2024 Annual Report
on Suicide Prevention Efforts

Prepared per California Penal Code § 2064.1
October 1, 2025

CALIFORNIA DEPARTMENT of CORRECTIONS AND REHABILITATION

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

2024 Annual Report on Suicide Prevention Efforts

Joseph H. Obegi and David Leidner
Statewide Mental Health Program
California Correctional Health Care Services
California Department of Corrections and Rehabilitation
October 2025

Suggested Citation

Obegi, J. H., & Leidner, D. (2025). 2024 Annual Report on Suicide Prevention Efforts. California Department of Corrections and Rehabilitation.

Acknowledgments

Nancy Beshara, Erika Windtberg, and Cassandra Albertson provided technical assistance.

Credits

Cover page art by Luke Chesser.

Inquiries

Please send all inquires abut this publication to: m_MHProgramSuicidePr@cdcr.ca.gov.

Introduction

This report fulfills the requirements set forth in California Penal Code § 2064.1. Established by Senate Bill SB 960,[1] Penal Code § 2064.1 directs the California Department of Corrections and Rehabilitation (CDCR) to "submit to the Legislature a report on the department's efforts to respond to and prevent suicides and attempted suicides among inmates." The report must address six areas:

1. Suicide risk evaluations
2. 72-hour treatment plans
3. Staff training
4. Implementing the Special Master's recommendations
5. Initiatives to reduce suicide risk
6. The process of notifying next-of-kin in the event of death or serious injury

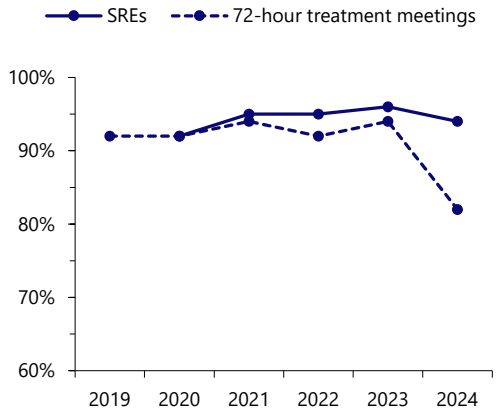
The department's progress in each area is presented below.

Suicide Risk Evaluations

Section a(1) of California Penal Code § 2064.1 requires: "A description of progress toward meeting the department's goals related to the completion of suicide risk evaluations in a sufficient manner." Per Senate Bill 960, the intent of this section was for the department to report on (a) "the number of suicide risk evaluations…completed," (b) "the criteria CDCR uses to assess the quality of the suicide risk evaluations," and (c) "the results of its assessments of the suicide risk evaluations."

Regarding (a), the department uses an automated key performance indicator (KPI) that calculates the percentage of suicide risk evaluations (SREs) completed on time. All facilities report their performance during meetings of the suicide prevention committee. In 2024, 92% of 67,395 policy-required SREs were completed on time. This exceeds the department's threshold of 85% for acceptable performance. Performance was similar to past years (Figure 1).

Figure 1. Timely Completion of SREs and Mental Health Treatment Plans



Note: For SREs, data for 2019 was unavailable.

Regarding (b), the department uses a standardized audit tool to assess the quality of SREs (Table A1). Facilities conduct quarterly audits of SRE quality. A passing score is 85%.

Regarding (c), facilities completed 701 quality audits in 2024. The pass rate was 76%. The pass rate was unchanged from 2023.

When a mental health provider fails the quality audit, institutions either initiate supervisory action or, more commonly, require the provider to complete additional training. The training involves pairing the provider with an experienced colleague who is a certified SRE mentor. The mentor observes the provider complete at least one SRE, provides coaching, and reviews the provider's submitted

1. Senate Bill 960, 2017–2018 Regular session. (Calif., 2018). https://spsf.senate.ca.gov/sites/spsf.senate.ca.gov/files/sb_960_analysis.pdf. The bill was a response to the California State Auditor's August 2017 report (https://information.auditor.ca.gov/reports/2016-131/index.html), which was requested by California's Joint Legislative Audit Committee following several consecutive years of suicides at one of CDCR's female facilities.

SRE. Finally, the mentor completes an SRE rating form that scores each of the five essential skills in assessing suicide risk. The provider must achieve a passing score; if they do not, they must either repeat the mentoring process or be referred to a supervisor. Upon hire, all mental health providers are required to complete the mentoring process.

