California Department of Corrections and Rehabilitation

2023 Annual Report on Suicides and Suicide Prevention Efforts in the CDCR

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Executive Summary

In 2023, 126,376 discrete individuals spent at least one night confined in the California Department of Corrections and Rehabilitation (CDCR). Out of that population, 30 individuals died by suicide during their incarceration. This was an increase from the previous year of 20 deaths by suicide. The 2023 rate is 31.2 suicides per 100,000 incarcerated individuals.

This report submitted pursuant to Penal Code Section 2064.1 and *Coleman* court requirements, provides information about suicide prevention initiatives and improvements in suicide prevention efforts made during calendar year 2023. This report describes CDCR's suicide prevention efforts, identifies successes in preventing suicides over the prior calendar year, and includes a more in-depth analysis of notable key trends from the suicide-related deaths that occurred that same year. Finally, this report assesses the efficacy of quality improvement plans established in response to the suicide-related deaths.

Nineteen (63%) of the 30 suicide decedents were patients in the statewide mental health program, lower than the 90% in 2022. Of the 19 in the mental health program, 17 of these decedents had a previous suicide attempt in the community or in CDCR, 10 in CDCR only and 7 in the community only. In 2023, Caucasians had the highest number of suicides for a race classification (14 decedents, or 47% of all suicides). This differs from the prior two years when individuals identified as Hispanic had the highest number of suicides in 2022 and 2021. In 2023, the remaining decedents included ten individuals identified as Hispanic, three individuals identified as African American, and 3 individuals listed as Other. In 2023, the age group with the greatest number of deaths by suicide was individuals 55 years and older, with 9 decedents (30%), while the greatest number of deaths by suicide in 2022 occurred among those between the ages of 25-34. In 2023, there were 14 decedents (47%) in Level III or Level IV, 13 decedents (43%) in Level I or Level II, and 4 decedents (13%) in a Reception Center. This is a change with Level II individuals which saw 10 decedents in 2023 as opposed to 5 decedents in 2022.

Each suicide in prison is a devastating tragedy that takes a profound toll on family and friends separated from their loved ones by distance and incarceration. Each suicide also significantly impacts staff and other incarcerated individuals within CDCR. Each suicide within CDCR is one too many and must be carefully examined for lessons and insights on how to prevent similar tragedies in the future. For over thirty years, CDCR has dedicated tens of millions of dollars towards developing a robust suicide prevention program based on nationally established best practices and a comprehensive system of quality mental health care for patients that few other state correctional systems can match. CDCR requires ***all*** CDCR staff complete suicide prevention training every year and ensures that all potential first responders to suicides in progress are trained in emergency procedures and lifesaving skills, such as cardiopulmonary resuscitation and basic life support. CDCR offers extensive training to the talented and dedicated mental health clinicians in suicide risk assessment and has systems in place for identifying individuals at risk of suicide and referring them to proper care. CDCR provides special care for individuals who are placed in higher risk settings, such as restricted housing units, and offers all incarcerated individuals suicide prevention information through videos, posters and pamphlets, and institutional suicide prevention events.

Since 1995, the *Coleman* Special Master has monitored CDCR's mental health care system and reports his findings and recommendations to the *Coleman* court. The *Coleman* Special Master's team, referred to as the Office of Special Master (OSM), includes dozens of experts, consultants, and attorneys. Of that team, the Special Master has a subset of experts who provide oversight to CDCR's suicide prevention program. CDCR has implemented numerous recommendations from seven separate audit reports by the OSM's suicide prevention expert. CDCR has a comprehensive suicide prevention program in place, which includes suicide risk assessment, safety planning, screenings, and other components. Many of the policies and procedures aimed at suicide prevention and response are compiled in the court-ordered Mental Health Services Delivery System (MHSDS) Program Guide.

Beginning in 2021, CDCR began self-monitoring its suicide prevention programs at the regional level. One Senior Psychologist Specialist was assigned to each of the four regions. This individual is responsible for engaging in regular on-site reviews of institutional suicide prevention practices. Using CDCR's Suicide Prevention Continuous Quality Improvement guidebook, these regional Suicide Prevention Coordinators summarize their findings in a report, with any necessary recommendations and expectations for corrective actions, and provide that report to the institutions for follow-up. In addition to their auditing responsibilities, the coordinators support institutions in their regions with expert advice in the development of suicide prevention initiatives, pertinent trainings, and other supportive activities to ensure institutions develop robust local suicide prevention programs.

In addition to reporting on the statistics related to the suicide deaths that occurred in CDCR during 2023, this report is also intended to respond to the requirements set forth in Penal Code 2064.1. Specifically, the report is required to include: a description of progress toward meeting the department's goals related to the completion of suicide risk evaluations; a description of progress toward meeting the department's goals related to the completion of 72-hour treatment plans; a description of the department's efforts to ensure that all required staff receive training related to suicide prevention and response; a description of the department's progress in implementing the recommendations made by the special master regarding [incarcerated individual] suicides and attempts; a description of the department's progress in identifying and implementing initiatives that are designed to reduce risk factors associated with suicide; and a description of the department's efforts and progress to expand upon its process of notification pursuant to Section 5022, including expansion of those notifications in cases of suicide attempts when deemed appropriate by the department. Progress in implementing each of the Penal Code requirements is discussed at length in this report. The following is a summary of the findings:

Suicide Risk Evaluations: In 2023, Department clinicians conducted on average more than 4,500 suicide risk evaluations each month, totaling over 55,000 suicide risk evaluations over the course of the year. The monthly average includes 4,275 evaluations completed in compliance with the Program Guide requirements. An additional 225 evaluations on average were completed by clinicians based on clinical judgment and patients' clinical needs. Ninety-five percent of suicide risk evaluations during the year were required by policy (e.g., admissions and discharges from inpatient psychiatric settings, required follow-up evaluations, and others), and the remainder were completed based on clinicians' judgment of clinical need.

Each risk evaluation is a complex clinical task that requires clinicians to make important clinical decisions. According to CDCR's policy, risk evaluations occur whenever an individual expresses suicidal ideation, makes a statement regarding self-harm, or makes a suicide attempt, at a number of key evaluation points, and during known higher-risk times for the patient. To improve the quality of the risk evaluations, CDCR maintains a Suicide Risk Evaluation Mentoring policy and training wherein clinicians receive regular training on conducting risk assessments and are then observed conducting the suicide risk assessments by a trained mentor. Additionally, CDCR employs regional suicide prevention coordinators to assist in auditing suicide risk evaluations and to provide direct feedback to clinical teams at the institutions.

Treatment Plans: In 2023, clinicians completed initial treatment plans for patients within 72 hours of admission to a Mental Health Crisis Bed (MHCB) unit in 97% of the cases, like previous years. CDCR continues to emphasize that the importance of clinical factors associated with individual suicidal risk are incorporated into each patient's treatment, and when indicated, that treatment goals are specifically targeted towards reducing the patient's suicidal risk. CDCR continues its efforts to ensure that the treatment plans meet quality standards set by the Statewide Mental Health Program (SMHP) through improved training and the use of quality improvement tools and audits. Despite these efforts, compliance

with the Chart Audit Tool (CAT) pass rates fluctuated between 71% and 77%, which is a decrease from the prior year's range of 70% and 83%.

Training: CDCR conducts a broad range of suicide prevention and response trainings. By the end of 2023, 93% of employees had completed their annual training. This average reflects compliance among custody, health care, and mental health staff.

Compliance with Court Ordered Recommendations: The OSM's initial audit on suicide prevention practices from 2015 included 32 recommendations, three of which were withdrawn, and 29 of which CDCR believes have been addressed and implemented or which are the subject of current policy development and physical plant improvements. Six reaudits have been conducted since 2015. Each re- audit has raised issues or concerns that CDCR continues to address, and those are described more fully in this report. The 6th re-audit was filed on March 1, 2024. This audit consisted of OSM's visits at 21 institutions and was the first re-audit to include all five PIPs. The OSM's expert conducted visits from April 4, 2023 to November 15, 2023. To date, the expert has found CDCR in compliance with 15 of the 29 recommendations. On April 1, 2024, CDCR filed objections to many of the expert's findings of noncompliance.

Next-of-Kin (NOK) Notification: During 2020, CDCR and the California Correctional Health Care Services (CCHCS) designed a NOK notification system for incarcerated individuals who engage in suicide attempts, and the system was implemented in April 2021. In June 2022, the Health Care Department Operations Manual (HCDOM) Section 3.1.19, Next of Kin Notification for Death, Serious Illness, or Serious Injury, was published. No additional updates or modifications to the Next of Kin Notification process were needed or warranted in 2023.

Departmental Initiatives: In addition to initiatives developed to address Coleman recommendations, CDCR has undertaken numerous suicide prevention projects. Many of CDCR's suicide prevention undertakings continued to see progress in 2023. CDCR continued developing and implementing policies essential to the improvement of CDCR's suicide prevention mission, including implementing the Transitional Help Rehabilitation in a Violence-Free Environment (THRIVE) program in CDCR's two male reception center institutions, and developing initiatives that began in prior years, such as replacing the safety planning intervention, modifying the suicide risk evaluation mentoring program, and updating local suicide prevention programs. As part of the broader *Coleman* data remediation project, CDCR worked to finalize auditing methodology for key suicide prevention indicators.

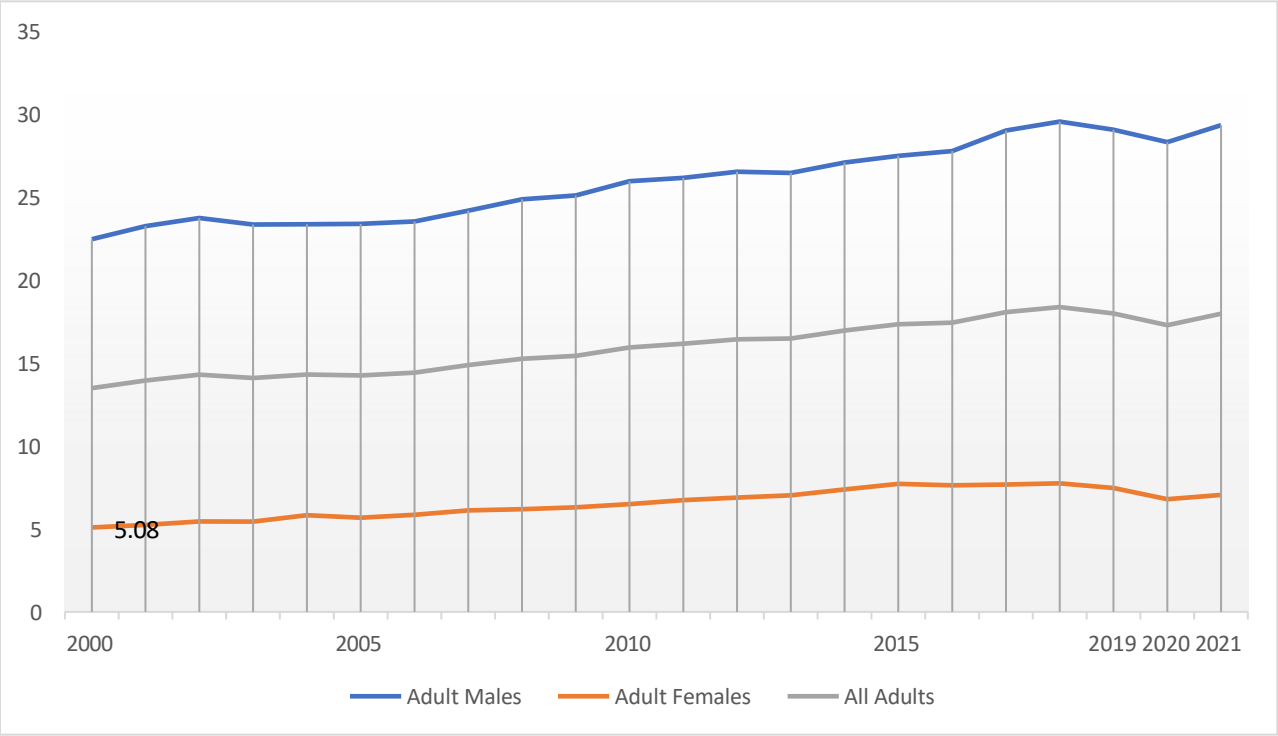
CDCR continues to focus on improving and expanding its suicide prevention practices, including by assessing the effectiveness of its initiatives and monitoring their quality and sustainability. The lessons learned from the suicides that occurred in 2023 are invaluable, and the analyses of these deaths is an essential part of a robust suicide prevention system.

Previous reports in this series proved helpful to CDCR and the State of California in identifying areas of improvement and areas that require more innovative thinking to address the unique needs of those who are most vulnerable.

Introduction

In the United States (U.S.), 1.2 million suicide attempts were reported in 2020.[1] The number of adult suicides in the U.S. increased by more than 50% between 2000 and 2019, from fewer than 30,000 per year to over 45,000 per year, while the overall U.S. population grew by only 22%. Prior to 2020, the rate of suicides in the U.S. was the highest rate in the country since the 1930s.[2] In 2023, 30 incarcerated individuals died by suicide in CDCR. This was an increase from 20 suicides in 2022 and 15 suicides in 2021.

*Figure 1: Graph of Adult Suicide Rates by Sex, 2000-2021**



Data accessed April 30, 2024 from CDC Web-based Injury Statistics Query and Reporting System (WISQARS), https://www.cdc.gov/injury/wisqars/fatal.html

Suicide prevention is a societal and complex public health problem that has frustrated the efforts of federal, state, and local agencies alike. In the U.S., suicide has long been more prevalent in jails than in prisons, and there have been significant increases in the number of suicides in jails in recent years. Among those detained in U.S. jails, the rate of suicide increased from 39 per 100,000 in 2005 to 42 per 100,000 in 2010. It reached 52 per 100,000 in 2015 before dropping in 2018 to 46 per 100,000 but climbed to 49 per 100,000 in 2019.[3] The rate of suicide for those incarcerated in all state prisons nationwide ranged from 14 per 100,000 to 27 per 100,000 from 2001 to 2019.[4] The rates of suicide among adult males in the U.S. and those in jails and prisons are shown in Figure 2.

The rate of suicide in CDCR during 2023 was 31.2 suicide deaths per 100,000 incarcerated individuals. The suicide rate for the last 20 years in CDCR was 23.7. The U.S. Bureau of Justice Statistics estimated the suicide rate among

[1] National Institutes of Mental Health: https://nimh.nih.gov/health/statistics/suicide, accessed on 02/13/2024

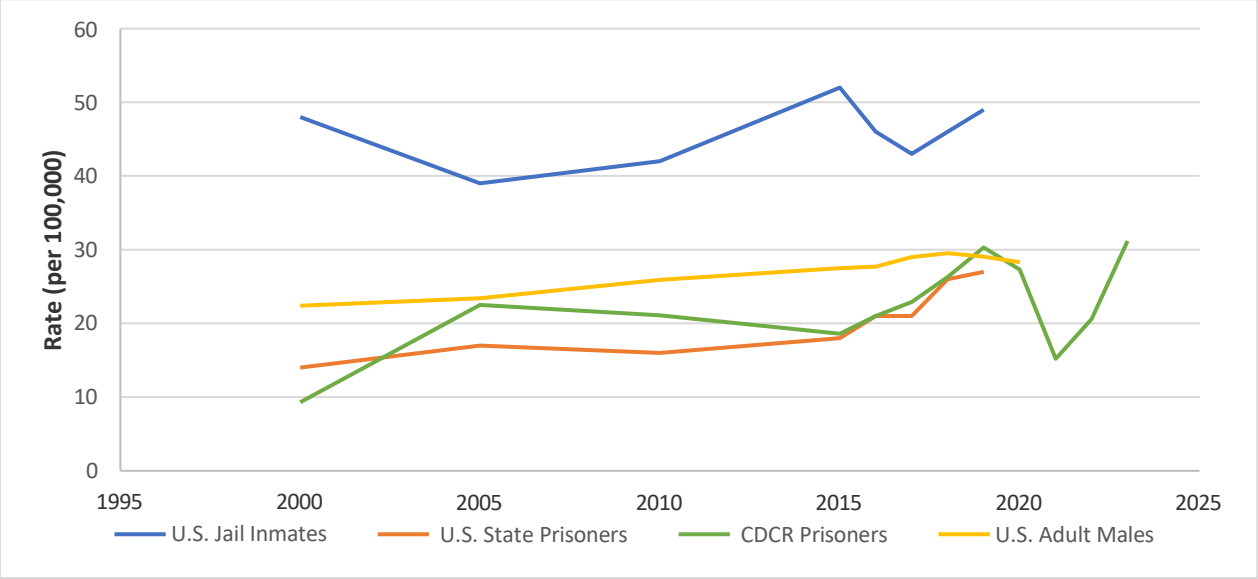
[2] Drapeau, C. W., & McIntosh, J. L. (for the American Association of Suicidology). (2020). *U.S.A. suicide: 2018 Official final data.* Washington, DC: American Association of Suicidology, dated February 12, 2020, downloaded from http://www.suicidology.org.

[3] *Mortality in Local Jails, 2000-2019 – Statistical Tables* (NCJ 256002, Bureau of Justice Statistics, October 2021)

[4] *Mortality in State and Federal Prisons, 2000-2019 – Statistical Tables* (NCJ 255970, Bureau of Justice Statistics, October 2021)

state prison incarcerated individuals nationally was 27 per 100,000 in 2019, the most recent data available.[5]

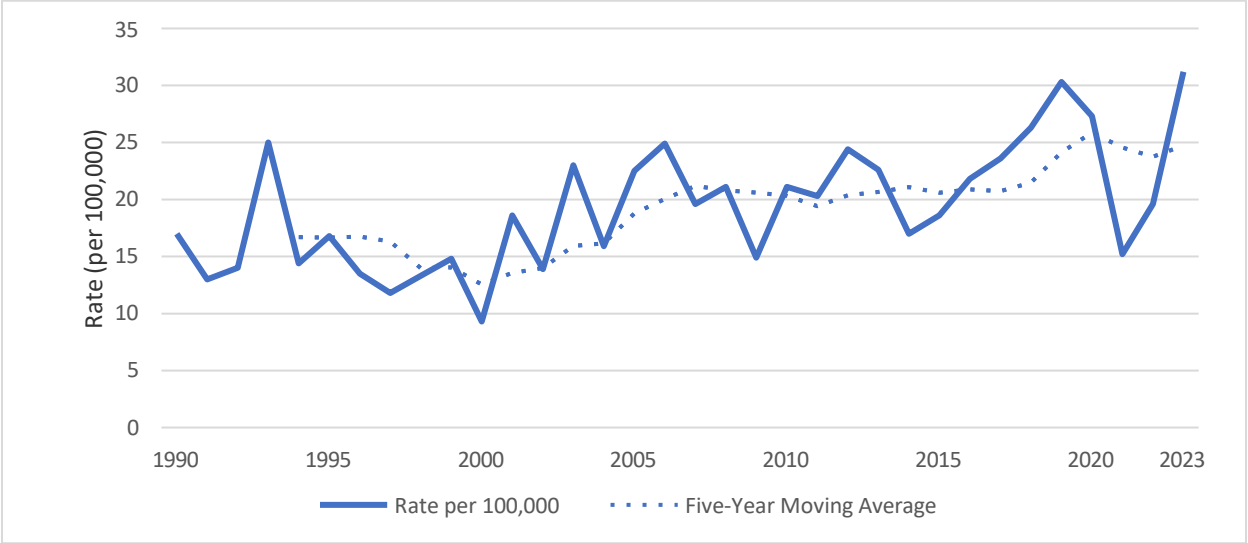
Figure 2: Comparison of Suicide Rates, 2000-2023 (US Jail, US State, CDCR, US Adult Males)



*** Most recent data from Bureau of Justice Statistics, CDCR, and** 21002767.1

In prison systems, suicide deaths have multiple contributing factors that can include longstanding medical and mental health issues, court and sentencing issues, issues involving family, lack of purposeful activity, conditions of the specific prison environment, and the stress of adjusting to incarceration.[6] In 1990, CDCR began tracking the annual suicide frequency and rate. The annual rate of suicide for each year is shown below in Figure 3. The rate of suicide in 2023 was the highest it has been since CDCR began tracking suicide rates. Prior to 2023, the highest rate of suicide occurred in 2019 with a rate of 30.3 per 100,000 and 38 suicides in total. In 2023, CDCR's rate of suicide was 31.2 per 100,000 with 30 suicides total.[7]

Figure 3: Rate of Suicide in CDCR, 1990-2023



[5] Carson, E.A. (2020). Mortality in State and Federal Prisons, 2001-2018 – Statistical Tables, Report NCJ 256002. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Washington, DC.

[6] https://www.psychiatryadvisor.com/home/topics/suicide-and-self-harm/preventing-suicide-in-prison-inmates/

[7] The CDCR suicide rate uses the mid-year June 30 CDCR population.

Over the last thirty years, CDCR has expended significant resources to develop and fully implement policies to improve CDCR's suicide prevention program. Specifically, CDCR has invested in enhancing the suicide resistance to locations where suicidal individuals are placed, and in other high-risk locations. The agency has also created specific mental health positions at all institutions that are explicitly devoted to overseeing the suicide prevention programs locally. Policies have been developed to guide institutional staff in creating, maintaining, and governing local suicide prevention efforts and the statewide oversight of the local initiatives have been bolstered through additional staffing resources. Federal court oversight of those efforts continues with the Coleman Special Master's expert conducting seven comprehensive audits of the suicide prevention efforts at individual prisons and reporting his findings to the federal court following each audit. The most recent audit was conducted from April 2023 to November 2023. The findings from the sixth re-audit were submitted to the *Coleman* court in March 2024.

CDCR has a comprehensive suicide prevention system in place for suicide risk screening, risk evaluation, and treatment planning, and remains committed to continuing to work and improve this system. These improvements include new and enhanced suicide prevention training for all staff, specialized emergency procedures training for all potential first responders to suicide attempts in progress, and training for mental health clinicians on suicide risk assessment, safety planning and treatment planning. Taking a public health approach to suicide prevention, the program targets both those incarcerated individuals who receive mental health treatment and those who do not. Additionally, CDCR provides patients with a range of mental health services and has a referral procedure for mental health evaluations, including procedures for protecting individuals during particularly vulnerable periods. CDCR has implemented policies to ensure safety concerns are addressed prior to a patient being discharged from an inpatient setting. The institutions are provided with suicide screening procedures and provides the prison population with suicide prevention information through videos, posters/pamphlets, and institutional suicide prevention events. Furthermore, many institutions within CDCR host myriad activities during Suicide Prevention Awareness month each September, where staff and the incarcerated population work to spread awareness of the impacts of suicide.

***Summary of 2023 Suicides**:* Suicides occurred in 17 CDCR institutions and 1 at a Fire Camp in 2023. Twenty-two (73%) suicides occurred among incarcerated persons with violent offense histories. Six (20%) individuals were in restricted housing units,[8] and 14 (47%) suicides occurred in high-custody programs (Level III and Level IV). Nineteen (63%) incarcerated individuals who died by suicide were sentenced to eleven years or more. Nineteen (63%) of the suicides occurred among those participating in mental health treatment, including eight (27%) suicides among Enhanced Outpatient Program (EOP) participants, 10 (33%) in the Correctional Clinical Case Management System (CCCMS) population, and one (3%) individual receiving inpatient psychiatric care. One individual was housed in inpatient settings during the year prior to the death. Seventeen of the 30 decedents (57%) had at least one prior suicide attempt. Ten of those had only one attempt (59%) while seven (41%) individuals had more than one suicide attempt during their lives.

Statistical Summary of 2023 Suicides

Suicide Definitions and Terms Used

The MHSDS Program Guide, 2021 Revision, provides definitions of suicide and suicide attempts. Several terms used in the last 2009 revision of the Program Guide are now considered obsolete within the field of

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

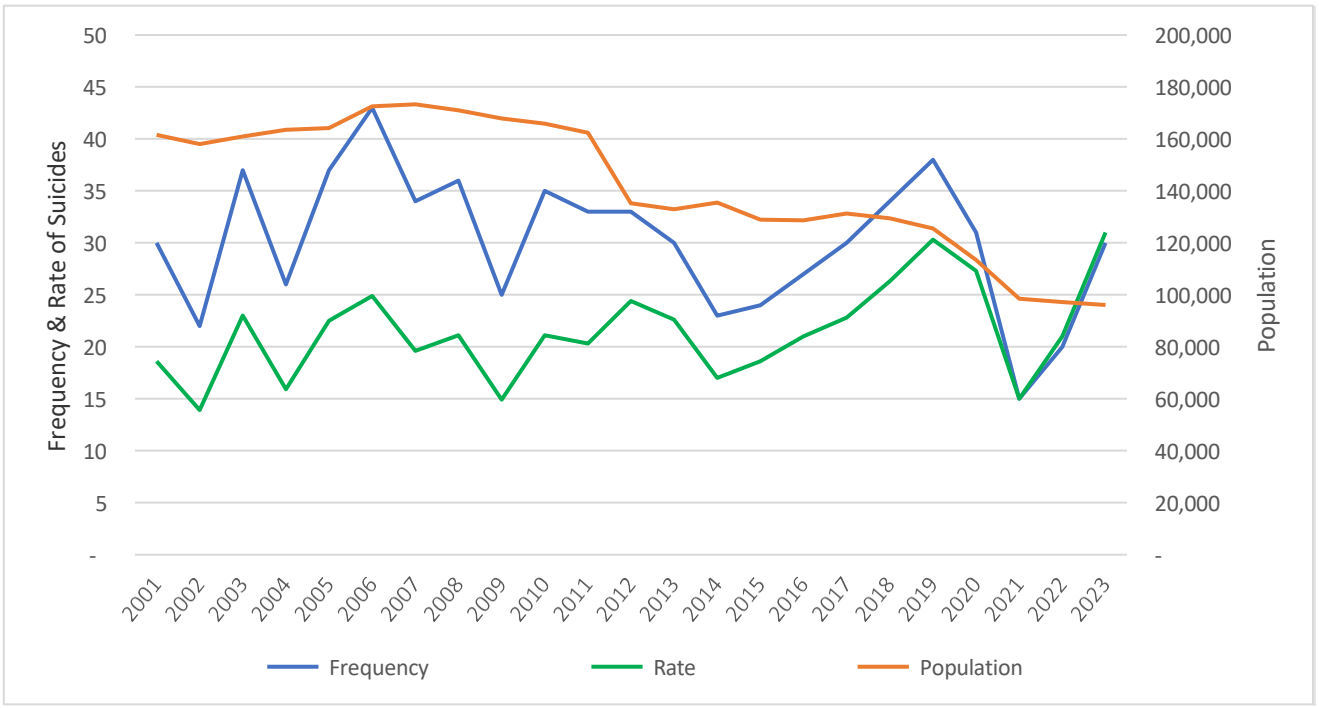
suicidology and will not be used in this report. Specifically, the terms "self-mutilation" and "suicide gesture" are found in the MHSDS Program Guide, 2021 Revision; however, a less-pejorative term, "non-suicidal self-injury" or NSSI, is used in this report and refers to self-injury for reasons other than death by suicide.

- Suicide: An intentional self-injurious behavior that causes or leads to death.
- Suicide Attempt: An intentional self-injurious behavior which is designed to deliberately end one's life and may require medical and/or custody intervention to reduce the likelihood of death or serious injury.
- Suicidal Ideation: Thoughts of suicide or death, which can be specific or vague, and can include active thoughts of committing[9] (that is, dying by) suicide or the passive desire to be dead.
- Suicidal Intent: The intention to deliberately end one's own life.
- Self-injurious Behavior: A behavior that causes, or is likely to cause, physical self-injury.

Review of Findings

The total population in CDCR in 2023 was 96,033. The annual suicide rate in CDCR in 2023 was 31.2 deaths per 100,000 incarcerated individuals, based on 30 suicides. The rate in 2022 was 20.6, and the rate in 2021 was 15.2. The 2023 rate is the highest rate since 2019 which was 30.3 deaths per 100,000 individuals. Figure 4 shows the annual rate, frequency, and population of CDCR since 2001.[10]

Figure 4: CDCR Suicide Rate, Frequency, and Population, 2001-2023



In CDCR, the rate of suicide averaged almost 40 per 100,000 in the 1980s, dropping to an average of 16 per 100,000 in the 1990s as the incarcerated population grew by 72%. In the 2000s, the rate averaged 18 per 100,000 as the population peaked in 2007 and then began to decline. In the 2010s, the rate averaged 23 per

[9] 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."

[10] CDCR population counts are from the Office of Research June 30th Monthly Report of Population. Suicide counts are from the CDCR Statewide Mental Health Program (SMHP).

100,000 even though CDCR's incarcerated population fell by 29% due to litigation, decreasing crime rates, criminal justice reform, and the passage of Assembly Bill (AB) 109 (Public Safety Realignment) in 2011. The average annual number of suicides rose from 16 per year in the 1980s, to 20 in the 1990s, to 33 in the 2000s, and to 31 in the 2010s. The number of suicides was 31 in 2020, 15 in 2021, 20 in 2022, and 30 in 2023 with an average annual number of twenty-four.

Sociodemographic Factors

Sociodemographic characteristics do not directly cause suicide but are important risk factors with indirect effects. However, they are important in understanding risk and how risk factors evolve over time. These factors are highlighted in order to examine for potentially emerging trends that would necessitate intervention.

Gender

Table 1 below presents the male, female, and overall frequency and rates of suicide in CDCR since 2004. In 2023, there were 30 individuals who died by suicide, 29 males and 1 transgender female, at a rate of 31.2 per 100,000. The trends for the last five years are consistent with the trends for the last 20 years with the majority being males who died by suicide. Since 2019, CDCR had a total of 130 male suicides and 4 female suicides[11].

*Table 1: Annual Frequency, Population, and Rate of Suicide by Gender and Total, 2004-2023**

Year	Male Frequency	Male Pop.	Male Rate	Female Frequency	Female Pop.	Female Rate	Total Frequency	Total Pop.	Total Rate
2004	23	152,859	15.0	3	10,641	28.2	26	163,500	15.9
2005	37	153,323	24.1	0	10,856	0.0	37	164,179	22.5
2006	39	160,812	24.3	4	11,749	34.0	43	172,561	24.9
2007	33	161,424	20.4	1	11,888	8.4	34	173,312	19.6
2008	36	159,581	22.6	0	11,392	0.0	36	170,973	21.1
2009	25	156,805	15.9	0	11,027	0.0	25	167,832	14.9
2010	34	155,721	21.8	1	10,096	9.9	35	165,817	21.1
2011	33	152,803	21.6	0	9,565	0.0	33	162,368	20.3
2012	32	128,829	24.8	1	6,409	15.6	33	135,238	24.4
2013	29	126,992	22.8	1	5,919	16.9	30	132,911	22.6
2014	21	129,268	16.2	2	6,216	32.2	23	135,484	17.0
2015	22	123,268	17.8	2	5,632	35.5	24	128,900	18.6
2016	24	122,874	19.5	3	5,769	52.0	27	128,643	21.0
2017	28	125,289	22.3	2	5,971	33.5	30	131,260	22.9
2018	33	123,511	26.7	1	5,906	16.9	34	129,417	26.3
2019	37	119,781	30.9	1	5,691	17.6	38	125,472	30.3
2020	31	108,682	28.5	0	4,721	0.0	31	113,403	27.3
2021	13	94,562	13.7	2	3,910	51.2	15	98,472	15.2
2022	20	93,510	21.4	0	3,669	0.0	20	97, 179	20.6
2023	29	92,271	31.4	1	3,762	26.6	30	96,033	31.2

[11] There were 2 transgender suicides between 2019 through 2023, while CDCR did not maintain data prior to this time related to gender identity of the decedents.

*All populations are mid-year monthly as of June 30th of each year. Total population includes camps, institutions, in-state and out-of-state contract beds.

Race/Ethnicity

Of the 30 suicide deaths in 2023, 14 (47%) were individuals identified as Caucasian, 10 (33%) were individuals identified as Hispanic, three (10%) were individuals identified as African American, and three (10%) were listed in the Other category. Historically, men identified as Caucasian have had the highest number of suicides per year apart from 2021 and 2022 which saw individuals identified as Hispanic have the highest number of suicides. Table 2 breaks down the last five years of death by suicide based on race as well as provides the overall CDCR Population by racial/ethnic group. The category of Other includes American Indian, Asian, and Pacific Islander.

Table 2: Frequency and Percent of CDCR Suicide Decedents by Race/Ethnic Group, 2019-2023

Racial/Ethnic Group	2019	2020	2021	2022	**2023**	**2023 Overall CDCR Population**
African American	8 (21%)	5 (16%)	4 (27%)	3 (16%)	**3 (10%)**	**27.5%**
Hispanic	11 (29%)	9 (29%)	6 (40%)	11 (58%)	**10 (33%)**	**46.0%**
Caucasian	13 (34%)	12 (39%)	5 (33%)	5 (26%)	**14 (47%)**	**20.0%**
Other	6 (16%)	5 (16%)	0 (0%)	0 (0%)	**3 (10%)**	**6.5%**

Age

Table 3 shows annual age group suicides for the five-year period 2019 through 2023 and the percentage of suicides in each group as well as the overall CDCR population for each age group. In 2023, the number of total suicides of those 55 years and older represented the highest number of suicides. The average age of a suicide decedent in 2023 was 43 years, similar to prior years.

