kapur, N. (2013). Suicide within two weeks of discharge from psychiatric inpatient care: a case-control study. *Psychiatric services 64*(7), 653 659. https://dx.doi.org/10.1176/appi.ps.201200026

readied for distribution and trainings (co-taught by mental health and nursing staff) were prepared, again via the Training for Trainers format. The form was released for use on June 10, 2016.

- **Provision of Beds for Alternative Housing Cells**: Tours and audits of suicide prevention practices at institutions in 2014 and 2015 noted the lack of a physical bed in certain alternative housing cells. These cells are used with patients who are awaiting transfer to a MHCB and patients in these cells are typically on Suicide Watch (direct, one-on-one observation). Without available beds, patients were placed temporarily in cells with a mattress placed directly on the floor. As this could be experienced as punitive and could discourage inmates from asking for help during crises times, CDCR agreed to ensure beds were placed in all alternative housing cells. A bed (Norix Stack-a-Bunk) was selected and purchased for this purpose. Beds were delivered to all institutions in need of them by the end of 2015. Directives for the use of these beds was made to all institutions. The implementation and audit of the use of these beds began in 2016.

- **Updated Initial SRE Mentoring Training for Trainers**: The SRE Mentoring training slides and webinar were updated to place more emphasis on mentoring safety/treatment planning, to develop more of an understanding of the interplay of chronic and acute risk factors in cases, to further explore the role of the mentor in assessing and expanding clinician competencies around suicide risk evaluation, and to further teach the Quality of Care Tool for SRE Mentors. The revised training was offered on several occasions in 2015 and 2016 and was well received. Additional revisions were made to the presentation in November 2016.

- **Development of SRE Mentoring 'Booster' Training**: The requirement for an annual "booster" training was created and a presentation developed for current mentors. The booster training was developed as an advanced course in SRE mentoring, with a focus on risk assessment competencies, methods for competency assessment, and ways to enhance SRE skills in clinicians at all levels of proficiency. The training was developed at the end of 2015 and delivered in 2016, beginning with a live mentoring booster training attended live by 50 current mentors in November 2016. Mentors who could not attend the live training were provided the course by webinar in December 2016.

- **Clarification of SRE Mentoring Requirements**: A memorandum dated March 15, 2016, was delivered to all CEOs and CMHs to notify institutions of the revised requirements for SRE Mentoring. Clinicians working in Mental Health Crisis Bed settings were required to complete mentoring annually, whereas other clinicians were maintained on an every-other-year schedule. Clinicians were also notified of two SRE audits; one conducted by institutional program supervisors and one by headquarters staff. Institutional mental health clinician were to be audited on a completed SRE at least once every six months. Processes

for corrective action when audit criteria are not met were described as well. Finally, the memorandum notes the expectation that SRE Mentors would receive annual 'booster' training by headquarters webinar. Institutional program supervisors began auditing SREs using the Chart Audit Tool, reporting results through the Quality Management Portal. Headquarters audits have been modified to solely focus on inter-rater reliability checks on institutional audits.

- **Clarification of SRE Training**: A memorandum was released on March 24, 2016, to clarify requirements for the seven-hour Suicide Risk Evaluation Training. The training is a seven-hour Continuing Medical Education (CME) approved course that is provided to all CDCR mental health clinicians within 180 days of hire and every two years thereafter. The SMHP updates the seven-hour SRE class annually. The updated class is provided to clinicians from institutions in each region as a training-for-trainers, with these trainers then teaching the class at their home institutions. This process of annual updates in training-for-trainers also ensures trainers are adherent to the content and focus of the course. The memorandum additionally clarified that the requirement extends to clinicians hired through a registry and psychiatrists who practice by telepsychiatry. Training-for-trainers sessions were held in October 2015 for the 2016 training year and in November 2016 for the 2017 training year.

- **Clarification of SPR FIT Coordinator Duties**: An August 14, 2015, memorandum instructed all institutions to designate one Senior Psychologist, Specialist, to the role of institutional SPR FIT Coordinator, tasked with leading suicide prevention efforts at each facility. The role also includes coordination of mental health assessments/evaluations and mental health training/orientation. A duty statement for the position was attached to the memorandum. The memorandum and clarification of duties was designed to ensure all institutions had dedicated resources within mental health programs to coordinate suicide prevention efforts. The memorandum is found in Appendix VII.