72-Hour Treatment Plans

Section a(2) of California Penal Code § 2064.1 requires: "A description of progress toward meeting the department's goals related to the completion of 72-hour treatment plans in a sufficient manner." Per Senate Bill 960, the intent of this section was for the department to report on (a) "the number of…comprehensive mental health treatment plans completed," (b) "the criteria CDCR uses to assess the quality of the…comprehensive mental health treatment plans," and (c) "the results of its assessments of…the comprehensive mental health treatment plans."

Regarding (a), the department uses an automated KPI to calculate the percentage of mental health treatment team meetings completed within 72 hours. Because mental health treatment plans are completed at the same time, the KPI also approximates the timely completion of mental health treatment plans. In 2024, 82% of 10,892 required meetings were completed on time. (Meetings held past the 72-hour mark were 17 hours late on average.)

Regarding (b) and (c), the department uses a standardized audit tool to assess the quality of 72-hour treatment plans (Table A2). Facilities complete quarterly chart audits of plan quality at their discretion based on upon available resources. Audits were not completed in 2024.

Staff Training

Section a(3) requires: "A description of the department's efforts to ensure that all required staff receive training related to suicide prevention and response."

The department requires all staff to complete suicide prevention training upon hire and annually thereafter. In 2024, 94% of staff completed the training.

Implementing the Special Master's Recommendations

Section a(4) of California Penal Code § 2064.1 requires: "A description of the department's progress in implementing the recommendations made by the Special Master regarding inmate suicides and attempts, to include the results of any audits the department conducts, at the headquarters or regional level, as part of its planned audit process to measure the success of changes the department implements as a result of these recommendations."

In 2015, the Special Master's expert made 32 recommendations,[2] three of which were subsequently withdrawn.[3] Since 2015, the Special Master's expert has found that 14 recommendations have been fully implemented. In March 2024, the Special Master's expert reported that one additional recommendation was fully implemented (Recommendation 20).[4]

Progress in 2024 on the remaining 14 recommendations is discussed below and summarized in Table 1.[5] Discussion is limited to the same 21 facilities assessed by the Special Master's expert. (For details about how progress was assessed, see Methodology.)

Recommendation 3

Ensure that all custody and health care staff receive both pre-service and annual suicide prevention training.

The Special Master's expert assesses the implementation of Recommendation 3 by evaluating the extent to which custody, medical, and men-

2. ECF 5259, filed 1/14/15; ECF 5271, filed 2/3/2015
3. ECF 5762, filed 1/25/2018
4. ECF 8143-1, filed 03/01/2024
5. In August 2025, the court appointed a Receiver to resolve the outstanding recommendations. Thus, the Receiver may shape the department's future approach to the recommendations.

tal health staff complete the suicide prevention training.

The department was compliant with Recommendation 3. For the second consecutive year, the training compliance for each discipline—custody, medical, and mental health—exceeded 90%.

Recommendation 7

The nurse's 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 Special Master's expert assesses the implementation of Recommendation 7 by evaluating whether nurses always ask all required screening questions.

The department was compliant with Recommendation 7. Regional suicide prevention coordinators reported that all facilities conducted the intake screenings, and nurses consistently asked all required questions.

Recommendation 8

Nurse and officer safety should remain the top priority during the intake screening process. If an IP's [inmate-patient's] security classification or unknown security status creates a safety concern, the screening should be conducted in the least restrictive setting that ensures both staff safety and IP confidentiality.

The Special Master's expert assesses the implementation of Recommendation 8 by evaluating whether the intake screenings are confidential.

The department was compliant with Recommendation 8. Regional suicide prevention coordinators reported that all intake screenings were held in a confidential setting.

Recommendation 9

CDCR should revise its SRE Mentoring Program to eliminate its "graduation" component after completion of two adequate assessments, conduct ongoing mentoring throughout the year, and audit clinicians' SREs on a regularly scheduled basis.

Table 1. Progress in 2024 on the Special Master's Recommendations

Recommendation	Progress in 2024
3	Compliant
7	Compliant
8	Compliant
9	Partially compliant
10	Compliant
12	Compliant
13	Compliant
17	Partially compliant
18	Compliant
21	Compliant
28	Partially compliant
29	Partially compliant
31	Partially compliant
32	Partially compliant

Note: For definitions of "Compliant" and "Partially compliant," see Methodology.