Table 3: Frequency & Percent of CDCR Suicide Decedents by Age Group, 2019-2023

Age Group	2019	2020	2021	2022	2023	**2023 Overall CDCR Population**
18-24	1 (3%)	4 (13%)	4 (27%)	1 (5%)	**3 (10%)**	**5%**
25-34	10 (26%)	9 (29%)	6 (40%)	7 (37%)	**7 (23%)**	**28%**
35-44	15 (40%)	5 (16%)	5 (33%)	3 (16%)	**7 (23%)**	**28%**
45-54	9 (24%)	6 (19%)	0 (0%)	3 (16%)	**4 (13%)**	**19%**
55+	3 (8%)	7 (23%)	2 (13%)	5 (26%)	**9 (30%)**	**20%**

Marital Status

Of the 30 individuals who died by suicide in CDCR during 2023, 8 (27%) were married at the time of their death, one (3%) was divorced, 19 (63%) were single, and two (7%) were widowed. In 2022, of the 20 decedents, four (20%) were married at the time of their death, three (15%) were divorced, thirteen (65%) were single, and none were widowed. In 2021, of the 15 decedents, one (7%) was married at the time of their death, three (20%) were divorced, eleven (73%) were single, and none were widowed. There continues to be an overwhelming percentage of single decedents throughout the years.

Education, Juvenile Criminal History, and Work History

In 2023, 11 (37%) of the 30 had less than a high school education. Six decedents (20%) finished 12 years of schooling, ten (33%) had a GED certificate, and 1 (3%) had a college degree. Two individuals were not listed as their educational attainment was unclear from the records; one individual was listed as unknown and the second individual was listed as unclear if he had a bachelor's degree or a master's degree completed. Three individuals were in special education classes.

Among the 30 individuals in CDCR custody who died by suicide in 2023, thirteen (43%) had a history of crime as juveniles with an average age at first arrest of 15 years. Of these thirteen individuals, eight (62%) had some level of gang involvement either inside or outside of prison.

Twenty-four (80%) of the 2023 suicide decedents records had information about employment prior to incarceration, higher than prior years. Of the 24 who had employment histories, five were skilled workers while nineteen were unskilled workers. Seven (23%) of the decedents had job placements while incarcerated, including one who died while assigned at a fire camp.

Languages Spoken

For 25 (83%) of 2023's suicide decedents, English was their primary spoken language. For five individuals (17%), Spanish was their primary spoken language.

Health Factors

Incarcerated populations have higher rates of both chronic medical conditions and infectious diseases than members of the community at large[12] and medical conditions increase the risk of suicide.[13]

In 2023, 13 (43%) of the 30 individuals who died by suicide in 2023 had both past and current medical conditions. Three individuals had chronic back pain. One of the three also had Barrett's esophagus, which includes symptoms such as difficulty swallowing food. The remaining 10 individuals had conditions to include: high blood pressure, thrush; neurological concerns as a result of a brain aneurysm; hernia and gastrointestinal problems; type 2 diabetes with diabetic neuropathy of the feet, kidney disease, and hypertension; type 1 diabetes; knee problems due to sports injury; epilepsy; diabetes with amputations; and COPD. In contrast, seven (35%) of the 20 individuals who died by suicide in 2022 had both past and current medical conditions. This is significantly lower than the thirteen (87%) of the 15 individuals who died by suicide in 2021.

Temporal Factors

Over the years, annual reports have inspected the distribution of suicides by custody watches (1st, 2nd, 3rd), day of week, quarter of year, and month to see if it was more likely that suicide deaths occurred during one temporal domain rather than another.

The distribution of 2023 suicides by day of week, time of day (watch), day of week, month, quarter, and time of year was tested against the hypothesis that all things being equal, suicides would be distributed evenly across these temporal sequences. The analyses found that, in 2023, no day of week, time of day, month, quarter, or holiday season was statistically more likely to have more suicide deaths than any other.

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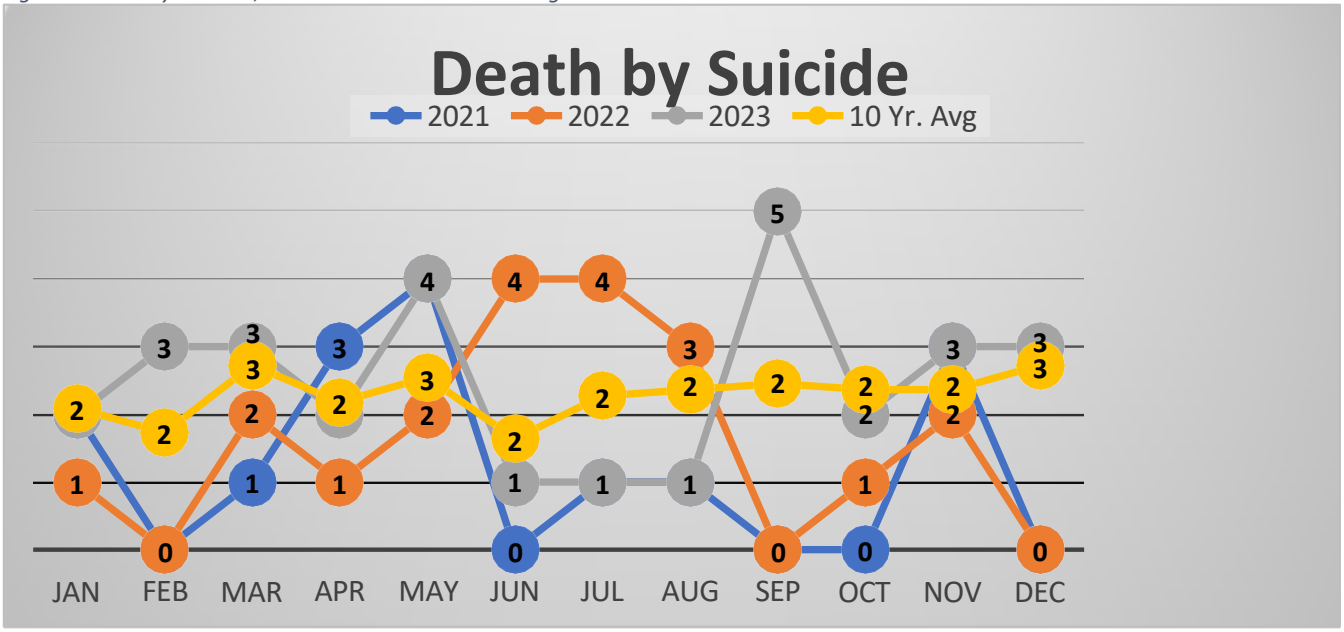
[12] Maruschak, L.M. & Berzofsky, M. (2016). "Medical Problems of State and Federal Prisoners and Jail Individuals, 2011-12." Report NCJ 251920. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Washington, DC. Available at: https://www.bjs.gov/pub/pdf/mpsfpji1112.pdf

[13] Ahmedani, B. K., Peterson, E. L., Hu, Y., Rossom, R. C., Lynch, F., Lu, C. Y., et al. (2017). Major Physical Health Conditions and Risk of Suicide. *American Journal of Preventive Medicine, 53*(3), 308–315. https://doi.org/10.1016/j.amepre.2017.04.001

It is commonly believed suicide increases around the winter holidays of Thanksgiving and Christmas, though broader data does not support this.[14] In 2023, September had five suicides, the most of any other month in 2023. Figure 5 shows the 2021-2023 number of suicides by month and the 10-year average.

Figure 5: Monthly Suicides, 2021-2023 and 10 Year Average



In 2023, there were six suicides on a Wednesday and a Thursday and five on a Tuesday, Saturday, and Sunday. There were three on a Monday. There were no suicides on a Friday. In contrast, of the 20 suicides in 2022, there were seven suicides on a Saturday, four on a Monday, three on a Tuesday, three on a Wednesday, and one each on a Thursday, Friday, and Sunday. In 2023, 1st watch (10PM to 6AM) had nine suicides, 2nd watch (6AM to 2PM) had 12 suicides, and 3rd watch (2PM to 10PM) had nine suicides. In contrast, in 2022, 1st watch (10PM to 6AM) had four suicides, 2nd watch (6AM to 2PM) had four suicides, and 3rd watch (2PM to 10PM) had twelve suicides. There are different number of suicides, per watch, across years. This suggests that there is no distinguishable trend.

Rigor mortis[15] is a condition of the body after death that involves stiffening of the musculature due to post-mortem chemical reactions and indicates a person has been deceased for a period ranging from two to six hours. In 2023, four (13%) of the 30 decedents were found in rigor mortis. Two of these decedents were on Guard 1 checks (required 30-minute observations conducted by custodial staff for incarcerated individuals housed in restricted housing units) at the time of death, which resulted in a Quality Improvement Plan (QIP) in each of the suicide case reviews for these decedents. Three of the decedents found in rigor mortis were in restricted housing units (one in STRH and two in ASU) and one was in GP Non-Designated housing. For reference, in 2022, three (15%) of the 20 decedents were found in rigor mortis.

In 2023, four (13%) of the 30 decedents were under custody discharge checks/guard 1 checks at the time of their death. In contrast, in 2022, five (25%) of the 20 decedents were under custody discharge checks/guard 1 checks at the time of their death. In 2021, five (33%) of the 15 decedents were under

[14] See: Suicide Rate is Lower During Holidays, But Holiday-Suicide Myth Persists | The Annenberg Public Policy Center of the University of Pennsylvania

[15] Rigor mortis is "the state of postmortem stiffening." It "starts developing within 1 to 2 hours after death," "becomes apparent in the small muscle groups first" including "eyelids, lower jaw, face," "but on an average it may be said to commence 2-4 hours after death…" Kori (2018). Time since death from rigor mortis: Forensic perspective," *Journal of Forensic Sciences and Criminal Investigation, 9* (5), 1-9.

checks at the time of their death. In 2020, one individual's death (3%) led to concerns related to the quality or inadequacy of custody/welfare checks at the time of the death by suicide whereas in 2019, there were 5 (13%) cases with custody/welfare checks concerns.

The total number of rules violation reports (RVRs) received by the 30 decedents while incarcerated ranged from 0 – 41 RVRs with an average of 8.3. In 2022, the RVRs for the 20 decedents ranged from 0 – 36 RVRs with an average of 8.2. In 2021, the range of RVRS for the 15 decedents was from 0 – 23 RVRs with an average of 5.5.

For the individuals who died in 2023, there was a range of 0 - 47 inter-facility transfers for the 30 decedents with a total average of 7.6 transfers (2 transfers per year) during the entirety of their incarcerations. Three decedents had 0 transfers, 18 decedents had less than 10 transfers, six decedents had from 10 to less than 20 transfers, one decedent had from 20 to less than 30 transfers, one decedent had from 30 to less than 40 transfers, and one decedent had 47 transfers, having spent almost 19 years in prison at the time of his death. In 2022, there was a range of 0 – 42 inter-facility transfers for the 20 decedents with a total average of 9.7 transfers (1.2 transfers per year). Two decedents had 0 transfers, 12 decedents had less than 10 transfers, 3 decedents had from 10 to less than 20 transfers, one decedent had from 20 to less than 30 transfers, one decedent had from 30 to less than 40 transfers, and one decedent had 42 transfers, having spent over 33 years in prison at the time of his death. In 2021, there was also a range of 0 – 25 inter-facility transfers for the 15 decedents with a total average of 0.9 transfers.

Custodial and Correctional Factors

The environment of any institution can have an impact on an individual's risk of suicide. Understanding these unique correctional factors is particularly important to determine if intervention is needed to protect individuals during incarceration.

Institution at Time of Death

In 2023, suicides occurred in 17 CDCR institutions and one at a fire camp (Table 4). Institutions vary in the number of patients in the mental health program[16], the acuity of the mental health mission, the predominance of violent offenders, and the total number of individuals housed. There are fluctuations in the number of suicides occurring at an institution due to 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 individual from one institution to another, further complicating the interpretation of *why* suicides occur at certain institutions more frequently.

Suicides are more frequent in institutions with intensive mental health programming (e.g., EOP institutions). Historically, suicides have also been more frequent in higher security (Level III or Level IV) institutions than in lower security settings. The institutions that have the highest average annual suicides, such as Salinas Valley State Prison (SVSP), are those where high security Level IV incarcerated individuals are housed and being treated for severe and chronic mental health and behavior problems.

Table 4: 2023 CDCR Suicides by Institution, Security Level and Available Mental Health Program[17]

[16] Levels of care in the Mental Health Services Delivery System (MHSDS): Correctional Clinical Case Management System (CCCMS); Enhanced Outpatient Program (EOP); Mental Health Crisis Bed (MHCB); and Psychiatric Inpatient Program (PIP)

[17] Levels of mental health care are: Correctional Clinical Case Management System (CCCMS); Enhanced Outpatient Program (EOP); Mental Health Crisis Bed (MHCB); and Psychiatric Inpatient Program (PIP), Developmental Disabilities Program (DDP)

Institution	Level I and II	Level III	Level IV	Unclassified	Mental Health Programs Available
California Correctional Institution			1		CCCMS, EOP
California Men's Colony		1	1		CCCMS, EOP, EOP-RHU, MHCB
Mule Creek State Prison		2	1		CCCMS, EOP, EOP-RHU, MHCB
Kern Valley State Prison			2		CCCMS, EOP, CCCMS-RHU, MHCB
Valley State Prison	1				CCCMS, EOP
California State Prison – LAC			2		CCCMS, EOP, EOP-RHU, CCCMS-RHU, MHCB
Wasco State Prison	1			3	RC, CCCMS, MHCB
Richard J. Donovan Correctional Facility	1				CCCMS, EOP, EOP-RHU, MHCB
California Health Care Facility	1				CCCMS, EOP, EOP-RHU, MHCB, APP, ICF
California Medical Facility	1				CCCMS, EOP, EOP-RHU, MHCB, APP, ICF
Folsom State Prison	2				CCCMS
High Desert State Prison			1		CCCMS, EOP, CCCMS-RHU, MHCB
California State Prison – Corcoran	1		1		CCCMS, EOP, CCCMS-RHU, EOP-RHU, MHCB

Institution	Level I and II	Level III	Level IV	Unclassified	Mental Health Programs Available
California Rehabilitation Center	1				CCCMS
San Quentin	2				CCCMS, EOP, MHCB, APP, ICF
Sierra Conservation Center	1				CCCMS
Correctional Training Facility	1				CCCMS
Salinas Valley State Prison			2		CCCMS, EOP, CCCMS-RHU, MHCB, ICF
Total (Percent)	13 (43%)	3 (10%)	11 (37%)	3 (10%)	

Table 5 presents the data on suicides in each institution over the ten-year period 2014-2023 along with the 10-year annual average per institution. One institution had, on average, at least two suicides per year while twelve institutions had at least one suicide per year. These twelve institutions represented 171 of the 242 (71%) of all suicides over the 10 years, accounting for an average of 14 per year.

Table 5: Frequency of Suicide by CDCR Institution, 2014-2023, 10-Year Total, and 10-Year Annual Average[18]

Institution	2014	2015	2016	2017	2018	2019	2020	2021	2022	**2023**	Annual Average
CSP Sacramento	2	3	3	1	2	9	3	0	1	**0**	2.4
Salinas Valley SP	2	0	4	2	2	1	1	2	2	**2**	1.8
California Correctional Institute	3	1	2	0	2	2	4	1	1	**1**	1.7
Kern Valley SP	1	0	3	1	5	2	2	0	2	**1**	1.7
San Quentin SP	2	3	0	2	2	1	1	1	0	**2**	1.4
CSP LA County	0	0	2	4	2	2	2	0	2	**2**	1.6
Corcoran SP	0	2	0	2	3	4	2	0	0	**2**	1.5
Mule Creek SP	2	0	0	2	2	2	2	2	0	**3**	1.5
RJ Donovan	1	2	0	1	4	0	1	1	1	**2**	1.3
California Men's Colony	0	3	3	0	1	0	0	0	4	**2**	1.3
California Medical Facility	1	2	0	2	0	3	1	0	1	**1**	1.1

[18] Chuckawalla Valley SP, Avenal SP, Centinela CP, and California City CF had no suicides during the ten years 2013-2023

Institution	2014	2015	2016	2017	2018	2019	2020	2021	2022	**2023**	Annual Average
Wasco SP	0	0	0	4	0	0	2	0	1	**4**	1.1
Deuel Vocational Institute*	0	3	0	4	1	3	0	0	N/A	**N/A**	1.1
California Institute for Women	2	2	2	1	0	1	0	1	0	**0**	0.9
High Desert SP	1	0	0	0	2	1	3	0	0	**1**	0.8
Correctional Training Facility	0	0	0	0	2	1	3	0	0	**1**	0.7
California Institute for Men	1	1	0	0	0	1	1	3	0	**0**	0.7
Substance Abuse & Training Facility	2	0	0	0	0	1	0	1	1	**0**	0.5
California Health Care Facility	0	1	0	0	1	1	2	0	0	**1**	0.6
North Kern SP	0	0	1	0	0	2	0	0	2	**0**	0.5
Pleasant Valley SP	0	0	2	0	0	1	0	0	0	**0**	0.3
Folsom State Prison	0	1	1	0	0	0	0	0	0	**2**	0.4
Pelican Bay SP	1	0	1	1	0	0	0	0	0	**0**	0.3
California Correctional Center	1	0	1	1	0	0	1	0	0	**0**	0.4
Valley SP	0	0	0	0	0	0	0	1	2	**1**	0.4
Out-of-State Institutions	0	1	0	0	1	0	0	0	0	**0**	0.2
CSP Solano	1	0	0	1	1	0	0	0	0	**0**	0.3
Central California Women's Facility	0	0	1	1	1	0	0	0	0	**0**	0.3
California Rehabilitation Center	0	0	0	0	0	0	0	0	0	**1**	0.1
Sierra Conservation Center	0	0	0	0	0	0	0	0	0	**1**	0.1
Ironwood State Prison	0	0	0	0	0	0	0	1	0	**0**	0.1
Avenal State Prison	0	0	0	0	0	0	0	0	0	**0**	0.0
Centinela SP	0	0	0	0	0	0	0	0	0	**0**	0.0
Total	**23**	**25**	**26**	**30**	**34**	**38**	**31**	**15**	**20**	**30**	**24.2**

*Deuel Vocational Institute closed in 2021

Housing Type

Incarcerated individuals in CDCR are housed in a variety of physical settings, from dormitory settings with up to 200 people, to the most common type, celled housing, which house one or two persons. Table 6 presents the number and percentage of suicides in each type of CDCR housing from 2019 – 2023.

The types of housing where an incarcerated person lives can be associated with prison-related difficulties. For instance, individuals entering CDCR with a new prison term or whose parole has been revoked are initially housed in Reception Center institutions. During 2023, four individuals died by suicide in a Reception Center institution. During 2022, one individual died by suicide in a Reception Center institution. Currently, there are two Reception Center institutions designed to house males (NKSP and WSP) and one designed to house females (CCWF).

Table 6: Frequency and Percent of Housing Placements of CDCR Suicide Decedents, 2019-2023

Housing Type	2019	2020	2021	2022	**2023**	**CDCR Pop. Proportion in 2023***
Administrative Segregation (including EOP Hub units)	6 (6%)	3 (10%)	4(27%)	6 (30%)	**5 (17%)**	**8%**
Condemned Housing	1 (3%)	1 (3%)	1 (7%)	0 (0%)	**0 (0%)**	**1%**
Psychiatric Services Units	5 (13%)	1 (3%)	0 (0%)	1 (5%)	**0 (0%)**	**0.1%**
Short-Term Restricted Housing	1 (3%)	5 (16%)	2(13%)	1 (5%)	**1 (3%)**	**1%**
Long-Term Restricted Housing	0 (0%)	1 (3%)	0 (0%)	0 (0%)	**0 (0%)**	**0.1%**
Security Housing Units	0 (0%)	0 (0%)	0 (0%)	0 (0%)	**0 (0%)**	**0.1%**
Sensitive Needs Yard	0 (0%)	0 (0%)	2(13%)	5(30%)	**3 (10%)**	**10%**
Psychiatric Inpatient Program (PIP)	1 (3%)	2 (6%)	2(13%)	1 (5%)	**1 (3%)**	**0.3%**
Reception Centers	3 (8%)	1 (3%)	0 (0%)	1 (5%)	**4 (13%)**	**7%**
Fire Camp	0 (0%)	0 (0%)	0 (0%)	0 (0%)	**1 (3%)**	**2%**
Outpatient Housing Unit (Medical)	0 (0%)	2 (6%)	0 (0%)	1 (5%)	**0 (0%)**	**1%**
Correctional Treatment Center/MHCB	0 (0%)	0 (0%)	0 (0%)	1 (5%)	**0 (0%)**	**1%**
General Population	21(82%)	15(48%)	4(27%)	3(15%)	**10 (33%)**	**28%**

*Does not equal 100%. There are other lesser used classifications that comprise the rest of the 21002767.1

Restricted Housing

Individuals alleged to be, or found guilty of, committing certain disciplinary infractions are typically placed in restricted housing. If found guilty, sanctions can include loss of time credits, loss of privileges, or other consequences. Incarcerated individuals can also be placed in restricted housing at their own request for protection due to perceived interpersonal safety risk[19]. In 2023, 2,982 individuals, or 3% of the total CDCR population, were housed in restricted housing.

[19] For this report, segregated housing includes: Administrative Segregation (ASU), Short-Term Restricted Housing (STRH), Long-Term Restricted Housing (LTRH), ASU-EOP Hubs, Psychiatric Services Units (PSU), Security Housing Units (SHU), and Condemned housing.

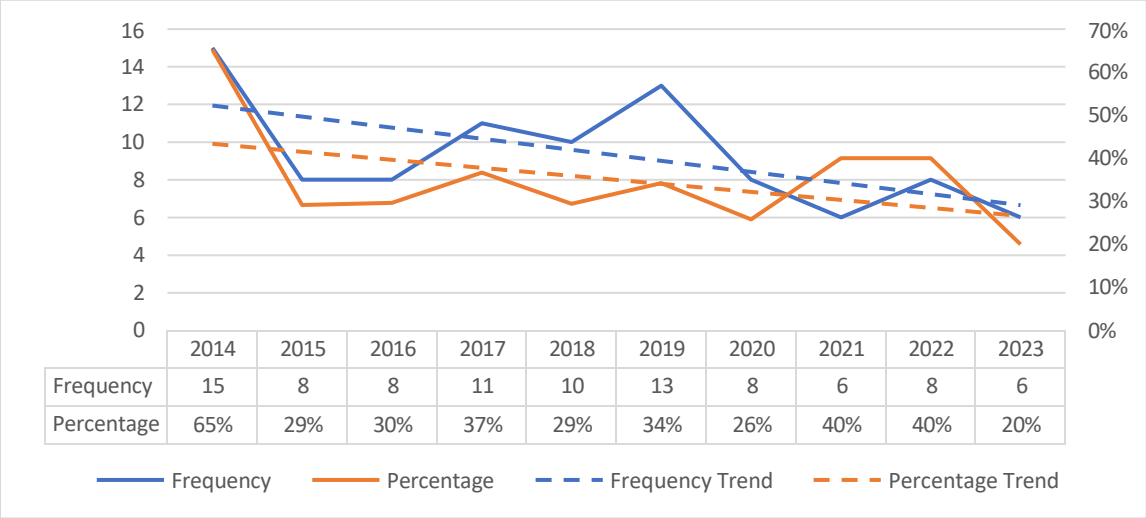
The units and cells in restricted housing are often physically similar to other housing units. But the regulations and routines of restricted housing limit an individual's movements and privileges, which can affect their mental status and functioning. The conditions of confinement in restricted housing may result in significant distress for some people, and for some, placement in restricted housing increases the risk of self-injury.

Over the last twenty years, CDCR has implemented policies and programs to increase mental health services and to reduce the risk of suicide in restricted housing. In the early 2000s, the department created specialized ASU "Hub" units and Psychiatric Services Units (PSU) for EOP patients. In 2015, CDCR developed the Short-Term and Long-Term Restricted Housing (STRH/LTRH) units for incarcerated persons at the CCCMS level of care. These units correspond to the RHU (formally known as ASU) and Security Housing Units for the non- MHSDS population, respectively. In 2023, CDCR began the process of modifying the types of restricted housing units, and re-evaluating the infractions that result in restricted housing placements, the lengths of stays associated with those infractions, and implemented rules to allow incarcerated individuals to reduce their stays in restricted housing units by engaging in rehabilitative programming. In November 2023, the system was reorganized to include an EOP RHU, a CCCMS RHU, and a General Population RHU. These changes were made to reduce the number of incarcerated persons sent to RHU; to reduce the length of time an incarcerated person spends in RHU, and to increase continuity of care by reducing transfers between different types of RHUs.

During 2023, six (17%) out of the 30 decedents were housed in CDCR restricted housing units. Of these, four were participants in the MHSDS – two at the CCCMS level of care and two at the EOP level of care. The remaining two individuals were not participants in the MHSDS at the time of their death.

Suicide rates for restricted housing are higher than in the rest of CDCR, 201 per 100,000, in 2023. There were 6 suicides that occurred in restricted housing units in 2023. For reference, the rate of suicide in segregated housing in 2022 was 269 per 100,000 which is based on 8 suicides in those settings, in 2021 was 197 per 100,000 based on 7 suicides, and in 2020 was 236 per 100,000, based on 11 suicides. In the past few years, the annual total of suicides and the percentage of total CDCR suicides that occurred in restricted housing has trended downward. However, in 2021, while the annual total number of suicides in restricted housing units significantly decreased, the percentage increased. This was due to the lower number of deaths by suicide in 2021. Figure 6 shows the number and percentage of total CDCR suicides that occurred in restricted housing from 2014 through 2023.

Figure 6: Percentage of Suicides in Restricted Housing, 2014-2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Frequency	15	8	8	11	10	13	8	6	8	6
Percentage	65%	29%	30%	37%	29%	34%	26%	40%	40%	20%

Time in Restricted Housing

The initial few days in restricted housing can be very stressful for some individuals. Similarly, extended stays (greater than 30 days) can also lead to a deterioration of an individual's mental well-being.[20] In 2007, CDCR began a program to retrofit a number of RHU cells as "intake" cells. These cells have physical modifications which include removing ligature attachment sites to increase the safety of the cells. CDCR assigns incarcerated people who are moved to restricted housing units to these intake cells for their initial 72 hours in the unit, and then transfers them to regular restricted housing cells. If an individual is double celled upon placement in the unit, they are not required to be placed in an intake cell. In 2023, six individuals were in ASU or STRH at the time of their death. The average time from ASU/STRH entry to death by suicide was 23 days, with a range from 7 days to 52 days. In 2022, five individuals were in ASU or STRH at the time of their death. The average time from ASU/STRH entry to death by suicide was 62 days with a range from 8 days to 125 days. In contrast, in 2021, the average time from ASU/STRH entry to death by suicide was 39 days with a range from 7 days to 75 days. Compared to the previous five years (2017-2021), the average time from ASU/STRH entry to suicide was 68 days.

Offense Type

Individuals whose commitment offenses were crimes against persons have a high suicide rate.[21] Individuals incarcerated for violent crimes have a suicide rate that is more than twice the rate for those incarcerated for non-violent crimes.[22] Consistent with these trends, in 2023, 22 (73%) of the suicide decedents were incarcerated due to violent crimes. Table 7 shows the number and proportion types of crimes committed by CDCR suicide decedents in 2019-2023, and the overall proportion of these crimes by the CDCR population.

[20] Haney, C. (2018). Restricting the use of solitary confinement. *Annual Review of Criminology, 1*. 285-310. https://doi.org/10.1146/annurev-criminol-032317-092326

[21] Most incarcerated individuals are charged and found guilty of multiple charges. The charges in Table 7 are the primary charges. The CDCR and the California Department of Justice define crimes against persons as violent offenses and make a distinction between those crimes and property and other crimes. Although sex crimes are considered crimes against persons, they are separated out in this report. See https://openjustice.doj.ca.gov/resources/glossary

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

Table 7: Frequency and Percent of Commitment Offenses of Suicide Decedents, 2019-2023, and CDCR Proportions for 2023

Type of Offense	2019	2020	2021	2022	**2023**	**CDCR Population Proportions in 2023**
Violent Crimes	31 (82%)	24 (77%)	9 (60%)	14 (70%)	**22 (73%)**	**73%**
Property Crimes	3 (8%)	2 (7%)	3 (20%)	4 (20%)	**3 (10%)**	**2%**
Sex Crimes	3 (8%)	5 (16%)	3 (20%)	2 (10%)	**5 (17%)**	**23%**
Other Crimes	1 (3%)	0 (0%)	0 (0%)	0 (0%)	**0 (0%)**	**2%**

Security Level

In 2023, 11 (37%) of 30 suicide decedents had Level IV classification points, the highest security level (Table 8). Three of those decedents were at Level III, ten were at Level II, and three were at Level I. Three decedents were listed as unclassified, as they died by suicide when housed in a reception center institution and had not completed processing to determine classification score. Table 8 shows that the pattern of classification levels for the higher classification levels is similar to that of the prior years.

Table 8: Frequency and Percent of Security Levels of Suicide Decedents, 2019-2023, and CDCR Proportions in 2023

Security Level	2019	2020	2021	2022	**2023**	CDCR Population Proportions in 2023
Level IV	24 (63%)	18 (58%)	8 (53%)	10 (50%)	**11 (37%)**	23%
Level III	5 (13%)	3 (10%)	1 (7%)	2 (10%)	**3 (10%)**	15%
Level II	5 (13%)	8 (26%)	5 (33%)	5 (25%)	**10 (33%)**	49%
Level I	1 (3%)	2 (7%)	1 (7%)	2 (10%)	**3 (10%)**	10%
Unclassified	3 (8%)	0 (0%)	0 (0%)	1 (5%)	**3 (10%)**	4%

Sentence Length

Another variable that is unique to suicides in correctional settings is sentence length. This variable looks at the total length of the sentence; how much time an incarcerated person served prior to the suicide death; and how much time the incarcerated person has left on his sentence at the time of death. Tables 9, 10, and 11 capture these variables. Length of sentence can have implications for the mental state of incarcerated individuals at the beginning of their prison term. Table 9 presents the sentence lengths of suicide decedents during the 2023 year as well as the past five years. In 2023, 1 (3%) of the 30 decedents was serving a life sentence without the possibility of parole (LWOP) and 3 (10%) of the 30 decedents were sentenced to 21+ years. In 2022, 7 (35%) of the 20 decedents were serving a life sentence without the possibility of parole (LWOP) and 4 (20%) of the 20 decedents were sentenced to 21+ years. This is a contrast to 2021, where almost half of the decedents were serving sentences between 11-20 years, three of which were sentenced to over 20 years.

Table 9: Frequency and Percent of Sentence Length of Suicide Decedents, 2019-2023

Sentence Length	2019	2020	2021	2022	**2023**
1-5 years	1 (3%)	5 (16%)	2 (13%)	3 (15%)	**3 (10%)**
6-10 years	5 (13%)	4 (13%)	1 (7%)	3 (15%)	**8 (27%)**
11-20 years	5 (13%)	1 (3%)	7 (47%)	2 (10%)	**9 (30%)**
21+ years	10 (26%)	6 (19%)	3 (20%)	4 (20%)	**3 (10%)**
Life w/ Possible Parole	10 (26%)	12 (39%)	1 (7%)	7 (35%)	**5 (17%)**
Life w/out Parole	6 (16%)	2 (7%)	0 (0%)	1 (5%)	**1 (3%)**
Condemned	1 (3%)	1 (3%)	1 (7%)	0 (0%)	**1 (3%)**

Table 10 shows time spent in CDCR during the current admission by individuals who died by suicide from 2019 to 2023. During 2023, the amount of time served at the time of death ranged from less than a month to more than 25 years. In 2022, the amount of time served at the time of death ranged from just 23 days to over 33 years.

Table 10: Frequency and Percent of Time Served at Time of Death of Suicide Decedents, 2019-2023

Time Served	2019	2020	2021	2022	**2023**
0-1 year	5 (13%)	4 (13%)	0 (0%)	6 (30%)	**4 (13%)**
1-5 years	12 (32%)	8 (19%)	6 (40%)	4 (20%)	**12 (40%)**
6-10 years	7 (18%)	6 (23%)	4 (27%)	4 (20%)	**6 (20%)**
11-20 years	11 (29%)	5 (39%)	5 (33%)	5 (25%)	**7 (23%)**
21+ years	3 (8%)	8 (26%)	0 (0%)	1 (5%)	**1 (3%)**

Table 11 shows the length of time remaining in sentences for those who died by suicide from 2019 – 2023. In 2023, the highest number of decedents (N= 12) had between one and five years left to serve on their sentences. This is similar to 2021 but differs from last year which saw half the decedents having more than 16 years left to serve. One decedent was not accounted for as parole was granted for the person, but the date was still pending.