- **Suicide Profiles for Transfers**: A memorandum released on March 3, 2016, instructed institutions to continue to print suicide history information for inclusion in transfer packets of inmates transferring between institutions. This was necessary during the gradual phasing in of the Electronic Health Record System (EHRS). As the phase-in of EHRS did not occur at all institutions until the end of 2017, institutions were mandated to continue to include suicide profiles printed from the Mental Health Tracking System (MHTS) in transfer packets.

- **Documentation**: A memorandum was sent to CMHs and CEOs on December 14, 2016, clarifying the requirements in EHRS that differed from the MHTS. Specifically, in the EHRS, the Suicide Risk Assessment and Self-Harm Evaluation (SRASHE) was considered

to be a free-standing document, rather than an ad-hoc assessment that would require an accompanying progress note.

- **Over-the-Counter (OTC) Medications**: A memorandum issued by CCHCS on September 7, 2016, gave expectations that psychiatrists and primary mental health clinicians would work with physicians to restrict OTC medications to inmates when necessary. Access to OTC was noted to be an option that could be restricted if the inmate could not safely or responsibly use these medications, or in situations where an inmate has a known risk of intentional overdose and could purchase OTC medications for such a purpose (e.g., Tylenol). Patients with a high risk of abusing OTCs or misunderstanding their use (e.g., Intellectual Disability and Dementia) also could have OTC restrictions placed for their safety.

- **Updated Cadet Training**: An update to training provided at the cadet training academy on the MHSDS and on Suicide Prevention was drafted and reviewed in 2015. Training-for-trainers on the updated version was delivered on November 30, 2015. The OSM's suicide expert Lindsay Hayes attended the updated training as it was being given to a cadet class and provided feedback on the training in December 2015. The training and accompanying lesson plans underwent revisions in light of Mr. Hayes' feedback at the end of 2015. This revised training was distributed on May 11, 2016.

- **Updated In-Service Training Class**: An updated two-hour class given to all CDCR staff on Suicide Prevention and Crisis Management (version 3.0) was released in May 2016. A training-for-trainers was developed and delivered at a number of institutions and regional locations by the date of the release of the training, with other training completed thereafter.

- **Safety Planning Training**: In response to reviews by regional staff, headquarters staff, and Lindsay Hayes, training entitled, "Safety/Treatment Planning for Suicide Risk Assessment" was created in 2014. The class was updated in 2015 with a slightly revised title, "Safety/Treatment Planning within Suicide Risk Assessment and Management." The class included new content focusing on the on-going role of safety planning in managing suicide risk within the inmate population. CME units are available to clinicians who take this course; attendance is mandatory for all clinical staff. The revised class was provided on multiple occasions in 2016, with training then planned to occur every six months in order to accommodate newly-hired clinical staff. The role of safety/treatment planning was also incorporated into other updated trainings in 2016 (e.g., in suicide prevention videoconferences, the seven-hour SRE course, and all SRE Mentoring classes).

- **Complex Diagnostic Cases**: Training, entitled, "Differential Diagnosis in Complex Mental Health Cases" was developed to assist treatment teams in considering cases

involving self-harm. Clinicians and clinical teams can err in underestimating or overestimating risk for suicide,[75] particularly when cases present with complex diagnostic presentations and when patients engage in negative [76] or positive impression management. [77] The under- or over-reporting of symptoms of distress and the within-patient variances in reporting suicidal ideation or desire for death can cause considerable clinical confusion. For example, a patient who reports self-harm behavior due to “needing to get off the yard” can be seen as manipulative and may represent little else in the case. However, for a more vulnerable patient the pressure exerted by other inmates can be a source of considerable distress and may indeed give rise to a desire to die. An approved version of this training was presented to mental health clinicians on multiple occasions in 2016.

- **Board of Prison Hearings (BPH) Commissioners**: Two informational talks were developed for the BPH. The first occurred in October 2015, with commissioners briefed on the topic of how mental health clinicians evaluate RVRs and how depression, psychosis, and other mental health conditions can influence behavior temporarily or when untreated. The second training was scheduled with the intention of exploring perceptions about mental illness and future risk of violence. An area of focus for the second training was on encouraging treatment participation and treatment compliance as a way of decreasing violence risk. This second training occurred in January 2016.