The Special Master's expert assesses the implementation of Recommendation 9 by evaluating the extent to which the department trains mental health staff in SREs and completes SRE mentoring.

Overall, the department was partially compliant with Recommendation 9.

In July 2022, the department implemented the part of the recommendation pertaining to revising the SRE mentoring program.

SRE training was temporarily paused in September 2024 pending revision. However, 95% of the 21 facilities were at 90% or greater compliance as of August 2024.

The department was partially compliant with SRE

mentoring. Only 48% of facilities were at 90% or greater as of the year's end.

Recommendation 10

Each facility's SPR FIT [Suicide Prevention and Response Focused Improvement Team] should audit the quality of completed SREs on a monthly basis.

The Special Master's expert assesses the implementation of Recommendation 10 by evaluating whether the department completes SREs when indicated.

The department was compliant with Recommendation 10 in 2024. The average compliance for completing SREs was 92% across the 21 facilities reviewed by the Special Master's expert. (When all CDCR facilities are considered, compliance was also 92%; see Figure 1.) Eighty-one percent of the facilities (17 of 21) completed SREs in at least 90% of cases.

Recommendation 12

CDCR should ensure that there are a sufficient number of suicide-resistant retrofitted cells to house newly admitted IPs (i.e., those within their first 72 hours of their housing in the unit) and the IPs of special concern or heightened risk of suicide (e.g., IPs recently released from suicide observation status).

The Special Master's expert assesses the implementation of Recommendation 12 by evaluating whether the department uses retrofitted cells for adults placed in a restricted housing unit.

The department was compliant with Recommendation 12. Regional suicide prevention coordinators reported that 95% of facilities (19 of 21) consistently used retrofitted intake cells.

Recommendation 13

CDCR should enforce its existing policy of housing only newly admitted IPs in retrofitted cells, and immediately rehouse IPs remaining in the retrofitted cells beyond their first 72 hours.

The Special Master's expert assesses the implementation of Recommendation 13 in the same way as Recommendation 12: by evaluating whether the department uses retrofitted cells.

The department was compliant with Recommendation 12. As reported above, regional suicide prevention coordinators reported that 95% of facilities (19 of 21) consistently used retrofitted cells.

Recommendation 17

CDCR should adopt the recommendations made in connection with SREs (Recommendations 9 and 10) set forth above, which will also improve safety planning contained in the SREs section above.

The Special Master's expert assesses the implementation of Recommendation 17 by evaluating whether the department completes (a) safety plans at the time of MHCB (Mental Health Crisis Bed) discharge and (b) supervisory reviews of safety plans.

The department was partially compliant with Recommendation 17. Regional suicide prevention coordinators reported that 81% of facilities (17 of 21) consistently completed safety plans and supervisory reviews of safety plans.

Recommendation 18

CDCR should develop a specific timetable for the training of all of its mental health clinicians on treatment planning for the suicidal IP [inmate-patient], using its PowerPoint presentation, "Safety/Treatment Planning for Suicide Risk Assessment."

The Special Master's expert assesses the implementation of Recommendation 18 by evaluating the extent to which the department has trained mental health staff in safety planning.

The department was compliant with Recommendation 18. The average training compliance was 96%. Eighty-six percent of facilities (18 of 21) had training compliances of 90% or greater.

Recommendation 21

CDCR should enforce its Program Guide requirements authorizing only the two levels of observation which may be provided for suicidal IPs: (1) observation at staggered intervals not exceeding every 15 minutes on Suicide Precaution, and (2) continuous observation for IPs on Suicide Watch.

The Special Master's expert assesses the implementation of Recommendation 21 by evaluating whether the department completes timely documentation of suicide precaution and suicide watch.

The department was compliant with Recommendation 21. As of December 2024, compliance with the timely documentation of suicide precaution and suicide watch was 96% and 92%, respectively, across all 21 facilities. Statewide, the figures were the same. Regarding suicide precaution, 19 of 20 applicable facilities exceeded 90%. Regarding suicide watch, 15 of 21 facilities exceeded 90%.