Table 11: Frequency and Percent of Time Left to Serve of Suicide Decedents, 2019-2023

Time Left to Serve	2019	2020	2021	2022	**2023**
0-1 year	4 (11%)	4 (13%)	2 (13%)	3 (15%)	**6 (20%)**
1-5 years	7 (18%)	8 (26%)	5 (33%)	5 (25%)	**13 (43%)**
6-10 years	5 (13%)	2 (7%)	3 (20%)	1 (5%)	**0 (0%)**
11-15 years	5 (13%)	1 (3%)	3 (20%)	1 (5%)	**3 (10%)**
16+ years	17 (45%)	16 (52%)	2 (13%)	10 (50%)	**7 (23%)**

**One decedent's time left to serve was unknown due to pending parole board calculations, and therefore not included.*

Cell Occupancy

It is not uncommon for individuals to attempt suicide when they are alone in their assigned housing. They may be alone because they have not been assigned a cellmate, are assigned a single cell, are housed in single cell designated housing (CTC, MHCB, ASU/STRH intake cells, condemned housing), or their cellmate is away from the cell. In 2023, 23 (77%) suicide decedents were either housed on single-cell status or were housed alone although eligible for a cellmate at the time of their death. Four (13%) were in a dorm setting and three (10%) individuals died while being housed in a double cell, although were alone at the time.

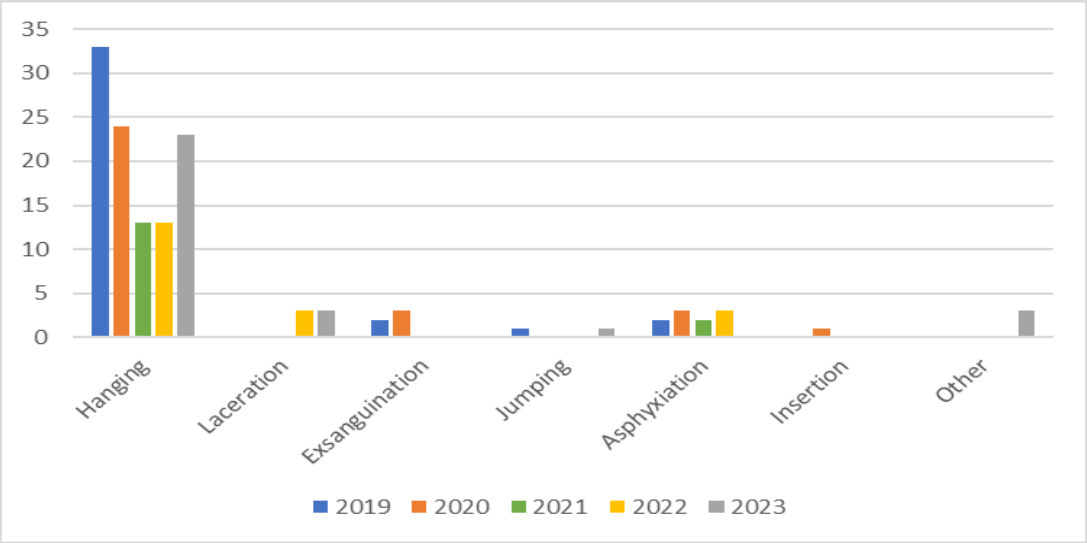
Job/School Assignment

In 2023, of the 30 individuals who died by suicide, 15 had a job or school assignment. The jobs included yard work, firefighting, and porter. In 2022, of the 20 individuals who died by suicide, ten had a job or school assignment during their incarceration.

Method of Suicide

Consistent with prior years, ligature hanging predominated as the method of suicide in 2023, with 23 of the 30 suicides (77%) completed using this method. In 18 of these 23 deaths, there was a recurring location where the noose was tied. Most decedents who died by hanging tied the noose to the bunk (30%; 7 individuals) and air vent (26%; 6 individuals), with a smaller number of ligature points at the cell door/cell door bars (13%; 3 individuals) and the window/window frame (9%; 2 individuals). The remaining seven individuals died by overdose (3 individuals), laceration (3 individuals), and jumping (1 individual). In 2022, 13 of the 20 decedents (65%) died by hanging. For those 13 deaths, the noose was tied to the bunk (31%; 4 individuals), air vent (31%; 4 individuals), the window (15%; 2 individuals), the light fixture (15%; 2 individuals), and a ladder (8%; 1 individual). The remaining seven individuals died by asphyxiation (4 individuals) and laceration (3 individuals). Unlike in previous years, no individuals utilized exsanguination or insertion as the method of their suicide in 2023. Figure 7 shows the proportions of the different methods of suicide from 2019-2023.

Figure 7: Method of Suicide, 2019-2023



Mental Health Factors

Suicide reviews and trends take into account suicide decedents' mental health factors because individuals with mental health conditions have an increased risk of suicide[23].

Mental Health Level of Care

The CDCR Mental Health Services Delivery System (MHSDS) provides mental health services to incarcerated people. The MHSDS is designed to provide an appropriate level of treatment and to promote individual functioning within the clinically least restrictive environment consistent with the safety and

[23] Yeh, H., Westphal, J, Hu, Y., Peterson, E., et.al (2019). Diagnosed Mental Health Conditions and Risk of Suicide Mortality. Psychiatric Services 70(9), https://doi.org/10.1176/appi.ps.201800346

security needs of the individual. CDCR's MHSDS is divided into levels of care corresponding to the intensity of treatment. Correctional Clinical Case Management System (CCCMS) and Enhanced Outpatient Program (EOP) are outpatient programs designed to manage mental health symptomology outside of a hospital setting. For patients who require more intensive, inpatient treatment, there are three programs available. The Mental Health Crisis Bed (MHCB) units and the Acute Psychiatric Program (APP) and Intermediate Care Facility (ICF) Psychiatric Inpatient Programs (PIPs) are programs with 24-hour nursing care provided for short, medium, and long-term hospitalization, respectively.

In both the community and correctional settings, individuals suffering from mental illness are overrepresented in the number of suicide deaths. In 2023, there were 34,219 individuals in MHSDS. CCCMS had 25,448 individuals, EOP had 7,470 individuals, MHCB had 255 individuals, Acute had 263 individuals, and ICF had 783 individuals. In 2023, 63% (N = 19) of incarcerated persons who died by suicide in CDCR were participants in the MHSDS. Eleven individuals were not in the MHSDS at the time of their death. Table 12 shows the frequency of suicides among the levels of care for 2014 through 2023 and the percent of total annual suicides for each year.

Table 12: Frequency of Suicide by MHSDS Level of Care and Percent of Total Annual Suicides, 2014-2023

Year	CCCMS	EOP	Inpatient	Percent of Total Annual Suicide Deaths in MHSDS
2014	12	9	1	96%
2015	9	5	0	58%
2016	7	15	0	82%
2017	8	10	2	67%
2018	12	10	1	68%
2019	11	16	0	71%
2020	11	7	3	68%
2021	5	3	2	67%
2022	9	7	2	90%
2023	10	8	1	63%

Mental Health Treatment Prior to Incarceration

Nineteen (63%) of the 30 suicide decedents in 2023 had a history of treatment for mental health problems in the community. Most of these individuals reported receiving mental health treatment as children or adolescents. The percentage, while in contrast to the 90% in 2022, was relatively the same as the percentages from 2017 – 2021. Table 13 shows the annual suicide rates of those incarcerated persons receiving mental health treatment in CDCR, those not receiving treatment, and the total CDCR populations from 2014 through 2023.[24]

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

Table 13: Suicide Rate (per 100,000) of Mental Health, Non-Mental Health, & Total CDCR Populations, 2014-2023

Year	Mental Health Population	Non-Mental Health Population	Total Population Rate
2014	56.3	2.2	18.2
2015	40.4	9.8	18.6
2016	58.3	5.5	21.0
2017	51.9	10.8	23.0
2018	60.9	12.0	26.3
2019	74.7	12.5	30.3
2020	70.7	13.2	17.3
2021	30.7	12.3	15.2
2022	55.3	6.1	20.6
2023	56.1	32.5	31.2
10 yr. average	**55.5**	**11.7**	**22.2**

Screening on Initial Arrival to CDCR

CDCR nursing staff administer an initial health screen to all newly arrived incarcerated individuals that includes several mental health questions. Within seven days of an incarcerated person's arrival at a reception center, a mental health clinician administers a mental health screening questionnaire as part of the Reception Center diagnostics process. The questionnaires cast a relatively wide net to identify individuals who need an in-depth mental health evaluation. Those who screen positive for mental health issues on the health screening are referred to the mental health program. Those who screen positive on the mental health screening are provided a more comprehensive mental health evaluation within 18 days of arrival, which is completed by a psychologist or clinical social worker. All 30 suicide decedents were screened upon initial arrival into CDCR at the commencement of their current incarceration.. However, not all those screenings were adequately administered. Deficiencies noted included not referring an individual to mental health expressing either suicidal ideations or mental health concerns and not adequately reviewing available records during the mental health screening. Of the 30 individuals who died by suicide during 2023, five individuals died within one year of their incarceration and one individual died the day after he arrived at CDCR. Of the 30 individuals, 19 were screened positive for mental health issues, received further mental health evaluations, and were subsequently placed in the MHSDS.

Psychiatric Medication

Of the 19 suicide decedents receiving mental health treatment at the time of their deaths, 14 were prescribed psychiatric medications as part of their treatment. Suicide case reviewers noted that medication compliance (either outright refusal or intermittent adherence) was an issue in 11 of the 14 cases. A small number of MHSDS patients are subject to involuntary psychiatric medication orders per

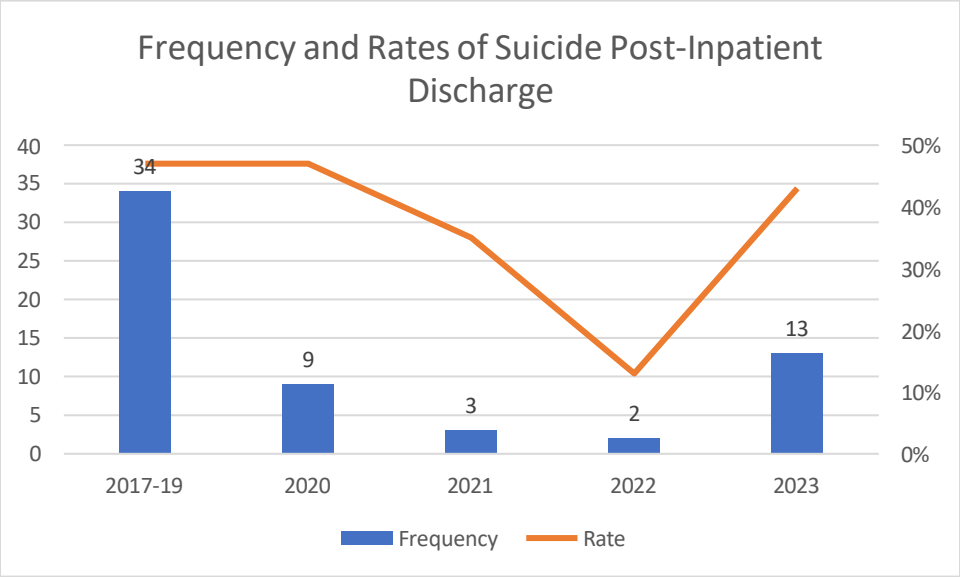
Penal Code Section 2602 due to severe mental illness and poor compliance with prescribed medications.[25] In 2023, no suicide decedents were subject to an involuntary medication order at the time of death.

History of Admissions to CDCR Psychiatric Inpatient Programs

Both in the community[26] and in correctional settings, one of the highest risk periods for suicide is after discharge from inpatient psychiatric hospitalization. Nineteen of the 30 decedents in 2023 were in the MHSDS at the time of their death, thirteen (43%) individuals were discharged from inpatient psychiatric hospitalization within a year from their death (9 MHCB admissions and 4 PIP admissions) - one within 30 days (17 days), four within 60 days, two within 90 days, and six within 90 days to a year. Sixteen of the 30 suicide decedents had been hospitalized in a CDCR inpatient psychiatric facility at some time during their CDCR tenure.

For reference, in 2022, one individual died by suicide within a year of his discharge from an inpatient psychiatric program, specifically 12 days after his discharge from an inpatient program. Due to the number of suicides that have occurred shortly after discharge from an inpatient psychiatric program, in 2021, CDCR finalized an overhaul to its High- Ri s k Management Program. CDCR changed the program's title to the Suicide Risk Management Program (SRMP) to reflect the focused attention on patients at increased risk for suicide. Additionally, specific parameters were placed around inclusionary criteria, expectations for providing treatment for individuals within the program, and guidance on when to consider a patient for removal of the program. CDCR built an automated report to aid treatment teams in identifying patients for the program, based upon the inclusionary criteria. There were no decedents enrolled in SRMP during their incarceration or at the time of their deaths, although there were six decedents who were found to have an underestimation of suicide risk.

Figure 8: Frequency and Rates of Suicides Post-Inpatient Discharge, 2020-2023



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

[26] Chung, D. T., Ryan, C. J., Hadzi-Pavlovic, D., Singh, S. P., Stanton, C., & Large, M. M. (2017). Suicide rates after discharge from psychiatric facilities. *JAMA Psychiatry, 74*(7), 694-9. doi.org/10/1001/jamapsychiatry.2017.1044

Psychiatric Diagnoses

Research has found that incarcerated individuals who die by suicide have, the presence of a psychiatric diagnosis is associated with suicide[27]. The mental health diagnoses of individuals who died by suicide during 2023 and in prior years are summarized in Table 14. Although many individuals use and abuse alcohol and illegal substances while incarcerated, substance-related and alcohol use diagnoses in Table 14 are included *only* when formally reported as a diagnosis in the medical record. All diagnoses are based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). As comorbidity is the rule rather than the exception among mental health patients, 12 of the 2023 suicide decedents had two or more diagnoses recorded.

Of the 24 individuals with DSM-5 mental health disorders in 2023, the most common categories of were substance use disorders (Opioid Use Disorder, Alcohol Use Disorder, and Amphetamine Use Disorder), which accounted for twelve, and mood disorders (Major Depressive Disorder, Depressive Disorder Not-Otherwise-Specified, and Bi-polar Disorder), accounting for ten diagnoses. Psychotic disorders (Schizophrenia, Schizoaffective Disorder, Delusional Disorder, and Psychotic Disorder Not-Otherwise-Specified), and personality disorders accounted for eight diagnoses each, totally sixteen.

Table 14: Frequency of Mental Health Diagnoses of Suicide Decedents, 2021-2023

Diagnosis	2021	2022	2023
Major Depressive Disorder	2	6	4
Unspecified Depressive Disorder	0	4	1
Bipolar Disorder	2	1	3
Schizophrenia and Schizoaffective Disorder	5	2	7
Psychotic Disorder Not-Otherwise-Specified	0	4	2
Delusional Disorder	0	0	0
Anxiety Disorder	3	3	1
Adjustment Disorder	1	2	3
Post-Traumatic Stress Disorder	2	3	4
Personality Disorders	4	2	8
Alcohol Abuse or Dependence	0	0	3
Any Substance Use-related Disorder	3	4	9
Other Diagnoses	1	0	2

Suicide Attempt History

In 2023, 57% (N=17) of suicide decedents had a history of suicide attempts in the community and/or while in CDCR custody. Of these, seven (41%) had documented reports of community suicide attempts but no attempts in CDCR custody. Self-reports or other documentation showed that nine of the 17 (53%) suicide decedents with a prior suicide attempt history had multiple suicide attempts in the past. The overall percentage of 2023 suicide decedents with a history of suicide attempts were higher than 2022 (50%) but slightly lower than the five years prior (2017-2021), when, on average, 63% of suicide decedents had a history of CDCR or community suicide attempts.

[27] Zhong, S., Senior, M., Yu, R., Perry, A., Hawton, K., Shaw, J., & Fazel, S. (2021). Risk factors for suicide in prisons: A systematic review and meta-analysis. *The Lancet Public Health, 6*(3), e164–e174. https://doi.org/10.1016/s2468-2667(20)30233-4

Suicide Precipitants and Behavior

When an individual dies by suicide, oftentimes there are stressful life events in the weeks or months prior to death that can play a role in triggering an individual's decision to make a suicide attempt[28]. These events are often described as "precipitating" events. In many cases, the precipitants or drivers are not entirely clear or definitively established. Rather, precipitating events identified by suicide case reviewers should be considered clinically presumptive about each individual's specific reasons for ending their life, based on available records and information reviewed posthumously.

Rarely can one precipitant or driver be identified as the sole reason someone made the decision to end their life. More often, suicide is the result of multiple precipitating events and pre-existing vulnerabilities. Reviewers identified seven separate categories of precipitants and drivers among the 30 2023 suicides. In total, there were 70 identified precipitants, as several decedents experienced multiple types of precipitants. The frequency of precipitants and drivers is greater than the total number of suicides, as nearly all suicide case reviews identified more than one precipitant for each suicide.

In 2023, the most frequent precipitant or driver found was a crisis of despair, isolation, loss, and hopelessness. This category was identified as significant in 16 (23%) of suicide decedents. Mental health symptoms were identified by reviewers as significant in 15 (21%) of suicide decedents. Twelve (17%) individuals had substance use issues.

The interpersonal culture of prison may include coercion and threats of violence.[29] Thus, the general category of "safety concerns" figured prominently in multiple suicides during 2023. These concerns can center on prison gang issues, threats based on a commitment offense (particularly sex crimes), gambling or drug debts, and/or medical vulnerabilities (supported or unfounded). Reviewers identified six (9%) decedents where the record suggested that safety concerns were a precipitant or driver to an individual's suicide death. Of note, 14 decedents had custodial issues which accounted for 20% of all precipitants or drivers.

Table 15: Suspected Precipitants/Drivers of Suicide in CDCR, 2023

Precipitant and Drivers Category	Frequency	Percentage of all Precipitants and Drivers Identified
Mental health symptoms	15	21%
Safety concerns, drug debts, fears of victimization	6	9%
Crises of despair and hopelessness, interpersonal losses, isolation, loneliness	1	23%
Medical illness and/or pain issues; medical disability	6	9%
Substance-related issues (use, withdrawal, etc.)	12	17%
Custodial issues (adverse transfer, long sentence, poor adjustment to prison, new charges, new court proceedings, etc.)	14	20%
COVID-19 issues (fears about illness; loss of support through illness)	0	0%

[28] Buchman-Schmitt, J. M., Chu, C., Michaels, M. S., Hames, J. L., Silva, C., Hagan, C. R., Ribeiro, J. D., Selby, E. A., & Joiner, T. E. (2017). The role of stressful life events preceding death by suicide: Evidence from two samples of suicide decedents. *Psychiatry Research, 256,* 345-352. https://doi.org/10.1016/j.psychres.2017.06.078

[29] 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

Board of Prison Hearings issues	0	0%
History of childhood trauma	0	0%

Of the 30 individuals who died by suicide during 2023, seven (23%) left suicide notes. This percentage is higher than is found in community samples (one in six),[30] but similar to 2022 in which 25% of decedents left a suicide note. It was higher than the 19% in the prior five years (2017-2021) of CDCR suicide deaths.

Determination of Unknown Causes of Death

When a death occurs in CDCR for which there is no obvious cause, it is classified as an "Unknown Death." These cases are tracked by the Suicide Prevention and Response Unit until the cause and manner of death is determined. If a death notification lists the cause of death as unknown or undetermined, the SMHP tracks the case until the death is classified. In some instances, the cause and manner of death is quickly classified during an 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 Mortality Review Committee (MRC) 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 MRC about these cases until the cause and manner of death is finalized. A member of the SMHP also sits on the MRC 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 MRC may discuss unknown or undetermined deaths with the headquarters SPRFIT Committee, particularly when a history of suicide attempts is present or if there is some suspicion an overdose was intentional, rather than accidental.

The following guidelines were developed for suicide reviewers to use when determining 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, inability to form intent, purposeful intoxication, etc.).
2. If an overdose on substances, is it reasonable that the substance (illicit or prescribed) may have been used 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 history of suicide attempts/self-injury behavior (check self-harm tracking). Did the individual:
    - Voice suicidal ideation (including conditional ideation)?
    - Have admissions to an MHCB unit?
    - Engage in self-injury 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?

[30] 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 57 The *Plata* Three-Judge panel recognized in 2011 that state-by-state comparisons are of "limited value" when they fail to "control for demographics of each state's inmate population." ECF No. 3641 at 88.

- If yes, what did the individual 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 individual facing criminal charges?
    - Did the individual lose an appeal?
    - Did the individual 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?

In 2023, 102 individuals' deaths were classified as unknown. Of importance, this number can change depending on subsequent coroners' reports of these 102 individuals.[31]

Self-Injury Incidents, Including Suicide Attempts

Self-injury among incarcerated persons is a serious problem. A 2011 national survey that collected data from 39 state and federal prison systems in the United States found that "in the average prison system less than 2% of individuals per year engaged in self-injurious behavior…."[32] Most systems surveyed reported that these types of incidents are at least somewhat disruptive to facility operations and consumed significant mental health resources.[33]

In 2017, CDCR established an electronic system to track incidents of self-injury. Suicide prevention coordinators in each institution enter data about intent, medical severity, method, and disposition into the electronic health record system. The On-Demand reporting system generates a real-time report available statewide that can be used to track individuals and injuries across all settings.

In 2023, the system reported 4,877 separate incidents of self-injury by 1,950 individuals. The majority of these incidents (N = 3,962) resulted in no or minor injury. Most incidents of self-injury (N = 4,204; 86%) during 2023, were determined to be non-suicidal when the intent was known (Table 16). However, 410 (8%) were considered suicide attempts (self-injury with intent to die), of which 30 (0.6% of total incidents and 7% of all incidents with intent) resulted in death by suicide (Table 17). For reference, in 2022, the system reported 5,382 separate incidents of self-injury by 1,973 unique individuals. The majority of these incidents (N = 4,674) resulted in no or minor injury. Most incidents of self-injury during 2022 (4,265 or 80% of all reported self-injury where the intent was known) were non-suicidal. However, 377 (7%) were considered suicide attempts (self-injury with intent to die), of which 20 resulted in death by suicide. There were also 10 incidents where intent could not be determined.

[31] Based upon the official coroner's report, 2 individuals were subsequently classified as suicides. These cases were reviewed in 2023.

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

[33] 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

Table 16: Non-Suicidal Self-Injury Incidents in CDCR by Mental Health Level of Care and Injury Severity, 2023 (excluding incidents with unknown intent)

Level of Care	No Injury	Minor	Moderate	Severe
GP	17	43	33	3
CCCMS	134	276	63	5
EOP	344	799	158	10
EOP Mod	3	13	2	0
MHCB	288	679	85	3
ICF	163	422	47	1
Acute	150	392	52	3
Total	1103[34]	2634[35]	442[36]	25

Of the 381 non-lethal incidents with intent to die, 156 (41%) had moderate or severe injuries ("serious" attempts). The majority of self-injury incidents with intent to die resulted in no or minor injury. Table 17 gives a breakdown of these incidents, including the ones which resulted in death in 2023. For reference, in 2022, of the 302 non-lethal incidents with intent to die, 109 (36%) had moderate or severe injuries ("serious" attempts). The majority of self-injury incidents with intent to die resulted in no or minor injury.

Table 17: Self-Injury Incidents in CDCR with Intent to Die, by Mental Health level of Care and Injury Severity, 2023 (excluding incidents with unknown intent)

Level of Care	No Injury	Minor	Moderate	Severe	Death
GP	11	11	12	4	9
CCCMS	17	46	22	7	8
EOP	13	37	55	20	8
EOP Mod	0	0	1	0	0
MHCB	11	36	15	5	0
ICF	12	6	7	1	1
Acute	11	14	6	1	0
Total	75	150	118	38	29[37]

Of the 4,204 incidents of non-suicidal self-injury (NSSI), 467 (11%) were classified as moderate or severe in medical severity. The most common methods of NSSI were lacerations, followed by ingestion, and insertion of objects. More than 88% of the NSSI lacerations were classified as No Apparent or Minor Injury. For reference, in 2022, of the 4,754 incidents of non-suicidal self-injury, 489 (10%) were classified as moderate or severe in medical severity. More than 89% of the NSSI lacerations were classified as No Apparent or Minor Injury.

Suicide Response Procedures

The process of responding to and reviewing suicide deaths is governed by the MHSDS Program Guide, 2021 Revision, Chapter Ten: Suicide Prevention and Response (12-10-23 to 12-10-28), and internal timelines of the Suicide Prevention Unit of the Statewide Mental Health Program.

[34] Data from the analysis lists an additional 4 instances of no apparent injury under the "unknown" and "blank" categories.

[35] Data from the analysis lists an additional 10 instances of minor injury under the "unknown" and "blank" categories.

[36] Data from the analysis lists an additional 2 instances of moderate injury under the "unknown" category.

[37] Data from the analysis lists the number of deaths as 29 not 30. Additionally, the tally equals 26. There were 3 deaths not listed in any category – 2 in "unknown" category and 1 in "blank" category.

Reporting of a suicide to stakeholders

When an incarcerated person dies by suicide, members of the SMHP complete two formal notification processes. First, a death notification is written and sent to the Office of the Special Master (OSM) and contains details of the suicide. Second, a summary of the suicide is composed and sent to the Deputy Director of the SMHP, the Undersecretary of the Division of Healthcare Services (DHCS), and the Governor's office. The Public Information Officer at the institution is assigned with any local notifications or reports regarding the death, including notifying the next of kin of the suicide.

Institutional internal review process

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

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

External review processes

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

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

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

DAI Mental Health Compliance Team (MHCT) reviews

The reviews completed by DAI's MHCT focus on the performance of custody staff members related to the death by suicide. The MHCT member reviews custody documentation and institutional records (i.e., SOMS). The MHCT member's role is to determine whether departmental suicide prevention and response practices and policies were followed by custody staff involved in the case. The MHCT reviewer, for example, evaluates whether custody staff followed procedure during the emergency response, how quickly the response was called once the suicide attempt was discovered, and whether all custody staff responding to the incident had received required training (e.g., in CPR, annual suicide prevention, and use of force trainings) within set timelines. The context of the suicide may necessitate additional review items. Most notably, if the individual was placed in a restricted housing unit at the time of the suicide, the MHCT reviewer will evaluate performance on tasks such as timeliness and quality of welfare checks, as specified by policy, whether incarcerated individuals new to an RHU were placed in intake cells, issued an entertainment appliance, and provided access to services such as yard, phones and treatment. The MHCT reviewer also constructs a timeline for the emergency response and for significant events leading up to the suicide. Finally, the MHCT reviewer will document any concerns noted and will recommend corrective action/QIPs.

Nursing reviews

At the same time as a death by suicide is reviewed by DAI's MHCT, a Nurse Consultant Program Reviewer (NCPR) is assigned by a Headquarters Chief Nurse Executive. The NCPR does not make an on-site visit but reviews all healthcare record documentation in Electronic Healthcare Record System (EHRS) as to the quality of nursing care in the case. All nursing suicide prevention practices including the Licensed Psychiatric Technician rounds, as well as nursing rounds for patients on suicide observation status, are covered within the nursing review. The NCPR and mental health case reviewer frequently consult with each other on cases during the review period.

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

CCHCS Mortality Review Committee

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

considered by the CCHCS Mortality Review Committee for corrective actions on either an institutional or individual basis.[38]

Statewide Mental Health Program (SMHP) reviews

Simultaneous to custody, medical, and nursing reviews, a trained member of the SMHP is assigned to review each suicide. The assigned Mental Health Suicide Reviewer, typically a Senior Psychologist Specialist, is tasked with completing a Suicide Case Review. The Mental Health Suicide Reviewer schedules an on-site visit with the institution and is accompanied by the custody reviewer. The site visit is conducted within seven calendar days of the death. The site review consists of an inspection of the location of the suicide and of the means used in the death, an inspection of the decedent's personal property, and interviews of incarcerated peers, officers, medical, mental health, or other staff members who knew, interacted with, and/or treated the deceased. The decedent's property is inspected to see if there is any information present related to the suicide, such as a suicide note, letters to the incarcerated person informing them of bad news, and other information associated with the death. Interviews focus on behavior and statements made in the days prior to the suicide, with questions about anything the decedent may have said about being distressed or suicidal in past days, weeks, or months. Photographs of the scene at the time of death and photographs of the autopsy are made available, as are phone records, trust accounts, toxicology reports, and other information. The Mental Health Suicide Reviewer may contact family members of the deceased to gain additional information about the individual's state of mind, statements made prior to the suicide, etc.

In addition to the on-site review, the Mental Health Suicide Reviewer examines extensive documentation from medical and custodial files, including all relevant information in each case. The focus of the review will vary, depending on the factors of each case, including, for example, evidence of the suicide decedent's mental health treatment received while in CDCR; the quality of suicide risk assessments; and the presence or absence of distress when an incarcerated person is placed in restricted housing. SMHP psychiatry staff review the psychiatric care and consult with the Mental Health Suicide Reviewer. The Mental health Suicide Reviewer will review information from each of the institutions where the deceased resided and will look at whether mental health policy and procedure was followed at each setting.

Determination and tracking of Quality Improvement Plans (QIPs)

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

SCR meetings are held by teleconference so that staff from the institution can attend. During the meeting, the case reviewer will read sections of the Suicide Report. The Suicide Case Review Committee (SCRC) is

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

made up of members of the CDCR SMHP, DAI MHCT, Nursing Executives, CDCR's Office of Legal Affairs, and medical personnel (as needed). The SCRC also discusses the QIPs raised within the Suicide Case Review with the institution. Institutional staff can respond to, or clarify, concerns raised in the report, can raise additional concerns, or can discuss ways of meeting the requirements of the QIPs. Since late 2015, experts from the *Coleman* OSM have participated in the SCR process and provided critiques of the preliminary draft report that have resulted in some revisions, including additional QIPs, of those reports. QIPs can also be written as pending concerns that need to be addressed if a fact or finding awaits further information, such as awaiting the results of a coroner's report to determine the time of death.

Timeliness of Suicide Case Reviews and Suicide Reports

The suicide response process, including completing reviews, writing, and editing reports, and tracking QIP compliance, is complex. Timelines for each step of the suicide response are specified in the MHSDS Program Guide, 2021 Revision. Internal deadlines have also been developed to ensure timelines for each step of the suicide response process are met. The number of days allotted to complete each step of the suicide response process as specified in the Program Guide are shown in Table 18.

Table 18: Suicide Case Review Tasks and Timelines as Specified by the MHSDS Program Guide

Case Review Actions	Number of Days after the DoD within which the action must be completed
Suicide reviewer assigned	2
Site visit	7
Institutional Internal Review submitted to the SMHP	10
Custody & Nursing Report due to MH Reviewer	22
Suicide Report received by the SMHP	25
Suicide Case Review conference	45
Final suicide report to institution approved and signed by MH/DAI	60
QIPs completed at the institution and submitted to the SMHP	60 (30 days from the receipt of the final report)
Final QIP Report reviewed and approved/signed by MH and DAI leadership	120
Final QIP report electronically transmitted to the OSM	180

The SMHP tracks adherence with the tasks reported above for each suicide that occurs. Table 19 provides a review of the compliance of steps for the suicides that occurred in 2023.

Table 19: Compliance with MHSDS Program Guide Timelines for Suicide Case Reviews

MHSDS Program Guide Timelines	Compliance
Suicide reviewer assigned	80% (6 late)
Site visit within 7 days	34%[39] (19 late, 1 N/A)
Institutional Internal Review submitted to the SMHP	65%[40] (11 late, 1 N/A)
Suicide Case Review conference	63% (11 late)
Final suicide report to institution approved and signed by MH/DAI	70% (9 late)
Final QIP Report reviewed and approved/signed by MH and DAI leadership	87% (4 late)

Table 19 summarizes the timeliness of the reporting and review process for 2023 suicides. In 24 (80%) of 30 cases, the suicide reviewer was assigned within two days, and in the remaining 6 cases, assignments were delayed due to internal administrative investigations or delayed coroner's reports. Of the review team (mental health and custody) site visits, only ten were completed within seven days of the date of the individual's death. Additionally, one of the cases did not require a site visit because the site review was conducted remotely. There were delays in scheduling site visits due to the availability of MH reviewers and DAI Lieutenants, as well as holidays and weekends. Eighteen (62%) of the institutional internal reviews were submitted to the SMHP in a timely manner, with one listed as not applicable as this was at a fire camp that had no MH staff at the camp to complete the review. Additionally, six institutional reviews were submitted within 1 day of the due date and one case did not require an institutional review due to having occurred at a Fire Camp. Two of the cases were submitted after the 10-day deadline because case reviews were delayed by internal investigations and late coroner's reports and the final three were delayed due to reviewer availability or illness. Four (33%) of the original reports were completed within 25 days of death. Ten of these were past the deadline due to internal investigations/coroner's reports delaying the cases' review start date, reviewer availability or illness and case complexity. The remaining 18 were completed within 8 days of the 25-day deadline due to weekends and holidays. The average time for an original report to be transmitted to the OSM was 33.7 days from the date of death. Nineteen SCR meetings (63%) were timely. Four (13%) meetings were held within one week of the required timeframe due to weekends and/or holidays falling within the 45-day time period. The remaining seven late meetings ranged from 11 to 63 days late due to the complexity of the cases and/or timelines being delayed due to administrative investigations or coroner's reports and/or reviewer availability.

After suicide reports are reviewed at the SCR meeting, final edits are completed, and a finished report is sent to the institutions within 60 days after the date of death. In 2023, 21 reports (70%) were sent to institutions within 60 days. Seven reports were sent between 63 to 75 days, being overdue between three to 15 days, due to case complexity and weekends/holidays delaying the reviewer finalizing the report. The final two were delayed due to the receipt of a coroner's determination which triggered the suicide case review process. QIPs are required to be reported back to headquarters where they are reviewed and eventually transmitted to the OSM. The timeframe for return of completed QIPs to headquarters is 120-days post death. In 2023, 26 (87%) reports were returned by the 120-day mark Two reports were submitted within 2 days of the 120-day mark due to holidays and weekends. The final two reports were delayed due to receipt of a coroner's determination which triggered the suicide case review process.

[39] Percentage is based on 29 of the 30 cases. One case was listed as N/A due to the reviewer not going to the institution. In the related case, the reviewer did not go to the institution as the decedent had been at the facility for less than 24 hours with no property issued.

[40] Percentage is based on 29 of the 30 cases. One case was listed as N/A due to the decedent being at a fire camp.

Compliance with many of the deadlines was negatively impacted by the fact that all reviewers and most institutional SPRFIT staff do not work weekends and holidays, but weekends and holidays are counted in the court mandated timelines. In addition, for five of the 30 cases in 2023 the review of the case was not started on the date of death due to internal investigations and/or coroner's reports triggering the suicide case review to start anywhere from 1 week to 68 days after date of death. Current policy does not provide exceptions to the timelines due to such late triggering events.

CDCR continues to work to improve timeliness and meet SCR deadlines. The SMHP Suicide Prevention and Response unit conducted an analysis of the timeline deficiencies and developed proposals to address the origin of the deficiencies. Additionally, there were modifications in internal processes to increase compliance with timeliness associated with SCRs.

Audits of Suicide Case Review quality

The SMHP's Suicide Prevention and Response Unit audits all SCRs for quality and adherence to a standard set of fifteen elements, found in Table 20. Of the SCRs completed in 2023, no audits item fell below 100%, demonstrating the Suicide Case Review process remains a strong and consistent component of CDCR's suicide response program.

Table 20: Results of Quality Audits, 2023 Suicide Case Review Reports

Audit Item	Applicable Cases	Compliance
1. Does the Executive Summary describe the means of death, the emergency response taken, and the Mental Health (MH) LOC of the patient?	30	100%
2. Are the sources for the Suicide Case Review (SCR) identified?	30	100%
3. Are substance abuse issues reported, if applicable?	23	100%
4. Does the Institutional Functioning section include information on institutional behavior, including disciplinary history?	30	100%
5. Does the Mental Health History review the adequacy of mental health care and screening?	30	100%
6. Are medical concerns discussed (e.g., chronic pain, terminal illness) or is the absence of medical conditions noted?	30	100%
7. Is the quality of the most recent suicide risk evaluations (past year) reviewed, with comment on risk level, safety planning, and risk and protective factors?	30	100%
8. Does the Suicide History section review all prior attempts, as applicable?	17	100%

9. Are significant pre-suicide events discussed (e.g., receipt of bad news or existence of a safety concern)?	30	100%
10. Was a risk formulation offered specific as to why the person was vulnerable to suicide?	30	100%
11. Does the review comment on the adequacy of the emergency response?	30	100%
12. Are all violations of policy and breaches of standards of care in mental health, medical, and nursing addressed in the reviewer's concerns, if applicable?	30	100%
13. Were custody policies followed? If not, were violations noted in the report?	30	100%
14. Were all concerns raised by reviewers (custody, nursing, and mental health) represented in Quality Improvement Plan recommendations?	30	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).	30	100%
Compliant Items/Total Items	431	100%

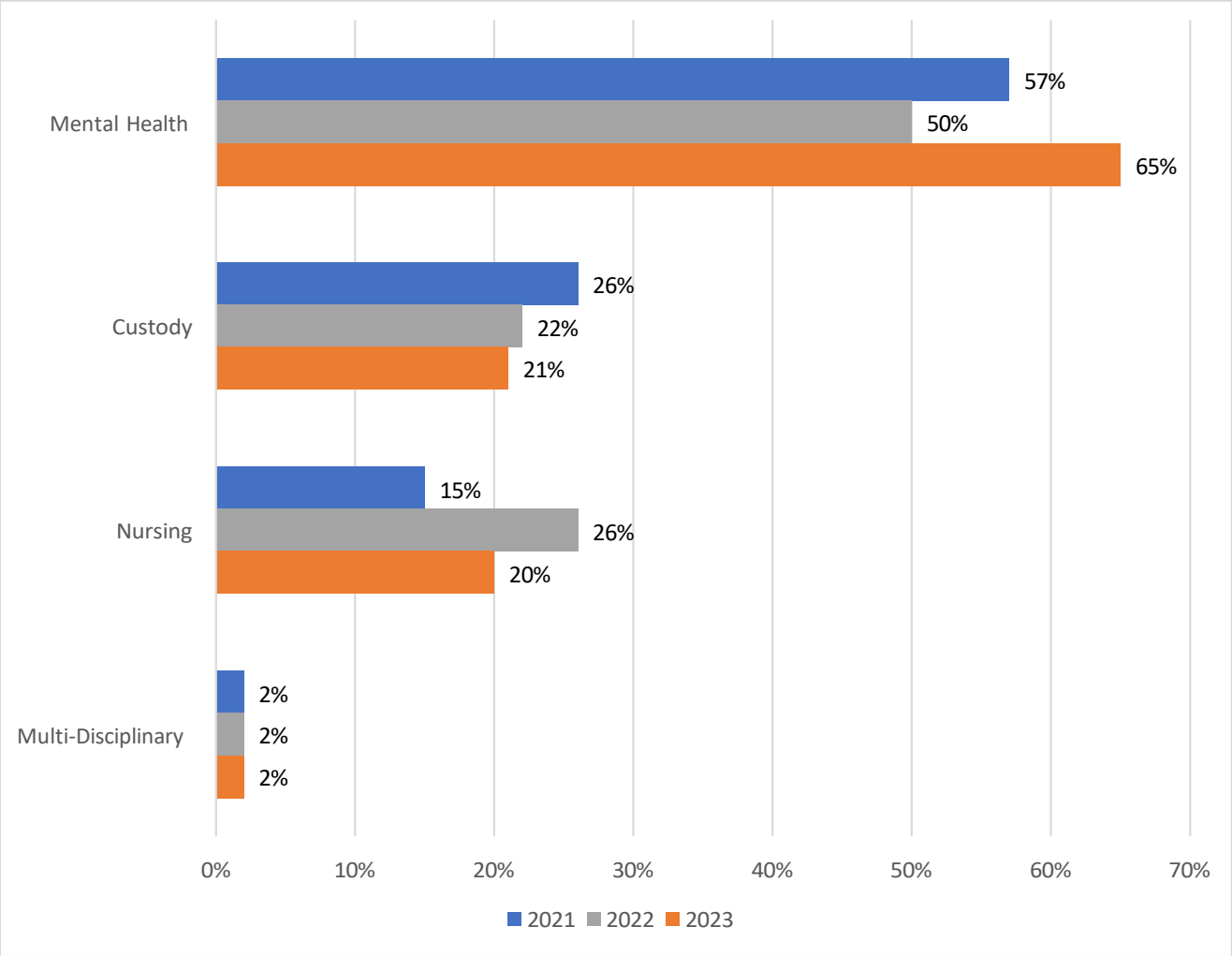
Analysis of Improvement Efforts

The purpose of assigning quality improvement plans is to ensure that the issue or deficiency identified is corrected for policy violations or deviations from standards of care. It is essential to close the feedback loop when a QIP is assigned to demonstrate improvement in practice. This section describes the tracking of QIPs to include the proportion of QIPs by discipline, commonalities in individuals SCRs, and efficacy in QIPs.

Determination and Tracking of Quality Improvement Plans

QIPs are developed based on concerns or departures from policies and procedures identified by custody, nursing, medical, and mental health case reviewers regardless of whether the concern or departure led to the suicide. 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. Once a QIP has been assigned to an institution, the assigned party has 60 days from the receipt of the final report to determine the action that will address the identified problem and provide proof of practice that the issue has been corrected. Historically, this is where the process ended. The Suicide Prevention and Response Unit at Mental Health Headquarters would review the documentation and determine if it was resolved, assuming all relevant information was provided. Figure 9 shows the proportion of QIPs assigned by discipline for 2021, 2022, and 2023.

Figure 9: Proportion of Suicide Case Review QIPs by Discipline, 2021- 2023



CDCR recognized that the QIP process may not resolve all identified issues and deficiencies or that it was effective at reducing future incidences of similar non-compliance and/or policy violations. With the allocation and hiring of the Suicide Prevention Coordinators (SPC) in each region, which was finalized in 2021, CDCR was able to begin developing the process of monitoring QIP efficacy. The SPCs in each of the regions track all QIPs after they have been completed by the institutions in their regions. During their regular onsite monitoring, the SPCs report on the ongoing status of the originally identified deficiency and discuss any concerns that have arisen with the institutional SPRFIT Coordinator and institutional leadership. An institution is determined to be compliant if, after two consecutive onsite visits, the issue appears to have been resolved in a sustained manner. Each QIP must be addressed based on the case factors at issue in the reported suicide.

In addition to identifying issues that arise in Suicide Case reviews, the statewide Suicide Prevention and Response Unit identifies issues across institutions that appear to be systemic and that necessitate intervention at an agency level, rather than relying on institutions to resolve the concerns locally. When such issues are identified, the statewide SPRFIT Committee works to develop and implement statewide solutions. This can come in the form of policy language revisions, introduction of new policies or procedures, or development of new programs or interventions.

In 2023, of the 187 QIPs assigned, 121 were MH-related, 40 were Custody-related, 38 were Nursing-related and 4 were multidisciplinary.[41] For the majority of the QIPs, CDCR expected the institutional leadership to identify the solutions and resolve the concerns within their respective institution. Institutional leadership, tasked with ensuring timely completion of actions deemed necessary to address the concerns identified in the QIP, implement specific solutions following the suicide case review call with stakeholders. Once solutions are implemented, the SPCs notate the action and conduct their own reviews of the originally identified deficiency during their regular onsite reviews. Once an institution has demonstrated sustained resolution of a QIP, measured by their own metrics and with external reviews by the statewide suicide prevention team, the QIP is deemed to be effective in resolving the specific issue. Four of the QIPs were assigned to headquarters to address, as they were systemic concerns. For comparison, in 2022, of the 126 QIPs assigned, 67 were MH-related, 30 were Custody-related, 35 were Nursing-related and 2 were multidisciplinary.

Headquarters-Assigned QIPs

There were four QIPs issued to HQ in 2023. The first HQ QIP involved a decedent who had a recent history of identified medical concerns that appeared to cause him significant distress. Further complicating these concerns was a reported fear that he would need to return to an institution for medical treatment, which he viewed as punitive, and it was speculated that this may have been a trigger for his ultimate suicide. While this issue was identified, it was not a reflection of staff at the institution, rather it was identified as a gap in our CDCR healthcare system. As a result, this was assigned to HQ SPRFIT. HQ SPRFIT reviewed this concern and provided a quarterly progress report to address this item. On August 18, 2023, HQ Nursing reported that it met with the CNEs and Regional CNEs from CIW, CMC, CRC and SCC, who have fire camps as part of their mission, As the first step in the response to the SPRFIT QIP. They discussed the current access to healthcare process at each of the fire camps or hubs and are scheduled to meet as a workgroup with MH and DAI to discuss their findings and how to proceed. This QIP remains open pending final workgroup determination.

The second HQ QIP involved a decedent's discharge from MHCB. In this case, a SRASHE was completed on April 12, 2023, but a safety plan was not completed and the SRASHE did not include a link to the Safety Plan form, which may have contributed to this concern. The institution was tasked to review the identified concern and decide the best course of action to ensure compliance with the Safety Plan policy. The HQ Suicide Prevention team was tasked to review this concern and work to resolve the issue identified regarding linking the Safety Plan with the SRASHE Powerform. On August 16, 2023, an update indicated HQ SPRFIT and MH Leadership reviewed the concern and will review the issue for resolution following an anticipated build of the revised SRE.

The third HQ QIP involved a transgender suicide decedent who had requested gender affirming surgery (GAS) in 2022. It is believed that the individual's distress surrounding the lack of response to their requests may have exacerbated their mental health symptoms. The Gender Affirming Surgery Review Committee (GASRC) meeting was noncompliant with the timelines under the policy (100 days outside of the compliance date of 90 calendar days from the time the GAS Request Packet was submitted) due to a significant statewide backlog. This backlog was determined to be a result of a frequent lack of quorum that prevented the committee from reviewing cases within a 90-day period after the GAS Request Packet was submitted to HQ. Statewide Mental Health Services and Medical Services HQ Deputy Directors over

[41] The total number of QIPs summarized here is 203, although the grand total reported is 187. This is due to the joint assignment of QIPs to more than one discipline. For example, a 911 activation QIP can be jointly assigned to Custody and Nursing as both disciplines have different roles in how that QIP should have been handled.

GASRC or corresponding designees will appoint a task force composed of two physicians, two psychiatrists, two psychologists, and at least two available GASRC members who may serve as Chairs, to mitigate the GASRC backlog so that compliance with HCDOM Policy 1.2.16 Gender Affirming Surgery Review Committee can be achieved consistently by July 1, 2024. All participants of this task force must be eligible to participate as GASRC voting members or be able and willing to undergo the training to become a GASRC voting member under the current HCDOM policy. The selection of task force members may be selected from CCHCS/CDCR HQ staff or institutional staff. Selected task force members shall have sufficient time allotted outside of their regular job duties to complete this special assignment.

The fourth HQ QIP involved the same transgender decedent described in the preceding paragraph. During the SCR, concerns related to misgendering of the patient in the health care record (using incorrect honorifics, pronouns, and an indication of describing the patient as male/a man when she was not) occurred frequently. Several items may contribute to this despite Banner Bar notification of the patient's pronouns and honorifics that were derived from the most recent GIQ entered into SOMS: (1) Mismatched gender/sex fields within EHRS, SOMS, and ERMS create confusion about gender, sex, and gender identity; (2) EHRS and SOMS lack an accurate way to reflect current legal gender marker and creates confusion in the data keeping records across CCHCS/CDCR; (3) Cisgender patients in SOMS and EHRS do not have updated pronouns and/or honorifics, often listed as “Ask Pt” in the Banner Bar, which may create ongoing confusion and oversight by healthcare staff.; and (4) the lack of guidance on how and when to query a patient regarding sexual orientation and gender identity (SOGI) related elements does not create healthcare accountability or personal engagement for our healthcare staff to appropriately interact with LGBTQIA+ patients. Staff are currently required to attend training on how to work with transgender, nonbinary, and intersex patients, but CCHCS lacks a system to track and reflect patient self-report of SOGI-related items consistently and periodically. The QIP resolution requires Executive leadership in Healthcare Services or designee(s) and Executive leadership in FOPS/DAI or designee(s) to incorporate a multidisciplinary driven system that allows for resolution of the issues mentioned above. Proof of practice would need to be provided indicating the IT tickets, committee approvals, and go-live dates or other documentation indicating that these changes have occurred in each record-keeping system. The status of this QIP is still open and ongoing.

Institution-Assigned QIPs

Most QIPs were issues that were handled by their respective institutions. These QIPs involved responsive actions such as training and mentoring to help prevent, among other things, issues with documentation and knowledge and application of policy. The addition of the Suicide Prevention Coordinators in 2021 help address these ongoing issues. The coordinators monitor their assigned institutions to determine if there are trends within the institution on reported deficiencies. Additionally, they assess for any delays and barriers to the implementations of the QIP. Concerns which arose in more than one suicide case review or at more than one institution are considered at the statewide level to explore whether there are systemic issues that need to be addressed.

CDCR conducted an in-depth review to determine if there were any pervasive issues within an institution that had more than one death by suicide in 2023. WSP had four individuals who died by suicide, all of whom were in the Reception Center. WSP had a total of 20 QIPs: 11 MH QIPs, 4 Custody QIPs, and 5 Nursing QIPs. Of the 20 QIPs, none were repeated or addressed the same or similar issues or deficiencies. However, there was some overlap in the Custody and Nursing QIPs. Custody had two individuals with QIPS related to cut down tool kit issues and Nursing had two individuals with QIPs related to referral issues.

MCSP had three suicides in 2023. MCSP had a total of 14 QIPs: 8 MH QIPs, 2 Custody QIPs, and 4 Nursing QIPs. Two cases identified similar issues with a failure to meet Program Guide timelines. There was no overlap between any of the custody QIPs. To address the nursing QIPs, CDCR implemented specific training and audits, and nursing documentation was updated in the annual nursing training at a statewide level.

COR, RJD, LAC, FSP, SQ, and CMC each had two deaths by suicide. COR had a total of 9 QIPs: 5 MH QIPs, 2 Custody QIPs, and 2 Nursing QIPs. Both cases had QIPs pertaining to institutional issues in Custody (rigor mortis) and Nursing (documentation). COR also had a multisystem QIP joint with CMF, which was discussed as the fourth headquarters QIP above in the Headquarters QIP section. RJD had a total of 21 QIPs: 10 MH QIPs, 8 Custody QIPs, and 3 Nursing QIPs. There were commonalities among the two cases pertaining to institutional issues in MH (Justification of Risk) and Custody (cut down tool kit). LAC had a total of 9 QIPs: 3 MH QIPs, 4 Custody QIPs, and 2 Nursing QIPs. There were commonalities in Nursing only, with both cases having nursing checks/rounds issues. FSP had a total of 2 QIPS: 0 MH QIPs, 1 Custody QIP, and 1 Nursing QIP. There were no commonalities among the two cases pertaining to institutional issues. SQ had a total of 9 QIPs: 6 MH QIPs, 0 Custody QIPs, and 3 Nursing QIPs. There were commonalities among the two cases pertaining to institutional issues in MH, specifically the Program Guide timelines. CMC had a total of 12 QIPs: 8 MH QIPs, 4 Custody QIPs, and 0 Nursing QIPs. There were commonalities among the two cases pertaining to institutional issues in MH, specifically Level of Care concerns.

The Statewide Suicide Prevention and Response Unit reviews QIP trends regularly to determine if intervention is required. Work remains to refine the various concerns identified above and specific efforts are underway to address each concern. For example, an ongoing concern that has been found across many suicide case reviews at nearly all institutions is adequate suicide risk justification. As indicated above, CDCR is revising the current suicide risk evaluation to assist clinicians in making more accurate risk justifications and streamlining the process of gathering critical information to aid in this decision making. As a result, in 2022, a workgroup convened with the *Coleman* OSM, representatives from CDCR Statewide Mental Health Program, and field leadership to review the current SRASHE form and make recommendations on how to improve the form. The workgroup is continuing to develop a new suicide risk evaluation for the field to use that addresses correctional-specific suicide risk factors and enhances clinicians' ability to assess and reduce suicide risk.

Once an institution has been assigned a QIP, the local leadership is tasked with developing a solution to ensure sustained correction has been achieved for the identified concern. Table 21 summarizes the actions taken by either individual institutions or Headquarters. The table below shows the breakdown by discipline of issues that were identified more than twice, which could be viewed as a pattern of concern. The "Frequency of QIPs" column provides the number of instances in which the concern was present, not the number of individual suicide decedents whose suicide review implicated the issue. The issues identified in Table 21 are generated from the QIP descriptors (Appendix B). For example, there are 16 instances of Safety Planning issues, identified as QIPs from 11 suicide reviews.

Table 21: Frequency of QIPs at Institutions Experiencing Suicide, 2023

Mental Health

Issue Identified	Frequency of QIPs	Institutions Involved	Action Taken
Safety Planning	16	COR (3), CMF (3), CMC (2), RJD (2), SAC, CIM, SQ, LAC, KVSP, WSP	Audit conducted; Training provided; increase of consultations
Program Guide Timelines	13.5	VSP (4), MCSP (2), CHCF (2), RJD, SVSP, COR, NKSP, HDSP, SQ, KVSP, WSP	Audit conducted. Training provided; 90-day process improvement plan
Treatment Planning	11.5	MCSP (2), SAC (2), VSP (2), SVSP-PIP, WSP, HDSP, SQ, CMC, LAC	Training provided; audit conducted; Self-Harm and Treatment Planning memo distributed
MH Documentation	9.5	CMF (2), WSP (2), CHCF (2), RJD, SVSP, MCSP, CMC	Training provided; audit conducted; Suicide Prevention memo by CMH; 90-day process improvement plan
SRE/Justification of Risk	7.5	RJD (3), KVSP, SAC, COR, CMF, MCSP	Training provided; audit conducted

Custody

Issue Identified	Frequency of QIPs	Institutions Involved	Action Taken
Cut Down/Tool Kit	8	RJD (3), SVSP, WSP, KVSP, LAC, CMC	Training provided; Investigation opened in 1 of the cases
Policy Violation	5	RJD, MCSP, CTF, LAC, WSP	Training provided; Investigation opened in 2 of the cases
911 Activation	4	LAC, WSP, CTF, CMC	Training provided; Investigation opened in 1 of the cases
Emergency Response	4	CMF, RJD, SVSP, WSP	Training provided; Investigation opened in 2 of the cases

Rigor	4	COR (2), SVSP, CMC	Investigation opened in all of the cases
Universal Precaution/ Protective Equipment	4	RJD, LAC, CRC, CMC	Training provided

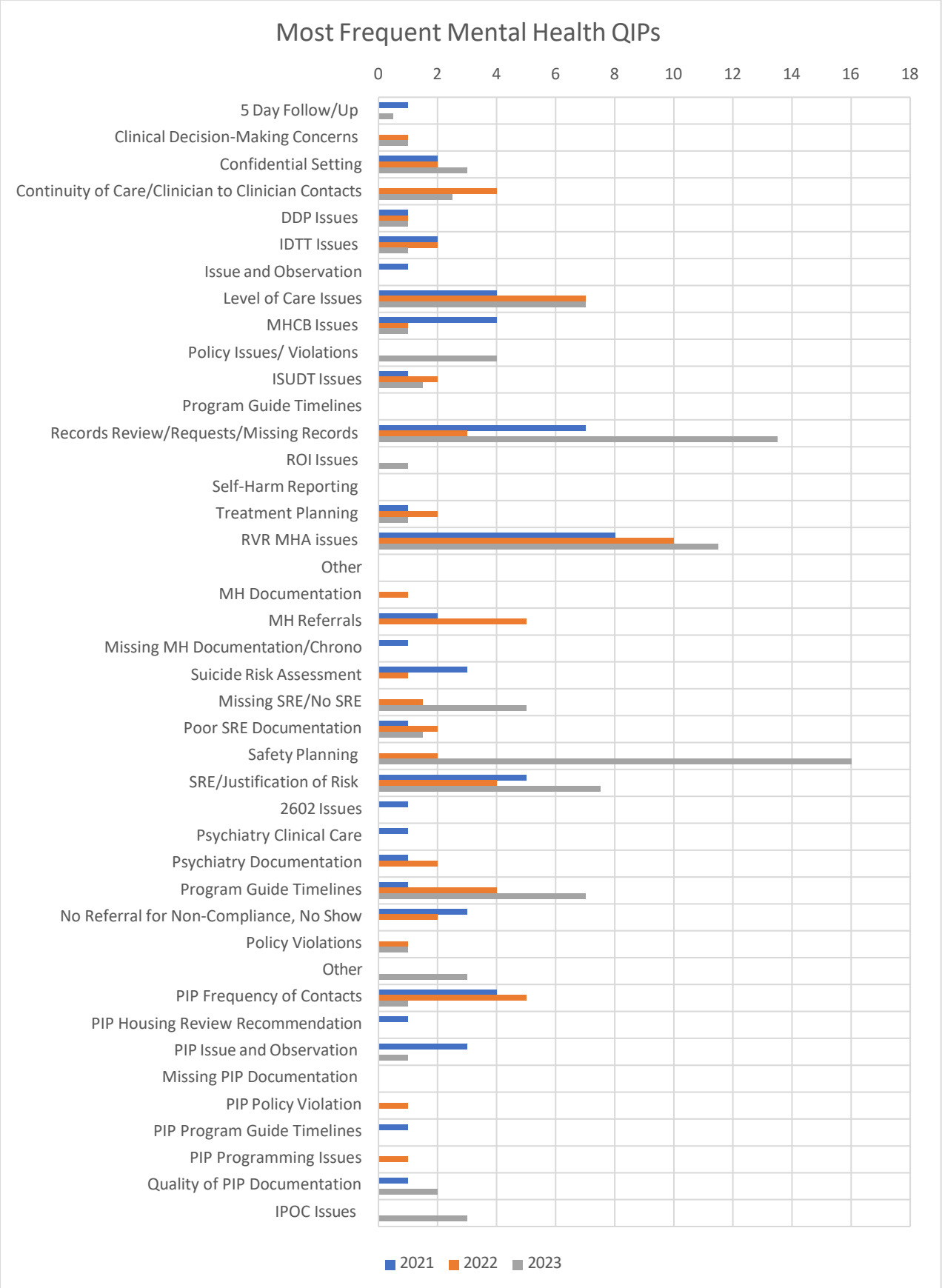
Nursing

Issue Identified	Frequency of QIPs	Institutions Involved	Action Taken
Nursing Checks/Rounds	8.5	RJD (2), COR, CIM, SQ, CMF, LAC, MCSP, CHCF	Training provided; audit conducted; corrective action
Nursing Documentation	7.5	COR (2), MCSP (2) KVSP (2), RJD, WSP	Training provided; audit completed; suicide watch monitoring; update in annual nursing training
Emergency Response	6.5	KVSP (2), WSP, CMF, FSP, HDSP, SQ	Training provided; update in annual nursing training; policy revision pending approval

Commonalities in Individual Case Reviews

In 2023, the most frequent Mental Health QIPs were Safety Planning (16 QIPs); Program Guide Timelines (13.5 QIPs); MH Documentation (9.5 QIPs); and SRE/Justification of Risk (7.5 QIPs). Figure 10 shows the Mental Health QIPs for the last three years. These categories are broad, so as to encompass the range of issues that can arise from these categories. For example, QIPs associated with safety planning focus on whether there was adequate safety planning, or any safety planning at all. As such, it covers quality and requirements to complete safety planning. The category of Program Guide Timelines is likely the broadest of categories but poses difficulty in whittling down more specifically without becoming overly caught in the weeds. Suffice it to say, this category covers treatment intervals for any type of mental health clinical contacts (treatment teams, individual contacts, initial assessments, RVR-MHA contacts, 5 day follow ups, etc.). Documentation concerns also look at both the quality and completeness of mental health documentation, which can relate to initial assessments or progress notes. Finally, the category of SRE/Justification of Risk focuses on the quality of the SREs being conducted as well as whether the justification of risk included in the SRE was appropriate and aligned with the rest of the suicide risk evaluation from which it was derived.

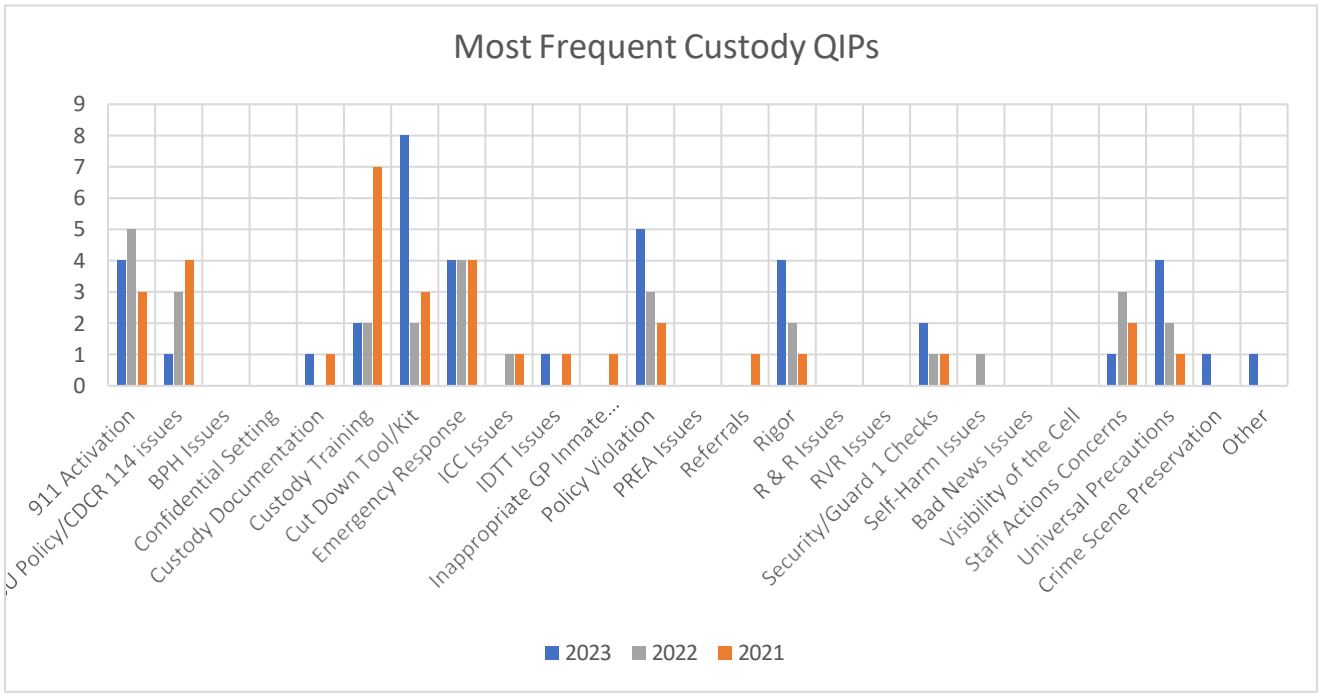
Figure 10: Most Frequent Mental Health QIPs, 2021-2023



In 2023, the most frequent Custody QIPs were Cut Down/Tool Kit (8 QIPs); Policy Violation (5 QIPs); and 911 Activation, Emergency Response, Rigor, and Universal Precaution/Protective Equipment (4 QIPs).

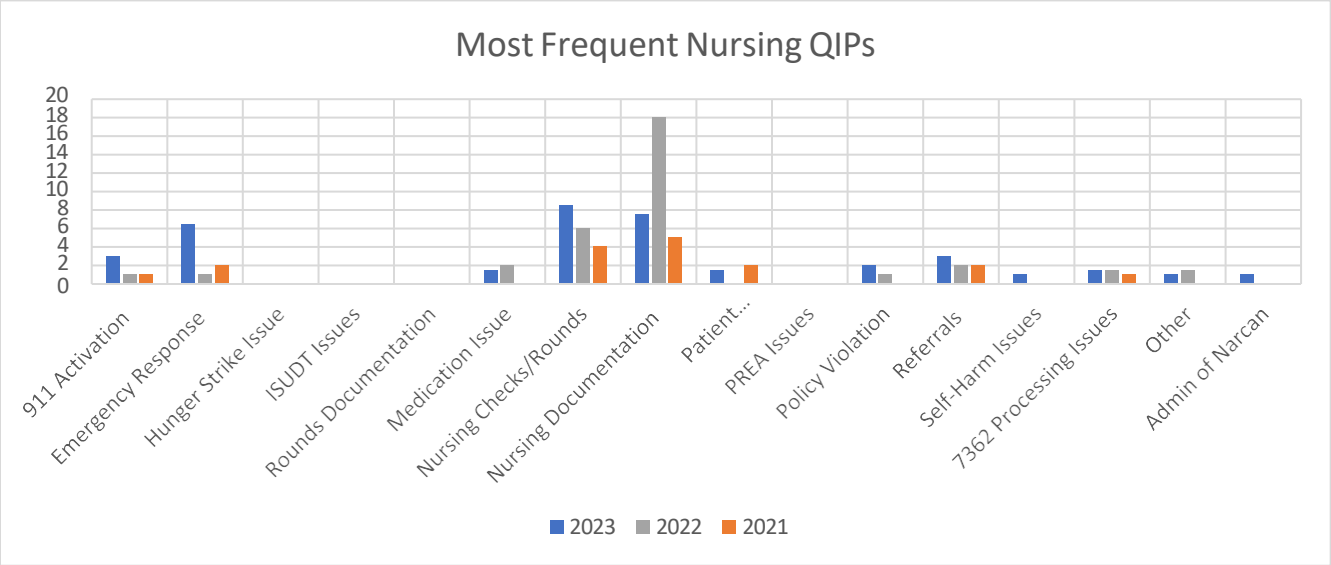
CDCR recognizes that cases in which decedents are found in rigor mortis, particularly those in restricted housing units where policy requires Guard 1 Checks every 30 minutes are particularly concerning. As such, 989 investigations for adverse action are utilized in these cases. Between 2022 and 2023, 11 instances of individuals found in rigor were noted. Of those, 10 cases were referred to the Office of Internal Affairs for 989 investigations. In one case, no discipline was recommended; in another case, the staff member resigned prior to any action being taken; and in 8 cases, disciplinary action was initiated against the staff members involved. Figure 11 shows the Custody QIPs for the last three years.

Figure 11: Most Frequent Custody QIPs, 2021-2023



In 2023, the most frequent Nursing QIPs were Nursing Checks/Rounds (8.5 QIPs); Nursing Documentation (7.5 QIPs); and Emergency Response (6.5 QIPs). Figure 12 shows the Nursing QIPs for the last three years.

Figure 12: Most Frequent Nursing QIPs, 2021-2023



In 2023, the most frequent Interdisciplinary QIPs were listed Other with 3 QIPs, which was when the issue did not fit into any other category. The fourth QIP was Program Guide Timelines at 1 QIP. Figure 13 shows the Interdisciplinary QIPs for the last three years.

Figure 13: Most Frequent Interdisciplinary QIPs, 2021-2023

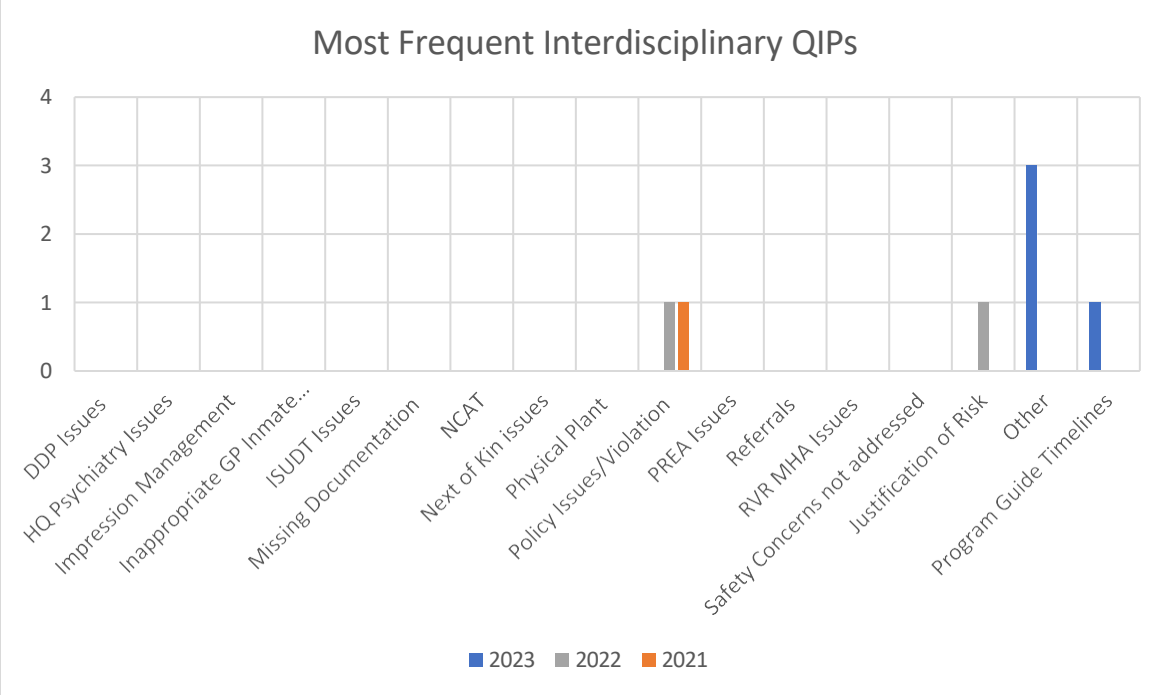


Table 22 shows the QIPs by Institution for 2021 – 2023. In number in parentheses under each column represents the number of suicides that occurred at the respective institution for that year. In 2023, RJD had 24 QIPs assigned to the institution. WSP had a total of 18 QIPs assigned to the institution. CMF and MCSP had 15 QIPs assigned to each institution. Some institutions such as: RJD, SVSP, SVSP-PIP, CMF, and VSP had QIPs in all three years.

Table 22: QIPs by Institution, Number of Suicides in Parentheticals, 2021-2023

Institution	2021	2022	2023
SATF	7 (1)	3 (1)	0
CCI	2 (1)	3 (1)	0 (1)
CMC	0	11 (4)	12 (2)
CIM	3 (1)	0	0
NKSP	0	8 (2)	2 (0)
WSP	0	4 (1)	18 (4)
KVSP	0	14 (2)	14 (1)
SAC	0	8 (1)	8 (0)
CTF	0	3 (0)	0 (1)
LAC	0	16 (2)	9 (2)
RJD	4 (1)	17 (1)	24 (2)
SQ	1 (1)	0	8 (2)
SQ-PIP	0	4 (0)	0
SVSP	15 (1)	9 (2)	8 (1)
SVSP-PIP	14 (1)	1 (0)	6 (1)
CHCF	0	5 (0)	13 (1)
CHCF-PIP	5 (0)	0	0
CIW	2 (1)	0	0
CIW-PIP	7 (0)	0	0
CMF	4 (0)	6 (1)	15 (1)
CMF-PIP	5 (0)	12 (0)	3 (0)
ISP	2 (1)	0	0
CCWF	8 (0)	0	0
VSP	3 (1)	9 (2)	12 (1)
CAL	1 (0)	0	0
COR	0	3 (0)	9 (2)
CIM	13 (3)	0	2 (0)
MCSP	5 (2)	0	15 (3)
SCC	0	0	1 (1)

CRC	0	0	5 (1)
FSP	0	0	2 (2)
HDSP	0	0	5 (1)

Case reviewers found a number of commonalities among the 30 suicides in 2023. Most of these variables are complex systemic issues that cross disciplinary and professional lines. Case reviews assess elements such as an individual's care, functioning, and behavior in the year leading up to their death and evaluate the institutional response to the suicide attempt.

When an element is found to be lacking or of poor quality, the reviewer will establish a QIP. Risk assessments are scrutinized closely to make sure they capture the essential elements and are accurate reflections of the individual's risk state. 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 the expectation is that staff members follow policy and will act professionally in all their work with individuals. In contrast, reviewers *must* identify 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 that are sent to the SMHP and DAI leadership for review. If a QIP response is inadequate, the SMHP and DAI will request clarification, additional development, or implementation of the QIP. QIPs are not considered final until approved at the Headquarters level.

Poor quality mental health treatment planning can affect an individual's ability to adequately program in the prison environment. Suicide risk assessment and formulation of risk is an important aspect of treatment planning. Additionally, if suicide risk is not recognized by clinicians and their team, then adequate management of that risk is not possible. Of the 30 suicide cases in 2023, most of the MH QIPs were for safety planning issues, including completing inadequate safety plans after an individual verbalized suicidal ideation, poor discharge planning from inpatient settings, insufficient efforts in dealing with the patient's poor treatment participation, and inadequate recognition of and efforts to deal with chronic suicidal ideation as potential issues. Specific to Mental Health, there were also issues with Program Guide timelines, documentation, and SRE/Justification of Risk.

Nursing QIPs included issues with nursing checks/rounds and documentation. In 2023, documentation accounted for 20% of the Nursing QIPs. This is a marked improvement from last year in which documentation accounted for over 50% of the Nursing QIPs. As part of the effort to address the documentation issues, Nursing leadership implemented several monthly and quarterly audits as well as provided training to ensure compliance on any identified nursing deficiencies. Effective January 2023, the Nursing implemented monthly audits of the Initial Health Screening in R&R areas to ensure screening and documentation is completed consistent with policy. Institutional nursing leadership provided a summary of deficiencies and corrective action plans. Suicide watch audits are conducted monthly utilizing the MH Observation Reporting Tool and the compliance percentage of suicide watch documentation is submitted monthly. Effective February 2023, the practice of submitting these audits to the institutional SPRFIT (Suicide Prevention and Response – Focused Improvement Team) Coordinator was implemented. Regional CNEs present the results of these audits to the HQ SPRFIT Committee monthly. Headquarters Nursing continues to meet with Regional CNEs and RHCEs to discuss the results of the audits to monitor operations for overall compliance. In April 2023, MH Nursing HQ's team provided eight MH Nursing

Training Webinars. These trainings were created to assist with documentation compliance and with the monitoring of Suicide Watch and Suicide Precaution.

Efficacy of Quality Improvement Efforts

Quality Improvement Plans follow a specific timeline outlined in the MHSDS Program Guide and are required to be submitted to the statewide suicide prevention and response unit within 60 days of receiving the finalized suicide case review report. CDCR recognizes the need to ensure ongoing monitoring of these QIPs beyond the completion of the final suicide case review. Given the frequency in which the regional suicide prevention coordinators visit institutions and provide consultation and support, they will monitor ongoing compliance with the underlying concern during their site visits. The regional Suicide Prevention Coordinators track institutional adherence to QIPs, and the sustainability of the improvement efforts made in response to the deficiencies that led to the assignment of the QIPs. The regional Suicide Prevention Coordinators are in constant contact with the institutions and make quarterly visits. The coordinators provide training when appropriate and follow up on the QIPs assigned to their respective institution to ensure outcome results. Many of the institutions have provided additional training to staff members as part of the action required for the majority of the QIPs. This is consistent through the disciplines of MH, Custody, and Nursing. Furthermore, in Mental Health, supervisors at the institution have completed audits of treatment plans by random selection. The coordinators continue to follow up with the institutions to reach a level of compliance to remediate the QIPs, specifically if there are multiple QIPs in any given institution. The regional suicide prevention coordinators determine a QIP has been durably sustained if after at least 90 days post-submission of the institutional response to the QIP, the underlying concern no longer appears to be out of compliance. There are instances, such as those listed below, that demonstrate the need for increased monitoring because the underlying concern has fallen out of compliance, despite the work that was done in the QIP process. These barriers to sustained compliance result in further monitoring, and at times, the regional suicide prevention coordinators will work with the institutions to prioritize these issues in their SPRFIT Committee project pipelines. It is important to note that there are some instances in which the original intervention contained in the QIP may have been deficient to correct the concern, whereas there are other instances in which the intervention was appropriate but needs to be refined to further improve performance. A longer span of time necessary to ensure sustained compliance does not always mean the QIP was not effective in resolving the initial concern. Continuous quality improvement means there is governance over the improvement project and ongoing monitoring to enhance the intervention may be necessary.

Sustained compliance is critical to understanding whether the underlying concern raised in the QIP is durably remediated. Sustained compliance is determined in different ways, depending on the nature of the original QIP. For some QIPs that require modification to LOPs, the regional coordinator can monitor to ensure that the LOP has been fully executed and distributed to staff. For other QIPs, particularly those that relate to the quality of care, rely upon auditing, training, and re-audited post-training or other intervention, to ensure the intervention appropriately targeted the problematic actions. Here, the regional coordinators will conduct their own observation of the clinical behavior to ensure there are no ongoing concerns. This is by far the most common method of monitoring the effectiveness of interventions. Additionally, given staffing concerns present at many institutions, the regional coordinators can participate in the delivery of trainings to assist institutions in delivery of that prescribed intervention.

MH QIPs were followed up by the coordinators in their respective regions where the outcomes were tracked. QIPs that were resolved were closed, and QIPs that were not resolved were either re-assigned as a CAP or were recommended for continued observation.

Region 1 had 10 suicides in 2023 that resulted in 42 MH QIPs. All QIPs were closed accordingly required timelines. For many QIPs, institutions ascertained that quality problem was limited to an individual staff person. Thus, training was the indicated and selected remedy. The problems identified in QIP were often note amenable to further monitoring. Some QIPs were not within the professional scope of the regional coordinator to monitor (e.g., a delayed response to referral for medical complaints, the application of a cervical collar). Other issues overlapped with areas that regional coordinators are already assigned to monitor (e.g., compliance with the timeliness of suicide precaution rounds, regularly offering privileges to inpatients) and so compliance reporting is embedded in the site visit reports coordinators produce. For some QIPs, the identified problem could not be reassessed because no quality measure was available (e.g., whether translation services were used when indicated) or not amenable to monitoring (inaccurate information being automatically pulled forward into new medical record documentation). Finally, some QIPs, like late or missed contacts, were attributable to a critical mental health staffing level and, thus outside the scope of the coordinator to correct.

Of the 34 Region II QIPs from 2023, training was deemed to be needed in ten. The training was completed and 844s were submitted for nine deeming these QIPs closed, and the plans durably implemented. For one of these a summary of results is pending. For nine of the region II QIPs clinician and/or documentation monitoring were needed. Of these five have been deemed closed due to changes being durably implemented and four are still being monitored by the regional SPRFIT coordinator due to not observing continuous improvement. Five region II QIPs involved significant and ongoing staffing issues in which triage plans are in place and regularly reviewed by the institution and the regional SPRFIT coordinator. Six of the region II QIPs required a new LOP or updated memo. In three of these cases this memo and process was completed, communicated and durably implemented. The other three are pending a follow-up summary from the institution. Two of the region II QIPs involved timeline issues which could not be avoided due to COVID-19 precautions and finally two QIPs were duplicates from a previous case and have been addressed.

Region 3 had 10 suicides in 2023 that resulted in 31 MH QIPs. The majority of the QIPs were completed and closed, as the coordinator determined there was significant improvement in the practices at those institutions and durable solutions were established. Yet some remain opened due to a lack of sustained improvement. For example, one QIP related to safety plans not being reliably completed for patients who are rescinded from suicide watch in alternative housing when they are assessed as low acute risk. This QIP remains open and is currently being monitored by the regional coordinator. Another QIP identified concerns with intake screening. This QIP remained open until confidentiality could be observed to be 100% compliant as reflected in SPRFIT minutes. Since the development of this QIP, the new Receiving & Release clinics have completed construction and now offer fully confidential screenings. There are also CAPs for supervisory reviews of discharge safety plans, treatment progress for patients in the SRMP not consistently being documented in the Master Treatment Plans of follow-up IDTTs, several deficiencies noted in the IDTT process, low compliance with Suicide Prevention related trainings, and safety plans not reliably being completed with alternative housing discharges that remain open. These remaining QIPs struggle to gain traction in sustained compliance given staffing shortages at the institutions that prohibit meaningful improvement in performance at this time.

Region 4 had 3 suicides in 2023 that resulted in 5 MH QIPs, all of which have been completed and closed. There was an issue with IDTTs at a specific institution where ten IDTTs were audited, which found that only eight met compliance with the IDTTs being timely. The regional mental health team assigned a corrective action plan for this specific issue prior to the death by suicide which was being monitored on a monthly basis. As such, the regional suicide prevention coordinator removed duplicative monitoring of this issue by closing out their monitoring of the issue.

CDCR recognizes there have been identified patterns in not only the 30 suicides from 2023, but over the past several years. For each discipline, CDCR's tracking has revealed the most repeated issues that have resulted in QIPs. CDCR recognizes the need to prioritize these issues and move them into the purview of the statewide SPRFIT. For concerns related to mental health treatment, there have been repeated deficiencies in issues related to adequate safety planning (8 cases from 12 distinct institutions between 2022 and 2023. No QIPs were assigned for this concern in 2021 due to revisions to the safety planning policy), adhering to Program Guide timelines in the provision of mental health care (20 cases from 14 distinct institutions between 2021 and 2023), development of treatment plans commensurate with the clinical needs of patients (22 cases from 16 distinct institutions between 2021 and 2023), adequate documentation of mental health services (13 cases from 9 distinct institutions between 2021 and 2023), and justification of suicide risk (17 cases from 17 distinct institutions between 2021 and 2023). QIPs assigned to custody staff also reveal similar patterns, most prominently noted in issues related to the appropriate use of cut down tools and kits (12 cases from 8 distinct institutions between 2021 and 2023), emergency response and 911 activation (23 cases from 13 distinct institutions between 2021 and 2023), and delayed identification of deceased individuals, noted by decedents found in rigor mortis (7 cases from 5 distinct institutions between 2021 and 2023). QIPs assigned to nursing staff reveal deficiencies in the appropriate completion of nursing rounds and checks (15 cases from 14 distinct institutions between 2021 and 2023), documentation (24 cases from 19 distinct institutions between 2021 and 2023), and emergency response (9 cases from 9 distinct institutions between 2021 and 2023).

Given the possibility that these frequent deficiencies found in suicide case reviews may indicate more systemic issues, as an agency committed to continuous quality improvement, focused attention must be paid to these issues. As such, CDCR is committed to assigning them to the Statewide SPRFIT for monitoring to identify common root causes of these deficiencies and developing focused strategies for improved patient outcomes. CDCR will nevertheless identify any possible modifications to policies, procedures, protocols, or practices that could improve the overall safety of the incarcerated population.

One significant impediment to full implementation has been the ability of institutions to develop appropriate mechanisms to understand the drivers of the noted deficiencies. With the roll out of the SPRFIT Reboot in 2021-2022, institutions were able to learn how to utilize quality management techniques to support their analysis of performance. Given the regional suicide prevention coordinators regular observation of institutional SPRFIT Committees as part of their site reviews, the coordinators can ensure quality of care problems identified in suicide case reviews as QIPs remain in the project pipeline and are appropriately prioritized. This oversight and support from the regional suicide prevention coordinators has emboldened the institutions to act more responsively to the concerns raised by the suicide case review process.

A second limitation to full implementation of QIPs is the staffing challenges present at many institutions across the state. Institutions suffer from decreased staffing and staff turnover that limits the institution's ability to make meaningful in-roads on many concerns. This is particularly salient when there is a need for additional trainings, which can take time away from critical patient care concerns, but also limits the ability of institutions from effectively auditing staff pre- and post- training, because of limited resources. This remains an ongoing barrier to full implementation of many QIPs statewide.

In addition to identifying deficiencies noted in the individual suicide case reviews, CDCR recognizes the need to regularly review the of the QIP process to ensure it continues to be well functioning. The MHSDS Program Guide lays out a general guideline for QIPs from the identification of a deficiency through the assignment of a QIP and the resolution of the QIP at the institutional or statewide level. As the agency has evolved, CDCR believes there are better ways to conceptualize QIPs and implement the improvement work at the institution level. Fundamentally, the 60-day timeline attached to implementing QIPs is a

barrier to fully understanding, developing, implementing, and monitoring durable solutions to many of the deficiencies that fall within the purview of the QIP process. In response to this lingering barrier, CDCR has contemplated alternative solutions to the current framework that is more supportive and effective to resolving QIPs. The SMHP is in the initial stages of developing a revised framework for QIP processes that can be applied across all disciplines, with more focused oversight on not only the assignment of QIPs in the suicide case reviews, but also on how institutions develop their plans for improvement, and how the statewide SPRFIT approves the results of the QIP. The goal is to create a process that fosters an environment of sustained improvement where durable solutions are created to address identified deficiencies. CDCR believes it is critical to create a functional feedback process for creating meaningful change when negative outcomes occur.

Progress of Suicide Prevention Efforts in CDCR

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

Progress Toward Completing Adequate Suicide Risk Evaluations

It is CDCR's goal to ensure that adequate and appropriate suicide risk evaluations are completed accurately and timely. The Suicide Risk Assessment and Self-Harm Evaluation (SRASHE), a set of electronic forms in the Electronic Healthcare Record System (EHRS), is the primary way that suicide risk evaluations are documented. The SRASHE is composed of 1) a standardized set of questions about suicide-related ideation and behavior – the Columbia-Suicide Severity Rating Scale;[42] 2) a review of the individual's history of self-injury; 3) a checklist of risk and protective factors and warning signs; 4) a risk formulation and its justification; and 5) a safety plan,[43] when clinically indicated. Under CDCR's policies, a suicide risk evaluation is conducted whenever any individual expresses suicidal ideation, makes suicidal threats, or makes a suicide attempt at a number of key evaluation points and during known high risk times.

Suicide Risk Evaluations remained an area required focused attention for improvement in quality in 2023. The SREs underestimated suicide risk and repetitive SRASHEs. Despite training and other remedial efforts, improvement has not been sustained. To address this issue, CDCR convened a workgroup comprised of experts from the OSM and CDCR to review and revise the current SRASHE.

Risk Evaluation Audits Using the Chart Audit Tool

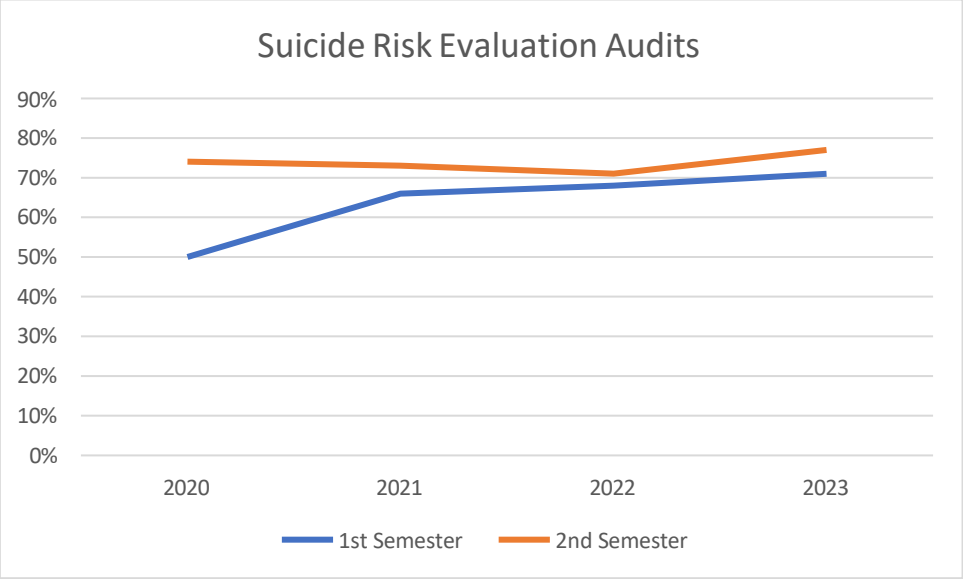
The SMHP uses a standardized audit method — the Chart Audit Tool (CAT) — for evaluating the quality of key mental health documents, including suicide risk evaluations (Appendix A). Audits are conducted on a quarterly basis, with results available to the mental health leadership at institutions, regional mental health administrators, and headquarters. A sample of risk evaluation forms are audited quarterly for quality. In addition, each mental health clinician's risk evaluation form is audited twice per year for

[42] See: https://cssrs.columbia.edu/

[43] A safety plan includes a specific strategy that describes signs, symptoms, and the circumstances in which the risk for suicides is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient and clinician can take if suicidal thoughts do occur.

completion and quality, using criteria first proffered by the California State Auditor in its 2017 report.[44] The pass rate is 85%. In 2023, institutional compliance rates show that the pass rate ranged from 71% to 77%. While it is still below the 85%, it is a slight improvement from 2022, where the pass rate ranged from 68% to 71%. Common reasons for a risk evaluation form to fail an audit include poor justification of suicide risk, under-estimation of suicide risk, and non-individualized safety planning. Currently, statewide figures still fall below the pass rate. A detailed description of one of the primary tasks CDCR is undertaking to improve the quality of the suicide risk evaluations is provided below. Figure 14 shows the rates of the SRE audits as they are broken down by semesters for 2020-2023.

Figure 14: Suicide Risk Evaluation Audits, 2020-2023



Suicide Risk Assessment Training and Mentoring

In 2021, CDCR began considering possible revisions to the suicide risk evaluation. In early 2022, a workgroup was created and comprised of CDCR Headquarters staff, institutional leadership, and experts from the OSM to review alternatives to the form. The workgroup's purpose was to refine the risk evaluation's utility and to enhance its efficacy for patients who are in crisis. Additionally, in 2022 CDCR finalized significant changes to the suicide risk evaluation mentoring program, which included revised policy and procedural language as well as a new comprehensive assessment tool for mentors to use when providing mentoring to other clinicians. For 2023, the rate of compliance was 96%. This is similar to prior years with the rate of compliance at 95% in 2022 and 2020 and 94% in 2021. Figure 15 shows mental health staff compliance with SRASHE Core Competency Building from 2020-2023.

Figure 15: Compliance with Suicide Prevention and SRASHE Core Competency Building, 2020-2023

[44] See: https://www.auditor.ca.gov/pdfs/reports/2016-131.pdf page 23

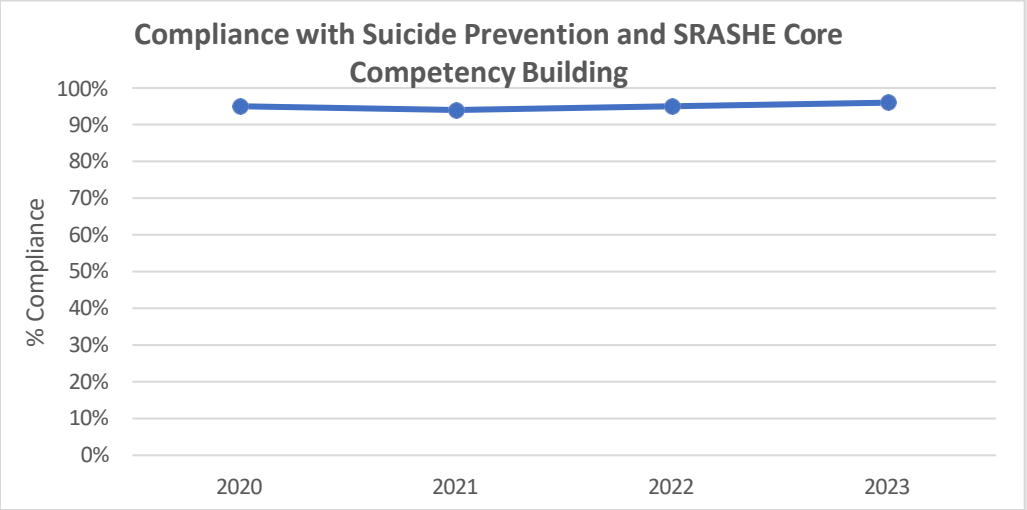
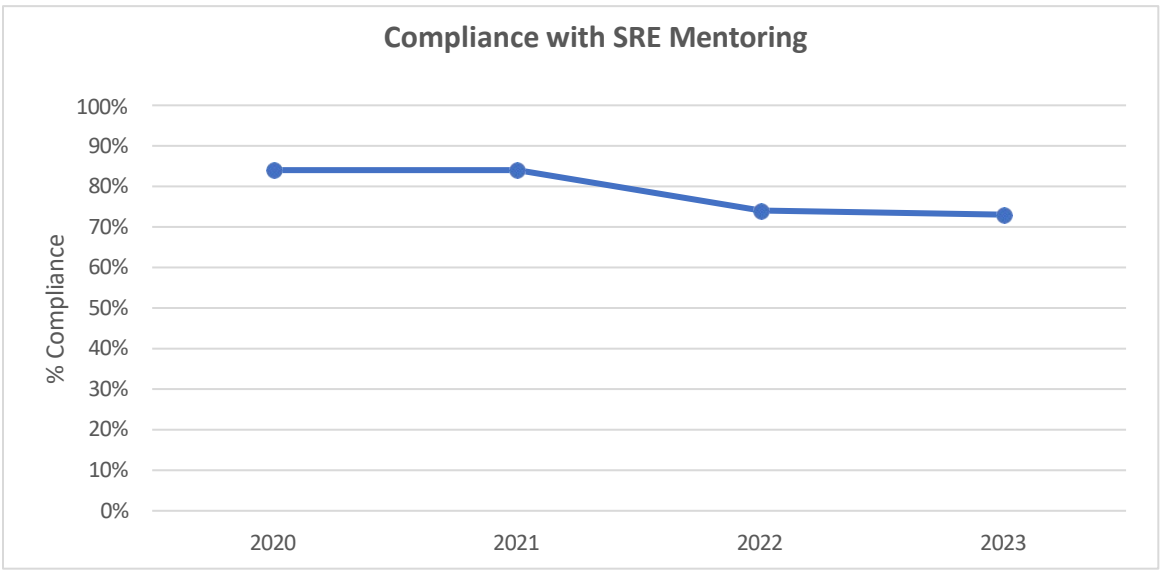


Figure 16 shows the mental health staff compliance with SRE Mentoring from 2020-2023. There was a decrease of 10% in compliance from 2021 to 2022 that continued in 2023. The decrease was likely attributable to at least two variables: the roll out of the new SRE mentoring training and staffing shortages across many institutions that led leadership to prioritize patient care over trainings.

Figure 16: Compliance with SRE Mentoring, 2020-2023



Progress Toward Completing 72-Hour Treatment Plans in a Sufficient Manner

CDCR recognizes that patients in acute crisis require timely treatment to address their mental health symptoms. The treatment plan is an individualized plan that identifies patient-specific treatment and individualized treatment goals to address the patient's clinical needs. Patients in crisis are transferred to a MHCB unit, where an evaluation and initial treatment plan is developed within 24 hours of admission.[13] To ensure the inpatient treatment is appropriately targeting the patient's risk factors and symptoms, the treatment team must develop an initial treatment plan that maps out the interventions that will be employed to reduce the most distressing symptoms. It is CDCR's goal to ensure that a full Initial Treatment

Plan in MHCB units is completed for all patients within 72 hours of admission.[45] The Initial Treatment Plan is discussed in the patient's IDTT meeting in the MHCB unit. Treatment teams are composed of, at a minimum, the patient's assigned psychiatrist and assigned primary clinician (typically a psychologist), a member of the MHCB unit nursing staff, a correctional counselor and the patient. The team members are responsible for ensuring that the treatment plan created is within timelines and meets the quality standards set by CDCR.

In 2017, the State Auditor's Report cited the completion and quality of the Initial Treatment Plans in MHCB units as a chief concern. The State Auditor noted several incidents where sections of the Initial Treatment Plans were left blank and reported several other deficiencies. Those deficiencies included inadequate treatment methods, including a lack of information on the frequency of interventions and who was responsible for the intervention; poor post-discharge follow-up plans; poor treatment goals or goals without measurable outcomes; and missing documentation of medication dosage and frequency.

CDCR expends considerable resources on training for staff to apply appropriate treatment team processes and quality treatment planning. Quarterly audits are conducted both in person by Regional Mental Health teams and in quarterly chart documentation audits. Training[46] designed to improve the quality of 72-hour treatment planning was developed and first delivered during 2019 and 2020 in all institutions that have MHCB units. The training emphasizes the importance of the treatment plan to MHCB supervisors and clinicians. The training focuses on the role of the 72-hour initial treatment team meeting in suicide prevention and crisis resolution and reinforces good treatment team practice and high-quality documentation. The training, which remains ongoing, complements existing treatment team process training. The documentation is audited through the CAT process and the Mental Health Compliance teams continuous work with the institutions to review compliance and implement CAPs for ongoing deficiencies. Work continues to assist institutions in developing durable solutions to any ongoing deficiencies noted in the CAT audit process.

Audits of Treatment Plans

Mental Health Crisis Bed treatment plan audits are required for both 72-hour treatment plans and discharge treatment plans. Results of the chart audits are monitored by regional and institutional mental health supervisors and managers. Audits review and assess whether a summary of mental health symptoms and treatment is present; whether the diagnosis and clinical summary are consistent with the problems found; whether medications are listed that target symptoms; if the goals and interventions include individualized, measurable objectives; if progress was discussed among team members and with the patient; if there is a meaningful discussion of a discharge plan or future treatment needs; if the rationale for the level of care is sound; and whether the plan is updated to reflect current functioning. Audits of the treatment plans are conducted by clinical supervisors or senior psychologists who oversee the programs. Auditors use findings to provide feedback to staff and to develop plans to improve documentation.

The audit results related to quality of MHCB treatment planning documentation during 2023 ranged from 71% to 77% of MHCB treatment plans complying with all audit criteria.[47] There were 679 audits conducted in the first half of the year with a 71% pass rate and 648 audits in the second half of the year with a 77% pass rate. For reference, in 2022, it ranged from 65% to 74% of MHCB treatment plans complying with all audit

[45] MHSDS Program Guide page 12-5-12 17

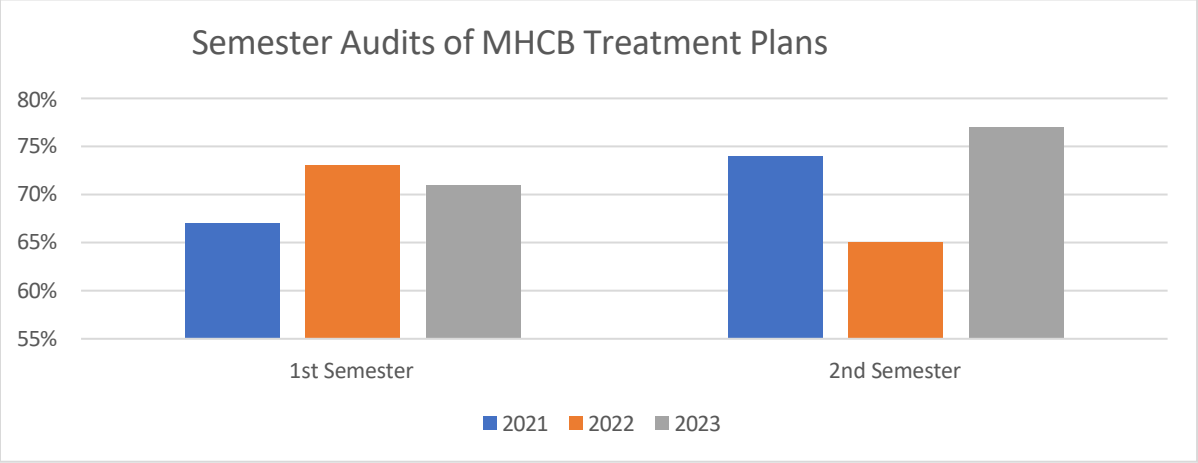
[46] Other IDTT Trainings currently exist, such as "IDTT: An overview of the clinical thinking and process," a seven-hour training for treatment planning for all levels of care.