- **Columbia Suicide Severity Rating Scale (C-SSRS) Training and Inclusion in the EHRS**: The C-SSRS is a well-established, empirically established, standardized suicide risk measure[78] that has been incorporated as part of all SREs in the CDCR’s Electronic Health Record System (EHRS) beginning in 2016. The primary author of the measure, Kelly Posner, Ph.D., of Columbia University, was invited to present on the measure in 2015. She accepted and presented the C-SSRS to a group of 50 CDCR clinician-trainers from over 30 institutions in October 2015. The training was video-recorded and was just under two hours long. A group of handouts and a brief PowerPoint slideshow was constructed to aide clinicians in becoming familiar with administering the C-SSRS. The C-SSRS assists mental health clinicians by providing a structured way to inquire about suicidal history, to evaluate the intensity of suicidal ideation, and to assess the potential

[75] Horon, McManus, Schmollinger, Barr, & Jimenez (2013). A study of the use and interpretation of standardized suicide risk assessment measures within a psychiatrically hospitalized correctional population. *Suicide and Life-Threatening Behavior,* 43, 17-38.
[76] Sullivan & King (2010). Detecting faked psychopathology: A comparison of two tests to detect malingered psychopathology using a simulation design. *Psychiatry Research 176*. 75-81.
[77] Bagby & Marshall (2003). Positive impression management and its influence on the Revised NEO Personality Inventory: A comparison of analog and differential preference group designs. *Psychological Assessment 15*. 333-339.
[78] Posner, Brown, Stanley, (2011). The Columbia-Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry 168*. 1266-1277.

and actual lethality of suicide attempts. The recorded video presentation by Dr. Posner, handouts and other materials were distributed in February 2016. Clinician trainers received two hours of approved CME credit on the C-SSRS based on the recorded DVD presentation. All institutions that received the EHRS in 2016 held C-SSRS training prior to their respective EHRS start dates.

- **Evaluating Self-Harm Incidents Training:** Webinars were held for SPR FIT Coordinators and mental health clinicians in March 2016 on the concepts related to making determinations regarding whether an act of self-harm was or was not a suicide attempt. The training covers evaluating motivations for suicide, suicidal intention, possible lethality of self-harm behavior, and other components to making determinations of self-harm.

- **On Demand Self-Harm Report**: Early in 2016, the On Demand reporting system began to include a report on self-harm. This report includes details provided by SPR FIT coordinators as part of their reporting of incidents of self-harm. In addition other pertinent demographic, clinical, and historic information about the events and the individual inmates is included to aide in tracking self-harm trends and patterns as well as provide assistance to clinicians as they work with inmates who self-harm. The report is also useful for institutional programs as a quality management tool.

- **Collaborative Assessment and Management of Suicidality (CAMS) Training**: The CDCR began discussions with David Jobes, Ph.D., a clinical researcher at the Catholic University of America (Washington, D.C.) during 2015. Discussions centered on training a group of clinicians within CDCR on CAMS. Dr. Jobes agreed to present on the principles of CAMS, a treatment intervention specific to working with suicidal patients, during a statewide suicide prevention videoconference in October 2015. CAMS represents a promising intervention for mental health clinicians within the CDCR, as the therapy has wide community use, good empirical backing, [79] good support with other established treatments,[80] and flexibility to be used in a variety of settings. CAMS may be effective in targeting patients with high chronic risk for suicide, patients on high risk lists or in high risk programs, and patients with recent contemplation of, or engagement in, self-harm with intent to die. By the end of 2015, a contract to train an initial group of 50 clinicians in CAMS was in process. A list of clinicians was identified at all institutions with mental health missions to be the first group to receive and use CAMS. CAMS note templates were under preparation for inclusion in the EHRS. Training began in January 2016 and

[79] Jobes, Wong, Conrad, Drozd, & Neal-Walden (2005). The Collaborative Assessment and Management of Suicidality versus treatment as usual: A retrospective study with suicidal outpatients. *Suicide and Life-Threatening Behavior 25*, 483-497.

[80] Andreasson, et al. (2016). Effectiveness of Dialectical Behavior Therapy versus Collaborative Assessment and Management of Suicidality for reduction of self-harm in adults with borderline personality disorder and traits. *Depression and Anxiety 33*, 520-530.

continued until July 2016. CAMS trainings occurred by using on-line training modules and a series of follow-up consultation calls with CAMS experts. Feedback from the first 50 clinicians trained in the intervention led to discussions of the best way to select clinicians by primary worksite, with a second round of clinician training anticipated for early 2017.

- **On-Going Training through Monthly Suicide Prevention Videoconferences**: Monthly suicide prevention videoconferences continue to occur. Institutional SPR FIT teams, SRE mentors, and other institutional staff and mental health clinicians participate in the videoconference by viewing presentations in conference rooms using video conferencing connections or, when unable to attend in this manner, through phone lines. In 2016, the suicide prevention videoconference was used to review suicides and trends in suicides within the department, to brief staff on new or revised policies and procedures, to notify staff of suicide prevention trainings and resources (e.g., membership in the American Association of Suicidology), to discuss findings from Lindsay Hayes' tours of institutions, and to provide didactic trainings. Trainings covered during 2016 included:
  - Key concepts and theories of suicidologists Edwin Schneidman and David Jobes
  - Understanding DDP and making referrals to DDP for additional supports and services[81]
  - Ensuring continuity in safety plans over time, across clinicians, and during transfers between institutions and updating safety plans as needed
  - Consideration of multiple attempt status in chronic risk formulation[82]
  - Understanding Fluid Vulnerability Theory[83] in multiple attempters
  - Examples of accurate chronic risk formulation versus poor chronic risk formulation and anchors for judgements of chronic risk
  - Complicated bereavement and suicidal thought
  - Formulation of acute risk for suicide, including an understanding of baseline risk for suicide and the 'suicidal mode' or patterns of behavior and thought when suicide crises emerge
  - Recommendations for clinicians on improving safety planning practice
  - Feedback from the first CAMS cohort on the use of the intervention within CDCR
  - A clinical vignette and presentation on maintaining continuity of care in risk management approaches, from reception center to inpatient discharge to outpatient
  - A review of how to restrict OTC medications when indicated
  - A review of a community study in the likelihood of survival after a suicide attempt (that is, how many went on to make a second attempt or died by suicide)

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[81] The process of referring patients for evaluation within the Developmental Disabilities Program (DDP) was presented at the videoconference in March, 2016 as a response to a QIP on a suicide case.

[82] A series on understanding chronic risk formulation was offered from March through May, 2016

[83] Rudd, M. David, Ph.D. (2006). The Assessment and Management of Suicidality. Professional Resource Press, Sarasota, FL.

- A vignette demonstration of how safety plans can and should be refined over time.
- A presentation of the California Men's Colony's Suicide Prevention month and walk-a-thon
- A review of safety planning cards as a crisis intervention, using Brown and Stanley's model.[84]
- A review of motivations and precipitants to 2015 suicides within the CDCR and implications to current suicide prevention efforts and interventions
- An introduction to the ad hoc suicide risk assessment tools available in EHRS.
  - November: A review of the Chronic Readiness Questionnaire[85]
  - December: A review of the Reasons for Attempting Suicide Questionnaire[86]

The suicide prevention videoconference is a continuing suicide prevention effort and continued in 2017.

- **Creation of the SRASHE and inclusion of additional suicide risk assessments in EHRS**: The addition of lifetime/clinical questions of the C-SSRS to the SRE was only one of the changes to the SRE that would result in the SRASHE within EHRS. The C-SSRS added a structured set of questions about the intensity of suicidal ideation and about the range of suicide attempts and suicidal behaviors in which the patient has engaged over his or her lifetime. The SRASHE adds detailed information about past suicide attempts when applicable, noting the timing of the attempt, the means used, the potential and actual lethality/medical consequence, and so forth. These additions should help clinicians construct more accurate judgments of acute and chronic risk, while ensuring greater accuracy in considering historic vulnerability to suicide. Finally, EHRS contains seven suicide risk assessment tools that may be used as needed by clinicians. These additional tools can help with understanding cultural protective and risk factors in cases,[87] to evaluate readiness [88] and/or capability for suicide, [89] and to evaluate motivations for suicide attempts.[90] These assessment tools were provided by researchers to CDCR without costs. Brief training in the additional suicide risk assessment tools available in EHRS occurred via a webinar in 2016, with additional trainings offered in monthly videoconferences. Live workshop trainings on these measures were planned for 2017. For the SRASHE, training was being phased in by institutions (upon adoption of EHRS), with a revised seven-hour training in development.

[84] This link was provided: http://www.sprc.org/sites/default/files/Brown_StanleySafetyPlanTemplate.pdf, though other examples of crisis cards were reviewed
[85] Chronic Readiness Questionnaire; Horon, McManus, & Sanchez-Barker (2013)
[86] Reasons for Attempting Suicide Questionnaire; Holden & Delisle (2006)
[87] CAPSSIP; Horon, Williams, & Lawrence (2013)
[88] Chronic Readiness Questionnaire; Horon, McManus, & Sanchez-Barker (2013)
[89] Acquired Capability for Suicide Scales—Fearlessness About Death; Ribeiro, Witte, Van Orden, Selby, Gordon, Bender, & Joiner (2014)
[90] Reasons for Attempting Suicide Questionnaire; Holden & Delisle (2006)

- **Revision to the MHCB Discharge Custody Check Procedures**: When inmates are discharged from a psychiatric inpatient setting, a process and a related form are completed by custody and mental health staff. Custody completes regular checks of the inmate, relaying their observations from these checks to mental health clinicians. Mental health clinicians then evaluate the inmate and determine whether custody checks should continue or if the inmate needs to return to an inpatient setting. Custody checks can be extended up to 72 hours. Two training-for-trainers classes were held in February 2016, with trainers required to train facility staff thereafter.
- **2016 Suicide Summit**: A two-day conference involving CMHs, SPR FIT coordinators, custody leadership, nursing leadership, and mental health headquarters staff occurred in February 2016. The summit contained a number of presentations and discussions, with presentations on self-harm definitions and the suicide attempt database, a review of SPR FIT duties and best practices, a review of trends in suicide within the department, discussion of each of the initiatives starting that month (including MHCB discharge checks and changes to five-day follow-up forms and ASU screening forms), a look at quality improvement processes and audit items, a discussion of the use of psychiatric medications that are used to reduce risk to self, a review of Lindsay Hayes' tour findings during 2015, and a number of small breakout group discussions and reports. The Suicide Summit was considered very helpful by the majority of participants who provided feedback and was being considered as a model for subsequent bi-annual or annual conferences.

- **ASU Activity Workbooks**: ASU Workbooks were created in order to provide in-cell activities for inmates and patients in segregated housing units. The workbooks contain a variety of activities that inmates might use to distract themselves from the stress of the ASU placement, as ASU, particularly early in the placement, is known to be a high risk time/location for suicide. In addition, the workbooks contain suicide prevention messages and referral information scattered throughout the other content. The workbooks also serve as an item that custody officers and psychiatric technicians can use to encourage interaction with inmates and patients. Version 1 of the workbooks was re-ordered during the calendar year 2015, an indication of the regular use of these workbooks. The workbooks are available in English and Spanish. Additionally, a second version of the workbook was in development. The use of tablet-based activity booklets, using the tablets currently available in the inmate canteen, was also discussed. Implementation of Version 1 of the workbook had been very successful. Version 2 of the ASU Activity Workbook was approved by the end of 2015 and workbooks were distributed throughout 2016.

Progress on each of these initiatives during 2016 will be reviewed in the 2017 Annual Report, along with all new initiatives undertaken in the 2017 calendar year.

V. CONCLUSIONS

A. INTRODUCTION

The numerous efforts undertaken by CDCR to reduce suicides, aided by the consultation of the OSM and the initiative of the department's staff, have been productive. While it may be impossible to say how many suicides were prevented in 2016, the on-going efforts and new initiatives for suicide prevention hold promise in reducing suicides within CDCR. The department remains committed to a comprehensive system of suicide prevention and to response efforts that make a difference. Yet work remains to be done and efforts are on-going. The number of suicides that occurred in 2016 was the most since 2013, illustrating the need to continue to press initiatives forward.

B. REPORT IMPLICATIONS AND FUTURE STEPS

Eight report implications are enumerated below. The order of these implications is based on the order in which each finding was presented in the annual report. Future steps regarding these implications are to be discussed during DHCS SPR FIT meetings in 2017.

1. **Suicides of female inmates**: The number of suicides (seven) among female inmates from 2014 through 2016 is an increase from historical levels. Only once in the past 20 years (1997-2016) had as many as seven suicides occur in female inmates over a 3-year period, which occurred from 2004-2006. To gain a better understanding into the increase in self-harm and suicides among incarcerated females, a multidisciplinary 'strike-team' of mental health and custody leadership began conducting interviews late in 2016 of all suicide attempt survivors in the past year at female institutions. The initial findings of this information gathering are likely to yield workgroups, direct action items, and other approaches to the problems identified.

2. **Suicides among inmates 55 years old or over**: In 2016, just over 20% of suicide deaths occurred among inmates older than 60 years, although this group comprise seven percent of the total CDCR population. Special attention should be paid to inmates over the age of 55 who are involved in mental health care and have co-morbid medical conditions. The percentage of inmates who died by suicide who also suffered from comorbid medical conditions in 2016 was 22%. Nursing and medical providers should be aware of the heightened risk in this age group, particularly when comorbid mental health and medical disorders are present.

3. **Suicides of EOP inmates**: More than half (15 of 27) of the suicides in CDCR in 2016 occurred among inmates at the EOP LOC. EOP programs have the advantage of offering

considerable services, such as weekly contacts with primary clinicians and a minimum of 10 hours of group treatment per week. However, EOP programs also contain the most chronically mentally ill inmates. It is important for all disciplines working with EOP inmates to understand the risk inherent in this group. For example, EOP mental health clinicians should be attuned to and able to monitor individual risks and provide suicide-specific treatment interventions, while custody and nursing (e.g. LPTs) should have particular awareness during safety checks and rounds with EOP inmates. These considerations are even more crucial in EOP inmates in Level III and Level IV housing, where additional risk is noted.

4. **Strategic cell occupancy**: In 2016, two-thirds of inmate suicides occurred in single cells, with an additional four cases occurring either outside the cell or in a two-person cell with single occupancy. Not all inmates can be safely housed with other inmates. However, a move to strategically place inmates in two-person cells with compatible cellmates in high-risk populations (e.g., Level III and IV EOP inmates and mental health inmates in segregated housing) stands to have protective benefit.

5. **Reviews of Psychiatric Medication Refusals**: In 2016, a number of QIPs related to issues with reporting of medication refusals by PTs or nurses, or questions were raised about medications being discontinued due to refusals in a way temporally connected with the suicide, or increased symptoms were noted in the weeks or months before the suicide without medication adjustments. In one case, an inmate's long-acting injectable antipsychotic medication was discontinued while the inmate was in an inpatient psychiatric facility. Subsequently he was discharged before the medication's 'wash-out' period could be observed, with tragic consequences. A specific psychiatry section to the SCR is needed (and in fact happened after 2016), with a focus on psychiatric practice and communication issues between nursing and psychiatry.
6. **Follow-up After Psychiatric Inpatient Hospitalization**: In 2016, six inmates died by suicide within 90 days of discharge from inpatient hospitalization, three following MHCB stays, and three following DSH stays. Additionally, 16 of the 27 suicides (59%) in 2016 occurred among inmates who had been in psychiatric inpatient settings in the twelve months prior to their death. Discharge from psychiatric hospitalization is a known high risk time for suicides and is particularly true when the hospitalization occurred for attempted suicide. [91] In psychiatric samples, this finding is heightened in individuals with schizophrenia and bipolar disorder.[92] CDCR has implemented a number of policies and

[91] Chung, Ryan, & Hadzi-Pavlovic. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis, *JAMA Psychiatry*, 74, 694-702.
[92] Tidemalm, Langstrom, Lichtenstein, & Runeson. (2008). Risk of suicide after suicide attempt according to coexisting psychiatric disorder: Swedish cohort study with long-term follow-up. *British Medical Journal*, 337.

procedures for inpatient discharges, such as five-day follow-up and MHCB discharge custody check procedures that provide additional observations and mental health contacts.

7. **Suicide Attempt History**: As was noted in this report and in the 2015 CDCR Annual Report on Suicide, most deaths by suicide in CDCR occur in individuals with at least one prior suicide attempt, with the majority having made multiple past suicide attempts. In 2016, 63% of those who died by suicide had made multiple prior attempts, and 74% had made at least one attempt. The lifetime risk of death by suicide increases with single attempts and much more so after a second attempt; this is true in psychiatric and non-psychiatric samples. The DHCS SPR FIT may consider additional interventions for inmates following suicide attempts or known to have high chronic risk (as multiple attempt status implies). Again, a program to pilot the use of CAMS treatment with identified high chronic risk patients may be useful. As noted, CAMS is a targeted intervention that is specific to suicide risk. The treatment includes patient ratings of what most fuels suicidal desire for them and what has historically contributed to a wish to die by suicide, while challenging this wish for death with considerations of making life worth living.

8. **Focus on Common Triggers or Motives for Suicide**: The most common precipitants noted in 2016 diverged considerably from those noted in 2015. Whereas in 2015, in-prison stresses such as safety or enemy concerns, victimization fears, gang pressures, or new charges were the most commonly seen motive for suicide, in 2016 mental health symptoms predominated as the most frequent suicide trigger. It is important that mental health clinicians do not underestimate the impact of in-prison stressors and the role of major mental illness in causing psychological pain and thus, duress that can lead to suicide. Suicide risk assessment and suicide prevention trainings should continue to integrate the findings of suicide case reviews, such as these common precipitants to suicide within CDCR.