Recommendation 28

All IPs discharged from an MHCB or alternative housing, where they had been housed due to suicidal behavior, should be observed at 30-minute intervals by custody staff, regardless of the housing units to which they are transferred.

The Special Master's expert assesses the implementation of Recommendation 28 by evaluating whether the department correctly completed page 1 of the form associated with 30-minute checks.

The department was partially compliant with Recommendation 28. Regional suicide prevention coordinators reported that 48% of facilities (11 of 27) completed page 1 of the form correctly.

Recommendation 29

The length of time an IP is observed at 30-minute intervals following MHCB or alternative housing discharge should be determined on a case-by-case basis by the mental health clinician and clinically justified in the IP's treatment plan. No other frequency of observation should be authorized.

The Special Master's expert assesses the implementation of Recommendation 29 by evaluating whether the department correctly completed page 2 of the form associated with 30-minute checks.

The department was partially compliant with Recommendation 29. Sixty-two percent of audited facilities (13 of 27) were found to be compliant with requirements for completing page 2 of the form.

Recommendation 31

CDCR, under the guidance of the Special Master, should reexamine and revise its local SPR FIT model to make the local SPR FITs a more effective quality assurance/improvement tool.

The Special Master's expert uses diverse standards to assess the implementation of Recommendation 31.

The department was partially compliant with Recommendation 31. The department revised its local SPR FIT model and implemented all changes in 2022. More specifically, in 2020, the department initiated a workgroup to modernize and standardize the quality management practices used by local SPR FIT committees. The workgroup's efforts produced two products. First, the department created a 4-day training to disseminate updated quality management practices. Members of all local SPR FIT committees completed the training as of 2022. Second, the department created two tools that permit committees to surveil the quality of their suicide prevention programs systematically: a quality dashboard and a measurement plan. The quality dashboard presents nine real-time KPIs and nine real-time indicators of emerging suicide risk. The dashboard allows committees to visualize performance trends at their facility, drill down on performance problems, and monitor the incarcerated population at their respective institutions for signs that suicide risks may be emerging. The measurement plan requires committees to review performance in over 60 key areas of suicide prevention policy on a prescribed schedule. Committees meet monthly and use the data from the

dashboard and the measurement plan to identify problems and initiate improvement projects.

Regional suicide prevention coordinators reported that most local SPR FIT committees were functioning adequately in 2024 (71%, 15 of 21). The remaining facilities had one or more problems in the following areas: quorum, meeting quality, meeting minutes, measurement, and policies.

Recommendation 32

CDCR, under the guidance of the Special Master, should examine and consider taking reasonable corrective actions to address these additional miscellaneous issues: Possessions and Privileges for IPs in MHCBs, Continuous Quality Improvement, and Reception Centers.

The Special Master's expert assesses the implementation of Recommendation 32 by evaluating privilege access for MHCB patients, the completeness of the department's guidebook for continuous quality improvement, and procedures at reception centers.

The department was partially compliant with Recommendation 32. Regional suicide prevention coordinators reported that 70% (14 of 20) applicable facilities were compliant with providing privilege access to MHCB patients and completing reception center procedures. In addition, the department developed its guidebook in collaboration with the Special Master's expert and released it for use in 2022. The guidebook is regularly updated, and coordinators rely on it to structure their facility audits and write their reports.

Initiatives to Reduce Suicide Risk

Section a(5) requires: "A description of the department's progress in identifying and implementing initiatives that are designed to reduce risk factors associated with suicide."

The department continually improves its suicide prevention program. In 2024, the department's Statewide Mental Health Program implemented five policy changes related to suicide prevention, some of which were recommended by the Special Master's expert. Specifically:

1. Improved the method by which supervisors review safety plans
2. Tightened timelines for documenting suicide risk assessments and safety plans
3. Required nurses to complete self-harm assessments upon admission to a PIP
4. Clarified the grounds for issuing tear-resistant smocks and blanks to avoid over-use
5. Updated the suicide risk assessment form to reflect recent developments in the field and clarified the clinical circumstances that require the form

Because suicide is affected by many factors, initiatives undertaken outside of the Statewide Mental Health Program are also relevant. The department adopted three regulations in 2024 that may lower suicide risk:

1. Revamped RHU regulations to reduce the use of segregated confinement.
2. Transferred condemned incarcerated adults to institutions with greater access to educational and vocational programs.
3. Expanded the offerings of in-prison credit-earning programs to further incentivize participation in rehabilitative programs.