[47] Due to the COVID-19 emergency, CAT audits were halted in Q2 2020

criteria and in 2021, it ranged from 67% to 73%. Figure 17 shows the results of Semester Audits of MHCB Treatment Plans for 2021 – 2023.

CDCR has set a pass rate of 85% for audited treatment planning documents. Institutions with pass rates under 85% are required to develop and implement corrective action plans to remedy the quality of their documentation for all audits that are included in the statewide performance improvement priorities. Institutions may also set Performance Improvement Work Plans to prioritize treatment plan quality through the site's Quality Management Committee.

Figure 17: Results of Semester Audits of the Quality of MHCB Treatment Plans, 2021-2023

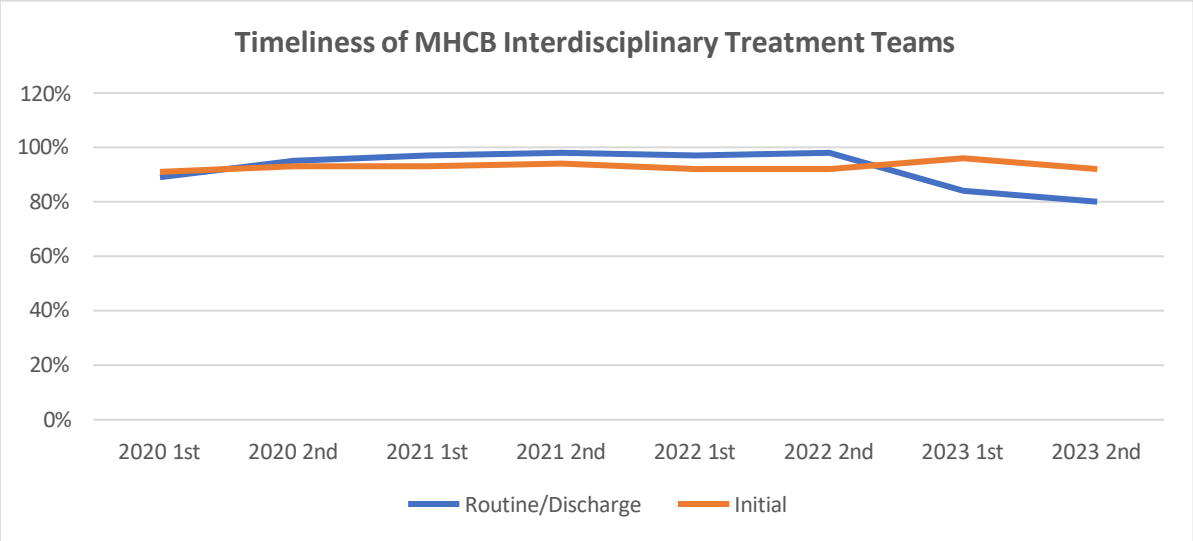


Timeliness of MHCB Treatment Plans

The timeliness of MHCB treatment plans is tracked by CDCR's Performance Report, a tool used for quality management purposes. Timeliness is defined by policy based on whether a treatment planning session occurred within 72 hours of admission for initial treatment plans, and then within seven days following the initial treatment planning session for routine treatment plans. In 2023, the overall timeliness of treatment plans completed by MHCB treatment teams was 87%. Over 15,000 MHCB interdisciplinary treatment team sessions were conducted, with 7,760 Initial or 72-hour, and 8,118 Routine treatment plans completed. Timeliness of routine treatment plans in MHCBs, including discharge treatment plans was 81% for the year (84% in the first half of the year and 80% in the second half of the year). The compliance for initial treatment plans was 94% (96% in the first half of the year and 92% in the second half of the year).[48] For reference, in 2022, the overall timeliness of treatment plans completed by MHCB treatment teams was 95%. Timeliness of routine treatment plans in MHCBs, including discharge treatment plans ranged from 97% to 98% in each half of 2022. The compliance for initial treatment plans was 92% in each half of 2022. In 2021, the overall timeliness of treatment plans completed by MHCB treatment teams was 95%. Timeliness of routine treatment plans in MHCBs, including discharge treatment plans ranged from 97% to 98% in each half of 2021. The compliance for initial treatment plans ranged from 93% to 94% in each half of 2021. This was a slight increase from 2020 where the timeliness of routine treatment plans in MHCBs, including discharge treatment plans ranged from 89% to 95% in each quarter of 2020 and the compliance for initial treatment plans ranged from 91% to 93% in each quarter of 2020. Figure 18 displays the timeliness of MHCB Interdisciplinary Treatment Teams for 2020 – 2023.

[48] Performance Report "Timely IDTTs" data extracted on 05/08/2024

Figure 18: Timeliness of MHCB Interdisciplinary Treatment Teams, 2020-2023



Progress Toward Ensuring That All Required Staff Receive Training Related to Suicide Prevention and Response

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

CDCR has efforts underway to improve how staff training is tracked. These efforts range from granular, institution-specific generation of compliance data and tracking, with supervisors expected to ensure staff's compliance in completing training, to broad efforts to adopt sophisticated training compliance tools using the intra-departmental Learning Management System (LMS). The LMS is a computer-based teaching and tracking tool that provides online training with options for offering recorded video and for requiring embedded knowledge checks. Each staff member is notified via email of the need to complete required trainings. The email includes a link to the LMS site. The LMS automatically records information about training completion status, which is accessible to the SMHP and CDCR's Division of Adult Institutions for compliance tracking.

Revisions to existing In-Service Training (IST) curricula were completed and adopted by CDCR's Office of Training and Professional Development (OTPD) in late 2019. Subsequently, live training for new IST facilitators was conducted in all regions in May and July 2021. The mental health and suicide prevention training for the correctional officer academy courses was revised during 2020 and was first delivered to cadets in June 2021. Beginning in 2024, the IST curricula will undergo revisions to update statistics and other components to ensure they are up-to-date and relevant. As of the date of this writing, the curricula remains under revision.

CDCR has a system in place to identify and remedy the lack of compliance. When individual employees are non-compliant with required training, non-compliance is identified by IST offices at institutions via the use of compliance tracking logs. Lists of non-compliant staff are sent to the supervisors of each discipline. For CCHCS employees, compliance is tracked with the LMS. The CCHCS Staff Development Unit reports

this data directly to the SMHP, which then sends the information to the institutional Chief Executive Officers (CEOs). This information is also given to the regional SPRFIT coordinators who can follow up with the local institutions.

In addition to the annual training delivered to all disciplines and new employees, custodial officers and nursing staff receive additional suicide prevention and response trainings. Compliance with required cardiopulmonary resuscitation and Basic Life Support classes is also tracked for potential first responders (custody and nursing), psychiatrists, and psychiatric nurse practitioners.[49]

CDCR provides broad training in suicide prevention and response to all employees upon their initial hiring and annually thereafter. Suicide prevention training is provided through the IST departments at all institutions. In its 2017 report, the State Auditor identified variable attendance[50] at this training between disciplines, with custodial attendance percentages often above those of mental health and other health care personnel. Improved compliance with this training since 2017 has been noted within all staff disciplines. In 2023, 47,755 staff members were required to take this training. Of these, 40,832 custody staff and 7,180 health care staff completed the training, with an overall compliance rate of 96% for custody and 95% compliance rate for health care staff.[51] Specific to mental health, 1,377 of the 1,427 active mental health staff completed the training, an 97% compliance rate.

In an effort to ensure that medical and mental health program staff comply with annual training requirements, Headquarters and Regional Mental Health staff track compliance and send updates and reminders to CEOs, Wardens, Chief Nursing Executives, and Chiefs of Mental Health. These institutional leaders are responsible for ensuring that their staff are attending required training. Compliance data about suicide prevention-specific trainings is reviewed by the statewide SPRFIT Committee and non-compliance results in the regional Suicide Prevention Coordinator working with the institution to establish corrective action. While data is not yet available to analyze the impact that the regional Suicide Prevention Coordinators' CAPs for institutions have had on compliance for 2023 annual suicide prevention training, CDCR is hopeful this approach will prove successful.

Figure 19 displays the compliance percentages with IST Suicide Prevention Training for Custody Staff for 2020 – 2023.

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

[50] www.auditor.ca.gov'/pdfs/reports/2016-131.pdf pages 43-45; 55-57.

[51] Data on custodial staff is from Division of Adult Institutions and Clinical Support. Data for CCHCS and SMHP staff are from Clinical Support. Health care staff include mental health, medical, nursing, ancillary, and administrative staff and does not include staff on long-term leave.

Figure 19: Compliance with IST Suicide Prevention Training, Custody Staff, 2020-2023

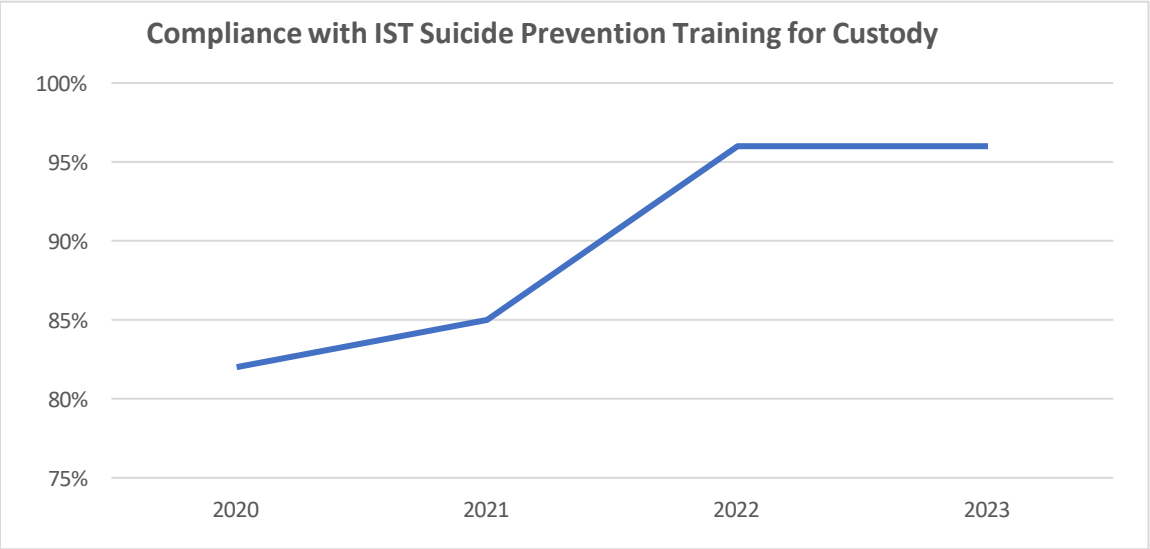


Figure 20 displays the compliance percentages with IST Suicide Prevention Training for Healthcare Staff for 2020 – 2023. Healthcare staff includes both Mental Health and Medical providers. There was a slight decrease from 89% in 2022 to 86% in 2023.

Figure 20: Compliance with IST Suicide Prevention Training, Healthcare Staff, 2020-2023

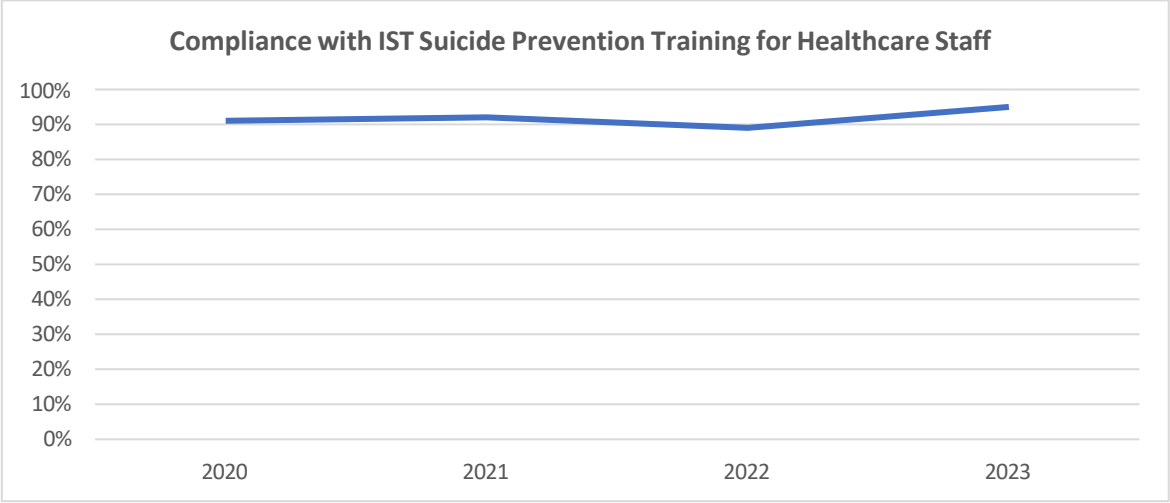
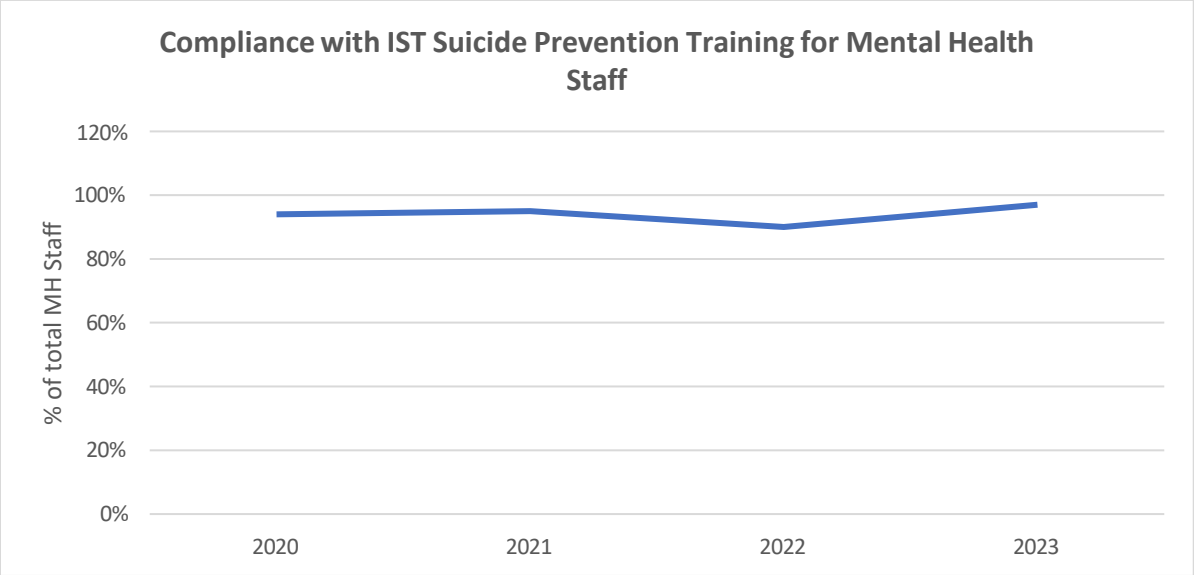


Figure 21 displays the compliance percentages with IST Suicide Prevention Training for Mental Health Staff for 2020 – 2023. There was a decrease from 95% in 2021 to 90% in 2022 and then a slight decrease in 2023 with 89%.

Figure 21: Compliance with IST Suicide Prevention Training, Mental Health Staff, 2020-2023



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

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

Figure 22 displays the compliance with Suicide Prevention and SRASHE Core Competency Building Training for 2020 – 2023. The figure displays the total number of MH staff and the number of staff trained. The number of MH staff decreased from 1,442 in 2021 to 1,301 in 2022 and again in 2023, which had 1,297. There was also a decrease in the staff trained from 1,349 in 2021 to 1,231 in 2022 however increased in 2023, which had 1,240.

Figure 22: Compliance with Suicide Prevention and SRASHE Core Competency Building Training, 2020-2023

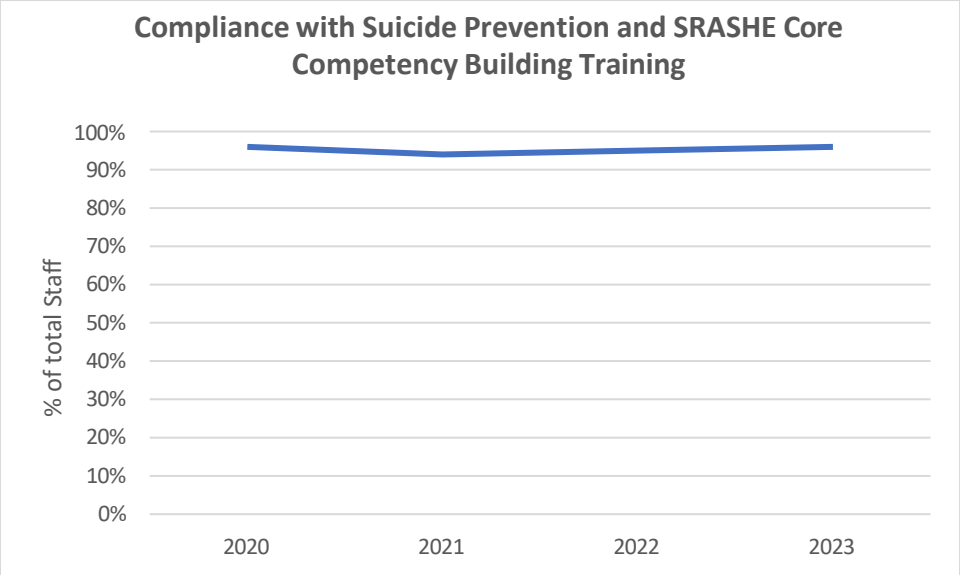
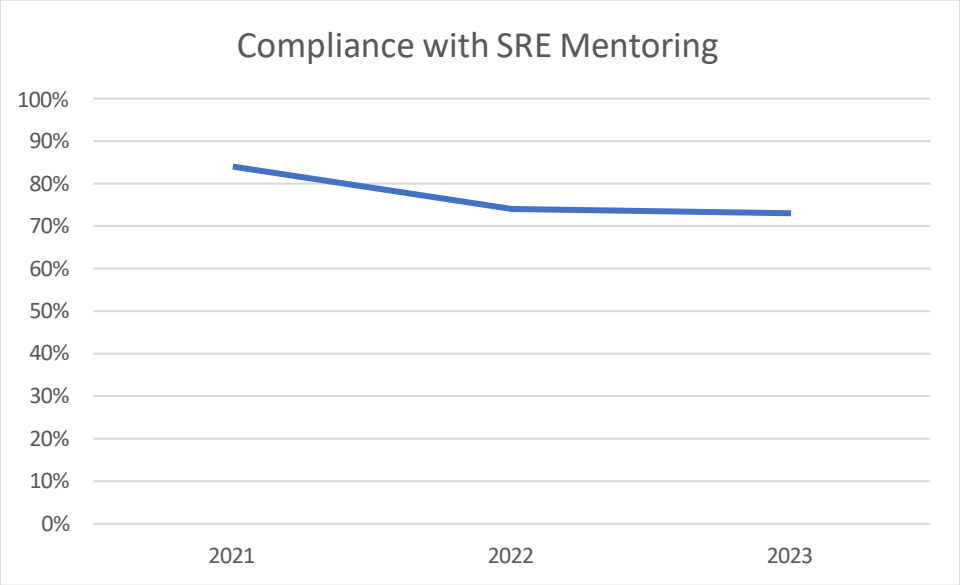


Figure 23 demonstrates compliance with Safety Planning Training for 2020 – 2023. The graph displays the number of MH staff and the number trained. In 2023, there were 1,285 MH staff and 1,198 (93%) were trained.

Figure 23: Compliance with Safety Planning Training, 2020-2023

Figure 24 demonstrates compliance with SRE Mentoring Training for 2020 – 2023. The graph displays the total number of MH staff as well as the staff trained. In 2023, there were 1,017 MH staff who were required to undergo mentoring. Of these, 745 (73%) were trained. The decrease in staff trained can be attributed to the staff shortages statewide. Specifically, some institutions experienced a loss of certified mentors, which impaired the ability for new clinicians to be mentored. Further, a loss of clinical staff at institutions resulted in increased need for primary clinicians to focus on providing direct patient care, which resulted in less time allotted for mentors to mentor other clinicians.

Figure 24: Compliance with SRE Mentoring Training, 2020-2023



Progress in Implementing the Recommendations Made by the Special Master Regarding Incarcerated Individual Suicides and Attempts

On July 12, 2013, the *Coleman* court ordered CDCR, the *Coleman* Plaintiffs, and the Special Master to convene a Suicide Prevention Management Workgroup. In 2015, the Special Master's expert, Lindsay Hayes, made 32 recommendations related to suicide prevention practices, which were ordered to be implemented by the court that same year[52]. Since 2015, CDCR has worked to implement the recommendations made by the workgroup and continues to meet with the OSM's experts to discuss progress on those recommendations. In 2018, three of those recommendations were withdrawn[53].

The OSM's expert has completed seven audits since 2013 and has issued reports for each of these audits. Mr. Hayes' sixth re-audit covered 21 institutions and was the first re-audit of the five PIPs managed by CDCR. He visited these institutions between January 2023 and November 2023, starting with the PIPs. The final report was submitted to the *Coleman* court in March 2024[54] but has not yet been adopted by the Court. In this report, the Special Master's expert notes that CDCR had not fully implemented 14 of the 29 recommendations. During the 6th re-audit CDCR was found to have fully complied with Recommendation 20, which states that CDCR should develop a corrective action plan (CAP) to ensure that supervising nursing staff regularly audits psychiatric technician practices during daily rounds of mental health caseload IPs in restrictive housing and during weekly and bi-weekly rounds in the SHUs. CDCR filed objections to the OSM expert's report on April 1, 2024, and disputed his findings of noncompliance with many of the remaining recommendations.

In his 5th reaudit of CDCR institutions, the OSM's expert conducted a baseline assessment of the suicide prevention practices in the five CDCR-ran Psychiatric Inpatient Programs (CHCF-PIP, CIW-PIP, CMF-PIP, SQ-PIP, and SVSP-PIP). At the time, he made 16 recommendations for improved practices within those

[52] Electronic Court Filing (ECF) 5259, filed 1/14/15, and ECF 5271, filed 2/3/2015

[53] ECF 5762, filed 1/25/2018

[54] ECF 8143-1, filed 03/01/2024

settings. During the 6th reaudit, the OSM's expert further opined on the current status of the suicide prevention practices within the PIPs.

Initial Health Screening and Receiving and Release (R&R) Environment

This item encompasses two recommendations. The first is to ensure that the "nurses office should be of sufficient size to conduct adequate intake screening, and the door to the office (which should contain a large viewing window) should remain closed during the screening process." The second states that "[n]urse and officer safety should remain the top priority during the intake screening process. If an [incarcerated individual's] security classification or unknown security status creates a safety concern, the screening should be conducted in the least restricted setting that ensures both staff safety and [incarcerated individual] confidentiality." Although not plainly part of either recommendation, the OSM expert also monitors whether all screening questions are asked during these contacts.

The purpose of these recommendations is to ensure that all individuals entering a CDCR facility receive an initial health screening, in a confidential setting, which includes specific questions targeted at understanding the individual's suicide risk. A standardized screening was introduced in 2018, which by and large, resolved this portion of the recommendation, although adherence to asking all required questions does not occur periodically. This is due to ongoing compliance concerns related to nursing not asking all the required questions on the health screening. Additionally, there are areas of non-compliance related to not maintaining a confidential space by leaving the door open. For example, until the completion of construction at WSP, the swing space used during construction led to ongoing deficiencies related to non-confidential settings. Currently, construction of the new clinics has been completed and R&R nursing screens are now being done in a confidential setting at WSP-RC.

In the sixth re-audit, OSM noted that "problems continued to be found with accurate completion of all 15 mental health/suicide risk inquiry questions on the Initial Intake Screening form (Recommendation 7), and not always providing reasonable privacy and confidentiality during the intake screening process (Recommendation 8). Regarding Recommendation 7, nursing staff at four facilities were observed to not be addressing all 15 mental health/suicide risk questions on the Initial Health Screening form." The report recommended that CDCR should develop CAPs for the eight facilities (CCI, CHCF, CIM, CIW, CMC, SQ, SVSP, and WSP) which had not implemented a sustainable solution to this recommendation.

CDCR's Regional SPRFIT Coordinators conducted regular monitoring of these recommendations during 2023. Their findings largely conflict with those of the OSM expert. For instance, after the OSM expert's CCI visit in April 2023, the Regional SPRFIT Coordinator conducted a follow-up visit in July 2023 and found that screening occurred confidentially and that the nurse asked all required screening questions. Following his May 2023 visit to SQ, where the OSM expert took issue with the nurse omitting certain screening questions, the Regional SPRFIT Coordinator conducted a follow-up visit in October 2023 and observed that all screening was confidential, and all questions were asked. At SVSP in October 2023, the OSM expert questioned the confidentiality of the contact with an agitated patient seen with the door open and an officer nearby. The Regional SPRFIT Coordinator conducted site visits to SVSP and, during the December 2023 visit, observed the screening was conducted in a confidential setting with all questions asked. At WSP, the OSM expert criticized the confidentiality of the space during his April 2023 visit. Since his visit, a new screening building was completed and the Regional SPRFIT Coordinator observed compliant screens during follow-up visits.

In other instances, the OSM expert's criticisms were either focused on whether all questions were asked or complained that custody officers were present during screenings of maximum custody patients. At

CHCF, the OSM expert made no criticisms centered on whether questions were properly asked but made no findings as to whether the contact was conducted confidentially or in an adequate treatment space. At CIM, the OSM expert took issue when a nurse informed him that a custody officer would be present during screening if there was a maximum-security incarcerated person in the room. The expert further disagreed with the compounding of two similar questions asking about whether the incarcerated person had received any bad news. At CIW, the OSM expert objected to the presence of an officer, with the office door closed, for an intake screening of a maximum-security incarcerated person. At CMC, the OSM expert took issue with the omission of some of the screening questions but made no findings about the size or confidentiality of the screening space.

Use of Suicide Resistant Cells for Those Newly Admitted to Administrative Segregation

This item encompasses two recommendations. The first requires that CDCR ensure "that there are a sufficient number of suicide-resistant retrofitted cells to house newly admitted incarcerated individuals (i.e., those within their first 72 hours of their housing in the unit) and incarcerated individuals of special concern or heightened risk of suicide (e.g., individuals recently released from suicide observation status)." The second requires that CDCR "enforce its existing policy of housing only newly admitted [incarcerated individuals] in retrofitted cells, and immediately re-house [incarcerated individuals] remaining in the retrofitted cells beyond their first 72 hours."

Individuals placed in restricted housing are to be housed in single-occupancy suicide resistant intake cells for the first 72 hours of their placement. They may occasionally need to be placed in non- intake cells, which is permissible, if housed with another individual.

The Division of Adult Institutions (DAI) created an automated report in its Strategic Offender Management System (SOMS) to track the usage of the intake cells at each institution. This report allows DAI to recognize when institutions are using the intake cells appropriately, transferring incarcerated individuals out of intake cells timely, and when they need additional intake cells. A formal announcement of this report was released to all institutions in April 2023.

In his sixth re-audit, the OSM expert found that seven institutions were noncompliant with use of suicide resistant intake cells, namely California Institution for Men (CIM), California Men's Colony (CMC), California State Prison, Los Angeles County (LAC), Kern Valley State Prison (KVSP), R.J. Donovan Correctional Facility (RJD), Salinas Valley State Prison (SVSP), and Wasco State Prison (WSP). CDCR's subsequent site visits showed that many of these issues have since been remedied.

At CIM, during an October 2023 site visit, the Regional SPRFIT Coordinator observed that the institution was in full compliance with adequate use of intake cells. All new intake incarcerated persons were in intake cells, and none were housed beyond 72 hours. Likewise, at CMC, during March and June 2023 site visits, CDCR's Regional SPRFIT Coordinator observed that CMC had adequate intake cell practices. All new intake incarcerated persons were in intake cells, and none were housed beyond 72 hours.

At LAC, during several 2023 site visits the Regional SPRFIT Coordinator never observed any new intake incarcerated persons housed in non-intake cells. At KVSP, the Regional SPRFIT Coordinator conducted a November 2023 site visit and observed appropriate use of intake cells. All new intake incarcerated persons were in intake cells, and none were housed beyond 72 hours. At SVSP, the Regional SPRFIT Coordinator observed adequate use of intake cells during her February and June 2023 site visits. All new intake incarcerated persons were in intake cells, and none were housed beyond 72 hours. Finally, at WSP,

the Regional SPRFIT Coordinator observed at three 2023 site visits that WSP was compliant with adequate intake cell practices. All new intake incarcerated persons were in intake cells, and none were housed beyond 72 hours.

MHCB Practices for Observation Status, Clothing, and Privileges

In his 2015 audit, Mr. Hayes recommended "taking reasonable corrective actions to address…additional miscellaneous issues" which included "privileges for [incarcerated individuals] in MHCBs." In that audit, Mr. Hayes found that crisis bed patients lacked access to recreation, visits, and telephone calls[55].

Three issues related to MHCB practices have been identified by Mr. Hayes: Errors in allowable property for patients, and the provision of out-of-cell activities and other privileges (e.g., access to a telephone).

In the sixth reaudit, OSM found "compliance with out-of-cell activities or privileges for MHCB patients continues to regress, with compliance falling from 53 percent in the fifth re-audit to only 33 percent in this sixth re-audit." Part of what OSM recommended to improve this issue is to "develop CAPs for 12 facilities (CCWF, CHCF, CIM, CIW, CMF, CSP/Corcoran, CSP/Sac, CSATF, KVSP, PBSP, RJD, and WSP) to remedy misuse of CDCR policies, including Daily Program Status Reports, and ignoring provider orders documented on daily Adaptive Support Form (CDCR 128 C-2) regarding the provision of authorized out-of-cell activities or privileges."

CDCR notes that the CCWF crisis bed had only recently reopened prior to Mr. Hayes's visit. The unit had been closed from November 8, 2021, until October 13, 2023 and Mr. Hayes visited the unit on November 14, 2023. The Regional SPRFIT Coordinator audited CCWF on February 22, 2024. Noting Mr. Hayes's findings of noncompliance with phone and dayroom opportunities, the reviewer found that, based on a review of ten crisis bed patients, yard, dayroom, showers, and phone calls were offered to all patients.

Mr. Hayes visited CHCF in June 2023. Regional SPRFIT Coordinators made several visits to CHCF in 2023 and found yard time was consistently offered in accordance with CDCR policy. During both the March and November 2023 site visits, the reviewer noted that the unit activity logs for the MHCB and PIP indicated that patients were offered yard, shower, and phone calls.

The SPRFIT Coordinator toured CIM four times in 2023—twice before and twice after Mr. Hayes's May 2023 site visit. On each visit by CDCR's Region 4 SPRFIT Coordinator (in February, April, July, and October 2023), the reviewer found that all crisis bed patients had been cleared and were being offered yard, showers, and phone calls.

The SPRFIT Coordinators audited CIW four times in 2023. During the first visit in January 2023, the reviewer observed that crisis bed patients had been cleared for yard and dayroom, though phone calls were not documented. In the unlicensed crisis bed, the reviewer observed that yard, phone calls, dayroom, and other out of cell activities were being offered. During the follow up visit in April 2023, the reviewer observed that all patients in the crisis bed were offered yard, phone calls and dayroom. During the July 2023 visit, the reviewer observed that yard was not being offered for crisis bed patients watch in both the licensed and unlicensed units on suicide. Patients in the crisis bed were offered yard, phone calls, and dayroom. Then, during the November 2023 site visit, the Regional SPRFIT Coordinator observed that all patients in both licensed and unlicensed crisis bed were being offered out of cell contacts, including

[55] ECF No. 5259 at 33, 34.

yard, showers, and phone calls. Issues identified in the July 2023 visit had been remedied by November 2023.

At CSP/SAC, the Regional SPRFIT Coordinator conducted several site visits during 2023. In March 2023, the Coordinator noted that while patients were offered phone calls, no unstructured yard was running. A second site visit in August noted substantial improvement and custody staff had begun offering unstructured yard time and patients were receiving yard time on a rotating basis. In October, the SPRFIT Coordinator noted that 85% of the eligible patients audited were offered phone calls and 91% were offered yard.

The Regional SPRFIT Coordinator conducted audits at SATF in 2023 on March 23-24, September 20-21, and December 14-15. During the March and September site visits, deficiencies in privileges were noted, though none were noted as relating to a Program Status Report. Prior to the December 2023 site visit, the institution transitioned to the automated privilege tracking system. During the December 2023 site visit, the Region 3 SPRFIT Coordinator audited ten patients in the crisis bed during the review. All ten patients had been offered yard during their stay, nine had been offered dayroom, and eight had been offered phone calls.

The Regional SPRFIT Coordinator visited WSP three times in 2023. During these visits, patients were found to consistently receive yard access, and most had been offered telephone calls.

Mental Health Referrals and Suicide Risk Evaluations

Mr. Hayes recommended that "[e]ach facility's SPRFIT should audit the quality of completed SREs on a monthly basis." (ECF No. 6879 at 19, 27, 34). The court requires one hundred percent compliance with this recommendation (ECF No. 6973 at 7, 12). Mr. Hayes audits samples of urgent and emergent referrals for suicidal behavior or ideation to determine whether staff completed required SRASHEs.

When there is an emergent or urgent referral due to a patient reporting suicidality, in every case, it is expected that a mental health clinician conducts a suicide risk evaluation prior to determining the best course of action to address the patient's crisis.

In the sixth re-audit, OSM noted that with their input "…CDCR released a revised "Suicide Risk Evaluation Program Mentoring Program" policy [12.04.201] on June 7, 2023. The revised policy sought to increase the quality of completed SRASHEs by revamping the SRE training program.

Regarding Recommendation 10, Mr. Hayes found only two institutions 100 percent compliant and thirteen over 90 percent compliant. He recommended that CDCR develop a CAPs at the 6 facilities (CHCF, CMC, CSATF, NKSP, CSP/Solano, and RJD) that were under 90 percent compliance during the re-audit. Monthly audits of Emergent and Urgent consults are being completed by the regional suicide prevention coordinators and then reported to the statewide SPRFIT committee. In 2022, CDCR also developed a data indicator to measure the quality of selected SRASHE documentation. In 2023, CDCR conducted 1,445 such audits. Further, CDCR has raised several concerns related to the scope of these recommendations and they are currently under evaluation of the *Coleman* court.

Additionally, it was recommended that a "CAP should be developed for RJD to ensure that clinicians are prohibited from utilizing the Columbia-Suicide Severity Rating Scale (C-SSRS) screening form as an alternative to the SRASHE when IPs present as possible risks for suicide by expressing SI and/or engaging in SIB, as well

as when IPs are discharged from the MHCB and Alternative Housing when the reason for admission was danger to self."[56]

CDCR's use of the C-SSRS is authorized by statewide policy and is consistent with national standards of care. The Joint Commission requires screening for suicidal ideation using validated tools and lists the C-SSRS triage version as a validated and evidence-based tool for such screening.

Suicide Risk Evaluation Trainings

Mr. Hayes recommended that "CDCR should revise its SRE Mentoring Program to (i.) eliminate its "graduation" component after completion of two adequate assessments, (ii.) conduct ongoing mentoring throughout the year, and (iii.) audit clinicians' SREs on a regularly scheduled basis." According to his most recent report, Mr. Hayes gauges compliance with this recommendation based on whether CDCR staff "had completed both the SRE mentoring program and annual or biennial SRE Mentoring Booster training as applicable." (ECF No. 8143-1 at 37).

Mr. Hayes indicates that compliance with the recommendation related to Suicide Risk Evaluation training required that at least 90 percent of mental health clinicians at each audited CDCR facility should be compliant with the requirements of both the seven-hour SRE training and SRE mentoring program. Although Mr. Hayes found CDCR noncompliant at ten institutions with this recommendation because they failed to adhere to SRE training schedules, CDCR can demonstrate compliance with those trainings at California Correctional Institution (CCI). In 2023, CCI had a 94.38% completion rate for the SRE mentoring training and a 98.76% completion rate for the biennial SRE training.

While other nine institutions did not score over ninety percent for both initial and biennial SRE training, in 2023, five other institutions scored over ninety percent for the biennial SRE training. Those institutions are Central California Women's Facility (90.29%), California Men's Colony (93.52%), California Medical Facility (92.99%), California State Prison, Los Angeles County (97.25%), and California Healthcare Facility (95.43%). Statewide, in 2023, CDCR scored over ninety-one percent for completion of the biennial training.

Safety Planning for Suicidal Individuals

There are two recommendations associated with safety planning for suicidal patients. First, Recommendation 17 requires that CDCR should adopt the recommendations made in connection with SREs set forth above, which will also improve treatment planning contained in the SREs section above" Specifically, Mr. Hayes monitors whether CDCR institutions "maintain adequate treatment (safety) plans in at least 90 percent of reviewed cases." (ECF No. 6879 at 20.) Next, Recommendation 18 requires that "CDCR...develop a specific timetable for the training of all of its mental health clinicians on treatment planning for the suicidal incarcerated individual, using its PowerPoint presentation "Safety/Treatment Planning for Suicide Risk Assessment."

In both 2017 and 2018, OSM experts noted difficulties with the quality of safety plans written within suicide risk evaluations. During discussions, CDCR and the OSM experts agreed to supervisory[57]

[56] ECF 8143-1, page 39

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

monitoring of all safety plans written in suicide risk evaluations at the time of discharge from MHCB. The number of safety plans reviewed is dependent upon the number of discharges per week at any given institution. The supervisory reviews are designed to ensure that MHCB discharge safety plans were of good quality, reflected consultation with receiving treatment teams when indicated, and helped to ensure risk management efforts were described effectively. Over the course of 2023, CDCR identified that there remain deficiencies in many institutions with the completion of these supervisory reviews. In some instances, the supervisors are not completing these reviews on a regular basis; in other institutions, the supervisors have conducted the reviews on an intermittent basis. In still other institutions, the supervisors are conducting the reviews but there are significant concerns about the efficacy of those reviews, as they demonstrate results that are inconsistent with the reviews conducted by external auditors' review of the same discharge safety plans. As such, the SMHP has reviewed the process for these reviews and developed some modifications to data collection and will be finalizing a performance metric related to timely completion of the reviews.

In the sixth re-audit, OSM noted that the review "commenced in April 2023, subsequent to the defendants' safety plan policy issuance and required completion of training…the results were very poor, and the assessment found continuing problems with adequate safety planning for both patients discharged from Alternative Housing and MHCB units. Specifically, only 10 percent (2 of 21) of audited facilities with an MHCB unit or utilized Alternative Housing demonstrated adequate safety planning (Recommendation 17). The only facilities that demonstrated adequate safety planning were CIW and SQ. Multiple problems were found with safety planning in all other facilities, the most prevalent of which was that many clinicians were simply cutting and pasting the same repetitive narrative into each category of the safety plan grid in EHRS regardless of its relevance to that category."[58]

CDCR has created a uniform SharePoint site for institutional supervisory staff to input their data. This will allow the statewide suicide prevention and response unit to review the results in real-time to assist institutions who are struggling to reach compliance. Additionally, CDCR is in the development stage of hosting several forums for the field SPRFIT Coordinators and MHCB Supervisors to provide feedback on the safety plan and supervisory review process to determine how they can be modified to improve compliance. These forums are scheduled for Quarter 3 of 2024.

Mr. Hayes also found that six institutions were not in compliance with Recommendation 18's training requirement. CDCR issued new training in 2023 and required institutional staff to complete training by June 16, 2023. Three of the six institutions, visited prior to the June 16, 2023 deadline, – Wasco State Prison, California State Prison, Sacramento, and California Institution for Women – have since come into compliance.

Inpatient and Alternative Housing Discharge – Efficacy of Custody Welfare Checks and Five-Day Follow-Ups

When patients are discharged from Alternative Housing, inpatient beds in CDCR's PIPs and DSH, or an MHCB, custody officers in housing units upon which the patient returns to, must complete welfare checks every 30 minutes for at least 24 hours. After the first 24 hours, a mental health clinician must evaluate the patient and notify the housing officers about the patient's adjustment to the unit. This process can re-occur at 24-hour intervals for up to 72-hours. Additionally, when a patient is discharged from either Alternative Housing or an MHCB, mental health clinicians must re-evaluate the patient daily, recording their assessment on a Five-Day Follow-Up form. The form requires clinicians to ask about suicidal

58

ECF 8143-1, pp. 41-42

thoughts, signs of distress, while instructing the clinician to review MHCB discharge documents, and to review and/or revise the patient's safety plan.

In the sixth re-audit, OSM found that "clinicians were consistently completing the 'Interdisciplinary Progress Note-5-Day Follow-Up' (CDCR MH-7230-B) form in EHRS. However, the assessment also found that only two (CIW and CMC) of 20 audited facilities, or 10 percent, had clinicians and custody personnel correctly complete both pages of the 'Discharge Custody Check Sheet' (CDCR MH-7497) forms in 90 percent or more of the cases, a negligible increase from the fifth re-audit report (9 percent). In addition, 50 percent (10 of 20) of the audited facilities had neither clinicians nor custody personnel correctly complete both pages of the 'Discharge Custody Check Sheet' (CDCR MH-7497) forms in 90 percent or more of the cases." They also found clinicians to be "not accurately completing the first page; clinicians discontinuing custody checks in less than the required 24 hours; custody checks performed in excess of 30-minute intervals, and long gaps in time of required custody checks". Recommendations included CAPs to be developed "for the 18 audited facilities (CCI, CCWF, CHCF, CIM, CMF, CSP/Corcoran, CSP/LAC, CSP/Sac, CSATF, HDSP, KVSP, MCSP, NKSP, PBSP, RJD, SVSP,SQ, and WSP) that continued to be below 90 percent compliance with Page 1 and/or Page 2 of the 'Discharge Custody Check Sheet' (CDCR MH-7497) form."[59]

Of the eighteen audited facilities that Mr. Hayes raised concerns, CDCR's SPRFIT Coordinators conducted audits and found at least eight of those to have achieved high levels of compliance during 2023. CDCR's Regional SPRFIT Coordinator visited COR on December 12-13, 2023. The reviewer found that COR's 7497 scores were over ninety percent for July and August 2023 and at eighty-seven percent in September 2023.

CDCR's Regional SPRFIT Coordinator visited SATF on December 14-15, 2023, and, using the agreed upon audit, found SATF compliant for form 7497s in July, August, and September 2023. In July, SATF scored over ninety-three percent. In August, SATF scored nearly ninety-seven percent. And in September, SATF scored ninety-eight percent.

CDCR's Regional SPRFIT Coordinator visited HDSP in August 2023. The reviewer found that overall, 7497 compliance with ninety-six percent and that HDSP scored ninety-six percent in April 2023, 100 percent in May 2023, eighty-nine percent in June 2023, and ninety percent in July 2023.

CDCR's Regional SPRFIT Coordinator audited KVSP on November 8-9, 2023. KVSP was compliant with form 7497 practices during the review. The reviewer found that KVSP was ninety-six percent compliant in July 2023, ninety-seven percent compliant in August 2023, and ninety-five percent compliant in September 2023.

CDCR's Regional SPRFIT Coordinator visited MCSP three times in 2023. During the December 12, 2023, visit, the reviewer audited 7497 form compliance and found that MCSP was ninety-seven percent compliant in September, ninety-five percent compliant in October, and ninety-four percent compliant in November 2023.

CDCR's Regional SPRFIT Coordinator visited NKSP on November 15-26, 2023, and found NKSP compliant with 7497 forms in July, August, and September 2023. NKSP scored 100 percent in July and August 2023 and scored ninety percent in September 2023.

CDCR's Regional SPRFIT Coordinators visited San Quentin Rehabilitation Center twice in 2023. During the second visit in October 2023, the reviewer observed, using the agreed upon audit, reported that SQ had shown compliance with the 7497 forms, namely that it had scored nearly 100 percent in February 2023, ninety-four percent in March 2023, ninety-seven percent in April 2023, ninety-eight percent in May 2023,

[59] ECF 8143-1, pp. 49-50

ninety-eight percent in June 2023, ninety-nine percent in July 2023 and ninety-nine percent in August 2023.

CDCR's Regional SPRFIT Coordinator visited WSP after Mr. Hayes's visit. Using the agreed upon audit criteria, during his November 13-14, 2023, site visit, the reviewer noted that WSP had been over ninety-eight percent compliant with 7497s in July, August, and September 2023.

Local Suicide Prevention Programs

A critical component of any suicide prevention program is a governing body that continually assesses the quality of the program and takes necessary action to resolve deficiencies. The quality of the local Suicide Prevention and Response Focused Improvement Team (SPRFIT) committees continues to be an area of focus for Mr. Hayes. In 2015, Mr. Hayes recommended that CDCR, under the guidance of the Special Master...re-examine and revise its local SPRFIT model to make the local SPRFITs a more effective quality assurance/improvement tool. In assessing compliance, Mr. Hayes looks at five things: "1) the degree to which SPRFITs achieved six consecutive months of meeting quorums for all mandatory members or their designees; 2) the degree to which each SPRFIT conducted either semi-annual [Root Cause Analyses] or clinical case summaries of serious suicide attempts when appropriate;12 3) the degree to which each SPRFIT tracked IPs in the Suicide Risk Management Program (SRMP) and reviewed them during monthly meetings as required by policy; 4) the degree to which facilities had local operating procedures (for SPRFIT, Inmate-Patients Receiving Bad News, SRMP, and [Crisis Intervention Teams]); and 5) the degree to which each SPRFIT tracked prior corrective actions recommended by this reviewer and/or regional SPRFIT clinicians." (ECF No. 8143-1 at 52.)

In the sixth re-audit, the reviewers found that "only 33 percent (7 of 21) of facilities had adequate practices in all combined SPRFIT audited responsibilities. Individually, only 52 percent (11 of 21) of facilities achieved six consecutive months of meeting quorums, an improvement from the fifth re-audit (with only 26 percent). In addition, 81 percent (17 of 21) of the local SPRFITs had signed and/or dated LOPs that were consistent with the February 2018 CDCR directive for SPRFITs, as well as appropriate LOPs for "Inmate-Patients Receiving Bad News" and the "Suicide Risk Management Program," and "Crisis Intervention Teams." Further, only 62 percent (13 of 21) of the audited facilities tracked and reviewed SRMP IPs in monthly SPRFIT meetings. Finally, 81 percent (17 of 21) of the audited facilities tracked prior corrective actions recommended by this reviewer and/or regional SPRFIT clinicians in either monthly SPRFIT minutes or in separate documentation." The recommendations included "CAPs for the 10 facilities (CCI, CCWF, CIW, CMF, CSP/Corcoran, CSP/LAC, CSP/Solano, CSATF, PBSP, and SVSP) that did not achieve six consecutive months of SPRFIT meeting quorums for all mandatory members or their designees. CDCR should develop CAPs for the four facilities (CHCF, CSP/Corcoran, CSATF, and KVSP) that did not have LOPs (for SPRFIT, Inmate-Patients Receiving Bad News, CIT, and/or the SRMP) that were consistent with the SPRFIT memorandum. CDCR should develop CAPs for the eight facilities (CCI, CIW, CHCF, CMF, KVSP, MCSP, CSP/Solano, and SVSP) that did not track and review SRMP patients during monthly SPRFIT meetings."[60]

In 2020, the Statewide Mental Health Program, in coordination with CCHCS Quality Management, initiated a workgroup to begin to enhance the institutional SPRFIT committees. This workgroup included representatives from the suicide prevention unit within the SMHP, CCHCS QM, regional mental health teams, and the OSM. By 2022, the workgroup members had developed a comprehensive package of training materials, automated reports, measurement plans and schedules, and administrative support tools designed to utilize validated quality management techniques for improved committee functioning.

[60] ECF No. 8143-1, pp. 52-53

All required members of the SPRFIT Committees from every institution received a four-day training, known as the SPRFIT Committee Reboot, by the end of 2022. In addition to the quality of the institutional SPRFIT Committee, the fourth re-audit report recommended prioritizing the completion of local operating procedures and High-Risk Management Programs. In addition, the OSM experts recommended further work with the local institutions on "bad news" policies and implementing the Root Cause Analysis (RCA) policy, which is currently being reviewed for possible changes. While the RCA policy is being reviewed for possible changes, institutions continue to be required to complete thorough reviews of all serious suicide attempts.

CDCR has raised several concerns related to the scope of this recommendation and whether it audits the actual adequacy and quality of these committees. These concerns are currently under evaluation of the *Coleman* court.

Continuous Quality Improvement (CQI)

In 2020, Mr. Hayes recommended that CDCR "1) incorporate all of this reviewer's 19 "Suicide Prevention Audit Checklist" measures into any CQI Guidebook, and 2) any CQI audit report of an individual facility's suicide prevention practices should be formatted to contain data on all 19 suicide prevention measures." (ECF No. 6879-1 at 36.) Although Mr. Hayes found CDCR non-compliant with this recommendation in his sixth re-audit, Mr. Hayes also found that CDCR "adequately" contained all nineteen of his suicide prevention measures. (ECF No. 8143-1 at 59.) He also found that CDCR's SPRFIT Coordinator reports are "more or less consistent with this reviewer's audit reports." (*Id.*)

CDCR, in consultation with the OSM experts, has agreed to monitor 19 suicide prevention audit items through a CQI process. In 2018, CDCR worked with the OSM on a final CQI report format. The Court adopted Mr. Hayes' recommendation that his 19 suicide prevention audit measures be included in the CQI process in the Third Re-Audit Report.[61] This format integrates suicide prevention audit findings with other CQI assessments, with the comprehensive group of findings detailed in a written report. The CQI Tool (CQIT) involves reviewers from multiple disciplines within each institution (e.g., custody, nursing, and mental health disciplines) to ensure that the audit is done comprehensively. A self-audit guidebook containing these items was distributed to institutions.

CDCR employs four Regional SPRFIT Coordinators who audit their assigned institutions several times per year. During those audits they use the most current version of the Comprehensive CQI Audits Guidebook which includes a chapter on suicide prevention measures. Suicide prevention measures were first integrated into the Comprehensive CQI Audits Guidebook in March 2023, however, the Regional SPRFIT Coordinators used a standalone version of the suicide prevention measures prior to that merger in 2022. CDCR's Comprehensive CQI Audits Guidebook is updated on a quarterly basis to reflect the most up to date version of the various audits. This is by design. Since October 2022, the combined guidebook has included "all of Mr. Hayes' 19 Suicide Prevention Audit Checklist measures." The Guidebook does more than mimic a Hayes tour. In addition to the nineteen Hayes items the Guidebook includes and the SPRFIT Coordinators report on the following additional suicide prevention measures:

- RHU Morning Meetings
- Compliance with ASU Pre-Placement Screens
- Compliance with ASU Screening Questionnaires
- Number of Suicide Risk Evaluations Completed in a Confidential Setting

[61] ECF No. 5993-1

- Five-day follow up compliance.
- Suicide Risk Management Program Reviews
- Suicide Risk Evaluation compliance.
- Sustainability of Quality Improvement Plans
- Training on suicide screenings, Suicide Risk Management Program, and discontinuing the use of safety contracts in inpatient settings.

After a site visit, CDCR's Regional SPRFIT Coordinators produce a report within weeks to give institutions close to real time feedback and corrective action plans. Those reports are formatted to contain data on all 19 suicide prevention measures. After issuing their report, the Regional SPRFIT Coordinators conduct return visits with their institutions to again fully assess the institution's compliance with suicide prevention policies and to review the status of any corrective action plans. Corrective action plans are updated or marked as fulfilled as indicated during the follow up visits.

Suicide Prevention Training

Mr. Hayes recommended that CDCR "[e]nsure that all custody and health care staff receive both pre-service and annual suicide prevention training."

Mr. Hayes attended selected in-service training (IST) annual suicide prevention classes held within audited institutions. He opined that the course content was too large for a two-hour class, yet still did not include important topics. Mr. Hayes made recommendations for course content that has been since integrated into a revised training. The revised training was reviewed by Mr. Hayes and sent to the OTPD in the spring of 2020 for review. It was approved in August 2020 and the new revision was released to the field in January 2021.

In the sixth re-audit, the OSM experts "found that 95 percent (20 of 21) of the audited facilities had compliance rates for annual suicide prevention training of custody personnel that were above 90 percent for 2022; 62 percent (13 of 21) of the audited facilities had compliance rates for annual suicide prevention training of medical personnel that were above 90 percent for 2022, and 86 percent (18 of 21) of the audited facilities had compliance rates for annual suicide prevention training of mental health personnel that were above 90 percent for 2022. Overall, only 52 percent (11 of 21) of the audited facilities had compliance rates of 90 percent and above for all three disciplines (custody, medical, and mental health)." They recommended that "CDCR should develop CAPs for all facilities that had compliance rates below 90 percent for annual suicide prevention training, and specifically for the eight facilities (CIW, CMC, CMF, CSP/LAC, CSP/Sac, CSATF, HDSP, and SQ) that were below 90 percent compliance for suicide prevention training of medical personnel."

CDCR notes that compliance for this annual training across disciplines contradicts the findings of the OSM's expert based on data for 2023. Specifically, CDCR found that LAC's compliance for custody staff was 91%. Additionally, CDCR found that compliance for mental health staff at LAC was 87%, CHCF was 82%, MCSP was 96% and SVSP was 95%. Finally, CDCR notes compliance for medical staff was 87% for LAC, 83% at CIW, 94% at CMC, 92% at CMF, 94% at HDSP, 88% at CSP-SAC, 93% at CSATF, 84% at SQ and 83% at CHCF.

Reception Centers

Reception Centers are prisons where individuals committed to CDCR are received from county jails for initial processing. There was a cluster of suicides in Reception Center institutions in 2018. Some of the issues identified as impacting suicide prevention in reception included inconsistent posting of suicide prevention posters and difficulties receiving jail mental health records in a timely manner. Regional Mental Health Compliance Teams are directed to inspect reception center institutions for suicide prevention posters on a routine basis. The SMHP released a memorandum to the field in January 2021 providing direction to reception center mental health clinicians regarding expectations for obtaining and reviewing jail records for newly received individuals. Mr. Hayes audits four responsibilities of Reception Centers in determining compliance. Those include the displaying of suicide prevention posters as well as several duties of the diagnostic clinicians in completing initial screening. (ECF No. 7636 at 29.)

In the sixth re-audit, OSM experts "observed the diagnostic clinician screening process, as well as reviewed several medical charts for in-coming IPs at each of the three Reception Centers (CCWF, NKSP, and WSP). Similar to the previous assessment, the current re-audit found mixed results. Although privacy and confidentiality were maintained during the RC process at each facility, and suicide prevention placards were found in each clinician's office, there were continued concerns regarding thorough review of nursing Initial Intake Screening forms and county jail records, as well as applicable ROI forms still not always requested (Recommendation 32)."[62]

CDCR's Regional SPRFIT Coordinators made site visits to WSP and did not observe or discover similar issues. During the November 2023 site visit, the reviewer observed two clinicians completing diagnostic screenings. Between the two clinicians, a total of five screenings were observed. The county jail records, and the initial health screening were reviewed in all five cases. There was a total of two patients who reported having received mental health treatment in the community and the clinician appropriately made a request for authorization of a release of information. Both observed clinicians asked all the questions appropriately and arrived at an appropriate determination regarding referral for an initial clinical assessment.

PIP Intake Screening

All patients who arrive to a PIP, much like every other institution in CDCR, should receive an initial health screening as part of the admission process. However, the OSM expert observed disparate practices across the five PIPs, including concerns about some questions related to suicide history were not asked, or different forms being used across different institutions. As a result of these findings, the OSM expert recommended that CDCR must create a uniform screening process for all new intakes into the PIP setting that appropriately asks patients about mental health and suicide-related questions.

In his 6th reaudit, the OSM expert noted continued concerns about the uniformity of the screening process at the PIPs. While unable to observe the initial screening process at some of the facilities, he was able to observe the process at two locations. At those institutions, it was noted that while the nurses were completing an intake screening, they were not asking all of the necessary questions related to suicide history.

As a result of these concerns, CCHCS Nursing Services modified the intake screening for PIP admissions inside of the EHRS. The standardized screening now contains relevant questions related to the patients' suicide and mental health history. Further, training has been provided for all nursing staff, and as of the

[62] ECF 8143-1, page 69

writing of this report, compliance with the training is 90%. Compliance, in practice, will be monitored on a quarterly basis by the regional suicide prevention specialists during their regularly scheduled site visits. Non-compliance will result in corrective action, as necessary.

Admission and Discharge SRASHEs

When a patient is admitted to an inpatient setting for longer term stabilization, such as the PIP, it is necessary to conduct a suicide risk evaluation to ensure the treatment team is aware of the current presentation of the patient. This allows the treatment team to make informed decisions about treatment goals and interventions during the patient's stay. Further, upon discharge, it is critical for the primary clinician to complete a new suicide risk evaluation to document the progress of the patient's suicidal presentation. This evaluation is instructive to the receiving treatment team in understanding the patient's residual risk factors. It also allows for the receiving institution to implement the safety plan that accompanies the discharge suicide risk evaluation.

During the baseline assessment of PIP suicide prevention practices, the OSM expert noted that CDCR's suicide prevention policy for PIPs required a suicide risk evaluation be completed within 72 hours of admission, at discharge, and at any point during the stay in which a patient expressed suicidality or engaged in self-harm behavior. However, during the OSM expert's tour of the PIP facilities, CDCR released a clarifying memo altering the language of the original policy to only require a suicide risk evaluation to be completed at admission and discharge, or when clinically indicated.

In his 6th reaudit, and second assessment of the PIPs, the OSM expert noted that while timeliness of completion of the suicide risk evaluations improved at the PIPs, there remained problems associated with who was completing these suicide risk evaluations. Specifically, the CDCR PIP suicide prevention policy requires that only licensed psychologists and psychiatrists complete these evaluations. However, at several PIP facilities, the evaluations were completed by licensed and unlicensed social workers and unlicensed psychologists. As a result, the OSM expert recommended that these evaluations only be conducted by authorized personnel.

Subsequent to the release of the expert's report, CDCR reviewed California Code of Regulations Title 22 to determine whether there are specific prohibitions on licensure status for completion of evaluations in psychiatric inpatient settings. As a result, it was determined that there are no limitations on what an unlicensed provider can do in these settings, so long as they have a valid waiver to practice through the California Department of Public Health. On July 31, 2024, CDCR released a memo authorizing licensed psychologists and clinical social workers, as well as unlicensed psychologists and clinical social workers with a valid waiver to complete suicide risk evaluations. The regional suicide prevention coordinators continue to review the timeliness of the suicide risk evaluations completed in PIP settings during their regular site reviews of these facilities.

Suicide Resistant Beds

In the baseline assessment of PIP suicide prevention practices, the OSM expert determined that at two locations – CMF-PIP and SVSP-PIP – there were limited, or no, suicide resistant beds to house patients who are at risk of suicide. Subsequently in the second audit of the PIP suicide prevention practices, the OSM expert noted that at the CMF-PIP one unit (L-1) had been closed and was no longer in use and that 32 cells in the 64-bed PIP unit had been fully retrofitted for safety concerns. The OSM expert remained concerned that there were no retrofitted cells within the SVSP-PIP housing units.

CDCR contends that retrofitting of cells within the SVSP-PIP had been underway, and many had been completed. Two units – C-5 and C-6 had retrofits completed in several cells in December 2023. Further, retrofits for two additional units (TC-1 and TC-2) began in December 2023 and were completed in July 2024. In addition to the retrofit projects conducted in the units of the SVSP-PIP, there are policies in place that prevent suicidal patients from being housed in cells on the second tier of C-5 and C-6 in order to protect them from self-harm via jumping from the tier. Additionally, CDCR does not believe these units present an acute danger for suicide attempts, nor has there been a documented suicide attempt, via hanging in these housing units.

Observation of Suicidal Patients

In the baseline assessment of suicide prevention practices in the PIPs, the OSM expert noted several problematic practices related to the observation of suicidal patients. There were noted issues related to confusing documentation for patients on suicide precautions and non-suicide related 15-minute checks. There were also concerns related to inappropriate terminology that was colloquial in nature, and not official policy-derived terms for suicide watch or precautions. Beyond documentation concerns, there were also concerns found related to clinicians not assessing the patients on observation status on a daily basis. Finally, the timeliness of the suicide precaution and watch checks were observed to be less than 100% compliant.

In the second assessment of the suicide prevention practice sin the PIPs, the OSM expert noted some improvement across the institutions, but that there remained issues at several of the PIP institutions. Specifically, CIW-PIP continued to use other observation frequencies not authorized in the suicide prevention policy for the PIPs. There, the providers tended to utilize a 60-minute behavioral suicide watch status. Additionally, at SVSP-PIP, most patients are placed on suicide watch because, as noted by the OSM expert, the providers felt uncomfortable putting potentially high-risk patients in non-retrofitted cells without constant observation. The OSM expert made three recommendations associated with this indicator: develop CAPs for all PIPs that are not at 100% compliance for suicide watch and precaution rounds, develop a CAP for CIW-PIP to discontinue the use of behavioral suicide observation, and to ensure providers are completing daily assessments of patients on enhanced observations.

CDCR conducts millions of observation checks each year on suicidal patients, including within the PIP faciliies. A 100% standard is impossible given the number of checks conducted. CDCR continues to work with the PIPs to ensure they are reaching maximum compliance for their high-risk patients, but believes it is unnecessary to assign additional CAPs and would detract from other corrective action priorities at each PIP. As it relates to the concerns at CIW-PIP and the behavioral suicide watch observation level, the regional suicide prevention coordinator established a CAP to address the issue and it was subsequently deemed to be corrected and has remained corrected to date. Finally, the concerns raised at SVSP-PIP related to daily contact by providers was reviewed by the regional suicide prevention coordinator found that in her site visit in December 2023 the issue was no longer present and subsequently remained corrected.

Proper Clothing and Possessions

The baseline assessment of suicide prevention practices conducted by the OSM's expert found that at the PIP facilities, patients were not always receiving proper clothing and possessions commensurate with their level of observation, or lack of enhanced observation. At CMF-PIP there were concerns noted where patients were not on suicide observation status but were clothed in less than full-issue or in safety smocks.

At CHCF-PIP, patients were offered state-issued blue pants and shirts, but not boxers or t-shirts because some providers felt these could be easily torn and used as ligatures.

In his second assessment of suicide prevention practices in PIPs, the OSM expert continued to find problems at both CMF-PIP and CHCF-PIP. At CMF-PIP providers were writing progress notes and issue orders that restricted clothing for suicidal patients rather than placing the patients on enhanced observation or discontinuing the observation status but continuing the limited issue orders. At CHCF, the expert noted problems persisted around documenting clinical rationales for issuance of clothing and property.

CDCR's regional suicide prevention coordinator assigned to the CMF-PIP has worked with the staff at CMF-PIP and noted in the December 2023 site visit report that issues surrounding documentation of rationales for clothing and possessions is no longer problematic and that only "minor issues" were found and that orders were up-to-date and accurate. Conversely, the coordinator assigned to the CHCF-PIP instructed the institution to place this concern on their SPRFIT Committee project pipeline for prioritization in April 2023 and this remains an outstanding concern that remains a focus for the institution.

Out-of-Cell Activities

The baseline assessment of suicide prevention practices in the PIPs noted that there are concerns related to the allowance of patients on enhanced observation status to receive out-of-cell time to improve their mental health functioning. Specifically at CMF-PIP, CHCF-PIP, and SVSP-PIP, the OSM expert noted problematic practices where patients on suicide watch/precautions or on MAX custody status did not receive out-of-cell time. There were also concerns noted in the Non-Clinical Activity Tracking (NCAT) data related to the out-of-cell activities offered to the patients.

In his second assessment of suicide prevention practices in the PIPs, the OSM expert noted continued deficiencies in the practices of offering patients out-of-cell activities at CMF-PIP, SVSP-PIP, CHCF-PIP, and CIW-PIP, when using NCAT data, which was deemed to be a reliable source for the provision of those activities. The expert looked at yard/dayroom, telephone, visitation, and shower time in the review of out-of-cell activities.

CDCR continues to utilize the regional suicide prevention coordinators and their regular site visits to the PIPs to analyze the current practices surrounding out-of-cell activities for patients housed in those facilities. When there are noted deficiencies in the data, the coordinators will work with institutional leadership to increase out-of-cell activities. It should be noted that it wasn't until 2024 that the *Coleman* court issued a court order requiring a specific number of hours of out-of-cell time, and as a result, the standards in which the OSM's expert was holding CDCR to in the first two assessments of suicide prevention practices in the PIPs were not based in policy.

IDTT Meetings

In his baseline assessment of suicide prevention practices in the PIPs, the OSM's expert reported that IDTT meetings within all of the PIPs were inconsistent. Despite reporting that there was good representation from all members of the IDTTs, most meetings demonstrated inconsistent case presentations with limited discussion related to higher level of care considerations (specific to ICF patients), and inadequate discussions about suicide history, current suicide risk, and safety plans to reduce further suicidal ideation.

In the second assessment of suicide prevention practices in the PIPs, the OSM's expert continued to find concerns related to the clinical presentations during IDTTs at all of the PIPs except for SQ-PIP. Ongoing problems were found with the clinical discussions, review of diagnoses, little to no discussion about observation level and possessions and inadequate discussions regarding suicide risk and safety planning.

CDCR has objected to the OSM's expert opining on clinical processes as he is not a clinician. This objection pertains to the observation of IDTT meetings. Further, the regional suicide prevention coordinators are licensed psychologists and, as part of their regular monitoring of PIP suicide prevention practices, observe IDTT meetings. As part of this observation, if concerns are noted with the clinical presentation or interaction, the coordinators will establish corrective action plans for the institution to improve those meetings.

Safety Planning

In his baseline assessment of suicide prevention practices in the PIPs, the OSM's expert noted that safety planning was problematic at all of the PIPs. The expert noted that policy requires that supervisors review all discharge safety plans prior to, or during, the discharge IDTT where it is discussed. It was found that the reviews were untimely, not occurring at all, or incorrectly determining that the safety plans were not required.

In his second assessment of the suicide prevention practices in the PIPs, the OSM's expert found ongoing concerns with the completion of the supervisory reviews at three of the PIPs but found that SQ-PIP and CIW-PIP were timely and appropriately completed in most cases. At CMF-PIP, the expert was informed that the supervisory reviews were not being completed due to shortages in supervisory staff. The review process at CHCF-PIP was "seriously flawed" by missing data and that the safety plans were completed by unauthorized clinicians (clinical social workers). At SVSP-PIP, the supervisory reviews were completed in an uneven manner, but were being attempted. It was also found that at SVSP-PIP multiple templates contained within EHRS were being used, rather than the actual supervisory review of discharge safety plans.

CDCR monitors the adequacy of safety planning through its Chart Audit Tool as well as a remediated data indicator, Quality of Safety Planning to Reduce Suicide Risk. Additionally, supervisory reviews are completed on a statewide SharePoint which requires that supervisors identify if modifications were needed in the safety plans being reviewed. CDCR continuously assesses the effectiveness of the SharePoint system. CDCR notes that the OSM's expert found multiple types of EHRs templates in its review of safety plans at SVSP-PIP. However, the regional suicide prevention coordinator routinely monitors the practices at SVSP-PIP and in those reviews, it can be seen that the SVSP-PIP is no longer utilizing the other templates for the supervisory reviews.

Contracting for Safety

In his baseline assessment of the suicide prevention practices in the PIPs, the OSM's expert found progress notes at CMF-PIP, SVSP-PIP and CIW-PIP utilizing the term "contracting for safety", which has been found in literature to be ineffective in the management of suicidal individuals. This practice has been previously discontinued in previous CDCR suicide prevention training curricula. This practice was found to occur across clinical classifications at the PIP facilities.

In his second assessment of the suicide prevention practices in the PIPs, the OSM's expert noted that CDCR responded to the findings in his first assessment by issuing two memoranda in 2023 to discontinue the

practice of using safety contracts for nursing staff and for clinical providers. During this assessment, the expert noted sparse references to “contracting for safety” in PIP units.

CDCR’s regional suicide prevention coordinators continue to review clinical documentation as part of their regular monitoring of the PIP facilities. As part of their documentation review, the coordinators will search for references to contracting for safety. In the rare instances in which it is noted, corrective action is recommended for the institutions to work with the identified staff to correct this practice.

CPR Training

In both his baseline and second assessments of the suicide prevention practices in the PIPs, the OSM’s expert noted high rates of compliance with CPR training for both custody and medical staff in all of the PIPs.

This is an item that is regularly reviewed by the regional suicide prevention coordinators’ onsite reviews of the PIPs. Any PIP found to be below 90% compliant on this indicator will result in corrective action. At the time of this writing, no PIP was found to be below 90% compliant for CPR training.

Suicide Prevention Training

In his baseline assessment of the suicide prevention practices in the PIPs, the OSM’s exert noted that in three of the PIPs, there were high rates of compliance with annual suicide prevention training for custody, medical and mental health staff. The only non-compliant institutions were CMF-PIP and CHCF-PIP. Further, the expert noted that all of the PIPs had high compliance with safety planning. Finally, the expert found that CMF-PIP, CHCF-PIP, and SVSP-PIP fell below 90% compliance for the SRE mentoring program and the seven-hour SRE training.

The second assessment of the suicide prevention practices in the PIPs found continued deficiencies in suicide prevention-related trainings. For annual suicide prevention training, only CMF-PIP demonstrated compliance above 90% for all of the disciplines. At all other facilities, at least one discipline was found to be below 90% compliant. Wide variation was found in compliance for the SRE mentoring, seven-hour SRE, and safety planning trainings at all of the PIPs. Only SQ-PIP was above 90% for all of the aforementioned trainings; CIW-PIP was compliant in all but one of the trainings. The remaining 3 PIPs were non-compliant for all of the clinical trainings.

This is an item that is regularly reviewed by the regional suicide prevention coordinators’ onsite reviews of the PIPs. Any PIP found to be below 90% compliant on this indicator will result in corrective action.

SPRFIT Committees

In his initial assessment of suicide prevention practices in the PIPs, the OSM expert noted that there were problematic SPRFIT Committees related to attendance and reach quorum, as well as a lack of identification or correction of the deficiencies found by the expert.

The second assessment of suicide prevention practices in the PIPs found continued deficiencies with the SPRFIT Committees in all but one (SQ-PIP) PIP facility. The expert continued to note problems with committees meeting quorum requirements as well as finding the minutes to be “unremarkable”. Further, none of the recommended corrective actions from the expert’s first assessment were found to be

reviewed during the committee meetings. Further, none of the deficiencies this expert found had been identified by the SPRFIT Committees at any of the PIPs, except SQ-PIP.

CDCR's regional suicide prevention coordinators have assessed the SPRFIT Committees as part of their regular site visits. In these reviews, the coordinators have found that the committees at CHCF-PIP, CIW-PIP, and SVSP-PIP also have no issues with maintaining quorum for six consecutive months. Further, the regional suicide prevention coordinators have noted that the SPRFIT committee minutes at CHCF-PIP, CIW-PIP, and CMF-PIP all adequately track and review corrective action plans. For the remaining non-compliant PIPs, the regional coordinators continue to monitor compliance with the SPRFIT committees and establish necessary corrective action plans when deficiencies are noted.

Progress in Identifying and Implementing Initiatives Designed to Reduce Risk Factors Associated with Suicide

There are many potential sources of information to consider in identifying initiatives for suicide prevention. Such information can be gleaned from input and innovation of institutional staff and leadership, input from the incarcerated population and their family or loved ones, as well as information from the field of suicidology. Furthermore, the results of suicide reviews and reviews of serious incidents of self-injury, quality management reviews, the findings of CDCR's informatics system and healthcare data warehouse, the dissemination of best practices at institutions, the practices of other agencies or states, the review of community or agency suicides or suicide attempts, insights from formal research on correctional populations, and the adoption and implementation of Crisis Intervention Teams also provides invaluable information in this realm.

All incarcerated persons in CDCR, patients and non-patients alike, are important sources of information about the issues affecting them individually and as a group, what external stressors may be contributing to the development of suicidal thoughts and behaviors in some individuals, and what they find helpful to reduce the risk for suicide. Individuals incarcerated in CDCR may tell custody officers, nurses, or other staff members about certain stressors, such as peers who are in danger from other peers. Individuals living in CDCR may divulge personal issues or stressors contributing to their thoughts of suicide and identify those unique risk factors that may have application beyond the individual case.
The field of suicidology is represented nationally by the American Association of Suicidology (AAS). Most major suicide prevention agencies are members or affiliates of the AAS. CDCR is a corporate member of AAS, meaning any staff member employed by CDCR may join the AAS without cost, which allows the staff member to gain access to the association's journal *Suicide and Life-Threatening Behavior*, informational webinars, libraries, and discounted attendance fees to AAS events. CDCR staff are reminded how to join and access AAS materials routinely via videoconferences, with documents regarding how to join the AAS posted on the suicide prevention SharePoint site. SMHP staff attend the annual AAS conference and have given presentations and trainings for correctional staff from across the country.

Reviews of suicide deaths and attempts inform the practice of suicide prevention. The pace of efforts derived from findings from suicide reviews continued in 2023. Below are three continually important projects that emerged from suicide case reviews:

- PIP and MHCB unit discharge workgroup.
- PIP suicide prevention program coordinator positions were filled in all PIP programs.
- Release of the PIP suicide prevention policy.

There are many quality management processes occurring at institutions as well as Patient Safety and Quality Management Committees at institutions. These institutional efforts are supported by regional healthcare, mental health, nursing, and custody staff members. The various quality management activities monitor many institutional functions, highlighting when programs are underperforming, and lead to innovation in determining how quality can be improved. In 2020, CDCR hired a Suicide Prevention Coordinator for each of CDCR's four regions. These new positions are an extension of the Suicide Response and Prevention unit at CCHCS Headquarters but based in their respective regions. While not directly reporting to the Regional Mental Health Administrators, all regionally based Suicide Prevention Coordinators work directly with their respective multidisciplinary regional teams. These positions afford CDCR's suicide prevention efforts an extended reach to provide assistance to the local institutions on improving and sustaining compliance, and developing institution-specific suicide prevention approaches that are consistent with statewide policy. The Suicide Prevention Coordinators are actively involved in all statewide suicide prevention processes, including suicide case reviews and at suicide prevention quality management activities.

Currently, CCHCS Quality Management provides comprehensive management and executive reports, operational tools, resources for local committees and subcommittees, leadership tools and training, and best practice information to institutions. The Quality Management portal contains, for example, information on conducting Performance Improvement Work Plans and Lean Six Sigma projects. They are also assisting in suicide prevention initiatives with the CIT Reporting Tool and the Nursing Observation Reporting Tool. Institutional leadership can review performance on a variety of metrics across units, programs, and facilities over periods of time, allowing leaders to adjust staffing, identify and address problems, and manage compliance issues.

The Mental Health Performance Report, is a performance analytics tool that helps recognize, measure and visualize performance indicators, among other reporting tools, supplies metrics to mental health leadership regarding quality and compliance, including timeliness of transfers and required evaluations, the number of treatment hours offered to patients at different levels of care, and so forth. The timeliness of suicide risk evaluations, five-day follow-ups, IDTT, inpatient discharges, outpatient appointments, and amount of treatment scheduled and offered is updated and reported daily. Compliance rates can be compared between institutions and can be addressed by regional resources, as well as institutional leadership. The Performance Report is updated regularly to reflect changes in program requirements.

This robust mental health quality management structure and reporting capability has led to a natural process of information and best practices sharing. Institutional programs that are not meeting standards often reach out to institutions that are meeting standards. Alternatively, regional staff members share what is working in one institution to other institutions in their region as best practices and as ways to improve on specific indicators. For example, institutions which were not meeting compliance standards regarding the completion of MHCB Discharge Custody Checks were assisted by regional staff by identifying methods used by high-performing institutions. In addition, CEOs at institutions meet with institutional quality management staff members and with other executives regularly, allowing for information to be shared from high-performing institutions with other sites. Best practices can be highlighted in discussions within and between institutions. CDCR, in collaboration with the Receiver's medical staff, has implemented numerous ways in which staff members and institutions can inform others or review best practices. Staff members at all levels are able to become involved in learning and using tools for performance improvement, with opportunities to inform institutional leadership and statewide leadership on specific projects or issues. Several methods are available to train staff in leadership skills, focused improvement projects, and projects that promote efficiency. In turn, each of these methods result in identifying best practices, which are then available for dissemination.

The SMHP and the Receiver's medical staff jointly administer a healthcare data warehouse to house information and analyze system-wide data. The warehouse is a repository for data from the EHRS and other and other application CDCR utilizes. This wealth of data is then aggregated and disseminated for quality improvement purposes. This shared data warehouse allows CDCR to analyze variables found in self-harm and death by suicide to inform policy decisions. The use of informatics allows mental health leadership to look at "big picture" items, and share this information with other stakeholders (e.g., custody leadership).

The California Model

Governor Newsom announced a plan to transform the criminal justice system in California. The plan includes a complete overhaul of San Quentin State Prison, which will be renamed San Quentin Rehabilitation Center (SQRC). It will focuse on preparing individuals for a successful return to the community. Systemwide, this culture shift will leverage international best practices and processes, including those being developed at San Quentin, to address longstanding challenges related to incarceration and correctional working conditions. The innovation in development at San Quentin provides a unique opportunity to reimagine how CDCR/CCHCS staff can collaborate with stakeholders throughout California to ensure we are providing the best services to the population while they are incarcerated and to prepare them for their return home. The transformation of SQRC will run concurrently with the overarching design of the California Model.

There are three goals for the California Model: *Wellness of Staff and the Population We Serve*: Improving the working environment of California prisons through staff training and facility enhancements in order to improve the health and well-being outcomes of people who live and work in state prisons, with a focus on reducing trauma and toxic stress; *Public Safety*: Returning people as better neighbors and family members, set up to thrive, thereby reducing recidivism and increasing public safety; and *Trauma-Informed Organization*: Reducing incidents of use of force, staff assaults, overdoses, self-harm, homicides, suicides, grievances, self-isolation, mental health crisis bed admissions, and other identified outcomes.

The California Model builds upon work already underway to facilitate the successful reintegration of individuals into their communities. CDCR/CCHCS will continue to collaborate with subject matter experts to identify best practices and build upon rehabilitative successes, including:

- Enhancing staff training to include implicit bias as well as developing training for 2024 based on California Model principles.
- Implementing face-to-face college at all prisons.
- Providing secure laptops to all incarcerated college students to use in their studies.
- Rolling out tablets statewide to enhance connections with loved ones as well as provide positive downtime activities such as books and music.
- Adding a third day of in-person visits at all institutions.
- Implementing programs and events designed to include people of all ages and physical abilities.
- Encouraging institution beautification efforts, including drought-tolerant gardens, landscaping, and murals.
- Improving furniture and bedding choices to provide more comfortable and attractive options.
- Expanding reentry services statewide.
- CDCR/CCHCS has incorporated California Model principles at various test sites, including Valley State Prison (VSP), Salinas Valley State Prison (SVSP), and Central California Women's Facility (CCWF). These sites focused on the core principles of Dynamic Security, Progression, and Re-entry. In May 2023, after visiting Norway, expanded to five additional prisons: California State Prison – Corcoran (CSP-COR), Richard J. Donovan State Prison (RJD), California State Prison – Sacramento (CSP-SAC),

California Substance Abuse and Treatment Facility (SATF), and San Quentin Rehabilitation Center (SQRC).

- **VSP:** Custody staff working in the Youth Offender Rehabilitative Community have received intensive training in dynamic security and the importance of creating a more normalized living environment. Additionally, custody and health care staff are working with incarcerated people and community leaders to develop an in-prison reentry facility in which community organizations provide services to people in the last one to two years of their sentence to prepare them for release. Through the Youthful Offender Program (YOP), incarcerated people participate in intensive trauma-informed programs that address the root causes of criminal behavior as well as victim impact and family relationships.
- **SVSP:** Custody staff have tailored the "Resource Team" approach, developed in Norway, to their work in an SVSP unit with the highest-risk, highest-needs individuals who have co-occurring serious psychiatric needs and who engage in profound violence. After implementing the Resource Team approach in the Psychiatric Inpatient Program (PIP), staff have seen a decrease in violence and assaults on staff and improved their occupational health and professional pride. Feedback from both staff and patients in the unit is very positive.
- **CCWF:** Custody staff are using the principle of dynamic security to develop a more professional rapport with the population in order to better understand their needs, prevent and reduce grievances, and improve engagement in programming. The goal is for CCWF to ultimately develop an integrated approach across the prison that greatly improves the interactions between staff and incarcerated people and helps clients leave prison with more tools to lead a successful life in the community than they had when they arrived in prison.

Ongoing Projects

***Suicide Prevention SharePoint Site**:* Like most SharePoint sites, the Suicide Prevention SharePoint allows users to share documents, post articles of interests, and share training materials. The site currently contains over 320 research or clinical articles, archived suicide prevention slide shows from monthly instructional video conference presentations (2011 to present), instructions on joining the AAS, groups of presentations made at the CDCR's Suicide Summits, contact lists for institutional suicide prevention program coordinators and headquarters suicide prevention staff, resources for staff suicide prevention, and resources for the entire CDCR population (videos, pamphlets, and posters). The information sharing occurring on SharePoint sites is another way of disseminating best practice information.

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

Statewide Suicide Prevention Coordinator Conference Calls: In addition to monthly suicide prevention video conferences that can be viewed by all staff, Suicide Prevention Program coordinators from headquarters and from all institutions have held quarterly conference calls since 2014 to discuss issues impacting suicide prevention efforts statewide. These calls continued during 2023.

Leadership Meetings Related to Suicide Prevention: In past years, the SMHP has held Mental Health Leadership conferences and a two-day Suicide Prevention Summit conference annually. Mental Health Leadership conferences are meant to disseminate best practice information in a variety of areas, including suicide prevention. The Suicide Prevention Summit is focused more specifically on advancements within CDCR as to policy, procedure, best practices, innovations, and interventions to improve suicide prevention

and response. In 2023, leadership meetings were held on September 7th and 8th both in person and virtually.

In 2023, the annual Suicide Prevention Summit was held in person, the first time since before COVID-19. The topics presented included: "The California Model and Suicide Prevention", "Suicide Risk Assessment: A Research Update", "The Power of Listening", "Phoenix Coaching Program: Rise, Transform & Soar to Your Full Potential", "Blinded with Incredible Pain", "From Data to Action: Enhancing Suicide Prevention with An Interactive Dashboard", "Division of Rehabilitative Programs Overview", "Hope Through Healing with Staff Interaction and Rehabilitative Programs", "Seeking Wellness: I Need Help, and It's OK", and "Improving Suicide Prevention Through Nursing Initiatives". All presentations from the 2023 Suicide Summit are found on the Suicide Prevention SharePoint site.

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

Crisis Intervention Teams: Previous reports to the Legislature noted the establishment of Crisis Intervention Teams in CDCR institutions. These teams have been adapted through a partnership between mental health, nursing and custodial personnel to provide an interdisciplinary team to intervene in crisis situations. If an individual reports a desire to kill themself, the team will evaluate the situation, identify sources of distress, attempt to resolve or mitigate the sources of distress at the point of service, and arrange follow-up (which may or may not include placement in an inpatient unit). For example, if an individual is distressed by a perceived lack of medical attention, the presence of a nurse may help to clear any misunderstanding. A relatively common example of the value of a Crisis Intervention Team is developing an understanding of how suicidal thoughts may be associated with interpersonal conflicts. These conflicts can create significant distress and can quickly develop into significant fears for one's safety. Whereas mental health clinicians may not be able to address safety concerns directly, they can work collaboratively with custody personnel who may be able to work out a reasonable solution, thus relieving the distress. The Crisis Intervention Teams help to problem-solve issues related to prison life that may not be directly related to a mental health issue.

The initial Crisis Intervention Teams were established at 22 institutions between late 2018 and early 2020. In 2023, the teams had 3,691 contacts with individuals, an average of 307 each month. Twenty-seven percent (N = 1,002) of the contacts resulted in admission to a MHCB unit. Fifty-nine percent (N = 2,194) were returned to their housing, 18% (N = 675) were provided conflict resolution skills and returned to their housing unit. Twenty-seven percent (N = 1002) were educated regarding a custody process and 11% (N=400) custody addressed safety concerns. Two percent (N=73) were not provided a resolution. Prior to the inception of CITs, it was most likely that a much higher proportion of individuals with crisis issues would have been admitted to costly inpatient psychiatric beds around the state. CDCR cannot definitively state that the use of the CIT was able to prevent specific individuals from attempting, or dying by, suicide. However, the data does suggest the CITs have been effective at identifying root causes of patient crises and providing the most effective intervention for the individuals' crises, which includes inpatient hospitalization for acutely suicidal individuals.

Progress Toward Expanding the Process of Notification Pursuant to Penal Code Section 5022

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

CDCR collects and maintains notification lists, commonly referred to as Next of Kin Designations. A CDCR Next-of-Kin form is completed regularly and is renewed at least annually with all individuals who agree to do so. However, to ensure protected personal healthcare information is appropriately provided only to a Next-of-Kin designee, the patient must also complete a Health Care Release of Information form, which allows a patient to designate an individual to receive protected health information for medical and mental health purposes.

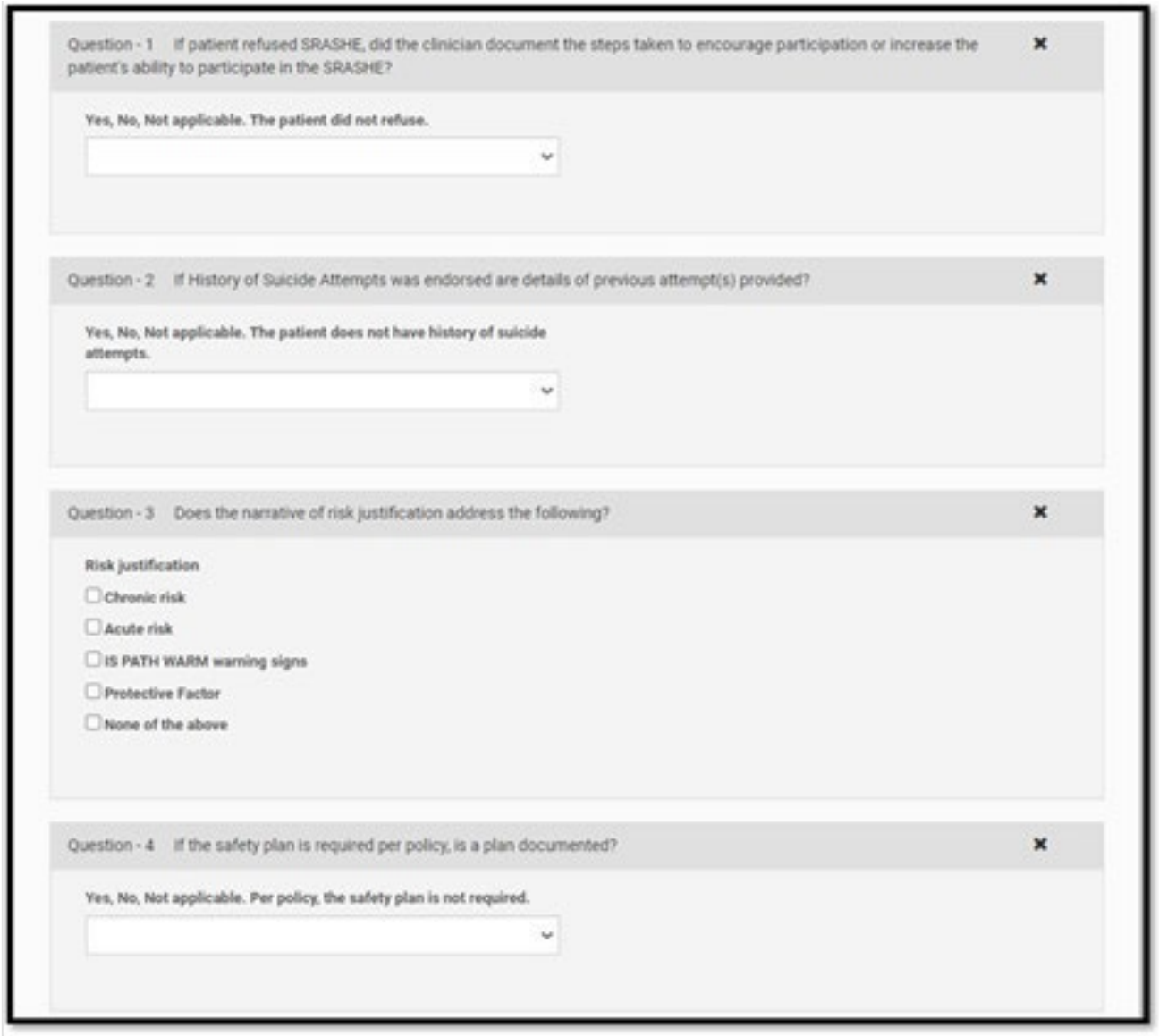
In 2020, CDCR assembled a workgroup involving DAI, the SMHP, and CCHCS to develop uniform guidance on Next of Kin designations and the Health Care Release of Information process. The Health Care Department Operations Manual (HCDOM) Section 3.1.19, Next of Kin Notification for Death, Serious Illness, or Serious Injury, was published in June 2022 and remains in effect.

Summary

Of the more than 126,000 individuals who spent a night in CDCR custody in 2023, 30 individuals died by suicide during their time of incarceration. This number of suicides was an increase from the last two years but consistent with 2020, however, the rate of suicide in 2023 remains the highest in CDCR since suicide rates were tracked in 1990. The majority of decedents died by hanging, like previous years. Individuals identified as Caucasian represented the majority of those who died by suicide. The ages of the decedents ranged from 21 to 76 years, with the largest represented group being those 55+ years of age. Most of the decedents were Level IV custody level, like previous years. Additionally, most self-harm incidents were non-suicidal, consistent with prior years. Nineteen of the 30 suicide decedents were patients in the statewide mental health program, with the majority of those 19 decedents in outpatient care. CDCR always continues to strive for improvement and will continue to assess effectiveness and monitor for quality and timeliness of suicide risk evaluations, treatment plans, and suicide prevention plans. CDCR continues to follow policies and procedures provided in the MHSDS Program Guide and continues to utilize its resources to improve upon and expand its initiatives to help reduce the number of suicides in any given year.

Appendix A

Chart Audit Tool



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

Yes, No, Not applicable. The patient did not refuse.

Question - 2 If History of Suicide Attempts was endorsed are details of previous attempt(s) provided?

Yes, No, Not applicable. The patient does not have history of suicide attempts.

Question - 3 Does the narrative of risk justification address the following?

Risk justification

- Chronic risk
- Acute risk
- IS PATH WARM warning signs
- Protective Factor
- None of the above

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

Yes, No, Not applicable. Per policy, the safety plan is not required.

Appendix B

QIP Descriptors

MH QIPs
Clinical Care

- 5 Day Follow/Up (e.g., not completed as required; not of adequate quality; failure to tie to safety plan)
- Clinical Decision Making Concerns - Multiple clinical components going on within a QIP (e.g., discharging diagnoses outside of IDTT, not addressing the clinical issues in 7362s, no consideration of LOC change or no rationale for LOC change, lack of interventions to mitigate risk, no rationale for clinical decisions, no plan for follow-up care)
- Confidential Setting (e.g., lack of use, lack of availability; seen cell-front by MHPC without documentation of
- reason why in progress note)
- Continuity of Care/Clinician to Clinician Contacts
- DDP Issues (e.g., failure to complete required assessments, lack of timely assessments, lack of inclusion of adaptive supports, failure to adequate provide adaptive supports; victimization issues)
- Diagnosis Issues (e.g., lack of diagnosis, conflicting diagnoses, diagnostic disagreement not addressed)
- IDTT Issues (e.g., lack of required membership;; not adequately updated)
- Issue and Observation – including Alternative Housing, TMHU (2020), MHCB, and PIP (e.g., failure to order properly, failure to complete orders daily, failure to provide what was ordered; poor rationale)
- MHCB: Issue and Observation (e.g., failure to order properly, failure to complete orders daily, failure to
- provide what was ordered; poor rationale)
- MHCB: Other
- Policy Issues/ Violations (includes lack of policy, inadequate policy) (Catchall for Policy Violations not otherwise categorized)
- Program Guide Timelines (includes contacts and)
- Records Review/
- Requests/Missing Records (e.g., failure to request records, failure to review available records)
- ROI Issues -- (e.g., ROI not on file, verbal consent instead of written as required, no follow-up with family, family request to speak to clinician not properly forwarded to Mental Health)
- Self-Harm Reporting (e.g., failure to track,)
- Treatment Planning (e.g., failure to do a treatment plan, treatment and treatment plan disconnect; inadequate treatment plan, failure to update treatment plan)

- RVR MHA issues (e.g., not completed, inadequate, poor rationale)
- Failure to address patient victimization issues (e.g., safety concerns, PREA evaluation/referrals)
- Not offered required programming/lack of access to out of cell programming
- Other

Documentation

- MH Documentation (e.g., includes failure to document adequately, copied documentation, incomplete documentation; inaccurate documentation)
- MH Referrals (e.g., failure to refer, failure to document response to referral adequately, failures in
- communication between disciplines)
- Missing MH Documentation/Chrono

Suicide Risk Assessment

- Missing SRE/No SRE
- Poor SRE Documentation
- Safety Planning (e.g., lack of safety plan, inadequate safety plan)

MH QIPs

- SRE/Justification of Risk (e.g., poor justification of risk; inadequate justification of risk; failure to include identified risk factors)
- Over reliance on patient self-report

Psychiatry
MH QIPs

- SRE/Justification of Risk (e.g., poor justification of risk; inadequate justification of risk; failure to include
- identified risk factors)
- Over reliance on patient self-report
- Psychiatry
- 2602 Issues (e.g., not sought when indicated, not renewed, not followed)
- Psychiatry Clinical Care (e.g., not provided, inadequate)
- Psychiatry Documentation (e.g., copy and paste issues, inadequate, inconsistent, not present, not timely)
- Program Guide Timelines not met
- Psychiatry No Referral for Non-Compliance, No show
- Psychiatry Policy Violations
- Medication discontinued without face-to-face
- Other

Psychiatric Inpatient Program (PIP)

- Frequency of Contacts – (e.g., MHMD/MHPC/RT contacts and group treatment)
- Housing Review Recommendation
- Issue and Observation (e.g., failure to order properly, failure to complete orders daily, failure to provide what was ordered; poor rationale)
- Missing PIP Documentation – (e.g., MHMD/MHPC/RT missing progress notes for individual contacts, group
- treatment, and assessments; RT documentation re: in-cell treatment materials provided)
- PIP Policy Violation
- Program Guide Timelines
- Programming Issues
- Quality of PIP Documentation – (e.g., copy and paste/pulled-forward without change from a previous assessment at same or different facility)

CUSTODY QIPs

- 911 Activation (e.g., failure to activate, delayed activation)
- ASU Policy/CDCR 114 issues
- BPH Issues
- Confidential Setting - (e.g., joint QIP with mental health in which lack of confidential setting utilized)
- Crime Scene Preservation
- Custody Documentation (e.g., poor documentation, conflicting documentation)
- Custody Training (e.g., not timely, not done, inadequate)
- Cut Down Tool/Kit
- Emergency Response (e.g., CPR issues, failure to activate personal alarm, delayed cell entry, failure to don proper PPE)
- ICC Issues
- IDTT Issues – (e.g., no correctional counselor present in IDTT; custody failed to bring patient to IDTT)
- Inappropriate GP Incarcerated Individual Restraint
- Policy Violation
- PREA Issues
- Referrals (e.g., failure to make referral when indicated)
- Rigor – should this be under security/guard one checks?
- R & R Issues – (e.g., property did not transfer with patient to a new institution as required per policy)
- RVR Issues – (e.g., lack of evidence to support guilty finding on RVR by hearing officer)

CUSTODY QIPs

- Security/Guard 1 Checks (e.g., not completed, not timely)
- Self-Harm Issues – (e.g., joint issues with Mental Health- poor communication and documentation of suicide attempts; 837 incident package not completed as required by policy; post suicide hand-written note in patient's clothing stated in part "police just came, saw rope hanging, said nothing"; joint QIP with Nursing- tried to strangle self under the blanket with a blue shirt while on suicide watch)
- Staff Actions Concern
- Universal Precautions
- Visibility of the Cell
- Failure to provide property/privileges
- Failure to adequately address safety concerns/victimization issues (not PREA)

NURSING QIPs

- 5 Day Follow/Up (e.g., not completed as required; not of adequate quality; failure to tie to safety plan)
- 911 Activation (e.g., failure to activate, delayed activation)
- 7362 Processing Issues
- Administration of Narcan
- Emergency Response (e.g., CPR/AED issues, delayed treatment, inadequate treatment, improper treatment)
- Hunger Strike Issue
- ISUDT Issues
- Medication Issue (e.g., failure to follow 2602 order, failure to provide medication, failure to notify psych of med misses)
- Nursing Checks/Rounds
- Nursing Documentation (e.g., failure to document, inadequate documentation, conflicting documentation)
- Patient Care/Continuity of Care
- Policy Violation
- PREA Issues
- Referrals (e.g., failure to refer, delayed referral, communication issues between disciplines)
- Self-Harm Issues
- Universal Precautions
- Other

SPRFIT-Multisystem QIPs

- 911 Activation (e.g., failure to activate, delayed activation)
- Bad News Issues
- DDP Issues – (e.g., assessment and treatment of DDP patients in PIP; victimization concerns; custody responsibility for moving incarcerated individuals with victimization concerns)
- HQ Psychiatry Issues
- Impression Management
- Inappropriate GP incarcerated individuals Restraint
- ISUDT Issues
- Missing Documentation – This refers to policy required documentation (e.g., Mental Health 5 Day Follow-up combined with Custody Check form; self-harm attempts must be documented on specific forms when there is a suicide attempt, which may then generate a 837) versus records that might be unable to be located for
- some reason (Records Review/Request/Missing Records category)
- NCAT

SPRFIT-Multisystem QIPs

- Next of Kin issues
- Physical Plant (e.g., cell/structural safety issues)
- PIP Policy (includes lack of policy)
- Policy Issues/Violation (includes lack of policy, inadequate policy)
- Poor SRE Documentation (e.g., not done when required, inadequate, incomplete, not updated, failed to incorporate prior information)
- PREA Issues
- Program Guide Timelines
- Records Review/Request/Missing Records
- Referrals (e.g., making referrals, responding to referrals, documenting referrals)
- RVR MHA Issues (e.g., not done, inadequate, poor rationale)
- Safety Concerns not addressed