Finally, the department regularly updates training curricula to enhance the skills and knowledge of staff. The department released one revised training curriculum in 2024:

1. Updated the training on mental health treatment planning to reflect new developments in the field.

Notification Process

Section a(6) requires: "A description of the department's efforts and progress to expand upon

its process of notification pursuant to [California Penal Code] Section 5022, including expansion of those notifications in cases of suicide attempts when deemed appropriate by the department, and when inmates have consented to allow release of that information."

DOM section 51070.10 describes the procedure for fulfilling Section 5022. Upon receipt of an incarcerated adult and annually thereafter, the department completes the form *Notification in Case of Inmate Death, Serious Injury, or Serious Illness*, which captures the name and contact information of persons that the adult wishes the department to notify in the event they die or experience a serious injury or illness. The procedure also describes how to notify the listed persons.

In response to AB 960, the department issued a statewide memorandum in April 2021 that expanded the notification requirements to include serious injury due to self-harm and suicide attempts. Expectations were further clarified in a second memorandum released in January 2022. Finally, in June 2022, the change was memorialized in Section 3.1.18 of the Health Care Department Operations Manual, which reads: "The Warden, or designee, is responsible for the initial NOK [next-of-kin] notification for death, serious illness, or serious injury including incidents of serious injury due to self-harm, suicide attempts, or accidents." In addition, the Warden or designee shall "document and track the initial NOK notification." Thus, the department has policies that fully realize the requirements of Section a(6).

Methodology

Progress on the Special Master's Recommendations

Determinations of progress were based on the department's regional coordinators' assessments conducted throughout 2024 rather than the Special Master's assessment that was conducted from 2022 to 2023 because the former is more current. Where available, progress on a recommendation was measured using an automated KPI. Where automated KPIs were unavailable, this report relies on the audits of facilities completed by regional suicide prevention coordinators.

This report also adopts two terms to describe progress on a recommendation. "Compliant" means the overall KPI was greater than or equal to 90%, or 90% of institutions were judged by regional suicide prevention coordinators as compliant at year's end. "Partially compliant" means the KPI fell short of 90%, or fewer than 90% of institutions were judged by regional suicide prevention coordinators as having implemented the recommendation at year's end.

Appendix

Table A1. Audit Criteria for Suicide Risk Evaluations

1. If the patient refused the SRE, did the clinician document the steps taken to encourage participation or increase the patient's ability to participate in the SRE?
2. If a history of suicide attempts was endorsed are details of previous attempt(s) provided?
3. Does the narrative of risk justification address the following? Chronic risk; acute risk; suicide warning signs

Table A2. Audit Criteria for Mental Health Treatment Plans

1. Does the clinical summary include a brief synopsis of treatment over time including inpatient treatment history and a brief description of current mental health symptoms?
2. Is the clinical summary consistent with the symptoms, the DSM diagnoses (problems), and interventions?
3. Does the psychiatry treatment plan list the medications with the target symptoms, dosage, and frequency?
4. Are the identified goals individualized and measurable to target the specified problems to target current DSM diagnoses (problems), symptoms, and functional impairments?
5. Are the identified interventions individualized and measurable to target current DSM diagnoses (problems), symptoms, and functional impairments?
6. Does each intervention support achieving each treatment goal?
7. Are active MH Interdisciplinary Plans of Care ordered, updated (if applicable) and indicate which discipline is responsible for the interventions?
8. When compared to the last treatment plan, has the treatment plan been updated to address the patient's current functioning and mental health treatment progress?
9. Is the treatment plan based on the patient's history, past treatment, and factors that cause the current symptoms to persist?
10. Is the rationale for the IDTT level of care decision patient specific and consistent with the current clinical presentation and degree of functional impairment?
11. Is there a meaningful discharge plan for future treatment needs?
12. For ML EOP Initial IDTTs only, was a 128C Chrono generated after the IDTT, addressing eligibility for program assignment?

Note: DSM = Diagnostic and Statistical Manual of Mental Disorders. IDTT = Interdisciplinary Treatment Team. MH = Mental health. ML = Mainline.

CALIFORNIA DEPARTMENT *of*
CORRECTIONS AND
REHABILITATION

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES