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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

EDMUND G BROWN, JR., et al.,

Defendants.

Case No. 2:90-CV-00520-KJM-DB

DECLARATION OF MICHAEL W. BIEN IN SUPPORT OF PLAINTIFFS' RESPONSE TO ORDER OF JULY 2, 2020

I, Michael W. Bien, declare:

1. I am an attorney duly admitted to practice before this Court. I am a partner in the law firm of Rosen Bien Galvan & Grunfeld LLP, counsel of record for Plaintiffs. I have personal knowledge of the facts set forth herein, and if called as a witness, I could competently so testify. I make this declaration in support of Plaintiffs' Response to the Order of July 2, 2020.

2. Attached hereto as **Exhibit A** is a true and correct copy of a press release the California Department of Corrections and Rehabilitation (CDCR) issued on July 10, 2020, "CDCR Announces Additional Actions to Reduce Population and Maximize Space Systemwide to Address COVID-19," which is available at https://www.cdcr.ca.gov/news/2020/07/10/cdcr-announces-additional-actions-to-reduce-population-and-maximize-space-systemwide-to-address-covid-19/.

3. Attached hereto as **Exhibit B** is a true and correct copy of a document from the California Secretary of State's website regarding the November 3, 2020 Statewide Ballot Measures, including Proposition 20, which is available at https://www.sos.ca.gov/elections/ballot-measures/qualified-ballot-measures/. Attached hereto as **Exhibit C** is a true and correct copy of a description of Proposition 20 for the November 2020 ballot from Ballotpedia, which is available at https://ballotpedia.org/California_Proposition_20,_Criminal_Sentencing,_Parole,_and_DNA_Collection_Initiative_(2020).

4. The total CDCR in-custody population was 165,630 people as of August 31, 2009. This figure is provided in CDCR's monthly population report for August 31, 2009. A true and correct copy of that report is attached hereto as **Exhibit D**, which my office received by contacting CDCR's Office of Research Data at the email address for historical reports listed at https://www.cdcr.ca.gov/research/population-reports-2/. The total CDCR in-custody population as of February 29, 2020 was 123,123 people, according to CDCR's monthly population report for that date. This report, a true and correct copy of which is attached hereto as **Exhibit E**, is available at https://www.cdcr.ca.gov/research/wp-

content/uploads/sites/174/2020/05/Tpop1d2002.pdf. The total in custody population as of July 8, 2020 was 112,507 people, according to CDCR's weekly population report for that date. This report, a true and correct copy of which is attached hereto as **Exhibit F**, can be found at: https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/07/Tpop1d200708.pdf.

5. The total in-custody population as of February 29, 2020 is 42,507 individuals fewer, or 25.7%, than the total in-custody population as of August 31, 2009. A paralegal at my office, Emma Cook, working under my direction and supervision, calculated this reduction by subtracting the total population in February 2020 from the total population in August 2009 and then dividing the resulting figure by the total population in August 2009. Using this same method, Ms. Cook calculated that the total in-custody population as of July 8, 2020 was 10,616 individuals fewer, or 8.6%, than the total in-custody population as of February 29, 2020.

6. According to the February 29, 2020 Population Report (Exhibit E), several prisons in CDCR were at over 137.5% of design capacity as of February 29, 2020. California Rehabilitation Center, Correctional Training Facility, North Kern State Prison, California Substance Abuse Treatment Facility, Valley State Prison, and Wasco State Prison were over 150% full as of this date, and Chuckawalla Valley State Prison and CSP-Solano were over 160% full.

7. The Legislative Analyst's Office released a report on October 16, 2019 entitled "Planning for a Declining Inmate Population." A true and correct copy of this report, available at https://lao.ca.gov/handouts/crimjust/2019/Declining-Population-101619.pdf, is attached hereto as **Exhibit G.**

8. The total population of *Coleman* class members as of August 28, 2009 was 35,821 people, according to the August 2009 Health Care Placement Oversight Program Information Report (HCPOP Report) produced to Plaintiffs' Counsel on September 30, 2009. This report, a true and correct copy of which is attached hereto as **Exhibit H**, also states that as of August 2009 the Enhanced Outpatient Program (EOP) population was

4,742 people and the CCCMS population was 30,074 people. According to Defendants' Mental Health Services Delivery System (MHSDS) Management Information Summary Report ("MIS Report") for February 24, 2020, the total *Coleman* population as of that date was 35,836 people. A true and correct copy of this report, was provided to Plaintiffs' Counsel on March 16, 2020 as part of Defendants' ongoing monthly data reporting for this case, is attached hereto as **Exhibit I.** This report also states that the total EOP population as of February 24, 2020 was 6,748 people, and that the total CCCMS population as of the same date was 27,207 people. According to Defendants' MIS Report for July 8, 2020, the total *Coleman* population as of that date was 33,400 people. A true and correct copy of this report, which was provided to Plaintiffs' Counsel on July 10, 2020 as part of Defendants' ongoing monthly data reporting for this case, is attached hereto as **Exhibit J**. This report also states that the total EOP population as of July 8, 2020 was 6,636 and the CCCMS population as of the same date was 25,092. Using these reports, Ms. Cook subtracted the August 2009 EOP population from the February 2020 EOP population, and then divided the resulting figure by the August 2009 EOP population to determine the percentage increase of the EOP population since the Court's August 2009 Order. According to her calculations, the EOP population grew by 42.3% from August 2009 to February 2020.

9. Attached hereto as **Exhibit K** is a true and correct copy of a chart prepared by Ms. Cook, which is also set forth in the body of Plaintiffs' Response. This chart shows the increase in the EOP population from August 2009 to February 2020 alongside the decrease in the total CDCR population in the same period. Ms. Cook prepared this chart using data from the reports provided as Exhibits H, I, and J hereto (described *supra*), along with the "Chart Tools" function in Microsoft Excel.

10. As set forth in paragraph 4 *supra*, the total CDCR in-custody population as of August 31, 2009 was 165,630 people. The corresponding MHSDS population in August 2009 was 35,821 people, meaning that the Non-MHSDS population at the time was 129,809 people. By the end of February 2020, the Non-MHSDS CDCR population

was 87,287 people, which represents a decrease of 42,522, or 32.8%. As stated *supra* in paragraph 8, there were 4,742 EOP class members in August 2009 and 6,478 EOP class members in February 2020. If the EOP population had mirrored the overall population drop rate of 32.8% between August 2009 and February 2020, the EOP population in February 2020 would have been 3,187 people, or approximately 47.2% of the actual February 2020 EOP population. Similarly, if the CCCMS population had dropped by 32.8% between August 2009 and February 2020, the CCCMS population in February 2020 would have been 20,210, which is 6,997 fewer patients than it actually was. Similarly, the total CDCR in-custody population as of February 29, 2020 was 123,123 people. The corresponding MHSDS population in February 2020 was 35,836 people, meaning that the Non-MHSDS population at the time was 87,287 people. As of early July 2020, the Non-MHSDS CDCR population was 79,107 people, which represents a decrease of 8,180, or 9.4%. As stated *supra* in paragraph 8, there were 6,748 EOP class members in February 2020 and 6,636 EOP class members in July 2020. If the EOP population had mirrored the overall population drop rate of 9.4% between February 2020 and July 2020, the current EOP population would be 6,114 people, or approximately 92.1% of the current EOP population. Similarly, if the CCCMS population had dropped by 9.4% between February 2020 and July 2020, the current CCCMS population would be 24,649, which is 443 fewer patients than the current population. Under my direction and supervision, Ms. Cook calculated these figures using the reports in Exhibits D, E, F, H, I, and J.

11. In August 2009, the EOP population also constituted 2.9% of the total CDCR population, as there were only 4,742 EOP patients out of a total CDCR population of 165,630 people. *See* Ex. D, Ex. H. In February 2020, the EOP population had nearly doubled to 5.5% of the total CDCR population, and as of July 2020, the EOP population had grown to 5.9% of the total CDCR population *See* Ex. E, Ex. F, Ex. I, Ex. J. EOP patients also constitute a larger share of the overall MHSDS population than they did at the time of the Three-Judge Court's Order: in August 2009, EOP patients constituted 13.2% of the total MHSDS population, whereas by February 2020, they had grown to 18.8% of

the total MHSDS population, and by July 2020, they had grown to 19.9% of the total MHSDS population. Working under my direction and supervision, Ms. Cook calculated these figures using the reports described in ¶¶ 4 and 8, *supra.*

12. As set out in ¶ 4, *supra*, the total in-custody population as of February 29, 2020 is 42,507 individuals fewer, or 25.7%, than the total in-custody population as of August 31, 2009. If the CCCMS population had dropped at the same rate between August 2009 and February 2020, the CCCMS population would have been 22,345 people in February 2020, 4,862 fewer people than were actually at the CCCMS level of care during that time. In other words, the CCCMS population dropped only by 9.5% during the same period that the total CDCR population dropped 25.7%. The total in custody population as of July 8, 2020 is 10.616 individuals fewer, or 8.6% lower, than the total in custody population of February 2020. If the CCCMS population had dropped by 8.6% between February and July 2020, there would be 24,867 CCCMS patients as of July 8, 2020, 225 fewer than were actually at the CCCMS level of care at that time. In other words, the CCCMS population only dropped by 7.8% during the same period the total in custody population dropped by 8.6%. Similarly, the total in-custody population as of February 29, 2020 is 42,507 individuals fewer, or 25.7%, than the total in-custody population as of August 31, 2009. If the EOP population had dropped at the same rate between August 2009 and February 2020, the EOP population would have been 3,524 people in February 2020, 3,224 fewer people than were actually at the EOP level of care during that time. In other words, the EOP population increased by 42.3% during the same period that the total CDCR population dropped 25.9%. The total in custody population as of July 8, 2020 is 10,616 individuals fewer, or 8.6%, than the total in custody population of February 2020. If the EOP population had dropped by 8.6% between February and July 2020, there would be 6,168 EOP patients as of July 8, 2020, 468 fewer patients than were actually at the EOP level of care at that time. In other words, the EOP population only dropped by 1.6% during the same period the total in custody population dropped by 8.6%. Working under

my direction and supervision, Ms. Cook calculated these figures using the reports described in ¶¶ 4 and 8, *supra*.

13. The State Auditor's Office released a report in August 17, 2017 entitled "California Department of Corrections and Rehabilitation: It Must Increase Its Efforts to Prevent and Respond to Inmate Suicides." A true and correct copy of this report, available at https://www.auditor.ca.gov/pdfs/reports/2016-131.pdf, is attached hereto as **Exhibit M**.

14. Current psychiatrist staffing ratios are determined by Defendants' Court-Ordered Staffing Plan, which prescribes required ratios of clinical staff to incarcerated patients. *See* Defendants' Staffing Plan, ECF No. 3693 (Staffing Plan). For instance, the Staffing Plan requires one staff psychiatrist for every 280 incarcerated patients at the CCCMS level of care and one staff psychiatrist for every 120 incarcerated patients at the EOP level of care. *See id.* at 12, 17. The Staffing Plan also sets forth unit and bed-based staffing for Mental Health Crisis Beds (MHCB), Outpatient Housing Units (OHU), Crisis Intervention, and Desert Institutions. *See id.* at 21-25. Using the prescribed ratios in the Staffing Plan, Ms. Cook calculated the approximate number of psychiatrists required statewide if the MHSDS population had decreased at an equivalent rate to the Non-MHSDS population for the time period from August 2009 to February 2020. To do this, Ms. Cook first calculated the percentage drop in that period if the CCCMS and EOP populations had both decreased by 32.8% from August 2009 to February 2020. According to her calculations, if the EOP and CCCMS populations had decreased at the same rate that the non-MHSDS population did, the EOP population would have been 47.2% of the EOP population in February 2020, while the CCCMS population would have been 74.3% of the CCCMS population in February 2020.

15. Ms. Cook then applied these percentage reductions to the four subgroupings of the EOP and CCCMS populations that have different ratio allocations in the Staffing Plan: General Population, Reception Center, ASU/Condemned, and SHU. *See* Staffing Plan at 8-17. A table displaying these adjusted populations is attached hereto as **Exhibit N.** Ms. Cook used these figures and the Staffing Plan's allocation process to

calculate the number of required psychiatrists if the MHSDS population had been reduced by an equivalent amount as the Non-MHSDS population in the period from August 2009 through February 2020. She then calculated the reduced unit-based staffing by reducing the Staffing Plan's MHCB, OHU, Crisis Intervention, and Desert Institution Based Staffing by 32.8%. A table showing the prescribed ratios and resulting allocations is attached hereto as **Exhibit O.** From the calculations, CDCR would be required to have 184.46 staff psychiatrists if the MHSDS population had decreased by the same margin as the Non-MHSDS population.

16. Defendants' Psychiatry Vacancy Report for February 2020 (Psychiatry Vacancy Report), ECF No. 6563, shows that, in February 2020, CDCR employed 171.45 non-PIP, on-site staff psychiatrists – well within the 90% staffing rate required by the June 13, 2002 Order. This Psychiatry Vacancy Report also shows that if telepsychiatry is included, Defendants employed 216.14 psychiatrists in February 2020, which would have been well in excess of the Staffing Plan's requirements if the MHSDS population had decreased by the same margin as the Non-MHSDS population in the time period from August 2009 through February 2020.

17. According to the CDCR/CCHCS COVID-19 Employee Status Tracker, there were 755 active COVID-19 cases, three deaths, and 536 returned to work among CDCR staff members as of July 14, 2020. A true and correct copy of that report, which is generally available at https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19-status/, that was downloaded by a paralegal in my office on July 14, 2020 is attached hereto as **Exhibit P.**

18. Attached hereto as **Exhibit Q** is a true and correct copy of a document from Eureka Daye, Deputy Director for Statewide Mental Health Services, dated March 25, 2020 and entitled COVID-19 – Mental Health Delivery of Care Guidance, which was provided to Plaintiffs' counsel by counsel for Defendants.

19. Attached hereto as **Exhibit R** is a true and correct copy of an email dated July 6, 2020 from counsel for Defendants to Plaintiffs' counsel attaching Defendants' Tier

Report for the week of June 22-26, 2020. This report shows that, during the week of June 22 through June 26, forty mental health programs at sixteen institutions operated at a Tier 3 or 4, indicating that a significant number of staff members are unavailable, and there are substantial limitations to the mental health treatment being provided.

20. Attached hereto as **Exhibit S** is a true and correct copy of an email dated July 14, 2020 from counsel for Defendants to Plaintiffs' counsel attaching Defendants' Tier Report for the week of June 29–July 3, 2020. This report shows that, during the week of June 29 through July 3, forty-one mental health programs at the same sixteen institutions operated at a Tier 3 or 4, indicating that a significant number of staff members are unavailable, and there are substantial limitations to the mental health treatment being provided.

21. Attached hereto as **Exhibit T** is a true and correct copy of CDCR's January 2010 Mental Health Bed Study Report, which was provided to Plaintiffs' counsel by Defendants' counsel in 2010.

22. Attached hereto as **Exhibit U** is a true and correct copy of the Psychiatric Inpatient Program Staffing Report for February 2020, which was provided to Plaintiffs' Counsel on April 15, 2020 as part of Defendants' ongoing monthly data reporting for this case (Enclosure 1L).

23. Attached hereto as **Exhibit V** is a true and correct copy of an October 3, 2019 email from counsel for Defendants to Plaintiffs' counsel attaching a letter dated October 3, 2019 letter from Defendants to the Special Master concerning Defendants' planned mission changes. Attached hereto as **Exhibit W** is a true and correct copy of an November 1, 2019 email from counsel for Defendants to Plaintiffs' counsel attaching a letter from Defendants to the Special Master dated November 1, 2019 concerning Defendants' planned mission changes. Attached hereto as **Exhibit X** is a true and correct copy of a July 3, 2020 email from counsel for Defendants to Plaintiffs' counsel attaching a letter from Defendants to the Special Master dated July 3, 2020 concerning Defendants' planned mission changes.

24. Attached hereto as **Exhibit Y** is a true and correct copy of an email dated July 6, 2020 from counsel for Defendants to Plaintiffs' counsel attaching Defendants' TMHU Patient List Report, which lists the patients referred for inpatient care who had been in temporary mental health units ("TMHUs") or were being "treated in place" during the week of June 22-26, 2020. This document has been redacted by a paralegal in my office at my direction to remove patient names and identifying information.

25. Department of State Hospitals ("DSH"), released a memo on March 16, 2020 that was a directive on the "Suspension of Patient Admissions from the California Department of Corrections (CDCR"). A true and correct copy of this memo, available at https://www.dsh.ca.gov/Treatment/docs/DSH_DIrector_Letter_re_Suspension_of_Coleman_Admissions.pdf, is attached hereto as **Exhibit Z.**

26. Attached hereto as **Exhibit AA** is a true and correct copy of a document entitled DSH CDCR Patient Census and Waitlist Report: Data as: of 5/8/20, which was provided to Plaintiffs' Counsel by Defendants' counsel on May 11, 2020.

27. Attached hereto as **Exhibit BB** is a true and correct copy of a document entitled DSH CDCR Patient Census and Waitlist Report: Data as: of 7/10/20, which was provided to Plaintiffs' Counsel by Defendants' counsel on July 13, 2020.

28. Attached hereto as **Exhibit CC** is a true and correct copy of an excerpt of a document entitled MHCB Referrals Report, which was generated from CDCR's Mental Health Dashboard by an attorney in my office, Lisa Ells, on July 8, 2020. This report shows a summary of all MHCB referrals for the period of June 7 through July 7, 2019. The additional pages of this report include individual patient-level data, and thus were not included in this exhibit. Attached hereto as **Exhibit DD** is a true and correct copy of an excerpt of a document entitled MHCB Referrals Report, which was generated from CDCR's Mental Health Dashboard by an attorney in my office, Lisa Ells, on July 8, 2020. This report shows a summary of all MHCB referrals for the period of June 7 through July 7, 2020. The additional pages of this report include individual patient-level data, and thus were not included in this exhibit.

29. The suicide rate in CDCR prisons in 2019 was 30.3 deaths per 100,000 people. Catherine Johnson, a paralegal working under my supervision, calculated the 2019 rate by using the methodology employed by the Special Master's experts in their 2014 Suicide Report. Report on Suicides Completed in the California Department of Corrections and Rehabilitation, January 1, 2014 – December 31, 2014 ("2014 Suicide Report"), March 29, 2016, ECF No. 5428, at 1-6. In the report, the Special Master's experts give the CDCR suicide rates for the years 1999 through 2014, calculated by multiplying the number of suicides for the given year by 100,000 and then dividing this number by the total in-custody population as of June 30 of that same year. *See id.* at 2. Following this methodology, Ms. Johnson used the total in-custody population for June 30, 2019 that is reported in CDCR's Monthly Total Population Report. Attached hereto as **Exhibit EE** is a true and correct copy of the CDCR population report used for this calculation, available at https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2019/07/Tpop1d1906.pdf, which shows that the total in-custody population as of June 30, 2019 was 125,472 incarcerated people.

30. To calculate the number of suicides per year, Ms. Johnson used CDCR's Suicide Death Notifications, which Defendants regularly provide to Plaintiffs' Counsel in the *Coleman* case. After obtaining the number of suicides in 2019 (38 suicides), Ms. Johnson multiplied this figure by 100,000 and divided the resulting figure by the total in-custody population as of June 30, 2019. She used the same methodology to calculate the suicides rates in 2015, 2016, 2017, and 2018. After computing these rates, Ms. Johnson and Ms. Cook used the "Chart Tools" Excel function to format the chart in Plaintiffs' Response that displays the CDCR suicide rates by year. A true and correct copy of this chart is attached hereto as **Exhibit FF.** Ms. Johnson divided 365, the number of days in 2019, by 38, the total number of suicides in CDCR in 2019, which equals 9.6. That means that on average, a suicide occurred in CDCR custody less than every ten days in 2019.

31. Attached hereto as **Exhibit GG** is a true and correct copy of a CDCR report dated October 1, 2019 and entitled "Report on Suicide Prevention and Response within the California Department of Corrections and Rehabilitation", available at https://cchcs.ca.gov/wp-content/uploads/sites/60/MH/CDCR-2018-SB-960.pdf.

32. Attached hereto as **Exhibit HH** is a true and correct copy of a San Francisco Chronicle article dated October 8, 2019 by J. Fagone & M. Cassidy and entitled "California Prisons Head Acknowledges 'Inmate Suicide Crisis' After Report", available at https://www.sfchronicle.com/crime/article/California-prisons-head-acknowledges-inmate-14502131.php.

33. Attached hereto as **Exhibit II** is a true and correct copy of the Mortality in State and Federal Prisons, 2001-2016 – Statistical Tables, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, February 2020, NCJ 251920 ("BJS Report"), available at https://www.bjs.gov/content/pub/pdf/msfp0116st.pdf.

34. Of the thirty-eight suicides in CDCR institutions in 2019, nine (or 24%) occurred within thirty days after the decedent was discharged from a higher level of mental health care. In three of these cases, the decedent had been discharged from a PIP unit to a lower level of care. Six more of the 2019 suicides occurred within months to a year of a CDCR clinician's decision to drop that patient's level of mental health care. Members of my team computed these figures, under my supervision, by reviewing the Electronic Health Records System ("EHRS") records and the Final Suicide Reports for each decedent. Following each suicide notification sent by Defendants to Plaintiffs' Counsel announcing a prisoner had committed suicide in 2019, members of my team carefully reviewed health care records in the EHRS to determine whether the decedent's level of care had been lowered within the 30 days prior to the prisoner's suicide by reviewing all "Mental Health Master Treatment Plan" entries in each record, which document all level of care change decisions for a given patient. Our team also reviewed the Final Suicide Reports for individuals who committed suicide in 2019 to confirm their level of care changes prior to their suicides.

35. According to my team's review of the Final Suicide Reports and EHRS records for the individuals who committed suicide in 2019, sixteen of the thirty-eight individuals either had referrals to a Mental Health Crisis Bed rescinded before they were admitted, or they were never referred to a higher level of care despite clear signs such care was warranted, according to CDCR's Headquarters suicide case reviewers. Our review of the Final Suicide Reports also showed that in 23 of the 38 2019 suicides, or 60.5%, the CDCR suicide case reviewers concluded that there were failures related to utilization management issues that were significant enough to warrant Quality Improvement Plans (QIPs) for the relevant institutions' mental health staff. There has not been such a high percentage of Final Suicide Reports with utilization management-related QIPs in prior years.

36. Of the thirty-eight suicides in CDCR institutions in 2019, eleven came from patients at the CCCMS level of care and sixteen came from EOP patients. Together, these suicides represent 71% of all CDCR suicides in 2019. The levels of care for each suicide were compiled and tabulated by Ms. Johnson, who recorded the level of care noted on Defendants' Suicide Death Notifications.

37. The CCCMS and EOP suicide rates for 2019 were 39.5 and 247.6 per 100,000, respectively. The EOP rate was over twenty times higher than the rate for non-class members, who committed suicide at a rate of 12.3 per 100,000 in 2019. These rates were calculated by Ms. Johnson using the methodology described in ¶ 29 *supra*. The population figures used in these calculations were taken from Defendants' HCPOP Information Report, Summary of Mental Health Population by Institution and Level of Care (H-1) for June 2019, which provides data as of June 24, 2019. A true and correct copy of this report, which was provided to Plaintiffs' Counsel on August 14, 2019 as part of Defendants' ongoing monthly data reporting for this case, is attached hereto as **Exhibit JJ.** To obtain the Non-MHSDS population for the calculation of the 2019 Non-MHSDS suicide rate, Ms. Johnson subtracted the total MHSDS population given in the

report (35,944 patients) from the June 30, 2019 CDCR Population Report, provided as Exhibit DD.

38. Nine of the suicides in 2019 occurred at CSP-Sacramento.

39. So far in 2020, thirteen individuals have committed suicide while in CDCR custody. Seven of them, or 54%, were *Coleman* class members. From my team's review of the EHRS records for the thirteen individuals after we received notice of their suicides, we have concluded that five of the individuals, or 38%, had been discharged from a higher level of care within the 90 days preceding their deaths.

40. Members of my team have previously analyzed the 2016 suicides in CDCR. Twenty-seven of the reported suicides in 2016, twenty-two (82%) were deemed to be either foreseeable, preventable, or both, by CDCR case reviewers. In 2017, we were informed by counsel for Defendants that early in that year, CDCR had unilaterally elected to stop including determinations about whether suicides were foreseeable or preventable.

41. After years of negotiations with the Special Master and Plaintiffs regarding CDCR's draft aggregate report regarding 2015 suicides, CDCR on July 10, 2020 unilaterally published the report on its website despite Plaintiffs and the Special Master lingering concerns. A true and correct copy of CDCR's report, entitled Annual Report on Suicides in the California Department Of Corrections and Rehabilitation, January 1, 2015 – December 31, 2015, available at https://cchcs.ca.gov/wp-content/uploads/sites/60/SR/2015-Annual-Suicide-Report.pdf, is attached hereto as **Exhibit KK**. To Plaintiffs' counsel knowledge, CDCR has not completed initial drafts of the annual aggregate reports regarding suicides in 2016, 2017, 2018 or 2019.

42. The Special Master provided the parties with a draft of Lindsay Hayes's Fourth Re-Audit Report on May 14, 2020, and the parties have provided written comments on the draft report, but the final report has not yet been filed with the Court.

43. As of February 24, 2020, 8.4% of the EOP population and 4.4% of the CCCMS population were in segregation. These figures were calculated by Ms. Cook using the February 2020 MIS Report provided as Exhibit I. The MIS Report provides that

436 EOP patients were in an administrative segregation unit (ASU), non-disciplinary segregation (NDS), or short-term restricted housing (STRH), and that a further 129 EOP patients were in a psychiatric services unit (PSU), long-term restricted housing (LTRH), or security housing unit (SHU), for a total EOP segregation population of 565 incarcerated people, or 8.4% of the total EOP population in February 2020 (6,748 people). Similarly, Ms. Cook calculated that, according to the February 2020 MIS Report, as of February 24, 2020, there were a total of 1,203 CCCMS patients, or 4.4% of the total CCCMS population in February 2020 (27,207 people), in a segregation unit. As of July 6, 2020, 9.7% of the EOP population and 4.9% of the CCCMS population were in segregation. These figures were calculated as the July 2020 MIS Report, provided as Exhibit J. The MIS report provides that 529 EOP patients were in an ASU, NDS, or STRH, and that a further 118 EOP patients were in a PSU, LTRH, or SHU, for a total EOP segregation population of 647 incarcerated people, or 9.7% of the total EOP population. Similarly, Ms. Cook calculated that, according to the July 2020 MIS report, there was a total of 1,225 CCCMS patients in segregation as of July 8, 2020, or 4.9% of the CCCMS population.

44. Attached hereto **Exhibit LL** is a true and correct copy of a letter dated March 3, 2020 that was provided by counsel for Defendants to counsel for Plaintiffs on March 3, 2020, stating that as of March 2, 2020, 3.42%, or 2,693 of the 78,790 Non-MHSDS incarcerated people in CDCR institutions were housed in segregation. Attached hereto as **Exhibit MM** is a true and correct copy of a letter dated July 6, 2020 that was provided by counsel for Defendants to counsel for Plaintiffs on July 9, 2020, stating that as of July 2, 2020, 3.36%, or 2,435 of the 72,485 Non-MHSDS incarcerated people in CDCR institutions were housed in segregation.

45. As of the end of February and beginning of March 2020, 40% of the total CDCR segregation population were EOP and CCCMS patients. Similarly, while EOP patients constituted 5.5% of the total CDCR population (*see* paragraph 11, *supra*), they made up 12.7% of the total segregation population. Ms. Cook, under my direction and supervision, calculated these percentages. Ms. Cook added the population of non-MHSDS

individuals in segregation as of March 2, 2020 (from Exhibit LL), 2,693 individuals, to the total number of EOP and CCCMS individuals in segregation as of February 24, 2020 (from Exhibit I), 1,768, which results in 4,461 individuals. She then divided the number of EOP patients in segregation as of February 24, 2020 (565) by 4,461, to determine that EOP patients constituted 12.7% of the total segregation population. She then divided the number of CCCMS and EOP patients in segregation (1,768) by 4,461 to determine that 40% of the total segregation population was made up of EOP and CCCMS patients at the end of February 2020. Using the same method described above, Ms. Cook calculated that EOP and CCCMS patients together represented 43.5% of the total segregation population in July 2020. In contrast, EOP and CCCMS patients only constituted, 28% of the total CDCR population. Ms. Cook calculated that percentage by dividing the number of CCCMS and EOP patients in July 2020, 31,728 (*see* Exhibit J) by the total in custody population, 112,507 (*see* Exhibit F). Using the same methodology, she calculated that in July 2020, while EOP patients constituted 5.9% of the total CDCR population, they made up 15% of the total segregation population.

46. As of early March 2020, there were 410 patients at the EOP level of care or higher housed in an ASU or ASU Hub unit. These figures were calculated by Ms. Cook using the Segregation Length of Stay Averages spreadsheet produced by Defendants on March 3, 2020 as part of their ongoing monthly data reporting for this case. True and correct copies of excerpts from that report are attached hereto as **Exhibit NN.** Using this report, Ms. Cook added the number of patients at the EOP, ICF, and MHCB level of care in the ASU and ASU Hub (listed in the "Patient" row in the table) to get a total of 410. Using this same method, Ms. Cook calculated that as of July 1, 2020, there were 500 patients at the EOP level of care or higher housed in an ASU or ASU Hub unit, as shown in Defendants' July 1, 2020, Segregation Length of Stay Averages Spreadsheet, produced by Defendants on July 9, 2020 as part of their ongoing monthly data reporting for this case. True and correct copies of excerpts from that report are attached hereto as **Exhibit OO.** As such, the number of people at the EOP level of care or higher housed in ASU and ASU

Hub units increased by 22%. Ms. Cook calculated the percentage change from February to July by subtracting the July population of EOP, MHCB, and ICF patients in ASU and ASU Hubs from the February population of EOP, MHCB, and ICF patients in ASU and ASU Hubs, and dividing by the February population.

47. As of June 2012, 7.4% of the CDCR segregation population was part of the EOP level of care. This percentage was calculated by Ms. Cook, who utilized Defendants' Mental Health Population by Institution report for June 2012 to obtain the number of EOP patients who were in segregation in June 2012. A true and correct copy of this report showing data as of June 8, 2012, which was provided to Plaintiffs' counsel by Defendants' counsel as part of Defendants' ongoing monthly data reporting for this case, is attached hereto as **Exhibit PP**. Exhibit PP states at pages 4, 7, and 9 respectively that there were 375 EOP patients in the PSU, 483 EOPs in the ASU, and nine in the SHU, for a total EOP segregation population of 867 incarcerated people. This figure was then divided by the total CDCR segregation population in June 2012, 11,663, which is the figure reported at pages 8-9 of the Special Master's Expert's Report on Suicides Completed in the Second Half of 2012, ECF No. 5325.

48. Attached hereto as **Exhibit QQ** is a chart prepared by Ms. Cook showing the segregation and non-segregation suicide rates, which is also set forth in the body of Plaintiffs' Response. Working under my direction and supervision, Ms. Cook made this chart using the "Chart Tools" function in Excel. She calculated the segregation and non-segregation suicide rates using the methodology described in paragraph 29 *supra*. The housing location of each suicide from 2012 to 2019 was taken from CDCR's Suicide Death Notifications, which provide the bed type in which a decedent was housed at the time of their death. Segregation and non-segregation population figures were derived from a number of sources. The segregation and non-segregation population figures for years 2012, 2013, and 2014 were taken respectively from: pages 8-9 of the Special Master's Expert's Report on Suicides Completed in the Second Half of 2012, ECF No. 5325; page 10 of the Special Master's Expert's Report on Suicides Completed in 2013, ECF No. 5399;

and page 11 of the Special Master's Expert's Report on Suicides Completed in 2014, ECF No. 5428. The segregation and non-segregation population figures for years 2015, 2016, 2017, and 2018 were taken from CDCR's "Offender Data Points" Reports for June 2017 and June 2018, *available at* https://www.cdcr.ca.gov/research/offender-outcomes-characteristics/offender-data-points/. Attached hereto as **Exhibit RR** are true and correct excerpts from CDCR's June 2017 Offender Data Points report, which show the total in-custody and segregation populations for June 2015, June 2016, and June 2017. Attached hereto as **Exhibit SS** are true and correct excerpts from CDCR's June 2018 report, which show the total in-custody and segregation populations for June 2018. Using these figures, Ms. Cook derived the CDCR non-segregation populations for each year by subtracting the total segregation population from the total in-custody population. For 2019, Ms. Cook utilized the following two data points from Defendants' routine monthly data productions, true and correct copies of which are attached hereto at **Exhibits TT** and **UU**. Exhibit TT is a true and correct copy of the MIS Report showing data as of June 17, 2019, which Defendants provided to Plaintiffs' counsel on July 9, 2019 as part of their ongoing monthly data reporting for this case. Exhibit UU is a true and correct copy of a letter sent by Defendants' counsel to Plaintiffs' counsel dated June 7, 2019 letter regarding the number of Non-MHSDS incarcerated people in segregation. Together, these two reports provide a June 2019 segregation population of 4,735 incarcerated people. Ms. Cook calculated the non-segregation population used in the above non-segregation suicide rate analysis by subtracting this figure from the total CDCR population.

49. From these calculations, the segregation suicide rate in 2019 was 211.2 suicides per 100,000, compared to 23.2 in the non-segregated CDCR population. In 2015, the segregation suicide rate was 111.0 per 100,000 incarcerated people, compared to 12.4 per 100,000 in the non-segregated CDCR population.

50. Attached hereto as **Exhibit VV** is a true and correct copy of a July 13, 2020 email from counsel for Defendants to Plaintiffs' counsel attaching a report entitled

TMHU/TIP Roster (7/6-7/10/20), which contains a list of all *Coleman* class members housed in TMHUs from July 6-10, 2020.

51. On July 14, 2020, Amy Xu, an attorney under my direction, conducted the an analysis of total daily treatment hours offered for patients in maximum custody TMHUs from July 6-13, 2020. First, Ms. Xu identified all of the patients located in maximum custody TMHUs by referring to Exhibit VV, which is a list of all patients in TMHUs from July 6-10, 2020. Next, Ms. Xu used Defendants' TMHU Registry (Beta) on the CCHCS On Demand Suite to export data in a spreadsheet format for these patients from July 6-13, 2020 including daily treatment hours offered. There were fifteen patients listed as being in maximum custody TMHUs with information on the TMHU Registry (Beta). Ms. Xu then renamed each unique patient with a number, i.e., Patient 1-16, and removed columns with the patients' name, CDCR number, and cell location for confidentiality purposes. Ms. Xu then created a separate line for each day a patient was housed in a maximum custody TMHU from July 6-13 and averaged the daily total treatment hours offered to each patient located in a maximum custody TMHU. From this, Ms. Xu concluded that Defendants offered an average of 0.27 hours or 16.2 minutes of daily total treatment hours to each patient located in a maximum custody TMHU from July 6-13. A true and correct copy of the described spreadsheet is attached hereto as **Exhibit WW**. A complete copy of the described spreadsheet, which includes columns with the patients' names and CDCR numbers, will be provided to the Special Master and counsel for Defendants.

52. The vast majority of all mental health treatment provided in the maximum custody TMHUs is in a non-confidential setting. Data from column X (labeled "ConfHour") in Exhibit WW, which was exported from the TMHU Registry (Beta) as described in paragraph 51, shows that confidential mental health treatment was only provided to one of the fifteen patients in a maximum custody TMHU from July 6-13. Data from columns Y (labeled "Non ConfHour") and Z (labeled "Cell Front") in Exhibit WW, which was also exported from the TMHU Registry (Beta) as described in paragraph 51,

shows that all other mental health treatment provided in the maximum custody TMHUs from July 6-13, 2020 occurred in non-confidential settings and cell-front.

53. No group treatment was offered in the maximum custody TMHUs from July 6–13. This can be seen from data in columns T, U, and V in Exhibit WW, all of which was exported from the TMHU Registry (Beta) as described in paragraph 51. That data shows there were no groups attended, refused, or offered by any of the fifteen class members in maximum custody TMHUs during this period.

54. Attached hereto as **Exhibit XX** is a true and correct copy of a January 2019 Office of the Inspector General report entitled "Special Review of Salinas Valley State Prison's Processing of Inmate Allegations of Staff Misconduct," available at https://www.oig.ca.gov/wp-content/uploads/2019/05/2019_Special_Review_-_Salinas_Valley_State_Prison_Staff_Complaint_Process.pdf.

55. Attached hereto as **Exhibit YY** is a true and correct copy of an excerpt of CDCR's COMPSTAT report for "High Security" institutions for May 2018 – May 2018, available at https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2019/10/DAI-High-Security.pdf?label=High%20Security&from=https://www.cdcr.ca.gov/research/compstat/, showing the percentage of use of force incidents that involved MHSDS participants at SAC (88%), SVSP (82%), HDSP (69%), and LAC (81%).

56. Attached hereto as **Exhibit ZZ** is a true and correct copy of a December 2015 Office of the Inspector General report entitled "2015 Special Review: High Desert State Prison, Susanville, CA," available at https://www.oig.ca.gov/wp-content/uploads/2019/05/2015_Special_Review_-_High_Desert_State_Prison.pdf.

57. Attached hereto as **Exhibit AAA** is a true and correct copy of Defendants' HCPOP Information Report, Summary of Mental Health Population by Institution and Level of Care (H-1), showing data as of July 10, 2020. This document was emailed to Plaintiffs' counsel by counsel for Defendants on July 10, 2020.

58. With the help of my colleagues, including my co-counsel, Steven Fama of the Prison Law Office, I have collected information from records supplied by CDCR, including the EHRS and the COVID-19 Patient Registry, regarding each incarcerated person in CDCR who has died of COVID-19 or its complications. As of the evening of July 13, 2020, I had received from CDCR identifying information about 34 of these individuals. Fifteen (15 or 44%) of them were identified as *Coleman* class members at the time of their deaths. I frequently review the CDCR's COVID-19 Patient Registry, a non-public resource to which my colleagues and I have received access as class counsel in this matter. As of approximately 3 pm on July 14, 2020, the Registry listed 74 people as currently hospitalized, 26 of whom, or 35%, are identified as *Coleman* class members.

59. On January 27, 28, and 29, 2015, Jane Kahn and I participated as Plaintiffs' counsel in a three-day tour of the California Health Care Facility (CHCF) in Stockton, in the company of counsel for CDCR and several CDCR officials, as well as experts and monitors from the *Coleman* Special Master team. I observed that the mental health program was heavily reliant on physical restraint, including handcuffing of many patients when they were out of their cells. I observed than CHCF custody staff placed many patients on "max" custody status, and that custody practices at CHCF required extensive use of restraints, and very limited time out of cell. Walking through the units, I observed that patients were rarely in the yards or group rooms, and that the yards were small concrete enclosures with little or no recreational equipment. There was no "day room." I observed practices that were similar to segregation units in regular prisons rather than to inpatient psychiatric facilities. I observed that custody staff, rather than clinical staff, generally had control of whether a patient could move from "max" status to lower status with fewer use of restraints.

60. In January 2019, I learned that CDCR intended to increase the level of restraint in the clinical programs at CHCF's PIP by introducing the use of cages (which the CDCR officials call "Therapeutic Treatment Modules" or TTMs). The ostensible purpose of these cages is to allow CHCF PIP staff to offer group therapy to patients on "max"

status. As Plaintiffs' counsel in *Coleman,* I have advocated against the use of cages in all mental health programs, especially in what is supposed to be a licensed psychiatric hospital. For example, on July 15, 2019, I directed my associate Marc Shinn-Krantz to send a letter to CDCR detailing our objections to caged therapy, and outlining the many other ways of dealing with patients believed to be assaultive in other settings, such as the mental health units of the Veterans Administration, which to my knowledge do not use cages. A true and correct copy of the letter of July 15, 2019, with voluminous exhibits omitted, is attached hereto as **Exhibit BBB**.

61. Attached hereto as **Exhibit CCC** is a true and correct copy of the June 19, 2020 Memorandum Re: COVID-19 Mandatory 14-Day Modified Program sent to Associate Wardens, Division of Adult Institutions, and Wardens, which counsel for Defendants sent to Plaintiffs' counsel on June 22, 2020 by email.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that this declaration is executed at San Francisco, California this 15th day of July, 2020.

/s/ Michael W. Bien
Michael W. Bien

Exhibit A

CDCR Announces Additional Actions to Reduce Population and Maximize Space Systemwide to Address COVID-19

JULY 10, 2020

Estimates of 8,000 inmates could be eligible for release by end of August, in addition to the state's reduction of about 10,000 persons since the start of the pandemic

SACRAMENTO – The California Department of Corrections and Rehabilitation (CDCR) announced today additional actions to protect its most vulnerable population and staff from COVID-19, and to allow state prisons to maximize available space to implement physical distancing, isolation, and quarantine efforts. The department estimates up to 8,000 currently incarcerated persons could be eligible for release by end of August under these new measures, further decompressing facilities.

"We're glad the Governor is taking action to release more people. This is absolutely critical for the health and safety of every Californian. Too many people are incarcerated for too long in facilities that spread poor health. Supporting the health and safety of all Californians means releasing people unnecessarily incarcerated and transforming our justice system." Jay Jordan, Executive Director, Californians for Safety and Justice

CDCR's previous pandemic emergency decompression efforts have reduced inmate populations systemwide by approximately 10,000, to reduce the risk of COVID-19 transmission within its facilities.

"These actions are taken to provide for the health and safety of the incarcerated population and staff," CDCR Secretary Ralph Diaz said. "We aim to implement these decompression measures in a way that aligns both public health and public safety."

Under release authority granted to the CDCR Secretary, which allows alternative confinement or release in any case in which an emergency endangering the lives of incarcerated persons has occurred or is imminent, CDCR is pursuing a series of cohorted release efforts.

Some categories of releases will require additional review for certain incarcerated persons, and some cohorts will be screened on a rolling basis. The department estimates, that through these new efforts up to an estimated 8,000 currently incarcerated persons will be eligible for release.

All individuals will be tested for COVID-19 within seven days of release. CDCR is working closely with stakeholders, local law enforcement partners, and other agencies to leverage state and federal resources for housing in the community to

help meet the reentry needs of these individuals. For all those releasing under these efforts, CDCR is making victim notifications in accordance with all CDCR procedures and state law.

"The Anti-Recidivism Coalition is encouraged by the Governor's response to the dramatic spread of COVID-19 through California's prisons. During these difficult times, it is vital that we all work to protect this vulnerable population and treat them with the dignity and compassion they deserve." Sam Lewis, Exec Director of Anti Recidivism Coalition.

"After witnessing the deadly effects of COVID-19 inside California's dangerously overcrowded prisons, Governor Newsom's plan is the right decision to help protect the lives of people living and working inside prisons and in surrounding communities. In taking this important step, the Governor is following the universal advice of public health and medical experts. We applaud the Governor for working on two crucial fronts: getting the most vulnerable people out of harm's way and stemming the spread of COVID-19 inside prisons and neighboring communities." -Anne Irwin, Director, Smart Justice California.

New efforts:

Release and credit-earning actions

180-day release

This statewide cohort is currently being screened and released on a rolling basis in order to continuously create more space in all institutions throughout the pandemic. CDCR estimates that 4,800 people could be eligible for release by the end of July.

In order to be eligible, inmates must meet the following criteria:

- Have 180 days or less to serve on their sentence
- Are not currently serving time for domestic violence or a violent crime as defined by law
- Have no current or prior sentences that require them to register as a sex offender under Penal Code 290
- Not have an assessment score that indicates a high risk for violence

One-year release

CDCR is also reviewing for release incarcerated persons with 365 days or less to serve on their sentence, and who reside within identified institutions that house large populations of high-risk patients.

The institutions are: San Quentin State Prison (SQ), Central California Women's Facility (CCWF), California Health Care Facility (CHCF), California Institution for Men (CIM), California Institution for Women (CIW), California Medical Facility (CMF), Folsom State Prison (FOL) and Richard J. Donovan Correctional Facility (RJD).

In order to be eligible, inmates must meet the following criteria:

- Have 365 days or less to serve on their sentence
- Are not currently serving time for domestic violence or a violent crime as defined by law
- Have no current or prior sentences that require them to register as a sex offender
- Not have an assessment indicating a high risk for violence

Individuals who are 30 and over and who meet the eligibility criteria are immediately eligible for release. Those who meet these criteria and are age 29 or under will be reviewed on a case-by-case basis for release. CDCR will consider medical risk, case factors, and time served, among other factors, in determining whether to expedite release for those identified in this cohort.

These cohorts will be screened on a rolling basis until CDCR determines such releases are no longer necessary.

Positive Programming Credits

To recognize the impact on access to programs and credit earning during the COVID-19 pandemic, CDCR will award a one-time Positive Programming Credit (PPC) to all eligible incarcerated people.

This credit of 12 weeks will be awarded to help offset not only credits not earned due to program suspensions, but also to recognize the immense burden incarcerated people have shouldered through these unprecedented times.

In order to be eligible to receive this credit, an incarcerated individual must:

- Currently incarcerated
  - This includes all 35 adult institutions, community correctional facilities, fire camps, Male Community Reentry Program, Community Prisoner Mother Program, Custody to Community Transitional Program, Alternative Custody Program, and those serving a state prison sentence in a state hospital.
- Not be condemned to death or serving life without the possibility of parole
  - As this authorization exists in state law and therefore does not require a regulation change, CDCR must follow the exclusions outlined in the law, which means those serving life without the possibility of parole and people who are condemned are not eligible for credit earning.
- No serious rules violations between March 1 and July 5, 2020
  - This encompasses all Division “A” through “F” offenses, which include but are not limited to murder, rape, battery, assault, arson, escape, possession/distribution of contraband, possession of a cellphone, and gang activity.

CDCR estimates that nearly 108,000 people will be eligible for PPC. Of these, about 2,100 would advance to the point they are eligible for release between July and September.

High-Risk Medical

Individuals deemed “high risk” are considered to be at greater risk for morbidity and mortality should they contract COVID-19. They include people over age 65 who have

chronic conditions, or those with respiratory illnesses such as asthma or chronic obstructive pulmonary disease (COPD).

In order to be eligible, incarcerated persons must meet the following criteria:

- Deemed high risk for COVID-19 complications by CCHCS
- Not serving LWOP or condemned
- Have an assessment indicating a low risk for violence
- No high-risk sex offenders (HRSO)
  - HRSO indicates a convicted sex offender who is required to register pursuant to Penal Code Section 290, and has been identified to pose a higher risk to commit a new sex offense in the community, as determined using a standard risk assessment tools for sex offenders.

Based on individual review of each incarcerated person's risk factors, an estimated number of releases in this cohort is not available.

Additional release efforts

CDCR is reviewing potential release protocols for incarcerated persons who are in hospice or pregnant, as they are considered at high risk for COVID-19 complications. Everybody will be reviewed based on both their current health risk and risk to public safety.

CDCR will also be expediting the release of incarcerated persons who have been found suitable for parole by the Board of Parole Hearings and Governor, but who have not yet been released from prison.

Previous Decompression Efforts:

These new measures build on many others already taken to reduce the risk of COVID-19 to all who work and live in the state prison system. Those measures include:

- Reducing CDCR's population in its institutions by more than 10,000 since mid-March.
- Implemented measures to support increased physical distancing, including reducing the number of people who use common spaces at the same time, transferring people out of lower level dorms to celled housing, and erecting tents to create alternate housing and care sites.
- Suspension of movement within and between institutions, other than for critical purposes.
- Suspension of visitation, volunteers, and group programming.
- Implemented mandatory verbal and temperature screenings for staff before they enter any institutions and other CDCR work sites
- Reinforced commitment to hygiene, both institutional and personal, including greater availability of soap and hand sanitizer.
- Providing educational materials to all staff and incarcerated people, including posters, quick reference pocket guides, webinars, and educational videos.

###

Exhibit B

Alex Padilla
California Secretary of State

What can we help you with?

Search

Qualified Statewide Ballot Measures

The following is a list of statewide measures that have qualified for the ballot. For those measures that are currently attempting to qualify, see the **Initiative and Referendum Qualification Status (/elections/ballot-measures/initiative-and-referendum-status/)** page.

For initiative measures that are eligible for the ballot, see the **Eligible Statewide Initiative Measures (/elections/ballot-measures/initiative-and-referendum-status/eligible-statewide-initiative-measures/)** page. An eligible initiative measure is one in which the required number of signatures have been submitted to and verified by the county elections officials. Eligible initiative measures will become qualified for the ballot on the 131st day prior to the next Statewide General Election unless withdrawn by the proponents prior to its qualification by the Secretary of State.

For information on the campaign committees that have organized to support or oppose propositions and ballot measures on the statewide ballot, see the **Propositions and Ballot Measures Campaign Finance Activity (http://cal-access.sos.ca.gov/Campaign/Measures/)** page.

November 3, 2020, Statewide Ballot Measures

Proposition 14

1880. (19-0022A1)
AUTHORIZES BONDS TO CONTINUE FUNDING STEM CELL AND OTHER MEDICAL RESEARCH. INITIATIVE STATUTE.

Authorizes $5.5 billion in state general obligation bonds to fund grants from the California Institute of Regenerative Medicine to educational, non-profit, and private entities for: (1) stem cell and other medical research, therapy development, and therapy delivery; (2) medical training; and (3) construction of research facilities. Dedicates $1.5 billion to fund research and therapy for Alzheimer's, Parkinson's, stroke, epilepsy, and other brain and central nervous system diseases and conditions. Limits bond issuance to $540 million annually. Appropriates money from General Fund to repay bond debt, but postpones repayment for first five years. Summary of estimate by Legislative Analyst and Director of Finance of fiscal impact on state and local governments: **State costs of $7.8 billion to pay off principal ($5.5 billion) and interest ($2.3 billion) on the bonds. Associated average annual debt payments of about $310 million for 25 years. The costs could be higher or lower than these estimates depending on factors such as the**

interest rate and the period of time over which the bonds are repaid. The state General Fund would pay most of the costs, with a relatively small amount of interest repaid by bond proceeds. (**19-0022A1 (https://www.oag.ca.gov/system/files/initiatives/pdfs/19-0022A1%20%28%28Stem%20Cell%20Research%29%29_0.pdf)**.)

Proposition 15

1870. (19-0008A1)
INCREASES FUNDING FOR PUBLIC SCHOOLS, COMMUNITY COLLEGES, AND LOCAL GOVERNMENT SERVICES BY CHANGING TAX ASSESSMENT OF COMMERCIAL AND INDUSTRIAL PROPERTY. INITIATIVE CONSTITUTIONAL AMENDMENT.

Increases funding for K-12 public schools, community colleges, and local governments by requiring that commercial and industrial real property be taxed based on current market value. Exempts from this change: residential properties; agricultural properties; and owners of commercial and industrial properties with combined value of $3 million or less. Increased education funding will supplement existing school funding guarantees. Exempts small businesses from personal property tax; for other businesses, exempts $500,000 worth of personal property. Summary of estimate by Legislative Analyst and Director of Finance of fiscal impact on state and local governments: **Net increase in annual property tax revenues of $7.5 billion to $12 billion in most years, depending on the strength of real estate markets. After backfilling state income tax losses related to the measure and paying for county administrative costs, the remaining $6.5 billion to $11.5 billion would be allocated to schools (40 percent) and other local governments (60 percent).** (**19-0008 (https://www.oag.ca.gov/system/files/initiatives/pdfs/19-0008%20%28The%20California%20Schools%20and%20Local%20Communities%20Funding%20Act%20of%202020%29_1.pdf)**.)

Proposition 16

ACA 5 (Resolution Chapter 23), Weber. Government preferences. (PDF) (https://elections.cdn.sos.ca.gov/ballot-measures/pdf/aca-5.pdf)

Proposition 17

ACA 6 (Resolution Chapter 24), McCarty. Elections: disqualification of electors. (PDF) (https://elections.cdn.sos.ca.gov/ballot-measures/pdf/aca-6.pdf)

Proposition 18

ACA 4 (Resolution Chapter 30), Mullin. Elections: voting age. (PDF) (https://elections.cdn.sos.ca.gov/ballot-measures/pdf/aca-4.pdf)

Proposition 19

ACA 11 (Resolution Chapter 31), Mullin. The Home Protection for Seniors, Severely Disabled, Families, and Victims of Wildfire or Natural Disasters Act. (PDF) (https://elections.cdn.sos.ca.gov/ballot-measures/pdf/aca11.pdf)

Proposition 20

1840. (17-0044, Amdt.#1)
RESTRICTS PAROLE FOR NON-VIOLENT OFFENDERS. AUTHORIZES FELONY SENTENCES FOR CERTAIN OFFENSES CURRENTLY TREATED ONLY AS MISDEMEANORS. INITIATIVE STATUTE.

Imposes restrictions on parole program for non-violent offenders who have completed the full term for their primary offense. Expands list of offenses that disqualify an inmate from this parole program. Changes standards and requirements governing parole decisions under this program. Authorizes felony charges for specified theft crimes currently chargeable only as misdemeanors, including some theft crimes where the value is between $250 and $950. Requires persons convicted of specified misdemeanors to submit to collection of DNA samples for state database. Summary of estimate by Legislative Analyst and Director of Finance of fiscal impact on state and local government: **Increased state and local correctional costs likely in the tens of millions of dollars annually,**

primarily related to increases in penalties for certain theft-related crimes and the changes to the nonviolent offender release consideration process. Increased state and local court-related costs of around a few million dollars annually related to processing probation revocations and additional felony theft filings. Increased state and local law enforcement costs not likely to exceed a couple million dollars annually related to collecting and processing DNA samples from additional offenders. (17-0044 (https://www.oag.ca.gov/system/files/initiatives/pdfs/17-0044%20%28Reducing%20Crime%29.pdf).)

Proposition 21

1862. (19-0001)
EXPANDS LOCAL GOVERNMENTS' AUTHORITY TO ENACT RENT CONTROL ON RESIDENTIAL PROPERTY. INITIATIVE STATUTE.

Amends state law to allow local governments to establish rent control on residential properties over 15 years old. Allows rent increases on rent-controlled properties of up to 15 percent over three years from previous tenant's rent above any increase allowed by local ordinance. Exempts individuals who own no more than two homes from new rent-control policies. In accordance with California law, provides that rent-control policies may not violate landlords' right to a fair financial return on their property. Summary of estimate by Legislative Analyst and Director of Finance of fiscal impact on state and local governments: **Potential reduction in state and local revenues of tens of millions of dollars per year in the long term. Depending on actions by local communities, revenue losses could be less or more. (19-0001 (https://oag.ca.gov/system/files/initiatives/pdfs/19-0001%20%28Rental%20Affordability%20Act%29.pdf).)**

Proposition 22

1883. (19-0026A1)
CHANGES EMPLOYMENT CLASSIFICATION RULES FOR APP-BASED TRANSPORTATION AND DELIVERY DRIVERS. INITIATIVE STATUTE.

Establishes different criteria for determining whether app-based transportation (rideshare) and delivery drivers are "employees" or "independent contractors." Independent contractors are not entitled to certain state-law protections afforded employees—including minimum wage, overtime, unemployment insurance, and workers' compensation. Instead, companies with independent-contractor drivers will be required to provide specified alternative benefits, including: minimum compensation and healthcare subsidies based on engaged driving time, vehicle insurance, safety training, and sexual harassment policies. Restricts local regulation of app-based drivers; criminalizes impersonation of such drivers; requires background checks. Summary of estimate by Legislative Analyst and Director of Finance of fiscal impact on state and local governments: **Increase in state personal income tax revenue of an unknown amount. (19-0026A1 (https://www.oag.ca.gov/system/files/initiatives/pdfs/19-0026A1%20%28App-Based%20Drivers%29.pdf))**

Proposition 23

1882. (19-0025A1)
AUTHORIZES STATE REGULATION OF KIDNEY DIALYSIS CLINICS. ESTABLISHES MINIMUM STAFFING AND OTHER REQUIREMENTS. INITIATIVE STATUTE.

Requires at least one licensed physician on site during treatment at outpatient kidney dialysis clinics; authorizes Department of Public Health to exempt clinics from this requirement due to shortages of qualified licensed physicians if at least one nurse practitioner or physician assistant is on site. Requires clinics to report dialysis-related infection data to state and federal governments. Requires state approval for clinics to close or reduce services. Prohibits clinics from discriminating against patients based on the source of payment for care. Summary of estimate by Legislative Analyst and Director of Finance of fiscal impact on state and local governments: **Increased state and local health care costs, likely in the low tens of millions of dollars annually, resulting from increased dialysis treatment costs. (19-0025A1 (https://www.oag.ca.gov/system/files/initiatives/pdfs/19-0025A1%20%28%28Dialysis%29%29.pdf).)**

Proposition 24

1879. (19-0021A1)
AMENDS CONSUMER PRIVACY LAWS. INITIATIVE STATUTE.

Permits consumers to: (1) prevent businesses from sharing personal information; (2) correct inaccurate personal information; and (3) limit businesses' use of "sensitive personal information"—such as precise geolocation; race; ethnicity; religion; genetic data; union membership; private communications; and certain sexual orientation, health, and biometric information. Changes criteria for which businesses must comply with these laws. Prohibits businesses' retention of personal information for longer than reasonably necessary. Triples maximum penalties for violations concerning consumers under age 16. Establishes California Privacy Protection Agency to enforce and implement consumer privacy laws, and impose administrative fines. Requires adoption of substantive regulations. Summary of estimate by Legislative Analyst and Director of Finance of fiscal impact on state and local governments: **Increased annual state costs of roughly $10 million for a new state agency to monitor compliance and enforcement of consumer privacy laws. Increased state costs, potentially reaching the low millions of dollars annually, from increased workload to DOJ and the state courts, some or all of which would be offset by penalty revenues. Unknown impact on state and local tax revenues due to economic effects resulting from new requirements on businesses to protect consumer information.** (**19-0021A1 (https://www.oag.ca.gov/system/files/initiatives/pdfs/19-0021A1%20%28Consumer%20Privacy%20-%20Version%203%29_1.pdf)**.)

Proposition 25

1856. (18-0009)
REFERENDUM TO OVERTURN A 2018 LAW THAT REPLACED MONEY BAIL SYSTEM WITH A SYSTEM BASED ON PUBLIC SAFETY RISK.

If this petition is signed by the required number of registered voters and timely filed, a referendum will be placed on the next statewide ballot requiring a majority of voters to approve a 2018 state law before it can take effect. The 2018 law replaces the money bail system with a system for pretrial release from jail based on a determination of public safety or flight risk, and limits pretrial detention for most misdemeanors. (**18-0009 (https://oag.ca.gov/system/files/initiatives/pdfs/18-0009%20%28Referendum%20of%20SB%2010%29.pdf)**)

As new initiatives enter circulation, fail, become eligible for, or qualify for an election ballot, the Secretary of State's office will issue initiative status updates. The updates can be found on our **Initiative and Referendum Qualification Status (/elections/ballot-measures/initiative-and-referendum-status/)** page or by signing up for updates below.

Exhibit C

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California Proposition 20, Criminal Sentencing, Parole, and DNA Collection Initiative (2020)

California Proposition 20, the **Criminal Sentencing, Parole, and DNA Collection Initiative**, is on the ballot in California as an initiated state statute on November 3, 2020.

A "**yes**" vote supports this initiative to add crimes to the list of violent felonies for which early parole is restricted; recategorize certain types of theft and fraud crimes as wobblers (chargeable as misdemeanors or felonies); and require DNA collection for certain misdemeanors.

A "**no**" vote opposes this initiative to add crimes to the list of violent felonies for which early parole is restricted; recategorize certain types of theft and fraud crimes as wobblers (chargeable as misdemeanors or felonies); and require DNA collection for certain misdemeanors.

California Proposition 20



Election date
November 3, 2020

Topic
Law enforcement

Status
On the ballot

Type	Origin
State statute	Citizens

Overview

What would this ballot initiative change about criminal sentencing and supervision policies in California?

See also: Initiative design

The ballot initiative would amend several criminal sentencing and supervision laws that were passed between 2011 and 2016.[1]

The ballot initiative would make specific types of theft and fraud crimes, including firearm theft, vehicle theft, and unlawful use of a credit card, chargeable as misdemeanors or felonies, rather than misdemeanors. The ballot initiative would also establish two additional types of crimes in state code—serial crime and organized retail crime—and charge them as wobblers (crimes chargeable as misdemeanors or felonies).[1]

The ballot initiative would require persons convicted of certain misdemeanors that were classified as wobblers or felonies before 2014, such shoplifting, grand theft, and drug possession, along with several other crimes, including domestic violence and prostitution with a minor, to submit to the collection of DNA samples for state and federal databases.[1]

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The California Department of Corrections and Rehabilitation (DCR) has a parole review program in which felons convicted of nonviolent crimes, as defined in law, could be released on parole upon completing their sentence for his or her offense with the longest imprisonment term. The ballot initiative would require the parole review board to consider additional factors, such as the felon's age, marketable skills, attitude about the crime, and mental condition, as well as the circumstances of the crimes committed, before deciding whether to release a felon on parole. The ballot initiative would allow prosecutors to request a review of the board's final decision. The ballot initiative would also define 51 crimes and sentence enhancements as violent in order to exclude them from the parole review program.[1]

In California, counties are responsible for supervising paroled felons convicted of non-serious and non-violent crimes, as defined in law, and who were not classified as high-risk sex offenders nor classified as needing treatment from the state Department of Mental Health. Counties have discretion on whether to petition the judicial system to change a felon's post-release supervision terms or status. The ballot initiative would require local probation departments to ask a judge to change the conditions or status of a felon's post-release supervision if the felon violated supervision terms for the third time.[1]

What existing laws would this ballot initiative change?

The ballot initiative was designed to make changes to AB 109 (2011), Proposition 47 (2014), and Proposition 57 (2016)—three measures that were each intended to reduce the state's prison inmate population. According to Assemblyman Jim Cooper (D-9), the goal of the initiative is to "[reform] the unintended consequences of reforms to better protect the public."[2] Former Gov. Jerry Brown (D) disagreed with Cooper's assessment, saying the initiative is the "latest scare tactic on criminal justice reform."[3]

Before Proposition 47 and Proposition 57, and a month after the passage of AB 109, the U.S. Supreme Court ruled that overcrowding in the state's prisons resulted in cruel and unusual punishment and affirmed a lower court's order to reduce the prison population. AB 109 shifted the imprisonment of non-serious, non-violent, and non-sexual offenders, as defined in state law, from state prisons to local jails. AB 109 also made counties, rather than the state, responsible for supervising certain felons on parole. Proposition 47, which voters approved in 2014, changed several crimes, which the measure considered non-serious and non-violent, from felonies or wobblers to misdemeanors. Former Gov. Brown (D) developed Proposition 57, which voters approved in 2016. Proposition 57 increased parole chances for felons convicted of nonviolent crimes, as defined in state law, and gave them more opportunities to earn sentence-reduction credits for good behavior.

The Center on Juvenile and Criminal Justice, a nonprofit based in San Francisco, described AB 109 and Propositions 47 and 57 as successful sentencing reforms that reduced overcrowding in state prisons.[4] Andrew Do, chair of the Orange County Board of Supervisors, described the measures as "California's dangerous trifecta."[5]

Initiative design

Click on the arrows (▼) below for summaries of the different provisions of the ballot initiative.

►**Penalities for theft-related crimes:** classifying certain misdemeanors as wobblers

►**DNA collection:** requiring collection for specific misdemeanors

►**Criteria to consider in nonviolent offender parole program:** additional factors to consider before deciding parole

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►**Crimes defined as violent:** crimes not eligible for nonviolent offender parole program

►**Changes to probation and parole supervision:** rules regarding probation violations and exchange of information

Text of measure

Ballot title

The official ballot title is as follows:[9]

> “Restricts Parole for Non-Violent Offenders. Authorizes Felony Sentences for Certain Offenses Currently Treated Only as Misdemeanors. Initiative Statute.[10]”

Petition summary

The summary provided for inclusion on signature petition sheets is as follows:[9]

> “Imposes restrictions on parole program for non-violent offenders who have completed the full term for their primary offense. Expands list of offenses that disqualify an inmate from this parole program. Changes standards and requirements governing parole decisions under this program. Authorizes felony charges for specified theft crimes currently chargeable only as misdemeanors, including some theft crimes where the value is between $250 and $950. Requires persons convicted of specified misdemeanors to submit to collection of DNA samples for state database.[10]”

Fiscal impact statement

The fiscal impact statement is as follows:[9]

> “Increased state and local correctional costs likely in the tens of millions of dollars annually, primarily related to increases in penalties for certain theft-related crimes and the changes to the nonviolent offender release consideration process. Increased state and local court-related costs of around a few million dollars annually related to processing probation revocations and additional felony theft filings. Increased state and local law enforcement costs not likely to exceed a couple million dollars annually related to collecting and processing DNA samples from additional offenders.[10]”

Full text

The full text of the ballot initiative is below:[1]

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Support

Keep California Safe is leading the campaign in support of the ballot initiative.[11] Keep California Safe named the ballot initiative the **Reducing Crime and Keeping California Safe Act**.[1] The campaign is a project of the California Public Safety Partners (CAPSP).[2]

Supporters

Officials

- Asm. Jim Cooper (D-9)[12]
- Asm. Vince Fong (R-34)[13]

Municipalities

- Orange County Board of Supervisors[14]

Organizations

- Association for Los Angeles Deputy Sheriffs[15]
- Los Angeles Police Protective League[15]
- Peace Officers Research Association of California[15]

Businesses

- Albertsons Safeway[15]

Arguments

- **Asm. Jim Cooper** (D-9) said, "Right now California crimes that are considered nonserious and nonviolent—and that allow you to get out of jail or prison earlier—are drugging and raping somebody, raping a developmentally disabled person, spousal abuse, a drive-by shooting, human trafficking of a child. So a myriad of different crimes, some 17 to be exact. The public never had any idea. These were not considered serious or violent crimes in the state of California. When they hear it they're shocked."[16]

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Opposition

Opponents

Officials

- Gov. Jerry Brown (D)[17]

Organizations

- American Civil Liberties Union of Northern California[15]

Unions

- SEIU California State Council[18]

Individuals

- Lynn Schusterman[15]
- Patty Quillin[15]

Arguments

- **Ana Zamora**, director of prosecutorial reform for the ACLU of Northern California, said, "They would like us to believe that California is in dire straits in order to reverse many of the reforms we have put in place since 2012. ... We urge the proponents of this new effort to reject the Trump Administration's return to the failed 1990's era of harsh sentencing and mass incarceration, as the voters of this state have consistently done, and instead work toward keeping California's crime rates the lowest in history."[2]
- **Dan Newman**, a political consultant for the opposition campaign, said, "It's a prison spending scam at a time when we are actively closing prisons and reallocating funds toward what's needed in communities. They're doubling down on solidifying their places on the wrong side of history at a critical moment."[19]

Campaign finance

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See also: Campaign finance requirements for California ballot measures

The campaign finance information on this page reflects the most recently scheduled reports processed by Ballotpedia, which covered through March 31, 2020. The deadline for the next scheduled reports is July 31, 2020.

Two PACs—**Keep California Safe** and **Protecting California Cooper Ballot Measure Committee**—were registered to support the ballot initiative. Together, the committees had raised $3.99 million, including $2.00 million from the California Correctional Peace Officers Association Truth in American Government Fund. The committees had spent $2.38 million.[15]

Two PACs—**Committee for California Issues PAC** and **California Public Safety and Rehabilitation**—were registered to oppose the ballot initiative. Together, the committees had raised $809,978, including $250,000 from Patty Quillin and $250,000 from Lynn Schusterman. The committees had spent $232,713.[15]

	Cash Contributions	In-Kind Contributions	Total Contributions	Cash Expenditures	Total Expenditures
Support	$3,761,171.00	$232,622.90	**$3,993,793.90**	$2,145,484.98	$2,378,107.88
Oppose	$760,478.31	$49,500.00	**$809,978.31**	$183,213.22	$232,713.22

Support

The following table includes contribution and expenditure totals for the committee in support of the initiative.[15]

Committees in support of Proposition 20

Committee	Cash Contributions	In-Kind Contributions	Total Contributions	Cash Expenditures	Total Expenditures
Keep California Safe	$3,731,671.00	$232,622.90	$3,964,293.90	$2,132,855.59	$2,365,478.49
Protecting California Cooper Ballot Measure Committee	$29,500.00	$0.00	$29,500.00	$12,629.39	$12,629.39
Total	**$3,761,171.00**	**$232,622.90**	**$3,993,793.90**	**$2,145,484.98**	**$2,378,107.88**

Donors

The following were the top five donors who contributed to the support committee.[15]

Donor	Cash Contributions	In-Kind Contributions	Total Contributions

California Correctional Peace Officers Association Truth in American Government Fund	$2,000,000.00	$0.00	$2,000,000.00
Association For Los Angeles Deputy Sheriffs PIC	$200,000.00	$0.00	$200,000.00
Los Angeles Police Protective League Issues PAC	$200,000.00	$0.00	$200,000.00
Jim Cooper for Assembly 2018	$125,000.00	$0.00	$125,000.00
Albertsons Safeway	$100,000.00	$0.00	$100,000.00

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California Correctional Peace Officers Association

In December 2018, the California Correctional Peace Officers Association's (CCPOA) political fund contributed $2 million to the Keep California Safe PAC. On January 14, 2019, CCPOA president Kurt Stoetzl asked the PAC to return the contribution. Stoetzl said, "As you aware, during the last week of December 2018, CCPOA contributed two million dollars to your Issues Committee. As you may not be aware, this contribution was made by our past president in the final hours of his term. This contribution was made without the new leadership of CCPOA having the opportunity to evaluate the proposed initiative, to determine if the goals of your Issues Committee, and the initiative, are in step in the goals of CCPOA." Stoetzl said the CCPOA wanted the contribution back "so that we can evaluate your positions and determine whether or not we are in support."[20]

Opposition

The following table includes contribution and expenditure totals for the committee in opposition to the initiative.[15]

Committees in opposition to Proposition 20

Committee	Cash Contributions	In-Kind Contributions	Total Contributions	Cash Expenditures	Total Expenditures
California Public Safety and Rehabilitation	$500,000.00	$0.00	$500,000.00	$79,523.50	$79,523.50
Committee for California Issues PAC	$260,478.31	$49,500.00	$309,978.31	$103,689.72	$153,189.72
Total	**$760,478.31**	**$49,500.00**	**$809,978.31**	**$183,213.22**	**$232,713.22**

Donors

The following were the top donors to the opposition committee.[15]

Donor	Cash Contributions	In-Kind Contributions	Total Contributions
Lynn Schusterman	$250,000.00	$0.00	$250,000.00
Patty Quillin	$250,000.00	$0.00	$250,000.00
American Civil Liberties Union of Northern California	$200,000.00	$49,500.00	$249,500.00

Governor Brown's Ballot Measure Committee	$60,478.31	$0.00	$60,478.31

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Methodology

To read Ballotpedia's methodology for covering ballot measure campaign finance information, click here.

Background

Brown v. Plata

In 2009, a three-judge court ordered the state government to reduce the prison population to within 137.5 percent of the state prisons' designed capacities. The three-judge court said, "until the problem of overcrowding is overcome it will be impossible to provide constitutionally compliant care to California's prison population."[21]

California appealed the ruling to the U.S. Supreme Court. The state government said tools existed to resolve the overcrowding issue without reducing the prison population, including constructing new prisons and transferring prisoners to other states. In 2011, the U.S. Supreme Court ruled that overcrowding in the state's prisons resulted in cruel and unusual punishment—a violation of the Eighth Amendment—and affirmed the lower court's order to reduce the prison population. Justice Anthony Kennedy wrote the court's 5-4 decision, ruling, "the court-mandated population limit is necessary to remedy the violation of prisoners' constitutional rights." Justices Ginsburg, Breyer, Sotomayor, and Kagan concurred with the decision. The remaining four justices—Scalia, Thomas, Roberts, and Alito—dissented. Justice Scalia stated, "[Brown v. Plata] is perhaps the most radical injunction issued by a court in our Nation's history: an order requiring California to release the staggering number of 46,000 convicted criminals."[21]

Assembly Bill 109 (2011)

In 2011, the California State Legislature passed Assembly Bill 109 (AB 109), known as the criminal corrections realignment law. AB 109 transferred the management and supervision of certain felons, who were convicted of non-serious, non-violent, and non-sexual crimes (as defined in law), from the state government to county governments. Before AB 109, state law required felons to serve sentences in state prison.[22]

Title 2.05 of AB 109 was known as the Postrelease Community Supervision Act (PCSA), which required counties, rather than the state, to supervise felons convicted of certain types of crimes after their release from prison. PCSA affected felons who were convicted of crimes that the law described as non-serious and non-violent and who were not classified as high-risk sex offenders nor classified as needing treatment from the state Department of Mental Health. The PCSA gave counties the power to decide methods for punishing violations of supervision conditions, such as flash incarceration, mandatory community service, and mandatory drug treatment. Counties were also given the option to petition a hearing officer to change a felon's supervision conditions, incarcerate a felon in jail for longer than 10 days, or refer a felon to a reentry court.[8]

The California State Senate passed AB 109 in a vote of 24 to 16. The California General Assembly passed AB 109 in a vote of 51 to 27. Gov. Jerry Brown (D) signed AB 109 into law on April 4, 2011.[23]

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Proposition 47 (2014)

See also: California Proposition 47, Reduced Penalties for Some Crimes Initiative (2014)

In 2014, voters approved Proposition 47 in a vote of 59.6 percent to 40.4 percent. Proposition 47 classified crimes that the initiative considered *non-violent* and *non-serious* as misdemeanors instead of felonies unless the defendant has prior convictions for murder, rape, certain sex offenses, or certain gun crimes. It also permitted re-sentencing for those currently serving a prison sentence for any of the offenses that the initiative reduces to misdemeanors. Under Proposition 47, about 10,000 inmates were eligible for re-sentencing, according to Lenore Anderson of Californians for Safety and Justice.[24][25]

More than $10.97 million was raised to support the ballot initiative, including $3.50 million from the ACLU and $1.46 million from the Open Society Policy Center. Supporters included Lt. Gov. Gavin Newsom (D), along with U.S. Sen. Rand Paul (R-Kentucky) and former speaker of the U.S. House Newt Gingrich (R-Georgia).[26][27][28]

Opponents raised 5 percent of what supporters' received, totaling $551,800 in contributions. The top contributor to the opposition was the Peace Officers Research Association of California PIC, which provided $286,000. U.S. Sen. Dianne Feinstein (D-California) opposed Proposition 47, as did the state Republican Party.[29][30]

Proposition 57 (2016)

See also: California Proposition 57, Parole for Non-Violent Criminals and Juvenile Court Trial Requirements (2016)

Proposition 57 was approved with 64.5 percent of the vote. The initiative increased parole chances for felons convicted of nonviolent crimes and gave them more opportunities to earn credits for good behavior. The measure allowed individuals convicted of nonviolent felony crimes who served full sentences for their primary offense and passed screening for public security eligible for parole. It also allowed judges, not prosecutors, to decide whether to try certain juveniles as adults in court.[31] Using numbers from early 2016, there were about 25,000 nonviolent state felons that could seek early release and parole under Proposition 57.[32]

The measure was developed by Gov. Jerry Brown (D) and backed by Lt. Gov. Gavin Newsom (D), former speaker of the U.S. House Newt Gingrich (R), and the California Democratic Party.[33][34] The committees supporting Proposition 57 raised an aggregate $15.04 million, with $2.17 million from the state Democratic Party, $1.75 million from Tom Steyer, and $1.00 million from Mark Zuckerberg.

Opponents raised $1.51 million in contributions. The largest donors included the Association for Los Angeles Deputy Sheriffs PIC, which gave $200,000, and the Los Angeles County Professional Peace Officers' Association IEC, which donated $150,000. The California Republican Party, U.S. Rep. Tom McClintock (R-4), and U.S. Rep. Loretta Sanchez (D-46) were opposed to the measure.[35][36][30]

California's state imprisonment rate

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Prior to the enactment of AB 109's Postrelease Community Supervision Act (PCSA) on July 1, 2011, the state's imprisonment rate was 431 inmates per 100,000 residents. The next year the imprisonment rate was 356 inmates per 100,000 residents. In 2019, the rate fell to 317 inmates. The following graph illustrates the state's imprisonment rate from 1995 through 2019. Rates were calculated using the CDCR's prison population reports and the U.S. Census Bureau's annual population estimates.[37][38]

- The first orange bar represents the enactment of AB 109's PCSA on July 1, 2011.
- The second orange bar represents the enactment of Proposition 47 following the election on November 4, 2014.
- The third orange bar represents July 1, 2017—the date when the CDCR started referring inmates for Proposition 57's parole program.

California's state imprisonment rate per 100,000 residents, 1995-2019

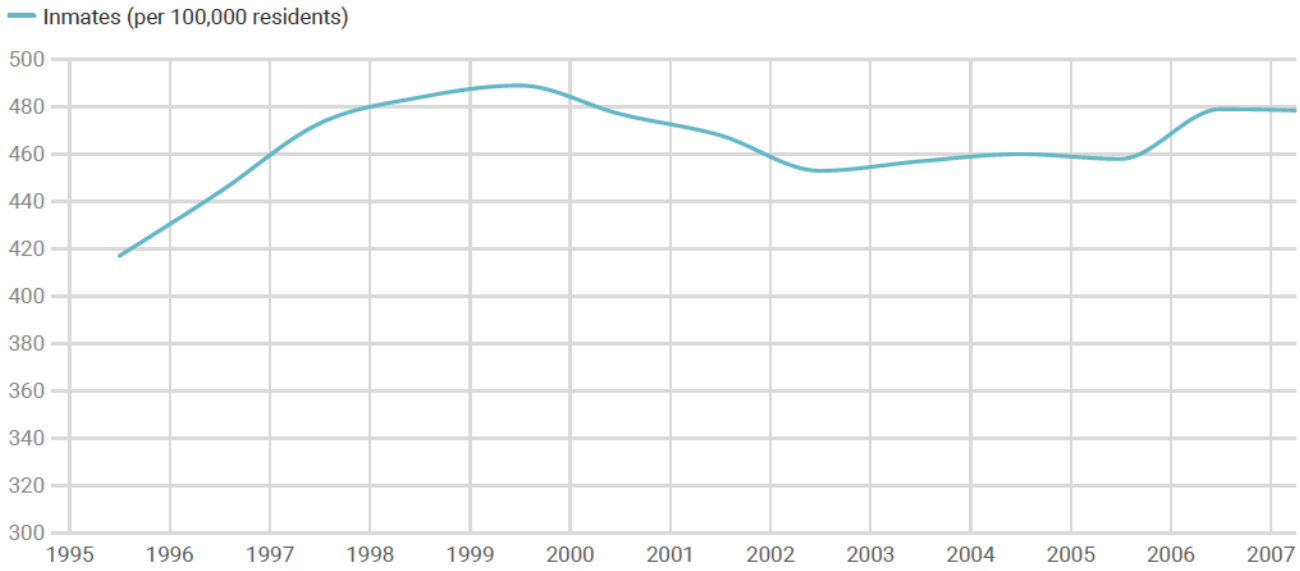


Chart: Ballotpedia • Source: California Department of Corrections and Rehabilitation

BALLOTPEDIA

Path to the ballot

See also: California signature requirements and Laws governing the initiative process in California

In California, the number of signatures needed to qualify a measure for the ballot is based on the total number of votes cast for the office of governor. For an initiated state statute, petitioners must collect signatures equal to 5 percent of the most recent gubernatorial vote. To get this measure on the 2020 ballot, the number of signatures required was 365,880. In California, initiatives can be circulated for 180 days. Signatures needed to be certified at least 131 days before the 2020 general election. As the signature verification process can take several weeks, the California secretary of state issues suggested deadlines for several months before the certification deadline.

The timeline for this initiative was as follows:[39]

- Nina Salarno Besselman submitted a letter requesting a title and summary on October 31, 2017.
- A title and summary were issued by the California attorney general's office on January 4, 2018.
- On February 7, 2018, the campaign reported collecting at least 25 percent of the required signatures.
- Proponents of the initiative needed to submit 365,880 valid signatures by July 3, 2018, in order for it to make the ballot.

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On July 9, 2018, Secretary of State Alex Padilla reported that more than enough signatures had been submitted for the measure to make the ballot in 2020.[40]

Cost of signature collection:
Sponsors of the measure hired Arno Petition Consultants to collect signatures for the petition to qualify this measure for the ballot. A total of $2,046,104.99 was spent to collect the 365,880 valid signatures required to put this measure before voters, resulting in a total cost per required signature (CPRS) of $5.59.

Brown v. Padilla and Salarno Besselman

Lawsuit overview

Issue: Required number of signatures for the ballot initiative

Court: Sacramento County Superior Court

Plaintiff(s): Gov. Jerry Brown

Defendant(s): Secretary of State Alex Padilla and Nina Salarno Besselman

Plaintiff argument:
The ballot initiative should have been considered a constitutional amendment, and thus should have required 585,407 signatures, rather than 365,880 signatures, to make the ballot.

Defendant argument:
The ballot initiative met the signature requirements as required by the secretary of state.

Source: Associated Press

On December 20, 2018, Gov. Jerry Brown (D) filed litigation against Secretary of State Alex Padilla (D) and initiative's official proponent, Nina Salarno Besselman, in the Sacramento County Superior Court. Gov. Brown asked the court to invalidate the initiative because, according to Brown, Secretary of State Padilla used the wrong signature threshold. Padilla required proponents to collect 365,880 signatures—the number required for initiated state statutes. Gov. Brown said 585,407 signatures should have been required—the number required for initiated constitutional amendments. According to Gov. Brown, the initiative should have been treated as a constitutional amendment because of its impact on the constitutional powers that Proposition 57 (2016) provided the Department of Corrections and Rehabilitation.[41]

Jeff Flint, a spokesperson for Keep California Safe, said, "The secretary of state told us how many

signatures are required and that's how many we collected."[41]

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How to cast a vote

See also: Voting in California

Click "Show" to learn more about voter registration, identification requirements, and poll times in California.

How to cast a vote in California	[show]

See also

2020 measures



- 2020 ballot measures
- Law enforcement on the ballot
- Civil and criminal trials on the ballot
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Footnotes

1. *California Attorney General*, "Initiative #17-0044," accessed October 31, 2017
2. *The Davis Vanguard*, "Ballot Measure Seeks to Undo California's Criminal Justice Reform," October 31, 2017
3. *The Sacramento Bee*, "Don't fall for this latest scare tactic on criminal justice reform, governor says," February 26, 2018
4. *Center on Juvenile and Criminal Justice*, "AB 109, Prop 47, and Prop 57 Are Safely Reducing the Prison Population, but Durable Public Safety Requires Further Cuts in

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Exhibit D

Data Analysis Unit
Estimates and Statistical Analysis Section
Offender Information Services Branch

Department of Corrections and Rehabilitation
State of California
September 8, 2009

MONTHLY REPORT OF POPULATION
AS OF MIDNIGHT August 31, 2009

TOTAL CDCR POPULATION

	FELON/ OTHER #1	CIVIL ADDICT	TOTAL	CHANGE SINCE 08/31/08 NO.	CHANGE SINCE 08/31/08 PCT.	DESIGN CAPACITY	PERCENT OCCUPIED	STAFFED CAPACITY
A. TOTAL INSTITUTIONS	165,630	853	166,483	-5,427	-3.1			
I. IN-STATE	157,798	853	158,651	-13,259	-7.7			
(MEN, Subtotal)	147,018	623	147,641	-7,867	-5.0			
(WOMEN, Subtotal)	10,780	230	11,010	-551	-4.7			
1. INSTITUTIONS/CAMPS	152,611	850	153,461	-7,112	-4.4	84,271	182.1	157,576
INSTITUTIONS	148,324	850	149,174	-7,030	-4.5	80,033	186.4	153,217
CAMPS(CCC & SCC)*	4,287		4,287	-82	-1.8	4,238	101.2	4,359
2. COMMUNITY CORR. CTRS.	4,944	3	4,947	-1,337	-21.2	5,846	84.6	
CCF PRIVATE	2,589		2,589	-317	-10.9	2,752	94.1	
CCF PUBLIC	1,906		1,906	-823	-30.1	2,461	77.4	
DRUG TREATMT FURLOUGH	262	3	265	-103	-27.9	440	60.2	
PRISONER MOTHER PGM	64		64	-8	-11.1	70	91.4	
FAMILY FOUNDATION PGM	70		70	-1	-1.4	70	100.0	
WORK FUR. IN CUSTODY #2	53		53	-14	-20.8	53	100.0	
3. DMH STATE HOSPITALS	243		243	+31	+14.6			
II. OUT OF STATE(COCF)	7,832	0	7,832					
ARIZONA	4,273		4,273					
MISSISSIPPI	2,492		2,492					
OKLAHOMA	1,067		1,067					
B. PAROLE	109,809	1,261	111,070	-13,039	-10.5			
COMMUNITY SUPERVISION	108,337	1,261	109,598	-13,096	-10.6			
COOPERATIVE CASES #3	1,472		1,472	+57	+4.0			
C. NON-CDC JURISDICTION #4	1,693	0	1,693	-118	-6.5			
OTHER STATE/FED. INST.	514		514	+1	+0.1			
OUT OF STATE PAROLE	941		941	-184	-16.3			
OUT OF STATE PAL	62		62	+3	+5.0			
CYA-W&IC 1731.5(c) #5 INSTITUTIONS	176		176	+62	+54.3			
D. OTHER POPULATIONS #6	18,757	133	18,890	-1,145	-5.7			
INMATES								
OUT-TO-COURT, etc.	2,909	40	2,949	+667	+29.2			
ESCAPED	208		208	-17	-7.5			
PAROLEES (PAL/RAL)	15,640	93	15,733	-1,795	-10.2			
TOTAL CDCR POPULATION	295,889	2,247	298,136	-14,888	-4.7			

CHANGE FROM LAST MONTH			
A. TOTAL INSTITUTIONS	-1,570	+8	-1,562
(MEN, Subtotal)	-1,524	+5	-1,519
(WOMEN, Subtotal)	-22	+3	-19
B. PAROLE	+8	-36	-28
D. PAROLEES (PAL/RAL)	-113	+11	-102

This report contains the latest available reliable population figures from OBIS. They have been carefully audited, but are preliminary, and therefore subject to revision.

*Figure excludes institution based camps. Total persons in camps, including base camps, are 4,294. Base camp at CMC is included in institution counts.

Report # TPOP-8.Questions: (916) 327-3262 (CALNET) 467-3262.

MONTHLY INSTITUTION/CAMPS POPULATION DETAIL — MIDNIGHT August 31, 2009

INSTITUTIONS/CAMPS	FELON/ OTHER	CIVIL ADDICT	TOTAL	DESIGN CAPACITY	PERCENT OCCUPIED	STAFFED CAPACITY
MALE						
ASP (AVENAL SP)	6,340		6,340	2,920	217.1	6,506
CCC (CAL CORRECTL CTR)	5,528		5,528	3,883	142.4	5,724
CCI (CAL CORRECTL INSTITN)	5,759		5,759	2,783	206.9	5,732
CIM (CAL INSTITN FOR MEN)	4,533	24	4,557	2,976	153.1	6,011
CMF (CAL MEDICAL FACIL)	2,711		2,711	2,297	118.0	2,875
CMC (CAL MEN'S COLONY)	6,341		6,341	3,838	165.2	6,458
CRC (CAL REHAB CTR, MEN)	3,666	552	4,218	2,491	169.3	4,408
CAL (CAL SP, CALIPATRIA)	4,264		4,264	2,308	184.7	4,218
CEN (CAL SP, CENTINELA)	4,500		4,500	2,308	195.0	4,508
COR (CAL SP, CORCORAN)	5,340	1	5,341	3,116	171.4	5,352
LAC (CAL SP, LOS ANGELES CO)	4,662		4,662	2,400	194.3	4,790
SAC (CAL SP, SACRAMENTO)	2,847	1	2,848	1,828	155.8	2,979
SQ (CAL SP, SAN QUENTIN)	5,233	8	5,241	3,082	170.1	5,274
SOL (CAL SP, SOLANO)	4,941		4,941	2,610	189.3	5,040
SATF (CAL SATF AND SP - COR)	6,868	3	6,871	3,424	200.7	7,009
CVSP (CHUCKAWALLA VALLEY SP)	3,378		3,378	1,738	194.4	3,593
CTF (CORRL TRAING FAC)	5,515		5,515	3,312	166.5	6,127
DVI (DEUEL VOCATL INSTITN)	3,895	6	3,901	1,681	232.1	3,811
FOL (FOLSOM SP)	4,144		4,144	2,469	167.8	4,078
HDP (HIGH DESERT SP)	4,453	13	4,466	2,324	192.2	4,486
IRON (IRONWOOD SP)	4,044		4,044	2,200	183.8	4,205
KVSP (KERN VALLEY SP)	4,691		4,691	2,448	191.6	4,825
MCSP (MULE CREEK SP)	3,733		3,733	1,700	219.6	3,812
NKSP (NORTH KERN SP)	5,449	3	5,452	2,694	202.4	5,354
PBSP (PELICAN BAY SP)	3,211		3,211	2,380	134.9	3,407
PVSP (PLEASANT VALLEY SP)	4,945		4,945	2,308	214.3	4,922
RIO (RIO COSUMNES COR CTR-RC)	466		466	0	-	400
RJD (RJ DONOVAN CORR FACIL)	4,755		4,755	2,200	216.1	4,814
SVSP (SALINAS VAL SP)	3,736		3,736	2,388	156.4	3,981
SRTA (SANTA RITA CO. JAIL-RC)	832		832	0	-	750
SCC (SIERRA CONSERV CTR)	5,637	1	5,638	3,736	150.9	5,621
WSP (WASCO SP)	5,988	11	5,999	2,984	201.0	5,848
MALE TOTAL:	142,405	623	143,028	78,826	181.4	146,918
FEMALE						
CIW (CAL INST FOR WOMEN)	2,393	205	2,598	1,386	187.4	2,715
CCWF (CENT CAL WOMEN'S FACIL)	3,911	4	3,915	2,004	195.4	3,966
FRCC (FRCCC BAKERSFIELD)	77		77	75	102.7	75
RIO (RIO COSUMNES COR CTR-RC)	14		14	0	-	0
VSP (VALLEY SP)	3,811	18	3,829	1,980	193.4	3,902
FEMALE TOTAL:	10,206	227	10,433	5,445	191.6	10,658
INSTITUTIONS/CAMPS TOTAL:	152,611	850	153,461	84,271	182.1	157,576

Data Analysis Unit
Estimates and Statistical Analysis Section
Offender Information Services Branch

Department of Corrections and Rehabilitation
State of California
September 8, 2009

MONTHLY REPORT OF POPULATION
NOTES
AS OF MIDNIGHT August 31, 2009

#1 Felon/Other counts are safekeepers, federal cases and inmates from other states, felons, county diagnostic cases and Youth Authority wards.

#2 Work Furlough in Custody are inmates in Work Furlough programs who are out-to-court, in jail, in hospitals, or escapees who have been taken into custody and are in jail.

#3 Cooperative Cases are parolees from other states being supervised in California.

#4 Non-CDC Jurisdiction are California cases being confined in or paroled to other states or jurisdictions.

#5 Welfare and Institution Code (W&IC) 1731.5(c) covers persons under the the age of 21 who were committed to CDCR, had their sentence amended, and were incarcerated at the California Youth Authority for housing and program participation.

#6 Other Population includes inmates temporarily out-to-court, inmates in hospitals, escapees, and parole and outpatient absconders.

Exhibit E

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
March 1, 2020

Monthly Report of Population
As of Midnight February 29, 2020

Total CDCR Population

Population	Felon/ Other	Change Since Last Month	Change Since Last Year	Design Capacity	Percent Occupied	Staffed Capacity
A. Total In-Custody/CRPP Supervision	123,123	-526	-3,414			
I. In-State	123,123	-526	-1,951			
(Men, Subtotal)	117,712	-475	-1,632			
(Women, Subtotal)	5,411	-51	-319			
1. Institution/Camps	117,344	-110	+162	89,663	130.9	123,895
Institutions	114,308	-157	+652	85,083	134.3	119,661
Camps(CCC, CIW, and SCC)	3,036	+47	-490	4,580	66.3	4,234
2. In-State Contract Beds	4,315	-429	-2,143			
Private Community Correctional Facilities	412	-380	-1,670			
Public Community Correctional Facilities	1,598	-2	-164			
Community Prisoner Mother Program	24	0	+11			
California City Correctional Facility	2,113	-27	-287			
Female Community ReEntry Facility, McFarland	168	-20	-33			
3. Department of State Hospitals	298	-3	+116			
4. CRPP Supervision	1,166	+16	-86			
Alternative Custody Program	135	+2	-57			
Custody to Community Treatment Reentry Program	384	+15	-8			
Male Community Reentry Program	620	0	-24			
Medical Parole	27	-1	+3			
B. Parole	52,399	+92	+3,022			
Community Supervision	50,620	+114	+3,131			
Interstate Cooperative Case	1,779	-22	-109			
C. Non-CDCR Jurisdiction	1,077	+96	+41			
Other State/Federal Institutions	305	-1	-12			
Out of State Parole	736	+94	+65			
Out of State Parolee at Large	16	+4	+5			
DJJ-W&IC 1731.5(c) Institutions	20	-1	-17			
D. Other Populations	6,568	-37	+461			
Temporary Release to Court and Hospital	1,626	+65	+221			
Escaped	198	-1	-1			
Parolee at Large	4,744	-101	+241			
Total CDCR Population	183,167	-375	+110			

This report contains the latest available reliable population figures from SOMS. They have been carefully audited, but are preliminary, and therefore subject to revision.

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
March 1, 2020

Monthly Report of Population
As of Midnight February 29, 2020

Monthly Institution Population Detail

Institutions	Felon/ Other	Design Capacity	Percent Occupied	Staffed Capacity
Male Institutions				
Avenal State Prison (ASP)	4,223	2,920	144.6	4,387
Calipatria State Prison (CAL)	2,977	2,308	129.0	3,451
California Correctional Center (CCC)	4,177	3,883	107.6	4,752
California Correctional Institution (CCI)	3,659	2,783	131.5	4,085
Centinela State Prison (CEN)	3,405	2,308	147.5	3,446
California Health Care Facility - Stockton (CHCF)	2,822	2,951	95.6	2,951
California Institution for Men (CIM)	3,552	2,976	119.4	4,226
California Men's Colony (CMC)	3,782	3,838	98.5	4,407
California Medical Facility (CMF)	2,485	2,361	105.3	2,861
California State Prison, Corcoran (COR)	2,915	3,116	93.5	4,476
California Rehabilitation Center (CRC)	3,937	2,491	158.0	3,084
Correctional Training Facility (CTF)	5,073	3,312	153.2	4,887
Chuckawalla Valley State Prison (CVSP)	2,904	1,738	167.1	2,578
Deuel Vocational Institution (DVI)	1,994	1,681	118.6	2,190
Folsom State Prison (FOL)	2,871	2,066	139.0	2,986
High Desert State Prison (HDSP)	3,255	2,324	140.1	3,461
Ironwood State Prison (ISP)	2,925	2,200	133.0	3,300
Kern Valley State Prison (KVSP)	3,512	2,448	143.5	3,622
California State Prison, Los Angeles County (LAC)	3,200	2,300	139.1	3,400
Mule Creek State Prison (MCSP)	4,003	3,284	121.9	4,105
North Kern State Prison (NKSP)	4,249	2,694	157.7	4,011
Pelican Bay State Prison (PBSP)	2,628	2,380	110.4	3,361
Pleasant Valley State Prison (PVSP)	3,203	2,308	138.8	3,433
RJ Donovan Correctional Facility (RJD)	3,893	2,992	130.1	4,038
California State Prison, Sacramento (SAC)	2,425	1,828	132.7	2,545
California Substance Abuse Treatment Facility (SATF)	5,297	3,424	154.7	5,111
Sierra Conservation Center (SCC)	4,326	3,836	112.8	4,570
California State Prison, Solano (SOL)	4,243	2,610	162.6	3,882
San Quentin State Prison (SQ)	4,051	3,082	131.4	3,984
Salinas Valley State Prison (SVSP)	2,957	2,452	120.6	3,509
Valley State Prison (VSP)	2,988	1,980	150.9	2,954
Wasco State Prison (WSP)	4,611	2,984	154.5	4,447
Male Total	**112,542**	**85,858**	**131.1**	**118,500**
Female Institutions				
Central California Women's Facility (CCWF)	2,760	2,004	137.7	2,988
California Institution for Women (CIW)	1,635	1,398	117.0	1,877
Folsom State Prison (FOL)	407	403	101.0	530
Female Total	**4,802**	**3,805**	**126.2**	**5,395**
Institution Total	**117,344**	**89,663**	**130.9**	**123,895**

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
March 1, 2020

Monthly Report of Population
As of Midnight February 29, 2020

Notes

- Felon/Other counts are felons, county contract boarders, federal boarders, state boarders, safekeepers, county diagnostic cases, Department of Mental Health boarders, and Division of Juvenile Justice boarders.
- Interstate Cooperative Cases are parolees from other states being supervised in California.
- Non-CDCR Jurisdiction are California cases being confined in or paroled to other states or jurisdictions.
- Welfare and Institution Code (W&IC) 1731.5(c) covers persons under the age of 21 who were committed to CDCR, had their sentence amended, and were incarcerated at the Division of Juvenile Justice for housing and program participation.
- Other Population includes inmates temporarily out-to-court, inmates in hospitals, escapees, and parolees at large.

Exhibit F

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
July 8, 2020

Weekly Report of Population
As of Midnight July 8, 2020

Total CDCR Population

Population	Felon/ Other	Change Since Last Week	Change Since Last Year	Design Capacity	Percent Occupied	Staffed Capacity
A. Total In-Custody/CRPP Supervision	112,507	-785	-12,930			
I. In-State	112,507	-785	-12,930			
(Men, Subtotal)	107,846	-736	-11,883			
(Women, Subtotal)	4,661	-49	-1,047			
1. Institution/Camps	107,591	-708	-10,147	89,663	120.0	125,791
Institutions	104,725	-603	-10,157	85,083	123.1	121,557
Camps(CCC, CIW, and SCC)	2,866	-105	+10	4,580	62.6	4,234
2. In-State Contract Beds	3,834	-35	-2,494			
Public Community Correctional Facilities	1,487	-15	-243			
Community Prisoner Mother Program	15	0	-8			
California City Correctional Facility	2,139	-16	-264			
Female Community ReEntry Facility, McFarland	193	-4	-63			
3. Department of State Hospitals	283	0	+88			
4. CRPP Supervision	799	-42	-377			
Alternative Custody Program	95	-14	-68			
Custody to Community Treatment Reentry Program	258	-7	-116			
Male Community Reentry Program	416	-23	-199			
Medical Parole	29	+1	+5			
State Community Custody Program	1					
B. Parole	53,345	-36	+2,564			
Community Supervision	51,727	-41	+2,806			
Interstate Cooperative Case	1,618	+5	-242			
C. Non-CDCR Jurisdiction	1,080	+4	+4			
Other State/Federal Institutions	305	0	-15			
Out of State Parole	720	-7	+6			
Out of State Parolee at Large	15	0	+1			
DJJ-W&IC 1731.5(c) Institutions	17	0	-11			
County Jail	23	+11				
D. Other Populations	7,246	+147	+848			
Temporary Release to Court and Hospital	1,720	+46	+197			
Escaped	199	0	0			
Parolee at Large	5,327	+101	+651			
Total CDCR Population	174,178	-670	-9,514			

This report contains the latest available reliable population figures from SOMS. They have been carefully audited, but are preliminary, and therefore subject to revision.

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
July 8, 2020

Weekly Report of Population
As of Midnight July 8, 2020

Weekly Institution Population Detail

Institutions	Felon/ Other	Design Capacity	Percent Occupied	Staffed Capacity
Male Institutions				
Avenal State Prison (ASP)	4,016	2,920	137.5	4,719
Calipatria State Prison (CAL)	3,097	2,308	134.2	3,451
California Correctional Center (CCC)	3,713	3,883	95.6	4,752
California Correctional Institution (CCI)	3,691	2,783	132.6	4,085
Centinela State Prison (CEN)	3,338	2,308	144.6	3,446
California Health Care Facility - Stockton (CHCF)	2,672	2,951	90.5	3,111
California Institution for Men (CIM)	2,928	2,976	98.4	4,350
California Men's Colony (CMC)	3,612	3,838	94.1	4,407
California Medical Facility (CMF)	2,331	2,361	98.7	2,981
California State Prison, Corcoran (COR)	3,563	3,116	114.3	4,476
California Rehabilitation Center (CRC)	3,066	2,491	123.1	3,262
Correctional Training Facility (CTF)	4,829	3,312	145.8	4,941
Chuckawalla Valley State Prison (CVSP)	2,190	1,738	126.0	2,578
Deuel Vocational Institution (DVI)	1,609	1,681	95.7	2,413
Folsom State Prison (FOL)	2,816	2,066	136.3	2,986
High Desert State Prison (HDSP)	3,555	2,324	153.0	3,461
Ironwood State Prison (ISP)	3,176	2,200	144.4	3,300
Kern Valley State Prison (KVSP)	3,681	2,448	150.4	3,622
California State Prison, Los Angeles County (LAC)	3,103	2,300	134.9	3,400
Mule Creek State Prison (MCSP)	3,979	3,284	121.2	4,207
North Kern State Prison (NKSP)	2,123	2,694	78.8	4,011
Pelican Bay State Prison (PBSP)	2,515	2,380	105.7	3,361
Pleasant Valley State Prison (PVSP)	3,165	2,308	137.1	3,535
RJ Donovan Correctional Facility (RJD)	3,792	2,992	126.7	4,038
California State Prison, Sacramento (SAC)	2,370	1,828	129.6	2,545
California Substance Abuse Treatment Facility (SATF)	4,808	3,424	140.4	5,111
Sierra Conservation Center (SCC)	4,085	3,836	106.5	4,570
California State Prison, Solano (SOL)	3,696	2,610	141.6	4,010
San Quentin State Prison (SQ)	3,392	3,082	110.1	4,357
Salinas Valley State Prison (SVSP)	2,888	2,452	117.8	3,509
Valley State Prison (VSP)	3,006	1,980	151.8	2,954
Wasco State Prison (WSP)	2,615	2,984	87.6	4,447
Male Total	**103,420**	**85,858**	**120.5**	**120,396**
Female Institutions				
Central California Women's Facility (CCWF)	2,494	2,004	124.5	2,988
California Institution for Women (CIW)	1,460	1,398	104.4	1,877
Folsom State Prison (FOL)	217	403	53.8	530
Female Total	**4,171**	**3,805**	**109.6**	**5,395**
Institution Total	**107,591**	**89,663**	**120.0**	**125,791**

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
July 8, 2020

Weekly Report of Population
As of Midnight July 8, 2020

Notes

- Felon/Other counts are felons, county contract boarders, federal boarders, state boarders, safekeepers, county diagnostic cases, Department of Mental Health boarders, and Division of Juvenile Justice boarders.
- Interstate Cooperative Cases are parolees from other states being supervised in California.
- Non-CDCR Jurisdiction are California cases being confined in or paroled to other states or jurisdictions.
- Welfare and Institution Code (W&IC) 1731.5(c) covers persons under the age of 21 who were committed to CDCR, had their sentence amended, and were incarcerated at the Division of Juvenile Justice for housing and program participation.
- Other Population includes inmates temporarily out-to-court, inmates in hospitals, escapees, and parolees at large.

Exhibit G

OCTOBER 16, 2019

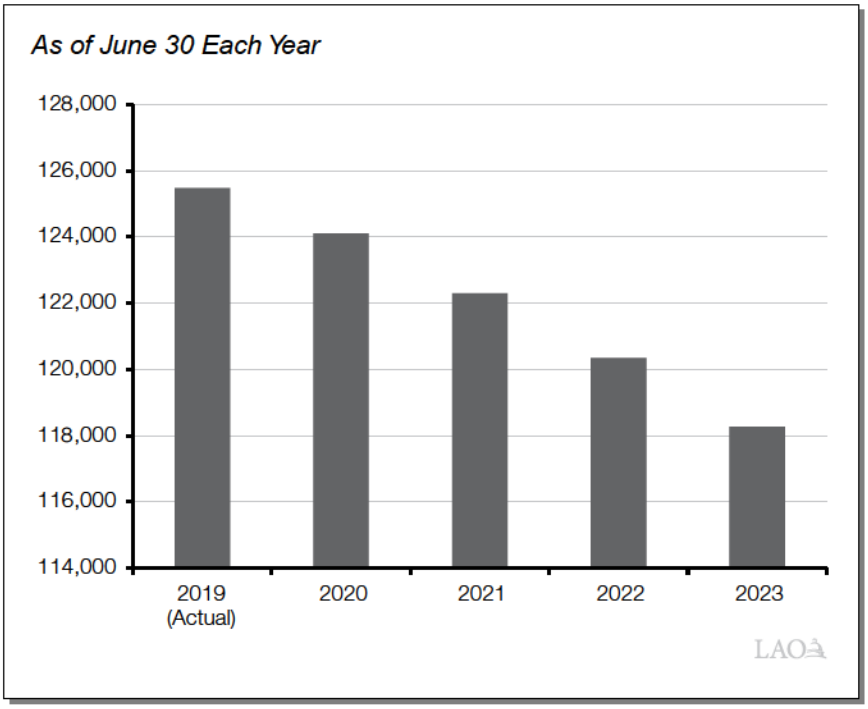
Planning for a Declining Inmate Population

PRESENTED TO: Assembly Budget Subcommittee No. 5 on Public Safety
Hon. Shirley N. Weber, Chair



LEGISLATIVE ANALYST'S OFFICE

State Inmate Population Projected to Decline



- The state's inmate population is projected to decline by 6,800 inmates over the next few years—from about 125,100 inmates as of October 9, 2019 to 118,300 as of June 30, 2023. We note, however, that there is considerable uncertainty regarding the specific magnitude.
- The decline is primarily due to Proposition 57 (2016), which made certain nonviolent offenders eligible for parole consideration and expanded the California Department of Correction and Rehabilitation's (CDCR's) authority to reduce prison terms through credits.
- The above population projections reflect adjustments that we made to the administration's most recent inmate population projections to account for the last nine months of actual data and the estimated effects of certain sentencing changes. One such change is Chapter 590 of 2019 (SB 136, Wiener), which eliminates a one year sentence enhancement for prior offenses in certain cases.

Court-Ordered Prison Population Cap

State Required to Limit Prison Overcrowding

- The state is under a federal court order to limit the population of its 34 state-owned prisons to about 117,000 inmates, based on their current capacity.
- To ensure the state does not exceed this cap, CDCR keeps the population in the state-owned prisons below the cap by a couple thousand inmates to "buffer" against unexpected increases in the population.

Inmates Housed Outside of State-Operated Prisons to Avoid Exceeding Population Cap

- CDCR is able to maintain compliance with the court order by housing inmates outside of the 34 state-owned prisons.
- As of October 9, 2019, CDCR housed about:
  - 1,400 male inmates and 270 female inmates in privately operated contract prisons.
  - 1,700 male inmates in publicly operated contract prisons.
  - 6,700 inmates in various other placements, such as state conservation camps.

Accommodating the Projected Decline in the Inmate Population

CDCR Required to Consider Various Criteria in Accommodating Population Declines

- As the inmate population declines, existing state law requires CDCR to first remove all male inmates housed in privately operated prisons.
- State law then authorizes CDCR to determine how to accommodate further population declines in the population, but specifies the various criteria that the department must use (such as cost and gender-specific housing needs).

Closing State-Operated Prisons Would Likely Allow for Greatest Savings

- After removing male inmates from privately operated prisons, we project that the state would need to accommodate a remaining reduction of 5,500 inmates by June 2023
- This decline could be accommodated in various ways. The three main ways are:
  - ***Closing State-Operated Prisons.*** The state could close both a small- and medium-sized prison yielding total operational savings of around a few hundred million dollars annually. In addition, this could also eliminate the need for costly infrastructure improvements that would otherwise have been made to these prisons.
  - ***Eliminating Remaining Contract Prison Beds.*** The state could remove the nearly 2,000 remaining inmates from contract prison beds (270 privately operated female beds and 1,700 publicly operated male beds). We note that, given the size of the population decline, the state could eliminate all such beds, as well as close a medium-sized prison. We estimate that such actions could yield total operational savings of a couple hundred million dollars annually.
  - ***Allowing Population of State-Operated Prisons to Decline Without Closures.*** We estimate that this approach could yield total operational savings in the several tens of millions of dollars annually.

Options to Accelerate Elimination of Contracts and/or Prison Closure

- To the extent that the state is interested in closing state-operated prisons or eliminating contract prison beds, it could take steps to accelerate the timing of such actions. Below, we discuss some of the options available to achieve this. The impacts of these options may vary significantly in their magnitude and timing and could be subject to implementation challenges.

Make Further Reductions to the Overall Inmate Population

- Require the Board of Parole Hearings to initiate release consideration for certain nonviolent offenders 60 days earlier than they do now to expedite releases, as we have previously recommended.
- Expand access to minimum custody placements, allowing some inmates to earn more credits, such as by admitting inmates with minor felony detainers, as we have previously recommended.
- Enact sentencing changes, such as expanding eligibility for the youth offender or elderly parole processes. For example, elderly inmates are generally considered for release if they have served more than 25 years in prison and reach 60 years old. Reducing the time served or age eligibility requirements could increase releases.
- Increase credit earning rates and recommend inmates to the courts for resentencing.

Increase the Number of Inmates in Placements Not Subject to the Population Limit

- Increase the conservation camp population by expanding inmate eligibility (such as by allowing inmates with minor felony detainers into camps) or providing greater participation incentives (such as better pay), as we have previously recommended.
- Allow more inmates to serve the last portion of their sentence outside of prison through the Alternative Custody Program, such as by admitting inmates with more than 12 months left to serve.

Options to Accelerate Elimination of Contracts and/or Prison Closure

(Continued)

Operate 34 Prisons With a Smaller Buffer

- CDCR could house more inmates in state-owned prisons by reducing the roughly 2,000 inmate buffer against the cap. For example, CDCR could shift 500 inmates from contract beds to state-owned prisons without exceeding the cap. However, the state may want to take additional actions to mitigate the increased risk of violating the court order.

Exhibit H

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA 94283-0001

September 30, 2009

Matthew A. Lopes, Jr., Esq.
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Way, Suite 301
Providence, RI 02908

Via: Debbie Vorous, Esq.
Jeff Steele, Esq.
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of August 2009 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History. **(Pending - to be posted next week)**
2. MHSDS Hiring Activity Report. **(Pending - to be posted next week)**
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The DMH Monthly Report of CDCR Patients in DMH Hospitals--Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report.
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.

16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison-San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,

DENNIS BEATY
Deputy Director, Program Services
Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Sharon Aungst, Chief Deputy Secretary, Correctional Health Care Services
Marion Chiurazzi, Psy.D, Deputy Director, Clinical Services, Statewide Mental Health Program, DCHCS
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Karen Higgins, M.D., Deputy Director (A), Psychiatry Services, DCHCS
Judy Burleson, Coleman Compliance Manager, DCHCS
Mary Neade, Correctional Counselor II, Division of Adult Institutions
Sharon Riegel, HPS II, DCHCS

Mental Health Population - Placement Per Institution

Grouped by: Ad-Seg, GP, RC, and SHU

DDPS Download Date: August 28, 2009

CONFIDENTIAL

SUMMARY

Mental Health Population - Combined Placement Per Institution

Institution	CCCMS			EOP			MHCB	Total MH Pop
	Capacity	Current Pop	% of Capacity	Capacity	Current Pop	% of Capacity	Capacity	
ASP	1099	1371	125%		16			1387
CAL		33			1			34
CCC		1						1
CCI	1349	1184	88%		58			1242
CCWF	899	1184	132%	54	55	102%	12	1239
CEN		27						27
CIM	999	1085	109%		189		34	1274
CIW	499	688	138%	85	109	128%	10	797
CMC	1099	1210	110%	634	539	85%	36	1749
CMF	599	620	104%	591	544	92%	70	1164
COR	949	1235	130%	204	202	99%	23	1437
CRC-M	848	1042	123%					1042
CTF	745	952	128%		8			960
CVSP		16			2			18
DVI	649	642	99%		55			697
FOL	599	751	125%		3			754
HDSP	699	909	130%		17		10	926
ISP		20			2			22
KVSP	1000	1221	122%	96	110	115%	12	1331
LAC	1149	1184	103%	354	411	116%	12	1595
MCSP	1149	1340	117%	546	525	96%	8	1865
NKSP	799	928	116%		73		10	1001
PBSP	349	347	99%	66	73	111%	10	420
PVSP	1499	1734	116%		6		6	1740
RJD	1199	1354	113%	393	414	105%	14	1768
SAC	849	827	97%	458	442	97%	24	1269
SATF	1199	1531	128%		15		20	1546
SCC	499	611	122%		16			627
SOL	1199	1490	124%		6		9	1496
SQ	899	1155	128%	36	124	344%		1279
SVSP	999	1099	110%	237	241	102%	10	1340
VSPW	849	1103	130%	9	24	267%		1127
WSP	1049	1180	112%		110		6	1290
TOTAL	**25718**	**30074**	**117%**	**3763**	**4390**	**117%**	**336**	**34464**

Group / Institution[1]	CCCMS Capacity	CCCMS Current Pop	CCCMS % of Capacity	EOP[2] Capacity	EOP Current Pop	EOP % of Capacity	MHCB Capacity	Total MH Pop	Comments
Administrative Segregation Unit (Ad-Seg, ASU)									
ASP Ad-Seg		38			1			**39**	
CAL Ad-Seg		5						**5**	
CCI Ad-Seg		86			10			**96**	
CCWF Ad-Seg		20			3			**23**	
CEN Ad-Seg		6						**6**	
CIW Ad-Seg		14		10	7	70%		**21**	*ASU-EOP Hub*
CMC Ad-Seg		46		54	49	91%		**95**	*ASU-EOP Hub*
CMF Ad-Seg		15		58	48	83%		**63**	*ASU-EOP Hub (currently accommodates own population)*
COR Ad-Seg		87		54	54	100%		**141**	*ASU-EOP Hub*
CTF Ad-Seg		39						**39**	
DVI Ad-Seg		46			14			**60**	
FOL Ad-Seg		44			1			**45**	
HDSP Ad-Seg		96			8			**104**	
ISP Ad-Seg		4						**4**	
KVSP Ad-Seg		88			5			**93**	
LAC Ad-Seg		179		54	63	117%		**242**	*ASU-EOP Hub*
MCSP Ad-Seg		59		36	26	72%		**85**	*ASU-EOP Hub*
PBSP Ad-Seg		55						**55**	
PVSP Ad-Seg		136			2			**138**	
RJD Ad-Seg		91		63	51	81%		**142**	*ASU-EOP Hub*
SAC Ad-Seg		70		74	62	84%		**132**	*ASU-EOP Hub*
SATF Ad-Seg		95			6			**101**	
SCC Ad-Seg		33			4			**37**	
SOL Ad-Seg		63						**63**	
SQ Ad-Seg		62		36	18	50%		**80**	*ASU-EOP Hub (currently accommodates own population)*
SVSP Ad-Seg		180		45	58	129%		**238**	*ASU-EOP Hub*
VSPW Ad-Seg		27		9	4	44%		**31**	*ASU-EOP Hub*
WSP Ad-Seg		32			20			**52**	
Group Total for Ad-Seg		**1,716**		**493**	**514**	**104%**		**2,230**	

Group / Institution[1]			CCCMS Capacity	CCCMS Current Pop	CCCMS % of Capacity	EOP[2] Capacity	EOP Current Pop	EOP % of Capacity	MHCB Capacity	Total MH Pop	Comments
General Population (GP)											
ASP	II		1,099	1,333	121%		15			**1,348**	
CAL	I,IV	+		28			1			**29**	
CCC	I,II,III			1						**1**	
CCI	I,II,III,IV	*	1,053	750	71%		11			**761**	
CCWF			745	994	133%	54	52	96%	12	**1,046**	
CEN	III			21						**21**	
CIM	I		366	478	131%		26		34	**504**	
CIW			367	523	143%	75	102	136%	10	**625**	
CMC	I,II,III		1,099	1,164	106%	580	490	84%	36	**1,654**	*Court ordered temporary MHCB cap of 36, beginning 8/2/06.*
CMF	I,II,III		599	605	101%	533	496	93%	70	**1,101**	*20 of the MHCBs are temporary (licensed as acute).*
COR	I,III,IV	+ *	499	702	141%	150	147	98%	23	**849**	
CRC-M	II		848	1,042	123%					**1,042**	
CTF	I,II		745	913	123%		8			**921**	
CVSP	I,II			16			2			**18**	
DVI	I,II		85	79	93%		6			**85**	
FOL	III		599	707	118%		2			**709**	
HDSP	I,III,IV	*	608	698	115%		4		10	**702**	
ISP	I,III			16			2			**18**	
KVSP	I,IV		1,000	1,133	113%	96	105	109%	12	**1,238**	*SNY EOP*
LAC	I,III,IV	+	1,000	740	74%	300	267	89%	12	**1,007**	
MCSP	I,II,III,IV	+	1,149	1,281	111%	510	499	98%	8	**1,780**	*SNY EOP*
NKSP	I,III		80	111	139%		1		10	**112**	
PBSP	I,IV	*	349	277	79%	66	73	111%	10	**350**	
PVSP	I,III		1,499	1,598	107%		4		6	**1,602**	
RJD	I,III		800	806	101%	330	285	86%	14	**1,091**	
SAC	I,IV	*	849	728	86%	384	380	99%	24	**1,108**	
SATF	II,III,IV	*	1,199	1,436	120%		9		20	**1,445**	
SCC	I,II,III		499	578	116%		12			**590**	
SOL	II,III		1,199	1,427	119%		6		9	**1,433**	
SQ	I,II		350	575	164%		65			**640**	
SVSP	I,IV	*	999	919	92%	192	183	95%	10	**1,102**	

Group / Institution[1]	CCCMS Capacity	CCCMS Current Pop	CCCMS % of Capacity	EOP[2] Capacity	EOP Current Pop	EOP % of Capacity	MHCB Capacity	Total MH Pop	Comments
VSPW	687	890	130%		5			**895**	
WSP I,III	105	69	66%				6	**69**	
Group Total for GP	**20,476**	**22,638**	**111%**	**3,270**	**3,258**	**100%**	**336**	**25,896**	
Reception Center (RC)									
CCI-RC	166	203	122%		29			**232**	
CCWF-RC	154	170	110%					**170**	
CIM-RC	633	607	96%		163			**770**	
CIW-RC	132	151	114%					**151**	
DVI-RC	564	517	92%		35			**552**	
HDSP-RC	91	115	126%		5			**120**	
LAC-RC	149	265	178%		81			**346**	
NKSP-RC	719	817	114%		72			**889**	
RJD-RC	399	457	115%		78			**535**	
SQ-RC	549	518	94%		41			**559**	
VSPW-RC	162	157	97%		13			**170**	
WSP-RC	944	1,079	114%		90			**1,169**	
Group Total for RC	**4,662**	**5,056**	**108%**		**607**			**5,663**	
Security Housing Unit (SHU)									
CCI-SHU	130	145	112%		8			**153**	
COR-SHU	450	446	99%		1			**447**	
PBSP SHU		15						**15**	
SAC SHU		29						**29**	
VSPW SHU		29			2			**31**	
Group Total for SHU	**580**	**664**	**114%**		**11**			**675**	

Group / Institution[1]	CCCMS Capacity	CCCMS Current Pop	CCCMS % of Capacity	EOP[2] Capacity	EOP[2] Current Pop	EOP[2] % of Capacity	MHCB Capacity	Total MH Pop	Comments
GRAND TOTALS	**25,718**	**30,074**	**116.9%**	**3,763**	**4,390**	**116.7%**	**336**	**34,464**	

	PSU[2] Capacity	PSU[2] Current Pop	PSU[2] % of Capacity
CIW	10	6	60.0%
PBSP	128	116	90.6%
SAC	256	230	89.8%
Total PSU	**394**	**352**	**89.3%**

	DMH Capacity	DMH Current Pop	DMH % of Capacity
ASH-ICF	256	170	66.4%
CSH-ICF	50	50	100.0%
CMF-APP[3]	162	127	78.4%
CMF-ICF	84	67	79.8%
CMF-ICF-H[4]	30	26	86.7%
SVPP-ICF-H	244	229	93.9%
Totals DMH	**826**	**669**	**81.0%**

GRAND TOTALS

(Without MHCB data)

Total MH Capacity	Total MH Population	Percent of Total MH
30,701	**35,485**	**115.6%**

Report Footnotes

(1) " + " is a 270 Design Facility. " * " is a 180 Design Facility.

(2) EOP, ASU-EOP, and PSU may not reflect actual program vacancies because beds can be held vacant for inmate-patients temporarily housed in MHCB and OHU.

(3) CMF-APP cap has been temporarily reduced from 166 to 162. There is a Suicide Proofing Project currently underway. This project began on 4/20/09 and is expected to continue through 2010. During this period, four beds will be down at a time.

(4) Pursuant to the 6/17/09 Coleman court order, 36 high custody ICF beds at CMF converted to APP beds. The CMF APP capacity increased by 36 as patient admissions began 8/21/09.

Exhibit I

DIVISION OF HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 588500
Elk Grove, California 95758

March 16, 2020

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes Devereaux & O'Gara LLC
Northwoods Office Park
1301 Atwood Avenue, Suite 215 N
Johnston, RI 02919

via: Elise Owens Thorn, Esquire
Deputy Attorney General
Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550

RE: *COLEMAN* MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the *Coleman* Monthly Report reflective of January, 2020, data (or as otherwise noted). The following is the list of enclosures:

1. California Department of Corrections and Rehabilitation (CDCR) Staffing Report.
   a. Mental Health Executive Summary.
   b. Mental Health Institution Vacancy by Classification.
   c. Mental Health Institution Vacancies Summary by Classification.
   d. Mental Health Month to Month Registry Usage.
   e. Mental Health Six-Month Vacancy Summary.
   f. Mental Health Program Institution Vacancies - Summary by Classification.
   g. Statewide Mental Health Program Compliance Summary Report.
   h. Enhanced Outpatient Program Administrative Segregation Unit (EOP ASU) Case Manager Positions and Vacancies.
   i. Mental Health Hiring Progress Report.
   j. Mental Health Statewide Hire Tracking Summary - Clinical Positions Only.
   k. Mental Health Telepsych Allocated and Filled Positions Report.
   l. Psychiatric Inpatient Program (PIP) Staffing Data.
   m. Department of State Hospitals (DSH) Staffing Data.

2. Reception Center Monthly Reports.
   a. Reception Center Mental Health Screening Report.
   b. Reception Center Transfer Timelines Report.

3. Continuous Length of Stay Counts for Mental Health Services Delivery Systems (MHSDS) ASU, Secured Housing Unit (SHU), and Psychiatric Services Unit (PSU) report.

4. EOP Inmates Waiting Transfers to PSU.

5. EOP ASU Hub Trends.

6. Population and Census Reports.
   a. Health Care Placement Oversight Program (HCPOP) Information Report, Summary of Mental Health Population by Institution and Level of Care (H-1).
   b. MHSDS Management Information Summary (MIS).
   c. Weekly EOP/Outpatient Psychiatric Program Report.

7. Mental Health Crisis Bed (MHCB) Reports.
   a. MHCB Referrals report.
   b. MHCB Stays report.
   c. MHCB Wait List.

8. DSH and Inpatient Program Referral Reports.
   a. Referrals for Transfer to Inpatient Programs Report.
   b. DSH Monthly Report of CDCR Patients in DSH Hospitals, Summary of PC 2684s Report.

9. Milestone Credits Report.

10. Work Assignments Report.

11. Out of Level Housing Report.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

EUREKA C. DAYE, Ph.D, MPH, MA, CCHP
Deputy Director (A), Statewide Mental Health Program
California Department of Corrections and Rehabilitation

Enclosures

cc: Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
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Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert

Mary Perrien, Ph.D., *Coleman* Expert
Henry A. Dlugacz, Esq., *Coleman* Expert
Patricia Williams, Esq., *Coleman* Monitor
Nicholas Weber, Esq, Office of Legal Affairs, CDCR
Melissa Bentz, Esq, Office of Legal Affairs, CDCR
Michael Bien, Esq., Rosen, Bien and Galvan
Donald Specter, Esq., Prison Law Office
Steve Fama, Esq., Prison Law Office
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Laura Ceballos, Ph.D., Mental Health Administrator, Inpatient Facilities and Quality Improvement, Statewide Mental Health Program, DHCS
Steven Cartwright, Psy.D. Chief Psychologist, Quality Management, Statewide Mental Health Program, DHCS
Teresa Owens, Health Program Specialist I, Quality Management, Statewide Mental Health Program, DHCS

MENTAL HEALTH SERVICES DELIVERY SYSTEM (MHSDS)
MANAGEMENT INFORMATION SUMMARY (MIS) REPORT
2/24/2020

Level of Care	Housing Program	MALES			FEMALES		
		Capacity	Census[1]	Awaiting Placement[2]	Capacity	Census[1]	Awaiting Placement[2]
Correctional Clinical Case Management System (CCCMS)		**27,000**	**25,119**		**2,250**	**2,088**	
CCCMS	Reception Center (RC)		2,309			244	
	General Population (GP)		20,933			1,719	
	Enhanced Outpatient Program (EOP)		90			0	
	Mental Health Crisis Bed (MHCB)		3			1	
	Psychiatric Inpatient Program (PIP)		0			0	
	Specialized Medical Beds Housing		539			20	
	Administrative Segregation Unit (ASU)		239			63	
	Condemned		130			16	
	Long Term Restricted Housing Unit (LTRH)	130	224			0	
	Non-Disciplinary Segregation (NDS)		0			0	
	Psychiatric Services Unit (PSU)		13			0	
	Security Housing Unit (SHU)		0			25	
	Short Term Restricted Housing Unit (STRH)	1,125	639			0	
Enhanced Outpatient Program (EOP)		**7,075**	**6,559**		**225**	**189**	
EOP	Reception Center (RC)		162			1	
	General Population (GP)		60			48	
	Enhanced Outpatient Program (EOP)	6,318	5,524		195	119	
	Mental Health Crisis Bed (MHCB)		7			1	
	Psychiatric Inpatient Program (PIP)		21			0	
	Specialized Medical Beds Housing		178			3	
	Administrative Segregation Unit (ASU)	585	390	34	20	14	0
	Condemned		59			0	
	Long Term Restricted Housing Unit (LTRH)		0			0	
	Non-Disciplinary Segregation (NDS)		0			0	
	Psychiatric Services Unit (PSU)	172	126	10	10	3	0
	Security Housing Unit (SHU)		0			0	
	Short Term Restricted Housing Unit (STRH)		32			0	

Level of Care	Capacity	Census[1]	Awaiting Placement[2]	Capacity	Census[1]	Awaiting Placement[2]
Mental Health Crisis Bed (MHCB)	**407**	**323**	**12**	**41**	**31**	**3**
Psychiatric Inpatient Programs: Intermediate Care Facility (ICF)	**1,131**	**1,062**	**103**			
Low Custody	390	360	32			
Atascadero State Hospital (ASH)	256	237	22			
Coalinga State Hospital (CSH)	50	48	2			
California Medical Facility (CMF)	84	75	8			
High Custody	741	702	71			
California Health Care Facility (CHCF)	331	322	21			
CMF Single Cells	94	90	22			
CMF Multi Cells	70	52	8			
SVPP Single Cells	202	195	17			
Salinas Valley Psychiatric Program (SVPP) Multi Cells	44	43	3			
Acute Psychiatric Program (APP)	**421**	**388**	**36**			
ASH	0	0	0			
CHCF	203	193	17			
CMF	218	195	19			
Psychiatric Inpatient Program (PIP)	**40**	**29**	**1**	**75**	**48**	**5**
California Institution for Women (CIW)				45	35	3
Patton State Hospital (PSH)				30	13	2
SQ	30	27	1			
SQ (Non-condemned)[6]	10	2	0			
Penal Code 2974s (Parolees)[5]		**2**				
Metro State Hospital (MSH)		0				
Napa State Hospital (NSH)		2				
Patton State Hospital (PSH)		0				
TOTALS (excluding Parolees)	**36,074**	**33,480**	**196**	**2,591**	**2,356**	**8**

	Total Capacity	Total Census[1]	Total Awaiting Placement[2]	Total Over Timeframes[3]	CENSUS PERCENTAGES % MHSDS	% CDCR[4]
CCCMS	29,250	27,207			75.92%	22.07%
EOP	6,513	6,183			17.25%	5.02%
EOP-ASU/NDS/STRH	605	436	34	6	1.22%	0.35%
EOP-PSU/LTRH/SHU	182	129	10	0	0.36%	0.10%
MHCB	448	354	15	0	0.99%	0.29%
PSYCHIATRIC INPATIENT	1,667	1,527	145	3	4.26%	1.24%
GRAND TOTAL	**38,665**	**35,836**	**204**	**9**	**100.00%**	**29.07%**

[1] Census sources: HCODS for CCCMS, EOP; HEART for MHCB; RIPA reports for ICF, APP, and PIP programs.

[2] Awaiting Placement = The sum of inmates waiting to be placed in a bed at a specific level of care. Those awaiting placement to ICF, APP, and PIP include referrals that have been custodially reviewed by HCPOP and are awaiting bed availability, inpatient program acceptance, or transfer to the inpatient program as of the reporting date (based on the Referrals to Inpatient Programs Application (RIPA)).

[3] Total Over Timeframes = The number of referrals that are beyond Mental Health Program Guide transfer timeframes: EOP-ASU includes cases in non-hubs waiting > 30 days, PSU includes cases with an original CSR endorsement date > 60 days, MHCB includes referrals > 24 hours, Psychiatric Inpatient includes Intermediate referrals > 30 days and Acute referrals > 10 days.

[4] CDCR pop as of 2/19/20 (OISB). Based on Total In-State Institution Population and Out of State (COCF).

[5] Census numbers are tracked and updated by Department of State Hospital (DSH).

[6] SQ for non-condemned has two MHCB placements.

Exhibit J

MENTAL HEALTH SERVICES DELIVERY SYSTEM (MHSDS)
MANAGEMENT INFORMATION SUMMARY (MIS) REPORT
7/6/2020

Level of Care	Housing Program	MALES Capacity	MALES Census[1]	MALES Awaiting Placement[2]	FEMALES Capacity	FEMALES Census[1]	FEMALES Awaiting Placement[2]
Correctional Clinical Case Management System (CCCMS)		**27,000**	**23,189**		**2,250**	**1,903**	
CCCMS	Reception Center (RC)		1,183			120	
	General Population (GP)		20,056			1,655	
	Enhanced Outpatient Program (EOP)		99			0	
	Mental Health Crisis Bed (MHCB)		5			0	
	Psychiatric Inpatient Program (PIP)		2			0	
	Specialized Medical Beds Housing		562			29	
	Administrative Segregation Unit (ASU)		419			70	
	Condemned		142			14	
	Long Term Restricted Housing Unit (LTRH)[6]	270	157			0	
	Non-Disciplinary Segregation (NDS)		1			0	
	Psychiatric Services Unit (PSU)		5			0	
	Security Housing Unit (SHU)		0			15	
	Short Term Restricted Housing Unit (STRH)[6]	1,125	558			0	
Enhanced Outpatient Program (EOP)		**7,075**	**6,472**		**225**	**164**	
EOP	Reception Center (RC)		76			1	
	General Population (GP)		149			36	
	Enhanced Outpatient Program (EOP)	6,318	5,316		195	112	
	Mental Health Crisis Bed (MHCB)		20			0	
	Psychiatric Inpatient Program (PIP)		24			0	
	Specialized Medical Beds Housing		192			1	
	Administrative Segregation Unit (ASU)	585	439	113	20	11	0
	Condemned		62			0	
	Long Term Restricted Housing Unit (LTRH)		0			0	
	Non-Disciplinary Segregation (NDS)		0			0	
	Psychiatric Services Unit (PSU)	172	115	59	10	3	1
	Security Housing Unit (SHU)		0			0	
	Short Term Restricted Housing Unit (STRH)		79			0	

Level of Care	Capacity	Census[1, 7]	Awaiting Placement[2]	Capacity	Census[1, 7]	Awaiting Placement[2]
Mental Health Crisis Bed (MHCB)[7]	**424**	**262**	**3**	**41**	**14**	**0**
Psychiatric Inpatient Programs: Intermediate Care Facility (ICF)	**1,165**	**1,037**	**56**			
Low Custody	390	335	9			
Atascadero State Hospital (ASH)	256	224	9			
Coalinga State Hospital (CSH)	50	46	0			
California Medical Facility (CMF)	84	65	0			
High Custody	775	702	47			
California Health Care Facility (CHCF)	356	350	15			
CMF Single Cells	105	103	6			
CMF Multi Cells	68	45	1			
SVPP Single Cells	202	168	20			
Salinas Valley Psychiatric Program (SVPP) Multi Cells	44	36	5			
Acute Psychiatric Program (APP)	**368**	**290**	**22**			
ASH	0	0	0			
CHCF	161	100	18			
CMF	207	190	4			
Psychiatric Inpatient Program (PIP)	**40**	**30**	**0**	**75**	**39**	**0**
California Institution for Women (CIW)				45	29	0
Patton State Hospital (PSH)				30	10	0
SQ	30	23	0			
SQ (Non-condemned)	10	7	0			
Penal Code 2974s (Parolees)[5]		**2**				
Metro State Hospital (MSH)		0				
Napa State Hospital (NSH)		2				
Patton State Hospital (PSH)		0				
TOTALS (excluding Parolees)	**36,072**	**31,280**	**253**	**2,591**	**2,120**	**1**

	Total Capacity	Total Census[1]	Total Awaiting Placement[2]	Total Over Timeframes[3]	CENSUS PERCENTAGES % MHSDS	% CDCR[4]
CCCMS	29,250	25,092			75.13%	22.15%
EOP	6,513	5,989			17.93%	5.29%
EOP-ASU/NDS/STRH	605	529	113	72	1.58%	0.47%
EOP-PSU/LTRH/SHU	182	118	60	25	0.35%	0.10%
MHCB	465	276	3	1	0.83%	0.24%
PSYCHIATRIC INPATIENT	1,648	1,396	78	35	4.18%	1.23%
GRAND TOTAL	**38,663**	**33,400**	**254**	**133**	**100.00%**	**29.48%**

[1] Census sources: HCODS for CCCMS, EOP; HEART for MHCB; RIPA reports for ICF, APP, and PIP programs.

[2] Awaiting Placement = The sum of inmates waiting to be placed in a bed at a specific level of care. Those awaiting placement to ICF, APP, and PIP include referrals that have been custodially reviewed by HCPOP and are awaiting bed availability, inpatient program acceptance, or transfer to the inpatient program as of the reporting date (based on the Referrals to Inpatient Programs Application (RIPA)).

[3] Total Over Timeframes = The number of referrals that are beyond Mental Health Program Guide transfer timeframes: EOP-ASU includes cases in non-hubs waiting > 30 days, PSU includes cases with an original CSR endorsement date > 60 days, MHCB includes referrals > 24 hours, Psychiatric Inpatient includes Intermediate referrals > 30 days and Acute referrals > 10 days.

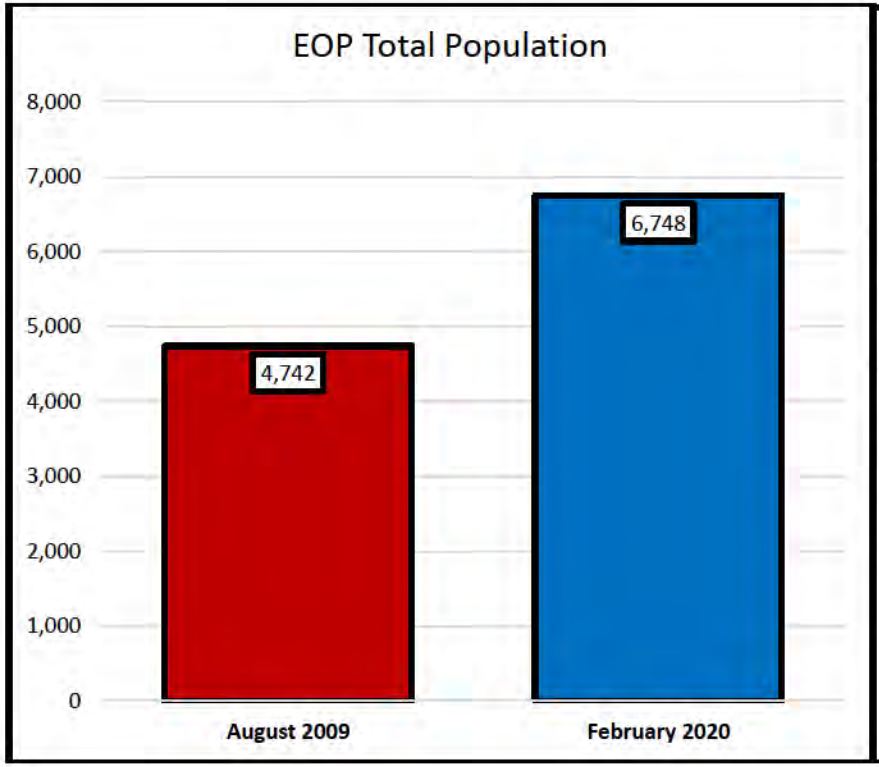
[4] CDCR pop as of 7/1/20 (OISB). Based on Total In-State Institution Population and Out of State (COCF).

[5] Census numbers are tracked and updated by Department of State Hospital (DSH).

[6] LTRH and STRH capacity numbers obtained from the PMU Weekly Population Summary Report dated March 6, 2020.

[7] In response to CDCR COVID-19 Guidelines some patients may be housed outside of their level of care and/or in a Temporary Mental Health Unit.

Exhibit K


EOP Total Population
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
4,742
6,748
August 2009
February 2020

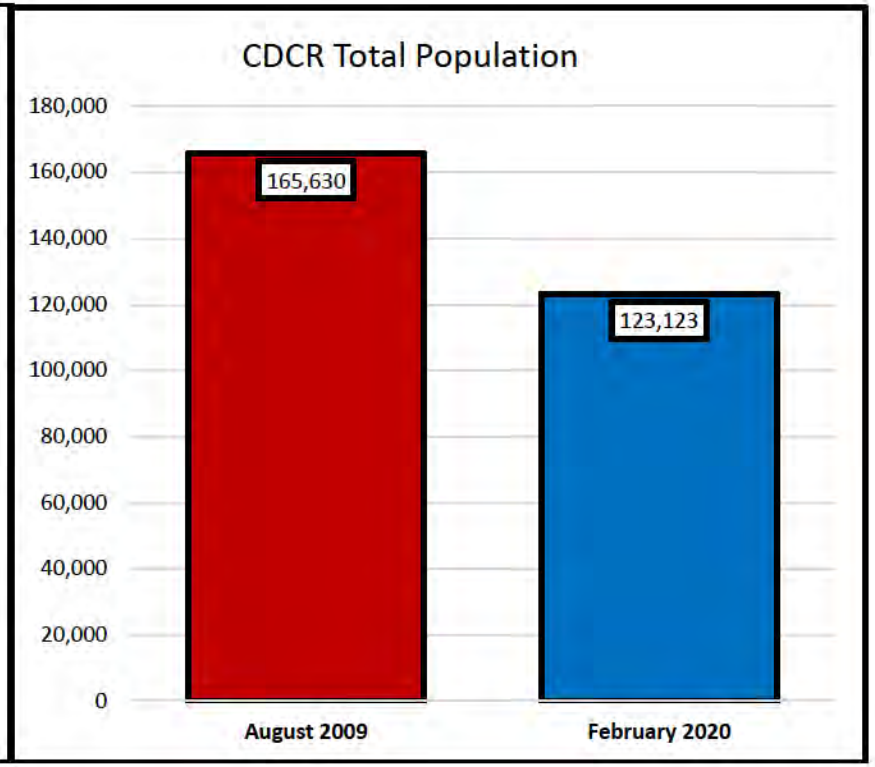

CDCR Total Population
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
165,630
123,123
August 2009
February 2020

Exhibit M

California State Auditor

August 2017



California Department of Corrections and Rehabilitation

It Must Increase Its Efforts to Prevent and Respond to Inmate Suicides

Report 2016-131



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California State Auditor

Elaine M. Howle State Auditor
Doug Cordiner Chief Deputy

August 17, 2017 2016-131

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning the California Department of Corrections and Rehabilitation's (Corrections) policies, procedures, and practices for suicide prevention and reduction, with a particular emphasis on the recently elevated suicide rate at the California Institution for Women. Although female inmates account for about 4 percent of Corrections' total inmate population, they accounted for 11 percent of inmate suicides from 2014 through 2016. This report concludes that Corrections should provide increased oversight and leadership to ensure that prisons follow its policies related to suicide prevention and response.

We identified significant weaknesses in prisons' suicide prevention and response practices at the four prisons we reviewed. Specifically, we found that the prisons failed to complete some required evaluations to assess inmates' risk for suicide and those that the prisons did complete were often inadequate. The inadequacies included leaving sections of the risk evaluations blank, failing to appropriately justify the determinations of risk, failing to develop adequate plans for treatment to reduce the inmates' risk, and relying on inconsistent information about inmates to determine risk. Also, the prisons we reviewed did not properly monitor inmates who were at risk of committing suicide. For example, we found that staff were not staggering behavior checks or conducting checks in the required 15-minute intervals. Finally, we found that some staff members at the prisons we visited had not completed required trainings related to suicide prevention and response. These conditions may have contributed to elevated suicide and attempted suicide rates at California prisons.

Corrections also lacks assurance that prisons are implementing its policies to address serious issues. For many years, a court-appointed special master, working with Corrections to address inmate mental health care, identified many of the same issues we discuss in this report. In 2013 Corrections began developing an audit process to review prisons' compliance with its policies and procedures, including those it issued in response to the special master's reports; however, that process is still in development. In addition, Corrections could provide additional leadership to prisons regarding the communication of best practices related to suicide prevention efforts. Finally, Corrections' policies require it to complete a thorough review of a prison's compliance with policies and procedures following an inmate's suicide, but Corrections does not complete such reviews for suicide attempts. This hinders Corrections' ability to identify problems with a prison's compliance with crucial policies and procedures until after an inmate dies.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

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Selected Abbreviations Used in This Report

CCWF	Central California Women's Facility
CIW	California Institution for Women
Corrections	California Department of Corrections and Rehabilitation
health care division	Corrections' Division of Health Care Services
RJD	Richard J. Donovan Correctional Facility
SAC	California State Prison, Sacramento
VSPW	Valley State Prison for Women

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Summary

Results in Brief

Despite the fact that the rates of inmate suicide in California's prisons has been higher on average than those of all U.S. state prisons for several years, the California Department of Corrections and Rehabilitation (Corrections) has failed to provide the leadership and oversight necessary to ensure that its prisons follow its policies related to inmate suicide prevention and response. Corrections is responsible for providing mental health services to its inmates who are unable to function within the usual correctional environment because of mental illness. However, from 2005 through 2013, the average suicide rate in Corrections' prisons was 22 per 100,000 inmates—substantially higher than the average rate of 15.66 per 100,000 in U.S. state prisons during the same period. Further, in recent years, the rates of female inmates who committed suicide while in Corrections' prisons have soared: from 2014 through 2016, female inmates made up only about 4 percent of Corrections' total inmate population, yet they accounted for about 11 percent of its inmate suicides. These statistics, combined with the significant deficiencies we identified when we reviewed suicide prevention and response practices at four prisons, raise questions regarding Corrections' leadership on this critical issue.

When we reviewed the California Institution for Women (CIW); California State Prison, Sacramento (SAC); Central California Women's Facility (CCWF); and Richard J. Donovan Correctional Facility (RJD), one area in which we identified significant weaknesses was the four prisons' evaluations of inmates' suicide risk. Specifically, for various reasons, including when inmates attempt suicide, express suicidal thoughts, or engage in self-harm, Corrections' policy requires that prison mental health staff (mental health staff) complete suicide risk evaluations (risk evaluations) to assess an inmate's risk for suicide. These risk evaluations are critical to successful suicide prevention because they help mental health staff identify inmates who are likely to attempt suicide and the treatments needed to prevent them from doing so. Nonetheless, over the past several years, court-appointed mental health experts have repeatedly notified Corrections of problems related to its risk evaluations. Further, when we examined risk evaluations for the 36 of 40 inmates we reviewed who required them, we found that the prisons failed to complete at least one required risk evaluation for 10 of the inmates and completed inadequate risk evaluations for 26 of the inmates. The inadequacies we noted included leaving sections of the risk evaluations blank, failing to appropriately justify the determinations of risk, failing to develop adequate plans for treatment to reduce the inmates' risk, and relying on inconsistent or incomplete information about the inmates to determine risk.

Audit Highlights . . .

Our audit of Corrections' policies and practices for inmate suicide prevention and response highlight the following:

- *The average suicide rate in Corrections' prisons was substantially higher than the average of U.S. state prisons.*
- *The rates of female inmates who committed suicide while in Corrections' prisons have soared in recent years.*
- *We found significant weaknesses in compliance with suicide prevention and response policies when we reviewed 40 files on inmates who committed or attempted suicide at four prisons.*
  - *Prisons failed to complete or completed inadequate risk evaluations for many of those inmates who required them.*
  - *Prisons did not complete or created inadequate treatment plans for some inmates—plans did not always specify medication dosage and frequency, treatment methods, provider information, or follow-up upon discharge.*
  - *Prisons did not properly monitor inmates who were at risk of committing suicide.*
- *Although Corrections has known about many of the issues related to suicide prevention and response policies and practices that we found for a number of years, it has not fully implemented processes to address the issues that have been raised.*
- *Corrections could take a more proactive leadership role in identifying programs or best practices and reviewing a prison's practices following an inmate's suicide attempt.*

In 2013 Corrections established a risk evaluation training, as well as a mentoring program to assess, every two years, whether mental health staff adequately completed risk evaluations and to provide training as needed. Corrections enhanced the mentoring program in 2016 by requiring prisons to audit mental health staff's risk evaluations twice each year and to have these staff undergo mentoring if they failed the audit; however, the results of our review demonstrate that this program has not resolved the problems. The failure may be due in part to Corrections allowing mental health staff to improperly complete significant sections of the risk evaluations and still pass Corrections' audit. According to Corrections' clinical support chief, Corrections does not expect perfection from its mental health staff. She also stated that despite their training, some mental health staff still do not know how to complete risk evaluations, and that others may rush when completing them because of their heavy workloads. Although Corrections has taken some steps to address these issues, the fact that the problems with the risk evaluations have continued shows that Corrections must increase its oversight.

Similarly, the prisons we reviewed failed to complete required treatment plans for some inmates and created inadequate treatment plans for others. Treatment plans are crucial to suicide prevention: based on the inmates' needs, they set goals for the inmates' treatment and determine the specific treatment methods mental health staff will use. State regulations and Corrections' policy require that prisons complete a plan for initial treatment (initial treatment plan) within 24 hours of an inmate's admission to a mental health crisis bed (crisis bed) and a more comprehensive plan within 72 hours of admission (72-hour treatment plan). Initial treatment plans are important because they prescribe treatment for the first few days of an inmate's crisis-bed stay. Nonetheless, when we reviewed the files of 26 inmates who required them, we found that CIW, CCWF, and RJD did not complete initial treatment plans for some inmates. Further, 25 inmates also required 72-hour treatment plans, but one prison did not complete such plans for two inmates. Finally, all 23 of the remaining 72-hour treatment plans we reviewed failed to meet the requirements outlined in state regulations. The most common problems we identified were that the plans did not specify medication dosage and frequency, treatment methods, the providers responsible for the treatments, or the follow-up treatments for the inmates who were discharged.

The four prisons also did not properly monitor inmates who were at risk of committing suicide. Corrections' policies require prisons to conduct staggered behavior checks at intervals not to exceed every 15 minutes of inmates who are at high risk of self-injury but not in immediate danger. However, when we reviewed records for 25 such inmates, we found that the prisons exceeded 15-minute

intervals for checks on 17 inmates, did not stagger checks for 19 inmates, and appeared to have prefilled or preprinted the forms documenting checks for eight inmates. Corrections said that a new electronic health record system that it is currently implementing systemwide will reduce some of these issues, as will a planned audit process that will include automated monitoring of these checks. Nevertheless, we still found problems with staff not staggering checks or conducting checks that exceeded intervals of 15 minutes at two prisons that implemented the new system, bringing into question whether it will fully resolve the problems we identified.

Taken as a whole, the types of compliance issues we identified at the four prisons we reviewed may have contributed to Corrections' continuing high suicide rates relative to those of prison systems in other states. In addition, a number of specific factors may have contributed to elevated suicide and suicide attempt rates among Corrections' female inmates. As we mention previously, the rate of suicide among female inmates has increased dramatically since 2014. This increase is especially pronounced at CIW, where six of the seven suicides by female inmates from 2014 through 2016 occurred. Officials at Corrections and CIW identified a number of reasons why the suicide rate at CIW may have increased during this period, including domestic violence in interpersonal relationships, drug involvement, and drug trafficking. Officials at CIW further cited a change in prison culture resulting from the conversion of Valley State Prison for Women to a men's institution and the subsequent transfer of high-security-level inmates to CIW.

In addition, we found that some staff members at CIW and the other prisons we visited had not completed required trainings related to suicide prevention and response. Corrections' policies require prison staff to participate in specific trainings on issues such as preventing suicide, assessing inmates' suicide risk, and developing treatment plans. However, when we reviewed records for 20 staff members at CIW, we found that the prison could not provide evidence that the staff members attended all required trainings. For example, the prison could not demonstrate that four of the 20 staff members attended annual required suicide prevention training in 2016. Further, Corrections' officials reported that not all staff members at the other three prisons received required trainings in 2016. Corrections' clinical support chief was unable to explain why these staff members had not participated in trainings as required. Instead, she stated that Corrections relies on the prisons' in-service training units to address clinical training noncompliance issues.

The ongoing nature of many of the problems we identified at the four prisons we reviewed is particularly troubling. A court-appointed special master has overseen many aspects of Corrections' provision

of mental health care since 1995. Since at least 1999, the special master has identified many of the same problems we found in our audit. In January 2015, the special master filed a report that was an audit of suicide prevention practices in each of the 35 prisons, which contained 32 recommendations. Corrections responded to the majority of these recommendations through the adoption of new policies, improvements to its facilities, changes to its trainings, and other actions. However, Corrections has not yet fully ensured prisons' compliance with changes resulting from the recommendations. According to Corrections, it began developing an audit process in 2013 to audit prisons' compliance with policies and procedures, but it has not yet completed that process nearly five years later, explaining that it continues to work on finalizing it with the special master. Absent such monitoring, Corrections lacks assurance that the prisons are addressing the serious problems the special master has identified.

Further, Corrections could take a more proactive leadership role in identifying programs and best practices that may help in preventing inmate suicide. For example, we identified best practices at one of the prisons we visited that we believe could benefit certain inmates at other prisons. Although Corrections recently conducted a suicide prevention summit with the chiefs of mental health and other prison leadership, at which it discussed best practices related to prisons' suicide prevention efforts, its documentation and dissemination of innovative programs and best practices related to suicide prevention has generally been limited. Similarly, Corrections has not conducted thorough reviews of the circumstances surrounding suicide attempts. Pursuant to its policies, the death of an inmate by suicide initiates an intensive review process in which Corrections identifies any problems with the prison's compliance with policies and procedures. It then issues a report containing recommendations to address those problems. However, Corrections requires no such review for suicide attempts. Corrections' clinical support chief explained that Corrections plans to implement a process for each prison to review a selection of its incidents of inmate self-harm; however, we question whether such reviews will be sufficiently impartial and critical. Without a thorough and unbiased review of the factors contributing to inmate suicide attempts, Corrections is hindered in its ability to identify potential problems with a prison's suicide prevention and response practices until after an inmate dies.

Selected Recommendations

Legislature

To provide additional accountability for Corrections' efforts to respond to and prevent inmate suicides and attempted suicides, the Legislature should require that Corrections report to it in April 2018 and annually thereafter on the following issues:

- Its progress toward meeting its goals related to the completion of suicide risk evaluations in a sufficient manner.
- Its progress toward meeting its goals related to the completion of 72-hour treatment plans in a sufficient manner.
- The status of its efforts to ensure that all staff receive training related to suicide prevention and response.
- Its progress in implementing the recommendations made by the special master regarding inmate suicides and attempts. Corrections should also include in its report to the Legislature the results of any audits it conducts as part of its planned audit process to measure the success of changes it implements as a result of these recommendations.
- Its progress in identifying and implementing mental health programs at the prisons that may ameliorate risk factors associated with suicide.

Corrections

Corrections should immediately require mental health staff to score 100 percent on risk evaluation audits in order to pass. If a staff member does not pass, Corrections should require the prison to follow its current policies by reviewing additional risk evaluations to determine whether the staff member needs to undergo additional mentoring.

To ensure that prison staff conduct required checks of inmates on suicide precaution in a timely manner, Corrections should implement its automated process to monitor these checks in its electronic health record system by October 2017.

To address the unique circumstances that may increase its female inmates' rates of suicide and suicide attempts, Corrections should continue to explore programs that could address the suicide risk factors for female inmates.

To ensure that all prison staff receive required training related to suicide prevention and response, Corrections should immediately implement a process for identifying prisons where staff are not attending required trainings and for working with the prisons to solve the issues preventing attendance.

To ensure that prisons comply with its policies related to suicide prevention and response, Corrections should continue to develop its audit process and implement it at all prisons by February 2018. The process should include, but not be limited to, audits of the quality of prisons' risk evaluations and treatment plans.

To ensure that all its prisons provide inmates with effective mental health care, Corrections should continue to take a role in coordinating and disseminating best practices related to mental health treatment by conducting a best practices summit at least annually. The summits should focus on all aspects of suicide prevention and response, including programs that seek to improve inmate mental health and treatment of and response to suicide attempts. Corrections should document and disseminate this information among the prisons, assist prisons in implementing the best practices through training and communication when needed, and monitor and report publicly on the successes and challenges of adopted practices.

In an effort to prevent future inmate suicide attempts, Corrections should implement its plan to review attempts with the same level of scrutiny that it uses during its suicide reviews. Corrections should require each prison to identify for review at least one suicide attempt per year that occurred at that prison. To ensure that the reviews include critical and unbiased feedback, Corrections should either conduct these reviews itself or require the prisons to review each other. These reviews should start in September 2017 and follow the same timelines as the suicide reviews, with the timeline beginning once the team identifies a suicide attempt for review.

Agency Comments

Corrections stated it would address the specific recommendations in a corrective action plan within the timelines outlined in the report. We look forward to Corrections' 60-day response to our recommendations.

Introduction

Background

The California Department of Corrections and Rehabilitation (Corrections) is responsible for protecting the public by safely and securely supervising adult and juvenile offenders, providing effective rehabilitation and treatment, and integrating offenders successfully into the community. It operates two adult women's prisons and 33 adult men's prisons across the State.[1] According to a report Corrections issued in 2017, 123,540 male inmates and 5,876 female inmates were incarcerated within its facilities as of December 31, 2016. Figure 1 on the following page shows the locations of Corrections' prisons and highlights the four prisons we selected for review during the course of our audit work.

Corrections is responsible for the provision of mental health care to all of its inmates, including receiving, evaluating, housing, treating, and referring those inmates who are unable to appropriately function within the constraints of the usual correctional environment because of mental illnesses. Its Division of Health Care Services (health care division) provides mental health services through its Mental Health Services Delivery System (mental health system), the mission of which is "to provide inmates with an appropriate level of treatment and to promote individual functioning within the clinically least restrictive environment consistent with the safety and security needs of both [the inmates and prisons]." Corrections employs numerous individuals, such as psychiatrists, psychologists, social workers, and nurses, to provide mental health services to inmates (mental health staff). Prison staff may refer inmates to the prison's mental health program, or inmates may submit requests for services to the prison's mental health staff for their approval.

Despite the mental health services that Corrections provides, the rate at which its inmates commit suicide has generally been higher than the rates in most other states. Table 1 on page 9 shows the number of attempted suicides and suicides from 2012 through 2016 at the four prisons we reviewed, and Appendix A presents these data for all the State's prisons. According to a 2016 report by a mental health expert appointed by a U.S. district court, the average suicide rate in Corrections was 22 per 100,000 inmates from 2005 through 2013, significantly higher than the average rate of 15.66 per 100,000 inmates in U.S. state prisons during the same period. Although Corrections' 2014 inmate suicide rate of 16.97 per 100,000 inmates was lower than the 2014 rate of 20 per 100,000 inmates for all U.S. state prisons, Corrections' inmate suicide rates have been higher on average than those of U.S. state prisons since 1999.

[1] Corrections houses women within other facilities, including some medical facilities and a small facility at Folsom State Prison. In addition, Valley State Prison housed women before Corrections converted it to a men's facility in 2013.

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Figure 1
Map of Adult Correctional Institutions and the Four Prisons We Visited



Source: Corrections.

The suicide rate of Corrections' male inmates remained relatively static from 2012 through 2016; however, the suicide rate of its female inmates increased. In 2012 female inmates accounted for about 5 percent of Corrections' inmate population and for 4 percent of its suicides. However, although female inmates made up about 4 percent of Corrections' inmate population from 2014 through 2016, they accounted for about 11 percent of the suicides. Almost all of the suicides during this period occurred at the California Institution for Women (CIW). In fact, concern about CIW's high suicide rate was the impetus for this audit.

Table 1
Suicides and Suicide Attempts at the Four Prisons We Visited, From 2012 Through 2016

	WOMEN'S PRISONS		MEN'S PRISONS	
	CENTRAL CALIFORNIA WOMEN'S FACILITY (CCWF)	CIW	RICHARD J. DONOVAN CORRECTIONAL FACILITY (RJD)	CALIFORNIA STATE PRISON, SACRAMENTO (SAC)
2012				
Population*	2,931	1,642	3,539	2,698
Suicides	0	1	0	1
Attempts	5	13	28	22
2013				
Population*	3,531	2,082	3,364	2,246
Suicides†	0	1	3	1
Attempts	8	15	33	32
2014				
Population*	3,648	2,005	3,070	2,218
Suicides	0	2	1	2
Attempts	6	15	22	11
2015				
Population*	3,002	1,882	3,096	2,237
Suicides†	0	2	2	3
Attempts	11	34	51	12
2016				
Population*	2,865	1,863	3,094	2,327
Suicides†	1	2	0	3
Attempts	25	24	59	8
Totals				
Population*	**3,195**	**1,895**	**3,233**	**2,345**
Suicides†	**1**	**8**	**6**	**10**
Attempts	**55**	**101**	**193**	**85**

Sources: California State Auditor's analysis of Corrections' COMPSTAT metrics from 2012 through 2016, and the average daily population for each prison as reported by Corrections.

* *Population* is based on Corrections' average daily population. The total represents the average of the five years' populations.

† The numbers we present here reflect our amendments to Corrections' COMPSTAT data. As we discuss in Chapter 3, our review of various records from individual prisons revealed that COMPSTAT has consistently underreported the number of suicides in California prisons. We have therefore adjusted the number of suicides in 2013, 2015, and 2016 to include three suicides that we identified at CIW, RJD, and SAC; however, we caution that these numbers may still not be accurate.

Court-Ordered Oversight of Corrections' Mental Health Services

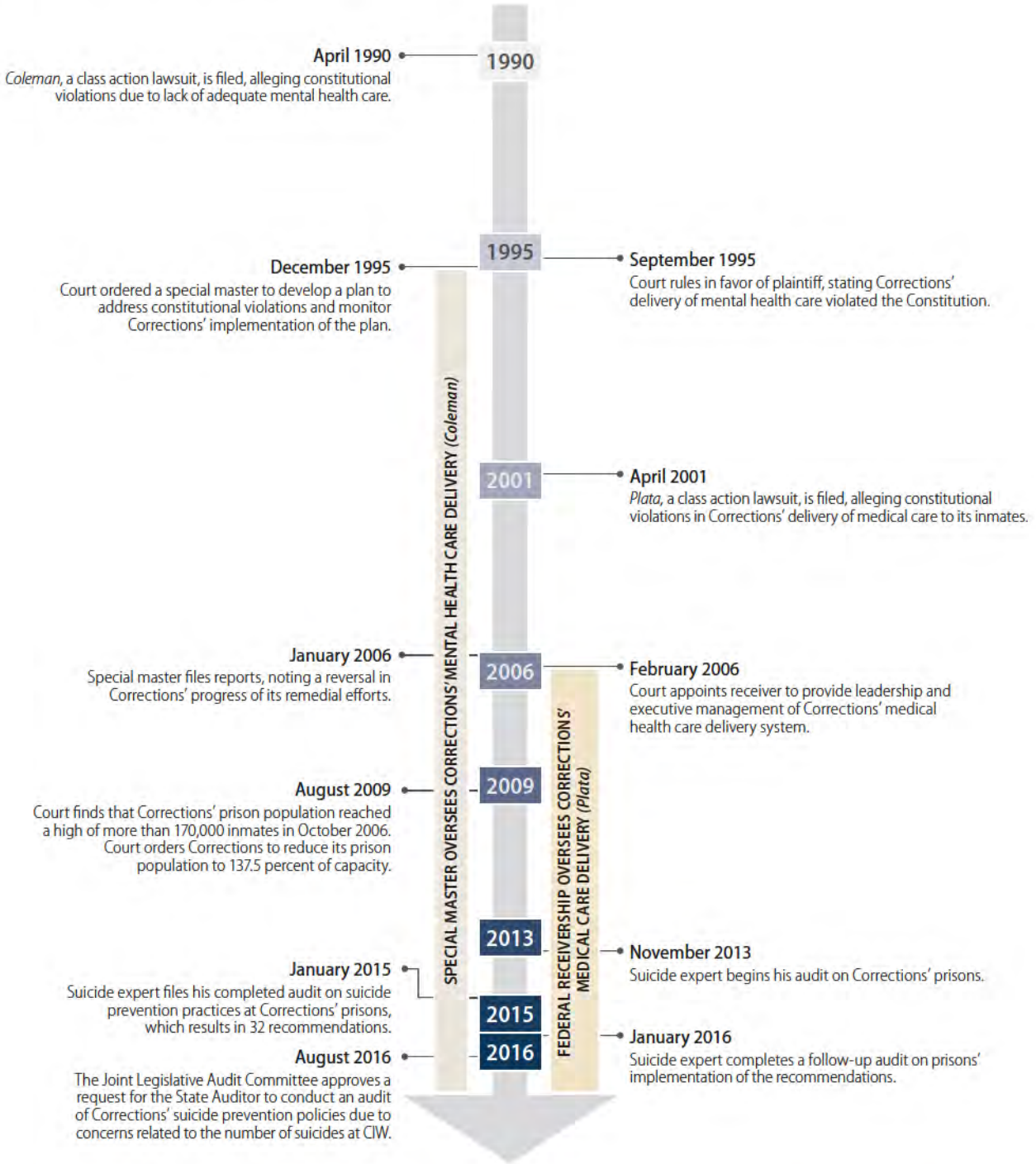
As Figure 2 shows, federal courts have monitored Corrections' delivery of mental health services to its inmates for over two decades, as a result of a decision on a lawsuit that began in 1990—*Coleman v. Brown* (*Coleman*).[2] This federal class action lawsuit alleged that Corrections failed to provide constitutionally adequate mental health care to mentally ill inmates. The court identified that Corrections had failed to provide timely access to necessary care, which exacerbated inmates' suffering and illnesses. In addition the court found that Corrections had an inadequate screening system for mental illnesses, deficient medical recordkeeping, improper administration of medication, and insufficient staffing. In December 1995, the court in *Coleman* appointed a special master to oversee and work with Corrections to address the constitutional violations, monitor implementation of court-ordered remedial plans, and submit reports on Corrections' progress in implementing improvements. Over the next decade, the special master submitted 15 reports to the court, which noted that although Corrections had made some progress, it still had not met its constitutional obligation to provide inmates with adequate mental health care during that time. Further, the special master's fifteenth report in January 2006 indicated a reversal in Corrections' progress. Specifically, this report noted systemwide increases in staffing vacancy rates and rates of inmate suicide.

In April 2001, another class action lawsuit, *Plata v. Brown* (*Plata*), alleged constitutional violations in Corrections' delivery of medical care to inmates that resulted in unnecessary pain, injury, and death.[3] These violations included delays in or failure to provide access to medical care, untimely responses to medical emergencies, and the interference of custodial staff with the provision of medical care. After the plaintiffs filed the lawsuit, they and Corrections agreed that Corrections would implement certain policies and procedures to improve its delivery of medical care, which the court entered as an order in 2002. However, in 2005 the federal court determined that Corrections had yet to ensure that its medical system met constitutional standards. As a result, the court appointed a receiver in February 2006 to provide leadership and executive management of Corrections' medical health care delivery system. This receivership is still in place.

[2] When this case was filed, it was called *Coleman v. Wilson*.

[3] When this case was filed, it was called *Plata v. Davis*.

Figure 2
Timeline of Court-Ordered Oversight of Corrections



Sources: Reports from the special master's suicide expert in 2015 and 2016, court documents, and minutes of the California State Legislature's Joint Legislative Audit Committee.

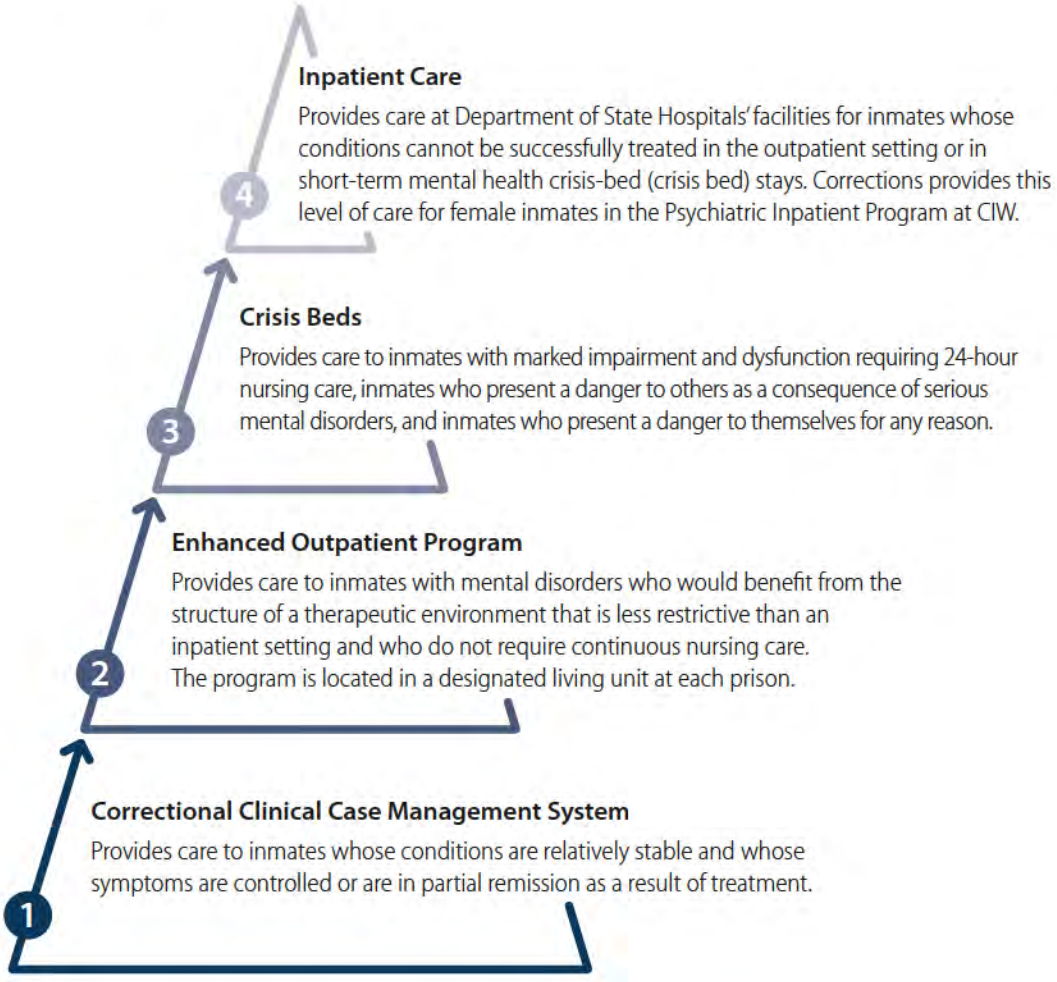
In 2007 the courts in *Coleman* and *Plata* recommended that both cases be assigned to a three-judge panel to address prison overcrowding. In August 2009, the three-judge panel noted that in 2006—the same year that the *Coleman* special master's report noted a reversal in Corrections' delivery of mental health services and the court in *Plata* appointed the receiver—California's prison population reached a historic high of more than 170,000 inmates. This historic high led to unprecedented overcrowding of California's prisons. The three-judge panel found overcrowding to be the primary cause of many of the issues relating to inadequate mental health and medical care in California's prisons. Therefore, the three-judge panel ordered Corrections to develop a plan to reduce its prison population, which at that time was at about 190 percent of capacity, to 137.5 percent of capacity. In 2011 the Legislature passed various laws that realigned the criminal justice system, which reduced overcrowding by allowing for inmates who were not convicted of serious or violent crimes, or felonies requiring registration as a sex offender, to serve their sentences in county jails instead of state prisons.

Although these efforts resulted in the reduction of Corrections' inmate population, a March 2013 *Coleman* special master's report identified continuing inadequacies in Corrections' delivery of mental health services. The special master had repeatedly identified many of these inadequacies in earlier reports, such as Corrections' failure to enforce its own policies regarding the delivery of mental health services and the prisons' failure to provide adequate emergency responses to suicides. In response to the report, the court in *Coleman* ordered Corrections to establish a suicide prevention and management workgroup consisting of members of Corrections' clinical, custody, and administrative staff; experts appointed by the special master; and others. The workgroup engaged a nationally recognized suicide prevention expert (suicide expert) to conduct a review of the suicide prevention practices at each of Corrections' prisons. In January 2015, the suicide expert filed his report, which contained 32 recommendations to Corrections. The suicide expert issued an update to this report in January 2016, in which he evaluated Corrections' progress in implementing the recommendations through a review of 18 prisons. We discuss the suicide expert's report and update in Chapter 3.

Suicide Prevention and Response

As we mention earlier, the goal of Corrections' mental health system is to provide appropriate levels of mental health treatment to seriously mentally ill inmates in the least restrictive environment. As presented in Figure 3, Corrections provides escalating levels of mental health care to inmates, up to and including referrals to Department of State Hospitals' facilities if Corrections cannot meet inmates' mental health needs.

Figure 3
Levels of Care in Corrections' Mental Health System



Sources: Corrections' 2009 *Mental Health Program Guide* (program guide) and *2014 Annual Accomplishments* report.
Note: Not all institutions contain all levels of care.

Terms Related to Inmate Suicide

Suicidal ideation: Thoughts of suicide or death. Such thoughts may be either specific or vague and may include the desire to be dead.

Suicidal intent: The intention to deliberately end one's life.

Self-harm without intent: An act of purposeful self-harm without suicidal intent.

Suicide attempt: An act of purposeful self-harm with the intent to die.

Suicide: An act of purposeful self-harm that causes or leads to one's own death.

Sources: Corrections' 2009 program guide and suicide risk evaluation training documents.

A primary component of Corrections' mental health system is crisis intervention, which is treatment for rapid-onset or worsening symptoms of mental illness in inmates. Such symptoms may include thoughts of suicide. Corrections has identified factors that can lead inmates to experience mental health crises while in prison, including the loss of an existing support system outside of prison, the restrictions of incarceration, and fears of being unable to cope with the outside world upon release. Corrections' policy states that staff must refer inmates who are dangers to themselves to crisis beds, an inpatient treatment setting for inmates who have acute symptoms of serious mental disorders or are suffering from significant or life-threatening disabilities. If no crisis beds are available at a prison, staff must place an inmate in a temporary housing location in the prison—known as *alternative housing*—pending admission to a crisis bed. Under these circumstances, policy requires prisons to transfer an inmate to a crisis bed at another prison if the other prison can provide the same level of custody and security.

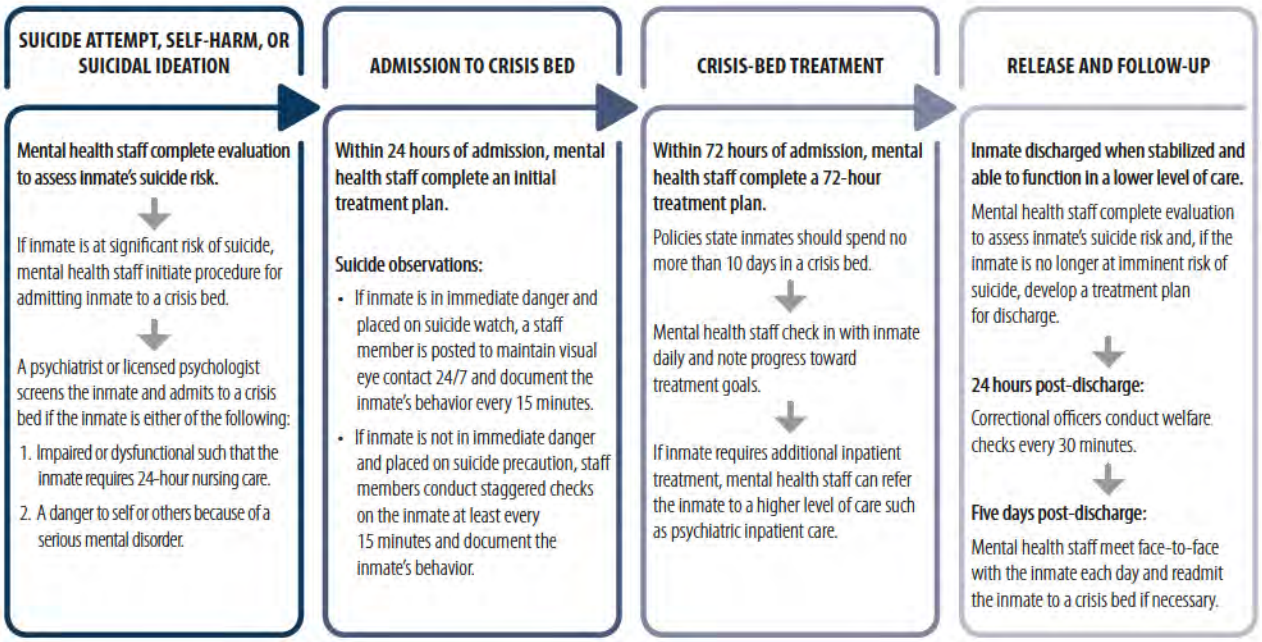
Corrections' policies outline specific steps prison staff must take when they become aware of inmates' suicidal ideation, suicidal intent, or self-harm, which the text box defines. If prison staff become aware of any of these conditions, Corrections' policy requires that they place inmates under observation until mental health staff can conduct a suicide risk evaluation (risk evaluation). As we discuss in Chapter 1, mental health staff use these evaluations to determine inmates' risk of suicide and to make specific recommendations regarding the level of care required.

Corrections also has a policy that prison staff must follow when staff discover inmates who are attempting suicide. When responding to a suicide attempt in progress, Corrections' policy requires prison staff to sound an alarm to summon additional personnel, respond appropriately when blood is present, neutralize any significant security threats to themselves or others, and initiate life-saving measures consistent with training. When medical personnel arrive, they take over responsibility for the medical treatment and life-saving measures.

Following the admission of inmates to crisis beds as a result of suicide attempts, ideation, or self-harm, prison staff must complete various steps in order to provide treatment. Figure 4 provides a summary of these steps. For example, while inmates are in crisis beds, prison staff must keep them under observation. Depending on whether inmates are in immediate danger, staff must either

maintain continuous visual contact with them or perform checks at staggered intervals not exceeding once every 15 minutes. Further, while inmates are in crisis beds, prison staff must complete treatment plans. According to Corrections' policies, crisis-bed stays are supposed to last for up to 10 days, although inmates may stay longer with the approval of a prison's chief of mental health.

Figure 4
Corrections' Process for Inmates' Admission to and Discharge From Crisis Beds



Sources: Corrections' 2009 program guide and related policy memos.

Corrections has taken certain actions to ensure that the prisons comply with its policies and to identify additional ways to prevent inmate deaths due to suicide. For example, Corrections has established its own Suicide Prevention and Response Focused Improvement Team (suicide prevention team) and established suicide prevention teams at each prison. The purpose of these teams is to provide staff with training and guidance with regard to suicide prevention, response, reporting, and review. The suicide prevention teams at each prison are also responsible for monitoring and tracking all self-harm incidents, suicide attempts, and deaths, as well as reviewing the prison's policies to ensure consistency with Corrections' policies. According to Corrections' policies, these teams must be composed of certain prison staff representing multiple disciplines, such as the chief psychologist and chief psychiatrist, and must meet once per month.

In addition, following each suicide, Corrections completes a review of the prison's compliance with policies and procedures, including examining the history of the inmate's mental health care while incarcerated and the prison's emergency response to the suicide. It describes the results of its review in a report (suicide report) that it provides to the prison. When warranted, Corrections makes recommendations to the prison to improve the quality of care and ensure compliance with its policies and procedures.

Chapter 1

PRISONS HAVE NOT FOLLOWED CORRECTIONS' POLICIES WHEN RESPONDING TO INMATES WHO HAVE ATTEMPTED OR ARE AT RISK OF ATTEMPTING SUICIDE

The four prisons we reviewed failed to consistently follow Corrections' policies for responding to, treating, and observing inmates who had attempted or were at risk of attempting suicide. For example, we found many instances in which prisons either did not perform or did not adequately complete required risk evaluations, even though mental health staff use these critical documents to determine the treatment inmates should receive. In addition, we identified numerous instances in which prisons did not include necessary information in inmates' treatment plans, potentially affecting the nature and timeliness of the care the inmates received. In fact, Corrections' reviews of inmate suicides and its own audits of the quality of both risk evaluations and treatment plans have found that prisons did not complete these documents to its required standards. Further, the four prisons may have placed inmates at risk of death by insufficiently monitoring them following suicide attempts, and some prisons failed to respond to suicide attempts in accordance with Corrections' policies.

The Prisons We Reviewed Did Not Properly Evaluate Some Inmates' Suicide Risk

Risk evaluations are critical to successful suicide prevention because they help prisons identify inmates who are likely to attempt suicide and determine the treatments needed to prevent them from doing so. The proper completion of a risk evaluation can therefore be the difference between life or death for an inmate. Corrections' policies require that mental health staff complete risk evaluations under a number of circumstances, including when inmates have initial face-to-face evaluations for suicidal thoughts, threats, attempts, or self-harm, as well as before their discharge from crisis beds. When completing risk evaluations, mental health staff are to examine inmates' mental status and determine the presence or absence of chronic and acute risk factors for suicide. The text box includes examples of such risk factors. They must also review any protective factors that may mitigate inmates' risk of suicide, such as religious beliefs, family support, and participation

Examples of Inmate Suicide Risk Factors

Chronic risk factors

- History of suicide attempts
- History of emotional, physical, or sexual abuse
- Chronic pain problem
- Long or life sentence
- History of depressive or psychotic disorders
- History of certain mental illnesses
- History of substance abuse

Acute risk factors

- Suicidal thoughts
- Recent trauma
- Recent bad news
- Agitation or anger
- Hopelessness or helplessness
- Increasing interpersonal isolation
- Single cell placement

Sources: Corrections' 2009 program guide and suicide risk evaluation form.

in group activities. Finally, mental health staff must document whether inmates are at high, moderate, or low risk for suicide and make specific recommendations regarding the appropriate level of care. Mental health staff must also address how the treatment plan will be implemented and any required follow-up procedures.

Despite the critical role risk evaluations serve, all four prisons we reviewed failed to complete at least one required risk evaluation.

Despite the critical role risk evaluations serve, all four prisons we reviewed failed to complete at least one required risk evaluation. Specifically, for a selection of 40 inmates who attempted or committed suicide from 2014 through 2016, we reviewed the risk evaluations the prisons conducted just before or immediately following the suicide attempt or suicide, and the suicide reports Corrections completed following the suicides. We identified that the prisons should have completed risk evaluations for 36 of these 40 inmates. However, as Table 2 shows, 10 of the 36 inmates were missing at least one required risk evaluation. Although the four prisons offered a number of reasons for the missing risk evaluations, they generally agreed that they had failed to comply with Corrections' policies. For example, the chief of mental health of CCWF stated that risk evaluations are not always necessary for inmates discharged to a higher level of care because the receiving institutions will complete them on admission. However, she acknowledged that Corrections' policies require prisons to complete risk evaluations under these circumstances, and Corrections' clinical support chief affirmed that conducting risk evaluations on discharge to a higher level of care is helpful for continuity of care.

In addition to failing to complete certain risk evaluations, the four prisons completed inadequate risk evaluations for 26 of the 36 inmates we reviewed. Each of these 26 inmates received at least one inadequate risk evaluation, and 13 received more than one. The types of problems we identified varied. For example, mental health staff left blank sections of the risk evaluations for 10 inmates, including sections detailing their consideration of some risk factors and identifying whether the inmates had a desire or plan to die. These blank spaces suggest that the mental health staff may not have considered all relevant information when determining the likelihood of the inmates attempting suicide, which could have caused them to underestimate the inmates' suicide risk level.

Further, for 18 of the 36 inmates, mental health staff did not adequately justify their determinations of the inmates' suicide risk levels. Specifically, either they did not incorporate risk factors when justifying their determinations or they simply listed inmates' risk factors without considering their behaviors or symptoms. In some cases, mental health staff noted the presence of several risk factors and warning signs of imminent suicide risk, yet they still concluded that inmates were at low acute risk, which refers to short-term

fluctuations in inmates' risk of attempting suicide, without adequately documenting the rationale for their determinations. For example, one mental health staff member at SAC indicated that an inmate was at low acute risk for suicide, despite noting that he demonstrated five of the 10 warning signs of imminent suicide risk. The mental health staff member did not include any of these warning signs in the justification of risk, but rather noted that the inmate denied a desire to commit suicide. However, the mental health staff member also indicated that the inmate stated that talking about his suicidal ideation was difficult because he had no intention of ever going to a crisis bed. The inadequate justification for this inmate's risk determination suggests that the mental health staff member may not have considered all risk factors and therefore may have incorrectly estimated the inmate's risk of suicide—a problem that we found repeatedly in the risk evaluations we reviewed.

Table 2
The Four Prisons We Reviewed Completed Inadequate Risk Evaluations

PRISON	NUMBER OF INMATES REVIEWED WHO REQUIRED ONE OR MORE RISK EVALUATIONS	NUMBER OF INMATES MISSING AT LEAST ONE REQUIRED RISK EVALUATION	NUMBER OF INMATES WITH ONE OR MORE INADEQUATE RISK EVALUATIONS
CCWF	9	7	7
CIW	8	1	4
RJD	9	1	6
SAC	10	1	9
Totals	**36**	**10**	**26**

	SPECIFIC PROBLEMS WITH THE RISK EVALUATIONS* (BY NUMBER OF INMATES)			
PRISON	SECTIONS IN RISK EVALUATION WERE BLANK	JUSTIFICATION OF RISK DETERMINATION WAS INCOMPLETE†	TREATMENT PLAN TO REDUCE RISK WAS MISSING OR INCOMPLETE†	STAFF USED INCONSISTENT OR INCOMPLETE INFORMATION ABOUT THE INMATE TO DETERMINE SUICIDE RISK
CCWF	5	5	3	2
CIW	2	2	2	1
RJD	0	4	5	3
SAC	3	7	8	4
Totals	**10**	**18**	**18**	**10**

Sources: California State Auditor's review and analysis of health records for 10 inmates at each of the four prisons, Corrections' 2009 program guide, and other Corrections' policies.

* We present the number of inmates who had risk evaluations with the problem listed. Some inmates had multiple inadequate risk evaluations, and some had risk evaluations that had more than one of the problems listed.

† We determined whether the justifications and risk reduction plans in the risk evaluations were complete based on whether they contained all required elements named in Corrections' suicide risk evaluation audits and mentoring documents.

The four prisons also failed to develop adequate plans for treatment within the risk evaluations for half of the inmates we reviewed. When completing risk evaluations, mental health staff must document treatments targeting modifiable risk factors, such as feelings of agitation, anger, or hopelessness. These treatments should be as specific as possible, leaving little room for misinterpretation or confusion. However, mental health staff failed to document such specific treatments in the risk evaluations for 18 of the 36 inmates we reviewed. For example, CIW's risk evaluation for an inmate that had just attempted suicide indicated that she demonstrated seven acute risk factors, including depression and agitation or anger. However, the mental health staff member did not prescribe treatment, noting only that the inmate should be observed and should continue her current medication. Prisons are not likely to be able to prevent inmates from attempting suicide without addressing the factors that increase their risk of doing so.

Prisons are not likely to be able to prevent inmates from attempting suicide without addressing the factors that increase their risk of doing so.

Further, for 10 of the inmates we reviewed, mental health staff completed risk evaluations based on inconsistent or incomplete information. For example, according to the suicide report Corrections completed following one inmate's suicide at SAC, mental health staff had completed for the inmate three different risk evaluations, which stated that he had certain protective factors in place to reduce his risk of suicide, including family support and good coping skills. However, a review of other documents in the inmate's file showed that he did not have these protective factors. Corrections stated in the suicide report that similarities among the three risk evaluations suggest that mental health staff copied the risk and protective factors from previous evaluations, resulting in an inaccurate picture of the inmate's mental health. Similarly, another one of Corrections' suicide reports stated that the final risk evaluation CIW completed before an inmate's suicide failed to note that she had a history of suicide attempts—a critical determinant of future suicide risk. According to the suicide report, the mental health staff member appeared to accept the inmate's denial of any prior suicide attempts and did not review the suicide attempt history documented in a previous risk evaluation.

Corrections offered some reasons for the prisons' failure to complete adequate risk evaluations. Specifically, its clinical support chief explained that mental health staff have heavy caseloads, which the four prisons we reviewed generally also indicated is a contributing factor. The clinical support chief stated that if prison management has not set clear expectations that suicide risk evaluations should be prioritized, mental health staff may rush to complete risk evaluations. She said prison management should help mental health staff by redirecting their workloads to allow

them to devote the necessary attention to complete adequate risk evaluations. She also stated that, despite existing training, mental health staff are still unsure of how to complete risk evaluations.

Despite its ability to point to reasons for deficiencies in risk evaluations, our review demonstrates that Corrections has not adequately addressed those factors, jeopardizing its ability to prevent inmate suicide attempts. In fact, for years mental health experts on suicide have called on Corrections to address many of the same problems we identified in our review. For example, a 2013 special master's report stated that for half of the suicide cases in 2011, prisons either did not complete risk evaluations or concluded that inmates had a low or "no appreciable" risk of suicide without adequate consideration of risk factors, past history, or medical records. Clinical experts that the special master engaged noted similar problems with risk evaluations each year through 2014, when they concluded that the prisons had either failed to conduct or had inadequately completed risk evaluations in almost 70 percent of the suicide cases that occurred that year. Further, beginning in November 2013 and continuing through July 2014, the suicide expert reviewed each prison's suicide prevention practices and found that mental health staff often did not complete required risk evaluations and that the quality of risk evaluations was frequently problematic. Specifically, the suicide expert's review of hundreds of risk evaluations found that many contained risk factors and protective factors that did not align with the mental health staff's assessments of the inmates' risk levels.

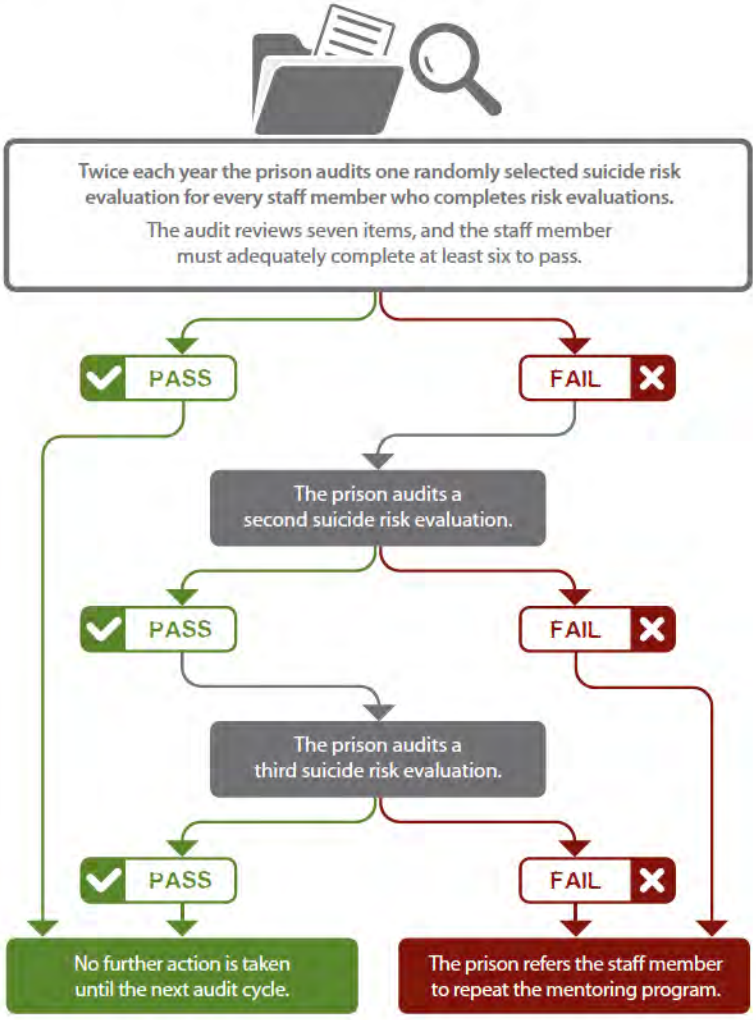
For years mental health experts on suicide have called on Corrections to address many of the same problems we identified in our review.

Although Corrections has taken actions in response to these findings, those actions have not resulted in significant change. For example, in 2013 Corrections issued policies requiring mental health staff to attend a seven-hour training and, every two years, undergo a mentoring program that focuses on administering risk evaluations. The mentoring program involves trained mentors observing mental health staff conducting one or more risk evaluations, assessing their skills, and when needed, providing training on the proper techniques for completing risk evaluations. However, as the reports cited demonstrate, neither the training nor the mentoring program ensured that mental health staff adequately completed risk evaluations. The suicide expert noted that mental health staff were required to complete only two risk evaluations under the supervision of a mentor and that they received no additional critiques until they had to undergo the mentoring program two years later. Based on his recommendations, Corrections modified its policy in early 2016 to, among other things, require that prisons audit risk evaluations for each mental health staff member twice each year, and to require that those who failed the audit repeat the mentoring program.

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Although we agree that this change was necessary to improve oversight of risk evaluations, room for further improvement in both the policy and its implementation remains. Specifically, Corrections' risk evaluation audits permit a degree of failure. Figure 5 shows the process prisons use when completing the audits to determine whether mental health staff members need additional mentoring. During the audit, program supervisors review seven items—which Table 3 lists—that must be in a risk evaluation. Corrections' policy requires that mental health staff correctly complete six of the seven items to pass the audit.

Figure 5
Corrections' Process for Determining Whether Mental Health Staff Require Additional Mentoring on Completing Risk Evaluations



Sources: Corrections' health care division's March 15, 2016, memorandum revising its risk evaluation mentoring program and Corrections' instructions for completing the risk evaluation audit.

However, as a result, a mental health staff member could fail to complete an important section in a risk evaluation, such as detailing the inmate's history of suicide attempts or describing the risk reduction plan, and still pass. Corrections' clinical support chief said that Corrections does not require that mental health staff obtain 100 percent because it does not expect perfection and because if too many failed the audit, it would not have enough mentors to complete the necessary mentoring. She also identified all but one item in the audit—the identification of sources of information—as critical. Nevertheless, listing the sources of information is important to ensure that mental health staff are considering all critical sources of information when evaluating an inmate's risk factors. In response to our concerns, Corrections' clinical support chief explained that Corrections could make passing certain items within the audit mandatory. However, because of the importance of each section of the risk evaluation, we believe requiring mental health staff to adequately complete all sections is essential for reducing the risk of inmate suicide.

Table 3
Items of a Risk Evaluation and Corrections' Corresponding Audit Criteria

	RISK EVALUATION AUDIT CRITERIA	
RISK EVALUATION ITEM	AUDIT ITEM	DESCRIPTION
Check boxes indicating the presence or absence of chronic and acute suicide risk factors.	1	Are all risk factor boxes checked?
Check boxes indicating the presence or absence of protective factors that mitigate suicide risk.	2	Are all protective factor boxes checked?
Check box indicating whether inmate has a history of suicide attempts.	3	Is the item complete?
Include details of previous suicide attempts.	4	If the inmate has a history of suicide attempts, did the staff member detail those attempts?
Include the sources of information used to complete the risk evaluation, such as inmate interview, staff interview, or mental health file review.	5	Did the staff member document the sources of information used?
Describe the justification of risk determination.	6	Are both chronic and acute risk levels checked and justified in the narrative, citing the presence or absence of identified risk factors, protective factors, and warning signs?
Describe the safety/risk reduction plan.	7	Did the staff member incorporate the identified modifiable risk factors, protective factors, and warning signs into a risk reduction plan?

Sources: Corrections' risk evaluation form and its risk evaluation audit criteria.

Although prisons reported that 71 percent of risk evaluations systemwide met the audit criteria from December 1, 2016, through May 31, 2017, it is still far below Corrections' established goal of 90 percent.

Corrections has similarly set the bar too low for the percentage of prisons' risk evaluations that must pass the risk evaluation audit—90 percent—yet it has still struggled to meet its own standards. According to Corrections' mental health administrator for quality management and inpatient facilities (quality administrator), the prisons report to Corrections the percentage of mental health staff members who passed the risk evaluation audit each month. A June 2017 Corrections report shows that from December 1, 2016, through May 31, 2017, prisons reported that 71 percent of risk evaluations systemwide met the audit criteria. Although this is a marked improvement from the prisons' performance in 2014 and 2015—Corrections' reports show that only 38 percent of the risk evaluations audited passed during that two-year period—it is still far below Corrections' established goal of 90 percent. However, even if Corrections achieved its goal, mental health staff would still have adequately completed only nine out of 10 risk evaluations. We believe that this is an unacceptable level of failure, given the potential consequences of deficient risk evaluations.

Corrections also sets its completion standards too low for the percentage of risk evaluations that each prison should complete on time. According to the quality administrator, Corrections uses an automated process to track the percentage of risk evaluations that each prison completes on time and requires prisons that score lower than 85 percent to develop an action plan for improvement. According to Corrections' reports, from December 1, 2016, through May 31, 2017, the prisons collectively achieved a score of 92 percent for being on time. The quality administrator said that it set the goal at 85 percent because that is a standard goal for health care processes. However, given that the timely completion of risk evaluations is critical to ensuring that inmates receive prompt and necessary treatment to reduce their risk of suicide, we believe Corrections should find it unacceptable for more than one in 10 inmates to not receive a risk evaluation on time.

Corrections could improve the quality of its risk evaluations by updating its electronic risk evaluation form. In our review of risk evaluations at RJD, we found that the prison had included prompts to aid the mental health staff member in completing the form. For example, in the section for documenting the treatment to reduce the inmate's risk, the prison included text instructing mental health staff to document treatment interventions for those risk factors that can be treated, which are referred to as *modifiable risk factors*. We found that this risk evaluation met all of the requirements of the risk evaluation audit. Although this was the only risk evaluation that we reviewed at RJD that contained these prompts, according to RJD's chief psychologist, the prison began including these prompts in early 2016 and she believed that they had contributed to an improvement in risk evaluations. Consistent with the chief's

statement, Corrections' risk evaluation audit reports showed that the percentage of RJD's risk evaluations that passed the audit increased from 77 percent in January 2016 to 100 percent in March 2017. Corrections' clinical support chief agreed that such prompts would be beneficial, and that Corrections could incorporate them into the risk evaluation forms in its electronic health record system.

Prison Staff Failed to Establish Treatment Plans for Some Inmates, and the Plans They Established for Others Were Inadequate

According to the suicide expert, treatment planning is a critical element of any correctional system's suicide prevention program. A treatment plan is based on a comprehensive assessment of an inmate's physical, mental, emotional, and social needs and must include the goals of treatment and identify the treatment methods prison staff will use. State regulations and Corrections' policies require that the admitting staff develop a provisional diagnosis and a plan for initial treatment (initial treatment plan) within 24 hours of an inmate's admission to a crisis bed. In addition, state regulations and Corrections' policies require that an inmate's treatment team—which must include, at a minimum, a crisis-bed psychiatrist, a crisis-bed clinician, nursing staff, a correctional counselor, and the inmate if appropriate—complete a treatment plan within 72 hours of the inmate's admission to a crisis bed (72-hour treatment plan). The text box describes selected information state regulations require in a 72-hour treatment plan.

Selected Requirements for a 72-Hour Treatment Plan

- All mental health diagnoses.
- Prescribed medication, dosage, and frequency of administration.
- Treatment goals with interventions, actions toward improvement, and measurable objectives.
- Treatment methods to be used, including the frequency of the methods and the persons or disciplines responsible for each method.
- Goals for aftercare and a plan for post-discharge follow-up.

Source: California Code of Regulations, Title 22, Section 79747.

Despite the importance of treatment plans, three of the four prisons we reviewed did not always comply with state regulations and Corrections' policy that require prison staff admitting inmates to crisis beds to develop an initial treatment plan within 24 hours. Corrections' policies state that this initial treatment plan should contain a provisional diagnosis and an initial plan for treatment. Although this is Corrections' only written requirement regarding initial treatment plans, its clinical support chief explained that she would expect an initial treatment plan to contain an admitting diagnosis, reason for admission, a description of symptoms, and immediate interventions to address those symptoms and target the reason for admission. However, mental health staff did not complete such plans for four of the 26 inmates who should have had them at the four prisons we reviewed. Because Corrections' policies state that inmates must be discharged from crisis beds within 10 days, unless otherwise approved for a longer stay, inmates

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without initial treatment plans may not have a treatment plan for up to 30 percent of their stays in crisis beds—until the 72-hour treatment plan is complete.

In addition, one of the prisons we reviewed failed to comply with state regulations and Corrections' policies for completing 72-hour treatment plans. As Table 4 shows, we reviewed 25 files for inmates who attempted or committed suicide from 2014 through 2016 who should have had 72-hour treatment plans following their admission to crisis beds at the four prisons. We found that mental health staff completed 23 of these 72-hour treatment plans. However, CCWF's mental health staff did not complete a 72-hour treatment plan for two inmates, but rather completed a separate supplemental section, which does not serve as the 72-hour treatment plan. CCWF's chief of mental health acknowledged that when she assumed her position in mid-2015, mental health staff were not completing all sections of the 72-hour treatment plans. She could not provide an explanation for this deficiency because she was not familiar with the guidance mental health staff had received at that time; however, she stated that after she noticed the practice, she reminded mental health staff that they needed to complete all sections of the 72-hour treatment plans.

Table 4
Problems With 72-Hour Treatment Plans at the Four Prisons We Reviewed

	PRISON				
	CCWF	CIW*	RJD	SAC	TOTAL
Number of inmates who...					
...should have had a 72-hour treatment plan	9	7	5	4	25
...did not receive a 72-hour treatment plan	2	0	0	0	2
...received a 72-hour treatment plan	7	7	5	4	23
Missing or incomplete items on the treatment plans reviewed					
Mental health diagnoses	0	0	0	0	0
Medication dosage and frequency	1	4	4	3	12
Treatment goals with interventions and measurable objectives	1	0	0	2	3
Treatment methods, including frequency and persons responsible for each method	7	4	5	4	20
Post-discharge follow-up plan	5	5	3	4	17

Sources: California State Auditor's analysis of mental health records for selected inmates at each of the four prisons reviewed, Corrections' 2009 program guide, and California Code of Regulations Title 22, Section 79747.

* Staff at CIW completed one treatment plan more than 72 hours after the inmate was admitted to a crisis bed.

Moreover, none of the 23 completed 72-hour treatment plans we reviewed were adequate based on the elements state regulations require. For example, many of the 72-hour treatment plans were missing either the treatment methods, the frequency at which the treatment methods should be completed, or who was responsible for administering the methods. Without this information, inmates may not receive necessary treatment from the correct providers at appropriate intervals. In addition, many of the 72-hour treatment plans we reviewed had missing or incomplete discharge follow-up plans. It is vital that the treatment teams begin planning for inmates' care following discharge from crisis beds as soon as possible because Corrections' policies state that crisis-bed stays should be 10 days or fewer, although crisis-bed stays may surpass 10 days with the approval of the prison's chief of mental health or a designee.

Further, some 72-hour treatment plans we reviewed had multiple deficiencies. For example, one 72-hour treatment plan at SAC—for an inmate admitted to a crisis bed after a suicide attempt in 2016—lacked specific treatment interventions, the frequency of treatment, and a discharge plan. Additionally, the prison's mental health staff left several other sections of this plan blank, such as a statement of the inmate's mental condition and descriptions of the long-term goals of the inmate and of the inmate's participation in the treatment planning process. When we inquired, prison officials at SAC stated that this treatment plan was not acceptable and that management would address the deficiencies with the mental health staff member.

Corrections has been aware for years that its 72-hour treatment plans were inadequate, because multiple experts have reached this conclusion. For instance, a 1999 special master's monitoring report found that several treatment team meetings failed to develop realistic and meaningful 72-hour treatment plans at one prison. The same report noted that another prison did not hold any treatment team meetings in the crisis-bed unit. Further, a special master's review of inmate suicides that occurred in the second half of 2012 determined that the prisons had provided inadequate 72-hour treatment plans for about 33 percent of the inmates who committed suicide, while a similar special master's review of inmate suicides that occurred in 2014 found that this number had risen to over 65 percent. Finally, the suicide expert found continued problems with the adequacy of treatment planning for patients identified as suicidal at all 18 prisons that he reviewed in his 2016 report on suicide prevention practices.

Corrections has been aware for years that its 72-hour treatment plans were inadequate, because multiple experts have reached this conclusion.

To address concerns related to treatment planning, Corrections stated that it implemented an internal audit of the quality of the 72-hour treatment plans beginning in September 2013. Every quarter, each prison must audit a random sample of 15 of its 72-hour treatment plans per institutional program, which includes

crisis beds. In these audits, the reviewers are instructed to examine 15 crucial aspects of the 72-hour treatment plans, including whether the interventions are measurable and specify frequency and duration, as well as whether the goals for the inmates are correlated to problems and interventions. According to Corrections' quality administrator, a plan must meet 13 of the 15 criteria in order for a treatment plan to pass the internal audit. She also stated that if the audits identify a systemic problem in a program or prison, the prison must work with Corrections' staff to create a corrective action plan that the prison must then submit to Corrections.

These audits found varying levels of treatment plan quality from 2014 through 2016 at the four prisons we reviewed. According to Corrections' reports, its overall monthly rate of 72-hour treatment plans that met the audit criteria from 2014 through 2015 fluctuated between 0 percent and 67 percent, with no treatment plans meeting the audit criteria for 14 of these 24 months. According to the quality administrator, none of the audited plans met the criteria during these months because the audits were new and the standards were fairly high. In the second half of 2016, the overall monthly rate of treatment plans that met audit criteria fluctuated from 55 percent to 68 percent. However, in at least one month, all four prisons we reviewed had lower percentages of treatment plans that met the audit criteria than Corrections' overall rate. In fact, in July 2016, only 33 percent of SAC's audited treatment plans met the audit criteria. The quality administrator stated that the prisons have continued to struggle to pass the audits because Corrections had examined only the timeliness of 72-hour treatment plans before 2014. She explained that mental health staff should now be more aware of the standards as the result of several trainings. However, Corrections has had regulations in effect since 1996 that specify what a 72-hour treatment plan should include. Therefore, Corrections' mental health staff should have already been aware of these requirements.

It had always been CIW's policy to allow inmates in crisis beds access to yard time; however, prior to this audit, privileges for inmates would only be documented in treatment plans if access to these privileges was restricted in any way.

As part of this audit, we were also requested to determine whether CIW allows inmates identified as suicidal to have access to inmate program activities or movements, such as yard time. The chief of mental health at CIW explained that it had always been CIW's policy to allow inmates in crisis beds access to yard time; however, prior to this audit, privileges for inmates would only be documented in treatment plans if access to these privileges was restricted in any way. He further described that any records of yard privileges for inmates in crisis beds would have been maintained by a recreation therapist separate from the treatment plan; however, CIW was unable to provide these records for the six inmates we reviewed. Thus, we were unable to determine whether these inmates had access to privileges like yard time. As a result of our audit, CIW stated that it has verbally instructed staff to improve their

documentation regarding inmate privileges such as yard time by indicating in treatment plans whether inmates have access to such privileges or by justifying why the inmates do not. Furthermore, in response to the suicide expert's recommendation, Corrections updated its policies in June 2016 to allow inmates in crisis beds to have access to phone and visitation privileges equal to the privileges the inmates would have when not in a crisis bed—privileges which inmates in crisis beds at CIW were previously not allowed to have.

In conducting our audit work, we observed that some inmates faced delays in being placed in a crisis bed.

In conducting our audit work, we observed that some inmates faced delays in being placed in a crisis bed. Specifically, in certain cases, inmates must await assignment to crisis beds because only a limited number of these beds are available. Corrections' policies require that inmates awaiting crisis beds be assigned to alternative housing, which is meant to be short-term and can include large holding cells or other housing where complete and constant visibility can be maintained. Inmates must be transferred out of alternative housing within 24 hours and, according to CCWF's chief of mental health, alternative housing should provide a crisis-bed level of care. Thus, we expected that inmates who remain in alternative housing for more than 24 hours would receive the same documentation of care as inmates in crisis beds, including initial and—if necessary—72-hour treatment plans. However, Corrections' clinical support chief for mental health stated that mental health staff complete treatment plans when inmates enter a new level of care and that alternative housing is a temporary placement rather than a level of care. She explained that completing treatment plans for inmates in alternative housing is not practical for various reasons, including that most alternative housing settings lack space to conduct confidential treatment plan meetings and not all members of the treatment team are required to see inmates in alternative housing. She also stated that inmates receive their standard medications while in alternative housing and that psychiatrists can order additional medication as necessary. Although these explanations appear to be reasonable, we remain concerned that Corrections has not always transferred inmates out of alternative housing within 24 hours.

For example, in a 2016 monitoring report, the special master found that 47 percent of CIW's alternative housing stays and 36 percent of RJD's alternative housing stays during the review period exceeded 24 hours. Our findings are similar to those of the special master. Specifically, 10 of 40 inmates we reviewed remained in alternative housing for more than 24 hours. For instance, one inmate was in alternative housing for approximately six days following a suicide attempt before being admitted to a crisis bed. Because she was discharged from the crisis bed about seven days after her admission, nearly half of her time at a crisis-bed level of care was spent in alternative housing. Of even greater concern,

Two inmates assigned to alternative housing ultimately committed suicide after not being admitted to crisis beds based on the mental health staff's assessments of their mental health.

two inmates assigned to alternative housing ultimately committed suicide after not being admitted to crisis beds based on the mental health staff's assessments of their mental health. Both of these inmates committed suicide within two weeks of discharge from alternative housing.

In order to address the fact that some inmates spend more than 24 hours in alternative housing while waiting to transfer to a crisis bed, Corrections submitted a budget change proposal for the 2017–18 fiscal year, requesting the construction of 100 new crisis beds. It is Corrections' belief that adding additional crisis beds will help alleviate the issue of inmates spending more than 24 hours in alternative housing, because many of the inmates that spend more than 24 hours in alternative housing do so because no crisis beds are available. The Legislature approved Corrections' request for 100 new crisis beds in its 2017–18 budget. According to the deputy director of the statewide mental health program, the 100 crisis beds should be sufficient; however, sufficiency assumes that the needs of Corrections' inmate population will not change in ways that will require additional crisis beds. Also, Corrections has the ability to monitor alternative housing stays that exceed 24 hours as a part of its audit process, which we discuss in Chapter 3.

Prison Staff Did Not Sufficiently Monitor At-Risk Inmates or Respond to Suicide Attempts as Corrections' Policies Require

At all four prisons we reviewed, we observed deficiencies in the prisons' efforts to monitor inmates who were at risk of committing suicide. Staff at each of the four prisons failed to appropriately observe inmates within the required time interval, giving inmates greater opportunities to injure themselves with potentially lethal results. Further, we found instances where prison staff prefilled observation logs and did not stagger the timing of checks. In addition, Corrections has determined that prison staff did not always respond appropriately upon discovering that inmates had attempted to commit suicide. Specifically, Corrections' reviews of inmate suicides found that prison staff sometimes failed to bring required life-saving equipment to the scene, did not appropriately relieve pressure on three hanged inmates' airways, and did not always promptly summon medical responders. Although Corrections agreed that these issues are problematic, it has only recently taken steps to address them.

Prison Staff Did Not Always Monitor Inmates at High Risk of Suicide as Corrections' Policies Require

Our review found that the four prisons have not always performed timely and appropriate checks of inmates placed on suicide precaution. As the text box shows, Corrections has established specific policies for monitoring inmates at risk of suicide, depending on whether they are in immediate danger of self-harm. Because suicide watch entails continuous, direct visual observation of inmates, we could not confirm through a review of watch logs whether this type of observation occurred. Instead, we focused our review on suicide precaution logs, which indicate when prison staff conducted their staggered behavior checks of inmates. Corrections' policy requires prison staff to stagger their behavior checks of inmates on suicide precaution in intervals not to exceed 15 minutes. According to the chief nursing executive at CCWF, the purpose of staggering behavior checks is to ensure that inmates are not able to anticipate when checks will occur and hurt themselves between checks. Nonetheless, the records for 19 out of 25 inmates we reviewed who were placed on suicide precaution indicated they did not always receive staggered behavior checks. Table 5 on the following page presents the problems we identified with suicide precaution checks at the four prisons we reviewed. When prison staff do not stagger the timing of their behavior checks of inmates on suicide precaution, they increase the risk that inmates will be able to injure themselves, perhaps fatally.

Suicide Watch and Suicide Precaution

When inmates are in crisis beds because of suicide risk and are in immediate danger of self-harm, they are placed on suicide watch, which entails the following:

- They are allowed only a no-tear smock or gown, a safety mattress, and a no-tear blanket. All furniture is removed.
- Staff must provide continuous, direct visual observation as well as nursing checks every 15 minutes.

When inmates are in crisis beds because of a high risk of attempting self-harm but are not in immediate danger, they are placed on suicide precaution, which entails the following:

- If they are at higher risk, they are allowed only a no-tear smock or gown, a safety mattress, and a no-tear blanket. If they are at lower risk, they are allowed certain clothing, reading and writing materials, and toiletries. Mental health staff must use their clinical judgment when allowing inmates access to these items.
- Staff must conduct staggered behavior checks of the inmate in intervals not to exceed 15 minutes.

Source: Corrections' 2009 program guide.

Table 5 on the following page shows that the prisons we reviewed did not always conduct suicide precaution behavior checks in a timely manner and that, for several inmates, prison staff prefilled or preprinted the observation logs. All four prisons exceeded the maximum requirement of 15-minute intervals between checks for some inmates, with several intervals at SAC and CCWF exceeding 20 minutes. In one particularly egregious example, prison staff at CCWF checked on an inmate on suicide precaution 90 times, but exceeded 15 minutes between checks more than 35 times, with one gap lasting longer than one hour. Further, we found that staff appeared to prefill times for checks on observation logs for eight of the 19 inmates on suicide precaution that we reviewed in prisons that used paper logs, rather than electronic logs. For example, we found several instances of logs with preprinted observation times for three inmates on suicide precaution who required staggered

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checks. We also identified logs that listed observation times after inmates had been discharged, suggesting the logs were prefilled. This strongly suggests that staff may not have actually conducted visual observation at the times the logs indicate, and may not have conducted the observations at all.

Table 5
Problems With Monitoring of Inmates on Suicide Precaution at the Four Prisons We Reviewed

PRISON	NUMBER OF INMATES OUT OF 10 ON SUICIDE PRECAUTION	INMATES ON SUICIDE PRECAUTION WHO DID NOT RECEIVE STAGGERED CHECKS		INMATES ON SUICIDE PRECAUTION WHO RECEIVED CHECKS WITH INTERVALS GREATER THAN 15 MINUTES		NUMBER OF INMATES WITH LOGS NOT COMPLETED APPROPRIATELY (I.E. PREFILLED OR PREPRINTED)	TOTAL NUMBER OF SUICIDE PRECAUTION RECORDS REVIEWED THAT HAD AT LEAST ONE OF THE ISSUES IDENTIFIED IN THIS TABLE
		NUMBER	PERCENTAGE	NUMBER	PERCENTAGE		
CCWF*	7	6	86%	6	86%	2*	7
CIW*	7	6	86	2	29	1*	6
RJD	5	4	80	4	80	2	5
SAC	6	3	50	5	83	3	6
Totals	**25**	**19**	**76%**	**17**	**68%**	**8**	**24**

Sources: California State Auditor's review and analysis of health records for 10 inmates at each of the four prisons, Corrections' 2009 program guide, and Corrections' other policies.

* CCWF and CIW transitioned to an electronic health record system in October 2015, and suicide precaution checks are now recorded electronically in this system. Therefore, we could only test for prefilling/preprinting for four of the seven inmates on suicide precaution at CCWF and six of the seven inmates on suicide precaution at CIW.

Officials at the four prisons agreed that suicide precaution observations have been problematic. The chief of mental health at CCWF stated that checks might have been late or not appropriately staggered in the past because staff did not understand how to implement staggered checks. She also explained that staff shift changes can cause intervals between checks that exceed 15 minutes and that staff are sometimes unable to conduct checks at the required times because they are engaged with other inmates. Prison staff at SAC indicated that the prison used preprinted forms in the past to help nurses stagger their checks but stopped this practice after the suicide expert's 2015 report stated that they were inappropriate. Further, they explained that SAC now conducts spot checks of its suicide precaution logs.

Although prison officials indicated the implementation of Corrections' new electronic health record system should reduce some of the issues we found, we still identified problems in the prisons that have implemented the system. According to Corrections' January 2016 report titled *An Update to the Future of California Corrections*, the electronic health record system allows providers to more efficiently prescribe treatment, maintain or

strengthen continuity of care, work cohesively with other treatment team members, and monitor inmate progress. Both CCWF and CIW implemented the system in October 2015, whereas Corrections' remaining prisons are in various stages of transitioning to the new system, with Corrections estimating that all prisons will have implemented it by October 2017. Prison officials at CCWF and CIW indicated that the shift to the new system has improved compliance with their monitoring of suicidal inmates because providers can order the behavior checks and set when they are due. However, we still found instances in which staff did not stagger behavior checks after CIW and CCWF implemented the system, and the checks continued to occur at predictable intervals. Corrections' chief psychologist of quality management and informatics asserted that he believed it is difficult in practice for mental health staff to mentally track every patient they are monitoring and plan to stagger the behavior checks. The continued problems we observed with staggering behavior checks suggest that Corrections needs to increase training for mental health staff on how to properly stagger such checks.

Additionally, out of the four prisons we reviewed, SAC and RJD did not regularly check on the welfare of inmates in certain housing units as required by Corrections' policies. The policies require that prison staff regularly observe all inmates placed in certain housing units.[4] These checks, known as security welfare checks, should occur at staggered intervals twice an hour, with the intervals not exceeding 35 minutes. However, the security welfare check data show that SAC and RJD did not conduct these checks as required. For example, four of the 10 inmates we reviewed at SAC were in segregated housing units, yet none appeared to have received timely security welfare checks on the days they either committed or attempted to commit suicide. For one of these inmates, SAC could not provide any evidence demonstrating the welfare checks occurred at all. For another inmate, the security welfare check log shows some intervals between checks were longer than an hour on the day the inmate committed suicide. According to a Corrections' suicide report, when staff discovered the inmate's body, more than 50 minutes had elapsed since the last check. As these examples clearly show, when they do not check on inmates as required, prison staff may miss opportunities to prevent inmates from injuring themselves or attempting to commit suicide.

Out of the four prisons we reviewed, SAC and RJD did not regularly check on the welfare of inmates in certain housing units as required by Corrections' policies.

Although Corrections has recently taken steps to ensure that prisons comply with the suicide precaution and security welfare check policies, it is too soon to determine the effectiveness of

[4] Inmates may be removed from a prison's general population and placed in segregated housing for various reasons, including that they pose an immediate threat to the safety of others.

these actions. In particular, the suicide expert recommended in his January 2015 report that Corrections enforce its policies regarding behavior checks at staggered intervals not to exceed 15 minutes between checks for inmates on suicide precaution. In response to this recommendation, Corrections issued a memorandum in March 2016 reiterating policies for inmates placed in crisis beds, including the requirements for observing inmates on suicide precaution. Additionally, Corrections' quality administrator explained that it is developing an audit process that it plans to implement statewide for reviewing prisons' compliance with its policies and procedures. Corrections' regional teams will conduct this process, and it will include a review of suicide precaution logs and security welfare check logs. We describe this audit process in more detail in Chapter 3. Further, she indicated that as part of this audit process, Corrections is developing automated monitoring of suicide precaution checks in its electronic health record system to ensure compliance with Corrections' policies. However, since Corrections has not yet finalized its development of the audit process, including the automated monitoring, it is too early to determine its effectiveness.

We found that mental health staff at CCWF, RJD, and CIW did not always make required daily progress notes for inmates in crisis beds.

Finally, we found that mental health staff at CCWF, RJD, and CIW did not always make required daily progress notes for inmates in crisis beds. Corrections' policies require mental health staff to assess and monitor on a daily basis the condition of inmates who are in crisis beds. According to the policies, mental health staff must document these daily contacts within 24 hours. However, four inmates we reviewed at CCWF, two inmates at RJD, and two inmates at CIW did not receive daily progress notes for at least one day while in crisis beds. Without these notes, prison staff are hindered in their ability to assess inmates' progress and determine whether they should be either discharged or referred to a higher level of care. For example, an inmate at CCWF spent over 20 days in a crisis bed before she was discharged—more than twice as long as Corrections' policies specify—yet she did not receive progress notes for several of the additional days. Had staff completed the daily progress notes, this inmate might have received the treatment she needed in a timelier manner. The chief of mental health at CCWF could not explain why staff did not make these progress notes. The quality administrator stated that Corrections does not currently monitor prisons' compliance with requirements for daily progress notes for inmates in crisis beds but is open to incorporating such monitoring into its audit process once all prisons have transitioned to the electronic health record system in October 2017.

Corrections' Suicide Reports Are Not Always Timely and Have Identified Various Concerns Regarding Prisons' Compliance With Emergency Response Requirements

One of the experts engaged by the special master noted that the suicide review process and the issuance of suicide reports on each inmate suicide is one of the strengths of Corrections' suicide prevention program. However, of the 16 suicide reports that we reviewed, Corrections completed nine later than the 60 days following a suicide that its policy requires. In two instances, Corrections took 137 days to complete a report—more than double the timeline established in its policies. Corrections' clinical support chief attributed two of the late reports to a shortage of resources caused by a large number of suicides that occurred over a short time frame, while she explained that several others were late due to the complexities of the necessary reviews. However, she stated that delays in completing a suicide report would not delay Corrections from informing a prison of an urgent problem that needed immediate attention; in such cases, while reviewers are still on-site, they would inform the prison of the issue. Nevertheless, we believe that it is critical that Corrections complete these reports as expeditiously as possible because they are a crucial tool for identifying problems with the prisons' clinical care and compliance with policies and procedures, including their emergency responses to suicides.

In fact, several suicide reports we reviewed identified that prison staff have not always complied with Corrections' requirements and state regulations for how to respond to suicide attempts. For instance, state regulations and Corrections' policy require that a cut-down kit be immediately accessible in each housing unit of a prison and that staff use the kit in cases of attempted hangings. The text box lists the cut-down kit's required contents—several of which can be used to provide life-support care or clear an obstruction to an airway—which Corrections has identified as being critical to saving the life of inmates who attempt suicide by hanging. However, of the 15 suicides by hanging that we reviewed, Corrections' suicide reports noted three instances in which responders did not indicate having or using all or part of a cut-down kit. For example, one suicide report found that prison staff immediately responding to the hanging did not use a resuscitator at the scene of the emergency. Rather, the report found that prison staff indicated the resuscitator was used after the inmate had been transported away from the scene of the emergency.

Contents of a Cut-Down Kit

A cut-down kit must be kept in a lockable metal box maintained within each housing unit and must contain the following:

- An inventory list affixed to the inside of the box door.
- One emergency cut-down tool.
- One single patient use resuscitator.
- One CPR mask.
- A minimum of 10 latex gloves.
- A disposable oral airway.

Source: Corrections' 2009 program guide.

Corrections offered several possible explanations for why prison staff may not have carried or used the entire kit when responding to suicide attempts. According to an associate warden for the Division of Adult Institutions' mental health compliance team (compliance team associate warden), staff who did not bring an entire cut-down kit may have had any missing items elsewhere on their persons or used their required training to perform the necessary life-saving measures. She also noted that the kits' storage locations in some units may have restricted staff's access to them. For example, she explained that some housing units store kits in secured control booths, even though the booth windows may not be large enough for the required metal boxes to pass through. According to the compliance team associate warden, this limitation has resulted in prisons using various bags, buckets, or other storage devices to store cut-down kits—all of which deviate from Corrections' policy that prisons store kits in lockable metal boxes.

Corrections is aware of the problems related to the storage of the cut-down kits and is in the process of taking steps to address them. Specifically, the clinical support chief for mental health indicated that Corrections had formed a workgroup to address keeping the kits in bags rather than boxes so that they could be more easily stored in secured areas. The compliance team associate warden also explained that her team is in the process of developing a memo to update Corrections' policies on when to use cut-down kits and how prison staff should maintain them. According to the compliance team associate warden, the memo will make some significant changes to Corrections' current policies, including requiring that prisons keep all cut-down kit items together in a durable bag and that prison staff bring the kits to suicide attempts by asphyxiation in addition to hangings. It will also emphasize that staff must transport the entire kit to the scene of an emergency. The compliance team associate warden expects that Corrections will finish and implement the memo by August or September 2017. Without such changes to its policies, Corrections risks additional instances of prison staff not having the entire kit at a moment when it could potentially save an inmate's life.

Without changes to its policies, Corrections risks additional instances of prison staff not having the entire kit at a moment when it could potentially save an inmate's life.

Corrections' suicide reports also note other issues with prisons' emergency response, and the suicide review process can result in changes to emergency response preparedness. For example, two suicide reports identified issues with the timing of summoning medical responders. Corrections addresses these types of issues by including recommendations in its suicide reports, which the prisons are responsible for implementing. Furthermore, Corrections' policy requires specific staff to follow up with prisons to ensure that they implement the recommendations. To address several issues related to their emergency responses, the prisons involved submitted to Corrections evidence that they had provided additional training

to their staff, which we believe is appropriate. In another example, three suicide reports identified concerns with staff not relieving pressure on an inmate's airway when the inmate was discovered hanging. However, CIW identified that prison staff involved in one of these incidents had most recently received suicide prevention training roughly six months before the suicide, but that the training did not provide specific instruction on relieving tension on the inmate's body by using a stable object for support. We find it concerning that Corrections omitted this critical information from this training, as its mental health policies have specified since 2009 that responding prison staff must relieve pressure on the inmate's airway. In 2016 Corrections updated its suicide prevention training to include instruction to support the inmate's airway. Corrections' clinical support chief stated that the information should have been included in previous versions of the training and that its omission was an oversight. She explained that the information was likely missing from previous versions of the training because when her team revised the training they focused on adding new issues rather than reviewing the training to ensure that all of the necessary information was included. She further explained that she was surprised to find that the information was missing, because the same team that assembled the 2009 program guide with Corrections' policies put together the training.

Recommendations

Legislature

To provide additional accountability for Corrections' efforts to respond to and prevent inmate suicides and attempted suicides, the Legislature should require that Corrections report to it in April 2018 and annually thereafter on the following issues:

- Its progress toward meeting its goals related to the completion of risk evaluations in a sufficient manner.
- Its progress toward meeting its goals related to the completion of 72-hour treatment plans in a sufficient manner.

Corrections

Corrections should immediately require mental health staff to score 100 percent on risk evaluation audits in order to pass. If a staff member does not pass, Corrections should require the prison to follow its current policies by reviewing additional risk evaluations to determine whether the staff member needs to undergo additional mentoring.

To ensure that it identifies inmates who are at risk of attempting suicide and determines the treatments needed to prevent them from doing so, Corrections should immediately reevaluate and revise its goals for the percentage of risk evaluations that mental health staff must complete on time and for the percentage of risk evaluations that must pass its risk evaluation audits. It should set revised goals that better take into consideration the importance of mental health staff completing adequate risk evaluations in a timely matter. Corrections should require prisons that perform below its revised goals to develop improvement plans.

To improve the quality of its risk evaluations, by December 2017 Corrections should develop and incorporate into its electronic risk evaluation form prompts to aid mental health staff in completing adequate risk evaluations that meet all audit criteria.

To minimize the number of inmates who spend more than 24 hours in alternative housing, Corrections should use the audit process it is developing to monitor the amount of time inmates spend in alternative housing and annually reassess its need for additional crisis beds.

To ensure that prisons document the privileges, such as yard time, that inmates receive while in a crisis bed, Corrections should immediately require prisons to develop and formalize policies to record on their treatment plans the privileges inmates are allowed and receive while in a crisis bed.

To ensure that prison staff conduct required checks of inmates placed on suicide precaution in a timely manner, Corrections should implement its automated process to monitor suicide precaution checks in its electronic health record system by the time it is implemented systemwide in October 2017. Further, Corrections should train staff on how to plan for and conduct staggered suicide precaution checks.

To monitor prisons' compliance with its requirement that inmates in crisis beds receive daily progress notes, Corrections should implement monitoring of these notes electronically into its audit process by the time the electronic health record system is in use systemwide in October 2017. Corrections should require prisons that are out of compliance to develop and implement quality improvement plans, and it should follow up on the prisons' implementation of those plans.

To ensure that prison staff appropriately respond to attempted suicides, Corrections should implement its proposed changes to its emergency response policies regarding cut-down kits by December 2017 and should include in its policies a method for monitoring prisons' compliance.

Chapter 2

A NUMBER OF FACTORS HAVE LIKELY CONTRIBUTED TO HIGH RATES OF INMATE SUICIDES AND SUICIDE ATTEMPTS AT CIW

From 2014 through 2016, the rates of inmate suicides and suicide attempts at CIW were significantly higher than the rates at either CCWF or Corrections' men's prisons. Staff at Corrections and CIW provided several reasons for CIW's elevated rates, including inmate drug involvement, domestic violence in interpersonal relationships between female inmates, and the transfer of additional inmates to CIW and CCWF following the conversion of a women's prison to a men's prison. Because suicide is the result of multiple factors, we believe many of these causes could have contributed to CIW's high rates of suicides and suicide attempts. In addition, we identified several factors that many of Corrections' prisons share in common that may influence rates of inmate suicides and suicide attempts. Specifically, Corrections has not established a means of ensuring that all staff receive required trainings related to suicide prevention and response, and as a result, some staff may not have the knowledge necessary to address inmates' mental health needs. Further, Corrections has struggled to fill certain mental health staff vacancies, particularly for psychiatrist positions. Finally, Corrections has not recently updated its staffing model to ensure that the prisons have adequate staff to meet their inmates' mental health needs.

Corrections Has Identified Possible Causes for the High Suicide Rate at CIW

As the Introduction discusses, the rates of suicides and suicide attempts at women's prisons in California have increased over the last several years. After declining from 2012 through 2013, the rates of both suicides and attempted suicides at women's prisons rose dramatically, from 3.7 attempts and 0.35 suicides per 1,000 inmates in 2014 to 10.3 attempts and 0.63 suicides in 2016.

Further, as Table 6 on the following page shows, the rates of suicides and attempted suicides at women's prisons were significantly higher and less stable than the rates at other prisons in California during this same time period. Although the increase in female inmate suicides is dramatic, Corrections' clinical support chief noted that even one suicide can significantly affect the rate because of the small population of female inmates. However, she acknowledged that there have been more suicides among female inmates than she would have expected and she believes that California's rates are high in comparison to large prison systems in other states.

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Table 6
Suicides and Attempted Suicides in Adult Prisons From 2012 Through 2016

		INMATE POPULATION* TOTALS	ATTEMPTED SUICIDES TOTALS	ATTEMPTED SUICIDES PER 1,000 INMATES	SUICIDES TOTALS†	SUICIDES PER 1,000 INMATES
2012	Women's prisons	6,643	30	4.5	1	0.15
	All other prisons‡	119,633	322	2.7	24	0.20
	All prisons	126,276	352	2.8	25	0.20
2013	Women's prisons	5,627	23	4.1	1	0.18
	All other prisons‡	117,611	351	3.0	25	0.21
	All prisons	123,238	374	3.0	26	0.21
2014	Women's prisons	5,646	21	3.7	2	0.35
	All other prisons‡	117,006	344	2.9	18	0.15
	All prisons	122,652	365	3.0	20	0.16
2015	Women's prisons	4,887	45	9.2	2	0.41
	All other prisons‡	109,243	346	3.2	17	0.16
	All prisons	114,130	391	3.4	19	0.17
2016	Women's prisons	4,743	49	10.3	3	0.63
	All other prisons‡	114,938	370	3.2	23	0.20
	All prisons	119,681	419	3.5	26	0.22
5-YEAR TOTALS	Women's prisons		168		9	
	All other prisons‡		1,733		107	
	All prisons		1,901		116	

Sources: California State Auditor's analysis of Corrections' COMPSTAT metrics and additional information on suicides provided by various prisons.

* *Inmate population* is the average of the 12 months in each year.

† The numbers we present here reflect our amendments to Corrections' COMPSTAT data. As we discuss in Chapter 3, our review of various records from individual prisons revealed that COMPSTAT has consistently underreported the number of suicides in California prisons. We have therefore adjusted the number of suicides in 2013, 2015, and 2016 to include three suicides that we identified at CIW, RJD, and SAC that were not included in the COMPSTAT data; however, we caution that these numbers may still not be accurate.

‡ According to a COMPSTAT research program specialist, Corrections expresses its numbers in COMPSTAT by institution and not by gender. Thus, *Women's prisons* includes CCWF and CIW, as well as the former Valley State Prison for Women (VSPW) in 2012, and CCWF and CIW from 2013 through 2016. *All other prisons* comprises nearly all male inmates; however, it does include inmates in other facilities, including some that house both men and women, such as certain medical facilities, and Folsom State Prison, which has a small women's facility.

The clinical support chief offered three primary reasons for why the suicide rate at women's prisons has been high in recent years. First, she explained that unlike male inmates, female inmates tend to build family units within prisons, and Corrections has found that domestic violence can occur within these units. She believes that this domestic violence has contributed to the higher suicide rates at women's prisons. She stated that in order to address this issue, Corrections is planning to develop a curriculum regarding same-sex domestic violence for female inmates who receive mental health services.

The second reason the clinical support chief pointed to was drug involvement. Specifically, she explained that substance abuse affects female inmates differently than male inmates because incarcerated women have high levels of past trauma. That trauma, combined with substance abuse, likely increases the risk of suicide. According to the clinical support chief, drugs or drug trafficking were involved in four of the six most recent suicides in women's prisons. She stated that in order to address this issue, Corrections is hoping to finalize a contract in the near future to establish a co-occurring disorders program at CIW and at other prisons. She explained that this program would be modeled on best practices that combine mental health issues with treatment for substance abuse.

Substance abuse affects female inmates differently than male inmates because incarcerated women have high levels of past trauma that, when combined with substance abuse, likely increases the risk of suicide.

Finally, the third reason she cited was that the realignment of prisons changed the composition of the inmate population in state prisons. In 2011 the Legislature passed various laws that realigned the criminal justice system by allowing inmates who were not convicted of serious or violent felonies, or felonies requiring registration as a sex offender, to serve their sentences in county jails rather than state prisons. She explained that as a consequence of realignment and lower-level offenders being sentenced to county jails, inmates who remain in state prisons generally have more severe behavioral issues and are more likely to have committed violent crimes. She also said that inmates who have committed violent crimes are potentially more likely to commit suicide because they have a history of using violence as a response to various situations, including self-directed violence. As a result, female inmates in the State's prisons may be more likely to make lethal suicide attempts.

These reasons, however, apply to all female inmates and do not necessarily explain the difference in the rates of suicides and attempts between CIW and CCWF, which are both women's prisons. As Table 1 in the Introduction shows, all but one of the suicides occurring from 2014 through 2016 at the two women's prisons we reviewed occurred at CIW. During this same period, there were also more suicide attempts at CIW than at CCWF, despite CIW's smaller inmate population. For example, there were 11 attempted suicides at CCWF in 2015, but 34 attempted suicides at CIW. We asked the clinical support chief why she thought the suicide and suicide attempt rates at CIW were higher than those at CCWF from 2014 through 2016 and she stated that she did not have any easy hypotheses for why the rates were higher at CIW. She additionally described that based on her understanding, the characteristics of the inmates at CIW and CCWF do not seem to differ significantly. Moreover, the Centers for Disease Control and Prevention has identified that suicidal behavior results from a combination of many factors—including genetic, developmental, environmental, psychological, social, and cultural factors—operating through diverse and complex pathways. It is therefore likely that there are many components to the cause for the difference in suicide and suicide attempt rates between CIW and CCWF.

Prison officials at CIW, however, did identify one other explanation for why the suicide rate at CIW was elevated from 2014 through 2016: they attributed the increased suicide rate at CIW to the conversion of VSPW to a men's prison and the subsequent transfer of higher-security-level inmates to CIW than the prison was designed to house. Corrections converted VSPW to a men's prison due to the decline in the number of female inmates in state prisons following realignment. According to Corrections' acting associate warden of female offender programs and services, Corrections transferred about 970 inmates to CCWF and 400 inmates to CIW from VSPW from September 2012 through January 2013. Two chief psychologists and a senior psychologist at CIW stated that the transfer of inmates resulted in a number of negative effects, including increases in gang influences, more drugs, higher-security-level inmates, and increased conflict in the housing units. The chief executive officer at CIW explained that CIW was not designed to house high-security-level offenders, and he agreed that the change in prison culture following the conversion of VSPW may have contributed to the increase in suicides and attempted suicides. We attempted to verify whether high-security-level inmates were transferred to CIW; however, Corrections' acting associate warden of female offender programs and services explained that Corrections does not have a historical breakdown of that information.

Two chief psychologists and a senior psychologist at CIW stated that the transfer of inmates resulted in a number of negative effects, including increases in gang influences, more drugs, higher-security-level inmates, and increased conflict in the housing units.

Although Corrections acknowledged at the time that the conversion of VSPW to a men's prison might significantly affect CIW and CCWF, it did little to prepare those prisons. According to documentation Corrections provided, beginning in 2011, Corrections developed action plans for the conversion of VSPW and held meetings with certain stakeholders to discuss these plans. However, Corrections was unable to provide evidence of such a meeting occurring at CIW. Further, CIW officials were unable to recall the occurrence of such a meeting. Corrections distributed a memorandum in late August 2012 announcing the conversion of VSPW and the resulting transfer of its female inmates to CIW, CCWF, and certain other special programs beginning the next month. However, the memorandum lacked any details regarding the steps the prisons should take to prepare for the new inmates; instead, it simply stated that the support of the wardens in ensuring their prisons' assistance was appreciated. According to Corrections' acting associate warden of female offender programs and services, the wardens at each prison were responsible for preparing their staff for the conversion and the subsequent increases in their inmate populations. Both an associate warden at CIW and its chief executive officer confirmed that, beyond the standard preparations made for inmate transfers, they could not remember any special preparations or training that CIW provided for its staff.

The inmates who transferred from VSPW were not the majority of those attempting suicide at either CIW or CCWF. This supports CIW officials' perspective that there was a cultural change at the prison subsequent to the transfers. According to CIW, inmates who transferred from VSPW committed 8 percent of the suicides and suicide attempts at CIW from 2014 through 2016. Similarly, CCWF's data show inmates who transferred from VSPW committed 12 percent of the suicide attempts at CCWF during this period. CIW's chief executive officer stated that before the transfer of inmates from VSPW, he would have described CIW as a prison that had relatively few issues with inmates. He explained that he could no longer describe the prison in this way after the transfer because the inmates from VSPW brought with them a culture of substance abuse, illegal drug trading, and violence related to drug trafficking.

CIW and Other Prisons Have Not Ensured That Their Staff Have Received Required Training on Suicide Prevention and Response

As we describe in the previous section, Corrections and CIW were able to identify certain factors that are unique to CIW and CCWF and that may have contributed to CIW's high rates of suicides and suicide attempts. However, we identified additional factors that may increase the risk of inmate suicides and attempts at both men's and women's prisons throughout the State. One of these factors is Corrections' failure to ensure that prison staff receive required training related to suicide prevention and response. We believe this lack of training may have contributed to some of the problems we identify in Chapter 1.

Because effective suicide prevention and response at prisons requires a collective effort, staff that routinely interact with inmates should receive training on how to identify and help inmates at risk of suicide as well as on how to respond to suicide attempts. When staff fail to fulfill their duties as Corrections' policies require, it may result in the serious injury or death of inmates whose lives depend on both the quality and promptness of the interventions that staff provide. The Joint Legislative Audit Committee (Audit Committee) asked us to evaluate the adequacy of the mental health and suicide prevention training specifically for CIW staff, and we found that the prison did not ensure that its staff received the required trainings. We also identified similar attendance concerns at the three other prisons we reviewed, and we found that some trainings need improvement in terms of their content and delivery.

Officials at CIW could not demonstrate that some staff had attended required training courses related to inmate suicide. State regulations and Corrections' policies require each prison to ensure that all staff

Officials at CIW could not demonstrate that some staff had attended required training courses related to inmate suicide.

Selected Training That Corrections Requires Related to Suicide Prevention and Response

Annual Suicide Prevention: Provides staff with a basic understanding of suicide prevention and their roles when working in a prison. This training includes elements related to responding to suicide attempts.

Risk Evaluation Mentoring Program: Provides one-on-one training and mentoring on the administration of risk evaluations. Mentoring includes feedback on suicide assessment, risk formulation, and crisis intervention skills.

Risk Evaluation for Mental Health Staff: Focuses on practical methods to improve the accuracy and reliability of risk assessments across staff and settings. This training is designed to complement the risk evaluation mentoring program.

Safety/Treatment Planning Within Suicide Risk Assessment and Management: Helps mental health staff know when and how to create adequate treatment/safety plans that contain specific actions mental health staff and inmates will undertake to reduce risk of suicide.

Sources: State regulations, Corrections' policies, 2016 lesson plans, and presentation slides for the listed trainings.

whose assignments routinely involve inmate contact complete various trainings related to suicide prevention and response. The text box lists some of these trainings. In addition, we reviewed a training on working with female offenders, which provides information and skills that support managing female inmates safely and effectively. However, when we reviewed training records for a selection of staff at CIW, we found that prison officials could not demonstrate whether some staff had attended certain trainings. Specifically, the in-service training manager at CIW could not demonstrate that four of the 20 staff members attended a required annual suicide prevention training during 2016. Further, of the 15 mental health staff we reviewed who were required to take the same course at CIW in 2015, the prison's documentation shows that only nine attended.

Moreover, some mental health staff at CIW did not attend a required training on conducting risk evaluations or receive mentoring. Corrections requires staff who will be evaluating whether inmates are at risk of suicide to attend a training on how to complete risk evaluations. We reviewed 10 psychologists, psychiatrists, or social workers who were required to attend this training within 180 days of hire; however, the documents the prison provided demonstrate that only six did so. Further, we found that CIW did not adequately audit risk evaluations for five of the 10 mental health staff we reviewed, and did not provide mentoring for two mental health staff that failed the audit. As Chapter 1 explains, the correct completion of risk evaluations is critical because they help mental health staff identify inmates who are likely to attempt suicide as well as the treatments needed to prevent them from doing so.

CIW provided several reasons for why it was unable to demonstrate that certain staff attended the required trainings. In particular, the in-service training manager explained that some of the staff simply did not attend the training. However, he also stated that before May 2015, CIW did not effectively track its training. Further, he explained that staff in the training units at CIW and other prisons do not always record attendance—which is demonstrated by a sign-in sheet—in Corrections' tracking system. He indicated that as a result, when staff transfer to CIW, CIW must directly contact the prisons at which they previously worked to determine if those prisons can provide the sign-in sheets for trainings. This situation could lead to staff missing required trainings. For example, CIW's in-service training manager stated that one staff member we

reviewed had received the required suicide prevention training at a different prison in 2016, but he could not provide documentation that the staff member had actually received this training.

Some of the problems we found are not unique to CIW: Corrections reported that not all staff at the prisons we reviewed received required trainings in 2016. For example, at SAC, about half of the required staff received training on the principles of safety planning for suicidal inmates. Attendance compliance at RJD, CIW, and CCWF was 72 percent, 83 percent, and 89 percent, respectively, with this training requirement, according to Corrections' reports. Staff attendance rates for the annual suicide prevention training ranged from 68 percent at CIW to 95 percent at CCWF. Staff attendance was similar for the suicide risk evaluation mentoring, with reported attendance rates ranging from 71 percent at SAC to 95 percent at CCWF. Corrections' clinical support chief stated that Corrections has not followed up with the prisons regarding the reasons for the low attendance rates. She explained that although the prisons provide Corrections with some staff attendance rates at trainings, Corrections does not request that they explain or justify those rates. Rather, she stated that Corrections relies on the prisons' in-service training units and chiefs of mental health to address training noncompliance issues. Lastly, although not a training on suicide prevention, a program regarding working with female offenders was offered in 2015 and 2016. CIW and CCWF reported average staff attendance rates of 74 percent and 91 percent, respectively, for this training.

This is not a new problem, nor is it isolated. In his 2016 report regarding selected prisons' suicide prevention practices, the suicide expert also identified concerns with staff attendance at required trainings in 2014. Specifically, he found that attendance for the annual suicide prevention training across 18 prisons varied from 0 percent to 100 percent during the period he reviewed. He reported that 94 percent of custody staff, 69 percent of medical staff, and 63 percent of mental health staff received the annual suicide prevention training in the 18 prisons during 2014. He concluded that the compliance rates for training both medical and mental health staff remained problematic.

The suicide expert found that attendance for the annual suicide prevention training across 18 prisons varied from 0 percent to 100 percent during 2014.

In addition, our review found that CIW's trainers themselves have missed required classes. Corrections requires that instructors teaching suicide prevention and risk evaluation trainings participate in specific train-the-trainer courses. Although both of CIW's instructors for the suicide prevention training and the instructor for the risk evaluation training attended the required courses, only one of five of its mentors had received the necessary training. Further, the two suicide prevention trainers taught several trainings before they were qualified to do so per Corrections' requirements. CIW's suicide prevention

team coordinator stated that she received training from Corrections and that she subsequently provided training to all mentors. She explained that she believed the training she provided was sufficient to fulfill the training requirements for mentors. However, the clinical support chief stated that all mental health staff are required to receive Corrections' training before mentoring other staff. She further explained that, at one point, Corrections allowed prisons to train their own mentors, but it discontinued this practice around 2013 after realizing the content was not always adequately communicated.

Unless Corrections ensures that its trainers have the knowledge and tools necessary to provide instruction in an engaging and effective manner, it reduces the effectiveness of its training about suicide prevention practices. In the suicide expert's January 2015 report, he stated that he attended the required one-hour suicide prevention trainings at seven prisons and that many were problematic. For example, the suicide expert noted that at one of the trainings, the instructor simply read the nearly 40 PowerPoint slides at a fairly quick pace, ending the presentation after about 25 minutes. The suicide expert pointed out that another training lasted roughly 40 minutes and that the only interaction between the instructor and the participants occurred when one participant asked about the length of the class. He also observed that one prison had only offered the suicide prevention training via DVD. If Corrections does not ensure that all trainers receive instruction on delivery, it risks its trainers poorly presenting information and failing to create meaningful discussions regarding the training topic, which significantly diminishes the value to those attending the training.

We found that some of Corrections' suicide prevention trainings were missing required content.

Additionally, we found that some of Corrections' suicide prevention trainings were missing required content. For example, Corrections' policies require that the annual suicide prevention and response training explain how to handle situations in which inmates with mental health concerns commit violations of prison rules. However, we did not find such content in the suicide prevention training from 2014 through 2016. Corrections offers a training that focuses on situations involving violations of prison rules, but that training is not offered to everyone whom Corrections requires to take the annual suicide prevention training. Corrections must also follow a 2015 court order requiring it to incorporate into its trainings certain topics that the suicide expert's January 2015 report outlines. The suicide expert recommended that Corrections expand the length and content of certain suicide prevention trainings by including various topics, such as dealing effectively with inmates perceived to be manipulative. Although the annual suicide prevention training, risk evaluation training, and a training aimed at helping staff improve the accuracy of diagnoses contained discussion of such perceptions, a webinar on treatment planning in risk evaluations did not. Without required content, Corrections' trainings will lack effectiveness in

preventing suicides and improving responses to attempted suicides. For example, if Corrections' staff assume inmates are expressing suicidal thoughts in order to obtain some benefit—in other words, are being manipulative—the staff may miss important warning signs of impending suicide attempts.

Staff Vacancies Continue to Challenge Corrections' Ability to Provide Sufficient Mental Health Services to Inmates

For more than 20 years, Corrections has continued to struggle to fill key mental health position vacancies, creating the risk that it may not be able to adequately serve inmates in need of mental health services. In a May 2016 report, the special master recounts that the court in *Coleman* ruled in 1995 that Corrections was significantly and chronically understaffed in the area of mental health care services and did not have sufficient staff to treat the large numbers of mentally ill inmates in its custody. The special master reported that during the intervening 20 years, the proportion of Corrections' inmates requiring mental health care soared from less than 15 percent to 29 percent of the total inmate population, for a total of nearly 37,000 inmates requiring mental health care. In 2002 the court ordered Corrections to maintain a vacancy rate among psychiatrists, psychologists, and social workers of not more than 10 percent.

When we reviewed Corrections' data on three key positions the court identified—psychiatrists, psychologists, and social workers—we found that vacancy rates were highest among psychiatrists. According to our analysis of Corrections' data, its prisons overall had a 31 percent vacancy rate for psychiatrists, 9 percent for psychologists, and 2 percent for social workers as of December 2016. Each of the four prisons we reviewed had vacancy rates below 10 percent for social workers and at or below 10 percent for psychologists. However, CCWF, RJD, and SAC have continued to struggle to fill psychiatrist positions, with vacancy rates of about 32 percent, 31 percent, and 44 percent, respectively. According to a March 2017 report from the National Council for Behavioral Health, there is a national shortage of psychiatrists. Only CIW had vacancy rates below 10 percent for all three classifications. When prisons do not maintain adequate mental health staff, their ability to provide quality mental health care to inmates can suffer. For example, according to the coordinator of SAC's suicide prevention team, a shortage of psychiatrists has a trickle-down effect because if inmates do not receive the proper medication, they may act out more and require additional attention or therapy, exacerbating mental health staff's already heavy workloads.

When we reviewed Corrections' data on three key positions the court identified—psychiatrists, psychologists, and social workers—we found that vacancy rates were highest among psychiatrists at 31 percent as of December 2016.

Furthermore, the prisons' total authorized mental health positions may not be enough to fulfill inmates' needs. For example, CIW's chief of mental health stated that even when CIW's mental health positions are almost fully staffed, mental health staff still feel overwhelmed and do not have time to meet with inmates as often as they believe is needed. Similarly, the chief of mental health at CCWF stated that although workloads seem manageable based on Corrections' minimum requirements for mental health care, inmates sometimes require significantly more visits than the minimum required, effectively increasing staff workload. She explained that given the increased workload for suicide prevention, mental health staff may neglect routine but important tasks, such as completing follow-up suicide risk evaluations, to focus on urgent matters, such as responding to imminent suicide threats.

The staffing problems that these prisons noted are likely in part due to the fact that Corrections has not updated its staffing model since 2009. Specifically, the chiefs of mental health at both CIW and CCWF expressed the need for Corrections to revisit the staffing model it uses to determine the number of mental health staff needed per prison. For example, CCWF's chief of mental health indicated that the staffing ratios for women's prisons is 20 percent higher than staffing ratios for men's prisons in the model; however, this adjustment is not enough to compensate for the increased number of mental health crises and referrals that arise with the female inmate population. Corrections' associate director of policy and clinical support (associate director) acknowledged that Corrections has not revised the model since 2009, eight years ago. She explained that when calculating the number of staff needed per prison, the model does not take into account the following factors: gender; facility layout; security level; and number of inmates in each security level, excluding restricted housing. The associate director explained that she believes Corrections needs to revisit the 2009 staffing model to take into account some of these factors as well as Corrections' revised policies, recent court orders, the prisons' implementation of the new electronic health record system, and the prisons' adherence to requirements based on its current filled positions.

Recommendations

Legislature

To provide additional accountability for Corrections' efforts to respond to and prevent inmate suicides and attempted suicides, the Legislature should require that Corrections report to it in April 2018 and annually thereafter on the following issues:

- The status of its efforts to ensure that all mental health staff receive required training and mentoring related to suicide prevention and response.
- The status of its efforts to fill vacancies in its mental health treatment programs, especially its efforts to hire and retain psychiatrists.

Corrections

To address the unique circumstances that may increase its female inmates' rates of suicide and suicide attempts, Corrections should take the following actions:

- Implement its planned same-sex domestic violence curriculum by December 2017.
- Continue to explore additional programs that could address the suicide risk factors for female inmates.

To ensure that all prison staff receive required training related to suicide prevention and response, Corrections should immediately implement a process for identifying prisons where staff are not attending required trainings and for working with the prisons to solve the issues preventing attendance.

To ensure that trainers and risk evaluation mentors at all prisons are able to train staff effectively, Corrections should immediately begin requiring prisons to report the percentage of their trainers and mentors who have received training on how to conduct training and mentoring. It should work with prisons to ensure that all trainers and mentors receive adequate training.

To maximize the value of its trainings related to suicide prevention and response, Corrections should ensure that starting in January 2018, its trainings include all content that the special master and its own policies require.

To ensure that it has enough staff to provide mental health services to all inmates who require care, Corrections should review and revise its mental health staffing model by August 2018.

Chapter 3

TO REDUCE INMATE SUICIDES AND ATTEMPTS, CORRECTIONS MUST STRENGTHEN ITS OVERSIGHT AND DEMONSTRATE GREATER LEADERSHIP

Corrections has struggled for decades to adequately provide mental health services to inmates. As a result, most of its efforts to reduce its inmate suicide rates in recent years have been in response to court-ordered oversight. For example, in response to the suicide expert's 2015 recommendations, it adopted a number of policies, implemented facility improvements, and improved its training. However, its policies are unlikely to have significant impact if it does not ensure that the prisons fully implement and adhere to them—which it has yet to do. Although Corrections stated it is developing an audit process to ensure that prisons comply with policies and procedures, it has known about their noncompliance for years, and it is uncertain as to when it will fully implement this process across all prisons. Similarly, Corrections created teams at each of the prisons to specifically focus on suicide prevention and response; however, it has not ensured that these teams consistently provide leadership on critical issues. In addition, Corrections has not always proactively sought opportunities to demonstrate leadership in regards to documenting and disseminating programs or best practices for preventing inmate suicide.

Although Corrections Has Developed Policies and Training to Address Past Recommendations, It Has Not Ensured That Prisons Fully Implement These Changes

From November 2013 through July 2014, the suicide expert conducted a comprehensive audit of suicide prevention practices in each of Corrections' prisons. This audit resulted in a January 2015 report containing 32 recommendations. The court in *Coleman* subsequently ordered Corrections to work with the special master to develop strategies to implement these recommendations, and it also ordered the suicide expert to provide an updated report on Corrections' progress. The suicide expert completed this updated report in January 2016, in which he stated that Corrections had begun to implement corrective actions in response to his recommendations. Through the adoption of new policies, improvements to its facilities, changes to its trainings, and other actions, Corrections has now addressed the majority of the recommendations from the suicide expert's January 2015 report. Table 7 on the following page lists selected recommendations from the suicide expert's 2015 report to Corrections and Corrections' responses to those recommendations.

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Table 7
Selected Recommendations From the Suicide Expert's 2015 Report

RECOMMENDATION	CORRECTIONS' ACTION IN RESPONSE TO RECOMMENDATION	DATE ACTION TAKEN	IS CORRECTIONS ENFORCING/MONITORING COMPLIANCE WITH THIS POLICY?
Corrections should revise its risk evaluation mentoring program to require ongoing mentoring throughout the year and audit mental health staff's risk evaluations on a regularly scheduled basis.	Issued memorandum to all prisons implementing a revised mentoring program and describing regular audits of risk evaluations.	March 2016	**No.** Corrections tracks aggregate information the prisons report to monitor compliance, but does not follow up with the prisons.
Corrections should enforce its policy authorizing only two levels of observation for suicidal inmates: *suicide precaution* and *suicide watch*.	Issued memorandum to all prisons reiterating existing policy that the only two levels of observation are suicide precaution and suicide watch.	March 2016	**No.** Will begin monitoring systemwide once it finalizes its audit process, which does not have an implementation date.
Corrections should take action to correct inaccurate documentation on inmate suicide precaution observation forms.	Issued memorandum to all prisons reiterating existing policy regarding documentation on suicide precaution observation forms.	March 2015	**No.** Will begin monitoring systemwide once it finalizes its audit process, which does not have an implementation date.
Corrections should enforce its policy of housing only newly admitted inmates in administrative segregation units in retrofitted suicide-resistant cells for their first 72 hours of admission to the prison.	Included reiteration of this policy in its annual suicide prevention training.	July 2015	**No.** Will begin monitoring systemwide once it finalizes its audit process, which does not have an implementation date.
Corrections should ensure all crisis beds are suicide resistant.	Developed a schedule to begin retrofitting cells at identified prisons.	November 2015	Corrections indicated one prison required extensive retrofitting and is still in progress.
Corrections should revise its policy so that all inmates discharged from a crisis bed or alternative housing, where they had been housed due to suicidal behavior, are observed at 30-minute intervals by custody staff, regardless of the housing units to which they are transferred.	Issued revised policy regarding checks of inmates discharged from crisis beds, and is working to finalize a policy regarding alternative housing.	January 2016	**No.** Will begin monitoring systemwide once it finalizes its audit process, which does not have an implementation date.
Corrections should take corrective action to address inconsistencies between privileges allowed for patients in crisis beds.	Issued memo reiterating and clarifying policy regarding privileges for inmates in crisis beds.	June 2016 (revised February 2017)	**No.** Will begin monitoring systemwide once it finalizes its audit process, which does not have an implementation date.

Sources: The suicide expert's 2015 report, Corrections' memoranda, and interviews with Corrections' officials.

Several of the recommendations from the suicide expert's 2015 report directed Corrections to revise, examine, or enforce existing policies. Corrections addressed several of these recommendations by issuing memos to the prisons that either reiterate or revise policies. For example, Corrections' 2009 program guide states that custody staff must conduct hourly checks for the first 24 hours after discharge of inmates at risk of suicide who had been admitted to a crisis bed or alternative housing. However, the suicide expert recommended in his 2015 report that these checks occur at 30-minute intervals. In response to this recommendation, Corrections issued a memorandum in January 2016 requiring checks every 30 minutes for the first 24 hours that inmates are discharged from crisis beds.

Corrections is working to finalize a similar policy for inmates released from alternative housing. Further, Corrections made changes to its suicide prevention training and risk evaluation mentoring program.

Corrections has yet to fully ensure prisons' compliance with the new and revised policies resulting from the suicide expert's recommendations.

However, Corrections has yet to fully ensure prisons' compliance with the new and revised policies resulting from the suicide expert's recommendations. For example, despite these policies, many of the problems we identify in Chapter 1 relate to the completion and quality of both risk evaluations and treatment plans. Further, these same issues have persisted for years: court-ordered reports by the special master dating back to 2002 identified similar concerns. In addition, Corrections has yet to ensure attendance at suicide prevention team meetings, as we describe later in this chapter. Further, as we show in Chapter 1, the monitoring it currently provides does not result in significant positive change at the prisons. Although revising policies and holding trainings are important parts of improving prisons' ability to prevent and respond to suicides, Corrections cannot ensure that prisons actually comply with its policies unless it provides adequate monitoring.

Corrections is still developing an audit process to, among other things, track implementation of several of the suicide expert's recommendations. According to Corrections' quality administrator, Corrections is integrating certain recommendations from the suicide expert's report into an audit process for conducting audits of prisons' compliance with policies and procedures. The portion of the audit process conducted on site at the prisons rates 12 broad areas—including treatment planning processes, suicide prevention and response to suicide, leadership, staffing, and quality management—on a scale ranging from *proficient* to *urgent concerns*. The resulting reports include specific recommendations.

We reviewed the report of a pilot audit that Corrections conducted of a certain prison and found that the audit was thorough and critical in its analysis of identified deficiencies. According to the report, the audit combined performance data, document reviews, patient and staff interviews, health care record reviews, and the regional teams' on-site observations of the prison's day-to-day operations. Our review suggests that the audit process may prove helpful as Corrections begins improving areas in which it has consistently struggled, particularly because it requires monitoring of several of the suicide expert's recommendations. For example, in response to one of the suicide prevention expert's recommendations, Corrections issued a memo to prisons in March 2016 that explicitly states that they can use only suicide watch or precaution levels of observation for suicidal inmates in crisis beds. According to the health care administrator in charge

of quality control, Corrections added instructions on reviewing prisons' use of suicide watch and precaution to the audit process in response to the suicide expert's recommendations.

Nevertheless, the audit process has been in development for some time. According to Corrections' chief psychologist of the health care division, the court in *Coleman* indicated several times that Corrections needs to demonstrate that it has a full quality improvement system in place that includes processes for continually monitoring, enforcing, and improving its policies and procedures. She explained that, to comply with this requirement with the eventual goal of replacing the court's monitoring, Corrections began developing the audit process and expanded the role of its regional teams, who will be following it. Corrections' quality administrator stated that Corrections first began development of the audit process in 2013, that the regional teams have conducted several initial audits of selected prisons, and that they plan to continue developing the process for use systemwide in the future. However, the quality administrator indicated that Corrections has not established a concrete date for implementation of the audit process systemwide. Corrections' quality administrator stated that it is continuing to work collaboratively with the special master to finalize the audit process. Until Corrections fully implements the audit process systemwide, it lacks assurance as to whether its prisons are adhering to the policies it put in place to address several of the suicide expert's recommendations.

Despite issuing and revising numerous policies, Corrections has not updated its program guide to reflect these changes since 2009.

Additionally, despite issuing and revising numerous policies, Corrections has not updated its program guide to reflect these changes since 2009, creating the potential for confusion for the prisons that must implement those policies. Corrections' clinical support chief stated that it would have to coordinate any formal revision to the entire program guide with the special master. However, she explained that prisons can access all of Corrections' policy changes at a central location on its intranet. Further, in March 2017 the court in *Coleman* encouraged Corrections to update its program guide through the publication of addenda called "pocket parts." However, the fact that prison and mental health staff must refer both to the program guide and to any relevant update memos and addenda when determining how to implement policies, is inefficient and adds needless confusion to an already complex process.

Updating the program guide would also help Corrections to identify and correct inconsistencies within it. For example, the program guide states that inmates must not stay in crisis beds for more than 10 days without the approval of a high-ranking official. However, one part of the program guide states that approval must come from the chief of mental health or the appropriate designee,

whereas another part states that approval must come from the chief psychiatrist or the appropriate designee. These are different positions at the four prisons we reviewed. Although we did not identify specific concerns related to this discrepancy, it is further indicative of the need for Corrections to review and revise its program guide. When Corrections does not ensure that prisons are implementing policy changes appropriately or does not document its policies in a clear, organized, consistent, and consolidated fashion, it risks creating confusion and inconsistency in the treatment that prisons provide to inmates. According to Corrections' deputy director of the statewide mental health program, Corrections intends to incorporate appropriate portions of the program guide into state regulations, which will help strengthen Corrections' mental health system. She explained that Corrections has been working on memorializing the policies in regulations, but has yet to begin the formal process for promulgating the regulations and does not have a time frame for when it intends to begin this process.

Corrections Has Not Ensured That Prisons' Suicide Prevention Teams Adequately Fulfill the Purposes for Which They Were Created

Although Corrections established a statewide suicide prevention team as well as suicide prevention teams at each of the prisons, it has not ensured that these teams exercise sufficient leadership to help prevent suicides. To reduce the risk of inmate suicides, Corrections' policies require the suicide prevention teams to provide staff with training and guidance with regard to suicide prevention, response, reporting, and review. Corrections' policies state that the statewide suicide prevention team and teams at each prison must meet at least monthly, and require that individuals in certain positions, as the text box shows, attend each meeting. However, only one of the four prisons we reviewed met Corrections' attendance requirements. Further, the suicide prevention teams often failed to discuss key issues that might enable the prisons to better prevent suicides.

Required Membership of Suicide Prevention Teams

Prisons:

- Suicide prevention team coordinator (chairperson)
- Chief psychiatrist*
- Chief psychologist*
- Supervising registered nurse
- Senior licensed psychiatric technician or licensed psychiatric technician
- Correctional health services administrator
- Department of State Hospitals' coordinator

Statewide:

- Suicide prevention team coordinator (chairperson)
- Chief psychiatrist
- Chief psychologist
- Nurse consultant
- Designated facility captain

Source: Corrections' 2009 program guide.

* A senior psychiatrist or senior psychologist attendance meets the quorum requirement in prisons without a chief psychiatrist or chief psychologist position.

Suicide prevention and response in California's prisons requires attention from multiple clinical disciplines. If required members are absent, they and the staff they supervise risk missing important information, and the suicide prevention team lacks the insight of the missing members. Nonetheless, only CCWF met attendance

requirements for its team in 2016. Although each of the four prisons we visited held monthly suicide prevention team meetings during 2016, the minutes of these team meetings at CIW, SAC, and RJD indicate that they did not meet attendance requirements for 11, 10, and eight monthly meetings, respectively, in 2016. We also found instances in which required suicide prevention team members missed several meetings. For example, at CIW the chief psychiatrist or a designee failed to attend eight of 12 meetings, and at SAC the supervising registered nurse missed six of 12 meetings.

These attendance issues have been brought to Corrections' attention before, and it has pointed to obstacles that make achieving a quorum challenging. For instance, the suicide expert stated in his 2016 report that he found that attendance by some required suicide prevention team members, particularly chief psychiatrists or their designees, was inconsistent at many prisons. Specifically, he explained that eight of the 18 suicide prevention teams he reviewed still fell short of attaining a quorum at their monthly meetings. Corrections' clinical support chief stated that prison staff have many competing demands, making it difficult for teams to coordinate schedules and added that Corrections overlooked the difficulties in assembling key participants in these meetings at the time leadership drafted the program guide. She further explained that some elements regarding suicide prevention team attendance are not clear, such as whether one individual may fill multiple roles and who may send designees. Nevertheless, we found that CCWF was able to meet the attendance requirements every month during 2016. CCWF's chief of mental health explained that its team plans several weeks in advance of a meeting to ensure that all required members can attend, reminds team members about the meeting during the week it is scheduled, and waits until all members are present before starting the meeting.

Selected Responsibilities of Prisons' Suicide Prevention Teams

- Ensure implementation of and compliance with all Corrections' policies and procedures relating to suicide prevention and response.
- Implement training related to suicide prevention and response.
- Update local operating procedures to ensure consistency with Corrections' policies regarding suicide prevention and response.
- Review all suicides and suicide attempts in response to which staff performed CPR or other medical procedures, as well as prison staff cell entry and cut-down procedures.
- Monitor and track all suicide gestures, suicide attempts, self-mutilations, and deaths.

Source: Corrections' 2009 program guide.

Further, the suicide expert raised concerns regarding whether the prisons' suicide prevention teams had fully met their responsibilities, some of which are listed in the text box. For instance, one of these responsibilities is ensuring each prison's implementation of and compliance with all of Corrections' policies and procedures relating to suicide prevention and response. However, in his 2016 report, the suicide expert found that the suicide prevention teams had not adequately monitored and evaluated the risk evaluations completed at their respective prisons. Specifically, the suicide expert stated that the prisons' suicide prevention teams were collecting only

quantitative but not qualitative monthly data on the completion of risk evaluations. Moreover, in his 2015 report, the suicide expert explained that he found that the prisons engaged in little discussion of overall suicide prevention strategies during their meetings. He commented that most meeting minutes reflected recitations of certain monthly statistics, but included few meaningful discussions about challenging cases or struggles with risk evaluations and treatment planning. In his January 2016 report, he stated that he found few positive changes in suicide prevention team practices at the 18 prisons he reviewed.

We identified similar concerns when we reviewed the minutes for the past three years of suicide prevention teams' meetings at the four prisons we visited. Specifically, the teams often did not discuss key issues, including self-harm incidents and the completion of risk evaluations. CCWF's minutes indicate that the suicide prevention team's reviews of attempted suicides were mostly narrations of events or recitation of statistics rather than analytical discussions focused on lessons learned and prevention. For example, its May 2016 minutes describe that two inmates attempted suicide by swallowing foreign objects, but the minutes do not indicate any actions required or lessons learned as a result of these incidents. In the same minutes, the team reported that the prison's mental health staff had a 29 percent passing rate for risk evaluation audits, but the minutes do not indicate that the team discussed what caused the low passing rate and how they planned to improve staff performance. Similarly, at RJD, discussions about mentoring and training prison staff regarding the completion of risk evaluations largely focused on quantitative data, such as attendance and completion rates. Further, RJD's suicide prevention team minutes do not indicate that discussions extended to the quality of the training or mentoring. Without such discussions, the work of the suicide prevention teams becomes more focused on reporting data rather than ensuring compliance with Corrections' policies and procedures related to suicide prevention and response.

Corrections Has Not Ensured That It Reports Reliable Data on Inmate Suicide and Suicide Attempts

Corrections collects and reports data related to its operations using an organizational management tool called COMPSTAT. Each month Corrections publishes a statistical report detailing more than 500 data points on its prisons' operations. According to the COMPSTAT operations manager, Corrections' staff conduct a quality control process that entails reviewing the data they receive from prisons each month. She explained that staff look for outliers, unexpected patterns, and system issues. In addition, she stated that Corrections' staff meet with each prison's staff annually to discuss

the data in detail, which includes a joint annual review with the prison's leadership to discuss each line item in the annual report to ensure that the COMPSTAT numbers match the prison's numbers.

We found discrepancies in the data related to COMPSTAT—Corrections' organizational management tool—that bring into question the data's accuracy.

Nevertheless, we found discrepancies related to COMPSTAT's data that bring into question the data's accuracy. For example, for each of the four prisons we reviewed, we selected four months of COMPSTAT data from 2014 through 2016 and compared those months to the prisons' incident logs. We found that COMPSTAT reported a greater number of attempted suicides at CIW and suicides at CCWF than were recorded in their incident logs, and that it reported fewer attempts at SAC and RJD than were recorded in their respective logs. Further, when we reviewed suicide prevention team meeting minutes, incident reports, and other records, we found that COMPSTAT did not include suicides that occurred from 2013 through 2016 at three of the prisons we reviewed. Moreover, we were surprised to find that the special master's reports identify significantly more suicides from 2012 through 2015 than are recorded in COMPSTAT. For instance, COMPSTAT shows 18 suicides in 2015, while the suicide expert reported 24—a 33 percent difference.

Corrections' clinical support chief offered a number of explanations for the discrepancies we identified. She stated that the special master's reports used data from Corrections' mental health program on suicides in prisons, which she believes are accurate because it is this program that determines whether a death is a suicide. She explained that the numbers in COMPSTAT may be understated because they are based on prison staff's initial incident reports. She told us that the classification of incidents may not be accurate because an inmate may die from an attempted suicide days or weeks after the attempt occurs. Further, she noted that mental health staff have the opportunity to more thoroughly review the circumstances of incidents, which may cause them to reach different conclusions than the prison staff's initial incident reports reflect. In these instances, the clinical support chief indicated that the mental health program's data will reflect its staff assessment of the incident, but COMPSTAT may not. Specifically, she explained that prison staff are supposed to update this information in COMPSTAT by providing updated incident reports; however, she believes this step may not have always occurred given the understated suicide numbers in COMPSTAT.

The clinical support chief stated that she has previously raised these concerns with the COMPSTAT team, and the team was not resistant to adjusting its processes in order to present more accurate data. Because COMPSTAT represents Corrections' comprehensive source of data it makes readily available to the public on suicides and attempted suicides for each of its prisons, it must take steps

to ensure that the data are accurate. Otherwise, the public may draw incorrect conclusions about the rate of suicides and suicide attempts at a given prison or in the system as a whole.

Corrections Can Increase Its Documentation and Dissemination to Prisons of Best Practices Related to Suicide Prevention

Although innovative programs and best practices related to inmate suicide prevention exist, Corrections could increase its efforts to document and disseminate this information to the prisons, and to monitor the success of programs or practices that could prove beneficial. For example, during our visit to RJD, we noted that it had implemented a program known as Striving to Achieve Rewards (STAR) that might benefit certain inmates at other prisons as well. RJD implemented STAR in August 2016 for inmates in its enhanced outpatient program, which provides care for mentally disordered inmates in a structured therapeutic environment that is less restrictive than inpatient care. According to a STAR pamphlet, the program's purpose is to improve inmate quality of life by creating a therapeutic community where inmates have many opportunities for positive experiences. STAR provides rewards to inmates for engaging in positive behavior, such as attending mental health groups and treating mental health staff and peers in a respectful manner. Over time, the inmates accumulate points that they can use for different levels of rewards, including participating in drama and book clubs and purchasing items, such as hygiene products, from the STAR store. RJD's chief psychologist stated that preliminary data, while not conclusive, have indicated that incidents of self-harm and rules violations have decreased since STAR began, even though RJD's inmate population has increased.

RJD implemented a program that rewards positive behavior, such as attending mental health groups and treating staff and peers in a respectful manner. RJD stated that incidents of self-harm and rules violations have decreased since the program began.

We also noted another program that RJD is in the process of developing that could prove useful for staff working in other prisons. Specifically, according to the program-related materials, workplace stress and job burnout are high among staff working in correctional settings. To better support its staff in managing its high-risk inmate population, RJD began developing a program named Helping Everyone Reach Objectives. The program's documentation indicates that RJD is designing a framework to provide additional resources and support to its multidisciplinary treatment teams who directly deal with inmate-patients. The program aims to ensure that RJD continues to provide high-quality care to its inmate population by providing staff with consultation and coaching, as well as fostering closer collaboration between all prison staff. According to RJD's chief psychologist, the prison had implemented aspects of the program with certain staff as of May 2017. It anticipates an increased rollout by the summer of 2017.

Corrections' clinical support chief agreed that RJD's programs are innovative and explained that implementing them on a systemwide basis might be useful at some prisons, depending on those prisons' missions, infrastructures, and security levels. Nevertheless, Corrections' documentation related to discussion and dissemination of innovative programs and best practices related to suicide prevention is limited. For example, the deputy director of Corrections' statewide mental health program stated that in February 2016, Corrections' mental health program held a summit regarding suicide prevention at its headquarters in Northern California. She explained that prison leadership, including prisons' suicide prevention team coordinators, chiefs of mental health, and selected wardens, attended the summit to discuss challenges with suicide prevention, share best practices, and identify additional initiatives that might help improve the suicide prevention efforts already in place. She noted that Corrections has a number of plans for implementing ideas such as increasing outreach to inmates both inside and outside of mental health care. However, she could not provide documentation of the best practices discussed or of the outcomes of the summit's discussions—she could only provide the agenda and a spreadsheet listing Corrections' suicide prevention team's July 2017 tasks and priorities, which indicated the suicide summit occurred and another one would be scheduled in the near future. She stated that Corrections is tentatively planning to hold another summit in October 2017, and acknowledged that holding these summits at least annually is a good idea. We believe such meetings should occur on an ongoing basis, not only to discuss and document best practices, but also to monitor their effectiveness. This approach would provide Corrections an opportunity to formally disseminate information regarding programs like those at RJD.

Additionally, Corrections' clinical support chief stated that it holds quarterly meetings at headquarters between the prisons' chiefs of mental health where informal discussion on best practices may occur. She further explained that the regional teams hold monthly calls for all prisons within their respective regions, which also allows for the sharing of ideas and best practices. However, because these discussions are not documented, the clinical support chief could not provide evidence of any best practices discussed. Because it has not documented the discussion of best practices during these meetings and calls, Corrections has likely missed opportunities to formally identify and disseminate innovative program ideas systemwide, as well as to evaluate the effectiveness of these practices.

Corrections Could Do More to Assess Ways to Reduce Suicide Attempts

Corrections' policies require that it review each suicide to determine whether staff complied with its policies and procedures, such as the prison's emergency response to the suicide, completion of suicide risk evaluations, and follow-up treatment after the inmate's discharge from a crisis bed prior to the suicide. The text box lists the specific information Corrections reviews. Corrections' policies require it to submit a report to the prison within 60 days of the inmate's death that includes recommended actions to address any problems it identified during its review and due dates for the prison to complete those actions. Prisons then have 90 days to submit documentation proving they have implemented the recommendations. According to Corrections' clinical support chief, Corrections established these timelines to ensure that it promptly identifies problems and that prisons take quick action to correct them.

Information Included in Corrections' Investigation of an Inmate Suicide

- Emergency response to the incident.
- Medical autopsy and toxicology findings.
- Inmate's background.
- Inmate's ability to function in an institutional setting.
- Inmate's mental health history.
- Inmate's suicide attempt history.
- Mental health care the inmate received while incarcerated.
- Inmate's medical history.
- Significant events preceding the suicide.

Source: California State Auditor's analysis of Corrections' suicide report template.

The resulting reports are comprehensive enough to provide Corrections and its prisons with information critical to improving suicide prevention and response. Nonetheless, Corrections does not conduct similarly detailed reviews of the circumstances surrounding suicide attempts. As a result, it may not identify problems with clinical care or prisons' compliance with policies until those problems have contributed to an inmate's death. Although Corrections' policies require prisons to monitor and track suicide attempts, we do not believe Corrections requires sufficient detail in these reviews. Specifically, as of March 2017, its policies require that prisons' suicide prevention teams review the appropriateness of treatment plans for these inmates and the daily follow-up checks that mental health staff must complete for five days following the inmates' discharges from crisis beds. However, Corrections does not require prisons to review other important circumstances surrounding suicide attempts, such as the actions of staff responding to the incidents and the adequacy of the risk evaluations that mental health staff completed before the attempts.

One of the four prisons we reviewed has implemented policies requiring in-depth documented reviews of selected self-harm incidents, including suicide attempts, at its facility. Specifically, SAC implemented a policy requiring its suicide prevention coordinator and supervisors involved with crisis triage and inpatient care to identify self-harm incidents that might require detailed review, such as incidents where the inmates suffered serious bodily injury.

SAC prison officials explained that the suicide prevention team assigns mental health staff to conduct a review of the identified incident. According to a prison official at SAC, since 2008 the prison has completed roughly 450 of these self-harm reviews, but has performed a decreasing number because of increasing workloads and time constraints. We reviewed three of these reviews that the prison completed in 2016 and found that they generally included a thorough review of the inmates' mental health history, mental health status, and suicide risk. However, the reviews did not contain an examination of the adequacy of the inmates' previous risk evaluations or treatment plans, and were not as detailed or pointed in their criticism as Corrections' suicide review process.

Corrections plans to require prisons to complete more detailed reviews of suicide attempts. According to Corrections' clinical support chief, Corrections will require prisons to conduct detailed reviews of a selection of self-harm incidents where the inmate intended to die and there was serious bodily injury beginning in July 2017. She said that the prisons will need to review all of the same items that are included in the suicide reviews, except those that are not applicable, such as autopsy and toxicology reports, or those that would be inappropriate due to the need to protect inmate privacy, such as cellmate or peer interviews. However, even if Corrections requires prisons to be more detailed in their examination of self-harm incidents, prison staff are less likely to be as critical of their own processes as an external reviewer from Corrections might be. Corrections' clinical support chief stated that requiring Corrections to conduct such reviews at each prison could be resource intensive, but that pairing each prison with another, similar prison and having them review each other could help to ensure that the reviews are impartial. Absent an unbiased, thorough review of the factors contributing to inmate suicide attempts, Corrections may not identify potential problems with prisons' suicide prevention and response practices until after inmates have already died.

Recommendations

Legislature

To provide additional accountability for Corrections' efforts to respond to and prevent inmate suicides and attempted suicides, the Legislature should require that Corrections report to it in April 2018 and annually thereafter on the following issues:

- Its progress in implementing the recommendations made by the special master's experts, the court-appointed suicide expert, and its own reviewers regarding inmate suicides and attempts. Corrections should include in its report to the Legislature the results of any audits it conducts as part of its planned audit process to measure the success of changes it implements as a result of these recommendations.

- Its progress in identifying and implementing mental health programs that may ameliorate risk factors associated with suicides at the prisons.

Corrections

To ensure that prisons comply with its policies related to suicide prevention and response, Corrections should continue to develop its audit process and implement it at all prisons by February 2018. The process should include, but not be limited to, audits of the quality of prisons' risk evaluations and treatment plans.

To ensure that prisons can easily access Corrections' current policies related to mental health, Corrections should ensure that its program guide is current and complete as it works to incorporate the program guide into regulations. Corrections should immediately begin working with federal court monitors to draft regulations.

To ensure that suicide prevention teams meet quorum requirements, Corrections should, starting January 2018, work with prisons that consistently fail to achieve a quorum to resolve issues that may be preventing the teams from having all required members present at meetings.

To eliminate confusion regarding suicide prevention team meeting attendance, Corrections should immediately update its program guide to clarify who is required to attend suicide prevention team meetings, which attendees may send designees, and the extent to which staff may fill multiple roles when meeting quorum requirements.

To ensure that suicide prevention teams exercise leadership at prisons, Corrections should immediately require them to use available information about critical factors—such as the number and nature of inmate self-harm incidents and the quality and compliance with the policy of risk evaluations and treatment plans—to identify systemic issues related to suicide prevention. Corrections should require the suicide prevention teams to assess lessons they can learn, create plans to resolve current issues, and prevent foreseeable problems in the future.

To provide the public and relevant stakeholders with accurate information on suicides and suicide attempts in its prisons, Corrections should immediately require prison staff to work with mental health staff to reconcile any discrepancies on suicides and suicide attempts before submitting numbers to the COMPSTAT unit.

To ensure that all its prisons provide inmates with effective mental health care, Corrections should continue to take a role in coordinating and disseminating best practices related to mental health treatment by conducting a best practices summit at least annually. The summits should focus on all aspects of suicide prevention and response, including programs that seek to improve inmate mental health and treatment of and response to suicide attempts. Corrections should document and disseminate this information among the prisons, assist prisons in implementing the best practices through training and communication when needed, and monitor and report publicly on the successes and challenges of adopted practices.

In an effort to prevent future inmate suicide attempts, Corrections should implement its plan to review attempts with the same level of scrutiny that it uses during its suicide reviews. Corrections should require each prison's suicide prevention team to identify for review at least one suicide attempt per year that occurred at its prison. To ensure that the reviews include critical and unbiased feedback, Corrections should either conduct these reviews itself or require the prisons to review each other. These reviews should start in September 2017 and follow the same timelines as the suicide reviews, with the timeline beginning once the team identifies a suicide attempt for review.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the Scope and Methodology section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

Elaine M. Howle

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State Auditor

Date: August 17, 2017

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Appendix A

RATES OF INMATE SUICIDES AND SUICIDE ATTEMPTS IN STATE PRISONS FROM 2012 THROUGH 2016

The Joint Legislative Audit Committee (Audit Committee) requested that we compare the rates of suicides and attempted suicides for male and female inmates in all state prisons from 2014 through 2016. In order to calculate these rates, we used data from Corrections' COMPSTAT system because it is the most comprehensive source of publicly reported data for the entire correctional system. Based on our analysis of COMPSTAT data, Table A beginning on the following page presents the rates and number of inmate suicides and suicide attempts at each state prison from 2012 through 2016. As we discuss in Chapter 3, the data from COMPSTAT on inmate suicides and attempted suicides are unreliable; however, they are also the most comprehensive, as well as being the data Corrections makes available to the public. Therefore, we present the data here but recommend in Chapter 3 that Corrections take steps to ensure its accuracy in the future.

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Table A
Suicides and Suicide Attempts in Each California Prison From 2012 Through 2016

	2012					2013				
		ATTEMPTED SUICIDES		SUICIDES			ATTEMPTED SUICIDES		SUICIDES	
PRISON	POPULATION	TOTAL	PER 1,000	TOTAL	PER 1,000	POPULATION	TOTAL	PER 1,000	TOTAL	PER 1,000
Avenal State Prison	5,020	5	1.00	1	0.20	4,497	3	0.67	0	0.00
California City Correctional Facility	—	—	—	—	—	—	—	—	—	—
California Correctional Center	4,657	2	0.43	0	0.00	4,903	2	0.41	0	0.00
California Correctional Institution	4,643	5	1.08	1	0.22	4,572	5	1.09	1	0.22
California Health Care Facility	—	—	—	—	—	—	—	—	—	—
California Institution for Men	5,002	10	2.00	0	0.00	4,747	7	1.47	0	0.00
California Institution for Women	*1,636*	*13*	*7.95*	*1*	*0.61*	*2,095*	*15*	*7.16*	*0*	*0.00*
California Medical Facility	2,363	17	7.19	1	0.42	2,250	28	12.45	2	0.89
California Men's Colony	5,368	21	3.91	0	0.00	4,983	29	5.82	0	0.00
California Rehabilitation Center	3,694	1	0.27	0	0.00	3,434	1	0.29	0	0.00
California State Prison, Corcoran	4,626	20	4.32	1	0.22	4,410	16	3.63	1	0.23
California State Prison, Los Angeles County	3,848	13	3.38	0	0.00	3,723	7	1.88	1	0.27
California State Prison, Sacramento	*2,693*	*22*	*8.17*	*1*	*0.37*	*2,233*	*32*	*14.33*	*1*	*0.45*
California State Prison, Solano	4,313	4	0.93	1	0.23	4,007	2	0.50	0	0.00
California Substance Abuse Treatment Facility and State Prison	5,683	15	2.64	0	0.00	5,603	11	1.96	0	0.00
California Training Facility, Soledad	5,759	4	0.69	0	0.00	5,279	3	0.57	2	0.38
Calipatria State Prison	3,814	0	0.00	0	0.00	3,621	12	3.31	0	0.00
Centinela State Prison	3,659	2	0.55	1	0.27	3,025	1	0.33	0	0.00
Central California Women's Facility	*2,934*	*5*	*1.70*	*0*	*0.00*	*3,532*	*8*	*2.27*	*0*	*0.00*
Chuckawalla Valley State Prison	2,712	0	0.00	0	0.00	2,594	0	0.00	0	0.00
Deuel Vocational Institution	2,504	12	4.79	2	0.80	2,515	6	2.39	0	0.00
Folsom State Prison	2,840	2	0.70	3	1.06	3,017	4	1.33	3	0.99
High Desert State Prison	3,695	8	2.17	0	0.00	3,359	2	0.60	1	0.30
Ironwood State Prison	3,503	3	0.86	0	0.00	3,273	3	0.92	0	0.00
Kern Valley State Prison	4,108	10	2.43	0	0.00	3,728	20	5.36	1	0.27
Mule Creek State Prison	3,027	15	4.96	1	0.33	2,822	13	4.61	1	0.35
North Kern State Prison	4,680	8	1.71	0	0.00	4,761	14	2.94	1	0.21
Pelican Bay State Prison	3,091	11	3.56	0	0.00	2,785	17	6.10	0	0.00
Pleasant Valley State Prison	3,737	8	2.14	2	0.54	3,412	5	1.47	1	0.29
Richard J. Donovan Correctional Facility	*3,537*	*28*	*7.92*	*0*	*0.00*	*3,355*	*33*	*9.84*	*3*	*0.89*
Sierra Conservation Center	4,555	1	0.22	1	0.22	4,856	4	0.82	0	0.00
San Quentin State Prison	3,853	13	3.37	3	0.78	4,206	14	3.33	3	0.71
Salinas Valley State Prison	3,607	37	10.26	4	1.11	3,503	27	7.71	2	0.57
Valley State Prison	2,074	12	5.79	0	0.00	3,004	3	1.00	0	0.00
Wasco State Prison	5,043	25	4.96	1	0.20	5,134	27	5.26	1	0.19
Totals*	**126,276**	**352**	**2.79**	**25**	**0.20**	**123,238**	**374**	**3.03**	**25**	**0.20**

Source: California State Auditor's analysis of Corrections' COMPSTAT metrics.

Notes: As we note in Chapter 3 on page 58, our review of various records from individual prisons revealed that COMPSTAT has consistently underreported the number of suicides in California prisons. The numbers in this table are not adjusted; we present them as they appear in COMPSTAT.

Italicized rows represent the four prisons reviewed in this audit.

* Because we calculated populations based on a 12-month average, annual population amounts may differ from the total prison populations due to rounding.

2014					2015					2016				
	ATTEMPTED SUICIDES		SUICIDES			ATTEMPTED SUICIDES		SUICIDES			ATTEMPTED SUICIDES		SUICIDES	
POPULATION	TOTAL	PER 1,000	TOTAL	PER 1,000	POPULATION	TOTAL	PER 1,000	TOTAL	PER 1,000	POPULATION	TOTAL	PER 1,000	TOTAL	PER 1,000
4,028	4	0.99	0	0.00	3,369	3	0.89	0	0.00	3,274	2	0.61	0	0.00
1,825	0	0.00	0	0.00	—	—	—	—	—	1,933	0	0.00	0	0.00
4,909	0	0.00	1	0.20	4,138	1	0.24	0	0.00	3,991	0	0.00	1	0.25
4,404	3	0.68	2	0.45	3,949	11	2.79	1	0.25	3,435	17	4.95	2	0.58
1,626	17	10.45	0	0.00	—	—	—	—	—	2,342	26	11.10	1	0.43
4,636	13	2.80	1	0.22	3,859	7	1.81	1	0.26	3,669	6	1.64	0	0.00
1,994	*15*	*7.52*	*2*	*1.00*	*1,887*	*34*	*18.02*	*2*	*1.06*	*1,882*	*24*	*12.75*	*2*	*1.06*
2,082	16	7.69	1	0.48	2,342	15	6.41	1	0.43	2,563	8	3.12	0	0.00
4,368	18	4.12	0	0.00	3,910	15	3.84	2	0.51	4,101	12	2.93	3	0.73
2,826	0	0.00	0	0.00	4,946	7	1.42	0	0.00	3,006	2	0.67	0	0.00
4,335	17	3.92	0	0.00	4,280	20	4.67	1	0.23	3,640	33	9.07	0	0.00
3,587	22	6.13	0	0.00	3,520	11	3.13	0	0.00	3,479	19	5.46	2	0.57
2,212	*11*	*4.97*	*2*	*0.90*	*2,240*	*12*	*5.36*	*3*	*1.34*	*2,339*	*8*	*3.42*	*2*	*0.86*
4,005	8	2.00	1	0.25	3,858	5	1.30	0	0.00	3,983	2	0.50	0	0.00
5,435	16	2.94	1	0.18	5,489	19	3.46	0	0.00	5,296	32	6.04	0	0.00
4,963	5	1.01	0	0.00	2,539	1	0.39	0	0.00	5,184	5	0.96	0	0.00
3,863	5	1.29	0	0.00	3,792	2	0.53	0	0.00	3,819	0	0.00	0	0.00
2,862	0	0.00	0	0.00	3,287	4	1.22	0	0.00	3,614	4	1.11	0	0.00
3,652	*6*	*1.64*	*0*	*0.00*	*3,000*	*11*	*3.67*	*0*	*0.00*	*2,861*	*25*	*8.74*	*1*	*0.35*
2,315	1	0.43	0	0.00	2,150	0	0.00	0	0.00	2,425	0	0.00	0	0.00
2,561	14	5.47	0	0.00	2,361	10	4.24	3	1.27	2,340	14	5.98	0	0.00
3,100	2	0.65	0	0.00	2,913	0	0.00	1	0.34	2,979	1	0.34	1	0.34
3,421	9	2.63	1	0.29	3,416	1	0.29	0	0.00	3,702	2	0.54	0	0.00
3,018	5	1.66	0	0.00	3,392	1	0.29	0	0.00	3,265	1	0.31	0	0.00
3,804	30	7.89	1	0.26	3,759	26	6.92	0	0.00	3,910	16	4.09	3	0.77
2,908	17	5.85	2	0.69	2,869	22	7.67	0	0.00	3,266	18	5.51	0	0.00
4,591	18	3.92	0	0.00	4,243	11	2.59	0	0.00	4,381	5	1.14	1	0.23
2,777	4	1.44	1	0.36	2,647	11	4.16	0	0.00	2,247	15	6.67	1	0.44
3,113	7	2.25	0	0.00	2,868	2	0.70	0	0.00	3,206	1	0.31	1	0.31
3,076	*22*	*7.15*	*1*	*0.33*	*3,114*	*51*	*16.38*	*1*	*0.32*	*3,112*	*59*	*18.96*	*0*	0.00
4,628	2	0.43	0	0.00	4,377	3	0.69	0	0.00	4,329	3	0.69	0	0.00
3,920	12	3.06	2	0.51	3,720	14	3.76	2	0.54	3,953	10	2.53	0	0.00
3,415	19	5.56	1	0.29	3,663	23	6.28	0	0.00	3,718	17	4.57	4	1.08
3,243	7	2.16	0	0.00	3,339	11	3.29	0	0.00	3,455	6	1.74	0	0.00
5,154	20	3.88	0	0.00	4,897	27	5.51	0	0.00	4,983	26	5.22	0	0.00
122,652	**365**	**2.98**	**20**	**0.16**	**114,130**	**391**	**3.43**	**18**	**0.16**	**119,681**	**419**	**3.50**	**25**	**0.21**

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Appendix B

SCOPE AND METHODOLOGY

The Audit Committee directed the California State Auditor to perform an audit of Corrections' policies, procedures, and practices related to suicide prevention and reduction. We were directed to review the suicide and attempted suicide rates for male and female inmates in all state prisons; Corrections' policies and procedures for inmate suicide prevention and response, as well as their implementation; and CIW's implementation of Corrections' policies. We were also asked to determine areas in which Corrections could improve its mental health services, causes for CIW's high suicide rates, and the adequacy of mental health and suicide prevention training for CIW staff. Table B lists the objectives that the Audit Committee approved and summarizes the methods we used to address those objectives.

Table B
Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	We reviewed relevant state laws and regulations.
2	Evaluate Corrections' policies and procedures for inmate suicide prevention and response, including those related to instances when an inmate exhibits suicidal behavior. Determine whether such policies and procedures are implemented consistently throughout California's state prisons.	• We judgmentally selected three prisons to review in addition to CIW based on an analysis of the number of suicides and suicide attempts from 2014 through 2016 and of the prisons' missions: CCWF, RJD, and SAC. • We obtained Corrections' policies and procedures for inmate suicide prevention and response. Further, we reviewed local operating procedures at each of the four prisons. • We reviewed the *Coleman* special master monitoring reports, Corrections' suicide reports, and the suicide expert's audits to identify recommendations made to CIW, Corrections, and the other three prisons. We determined if the appropriate policies and procedures reflected those recommendations. We also interviewed relevant Corrections' staff for perspective on the implementation of these recommendations. • We judgmentally selected 10 inmate suicides and suicide attempts from 2014 through 2016 from each of the four prisons. We reviewed the records for the 40 inmates' suicides and suicide attempts to determine if the prisons adhered to their local operating procedures and Corrections' policies and procedures on suicide prevention and response. We interviewed relevant staff at Corrections and at the prisons to obtain perspective on issues we found pertaining to these records.
3	For the most recent three-year period, compare the suicide and attempted suicide rates for male and female inmates in all state prisons.	• To better identify trends, we reviewed the five-year period from 2012 through 2016. • We gathered Corrections' statistics on inmate suicides and suicide attempts from 2012 through 2016 for all California state prisons from Corrections' organizational management tool called COMPSTAT. • We analyzed the COMPSTAT data to present the inmate suicide and suicide attempt rates by prison in Appendix A. • We obtained perspective from Corrections' officials on any trends or inaccuracies that we observed and the methods Corrections used to gather and track these data. • For Table 1 on page 9 and Table 6 on page 40, we adjusted the COMPSTAT data we present on suicides for the four prisons we reviewed based on documentation of suicides not recorded in COMPSTAT. In Table 1, we also adjusted the prison populations for the four prisons we reviewed based on average daily populations Corrections provided. In Appendix A, we did not adjust the COMPSTAT data as they are the data Corrections makes available to the public.

continued on next page . . .

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	AUDIT OBJECTIVE	METHOD
4	Identify areas where Corrections can improve its mental health services, particularly with respect to the safety and care for inmates needing mental health treatment.	• Using the results of the testing of policies and recommendations in Objective 2, we determined areas in which Corrections could improve its practices. We gathered perspective on these areas of improvement from relevant Corrections' staff. • We reviewed the monthly meeting minutes for the statewide suicide prevention team and the suicide prevention teams at each of the four prisons for 2016 to determine the meeting attendees and the topics staff addressed. • We interviewed Corrections' officials and reviewed available documentation to identify the methods used to discuss, document, and disseminate best practices to the prisons related to suicide prevention and response. • We obtained Corrections' reports on position vacancy rates as of December 2016 for social workers, psychiatrists, and psychologists at the four prisons we reviewed and for Corrections as a whole. • We interviewed key staff at the four prisons and Corrections' headquarters to gather perspective on staff vacancies.
5	In reviewing the CIW do the following: a. Evaluate whether CIW appropriately implemented Corrections' suicide prevention policies.	The procedures we performed in Objective 2 also addressed this objective.
	b. Identify and analyze CIW's policies and procedures in the event of a suicide, including any ensuing investigation and communication with the deceased inmate's family during and after such investigation.	• The procedures we performed in Objective 2 also addressed this objective. • We reviewed Corrections' procedures for communicating with a deceased inmate's family following a death. • We reviewed records for six inmates who committed suicide from 2014 through 2016 and determined that CIW complied with Corrections' policies for communicating with a deceased inmate's family following a suicide.
	c. To the extent possible, identify the causes or factors contributing to the higher rates of suicide and suicide attempts at CIW, including any systemic problems or failures.	• We interviewed key Corrections' headquarters staff and CIW staff to gather their perspectives on the causes for the higher rates of suicide and suicide attempts at CIW from 2014 through 2016. • We evaluated data from CIW and CCWF regarding the suicide attempts by inmates who transferred from VSPW. • We reviewed Corrections' available documentation of the plan to convert VSPW to a men's prison. • We interviewed officials at CIW and Corrections to determine if the conversion process accounted for the effect the transfer of inmates from VSPW would have on CIW.
	d. Identify and analyze CIW's policies and practices in the event that an inmate displays suicidal behavior. Evaluate CIW's ability to appropriately house and treat inmates identified as suicidal and determine whether CIW allows access to inmate program activities or movements such as yard time.	• The procedures we performed in Objective 2 for the 40 inmates' suicides and suicide attempts also addressed this objective. • We reviewed CIW's policies and documentation for six inmates regarding access to yard time.
	e. Evaluate the adequacy of the mental health and suicide prevention training for CIW staff.	• From a list containing all employees at CIW, we randomly selected 20 CIW staff members and determined the percentage who received annual suicide prevention training in 2014, 2015, and 2016. • From a list containing all mental health staff at CIW, we randomly selected 10 psychiatrists, psychologists, and social workers and determined how many received training on how to complete suicide risk evaluations and other trainings required for mental health staff. • We reviewed several suicide prevention trainings that Corrections' staff received to determine if the trainings contained the content Corrections' policies require and any additional content the suicide expert had recommended. • We obtained self-reported data on selected required trainings from CCWF, CIW, RJD, and SAC and identified instances of low compliance.
6	Review and assess any other issues that are significant to the audit.	• We interviewed selected advocacy groups to identify their key concerns related to our audit scope. • We addressed concerns related to delays in emergency response and monitoring inmates in Objective 2. • We also addressed concerns related to identifying and disseminating best practices in Objective 4.

Sources: California State Auditor's analysis of the Audit Committee's audit request number 2016-131, planning documents, and analysis of information and documentation identified in the table column titled *Method*.

Assessment of Data Reliability

In performing this audit, we obtained data from Corrections' COMPSTAT organizational management tool. The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of computer-processed information that we use to support findings, conclusions, or recommendations. Corrections' COMPSTAT tool provides monthly data to stakeholders and the public on a variety of measures at each of Corrections' prisons and other institutions. We used COMPSTAT data to report on the number of suicides and attempted suicides throughout California's adult prisons. We performed data-set verification procedures and found no errors. Further, as reported in Chapter 3, we assessed the accuracy and completeness of COMPSTAT data by comparing the data on suicides and attempted suicides for selected months to incident logs from the four prisons we visited and identified several errors. We also compared the number of suicides reported in COMPSTAT to those in reports from the special master's suicide experts and found they did not agree. Finally, during the course of our audit work, we identified one suicide each at three of the four prisons we visited that was not included in COMPSTAT. As a result, we determined that COMPSTAT data are not sufficiently reliable for the purposes of this audit. Nevertheless, we present these data in the report because COMPSTAT is Corrections' comprehensive source of data available on suicides and attempted suicides for each of its prisons, and it contains data Corrections makes publicly available. We discuss our findings in more detail in Chapter 3 and make a recommendation for improving the data on page 64.

We also obtained summary data from Corrections on the rates at which its employees attend various trainings. We tested selected employees at CIW and determined they did not all attend required trainings. We requested self-reported summary data from Corrections for each of the four prisons we visited to determine whether there was evidence at each prison to corroborate our findings at CIW. Because the data corroborated our findings, we determined it would be too resource-intensive to further test the accuracy and completeness of the prisons' self-reported data. Instead, we clearly attribute the data in the report to Corrections.

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STATE OF CALIFORNIA —DEPARTMENT OF CORRECTIONS AND REHABILITATION EDMUND G. BROWN JR., GOVERNOR

OFFICE OF THE SECRETARY
P.O. Box 942883
Sacramento, CA 94283-0001

July 31, 2017

Ms. Elaine M. Howle, State Auditor
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Corrections and Rehabilitation (CDCR) submits this letter in response to the California State Auditor's (CSA) audit titled "California Department of Corrections and Rehabilitation: It Must Increase Its Efforts to Prevent and Respond to Inmate Suicides."

CDCR takes its responsibility to prevent inmate deaths by suicide very seriously and reviews each case carefully to allow it to continue to refine the suicide prevention program. Delivery of mental health services to CDCR inmates has improved overall, and CDCR continues to create a culture of focused improvement, oversight, and accountability in the area of suicide prevention both with staff and inmates. CDCR is committed to continuously evaluating and improving the performance and quality of the entire Mental Health Services Delivery System, including suicide prevention and response practices.

CDCR has made a great deal of progress implementing policies, training, and support for suicide prevention practices statewide, and acknowledges there is further progress to make. CDCR has completed or has in progress 58 initiatives, only 29 of which were recommendations from external suicide experts. For example, CDCR is nearing completion of a contract to provide substance abuse treatment specifically designed for individuals with mental health issues at the California Institution for Women (CIW) and other institutions; is developing a contract to address domestic violence for inmates in the mental health system in CDCR's women's institutions; has implemented the use of new suicide assessment tools and treatment protocols that reflect best practices in the field of suicidology; and provides increased mental health outreach to all inmates at CIW (including those who are not in the mental health system) by offering access to brief, solution-focused counseling.

CSA's report on CDCR's suicide prevention policies highlights areas where CDCR has already improved its practices, and where improvements continue to be made. CDCR will consider the recommendations made by the auditors to continue to improve upon its ongoing suicide prevention mission.

CDCR would like to thank CSA for their work on this report and will address the specific recommendations in a corrective action plan within the timelines outlined in the report. If you have further questions, please contact me at (916) 323-6001.

Sincerely,

SCOTT KERNAN
Secretary

Exhibit N

Male Patients	CCCMS Population if Population was 74.3% of February 2020 Population	EOP Population if Population was 47.2% of February 2020 Population
General Population	16023	2733
Reception Center	1716	76
ASU/STRH/NDS/Condemned	749	227
SHU/LTRH/PSU	176	59
Total Population	18663	6559

Female Patients	CCCMS Population if Population was 74.3% of February 2020 Population	EOP Population if Population was 47.2% of February 2020 Population
General Population	1293	81
Reception Center	181	0
ASU/STRH/NDS/Condemned	59	7
SHU/LTRH/PSU	19	1
Total Population	1551	89

1 General Population figures include all patients at other levels of care but awaiting transfer to designated level of care, and all patients in specialized medical beds.

Exhibit O

PATIENT BASED STAFFING									
Staff Psychiatrist (9272)	**Relief Factor**	**Patients Per Clinician**	**Ratio as Decimal**	**Male Population With Reductions**	**Female Population With Reductions**	**FTEs[1] needed for Males**	**FTEs Needed for Females**		**TOTAL FTE Based on 2018 Numbers**
CCCMS GP	0.243	280	0.003571429	16023	1293	71.13	6.89		78.07
CCCMS Reception Center (RC)	0.243	200	0.005	1716	181	10.66	1.35		12.01
CCCMS ASU/STRH/Condemned/NDS	0.243	125	0.008	749	59	7.45	0.7		8.15
CCCMS SHU/LTRH/PSU	0.243	200	0.005	176	19	1.09	0.14		1.24
EOP GP	0.243	120	0.008333333	2733	81	28.31	1.01		29.32
EOP RC	0.243	120	0.008333333	76	0	0.79	0.00		0.79
EOP ASU/STRH/Condemned/NDS	0.243	64	0.015625	227	7	4.41	0.16		4.57
EOP PSU/SHU/LTRH	0.243	64	0.015625	126	3	2.45	0.07		2.52
POPULATION BASED TOTAL				**21826**	**1643**	**126.29**	**10.32**		**136.61**

UNIT OR BED BASED STAFFING									
Staff Psychiatrist (9272)	**Relief Factor**	**Base Staffing Per MHCB Unit**	**Staff per**	**Bed**	**Ratio As Decimal**	**Units**	**Beds**	**Beds less 5 beds per MHCB Unit**	**TOTAL FTE**
MHCB	0.74		2.35	25	0.094	13	227	162	26.50
Staff Psychiatrist (9272) on call for MHCB		0.3	0.3	50	0.006	13	227	162	4.87
MOHU	0.74		1	9	0.111111111		18		3.48
Desert Institutions	0.243	0.5				5			2.5
Crisis Intervention	0.74	0.3				35			10.5
UNIT OR BED BASED TOTAL									**47.85**
GRAND TOTAL									**184.46**

[1] Full-Time Employees

Exhibit P

CDCR/CCHCS COVID-19 Employee Status

Current number of active staff cases: 755

Updated July 14, 2020

Locations	Cumulative Confirmed	Staff Returned to Work
Avenal State Prison (ASP)	81	41
California City Correctional Facility (CAC)	8	3
Calipatria State Prison (CAL)	51	22
California Correctional Center (CCC)	8	0
California Correctional Institution (CCI)	92	10
Central California Women's Facility (CCWF)	9	2
Centinela State Prison (CEN)	69	22
California Health Care Facility (CHCF)	36	9
California Institution for Men (CIM)	105	67
California Institution for Women (CIW)	23	20
California Men's Colony (CMC)	6	2
California Medical Facility (CMF)	9	3
California State Prison, Corcoran (COR)	40	12
California Rehabilitation Center (CRC)	50	28
Richard A. McGee Correctional Training Center, Galt (CTC)	5	5
Correctional Training Facility (CTF)	2	2
Chuckawalla Valley State Prison (CVSP)	64	49
Deuel Vocational Institution (DVI)	5	2
Folsom State Prison (FSP)	4	4
High Desert State Prison (HDSP)	13	3
Ironwood State Prison (ISP)	95	58
Kern Valley State Prison (KVSP)	24	4
California State Prison, Los Angeles County (LAC)	61	46
Mule Creek State Prison (MCSP)	2	2
North Kern State Prison (NKSP)	78	11
Pelican Bay State Prison (PBSP)	2	2
Pleasant Valley State Prison (PVSP)	8	3
Richard J. Donovan Correctional Facility (RJD)	20	6
California State Prison, Sacramento (SAC)	9	8
Substance Abuse Treatment Facility (SATF)	13	8

Sierra Conservation Center (SCC)	8	1
California State Prison, Solano (SOL)	12	0
San Quentin State Prison (SQ)	209	53
Salinas Valley State Prison (SVSP)	6	1
Valley State Prison (VSP)	7	1
Wasco State Prison (WSP)	23	8
Northern California Youth Correctional Center (NCYCC)	4	2
OH Close Youth Correctional Facility (OH Close)	4	1
NA Chaderjian Youth Correctional Facility (NAC)	2	1
Ventura	1	1
CDCR/CCHCS Worksite Location —Los Angeles County	7	4
CDCR/CCHCS Worksite Location—Kern County	1	0
CDCR/CCHCS Worksite Location—Sacramento County	14	3
CDCR/CCHCS Worksite Location—San Bernardino County	5	3
CDCR/CCHCS Worksite Location —San Diego County	1	1
CDCR/CCHCS Worksite Location — San Joaquin County	2	2
STATEWIDE TOTAL	**1,291**	**536**

There have been three COVID-related staff deaths:
May 30– (https://www.cdcr.ca.gov/news/2020/05/31/cdcr-correctional-officer-dies-after-testing-positive-for-covid-19/)staff member from California Rehabilitation Center
June 3– staff member from Ironwood State Prison
July 13– staff member from North Kern State Prison

Exhibit Q

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date: March 25, 2020

To: Chief Executive Officers
Chief Psychiatrists
Chief of Mental Health
Senior Psychiatrist, Supervisors

From:
EUREKA C. DAYE, Ph.D., MPH, MA, CCHP
Deputy Director (A)
Statewide Mental Health Services

Subject: **COVID-19 – MENTAL HEALTH DELIVERY OF CARE GUIDANCE**

In response to the current coronavirus disease 2019 (COVID-19) pandemic and out of an abundance of caution the California Department Corrections and Rehabilitation (CDCR) Statewide Mental Health Program (SMHP) is taking necessary precautions to reduce exposure to Coleman patients and mental health staff by addressing exceptional allowances provided. This memorandum provides guidance for the delivery of mental health care with the understanding that new challenges and impacts of COVID-19 may permit more restrictions at some institutions than others as we move through this difficult time and may likewise lead to interim changes in practice and/or policy exceptions not otherwise allowed by the *Mental Health Services Delivery System Program Guide 2009 Revision.*

Clinical leadership (to include Chief Executive Officers, Chiefs of Mental Health, Chief Nurse Executives, Chief Medical Executives, and the Chief Psychiatrist) shall assess program capacity and make determinations on admission and discharge practices based on factors to include available workforce, known COVID-19 exposure, etc.. Leadership must consider individual patient needs, facility-system flows, and the degrees of risk when making these decisions.

To ensure patients continue to receive the most appropriate and effective interventions necessary to meet their needs, each clinical provider shall assess the patient's needs and continue to deliver services as appropriate in person, or via tele-health technology such as WebEx, Citrix, and other solutions.

The attached chart serves as a guide and provides a tiered approach on the delivery of care dependent upon each institution's staffing and operational circumstances. The CEOs, in consultation with the Wardens, will determine which tier shall be applied each day. Tier One

represents operating close to Program Guide requirements, while Tier Four represents dramatically decreased resources. The following factors shall be taken into consideration when determining the tier an institution will operate within:

- Clinical and custodial staffing levels
- Space availability
- Social distancing requirements
- Local and statewide restrictions on movement
- Quarantines and Isolations

Mental Health Patients

Mental health patients are at increased risk for escalation in depression, anxiety, panic attacks, psychomotor agitation, psychotic symptoms, delirium, and suicidality during this COVID-19 pandemic. Sources of stress include social isolation, decreased sensory stimulation, lack of access to standard clinical programing, diminished coping strategies, and limited outdoors or out-of-cell exercise and activities. We are focused on three critical areas during this COVID-19 pandemic: 1) Preserving life; 2) Stabilizing of acute mental health deterioration; 3) Helping the mental health population cope.

Provisions of Treatment

To the extent possible, institutions shall follow current Program Guide policies and procedures including, but not limited to: clinical contacts, group and treatment requirements, emergent and urgent referral processes, crisis intervention, suicide prevention, and inpatient referrals. However, to ensure patients receive the essential care and support services during this time of fewer onsite staff and various restrictions on patient movement the below and attached guidelines provide direction on ways to provide services and minimize the risk to both patients and staff:

- Individual clinical contacts shall continue while maintaining social distancing. As institutions move toward less patient movement measures and staffing levels decrease, individual contacts should be triaged by emergent referrals, patient acuity and levels of care.
- Interdisciplinary Treatment Teams (IDTT) shall continue while maintaining social distancing. In lieu of the tradition setting, the use of technology should be optimized to ensure attendance by all IDTT members. The best solution is to turn team meetings into teleconference meetings, with staff calling in from their individual offices.
- Groups shall continue but may be reduced in size in order to adhere to social distancing requirements. In addition, alternative locations should be explored. Larger classrooms or vocational space, temporarily closed during this time, could be used to allow for social distancing for groups. Develop in-cell Recreational Therapy and other group activities that can be conducted and distributed.
- Patients in isolation and/or quarantine will not attend groups but shall be provided with therapeutic treatment packets, workbooks, and other in cell activities and shall receive

daily rounding by at least one of the following designated staff to include: CNA, Psychologist, LVN, Recreational Therapists, PTs, RNs, or Social Workers.

- Psychiatry and primary care clinicians should be consulted urgently on patients expressing suicidal ideation or intent, psychosis, medication side effects, incomplete symptom control, or acute agitation.
- Psychiatry should also be consulted for other non-urgent significant psychiatric symptoms as usual.
- In the event of severe staffing shortages, frequent mental health wellness and surveillance rounding is required with liaison between psychiatrists, psychologists, suicide prevention coordinators and recreational therapists to identify significant concern for a patient's mental health sequelae. These rounds are to identify any urgent/emergent clinical issues including but not limited to acute suicidality.
- Issues identified through these rounds are to be promptly brought to the attention of the assigned psychiatrist.
- Staff performing rounds shall use appropriate personal protective equipment (PPE) as determined by public health.
- Psychiatry encounters may be via tele-psychiatry during the COVID-19 pandemic as approved by the hiring authority (See section on tele-psychiatry below for details).

Suicide Prevention

As much as possible, all Suicide Risk Assessments shall continue per policy and patients identified as a suicide risk will receive an in-person mental health evaluation. As operational abilities are impacted due to staff reductions, the clinician assessing the patient for suicidality will conduct the Columbia screener and a full mental health status exam and do the following:

1. If the patient screens positive, he/she shall be placed in alternative housing and be referred to a Mental Health Crisis Bed (MHCB). Within 24 hours of placement in the MHCB or if the patient remains in alternative housing longer than 24 hours, a full Suicide-Risk and Self-Harm Evaluation shall be completed.
2. If the patient screens negative, the clinician shall establish a safety plan with the patient and he/she can be returned to housing with a consult order for the primary clinician to see the patient with an urgent or routine referral.
   - All (5) five-day follow-ups will be completed in person, per policy, while maintaining social distancing.
   - As the operational abilities begin to limit clinical contacts and services, Administrative Segregated Unit workbooks shall be distributed to Enhanced Out-Patient housing units and the Correctional Clinical Case Management System population for in-cell activities.
   - Suicide Prevention and Response Focus Improvement Team Coordinators shall distribute the high risk list to all primary clinicians and psychiatrists. Cell visit check-ins with these patients shall be conducted by a mental health provider, in addition to the required scheduled appointments.

Inpatient Referrals and Services

As of March 17, 2020, the Department of State Hospitals (DSH) has temporarily suspended patient transfers to and from CDCR. As a result, patients referred to a higher level of care of at least a restrictive housing of a DSH facility will remain at CDCR. The below information and reminders are critical to ensure all patients currently housed or awaiting placement to an inpatient bed receive the appropriate care and oversight during this time.

- All referrals to higher levels of care shall continue as clinically indicated and determined by the IDTT.
- Patients housed out of their least-restrictive housing due to the inability to transfer to DSH, shall be placed in the least restrictive housing available within CDCR.
- As wait times increase, every effort shall be made to provide these patients with the services commensurate with their level of care. This includes providing enhanced out-of-cell time and therapeutic activities as well as daily rounds, as operations allow, while awaiting transfer.
- Patients housed in an MHCB awaiting transfer to a higher level of care and patients in alternative housing awaiting transfer to an MHCB will be provided enhanced out-of-cell time and therapeutic activities as well as daily rounds, as operations allow, while awaiting transfer.
- Inpatient licensed beds shall not be closed to admissions by the institutions without going through the proper authorization and notification process.

Patient Education

Clinical focus shall be on supporting patients by encouraging questions and helping them understand the current pandemic situation. Clarify misinformation and misunderstandings about how the virus is spread and that not every respiratory disease is COVID-19. Provide comfort and extra patience. Check back with patients on a regular basis or when the situation changes. Recognize that feelings such as loneliness, boredom, fear of contracting disease, anxiety, stress, and panic are normal reactions to a stressful situation such as a disease outbreak.

Key communication messages to mental health patients:

- The importance of reporting fever and/or cough or shortness of breath along with reporting if another patient is coughing in order to protect themselves. Indicate how these reports should be made.
- Reminders about good-health habits to protect themselves, emphasizing hand hygiene.
- Plans to support communication with family members if visits are curtailed.
- Plans to keep patients safe, including social distancing.

Patient Isolation (Symptomatic Patients)

A critical infection control measure for COVID-19 is to promptly separate patients who are sick with fever or respiratory symptoms away from other patients in the general population. Precautionary signs shall be placed outside the isolation cell and PPE appropriate protocols shall be followed.

Quarantine (Asymptomatic Exposed Patients)

The purpose of quarantine is to assure that patients who are known to have been exposed to the virus are kept separated from other patients with restriction of movement to assess whether they develop viral infection symptoms.

- Exposure is defined as having been in a setting where there was a high likelihood of contact with respiratory droplets and/or body fluids of a person with suspected or confirmed COVID19.
- Examples of close contact include sharing eating or drinking utensils, riding in close proximity in the same transport vehicle, or any other contact between persons likely to result in exposure to respiratory droplets.
- The door to the Quarantine Unit should remain closed. A sign should be placed on the door of the room indicating that it is a Quarantine Unit which lists recommended personal protective equipment (PPE).
- Medical Holds are employed for both isolation and quarantine. A temporary prohibition of the transfer of patients with the exception of legal or medical necessity is now in place.

Social Distancing

To stop the spread of COVID-19, social distancing must be employed. CDC officials recommend avoiding large gatherings of more than 10 people and maintaining a distance of 6 feet from other people. This reduces the chance of contact with those knowingly or unknowingly carrying the infection.

Patient-to-Patient; Patient-to-Staff Social Distancing

If group spaces are too small to accommodate the 6-feet rule, consider smaller group sizes in the interim. Groups can be smaller with higher frequency or this may mean needing to decrease the number of treatment offerings. Say to the patients that because of the COVID19, "We have a policy of keeping at least 6 feet of distance between patients and staff and patients and each other, which is why I'm sitting here and you're sitting there." If you don't say it, many patients may misinterpret social distancing (i.e. "my clinician is scared of me"). Maximize disinfection of all areas used for group and 1:1 treatment.

Tele-Psychiatry and Social Distancing

With the latest expansion of tele-psychiatry waivers, exceptions issued by the Center for Medicare and Medicaid Services (CMS), tele-psychiatry may be used to minimize any COVID-19 impacts that could disrupt the daily psychiatric services to patients. Psychiatrists who are unable to come into the institution because of personal risk factors (age > 65, chronic medical condition, etc.) or are under a personal quarantine who are otherwise fit to work can be authorized to use WebEx to conduct patient visits from a home computer that has a camera, speaker, and microphone. A state laptop with a VPN or any home computer with Citrix can access the EHRS.

- Each clinician who is providing tele-services will require a tele-presenter within the institution.
- Tele-presenters can include Medical Assistant, Certified Nursing Assistant, Licensed Vocational Nurse, Registered Nurse, or any other healthy employee who is available to assist. This could include support staff who are on Administrative Time Off.
- Presenters shall be provided PPE as needed based upon public health recommendations. Successful use of tele-psychiatry will require clinic space, tele-health equipment, IT assistance, scheduling organization, escort support, frequently updated telephone and email contact lists, and local executive leadership support.

cc: Diana Toche, DDS, Undersecretary
Joseph Bick, MD, CCHP, Director
Connie Gipson, Director
Regional Health Care Executives
Deputy Directors

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier One: Delivery of care continues with minor modifications up to and including: • Patient movement permitted between and within CDCR facilities. • Minor movement restrictions within specific housing units or yards. • Temporary suspension of transfers to DSH. • Adequate clinical staff are on site and available to provide services • Sufficient beds and staff are available for 1:1 watch and alternative housing. • Social Distancing Required	Referrals continue per policy. Patients out of LRH, due to bed unavailability (DSH unlocked dorm) will be placed in the least restrictive housing available within CDCR.	**Suicide Risk Assessments:** Continue to complete per policy. **Five day follow ups:** Complete in person per policy, while maintaining social distancing. **Referrals:** Continue to respond to referrals in accordance with MHPG timelines.	**IDTT:** Continue with social distancing. Optimize use of technology including VTC, SKYPE, conference calls, or other electronic alternatives. **Groups:** Continue but may be reduced in size or in alternative non confidential locations (e.g. day room, class rooms) for social distancing. **Individual contacts:** Continue, with social distancing. **Patients on isolation:** Provide with treatment packets/therapeutic activities to complete in cell. Treatment team members visit cell daily. **Personal Protective Equipment:** Those rounding in quarantined and isolated areas must be provided appropriate personal protective equipment (PPE) based upon the most recent public health recommendations. All staff shall receive training in the appropriate use of PPE.	**Pre-Release Planning:** All required activities to occur when social distancing can be followed. **MDO Evaluations:** MDO evaluations will continue and patients meeting MDO criteria will be admitted to DSH. If MDO evaluator cannot enter a facility review will occur remotely and the evaluator will work with the MDO Coordinator (CCI) at the facility to arrange for a telephonic interview.

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier Two: Minor movement restrictions and staff limitations impacting daily operations. • Patient movement permitted between and within CDCR facilities • Minor movement restrictions within specific housing units and/or yards • Temporary suspension of transfers to DSH. • Minor clinical staffing shortages requires triage for services • Sufficient beds and staff are available for 1:1 watch and alternative housing. • Social distancing required	Referrals continue per policy. As wait times increase, patients shall be provided enhanced care, which may include, but not limited to, daily rounds, out of cell time, and therapeutic activities as operations allow, while awaiting transfer. Patients awaiting MHCB will be placed in alternative housing on 1:1 status per current policy. Treatment frequency should be that of MHCB patients, when operations allow, while awaiting transfer.	**Suicide Risk Assessments:** Columbia Screener may be used with a mental status examination for suicide screening when staffing shortages prevent use of SRASHE. Patients identified as suicide risk will receive in person evaluation. **Five day follow ups:** Complete in person per policy, while maintaining social distancing. **Referrals:** Triage referrals responding to emergent and urgent first, and triage routine referrals for urgency. **Prevention:** Distribute ASU Workbooks to outpatient housing units (EOP) for in-cell activities. SPRFIT Coordinators distribute the high risk list to all primary clinicians. PCs to conduct cell visits for check-ins with individuals on this list. These visits should be in addition to required scheduled appointments. If decompensation is noted, patients should be brought out for assessment.	**Treatment may be triaged as follows as staffing shortages and space access are decreased:** **Triage Guidelines:** Individual contacts as follows: - Emergent referrals - Patients on high risk list - Patients in inpatient facilities - Patients awaiting transfer to inpatient LOC - Patients in segregated housing - Patients in EOP level of care - Patients in CCCMS level of care **IDTT:** Continue with social distancing. Optimize use of technology including VTC, SKYPE, conference calls, or other electronic alternatives. **Groups:** Continue but may be reduced in size or in alternative non confidential locations (e.g. day room, class rooms) for social distancing. May be triaged. - CCCMS groups may be reduced or cancelled to redirect resources to EOP and inpatient programs. -Consider altering work schedules to stagger groups and offer into late evenings and weekends.	**Pre-Release Planning:** Prioritize the ROIs to those releasing only to L.A. county and San Diego county Prioritize completion of the PRPA for those releasing to L.A. and San Diego counties first. The assigned psychiatrist will continue to be notified of the release date. Provide groups in accordance with group guidelines in treatment activities section of this document Complete 5150 requests per standard process Complete transportation Chrono's per standard process Conduct pre-release CCAT when possible (dependent upon outside clinician availability) **MDO Evaluations:** MDO evaluations will continue and patients meeting MDO criteria will be admitted to DSH. Evaluators will bundle evaluations for a single visit to reduce the number of trips to a facility. If MDO evaluator cannot enter a facility review will occur remotely and the evaluator will work with the MDO Coordinator (CCI) at the

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			-Develop in cell RT and other group activities and distribute when group offerings decrease. **Patients on isolation:** Provide with treatment packets to complete in cell. Treatment team members visit cell daily. **Psychiatry:** Psychiatrists check in & check out daily with Chief Psychiatrist to track availability and coverage. Updated contact lists and workflows will be determined and provided by each institution up to and including contact list for: - Nursing - MHCB/TTA/CTC - Institutional leadership (Chief Psychiatrist, CMH, CEO) - Medical providers - Pharmacists - Custody command chain - Telepsychiatry Seniors - Medication lines Begin to Triage as follows: Admissions and discharges and related inpatient processes Suicide watch assessments and orders - Suicide precaution assessments and orders - Emergency Medication orders during patient crisis, PC 2602s - Seclusion and Restraints "Face to Face" assessments or renewals - Stat Labs for patients with suspected toxicity e.g. Lithium)	facility to arrange for a telephonic interview.

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			- Renewing expiring psychiatric medications - Medication changes as necessary - Confirming lack of psychiatric medication-related medical issues - IDTT participation - Routine psychiatric follow up **Telepsychiatry:** Psychiatrists who are assigned to work on-site who are no longer able to come into the institution (for example >65 years old, high risk medical condition, quarantine but still able to work) can use WebEx to conduct patient visits from any home computer with a camera/ speaker/ microphone. A state laptop with a VPN (or any home computer with Citrix) can access EHRS. - Staff that could be used as telepresenters is decided by each institution to include: • MA or CNA • Any staff unable to perform their assigned duties during the crisis (with training), e.g. - Dental - ATO - support staff - any healthy state personnel - Any Mental Health provider (Group leader, RT, SW, LCSW, PhD/ PsyD) - LVN, RN	

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			- Any medical provider (PA, NP, MD) All telepresenters require personal protective equipment as in Tier 1 This will also require: office space, tele-health equipment, IT assistance, OT organization, Custody escort support, contact lists as in tier 2, and local leadership support	

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier Three Movement restrictions within facilities and staffing shortages requires substantial change in standard practice • Patient movement permitted between most CDCR facilities. • Movement restrictions are in effect within the institutions. • Temporary suspension of transfers to DSH. • Substantial clinical staffing shortages requires increased triage for services • There may be insufficient beds and/or staff for alternative housing and 1:1 watch.	Referrals continue per policy. **If staffing and space become unavailable:** **Alt Housing Location:** Patients who can be safely watched in their existing cell will be placed on 1:1 watch (must be single cell status, items removed per watch policy). These patients will be treated as MHCB patients for all clinical contacts as operations allow. **1:1 Watch:** When there are not enough staff for 1:1 watch, patients in alternative housing may be placed on 2:1 watch if the location allows for good line of sight and patients are next door to one another, allowing continuous watch of each. CEO to determine when this can be applied and will provide the direction above with oversight for safety.	**Suicide Risk Assessments:** *See Tier two* **Five day follow ups:** *See Tier Two* **Referrals:** *See Tier Two* **Prevention:** *See Tier Two and Provision of Treatment Column*	**Rounding:** Every day, every patient in the Mental Health Services Delivery System (CCCMS, EOP, MHCB, ICF, ACUTE) shall be rounded on by at least one of the following designated staff to include: CNA, Psychologist, LVN, Recreational Therapists, PTs, RNs, or Social Workers, by building and yard. The review includes questions of immediate, acute suicidality and/or medical concerns. Patients who answer in the affirmative must be brought to the attention of the assigned psychiatrist at least once a day (preferably twice) at fixed times for treatment. When patients respond in the affirmative: - A consult order shall be placed per current policy. - MH clinicians will address emergent issues per current policy. - Patients will be placed on a list for discussion with the psychiatrist. Rounds shall be documented in the healthcare record as follows: Nursing: Iview psych tech daily rounds. MH Clinicians: MH PC Progress note. Personal protective equipment required as in tier 1.	**Pre-Release Planning:** ROIs to those releasing only to L.A. county and San Diego county ONLY. Complete the PRPA for those releasing to L.A. and San Diego counties. For releases to other counties, the IMHPC or PC or other clinician who knows the patient, will determine if exigent circumstances related to release exist, and if so, will attempt to communicate those needs to the respective community stakeholders via email. Document efforts in a pre-release planning progress note. The assigned psychiatrist will continue to be notified of the release date. Provide groups in accordance with group guidelines in treatment activities section of this document. Complete 5150 requests per standard process Complete transportation Chrono's per standard process Conduct pre-release CCAT when possible (dependent upon outside clinician availability) **MDO Evaluations:** *See Tier Two*

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			As ability to provide out of cell groups decreases: - RTs play music and conduct other activities on the unit - Continue to replenish supply of in cell treatment materials. Direct Staff and Care as follows: - Emergent referrals - Five Day Follow Ups - Patients on high risk list - Patients in inpatient facilities - Patients awaiting transfer to inpatient facility - Patients in segregated housing - Patients in EOP level of care - Patients in CCCMS level of care **Telepsychiatry: As per tier 2 above**	

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier Four Patient movement restrictions between and within facilities is suspended and significant staffing shortages require substantial change in standard practice • Patient movement is not permitted between most CDCR facilities. • Patient movement restrictions in most units and/or yards within facilities • Temporary suspension of transfers to DSH. • Substantial clinical staffing shortages requires further triage for services • Insufficient beds and/or staff available for 1:1 watch and alternative housing.	*See Tier Three*	*See Tier Three*	*See Tier Three* **Psychiatry Services** Any physician, NP, or PA serves as psychiatrists for the plans in Tier 2 and 3 above. Laptops with VPN (or home computers with Citrix) provide for chart access from home, for the equivalent of basic on-call coverage. Local triage (by Chief Psychiatrist and CMH) to establish referral priority for tele-health.	**Pre-Release Planning:** - ROIs will not be completed - The PRPA will not be completed For releases, the IMHPC or PC or other clinician who knows the patient, will determine if exigent circumstances related to release exist, and if so, will attempt to communicate those needs to the respective community via email. The assigned psychiatrist will continue to be notified of the release date. - Complete 5150 requests per standard process - Complete transportation Chrono's per standard process - Conduct pre-release CCAT when possible (dependent upon outside clinician availability) **MDO Evaluations:** *See Tier Two*

Exhibit R

From: Weber, Nicholas@CDCR
To: Melissa Bentz; Coleman Team - RBG Only; Steve Fama; Angie Cooper; Braxton Medlin; Brian Main; Cindy Radavsky; Henry D. Dlugacz; Jamas DeGroot; Jeffrey Metzner; Joseph Sorah; Kahlil Johnson; Karen Rea; Kerry Courtney Hughes, MD; Kerry F. Walsh; Kristina Hector; Lindsay Hayes; Latricea McClendon-Hunt; Lana Lopez; Maria Masotta; Matt Lopes; Michael Ryan; Mohamedu Jones; Mary Perrien; Patricia M. Williams; Rachel Gribbin; Regina Costa; Rod Hickman Gmail; Sharen Barboza; Sofia Millham; Tim Rougeux; William Trezvant; Zelia M. Tavares
Cc: Elise Thorn; Tyler Heath; lucas.hennes@doj.ca.gov; Kyle Lewis; Dillon Hockerson; Stafford, Carrie@CDCR; Ryan, Amanda@CDCR
Subject: Coleman Tier Report and TMHU Patient List
Date: Monday, July 06, 2020 4:53:57 PM
Attachments: Tier Report 06222020 - 06262020 .pdf
TMHU Patient List 0622-06262020.pdf

All,

Attached is the Tier Report and TMHU/Treat in Place List for the week of June 22nd.

Nick Weber
Attorney
Department of Corrections & Rehabilitation
1515 S Street, Suite 314S
Sacramento, CA 95811-7243
(916) 323-3202

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June 22-26, 2020			
Region	**Institution**	**MH Porgram**	**Current Tier**
I	CMF PIP	Acute[1]	3
I	CMF PIP	ICF[1]	3
I	SAC	PSU	4
I	SAC	ASU	4
I	SAC	STRH	4
I	SAC	LTRH	4
I	SAC	EOP	4
I	SAC	CCCMS	4
I	SAC	TMHU	4
I	SAC	MHCB	4
I	SQ	STRH[2]	4
I	SQ	CCCMS[2]	4
I	SQ	ASU[2]	4
I	SQ	EOP[2]	4
I	SQ	Acute	4
I	SQ	ICF	4
I	SQ	MHCB	4
II	CCWF	CCCMS	4
II	CCWF	STRH	3
II	CTF	CCCMS[3]	3
II	CTF	TMHU[3]	3
II	SVSP	CCCMS	3
III	ASP	CCCMS[4]	3
III	LAC	ASU	3
III	LAC	EOP	3
III	LAC	TMHU	3
III	SATF	EOP[5]	3
III	SATF	STRH[5]	3
III	SATF	CCCMS[5]	3
IV	CAL	CCCMS	4
IV	CAL	EOP	4
IV	CAL	TMHU	4
IV	CEN	CCCMS	3
IV	CIM	MHCB	3
IV	CIM	STRH	3
IV	CIM	EOP	3
IV	CIW	CCCMS[6]	3
IV	CRC	CCCMS	4
IV	CVSP	TMHU	4
IV	ISP	THMU[7]	3

[1] Beginning 6/25 CMF PIP changed from Tier 4 to 3

[2]Beginning 6/24 SQ ASU, EOP, CCCMS and STRH changed from Tier 3 to 4

[3]CTF CCCMS and TMHU only identified as Tier 3 on 6/22. The rest of the week were Tier 2 only

[4] Beginning 6/24 ASP CCCMS identified as Tier 3

[5] Beginning 6/25 SATF EOP, CCCMS, and STRH identified as Tier 3

[6]Beginning 6/24 CIW CCCMS identified as Tier 3

[7]Beginning 6/23 ISP identified as Tier 3

Exhibit S

From: Nick Weber
To: Marc Shinn-Krantz; Melissa Bentz
Cc: Adriano Hrvatin; Damon McClain; Elise Thorn; Kyle Lewis; Lucas Hennes; Tyler Heath; Jessica Winter; Michael W. Bien; Lisa Ells; Matt Lopes; Kerry F. Walsh; Kent, Kristopher@DSH-S; Christine Ciccotti; Nina Raddatz; Steve Fama
Subject: RE: Coleman: PG Departures Update Stipulation [IWOV-DMS.FID6429]
Date: Tuesday, July 14, 2020 2:49:32 PM
Attachments: DRAFT Stip and Update Addressing Current Departures From Program Guide Requirements July 2020.DOCX
DRAFT JULY Monthly Update to Appendix A to Stip re PG Departures 7.10.20 489-3.DOCX
TMHU Patient List as of 0629-07032020.pdf
Tier Report 06292020 - 07032020.pdf

Hi Marc,

Attached are Defendants' revisions to the stipulation and Appendix A. I want to specifically address points five and six below. Regarding the Maps filing, Defendants agree to include the closure status of each institution on the face sheet for each map produced in the maps filing tomorrow.

Second, regarding the TMHU/TIP List, I want to clarify that each report covers a span of days – generally a workweek – and includes any patient reported to be in the TMHU or TIP during that week and if they were released that week. Thus, the reports are not point in time. The labeling of the document has been inconsistent which has led to this confusion. Accordingly, I have edited paragraph two to reflect the date spans for each report we will be submitting. Additionally, upon review of that, I realized that we did not provide tier or TMHU/TIP data for the week of June 29 – July 3, 2020, but skipped ahead to July 6 – July 10, 2020. I am providing that data now and it is reflected in the stipulation.

My plan is to redact all reports that include patient information listed in paragraph two and also, sometime in the morning, pull the TMHU registry off the On Demand reports. Last month, we ran the report from May 15 – June 15, 2020. I propose to run it from June 16- July 15, 2020. Please let me know if you disagree or would like to discuss any of these changes.

Thanks.

Nick Weber
Attorney
Department of Corrections & Rehabilitation
1515 S Street, Suite 314S
Sacramento, CA 95811-7243
(916) 323-3202

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June 29 -July 3, 2020			
Region	Institution	MH Porgram	Current Tier
I	CMF PIP	Acute[1]	4
I	CMF PIP	ICF[1]	4
I	SAC	PSU	4
I	SAC	ASU	4
I	SAC	STRH	4
I	SAC	LTRH	4
I	SAC	EOP	4
I	SAC	CCCMS	4
I	SAC	TMHU	4
I	SAC	MHCB	4
I	SQ	STRH	4
I	SQ	CCCMS	4
I	SQ	ASU	4
I	SQ	EOP	4
I	SQ	Acute	4
I	SQ	ICF	4
I	SQ	MHCB	4
II	CCWF	CCCMS	4
II	CCWF	STRH	3
II	CTF	CCCMS	3
II	CTF	TMHU	3
II	SVSP	EOP	4
II	SVSP	CCCMS	4
II	SVSP	ICF[2]	4
III	ASP	CCCMS	3
III	LAC	ASU	3
III	LAC	EOP[3]	3
III	LAC	TMHU	3
III	SATF	EOP	3
III	SATF	STRH	3
III	SATF	CCCMS	3
IV	CAL	CCCMS	4
IV	CAL	EOP	4
IV	CAL	TMHU	4
IV	CEN	CCCMS	3
IV	CIM	MHCB	3
IV	CIM	STRH	3
IV	CIM	EOP	3
IV	CIW	CCCMS	3
IV	CRC	CCCMS	4
IV	CVSP	TMHU[4]	4
IV	ISP	THMU	3

[1] CMF PIP Acute and ICF changed from Tier 4 to Tier 3 as of 7/1

[2] SVSP ICF Tier 3 on 6/29 and 6/30, changed to Tier 4 on 7/1-7/3

[3] LAC ASU changed to Tier 4 on 7/3

[4] CVSP THMU changed from Tier 4 to 3 on 7/1

Exhibit T

Consulting Services for California Department of Corrections & Rehabilitation

MENTAL HEALTH BED NEED STUDY Based on Fall 2009 Population Projections

January 2010

Navigant Consulting

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Assignment & Scope

The California Department of Corrections and Rehabilitation (CDCR) engaged Navigant Consulting for a three-year contract to provide semi-annual updates of the forecasts for CDCR Mental Health programs. Effective January 1, 2010, CDCR engaged McManis Consulting to continue the services for the next three years. As in previous reports, John Misener of McManis Consulting remains the lead author and forecaster for the materials in this report.

DATA USED

- The census and wait list data used for the FY2009 base year was complete through June 30, 2009.
- The "Fall 2009 Adult Population Projections" from the CDCR Offender Information Services Branch (OISB) were received and used for the models, replacing the Spring 2009 values. *These projections are based on policies and practices in place at the time the projections were developed. They do not include proposed legislation, programs, propositions, or policy changes that have not been signed or affirmed as of the beginning of the projection process.*

On October 11, 2009, Governor Schwarzenegger signed Senate Bill 18 (Third Extraordinary Session). The provisions of this bill, which include parole, sentencing, and time credit reforms, became law on January 1, 2010. These changes are expected to substantially impact the CDCR's overall population by tens of thousands of inmates and will be incorporated into the Spring 2010 Adult Population Projections. Moreover, its impact on CDCR's mental health caseload will be reflected in the Spring 2010 update of the Mental Health Bed Need Study.

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Fall 2009 Report – ISSUES & FEATURES

MALE

- Male population projections were only slightly lower than those of the Spring 2009 projections. Differences were greater in the early years of the forecast.
- Utilization and wait lists increased for the remaining six months of FY2009 creating a greater demand for Acute, Intermediate and MHCB forecasts. Most notably:
  - *There was a 38% increase in the Acute wait list from the Spring Report to this Fall 2009 study.*
  - *There was a 7.4% increase in the SVPP wait list, and a 144% increase in the ASH Intermediate wait list since the Spring 2009 study. This increase is attributed primarily to the "MHARP" (Mental Health Assessment and Referral Project), and therefore, may not be sustainable at the same level.*
- Census Rate changes:
  - Acute Male bed need increased due to an increase of 10.2% in the 2009 census rate.
  - Male CCCMS census rate dropped slightly (-1.4%) as did the population projections to create a decline of 843 beds (-2.7%) by 2014 compared to the Spring 2009 study.
  - Other male census rates increased: Intermediate (5.3%), MHCB (2.9%), EOP-GP (1.4%).

FEMALE

- Female population projections were significantly lower than the Spring 2009 projections: 3.7% lower in 2009, 12.1% lower in 2014, and 16.9% lower by 2019.
- Census rate changes varied. Acute/Intermediate and MHCB rates were stable. EOP-GP decreased 8.5% as did PSU (3.6%) but CCCMS increased 3.4% as did EOP-ASU (1.8%). But population projection declines resulted in lower forecasted program volumes across the board.

OVERALL

- The FY2009 Mental Health Services Delivery System (MHSDS) population, excluding CCCMS, is 0.3% higher than that estimated for the same year in the Spring 2009 study. This grows to 2.4% higher by 2014.

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Methodology

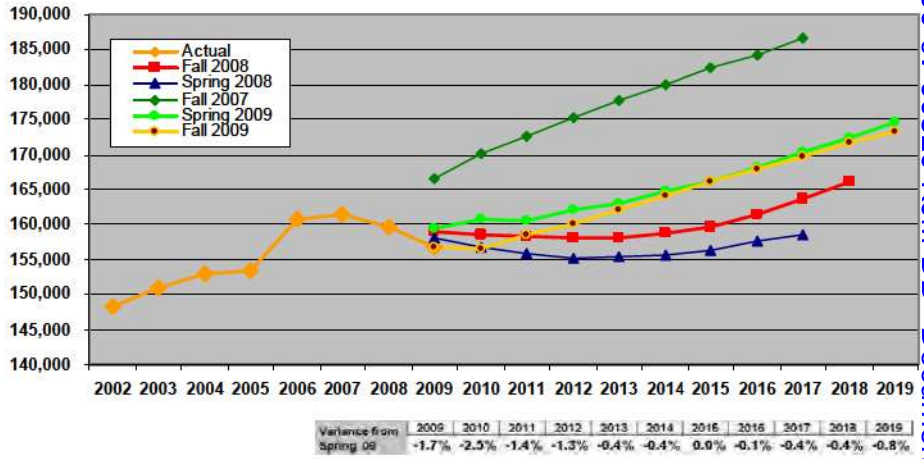
- The fundamental modeling approach for the Mental Health Bed Need Study is the Census Rate method, which is a population-based model. The method entails development of forecasts of the target populations and the development of use rates for those populations (based on average daily census per 1,000 inmates) for each level of care. Thus, this model uses the following variables:
  - Overall CDCR population
  - Periodic census counts by program
  - Periodic wait list counts by program

- The goal of the study is to address the adequacy of the capacities in each program so that those who are referred on the basis of a clinical judgment will not encounter barriers caused by inadequate supply. Occupancy standards were selected to ensure that, on the average, capacities would not be exceeded in the future given the forecasted bed requirements. The Division of Health Care Services decided to apply a 90 percent occupancy standard (rather than the 95 percent standard) to all *inpatient* programs. The lower occupancy standard increases the probability of having an empty bed available.

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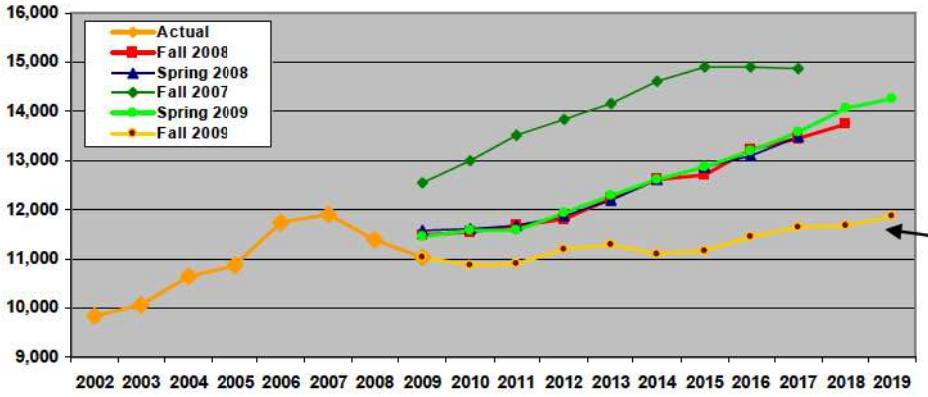
Fall 2009 Population Projections

The Fall 2009 projections from CDCR's OISB were received and published on December 31, 2009, and are deemed "final." The chart for Males shows that the new forecast is roughly the same as the Spring 2009 forecast. However, the chart for Females shows a significant departure from previous population reports.



Variance from Spring 09	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
	-1.7%	-2.5%	-1.4%	-1.3%	-0.4%	-0.4%	0.0%	-0.1%	-0.4%	-0.4%	-0.8%

The Fall 2009 population projection for females shows a substantial drop in future levels compared to prior forecasts.



Variance from Spring 09	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
	-3.7%	-6.2%	-5.9%	-6.2%	-8.2%	-12.1%	-13.2%	-13.3%	-14.3%	-16.9%	-16.9%

The Fall 2009 Male projections are only slightly lower than the previous Spring 2009 projections, with lower estimates in the early years.

The new projections grow more disparate over time. The Fall 2009 Female projection for 2019 is 16.9% lower than the older Spring 2009 forecast.

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Mental Health Program Capacities as of June 30, 2009

MALE	
Acute (CMF-VPP)	**126**
ICF	**390**
ASH	*256*
CSH	*50*
CMF-VPP	*84*
ICF (High Custody)	**274**
CMF-VPP	*30*
SVPP	*244*
MHCB	**314**
EOP	**3,141**
EOP - ASU	**474**
PSU	**384**
CCCMS	**23,471**

FEMALE	
Acute/ICF (PSH)	**30**
MHCB	**22**
EOP	**129**
EOP - ASU	**19**
PSU	**10**
CCCMS	**2,247**

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Acute Psychiatric Bed Need – Males

This Forecast is **Higher** than Spring 2009

Acute Inpatient Program Bed Need Forecast

Acute Psych - Male	--- Actual ---								--- Forecast ---									
Fiscal Year	2002	2003	2004	2005	2006	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Population (Fall 2009)	148,153	150,851	152,859	153,323	160,812	161,424	159,581	156,805	156,592	158,456	160,041	162,197	164,108	166,058	167,922	169,603	171,677	173,203
Census Rate	0.92	0.94	0.89	0.85	1.10	0.97	1.19	1.11	1.16	1.19	1.22	1.23	1.23	1.23	1.23	1.23	1.23	1.23
ADC from databases a/	137	142	136	129	145	115.1	134.4	**128.85**										
ADC - UNA est. unserved b/				2	1													
Wait List ADC c/					31	42.0	55.0	**45.9**										
Total ADC Est. & Forecast				131	177	157	189	175	182	189	195	200	202	204	207	209	211	213
Census Rate Adj. Factor d/								5.0%	4.0%	3.0%	2.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Bed Need (90% Occ)	**152**	**157**	**151**	**146**	**197**	**175**	**210**	**194**	**202**	**210**	**217**	**222**	**224**	**227**	**230**	**232**	**235**	**237**

a/ FY09 based on DMH daily census file 7/01/08 through 6/30/09 (avg. 119.66). ASH-APP average for July 2008-June 2009 (HC-POP MIS Reports) was 9.19. Also, it is reported by HC-POP that ASH-APP was converted to ICF beds in June.

b/ Distribution of patiert days during UNA study of transferred inmates: 80% in FY2005; 20% in FY2006

c/ Wait list based on average daily counts through 6/30/09 was 27.4. However, due to great variability by month the 90th percentile has been substituted to help improve bed availability for monthly fluctuations. This is an upward adjustment of 66%.

d/ Assumes that rates will continue to increase at a decelerating rate to 2014.

Forecast based on Spring 2009	**179**	**184**	**187**	**191**	**193**	**195**	**196**	**199**	**201**	**204**	**207**
Forecast based on Fall 2008	**210**	**218**	**225**	**229**	**231**	**231**	**232**	**233**	**236**	**240**	**246**
Forecast based on Spring 2008	209	216	221	224	225	225	226	226	229	230	

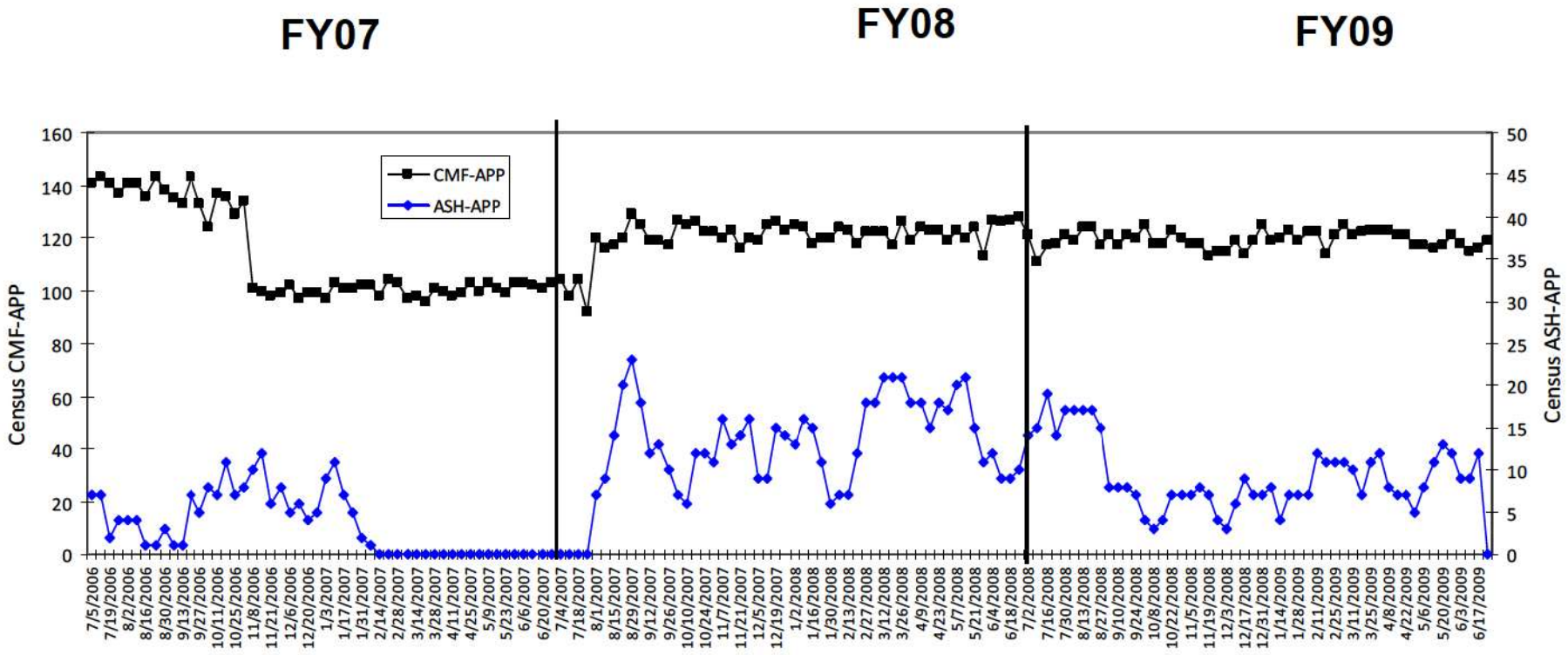
The Fall 2009 bed need forecast is higher than the Spring 2009, but did not return to the higher values from the Fall 2008 forecast. The main factor increasing bed need was the increase in the Acute wait list. Some of this increase is attributable to MHARP. This wait list is also effected by the Suicide Proofing Project currently underway. This project began in April 2009 and is estimated to be completed in March 2011. During this period, four beds will be down at a time.

Source: HC-POP "MIS SUM" files , and DMH's ""Census VPP FYE 09.xls"

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Acute Psychiatric Program – Male Census Trend

Acute Psychiatric Programs – Male Trends July 2006-June 2009

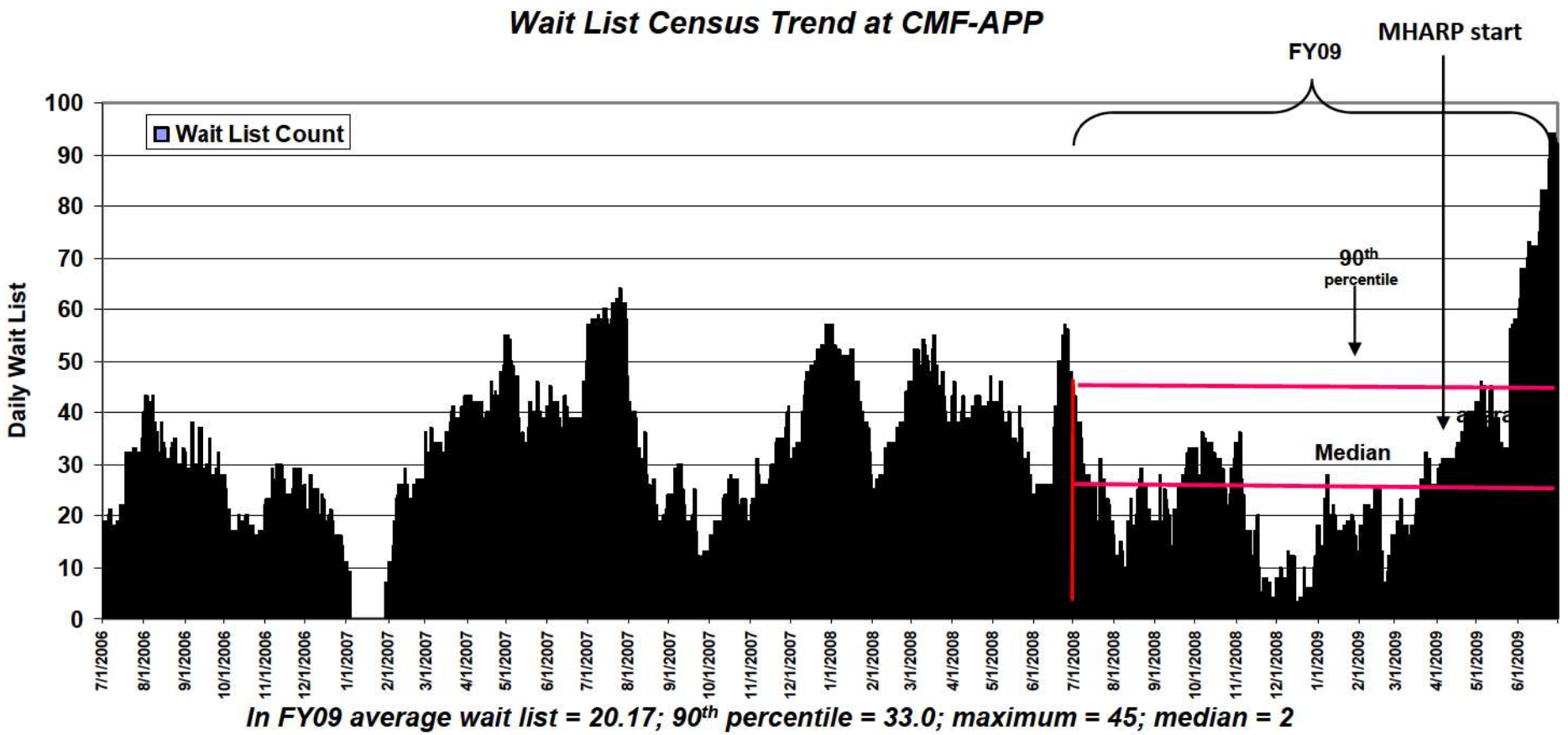


Twenty of the licensed Acute beds (S-2 unit) are being used as temporary MHCBs. Thus, the CMF-APP Census trends reflect only those inmates in the Acute program, not crisis beds.

Source: HC-POP "MIS SUM" files.

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Wait List Trend at CMF- Acute Psychiatric Program



In FY09 average wait list = 20.17; 90th percentile = 33.0; maximum = 45; median = 2

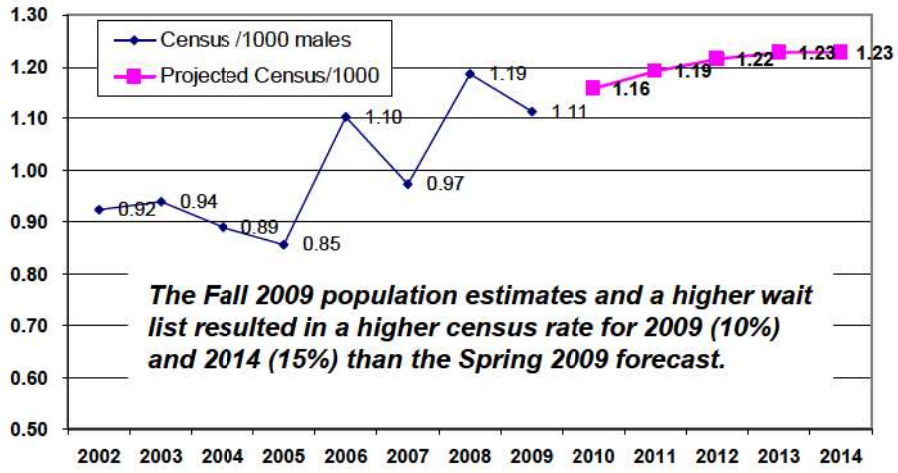
Periodic wait list spikes are pronounced. For this reason, this model adds the 90th percentile rather than the average wait list census prior to Bed Need calculation.

Data source: DMH's file "Census VPP FYE 09.xls" and prior year versions.

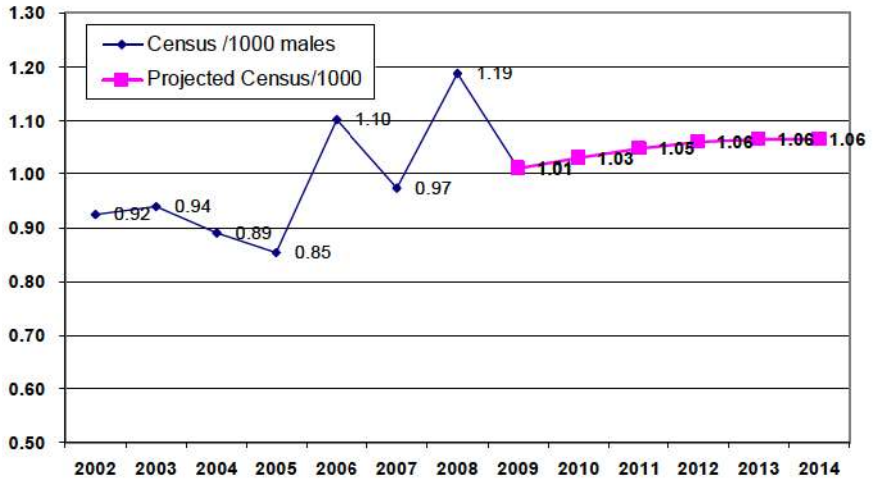
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Acute Psychiatric Bed Need – Males (Cont'd)

Census Rate Trends – CMF & ASH APP[1] (Fall 2009)



Census Rate Trends – CMF & ASH APP (Spring 2009)



This Fall 2009 forecast uses a higher census rate projection than the Spring 2009 forecast.

[1] In June 2009, ASH APP beds were converted to ICF.

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Acute & Intermediate Bed Need – Females

This Forecast is **Lower** than Spring 09

Patton State Hospital Acute and Intermediate Programs – Bed Need Forecast

Acute & Intermediate Female	--- Actual ---								--- Forecast ---									
Fiscal Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Population (Fall 2009)	9,826	10,080	10,641	10,856	11,749	11,888	11,392	11,027	10,861	10,889	11,180	11,284	11,095	11,167	11,440	11,640	11,688	11,855
Census Rate a/	**2.57**	**2.38**	**1.58**	**2.99**	**2.22**	**1.73**	**1.84**	**1.95**	1.95	1.95	1.95	1.95	1.95	1.95	1.95	1.95	1.95	1.95
Average Census b/	25.30	23.96	16.86	32.47	26.03	20.58	20.99	**21.52**	21.20	21.25	21.82	22.02	21.65	21.79	22.33	22.72	22.81	23.14
Bed Need @ 90% Occ						23	23	**24**	**24**	**24**	**24**	**24**	**24**	**24**	**25**	**25**	**25**	**26**

a/ Model now uses "Census Rate" method. Forecast uses the FY09 census rate as constant.
b/ ADC originally calculated using discharge rate model through 2006.

Forecast based on Spring 2009	25	25	25	26	27	27	28	29	29	30	31	
Forecast based on Fall 2008	23	23	24	24	24	25	26	26	27	28	28	
Forecast based on Spring 2008	23	22	22	22	23	23	24	25	25	26		

The Fall 2009 forecast dropped compared to the Spring 2009 forecast by 3 beds in 2014 (-12%) and 5 Beds in 2019 (-17%).

Data for Patton State Hospital was based on combining the weekly Management Information Summary reports from HC-POP for July 2008 to June 2009. The utilization is not at the level of 2005 and 2006 and no census rate adjustment factor was applied to the model. The census rate for the full fiscal year was stable, but bed need dropped due to the projected drop in population, especially in the outer years.

Source: HC-POP weekly MIS reports

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Intermediate Psychiatric Bed Need – Males

This Forecast Higher than Spring 09

CMF - ICF	--- Actual ---								--- Forecast ---									
Fiscal Year	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Population (Fall 2009)	148,153	150,851	152,859	153,323	160,812	161,424	159,581	156,805	156,592	158,456	160,041	162,197	164,108	166,058	167,922	169,603	171,677	173,203
Census Rate a/	0.53	0.52	0.50	0.52	0.62	0.67	0.84	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86
Avg. Census	79	79	76	80	100	107	134	135	135	137	138	140	142	143	145	146	148	150
Bed Need (90% Occ)	87	88	85	88	111	119	149	150	150	152	154	156	157	159	161	163	165	166
ASH																		
Census Rate a/	1.01	0.88	0.65	0.76	0.72	0.64	0.59	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86
Avg. Census (HC-POP weekly file)	150	132	100	117	116	103.6	94.0	**113.40**										
ASH-ICF wait List								**21.04**										
Total Avg. Census Est. & Forecast								134.4	134	136	137	139	141	142	144	145	147	149
Bed Need (90% Occ)	167	147	111	130	128	115	104	126	149	151	152	155	156	158	160	162	164	165
Coalinga																		
Census Rate a/	-	-	-	-	-	0.30	0.31	0.30	0.30	0.30	0.30	0.30	0.30	0.30	0.30	0.30	0.30	0.30
Avg. Census (HC-POP weekly file)						49.0	49.6	**46.92**	47	47	48	49	49	50	50	51	51	52
Bed Need (90% Occ)						54	55	52	52	53	53	54	55	55	56	56	57	58
SVPP																		
Census Rate b/	-	-	0.35	0.60	0.99	1.05	1.48	1.96	2.44	2.90	3.26	3.46	3.46	3.46	3.46	3.46	3.46	3.46
ADC (DMH daily census file)			43	51	49	96.4	156.4	**171.02**	383	459	521	561	568	575	581	587	594	599
ADC Dorm ADC					20	21.2	21.8	**26.85**										
ADC - UNA est. unserved				38	10													
ADC on Waitlist ("net" UNA) d/			11	3	100	72.8	79.5	**136.13**										
Total ADC Est. & Forecast			54	92	159	169	236	307	383	459	521	561	568	575	581	587	594	599
ADC on 1370 wait list						27.94	31.7	**32.39**	32.4	32.4	32.4	32.4	32.4	32.4	32.4	32.4	32.4	32.4
Bed Need (90% Occ) with 1370's	-	-	60	102	177	219	297	377	461	546	615	660	667	674	682	688	696	702

All Intermediate - Combined	--- Actual ---								--- Forecast ---									
Fiscal Year	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
ADC	228	211	231	268	375	429	513	624	699	779	845	889	899	910	920	929	941	949
Bed Need (90% Occ) excl. 1370's	254	234	256	320	416	477	570	693	**777**	**866**	**939**	**988**	**999**	**1,011**	**1,023**	**1,033**	**1,045**	**1,055**
ICF "Dorm-type" census rate **c/**					1.29	1.52	1.48	**1.65**	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65
Sub-Total Dormitory Housing ADC **c/**					208	246	236	259	258	261	264	267	271	274	277	280	283	286
Sub-Total Celled Housing ADC **c/**					167	184	277	365	441	518	581	621	629	636	643	650	658	664
Sub-Total Celled Housing Bed Need **c/**					185	204	308	406	490	576	645	690	699	707	715	722	731	737
Sub-Total Dorm-type Bed Need @ 90%					231	273	262	287	287	290	293	297	301	304	308	311	315	317

Forecast Based on Spring 2009								**671**	**753**	**824**	**888**	**925**	**935**	**942**	**954**	**967**	**978**	**991**

a/ CMF, Coalinga and ASH data from weekly HC-POP reports. Census rates for CMF-ICF, Coalinga and ASH are assumed to be constant at 2009 levels. CMF-DTP combined with CMF-ICF because unit was closed on 7/1/09

b/ 2008 and 2009 data from DMH daily census file. Census rate for SVPP in 2005 and 2006 includes potential census estimated for UNA inmates not transferred. Also the SVPP wait list is applied and included in the census rate. SVPP census rate was projected to decelerate 20% per year until 2014, based on the entire intermediate census rate change for last 5 years.

c/ The demand for celled housing was determined by subtracting the dormitory need from total need. The dormitory need was determined by calculating a census rate using historical volumes at the dormitory units at SVPP, CMF, ASH and Coalinga. This rate increased in FY06, dropped in FY08 then increased in FY09. Forecast years assumed the FY09 ratio as a constant.

d/ The average wait list of 139.0 for FY2009 was reduced by 2.83 which was the average overlap found in SVPP, PSU and MHCB wait lists for a sample of 12 dates during the period.

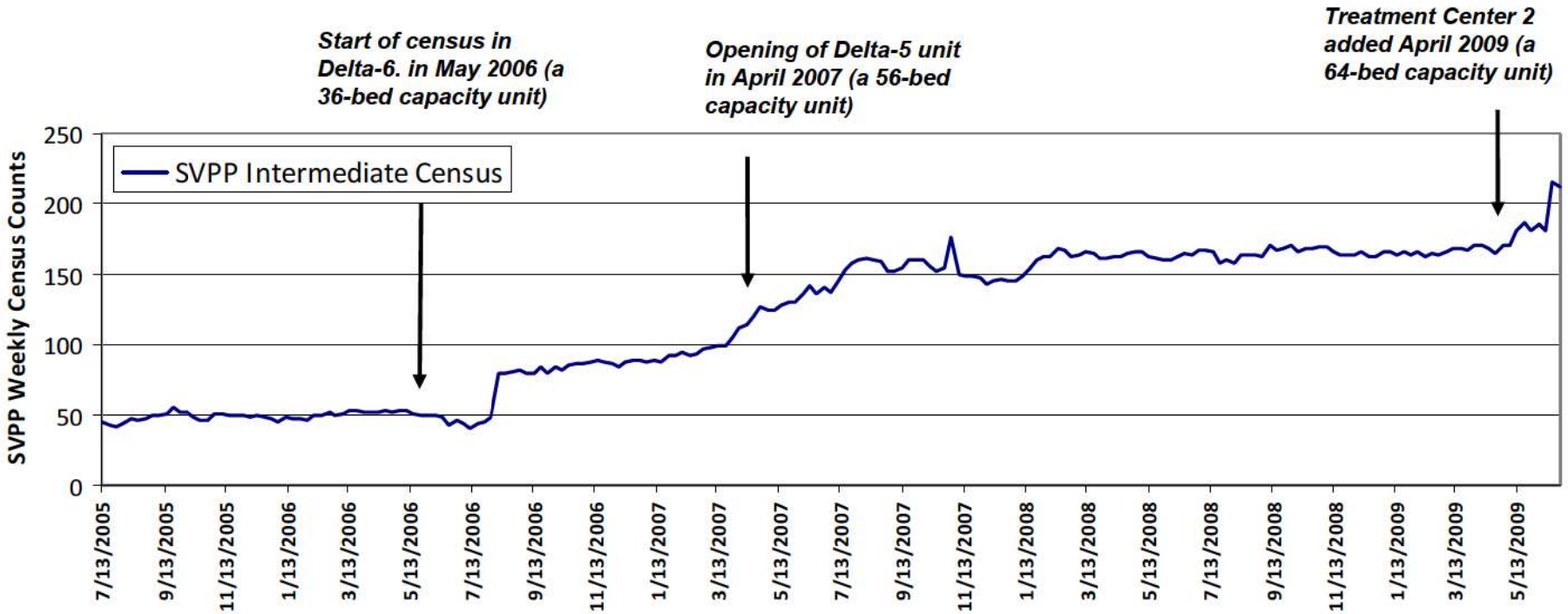
The Fall 2009 forecast resulted in an increase of bed need of 22 (3.3%) in 2009, 64 beds (6.9%) higher in 2014, and 63 beds (6.3%) higher in 2019 compared to the Spring 2009 study. Differences in population projections are deemed insignificant. Major increases occurred in the wait lists probably due in large part to the ongoing MHARP. Changes may be made in the forecast as final data is received.

Source: HC-POP 2009, and DMH's Census Files for SVPP, CSH and VPP.

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SVPP Census Trends
July 2005 – March 2009

The Census Trends at SVPP were relatively static until the new unit opened in May 2006. A second increase in capacity occurred in Spring 2007. There was a 5.6% increase in Average daily census in FY09 versus FY08.



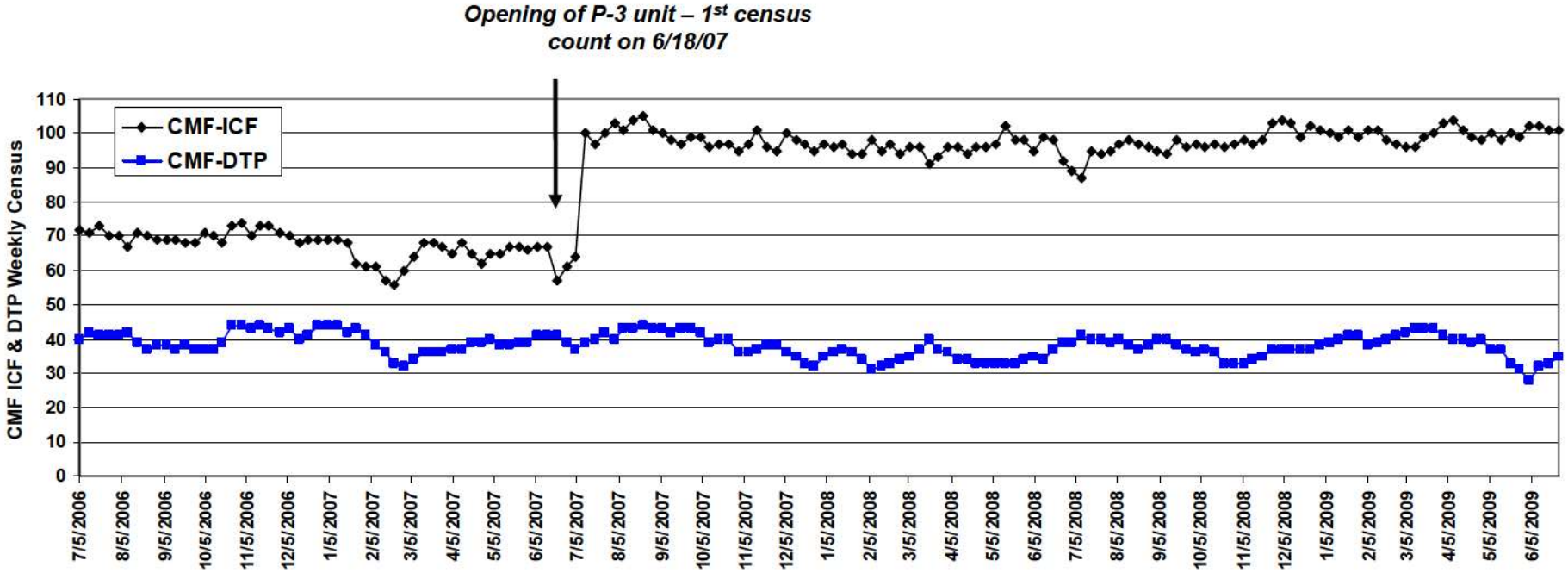
Fiscal Year	Average
FY06	49.0
FY07	93.8
FY08	157.4
FY09	169.3

Source: HC-POP weekly counts.

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CMF Intermediate Census Trends
July 2006 – June 2009

The census trends at CMF – ICF and Day Treatment Programs* have been remarkably constant until the addition of 30 new beds at CMF-ICF in June 2007 (P-3 unit). Census at CMF-ICF has fluctuated around 100 since this addition.



*** In July 2009, the 44 DTP beds at CMF were converted to ICF dorm beds.**

Fiscal Year	Avg. ICF	Avg. DTP
FY07	68.0	39.4
FY08	96.9	36.8
FY09	99.0	38.0

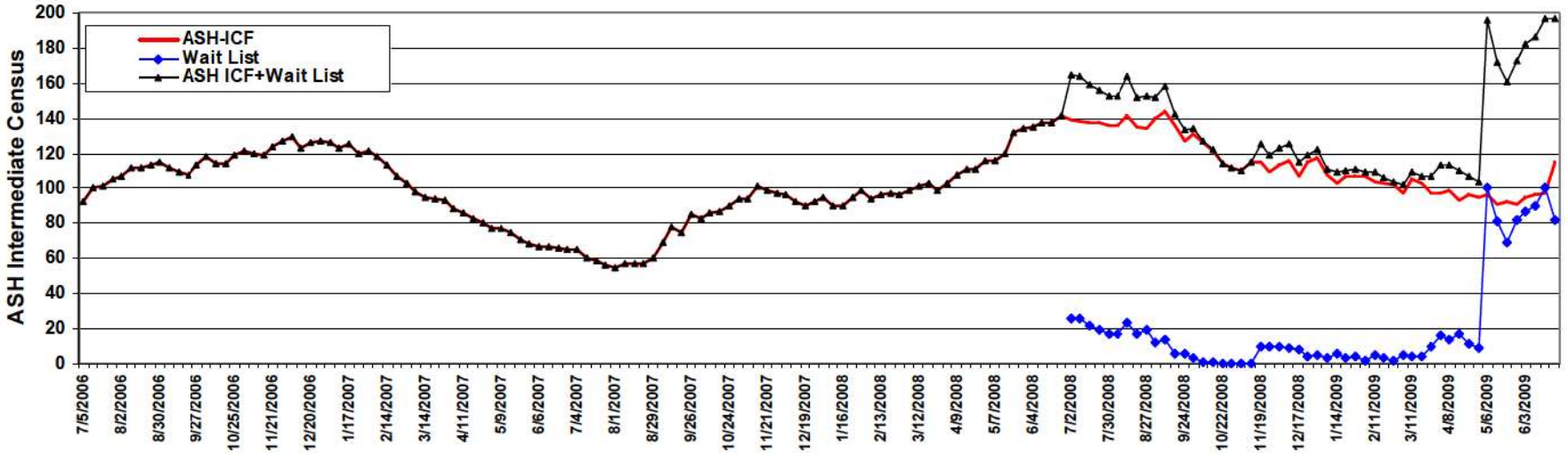
Source: HC-POP weekly counts. Table uses DMH's file "Census VPP FYE 09.xls" through Dec. 2009

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ASH Intermediate Census Trends
July 2006 – June 2009

The wait list at ASH has dramatically increased, presumably due to the MHARP.

As of 3/25/09, the average wait list (as reported in the Spring 2009 study) was 8.6. For the full year through June 2009, the average jumped to 21 with a large spike reaching 100 inmates in two reporting periods. However, because the increase is attributed primarily to MHARP, it may not be sustainable at the same level.

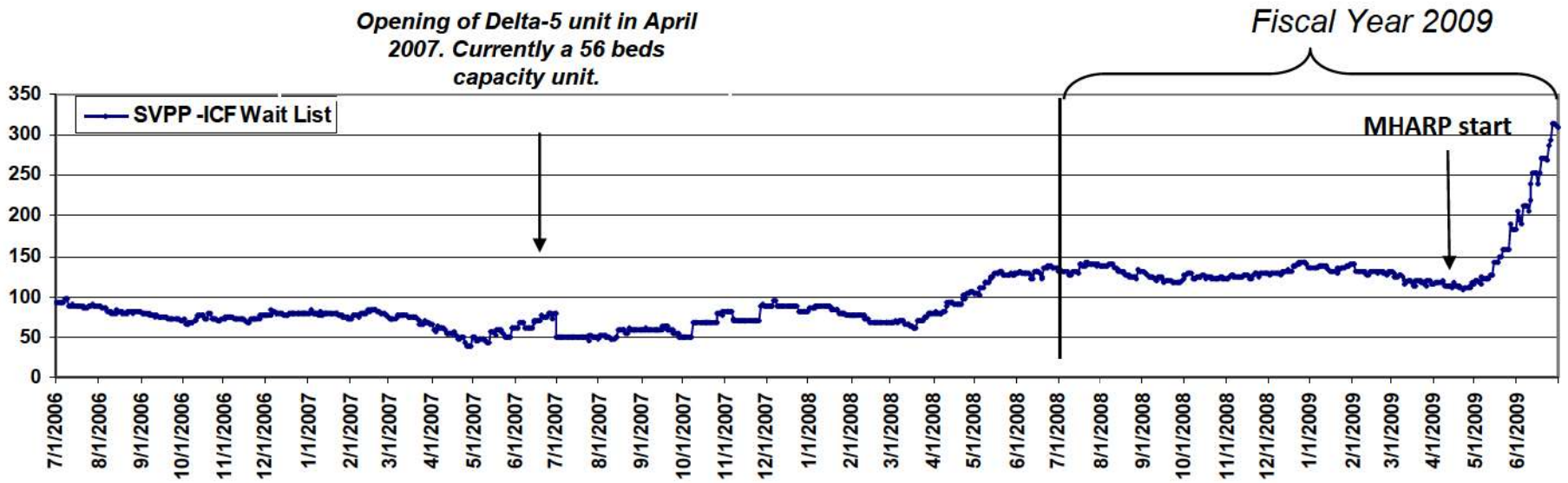


Source: HC-POP – weekly census counts

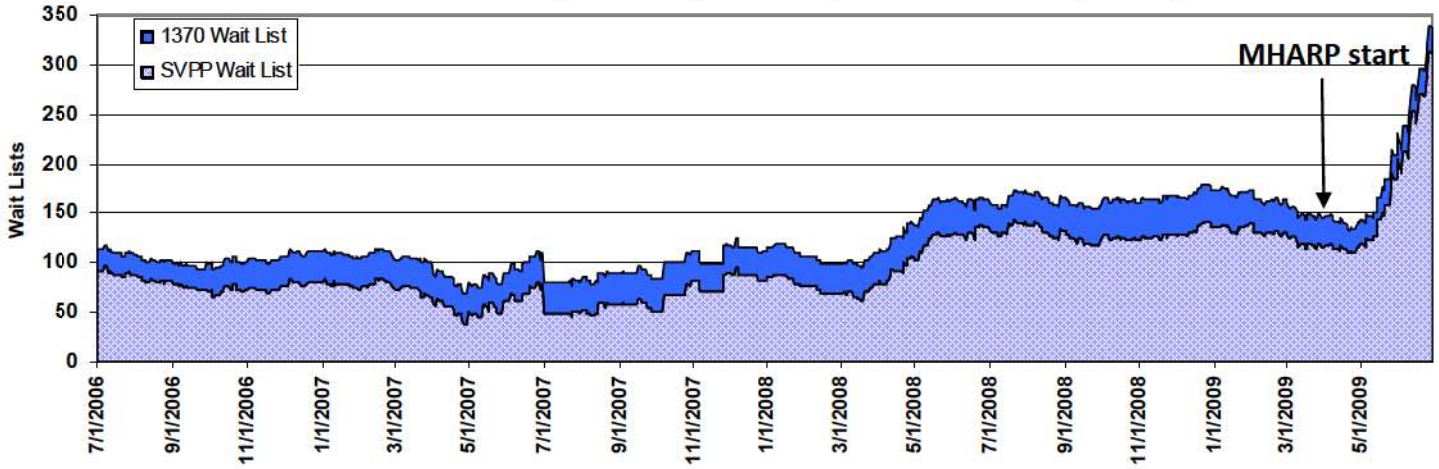
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SVPP Wait List Trend (Intermediate – Males)

SVPP Wait List Census Rate Trend – (PC2684's only)



The SVPP Wait List has increased significantly since April 2008 and especially since the MHARP.



Source: DMH's "SVPP Wait List..xls"

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Mental Health Crisis Bed Need - Males

This Forecast **Higher** than Spring 09

Male MHCB - Bed Need Forecast

MHCB - Males	--- Actual ---								--- Forecast ---									
Fiscal Year	2002	2003	2004	2005	2006	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Population (Fall 2009)	148,153	150,851	152,859	153,323	160,812	161,424	159,581	156,805	156,592	158,456	160,041	162,197	164,108	166,058	167,922	169,603	171,677	173,203
Census Rate **a/**	1.11	1.15	1.13	1.33	1.16	1.55	1.77	2.01	2.27	2.48	2.64	2.72	2.72	2.72	2.72	2.72	2.72	2.72
Average census	157	167	165	151	147	241	246.7	**292.4**										
Wait List	8	7	7	53	40	9.60	36.0	**23.4**										
Combined ADC	165	174	172	204	187	250	283	316	355	393	422	441	446	452	457	461	467	471
Census Rate Adjustment factor **b/**								15.7%	12.6%	9.4%	6.3%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Bed Need (90% Occ)	**183**	**193**	**192**	**227**	**208**	**278**	**314**	**351**	**395**	**437**	**469**	**490**	**496**	**502**	**508**	**513**	**519**	**524**

a/ Rate includes actual census and wait list average. FY2009 includes data for 12months of FY2009.
b/ Assumes that rates will continue to increase at a decelerating rate to 2014.

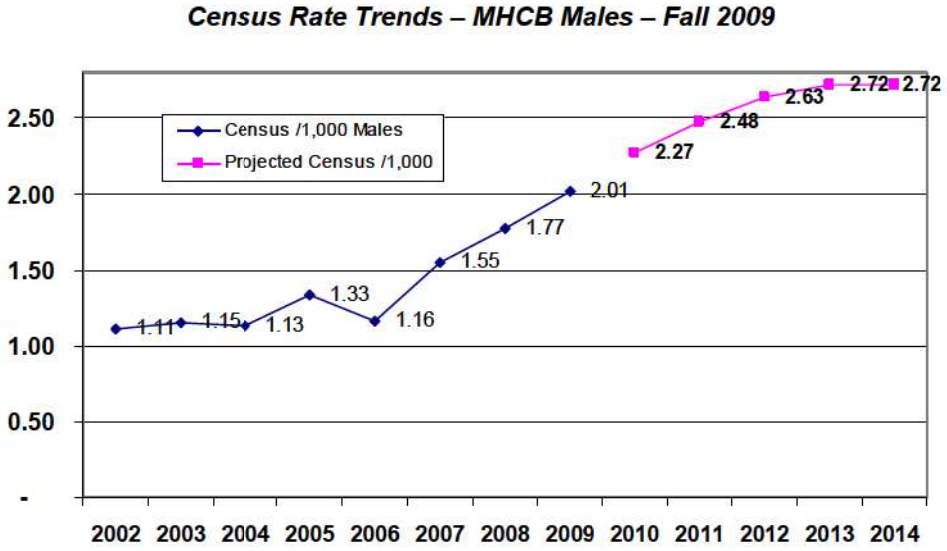
Forecast based on Spring 2009	**347**	**390**	**425**	**454**	**470**	**475**	**479**	**485**	**491**	**497**	**503**
Forecast based on Fall 2008	**314**	**340**	**360**	**375**	**383**	**383**	**384**	**386**	**391**	**397**	**402**

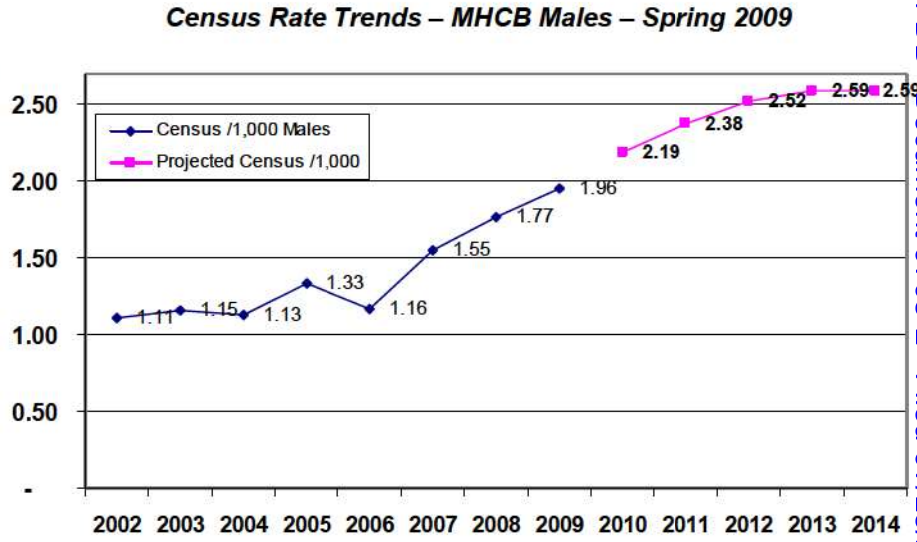
Compared to the Spring 2009 forecast, this Fall 2009 forecast increases bed need by 3 (1.2%) for 2009; 21 beds (4.5%) by 2014, and 20 beds (4.0%) by 2019.

Source: HC-POP – weekly MIS census reports

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Mental Health Crisis Bed Need – Males: Census Rate Trends & Forecasts



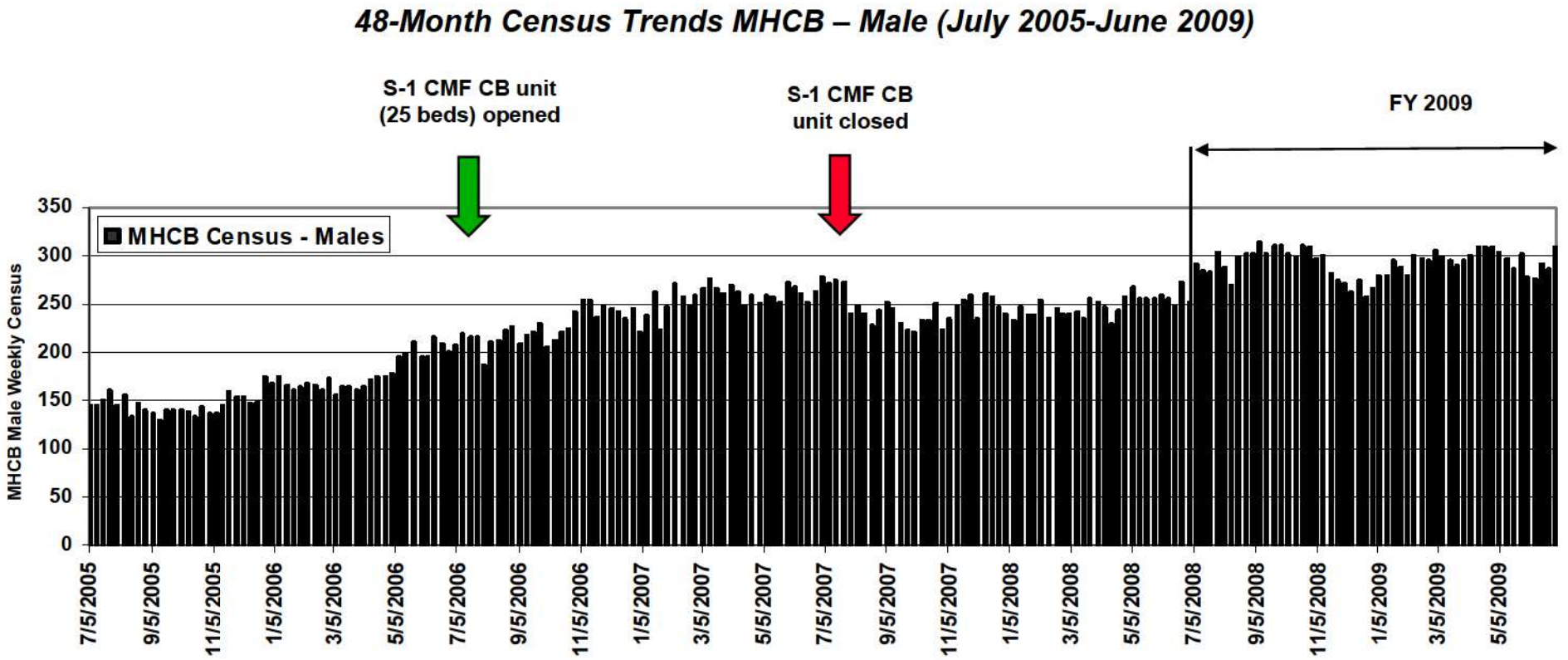


This Fall 2009 model exhibits a higher census rate projection (2.7%) than the Spring 2009 Study.

Source: Navigant Bed Need models

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Mental Health Crisis Bed Need – Males: Census Trends

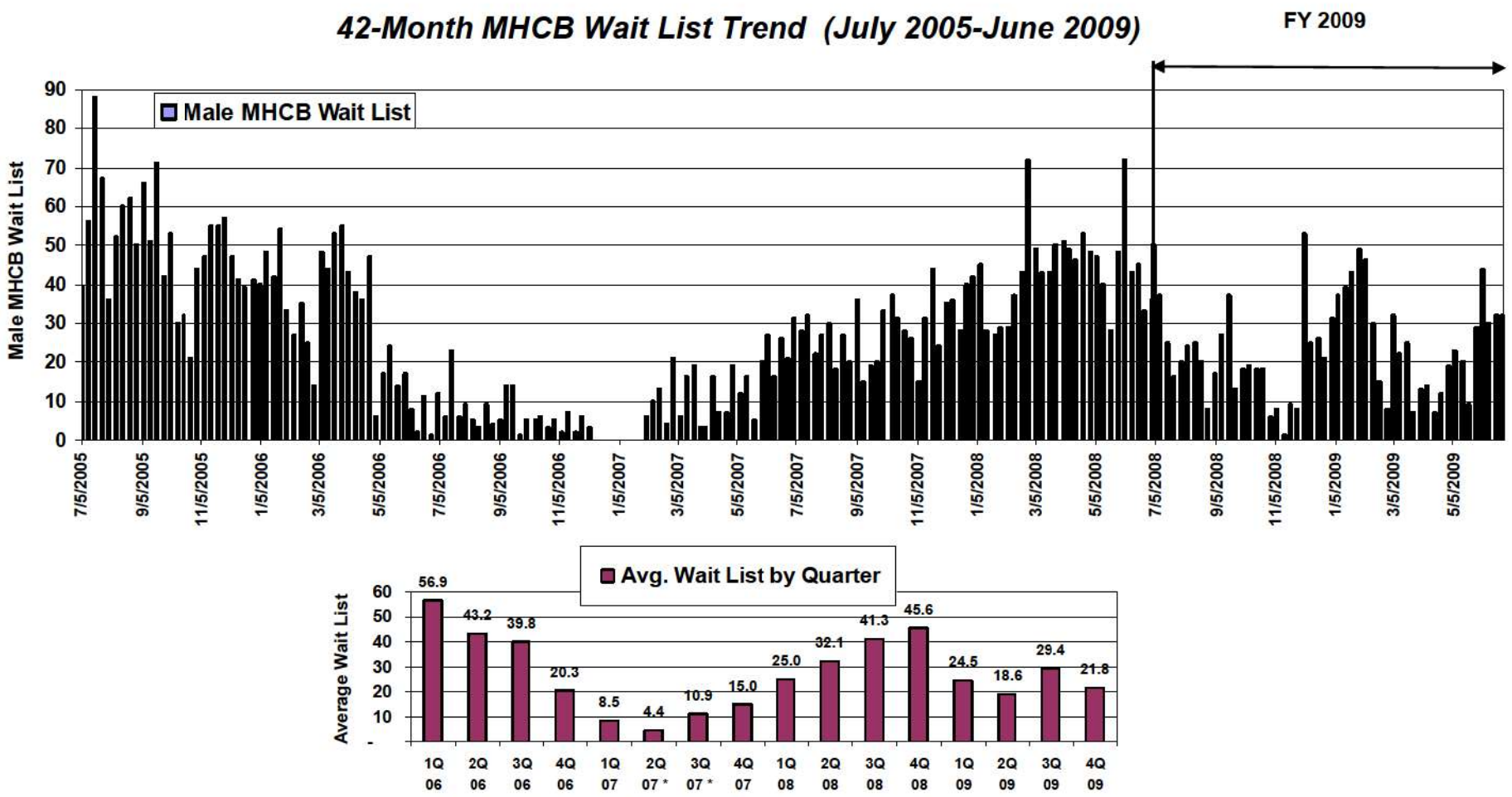


A new bed supply in July 2006 had a significant impact on the census and a concurrent drop in the wait list. Following closure of the CMF Crisis Bed unit (S-1), the census dipped while the wait list again increased. In FY2009, the census averaged 292.4 versus 246.7 in FY2008; an increase of 18.6%.

Source: HC-POP – weekly MIS census reports and earlier versions

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Mental Health Crisis Bed Need – Males: Wait List Trends



A shift in bed supply appears to have a direct effect on the wait list. New beds added at CMF in 7/06 led to a drop, but returning those 25 beds to Acute use and lowering the overall supply shows a wait list rebound in 2007. There was a drop of 2.7% in the FY09 Wait List compared to FY08. (* missing data between 12/4/06 and 1/10/07). MHCB capacity increased in late FY2008 to 314 from 259 with the addition of the 50-bed MHCB at CMF and capacity increases at SATF and PVSP.

Source: HC-POP – weekly MIS census reports and earlier versions

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Mental Health Crisis Bed Need – Females

This Forecast **Lower** than Spring 09

Female MHCB - Bed Need Forecast

MHCB - Females	Actual			--- Forecast ---									
Fiscal Year	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Population (Fall 2009)	11,888	11,392	11,027	10,861	10,889	11,180	11,284	11,095	11,167	11,440	11,640	11,688	11,855
Census Rate **a/**	1.04	1.15	1.20	1.27	1.32	1.36	1.38	1.38	1.38	1.38	1.38	1.38	1.38
Average census	12.4	13.2	**13.2**	14	14	15	16	15	15	16	16	16	16
Census Rate Adjustment factor b/			7.3%	5.8%	4.4%	2.9%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Bed Need (90% Occ)	**14**	**15**	**15**	**15**	**16**	**17**	**17**	**17**	**17**	**18**	**18**	**18**	**18**

a/ Includes CCWF and CIW.

b/ Assumes that rates will continue to increase at a decelerating rate to 2014. Based on an increase between 2007 and 2009.

Forecast based on Spring 2009	**15**	**16**	**17**	**18**	**19**	**19**	**20**	**20**	**21**	**22**	**22**
Forecast based on Fall 2008	**15**	**15**	**16**	**17**	**17**	**18**	**18**	**18**	**19**	**19**	**20**

The Spring 2009 projections indicate a decrease in bed need of 2.4 beds (-12%) in 2014 and 3.8 beds (-17%) in 2019 compared to the Spring 2009 study.

Source: HC-POP – weekly census counts

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EOP General Population Bed Need - Males

This Forecast **Higher** than Spring 2009

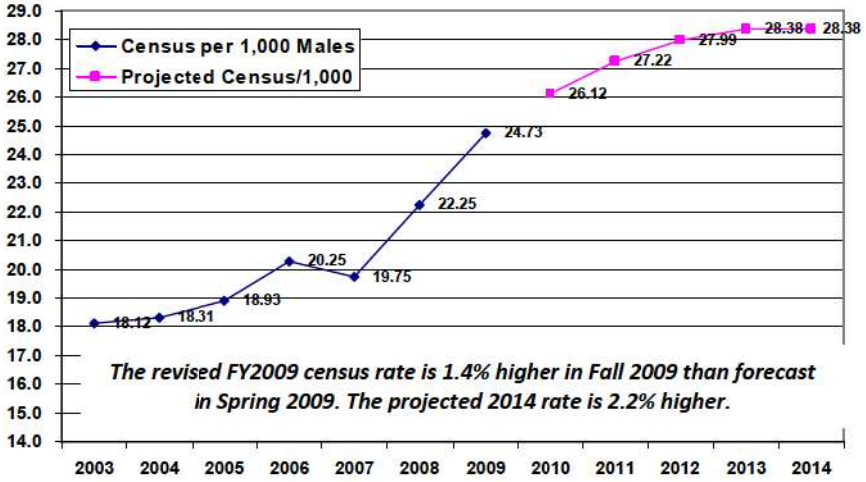
Male EOP–GP Bed Need Forecast

EOP-GP Need - Males	--- Actual ---							--- Forecast ---									
Fiscal Year	2003	2004	2005	2006	2007	2008	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Population (Fall 2009)	150,851	152,859	153,323	160,812	161,424	159,581	156,805	156,592	158,456	160,041	162,197	164,108	166,058	167,922	169,603	171,677	173,203
Census /1000 males	**18.12**	**18.31**	**18.93**	**20.25**	**19.75**	**22.25**	**24.73**	26.12	27.22	27.99	28.38	28.38	28.38	28.38	28.38	28.38	28.38
Average Census a/	2,733	2,798	2,902	3,257	3,189	3,550	**3878**	4,091	4,314	4,480	4,604	4,658	4,713	4,766	4,814	4,873	4,916
Census Rate Adjustment factor b/							7.0%	5.6%	4.2%	2.8%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Bed Need @ 95% Occ	**2,877**	**2,946**	**3,055**	**3,428**	**3,357**	**3,737**	**4,083**	**4,306**	**4,541**	**4,715**	**4,846**	**4,903**	**4,961**	**5,017**	**5,067**	**5,129**	**5,175**
Forecast based on Spring 2009							**4,094**	**4,343**	**4,516**	**4,677**	**4,763**	**4,816**	**4,855**	**4,915**	**4,981**	**5,040**	**5,107**
Forecast based on Fall 2008						**3,737**	**3,858**	**3,952**	**4,021**	**4,053**	**4,050**	**4,065**	**4,088**	**4,134**	**4,196**	**4,258**	
Level IV census as % of total **c/**					35.9%	35.2%	34.8%	34.8%	34.8%	34.8%	34.8%	34.8%	34.8%	34.8%	34.8%	34.8%	34.8%
Level I-III & RCs Bed Need (95%)					2,153	2,423	2,661	2,807	2,960	3,074	3,159	3,196	3,234	3,270	3,303	3,343	3,373
Level IV Bed Need (95%)					1,204	1,314	1,421	1,499	1,581	1,642	1,687	1,707	1,727	1,747	1,764	1,786	1,802
Total all Levels					**3,357**	**3,737**	**4,083**	**4,306**	**4,541**	**4,715**	**4,846**	**4,903**	**4,961**	**5,017**	**5,067**	**5,129**	**5,175**

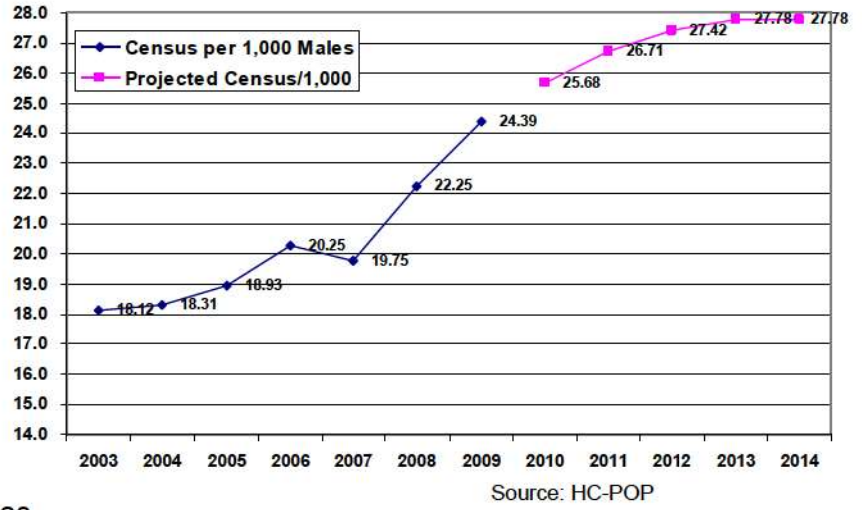
a/ Source: HC-POP Reports R1-1 through R1-4. Starting in FY07, data was captured every 2 weeks. FY09 was based on 12 months data.
b/ Assumes that rates will continue to increase but at a decelerating rate to 2014. Based on an increase of between 2004 and 2009..
c/ Data was available from HC-POP by Level of Custody (GP + Ad-Seg data combined). The FY09's ratio of Level IV / total census dropped from the FY08 level to 34.8%.

The Fall 2009 bed need dropped slightly by 11 beds (-.28%) in 2009 compared to the Spring 2009 forecast; increased by 87 beds (1.8%) in 2014 and by 68 beds (1.3%) in 2019.

Census Rate Trend/Forecast – Fall 2009



Census Rate Trend/Forecast – Spring 2009



Source: HC-POP

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EOP ASU Bed Need - Males

This Forecast Higher Than Spring 09

Male EOP–ASU Bed Need Forecast

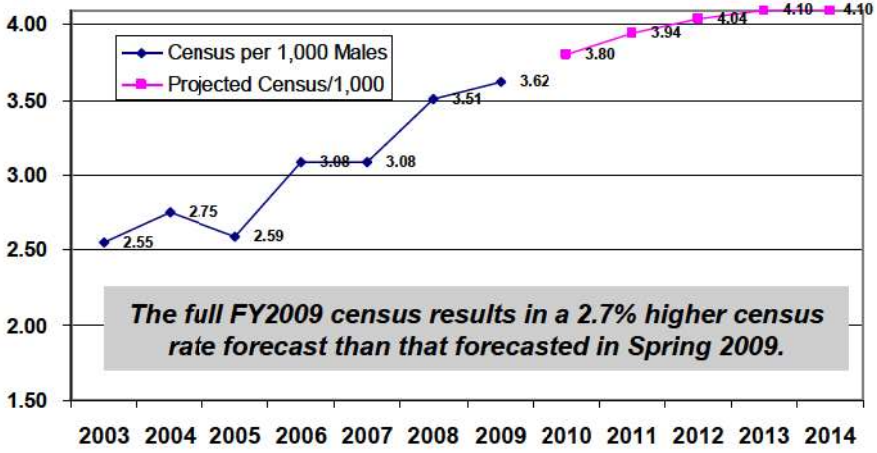
Ad-Seg EOP Need - Males	--- Actual ---							--- Forecast ---										
Fiscal Year	2003	2004	2005	2006	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Population (Fall 2009)	150,851	152,859	153,323	160,812	161,424	159,581	156,805	156,592	158,456	160,041	162,197	164,108	166,058	167,922	169,603	171,677	173,203
Census /1000 males	2.55	2.75	2.59	3.08	3.08	3.51	3.62	3.80	3.94	4.04	4.10	4.10	4.10	4.10	4.10	4.10	4.10
Average census a/	385	420	398	496	498	560	567	595	625	647	664	672	680	688	695	703	709
Census Rate Adjustment factor **b/**							6.3%	5.0%	3.8%	2.5%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Bed Need @ 95% Occ	405	443	419	522	524	589	**597**	**627**	**658**	**681**	**699**	**707**	**716**	**724**	**731**	**740**	**747**

Forecast Based on Spring 2009	**592**	**623**	**644**	**664**	**675**	**682**	**688**	**696**	**706**	**714**	**724**	
Forecast Based on Fall 2008	**589**	**622**	**648**	**667**	**677**	**676**	**679**	**683**	**690**	**701**	**711**	

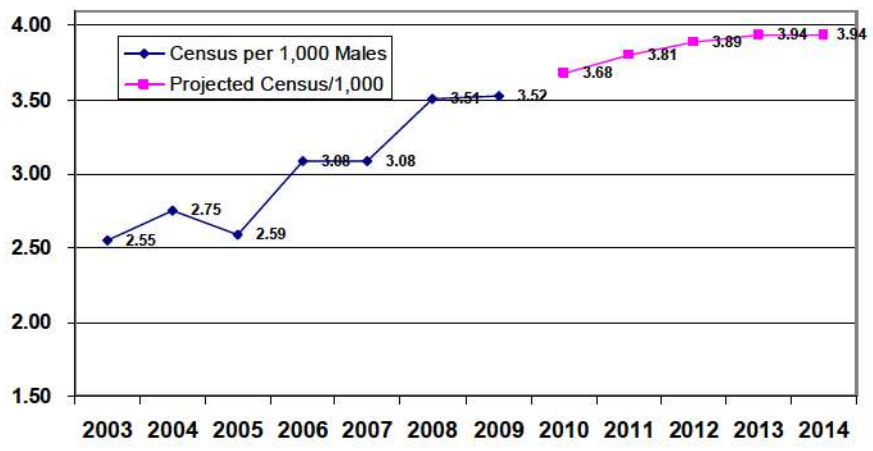
a/ Source: HC-POP Management Information Reports R1-1 through R1-4 for the first downloaded day of each month. Starting in FY07, data was captured every 2 weeks.
b/ Assumes that rates will continue to increase but at a decelerating rate to 2014.

The full FY2009 census rate is 2.7% higher than that calculated for 2009 in the Spring 2009 study. The 2009 bed need is 6 beds higher (1%) than calculated in the Spring 2009 study; 25 beds higher (3.7%) in 2014 and 23 beds higher (3.2%) in 2019.

Census Rate Trend/Forecast – Fall 2009



Census Rate Trend/Forecast – Spring 2009



Source: HC-POP

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Psychiatric Services Unit Bed Need - Males

This Forecast is **Higher** than Spring 2009

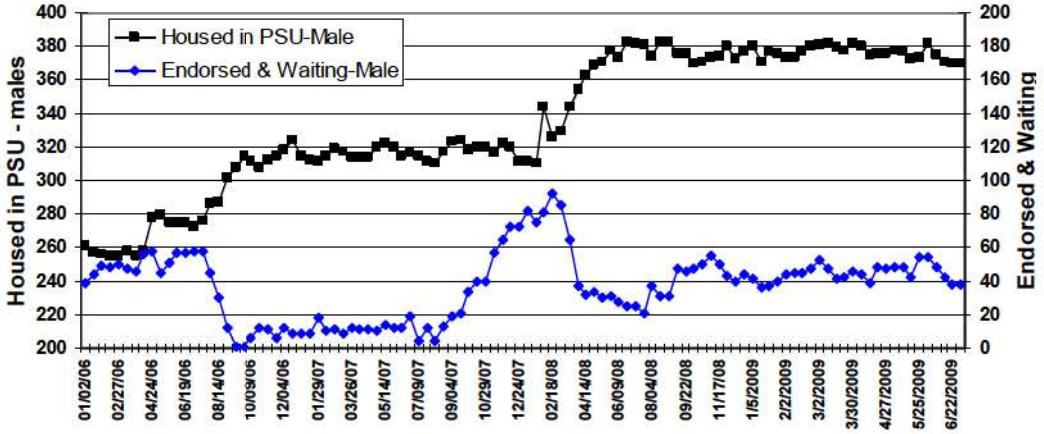
Male PSU Bed Need Forecast

PSU - Males	--- Actual ---								--- Forecast ---									
Fiscal Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Population (Fall 2009)	148,153	150,851	152,859	153,323	160,812	161,424	159,581	156,805	156,592	158,456	160,041	162,197	164,108	166,058	167,922	169,603	171,677	173,203
Census /1000 males	1.56	1.77	1.74	1.91	1.88	2.02	2.65	2.67	2.91	3.09	3.23	3.30	3.30	3.30	3.30	3.30	3.30	3.30
Average Census a/	231	267	265	292	303	310	380	376.4	455	490	517	535	541	548	554	559	566	571
Endorsed & Waiting a/						15.9	43	43.0										
Census Rate Adjustment factor b/								10.8%	8.6%	6.5%	4.3%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Bed Need @ 95% Occ	243	281	279	308	319	343	445	442	**479**	**516**	**544**	**563**	**570**	**577**	**583**	**589**	**596**	**601**
Forecast based on Spring 2009								**439**	**478**	**507**	**532**	**546**	**552**	**556**	**563**	**571**	**578**	**585**
Forecast based on Fall 2008							**400**	**479**	**506**	**526**	**535**	**535**	**537**	**540**	**546**	**554**	**562**	

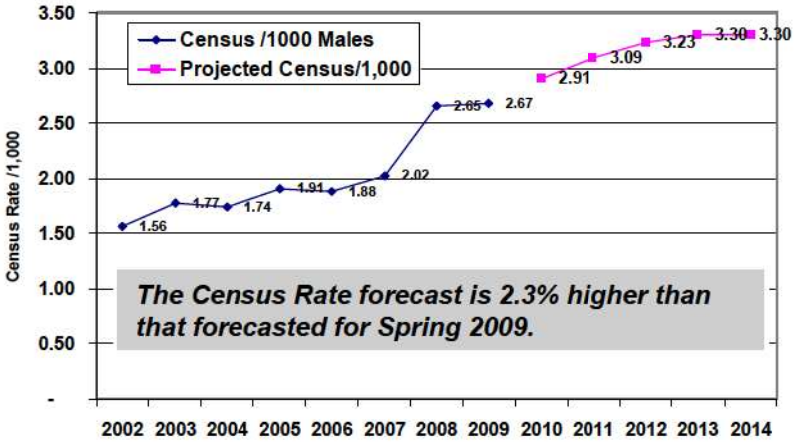
a/ Data starting in FY07 allows separation of actual census and endorsed & waiting counts. Both are included in census rate calculation. FY2009 data for 12 months.
b/ Census rate adjustment assumes that rates will continue to increase but at a decelerating rate to 2014 based on the change between 2004-2009.

The Fall 2009 forecast results in a lower bed need of 37 (-7.8%) in 2009 but a higher need of 33 beds (6.1%) compared to the Spring 2009 report. This is due to a lower population in 2009 but a higher census rate.

PSU Housed and PSU Waiting Census: 1/06 - 6/09



Census Rate Trend - PSU Fall 2009



Source: HC-POP

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EOP General Population Bed Need - Females

This Forecast is **Lower** Than Spring 09

Female EOP–GP Bed Need Forecast

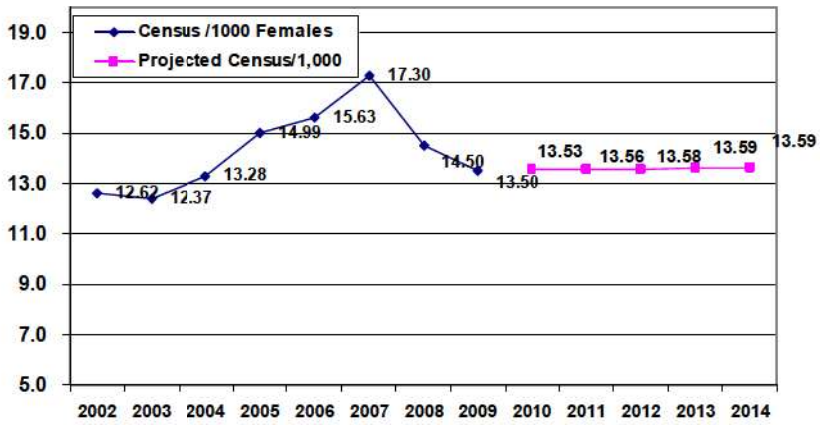
EOP-GP Female	--- Actual ---								--- Forecast ---									
Fiscal Year	2002	2003	2004	2005	2006	2007	2008	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Population (Fall 2009)	9,826	10,080	10,641	10,856	11,749	11,888	11,392	11,027	10,861	10,889	11,180	11,284	11,095	11,167	11,440	11,640	11,688	11,855
Census /1000 Females	12.62	12.37	13.28	14.99	15.63	17.3	14.5	13.5	13.53	13.56	13.58	13.59	13.59	13.59	13.59	13.59	13.59	13.59
Avg census a/	124	125	141	163	184	206	165	**148.9**	147	148	152	153	151	152	155	158	159	161
Census Rate Adjustment factor b/								0.3%	0.3%	0.2%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%
Bed Need @ 95% Occ	131	131	149	171	193	217	**174**	**157**	**155**	**155**	**160**	**161**	**159**	**160**	**164**	**166**	**167**	**170**

a/ Source: HC-POP Reports R1-1 through R1-4. FY09 based on full 12 months data.
b/ Census rate adjustment assumes that rates will continue to increase but at a decelerating rate to 2014 based on the change between 2004-2009.

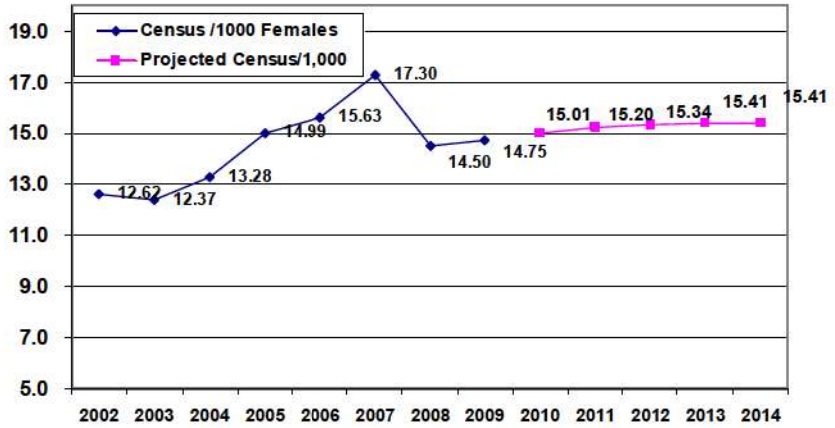
Forecast Based on Spring 2009	**178**	**183**	**185**	**192**	**199**	**205**	**209**	**214**	**220**	**228**	**231**
Forecast Based on Fall 2008	**174**	**180**	**185**	**189**	**193**	**200**	**206**	**208**	**216**	**220**	**225**

The Fall 2009 forecast is significantly lower than the Spring 2009 Forecast indicating 21 fewer beds (-12%) in 2009; to 62 fewer beds (-27%) by 2019. This is due both to the drop in utilization in the second half of FY2009 and the lower population projections.

Census Rate Trend – Fall 2009



Census Rate Trend – Spring 2009



Source: HC-POP

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EOP-ASU Bed Need – Females

Forecast is **Lower** than Spring 2009

Female EOP–ASU Bed Need Forecast

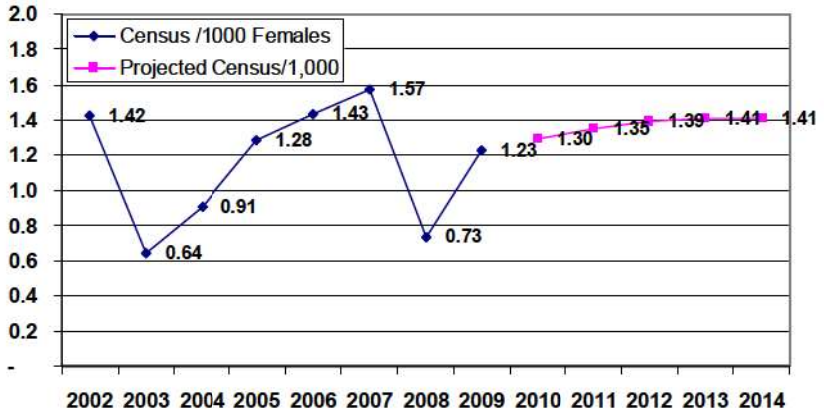
EOP-AdSeg Female	--- Actual ---								--- Forecast ---									
Fiscal Year	2002	2003	2004	2005	2006	2007	2008	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Population (Fall 2009)	9,826	10,080	10,641	10,856	11,749	11,888	11,392	11,027	10,861	10,889	11,180	11,284	11,095	11,167	11,440	11,640	11,688	11,855
Census /1000 Females	1.42	0.64	0.91	1.28	1.43	1.6	0.7	1.2	1.30	1.35	1.39	1.41	1.41	1.41	1.41	1.41	1.41	1.41
Avg census a/	14	7	10	14	17	18.7	8.3	**13.5**	14	15	16	16	16	16	16	16	16	17
Census Rate Adjustment factor b/								7.0%	5.6%	4.2%	2.8%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Bed Need @ 95% Occ	15	7	10	15	18	20	**9**	**14**	**15**	**15**	**16**	**17**	**16**	**17**	**17**	**17**	**17**	**18**

a/ Source: HC-POP Reports R1-1 through R1-4.
b/ Census rate adjustment assumes that rates will continue to increase but at a decelerating rate to 2014 based on the change between 2004-2009.

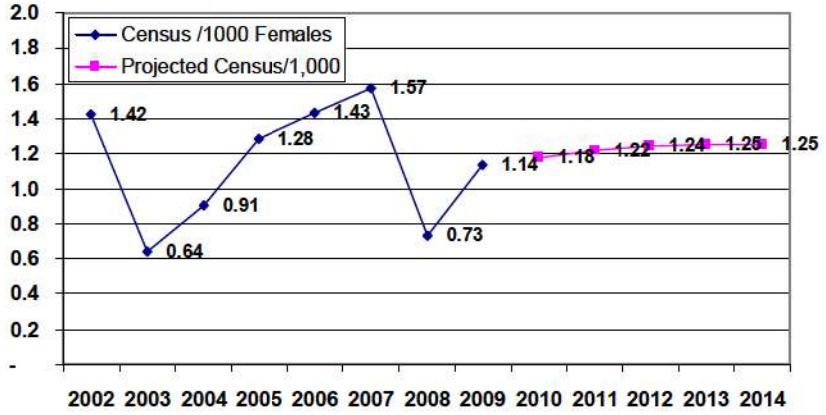
Forecast Based on Spring 2009	**14**	**14**	**15**	**16**	**16**	**17**	**17**	**17**	**18**	**19**	**19**	
Forecast Based on Fall 2008	**9**	**9**	**9**	**9**	**10**	**10**	**10**	**10**	**11**	**11**	**11**	

The Fall 2009 forecast is slightly higher by .6 beds (4%) than the Spring 2009 forecast due to higher census in the second half of FY2009, but comparatively lower in 2014 by -0.2 beds (-1.2%) and in 2019 by -1.25 beds (-6.6%) due to the drop in Female population projections.

Census Rate Trend/Forecast – Fall 2009



Census Rate Trend/Forecast – Spring 2009



Source: HC-POP

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Psychiatric Services Unit Bed Need - Females

This Forecast **Lower** than Spring 09

Female PSU Bed Need Forecast

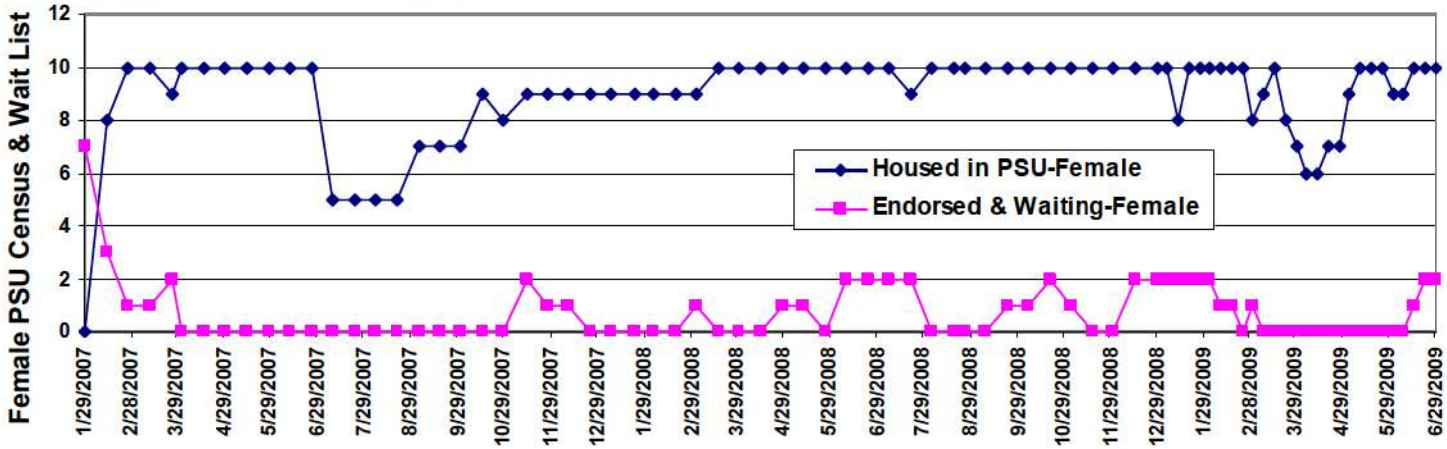
PSU - Females	--- Actual ---			--- Forecast ---									
Fiscal Year	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Population (Fall 2009)	11,888	11,392	11,027	10,861	10,889	11,180	11,284	11,095	11,167	11,440	11,640	11,688	11,855
Census /1000 females a/	0.87	0.80	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.91
Average Census	9.73	8.85	**9.30**	10	10	10	10	10	10	10	11	11	11
Endorsed & Waiting	0.64	0.25	**0.78**										
Bed Need @ 95% Occ	10.9	**9.6**	**11**	**10**	**10**	**11**	**11**	**11**	**11**	**11**	**11**	**11**	**11**

a/ Census rates calculated using actual census plus wait list. Census rate dropped in FY08 but increased in FY09. Assume a constant rate at the FY09 level.

Forecast Based on Spring 2009		**11**	**12**	**12**	**12**	**12**	**13**	**13**	**13**	**14**	**14**	**14**
Forecast Based on Fall 2008	**9.6**	**10**	**10**	**10**	**10**	**11**	**11**	**11**	**12**	**12**	**12**	

The census rate dropped in the full 12 months of FY2009 compared to the Spring 2009 forecast. With a lower census rate and lower population projections, the bed need was lower throughout the forecast period.

CDCR established the PSU program for women in January 2007. Though the rate dropped in FY08, the average census increased somewhat in FY09, but not to the level of FY07.



Source: HC-POP

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CCCMS - Males

This Forecast **Lower** than Spring 09

Male CCCMS Bed Need Forecast

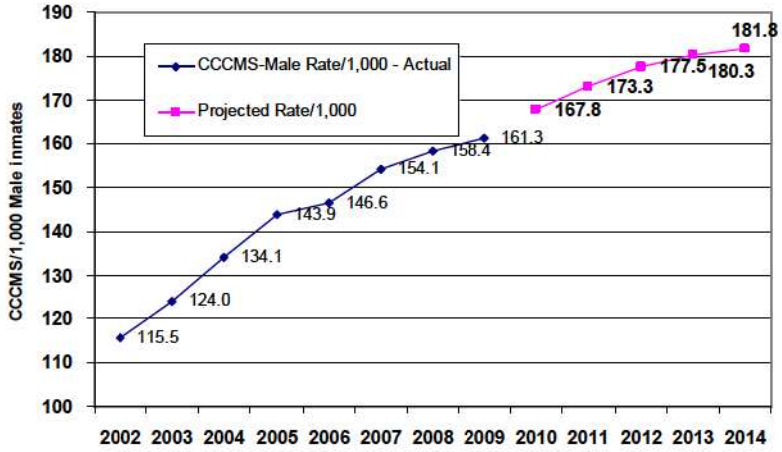
CCCMS - Males	--- Actual ---								--- Forecast ---									
Fiscal Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Population (Fall 2009)	148,153	150,851	152,859	153,323	160,812	161,424	159,581	156,805	156,592	158,456	160,041	162,197	164,108	166,058	167,922	169,603	171,677	173,203
Census/1,000 males a\	116	124	134	144	147	154	158	161	168	173	177	180	182	182	182	182	182	182
Census Rate Adj. Factor b/								4.1%	3.2%	2.4%	1.6%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CCCMS Census & Forecast	17,119	18,712	20,501	22,070	23,575	24,874	25,276	25,289	26,278	27,453	28,401	29,250	29,835	30,189	30,528	30,834	31,211	31,488

a/ Source: HC-POP Management Information Reports R1-1 through R1-4 for the first downloaded day of each month. FY09 based on 12 months data.
b/ Assumes that census rate will continue to increase but at a decelerating rate to 2014.

Forecast Based on Spring 2009	26,090	27,436	28,398	29,409	30,076	30,677	30,927	31,310	31,725	32,105	32,530
Forecast Based on Fall 2008	25,276	26,569	27,661	28,558	29,158	29,459	29,572	29,738	30,072	30,526	30,973

This Fall 2009 forecast is lower than the Spring 2009 forecast throughout the forecast period. The newer FY09 census rate is <u>lower</u> by 1.4%, and this rate decreases 2.4% compared to the 2014 and 2019 rates from the Spring 2009 study.

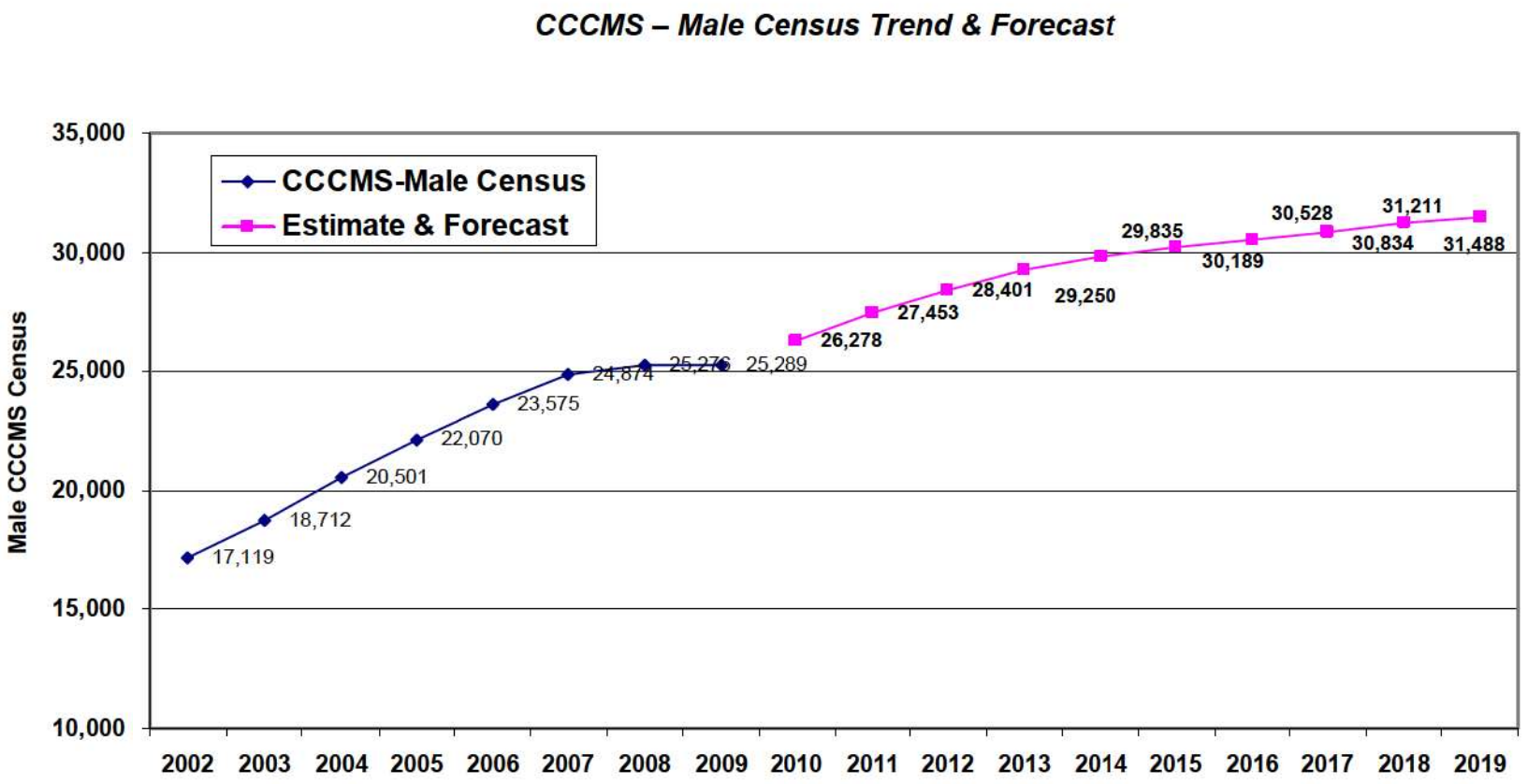
CCCMS – Male Census Rate/1000



Source: HC-POP

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CCCMS – Males: Census Trend & Forecast



Source: Navigant Bed Need models

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CCCMS - Females

This Forecast is **Lower** than Spring 2009

Female CCCMS Bed Need Forecast

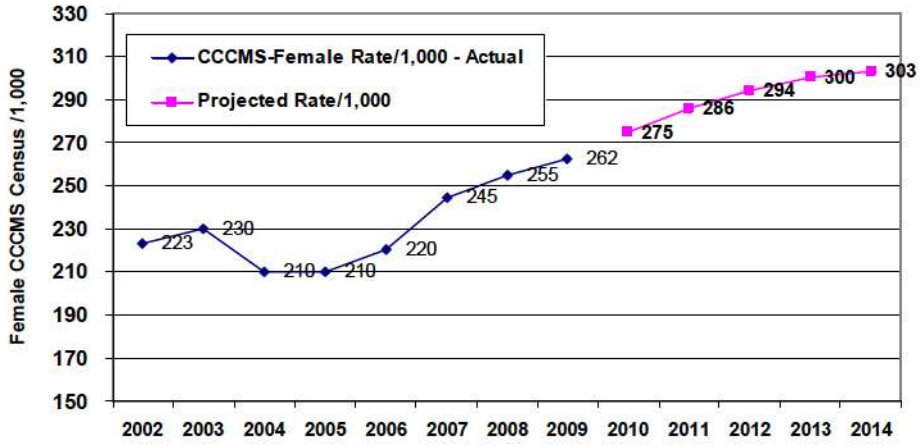
CCCMS - Females	--- Actual ---								--- Forecast ---									
Fiscal Year	2002	2003	2004	2005	2006	2007	2008	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Population (Fall 2009)	9,826	10,080	10,641	10,856	11,749	11,888	11,392	11,027	10,861	10,889	11,180	11,284	11,095	11,167	11,440	11,640	11,688	11,855
Census /1,000 Females a/	223	230	210	210	220	245	255	262	275	286	294	300	303	303	303	303	303	303
Census Rate Adj. Factor b/								4.9%	4.0%	3.0%	2.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CCCMS Census & Forecast	2,194	2,322	2,237	2,283	2,587	2907	2,903	**2,891**	**2,988**	**3,114**	**3,292**	**3,388**	**3,364**	**3,386**	**3,469**	**3,530**	**3,544**	**3,595**

a/ Source: HC-POP Management Information Reports R1-1 through R1-4 for the first downloaded day of each month. FY09 for 12 months.
b/ Assumes that census rate will continue to increase but at a decelerating rate to 2014.

Forecast Based on Spring 2009	**2,904**	**3,059**	**3,155**	**3,332**	**3,491**	**3,614**	**3,687**	**3,781**	**3,891**	**4,028**	**4,085**
Forecast Based on Fall 2008	**2,903**	**2,986**	**3,061**	**3,129**	**3,191**	**3,318**	**3,420**	**3,450**	**3,589**	**3,650**	**3,733**

The Fall 2009 forecast results in a lower program need in 2009, 2014, and 2018 compared to the Spring 2009 study due to a slightly lower average census for the full 12 months and, more significantly, a lower population projection.

Census Rate Trend/Forecast – Fall 2009



Source: HC-POP MIS Reports and Navigant Bed Need models

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Appendix

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Abbreviations used in report

- ADC – Average Daily Census
- ALOS – Average Length of Stay
- ASH – Atascadero State Hospital
- ASU – Administrative Segregation Unit
- CADDIS – Census And Discharge Data Information System
- CCCMS – Correctional Clinical Case Management System
- CCWF – California Correctional Women's Facility
- CDCR – California Department of Corrections and Rehabilitation
- CIW – California Institute for Women
- CMF-APP – California Medical Facility – Acute Psychiatric Program
- CMF-DTP – California Medical Facility – Day Treatment Program
- CMF-ICF – California Medical Facility – Intermediate Care Facility
- CMF-VPP – California Medical Facility – Vacaville Psychiatric Program
- CTC – Correctional Treatment Center
- DMH – Department of Mental Health
- EOP – Enhanced Outpatient Program
- FY – Fiscal Year – the convention used here indicates the fiscal year ending e.g. FY09 ends June 30, 2009
- GP – General Population
- HCCUP – Health Care Cost and Utilization Program
- HC-POP – Health Care Placement Oversight Program
- MHARP – Mental Health Assessment and Referral Project
- MHCB – Mental Health Crisis Bed
- MH-OHU – Mental Health Outpatient Housing Unit
- OHU – Outpatient Housing Unit
- PSH – Patton State Hospital
- PSU – Psychiatric Services Unit
- SAC – California State Prison, Sacramento
- SVPP – Salinas Valley Psychiatric Program
- UNA – Unmet Needs Assessment

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Comparison of Bed Need Forecasts
Fall 2009 vs. Spring 2009

The forecasts produced for this revised Fall 2009 report are compared to the forecasts in the Spring 2009 forecast. With the exception of Male CCCMS, all male programs are higher. All Female programs are lower.

Program	Higher/ Lower	2014 Fall 09 Study	2014 Spring 09 Study	2014 Fall 09 - minus Spring 09	% Variance (Fall 09 - Spring 09)
Males					
Acute	Higher	224	195	30	15.2%
Intermediate *	Higher	999	935	64	6.9%
MHCB	Higher	496	475	21	4.5%
EOP - GP	Higher	4,903	4,816	87	1.8%
EOP ASU	Higher	707	682	25	3.7%
PSU	Higher	570	552	18	3.2%
CCCMS	Lower	29,835	30,677	(843)	-2.7%
Females					
Acute/Intermediate	Lower	24	27	(3)	-12.0%
MHCB	Lower	17	19	(2.4)	-12.5%
EOP - GP	Lower	159	205	(46)	-22.4%
EOP ASU	Lower	16	17	(0.2)	-1.2%
PSU	Lower	11	13	(2)	-15.3%
CCCMS	Lower	3,364	3,614	(250)	-6.9%

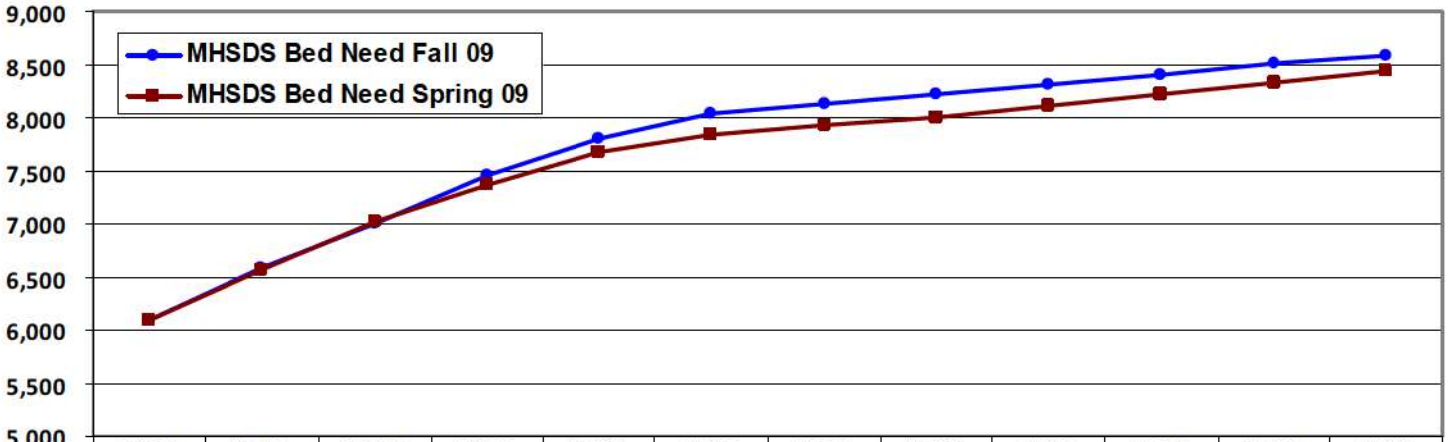
** Intermediate bed need excludes beds needed for 1370 inmates (ADC=32.4; bed need 36 @ 90% occupancy).*

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Mental Health Services Delivery System Bed Need

For the full 12-month FY 2009, the MHSDS population, that excludes CCCMS, is 0.3% higher than the same forecast in the Spring 2009 report. This grows to 2.4% higher by 2014. The variance is due to slightly higher utilization overall.

MHSDS Bed Need (excluding CCCMS) – Fall 09 vs. Spring 09



	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19
MHSDS Bed Need Fall 09	6,097	6,580	7,003	7,449	7,793	8,039	8,127	8,222	8,317	8,402	8,503	8,580
MHSDS Bed Need Spring 09	6,097	6,564	7,022	7,356	7,671	7,844	7,935	8,003	8,106	8,218	8,324	8,434

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Exhibit U

STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION GAVIN NEWSOM, GOVERNOR

DIVISION OF HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 588500
Elk Grove, California 95758

April 15, 2020

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes Devereaux & O'Gara LLC
Northwoods Office Park
1301 Atwood Avenue, Suite 215 N
Johnston, RI 02919

via: Elise Owens Thorn, Esquire
Deputy Attorney General
Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550

RE: *COLEMAN* MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the *Coleman* Monthly Report reflective of February, 2020, data (or as otherwise noted). The following is the list of enclosures:

1. California Department of Corrections and Rehabilitation (CDCR) Staffing Report.
   a. Mental Health Executive Summary.
   b. Mental Health Institution Vacancy by Classification.
   c. Mental Health Institution Vacancies Summary by Classification.
   d. Mental Health Month to Month Registry Usage.
   e. Mental Health Six-Month Vacancy Summary.
   f. Mental Health Program Institution Vacancies - Summary by Classification.
   g. Statewide Mental Health Program Compliance Summary Report.
   h. Enhanced Outpatient Program Administrative Segregation Unit (EOP ASU) Case Manager Positions and Vacancies.
   i. Mental Health Hiring Progress Report.
   j. Mental Health Statewide Hire Tracking Summary - Clinical Positions Only.
   k. Mental Health Telepsych Allocated and Filled Positions Report.
   l. Psychiatric Inpatient Program (PIP) Staffing Data.
   m. Department of State Hospitals (DSH) Staffing Data.

2. Reception Center Monthly Reports.
   a. Reception Center Mental Health Screening Report.
   b. Reception Center Transfer Timelines Report.

3. Continuous Length of Stay Counts for Mental Health Services Delivery Systems (MHSDS) ASU, Secured Housing Unit (SHU), and Psychiatric Services Unit (PSU) report.

4. EOP Inmates Waiting Transfers to PSU.

5. EOP ASU Hub Trends.

6. Population and Census Reports.
   a. Health Care Placement Oversight Program (HCPOP) Information Report, Summary of Mental Health Population by Institution and Level of Care (H-1).
   b. MHSDS Management Information Summary (MIS).
   c. Weekly EOP/Outpatient Psychiatric Program Report.

7. Mental Health Crisis Bed (MHCB) Reports.
   a. MHCB Referrals report.
   b. MHCB Stays report.
   c. MHCB Wait List.

8. DSH and Inpatient Program Referral Reports.
   a. Referrals for Transfer to Inpatient Programs Report.
   b. DSH Monthly Report of CDCR Patients in DSH Hospitals, Summary of PC 2684s Report.

9. Milestone Credits Report.

10. Work Assignments Report.

11. Out of Level Housing Report.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

EUREKA C. DAYE, Ph.D, MPH, MA, CCHP
Deputy Director (A), Statewide Mental Health Program
California Department of Corrections and Rehabilitation

Enclosures

cc: Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Kerry F. Walsh, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert

Mary Perrien, Ph.D., *Coleman* Expert
Henry A. Dlugacz, Esq., *Coleman* Expert
Patricia Williams, Esq., *Coleman* Monitor
Nicholas Weber, Esq, Office of Legal Affairs, CDCR
Melissa Bentz, Esq, Office of Legal Affairs, CDCR
Michael Bien, Esq., Rosen, Bien and Galvan
Donald Specter, Esq., Prison Law Office
Steve Fama, Esq., Prison Law Office
Angela Ponciano, Associate Director, Statewide Mental Health Program, DHCS
Laura Ceballos, Ph.D., Mental Health Administrator, Inpatient Facilities and Quality Improvement, Statewide Mental Health Program, DHCS
Steven Cartwright, Psy.D. Chief Psychologist, Quality Management, Statewide Mental Health Program, DHCS
Teresa Owens, Health Program Specialist I, Quality Management, Statewide Mental Health Program, DHCS

DIVISION OF HEALTH CARE SERVICES

Psychiatric Inpatient Program Staffing Report

Feb 2020

California Institution for Women - Psychiatric Inpatient Program										
Class Code	Classifications	Governor's Budget Authorized Positions (1)	Allocated Blanket Positions (2)	Total Positions	Filled Civil Service Positions (3)	Contracted FTE (4)	Overtime FTE (4)	Total Filled FTE	Functional Vacancy FTE	Functional Vacancy Rate
9288	Senior Psychologist, Supervisor	0.00	1.50	1.50	1.00	0.00	0.00	1.00	0.50	33%
8103	Program Director	1.00	0.00	1.00	1.00	0.00	0.00	1.00	0.00	0%
8102	Program Assistant	1.00	0.00	1.00	1.00	0.00	0.00	1.00	0.00	0%
9761	Senior Psychiatrist, Supervisor	1.00	0.00	1.00	1.00	0.00	0.00	1.00	0.00	0%
9287	Senior Psychologist, Specialist	0.00	0.50	0.50	0.50	0.00	0.00	0.50	0.00	0%
9283	Psychologist, Clinical	2.00	1.00	3.00	3.00	0.00	0.00	3.00	0.00	0%
9758	Staff Psychiatrist	2.00	1.00	3.00	1.00	0.00	0.00	1.00	2.00	67%
9872	Clinical Social Worker	4.00	0.00	4.00	3.00	0.00	0.00	3.00	1.00	25%
9286	Recreation Therapist	4.00	0.00	4.00	3.00	0.00	0.00	3.00	1.00	25%
8253	Psychiatric Technician	32.00	0.00	32.00	32.00	0.00	0.00	32.00	0.00	0%
8252	Senior Psychiatric Technician	6.00	0.00	6.00	6.00	0.00	0.00	6.00	0.00	0%
8104	Unit Supervisor	1.00	0.00	1.00	1.00	0.00	0.00	1.00	0.00	0%
	GRAND TOTAL	**54.00**	**4.00**	**58.00**	**53.50**	**0.00**	**0.00**	**53.50**	**4.50**	**8%**

(1) Authorized positions are based on the number of positions in the Governor's 2017/18 budget.

(2) Positions allocated per memorandum dated 1/27/15.

(3) Total filled civil service positions includes employees working second positions, retired annuitants, limited term, permanent intermittent.

(4) Contract hours and overtime hours worked during the reporting period are converted to full-time equivalent positions.

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DIVISION OF HEALTH CARE SERVICES

Psychiatric Inpatient Program Staffing Report

Feb 2020

California Medical Facility - Psychiatric Inpatient Program										
Class Code	Classifications	Governor's Budget Authorized Positions (1)	Allocated Blanket Positions (2)	Total Positions	Filled Civil Service Positions (3)	Contracted FTE (4)	Overtime FTE (4)	Total Filled FTE	Functional Vacancy FTE	Functional Vacancy Rate
9859	Chief Psychologist	0.00	1.00	1.00	1.00	0.00	0.00	1.00	0.00	0%
9288	Senior Psychologist, Supervisor	0.30	0.00	0.30	0.00	0.00	0.00	0.00	0.30	100%
8103	Program Director	0.00	1.00	1.00	1.00	0.00	0.00	1.00	0.00	0%
8102	Program Assistant	0.00	1.00	1.00	1.00	0.00	0.00	1.00	0.00	0%
9761	Senior Psychiatrist, Supervisor	0.00	1.00	1.00	1.00	0.00	0.00	1.00	0.00	0%
9287	Senior Psychologist, Specialist	0.40	0.00	0.40	0.40	0.00	0.00	0.40	0.00	0%
9283	Psychologist, Clinical	2.50	0.00	2.50	2.00	0.00	0.00	2.00	0.50	20%
9758	Staff Psychiatrist	2.50	0.00	2.50	0.00	2.00	0.00	2.00	0.50	20%
9872	Clinical Social Worker	2.50	0.00	2.50	2.00	0.00	0.00	2.00	0.50	20%
9286	Recreation Therapist	2.50	0.00	2.50	2.50	0.00	0.00	2.50	0.00	0%
	GRAND TOTAL	**10.70**	**4.00**	**14.70**	**10.90**	**2.00**	**0.00**	**12.90**	**1.80**	**12%**

(1) Authorized positions are based on the number of positions in the Governor's 2017/18 budget.

(2) Positions allocated per memorandum dated 5/15/17.

(3) Total filled civil service positions includes employees working second positions, retired annuitants, limited term, permanent intermittent.

(4) Contract hours and overtime hours worked during the reporting period are converted to full-time equivalent positions.

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DIVISION OF HEALTH CARE SERVICES

Psychiatric Inpatient Program Staffing Report

Feb 2020

San Quentin - Psychiatric Inpatient Program									
Class Code	Classifications	Governor's Budget Authorized Positions (1)	Total Positions	Filled Civil Service Positions (2)	Contracted FTE (3)	Overtime FTE (3)	Total Filled FTE	Functional Vacancy FTE	Functional Vacancy Rate
9859	Chief Psychologist	1.00	1.00	1.00	0.00	0.00	1.00	0.00	0%
9288	Senior Psychologist, Supervisor	0.40	0.40	0.00	0.00	0.00	0.00	0.40	100%
8103	Program Director	1.00	1.00	1.00	0.00	0.00	1.00	0.00	0%
8102	Program Assistant	1.00	1.00	1.00	0.00	0.00	1.00	0.00	0%
9761	Senior Psychiatrist, Supervisor	1.00	1.00	1.00	0.00	0.00	1.00	0.00	0%
9287	Senior Psychologist, Specialist	0.40	0.40	0.00	0.00	0.00	0.00	0.40	100%
9283	Psychologist, Clinical	2.70	2.70	3.00	1.00	0.00	4.00	-1.30	-48%
9758	Staff Psychiatrist	2.70	2.70	2.00	1.00	0.00	3.00	-0.30	-11%
9872	Clinical Social Worker	3.60	3.60	2.00	0.00	0.00	2.00	1.60	44%
9286	Recreation Therapist	3.60	3.60	3.00	0.00	0.00	3.00	0.60	17%
	GRAND TOTAL	**17.40**	**17.40**	**14.00**	**2.00**	**0.00**	**16.00**	**1.40**	**8%**

(1) Authorized positions are based on the number of positions in the Governor's 2017/18 budget.

(2) Total filled civil service positions includes employees working second positions, retired annuitants, limited term, permanent intermittent.

(3) Contract hours and overtime hours worked during the reporting period are converted to full-time equivalent positions.

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CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
Psychiatric Inpatient Program Staff
February 2020
Report submitted March 2020

CHCF PIP									
Classifications	**Governor's Budget Authorized Positions (1)**	**Governor's Budget/ Departmental Authorized (Blanket) Positions (2)**	**Total Authorized Positions**	**Total Filled Civil Service Positions (3)**	**Contracted FTE (4)**	**Overtime FTE (4)**	**Total Filled FTE**	**Functional Vacancy FTE**	**Functional Vacancy Rate**
Mental Health Staffing									
Psychologist	29.00	0.00	29.00	20.00	1.73	0.00	21.73	7.27	25.07%
Psychiatrist	33.00	3.50	36.50	14.00	1.90	0.00	15.90	20.60	56.44%
Clinical Social Worker, Health/Correctional Facility (Safety)	33.00	0.00	33.00	23.00	0.00	0.00	23.00	10.00	30.30%
Rehabilitation Therapist	32.00	0.00	32.00	24.00	0.00	0.48	24.48	7.52	23.50%
Total, Mental Health Staffing	127.00	3.50	130.50	81.00	3.63	0.48	85.11	45.39	34.78%
Direct Care Nursing Staff									
Psychiatric Technician	430.00	0.00	430.00	336.00	2.34	91.20	429.54	0.46	0.11%
Medical Technical Assistant	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
Registered Nurse	174.00	0.00	174.00	162.00	2.64	53.51	218.15	0.00	0.00%
Total, Direct Care Nursing Staff	604.00	0.00	604.00	498.00	4.98	144.71	647.69	0.00	0.00%
Administrative Staff									
Medical Director	1.00	0.00	1.00	1.00	0.00	0.00	1.00	0.00	0.00%
Supervising Psychiatric Social Worker	2.00	0.00	2.00	1.00	0.00	0.00	1.00	1.00	50.00%
Supervising Rehabilitation Therapist	3.00	0.00	3.00	2.00	0.00	0.00	2.00	1.00	33.33%
Chief Psychologist	1.00	0.00	1.00	1.00	0.00	0.00	1.00	0.00	0.00%
Senior Psychologist, Supervisor	3.00	0.00	3.00	2.00	0.00	0.00	2.00	1.00	33.33%
Senior Psychiatrist, Supervisor	2.00	0.00	2.00	0.00	0.00	0.00	0.00	2.00	100.00%
Senior Medical Technical Assistant	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
Supervising Registered Nurse	23.00	0.00	23.00	21.00	0.00	0.00	21.00	2.00	8.70%
Unit Supervisor	18.00	0.00	18.00	16.00	0.00	0.00	16.00	2.00	11.11%
TOTAL	**784.00**	**3.50**	**787.50**	**623.00**	**8.61**	**145.19**	**776.80**	10.70	1.36%

(1) Authorized positions are based on the number of positions in the Governor's 2019/20 budget.
(2) Governor's budget/departmental authorized blanket positions are authorized in the Governor's 2019/20 budget. They are established at a point in time based on need of the facilities.
(3) Total filled civil service positions includes employees working second positions, retired annuitants, limited term, permanent intermittent.
(4) Contract hours and overtime hours worked during the reporting period are converted to full-time equivalent positions.

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CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
Psychiatric Inpatient Program Staff
February 2020
Report submitted March 2020

CMF PIP									
Classifications	**Governor's Budget Authorized Positions (1)**	**Governor's Budget/ Departmental Authorized (Blanket) Positions (2)**	**Total Authorized Positions**	**Total Filled Civil Service Positions (3)**	**Contracted FTE (4)**	**Overtime FTE (4)**	**Total Filled FTE**	**Functional Vacancy FTE**	**Functional Vacancy Rate**
Mental Health Staffing									
Psychologist	27.50	0.00	27.50	16.00	0.00	0.00	16.00	11.50	41.82%
Psychiatrist	28.50	0.00	28.50	8.00	3.63	0.00	11.63	16.87	59.19%
Clinical Social Worker, Health/Correctional Facility (Safety)	27.50	0.00	27.50	19.00	0.69	0.00	19.69	7.81	28.40%
Rehabilitation Therapist	27.50	0.00	27.50	25.00	0.00	0.80	25.80	1.70	6.18%
Total, Mental Health Staffing	111.00	0.00	111.00	68.00	4.32	0.80	73.12	37.88	34.13%
Direct Care Nursing Staff									
Psychiatric Technician	33.00	0.00	33.00	37.00	0.00	10.63	47.63	0.00	0.00%
Medical Technical Assistant	218.00	0.00	218.00	74.00	0.00	18.86	92.86	125.14	57.40%
Registered Nurse	77.00	0.00	77.00	85.00	6.24	27.14	118.38	0.00	0.00%
Total, Direct Care Nursing Staff	328.00	0.00	328.00	196.00	6.24	56.63	258.87	69.13	21.08%
Administrative Staff									
Medical Director	1.00	0.00	1.00	1.00	0.00	0.00	1.00	0.00	0.00%
Supervising Psychiatric Social Worker	2.00	0.00	2.00	2.00	0.00	0.00	2.00	0.00	0.00%
Supervising Rehabilitation Therapist	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
Chief Psychologist	1.00	0.00	1.00	1.00	0.00	0.00	1.00	0.00	0.00%
Senior Psychologist, Supervisor	2.00	0.00	2.00	2.00	0.00	0.00	2.00	0.00	0.00%
Senior Psychiatrist, Supervisor	2.00	0.00	2.00	1.00	0.00	0.00	1.00	1.00	50.00%
Senior Medical Technical Assistant	39.10	0.00	39.10	24.00	0.00	2.04	26.04	13.06	33.40%
Supervising Registered Nurse	25.60	0.00	25.60	23.00	0.00	0.00	23.00	2.60	10.16%
Unit Supervisor	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
TOTAL	**511.70**	**0.00**	**511.70**	**318.00**	**10.56**	**59.47**	**388.03**	123.67	24.17%

(1) Authorized positions are based on the number of positions in the Governor's 2019/20 budget.
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(3) Total filled civil service positions includes employees working second positions, retired annuitants, limited term, permanent intermittent.
(4) Contract hours and overtime hours worked during the reporting period are converted to full-time equivalent positions.

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CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
Psychiatric Inpatient Program Staff
February 2020
Report submitted March 2020

SVSP PIP									
Classifications	**Governor's Budget Authorized Positions (1)**	**Governor's Budget/ Departmental Authorized (Blanket) Positions (2)**	**Total Authorized Positions**	**Total Filled Civil Service Positions (3)**	**Contracted FTE (4)**	**Overtime FTE (4)**	**Total Filled FTE**	**Functional Vacancy FTE**	**Functional Vacancy Rate**
Mental Health Staffing									
Psychologist	10.00	0.00	10.00	7.00	2.67	0.00	9.67	0.33	3.30%
Psychiatrist	10.00	0.00	10.00	0.00	4.60	0.00	4.60	5.40	54.00%
Clinical Social Worker, Health/Correctional Facility (Safety)	10.00	0.00	10.00	7.00	0.00	0.00	7.00	3.00	30.00%
Rehabilitation Therapist	9.00	0.00	9.00	7.00	0.00	0.21	7.21	1.79	19.89%
Total, Mental Health Staffing	39.00	0.00	39.00	21.00	7.27	0.21	28.48	10.52	26.97%
Direct Care Nursing Staff									
Psychiatric Technician	31.00	0.00	31.00	20.00	11.00	2.01	33.01	0.00	0.00%
Medical Technical Assistant	165.00	0.00	165.00	26.00	0.00	5.15	31.15	133.85	81.12%
Registered Nurse	50.00	0.00	50.00	42.00	2.55	7.77	52.32	0.00	0.00%
Total, Direct Care Nursing Staff	246.00	0.00	246.00	88.00	13.55	14.93	116.48	129.52	52.65%
Administrative Staff									
Medical Director	1.00	0.00	1.00	1.00	0.00	0.00	1.00	0.00	0.00%
Supervising Psychiatric Social Worker	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
Supervising Rehabilitation Therapist	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
Chief Psychologist	2.00	0.00	2.00	1.00	0.00	0.00	1.00	1.00	50.00%
Senior Psychologist, Supervisor	1.00	0.00	1.00	1.00	0.00	0.00	1.00	0.00	0.00%
Senior Psychiatrist, Supervisor	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
Senior Medical Technical Assistant	30.00	0.00	30.00	20.00	0.00	4.89	24.89	5.11	17.03%
Supervising Registered Nurse	22.00	0.00	22.00	17.00	0.00	0.00	17.00	5.00	22.73%
Unit Supervisor	5.00	0.00	5.00	4.00	0.00	0.00	4.00	1.00	20.00%
TOTAL	**347.00**	**0.00**	**347.00**	**153.00**	**20.82**	**20.03**	**193.85**	153.15	44.14%

(1) Authorized positions are based on the number of positions in the Governor's 2019/20 budget.
(2) Governor's budget/departmental authorized blanket positions are authorized in the Governor's 2019/20 budget. They are established at a point in time based on need of the facilities.
(3) Total filled civil service positions includes employees working second positions, retired annuitants, limited term, permanent intermittent.
(4) Contract hours and overtime hours worked during the reporting period are converted to full-time equivalent positions.

Case 2:90-cv-00520-KJM-DB Document 6768-2 Filed 07/15/20 Page 54 of 67

Exhibit V

From: Michael W. Bien
To: Coleman Team - RBG Only
Subject: FW: Coleman - Mission Change Letter
Date: Thursday, October 03, 2019 9:58:33 AM
Attachments: Ltr. NW-ML re Mission Changes 10.3.19.pdf

From: Weber, Nicholas@CDCR
Sent: Thursday, October 3, 2019 9:57:52 AM (UTC-08:00) Pacific Time (US & Canada)
To: Michael W. Bien; Steve Fama; Lisa Ells; Angie Cooper; Cynthia Radavsky; Henry D. Dlugacz; Jeff Metzner; Karen Rea-Williams; Kerry Courtney Hughes, MD; Kerry F. Walsh; Kristina Hector; Lindsay Hayes; L M. Hunt; Maria Masotta; Matt Lopes; Mohamedu Jones; Mary Perrien; Patricia M. Williams; Rachel Gribbin; Regina Costa; Rod Hickman Gmail; Roxie Dunbar; Steve Raffa; Tim Rougeux
Cc: Elise Thorn; Tyler Heath; Melissa Bentz; Hessick, Jerome@CDCR; Hockerson, Dillon@CDCR; Ponciano, Angela@CDCR; Mitchell, Kelly@CDCR; Brizendine, Brittany@CDCR; Moose, Kristen@CDCR; Laura Ceballos; Lorey, Dawn@CDCR; Golding, Michael@CDCR; Williams, Travis@CDCR; Worrell, Wendy@CDCR; Daye, Eureka@CDCR
Subject: Coleman - Mission Change Letter

All,

Please find attached this month's mission change letter.

Nick Weber
Attorney
Department of Corrections & Rehabilitation
1515 S Street, Suite 314S
Sacramento, CA 95811-7243
(916) 323-3202

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STATE OF CALIFORNIA —DEPARTMENT OF CORRECTIONS AND REHABILITATION GAVIN NEWSOM, GOVERNOR

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

October 3, 2019

Special Master Lopes
Pannone Lopes Devereaux and O'Gara LLC
Northwoods Office Park, Suite 215N
1301 Atwood Avenue
Johnston, RI 02919

VIA EMAIL

Dear Special Master Lopes:

I write regarding planned mission changes, crisis and inpatient bed closures, and tele-psychiatry office space.

1. Planned Mission Changes

Below are scheduled Enhanced Outpatient Program and segregation bed changes.

Institution	Bed Type	Housing Unit	Level	# of Beds	Date (Estimated)
COR	PSU	3A-3	PSU	50	TBD

As previously reported, California State Prison, Sacramento converted sixty-four Psychiatric Services Unit beds to sixty-four Long Term Restricted Housing (LTRH) unit beds on September 9, 2019.

California State Prison, Corcoran (COR) converted seventy-seven Security Housing Unit beds to seventy-seven LTRH beds on July 25, 2019.

COR also moved 150 Enhanced Outpatient Program (EOP) beds from 3A-3 to 3A-4 on July 3, 2019 and moved their Administrative Segregation Unit EOP Hub from 3A-4 to 3A-3 on that same date.

Salinas Valley State Prison (SVSP) took down ninety-six EOP beds and California Men's' Colony changed their D Yard from a level three to a level two in July 2019.

2. Crisis and Inpatient Beds

The following is a list of crisis or inpatient beds currently offline. Updates from the last letter are in red.

Institution	Deactivation	Cells	Reason	Activation Date
SVSP MHCB	January 25, 2019	10	Staffing	TBD
PVSP MIICB	February 19, 2019	6	Roof Repair	TBD
CMF PIP Q1	April 29, 2019	23	Staffing	TBD

Crisis beds at SVSP and Pleasant Valley State Prison (PVSP) and are closed. SVSP's crisis bed and Correctional Treatment Center (CTC) remain closed pending re-staffing of the unit. The unit closed in January for Root Cause Analyses and a subsequent accessibility retrofit which are now complete. PVSP's CTC roof was replaced, however, further internal repairs are ongoing due to water damage.

The California Medical Facility (CMF) PIP, unit Q1, is currently operating six acute beds due to nursing staffing. Twenty-three additional acute beds in Q1 remain offline. CMF PIP P2 is operating as an acute unit.

High Desert State Prison's (HDSP) Mental Health Crisis Bed reactivated in September 2019 as HDSP now has on-site psychiatry to service the unit.

The PIP and crisis beds at California Healthcare Facility have resumed normal intake following the Legionella decontamination. CDCR continues to monitor the units' water supply for Legionella.

3. Telepsychiatry Office Space

CDCR currently operates ninety-seven telepsychiatry offices at six locations.

Location	Number of Offices
Elk Grove, CA	17 Offices
San Quentin, CA	18 Offices
Rancho Cucamonga, CA	27 Offices
Diamond Bar, CA	18 Offices
Fresno, CA	2 Office
Santa Ana, CA	15 Offices
Subtotal	97 Offices

CDCR operates six telemedicine offices in Fresno and three telemedicine offices in Bakersfield. Two of those offices in Fresno are currently being used by telepsychiatrists. While those nine telemedicine offices have been offered to CDCR for telepsychiatry use as needed, the unused offices remain classified as telemedicine.

Below is a telepsychiatry office space activation and deactivation schedule.

Location	Number of Offices	Date
Diamond Bar, CA	1 Offices	November 2019
Rancho Cucamonga, CA	-9 Offices	December 2019
San Quentin, CA	18 Offices	2024/25

Sincerely,

/s/ Nick Weber

NICK WEBER
Attorney
Office of Legal Affairs

Exhibit W

From: Michael W. Bien
To: Coleman Team - RBG Only
Subject: FW: Coleman - Mission Change Letter
Date: Friday, November 01, 2019 3:43:20 PM
Attachments: Ltr. NW-ML re Mission Changes 11.1.19.pdf
Transfers P2 July 1-8 2019.pdf

From: Weber, Nicholas@CDCR
Sent: Friday, November 1, 2019 3:43:01 PM (UTC-08:00) Pacific Time (US & Canada)
To: Michael W. Bien; Steve Fama; Lisa Ells; Angie Cooper; Cynthia Radavsky; Henry D. Dlugacz; Jeff Metzner; Karen Rea-Williams; Kerry Courtney Hughes, MD; Kerry F. Walsh; Kristina Hector; Lindsay Hayes; L M. Hunt; Maria Masotta; Matt Lopes; Mohamedu Jones; Mary Perrien; Patricia Williams; Rachel Gribbin; Regina Costa; Rod Hickman Gmail; Roxie Dunbar; Steve Raffa; Tim Rougeux
Cc: Elise Thorn; Tyler Heath; Melissa Bentz; Hessick, Jerome@CDCR; Hockerson, Dillon@CDCR; Ponciano, Angela@CDCR; Mitchell, Kelly@CDCR; Brizendine, Brittany@CDCR; Moose, Kristen@CDCR; Laura Ceballos; Lorey, Dawn@CDCR; Golding, Michael@CDCR; Williams, Travis@CDCR; Worrell, Wendy@CDCR; Daye, Eureka@CDCR; Steven Cartwright; Robert Henkels; Kyle Lewis
Subject: Coleman - Mission Change Letter

All,

Please find attached this month's mission change letter.

Nick Weber
Attorney
Department of Corrections & Rehabilitation
1515 S Street, Suite 314S
Sacramento, CA 95811-7243
(916) 323-3202

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OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

November 1, 2019

Special Master Lopes
Pannone Lopes Devereaux and O'Gara LLC
Northwoods Office Park, Suite 215N
1301 Atwood Avenue
Johnston, RI 02919

VIA EMAIL

Dear Special Master Lopes:

I write regarding planned mission changes, changes in use for crisis and inpatient beds, and tele-psychiatry office space.

1. Planned Mission Changes

Below are scheduled Enhanced Outpatient Program (EOP) and segregation bed changes.

Institution	Bed Type	Housing Unit	Level	# of Beds	Date (Estimated)
COR	PSU	3A-3	PSU	50	TBD

Plaintiffs raised a number of questions regarding recent activations at California State Prison, Sacramento and California State Prison, Corcoran. Those questions are addressed below.

a. California State Prison, Sacramento Unit B8

As previously reported, the California Department of Corrections and Rehabilitation (CDCR) converted sixty-four Psychiatric Services Unit (PSU) beds to Long Term Restricted Housing (LTRH) unit beds on September 9, 2019. The beds are located in unit B8 at California State Prison, Sacramento. Class members in the LTRH received LTRH level of care. If a patient's level of care changes, they are transferred to the appropriate level of care pursuant to transfer timeframes outlined by policy.

Patients in B8 are offered fifteen hours or more of out of cell activity each week. They are offered ten hours of yard, three and a half hours of dayroom time, and a ninety minute structured group session. They also receive weekly 1:1 contacts with their primary clinicians. Psychiatric technicians round the unit daily.

The B8 LTRH shares eleven Individual Exercise Yards with the adjacent PSU on B facility. B PSU's treatment center has eighty therapeutic treatment modules (TTM) for group therapy spread out across eight treatment rooms with ten TTMs in each. Those treatment rooms are shared with B PSU. B8 itself has thirty-two restart chairs installed across its three sections. Ten are in sections A and B, and twelve are in section C. Those chairs are used solely for B8's population.

Finally, SAC B-8 does not have a policy to cluster transgender women patients in the Mental Health Services Delivery System or class members receiving hormone replacement therapy.

CDCR is still gathering September 9, 2019, census information for B8 per Plaintiffs' request and will provide it when available.

b. California State Prison, Corcoran Psychiatric Services Unit

Corcoran unit 3A-3, which is an Administrative Segregation Unit (ASU) EOP hub, has twenty Individual Exercise Yards and forty-nine TTMs available for group therapy. Corcoran is utilizing all beds in 3A-3 as an ASU EOP hub program as the conversion to PSU has not occurred. Should it occur, half the beds in 3A-3 will be converted to PSU. CDCR will provide written up-to-date information about staffing in advance of any further discussions about the proposed conversion.

Corcoran is in the process of installing fifteen restart chairs in unit 4A-2L for its LTRH program. Five restart chairs will be installed in each of the three sections of 4A-2L.

Corcoran unit 3A-4 is a general population EOP unit and does not use Individual Exercise Yards or TTMs for programming.

2. Crisis and Inpatient Beds

Like any large system, hospital beds will be taken offline for a myriad of reasons. Today, sixteen of CDCR's 474 crisis beds, or just over three percent, are offline due to physical plant damage or staffing. And thirteen of CDCR's 1,641 Psychiatric Inpatient Beds (PIP) beds, or less than one percent, are offline for staffing. Contrary to Plaintiffs' assertion, CDCR has not kept these beds offline because they are not needed. These beds are offline for the reasons noted and will reopen as soon as repairs are completed and are adequately staffed.

Plaintiffs' assertion that these bed closures violate court orders is similarly misplaced. Defendants have provided notice to the Special Master and Plaintiffs of every bed closure as they occur and regularly update the Special Master and Plaintiffs on the status of the beds. And the parties meet and confer regularly to discuss mission changes and bed closures.

The following is a list of crisis or inpatient beds currently offline.

Institution	Deactivation	Cells	Reason	Activation Date
SVSP MHCB	January 25, 2019	10	Staffing	TBD
PVSP MHCB	February 19, 2019	6	Roof Repair	TBD
CMF PIP Q1	April 29, 2019	13	Staffing	TBD

The following is a list of changes or activations in inpatient bed usage. These changes were originally noticed by separate emails and are discussed in more detail below.

Institution	Change Date	Cells	Reason
CMF PIP Q1	Oct. 12, 2019	10	Activate Redlined Acute Cells
CHCF A2B	Oct. 12 and 16, 2019	20	Flex MHCB to Acute
SQ PIP	Oct. 16, 2019	10	Permit Use of Available Beds for Non-Condemned Acute.

a. Salinas Valley State Prison Correctional Treatment Center and Crisis Beds

SVSP's crisis bed and Correctional Treatment Center (CTC) closed on January 25, 2019, for root cause analyses into the death of an inmate and treatment concerns regarding another inmate that did not result in death. The root cause analyses, and their resulting agitation and self-harm protocols, are maintained by the *Plata* Receiver. California Correctional Health Care Services will not release any of these documents to *Coleman* Plaintiffs. Likewise, because the death of Mr. Rivera is intertwined with the Root Cause Analysis, CDCR cannot respond to Plaintiffs' February 6 or October 15, 2019, inquiry regarding his death.

CDCR expects the CTC medical beds to reopen on November 4, 2019. The medical beds have all necessary and required staff, including nursing, medical, mental health, and custody. Medical patients in the Mental Health Services Delivery System are provided care from clinicians assigned to the outpatient caseload, not the crisis bed. The crisis bed remains closed pending identification of psychiatry staffing.

b. Pleasant Valley State Prison Crisis Bed

Pleasant Valley State Prison's crisis bed closed on February 19, 2019 due to roof damage following rain. As a result of the damage, the interior of the building was severely damaged. CDCR continues to repair the building but no reopening date is available at this time.

c. High Desert State Prison Crisis Bed

High Desert's crisis bed reopened on October 1, 2019. The psychiatrist who had previously worked in the crisis bed left state employment at the end of June 2019. High Desert is aware of its duty to continue to refer patients in need of crisis bed care to a crisis bed, regardless of whether their unit is open. According to the MHCB Referrals Report, for the three months the crisis bed was closed between July 1, 2019, and September 30, 2019, High Desert referred 84 patients for

crisis bed care. High Desert referred the same number of patients during the preceding three months of April 1, 2019, to Jun 30, 2019.

d. California Medical Facility Q1

California Medical Facility Q1 is an acute unit at the California Medical Facility PIP with twenty-nine beds. Currently, sixteen of twenty-nine beds are operating. In order to activate the remaining thirteen beds, CDCR must provide additional psychiatry staff.

e. California Medical Facility P2

California Medical Facility P2 is an acute unit at the California Medical Facility PIP. P2 has thirty-six beds. Originally, CDCR planned to close P2 and shift its resources to Q1 when Q1 reactivated from retrofits. That plan ultimately did not occur. P2 remained open, but instead flexed to acute on July 8, 2019, in response to an increased demand for acute beds. The ICF patients in P2 at that time were either transferred to additional ICF beds or discharged if they met clinical requirements. A list of all ICF patients who transferred out of P2, either through transfer to another ICF or discharge to another level of care, between July 1 and 8, 2019, is attached.

f. California Healthcare Facility

i. Water Safety

The PIP and crisis beds at California Healthcare Facility (CHCF) are currently accepting low and medium medical risk inmates and any high risk medical inmate that is medically cleared to be housed at CHCF.

CHCF first closed to intake on March 22, 2019 and was reopened on March 27, 2019, in response to legionella contamination. The facility was again closed on April 17 and reopened on April 18, 2019. On April 18, 2019, CHCF was open to only low medical risk inmates. On April 22, 2019, CHCF began admitting medium medical risk inmates as well as high medical risk inmates that were cleared for placement. That intake procedure remains in place today.

Plaintiffs' raised several questions in their October 15, 2019, letter. Those are addressed below:

- All patients at CHCF can use their building's regular showers. CHCF has resumed normal shower program.
- All water is safe in A-4, C-3, D-2, E-1, E-2, E-3, E-4, and E-5. For A-4, C-3, and D-2, water restrictions were lifted on October 10, 2019. Water restrictions in E-Facility were lifted on July 30, 2019, except for E-5 which was lifted September 17, 2019.
- Bottled water continues to be delivered for units A-1, A-2, B-1 through B-8, C-1, C-2, C-4, C-5, C-6, D-1, and D-3 through D-7.
- Water restrictions were re-imposed for part of the central mall, Facility Shared Services (FSS), on October 10, 2019 due to testing results. FSS 201N showed legionella average

readings above 1 CFU/ml and weekly monitoring was initiated. FSS 202N showed legionella average below 1 CFU/ml and is monitored monthly.

- CHCF continues with the steps to control legionella bacteria that began at the very end of July: (1) periodic thermal disinfection of certain water valves in the plumbing system, and (2) either monthly, weekly, or daily flushing of the plumbing pipes in all CHCF buildings. Some or all of these measures will become a part of CHCF's long-term water safety management plan.
- Water sampling continue in all buildings at CHCF on an at least monthly basis.

ii. Acute Flex

On October 12, 2019, in response to two broken windows in a CHCF acute unit, A2A, CDCR flexed two crisis beds in adjacent A2B to acute. Those windows were quickly repaired and the cells reactivated as acute on October 14, 2019.

On October 16, 2019, due to rising demand for acute beds, CDCR flexed an additional eighteen crisis beds in A2B to acute, for a total of twenty beds. As noted in my October 16, 2019, email, nursing services are provided by the team in A2A and patients were admitted by CHCF's acute team. Routine acute care is provided by CHCF mental health staff assigned to A2B.

g. San Quentin PIP

Also on October 16, 2019, CDCR opened up available PIP beds in the San Quentin PIP to non-condemned acute patients. CDCR had previously opened available San Quentin PIP beds to San Quentin non-condemned patients in need of crisis bed care. Subsequently, CDCR opened those beds to *any* non-condemned inmate in need of crisis bed care. CDCR maintains the same priority for San Quentin PIP beds as before:

- First Priority – PIP ICF Patients (Condemned only)
- Second Priority - PIP Acute Patients (Condemned only)
- Third Priority - PIP MHCB Patients (Condemned only)
- Fourth Priority - Non-Condemned MHCB or Acute Patients, depending upon bed need.

As with before, the Health Care Placement Oversight Program, in consultation with Headquarters' Inpatient Referral Unit, will be responsible for determining when there is need for a specific level of inpatient care necessitating a change of the program designation of these beds.

As of October 31, 2019, ten non-condemned acute patients are in the San Quentin PIP.

3. Telepsychiatry Office Space

CDCR currently operates ninety-seven telepsychiatry offices at six locations.

Location	Number of Offices
Elk Grove, CA	17 Offices
San Quentin, CA	18 Offices
Rancho Cucamonga, CA	27 Offices
Diamond Bar, CA	18 Offices
Fresno, CA	2 Office
Santa Ana, CA	15 Offices
Subtotal	97 Offices

CDCR operates six telemedicine offices in Fresno and three telemedicine offices in Bakersfield. Two of those offices in Fresno are currently being used by telepsychiatrists. While those nine telemedicine offices have been offered to CDCR for telepsychiatry use as needed, the unused offices remain classified as telemedicine.

Plaintiffs' inquired why Diamond Bar is only expected to have nineteen offices instead of the previously forecast twenty-three. Four offices were allocated to tele-medicine.

Below is a telepsychiatry office space activation and deactivation schedule.

Location	Number of Offices	Date
Diamond Bar, CA	1 Offices	November 2019
Rancho Cucamonga, CA	-9 Offices	December 2019
San Quentin, CA	18 Offices	2024/25

Sincerely,

/s/ Nick Weber

NICK WEBER
Attorney
Office of Legal Affairs

Exhibit X

From: Weber, Nicholas@CDCR
To: Coleman Team - RBG Only; Steve Fama; Elise Thorn; Tyler Heath; Lucas Hennes; Kyle Lewis; Melissa Bentz; Dillon Hockerson; Stafford, Carrie@CDCR; Ryan, Amanda@CDCR; Christine Ciccotti; Ponciano, Angela@CDCR; Nina Raddatz; Kent, Kristopher@DSH-S; Lorey, Dawn@CDCR; Bick, Joseph@CDCR; Fouch, Adam@CDCR; Golding, Michael@CDCR; Laura Ceballos; Steven Cartwright; Shama Chaiken; White, Lourdes@CDCR; Flores, Marcie@CDCR; Scholl, Jason@CDCR; Williams, Travis@CDCR; Angie Cooper; Braxton Medlin; Brian Main; Cindy Radavsky; Henry D. Dlugacz; Jamas DeGroot; Jeffrey Metzner; Joseph Sorah; Kahlil Johnson; Karen Rea; Kerry Courtney Hughes, MD; Kerry F. Walsh; Kristina Hector; Lindsay Hayes; Latricea McClendon-Hunt; Lana Lopez; Maria Masotta; Matt Lopes; Michael Ryan; Mohamedu Jones; Mary Perrien; Patricia M. Williams; Rachel Gribbin; Regina Costa; Rod Hickman Gmail; Sharen Barboza; Sofia Millham; Tim Rougeux; William Trezvant; Zelia M. Tavares
Subject: Coleman - Mission Change Letter
Date: Friday, July 03, 2020 4:32:46 PM
Attachments: Ltr. NW-ML re Mission Changes 7.3.20.pdf

All,

Attached please find this month's mission change letter.

Nick Weber
Attorney
Department of Corrections & Rehabilitation
1515 S Street, Suite 314S
Sacramento, CA 95811-7243
(916) 323-3202

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STATE OF CALIFORNIA —DEPARTMENT OF CORRECTIONS AND REHABILITATION GAVIN NEWSOM, GOVERNOR

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

July 3, 2020

Special Master Lopes
Pannone Lopes Devereaux and O'Gara LLC
Northwoods Office Park, Suite 215N
1301 Atwood Avenue
Johnston, RI 02919

VIA EMAIL

Special Master Lopes:

I write regarding planned mission changes, reception centers, inpatient bed closures, and tele-psychiatry office space.

1. Planned Mission Changes

The following are planned mission changes:

Planned Deactivations

Institution	Bed Type	Deactivation	# of Beds	Reason
COR 3A4	EOP III	July 1, 2020	150	Conversion to SNY

CDCR will deactivate 150 level III Enhanced Outpatient Program (EOP) beds at California State Prison, Corcoran (COR). The unit will be replaced by a non-EOP Sensitive Needs Yard housing unit.

Planned Conversions

Institution	Current Bed Type	Conversion Date	# of Beds	New Bed Type
COR 3B1	EOP IV	July 1, 2020	150	EOP II

CDCR will convert 150 level IV EOP beds to level II at COR. This conversion is part of COR's plan to convert yard 3B from level IV to level II. Conversion of 3B2, 3B3, 3B4, and 3B5, will also occur. Any level II EOP patient out of level at COR and any level III EOP warranting a behavioral override to level II at COR will be housed at 3B1 after its conversion. The conversion has begun but its completion date is dependent on COVID 19 restrictions.

//

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2. Reception Center Deactivations

CDCR will close the Reception Centers at San Quentin, California Institution for Men, and Deuel Vocational Institution on October 5, 2020. Those closures include any related reception center mental health programs such as programs for EOP patients or reception center Short Term Restricted Housing units. These mission changes are part of a transition to implement enhanced Reception Center processing and increase access to the Integrated Substance Use Disorder Treatment program. The transition will allow CDCR to reduce Reception Center length of stay while increasing access to rehabilitative programming opportunities. (See attached May 7, 2020, memorandum Reception Centers Expedited Processing Responsibilities and Timeframes.)

Planned Deactivations

Institution	Bed Type	Deactivation	# of Beds	Reason
SQ (Alpine, Badger, Carson, Donner)	RC	October 5, 2020	1006	Conversion to Level II NDPF
CIM (Birch, Cypress, Madrone, Sycamore)	RC	October 5, 2020	558	Conversion to Level II NDPF
DVI (East Hall, West Hall)	RC	October 5, 2020	449	Conversion to Level II GP
DVI (E, F, G, and H Wings)	RC	October 5, 2020	792	Conversion to Level III GP

3. Tents at San Quentin

In response to COVID-19, San Quentin has set up six tents able to house ten inmates in each. As of this writing, they have not yet been activated, but patients in the MHSDS will not be excluded. Tentatively, the plan is to house healthy inmate workers in the tents.

4. Crisis and Inpatient Beds

The following is a list of closed crisis or inpatient beds.

Institution	Deactivation	Cells	Reason	Activation Date
SVSP MHCB	January 25, 2019	10	Staffing	TBD
PVSP MHCB	February 19, 2019	6	CTC Repair	TBD
CMF PIP	April 29, 2019	13	Staffing	TBD
CMF PIP A3	April 23, 2020	2	COVID-19	TBD

a. Salinas Valley State Prison Mental Health Crisis Beds

Crisis beds at Salinas Valley State Prison (SVSP) closed on January 25, 2019, pending a root cause analysis regarding care provided in the Correctional Treatment Center (CTC). The crisis beds remain closed pending identification of staff for both psychiatry and primary clinicians. SVSP has one on-site psychiatrist and four telepsychiatrists; however, the on-site provider is primarily focused on the EOP patients and Temporary Mental Health Unit population.

b. Pleasant Valley State Prison Crisis Bed

Pleasant Valley State Prison's CTC and crisis bed closed on February 19, 2019 due to roof damage as a result of rain storms. As a result of the damage, the interior of the building was severely damaged. The main barrier to reactivating the unit is internal damage, particularly to the safety cell. Much of the work has been ongoing, however, the work is temporarily stalled due to COVID 19 and no reactivation date is available at this time. Construction within the secured perimeter of CDCR institutions has stopped until further notice.

c. California Medical Facility Psychiatric Inpatient Program

Defendants previously reported that California Medical Facility (CMF) Q1, a twenty-nine bed acute unit at the CMF Psychiatric Inpatient Program (PIP), was operating only sixteen beds, leaving thirteen offline due to staffing vacancies. CMF PIP has stopped clustering the thirteen closed beds in Q1. Instead, the thirteen closed beds are scattered throughout the PIP.

In addition to these closures, CMF PIP has taken down two dorm beds in unit A3, dorm 4, in order to achieve physical distancing due to COVID 19.

5. Telepsychiatry Office Space

CDCR currently operates one hundred three telepsychiatry offices at seven locations.

Location	Number of Offices
Elk Grove, CA	17 Offices
San Quentin, CA	19 Offices
Rancho Cucamonga, CA	27 Offices
Diamond Bar, CA	18 Offices
Santa Ana, CA	15 Offices
Fresno, CA	5 Offices
Bakersfield, CA	2 Offices
SUBTOTAL	103 Offices

Below is a telepsychiatry office space activation and deactivation schedule.

Location	Number of Offices	Date

Rancho Cucamonga, CA	-9 Offices	December 2021
San Quentin, CA	18 Offices	2024/25

Sincerely,

/s/ Nick Weber

NICK WEBER
Attorney
Office of Legal Affairs

ATTACHMENT A

Reception Centers Expedited Processing Responsibilities and Timeframes

May 7, 2020

State of California Department of Corrections and Rehabilitation

Memorandum

Date : May 7, 2020

To : Associate Directors, Division of Adult Institutions
Regional Health Care Executives
Wardens
Chief Executive Officers

Subject: **RECEPTION CENTERS EXPEDITED PROCESSING RESPONSIBILITIES AND TIMEFRAMES**

The California Department of Corrections and Rehabilitation (CDCR) is committed to comprehensive rehabilitative programming in order to ensure successful community re-entry outcomes. As part of this focus, CDCR is committed to processing inmates out of the Reception Centers (RC), to mainline institutions more efficiently than our current practice. The RCs are extremely limited on their ability to provide substantive programming. For inmates to obtain timely access to rehabilitative programming opportunities, including Integrated Substance Use Disorder Treatment programs, we must expedite our current processing timelines. Effective May 26, 2020, the below timelines will be implemented to expedite RC inmate processing.

The historical average of days spent at the RC prior to transferring to mainline institutions has varied over time, but in recent years that figure is approximately 105 days. By implementing new processing expectations, CDCR's goal is to transfer RC inmates to mainline institutions in approximately 30 days. This will be achieved through the collaboration and teamwork of multiple stakeholders, including, but not limited to, California Correctional Health Care Services staff, Case Records staff, Correctional Counselors, and Statewide Transportation Unit staff. The Warden and Chief Executive Officer shall ensure coordination in scheduling and escorting for all components to ensure an efficient process.

CDCR has adopted a standardized Local Operating Procedure (LOP) for use by each of the RC institutions. The attached LOP and flowchart has been approved and shall be utilized to revise and incorporate institutional specific processes where applicable. Wardens shall ensure their LOP is updated and a copy is submitted to their respective Associate Director by May 19, 2020.

As outlined in the LOP, the timeline for RC staff to complete RC processing is as follows:

- Case Records Staff - Complete the case records intake process within five business days of arrival.
- Mental Health (MH) Clinicians – Complete the MH and DDP screening process within five business days of arrival.
- Medical/Nursing Staff – Complete the initial health screening and Focused Health Assessment within five business days of arrival.
- Dental Staff – Complete the RC dental screening within five business days of arrival.

- Correctional Counselor (CC) I - Complete all components of the CC I casework within five business days of the inmate's file being ready for review.
- CC II Supervisor - The CC II Supervisor will have two business days from the date the casework is completed to conduct a review of the case to allow for referral to a Classification Staff Representative for transfer endorsement.

This memorandum provides the timelines and policies for Classification Services Unit (CSU) personnel, including the Classification Staff Representatives (CSR), Population Management Unit (PMU) counselors, and the Statewide Transportation Unit (STU).

Once RC counseling staff place the inmate's case in *Referred to Classification Staff Representative* Status in the Strategic Offender Management System (SOMS), a CSR will review the case within three business days, and endorse to a mainline program appropriate for the inmate's case factors. In the event the case has errors or omissions that preclude an endorsement, the CSR will send the case back to RC counseling staff for the necessary corrections, consistent with current policy. CSU, including the CSR Scheduler, will ensure that RCs have robust CSR coverage so cases are seen expeditiously after being placed in *Referred to CSR* status.

Once RC cases are endorsed for transfer by the CSR, PMU counseling staff will review these cases within two business days to confirm bed availability at the endorsed institution. In the event there are no available beds at the endorsed institution, PMU staff will advise RC staff to complete a Redirect Chrono with a specified alternate institution, consistent with current practices. The Chief and Captain in PMU will ensure the cases are reviewed by counseling staff within two business days.

After PMU staff have confirmed bed availability, the inmate will transfer from the RC within five business days. This will be accomplished by STU staff scheduling movement utilizing methods to establish the safest and most cost effective way to meet the established timeframe. Existing Bus Seat Requests from the RCs, currently sent weekly, will be conducted twice a week on Wednesdays by 1000 hours and Fridays by 1700 hours. STU will continue to produce the Send/Intake report at minimum once a week, and will evaluate the need for any additional reports that may need to be sent throughout the week. The Chief and Captain of STU will ensure RC inmates will be moved within the five business day timeframe.

In-Service Training (IST) Managers shall ensure all staff assigned to RC processing receive documented On-the-Job Training (OJT) regarding the changes to the RC processing, within 30 days from the date of this memorandum. The OJT shall include a copy of this memorandum as

well as the updated LOP. The IST Managers shall utilize training code, BET 11054489, with Reception Center Expedited Processing Responsibilities and Timelines, in the notes section.

Wardens and Chief Executive Officers shall ensure all staff training is completed for their institution, and shall provide a proof of practice certification memorandum to the RC Associate Director, and the applicable Regional Health Care Executive.

If you have any questions or require further clarification, please contact Dan Ross, Captain, RC Mission at (916) 324-6808 or Dan.Ross@cdcr.ca.gov, or Charlie Thompson, CC III, CSU, at (916) 322-7150 or Charles.Thompson4@cdcr.ca.gov.

Original Signed

CONNIE GIPSON
Director
Division of Adult Institutions

Original Signed

R. STEVEN THARRATT, MD, MPVM, FACP
Director, Health Care Operations
Statewide Chief Medical Executive
California Correctional Health Care Services

Original Signed

JOSEPH BICK, MD, CCHP
Director (A)
Division of Health Care Services

cc: Kimberly Seibel
Charles Callahan
Chris Podratz
J. W. Moss
Brian Moak
Dennis Halverson
John Herrera
Heidi Dixon
Dan Ross
Charlie Thompson

RECEPTION CENTER INTAKE PROCESSING
(Institutional Name Here)

Revision Date: XXXXXX

I. PROCEDURE NUMBER AND TITLE

Operational Procedure # (XXX)
Reception Center Intake Processing

This Operating Procedure (OP) supersedes all previous direction regarding the intake and processing of Reception Center (RC) inmates.

II. PURPOSE AND OBJECTIVES:

A. The purpose of this Local Operational Procedure (LOP) is to provide a standardized collaborative framework for the Department's goals regarding intake and processing of all RC inmates.

B. The California Department of Corrections and Rehabilitation (CDCR) recognizes that a collaborative partnership between custody and Health Care (HC) staff is necessary to improve and maintain efficient RC processing. CDCR recognizes that achieving organizational change can only occur if it is driven by the highest levels of leadership. Not only must leaders embrace the principals of organizational change, they must model and communicate the behaviors that are expected to achieve it.

C. The details of this operations procedure have been developed to achieve the Department's goals and to enhance collaboration. When fully implemented, this procedure will create a continuity of teamwork amongst all disciplines, improve RC processing time frames and greatly reduce the inmate's length of stay in RC housing.

III. COMPLIANCE INDICATORS:

To comply with this policy, the following expectations shall be met:

A. The guidelines outlined in this LOP will be utilized to develop expectations and time frames for processing all RC intake inmates.

B. The Strategic Offender Management System (SOMS) report titled, "Unclassified Inmates and RC Processing Completion Dates" will also be utilized as a tracking tool. This report captures the Case Records, Institution Staff Recommendation Summary (ISRS), Classification Services Representative (CSR), portions of processing and will identify any overdue or missing documentation.

C. Wardens will develop a process to maintain monitoring of LOP compliance.

D. Each RC institution will provide weekly RC processing reports to the RC Associate Director's office.

IV. REFERENCES:

A. California Code of Regulation, Title 15, Section(s) 3075, 3075.1, 3.999.305

B. Health Care Department Operations Manual (HCDOM), Chapter 3, Article 1, Section 3.1.7, Care Management/Care Coordination.

C. Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.8, Reception Center.

D. Health Care Department Operations Manual, Chapter 3, Article 3, Section 3.3.2.2, Dental Care – Reception Center.

E. Mental Health Services Delivery System (MHSDS) Program Guide, Chapter 2, Reception Center Mental Health Assessment.

F. LOP XXX (Any other institution specific LOP that should be referenced or could be impacted based on this direction.)

V. APPROVAL AND REVIEW:

A. This procedure shall be reviewed and updated annually by the Associate Warden of the Reception Center (AWRC), the Chief Nurse Executive (CNE), and the Chief of Mental Health (CMH) and the Supervising Dentist (SD). This annual review shall include an update of the operational procedures to align with modifications in the CDCR MHSDS Program Guide and the HCDOM where appropriate.

B. After approval by the Chief Executive Officer (CEO), the procedure shall be forwarded to the Warden for review and approval.

VI. RESPONSIBILITY:

The CEO and Warden have overall responsibility for the implementation and operation of this operational procedure.

VII. INTAKE PROCEDURE:

A. To achieve the Department's RC processing goals it will require a detailed collaboration of Case Records Staff, Classification Services and Correctional Counselors as well as Mental Health (MH), Medical, Nursing and Dental professionals. Each discipline will be required to complete their specific role in the process within the established time frames to ensure continuity and efficiency.

B. The intake screening process will initiate for each Inmate/Patient (IP) upon their arrival to the RC. Each disciplines role in the process is described below:

1. Case Records Staff
   a. Receive and review all documentation that arrives with the IP from the county.
   b. Within the first (5) business day of arrival, complete the case records intake process.
2. MH Clinicians
   a. Within the first (5) business days of arrival, the IP's shall receive a MH screening as described in the MHSDS Program Guide Chapter 2, Reception Center Mental Health Assessment.
3. Medical/Nursing Staff
   a. Within the first (5) business days of the IP's arrival they shall receive an initial health screening and triage as described in HCDOM 3.1.7, Care Management/Care Coordination and HCDOM 3.1.8, Reception Center.
4. Dental Staff
   a. Within the first (5) business days from the IP's arrival, perform a Reception Center screening as described in HCDOM 3.3.2.2 Dental Care – Reception Center.
5. Correctional Counselor I (CCI)
   a. Within the first (5) business days from the IP's arrival, the file should be ready for review by the CCI.
   b. Review the inmate's electronic record in the Strategic Offender Management System (SOMS) and Electronic Records Management System (ERMS).
   c. The CCI will be expected to complete all components of the counselor casework within (5) business days of the inmate's file being ready for review.
   d. The CCI's completed casework will be forwarded to their assigned CCII for review and approval in SOMS.

e. If the casework is returned to the CCI for corrections the CCI will have (2) business days from the date of return to make the corrections and resubmit it back to the CCII.

6. Correctional Counselor II (CCII)

a. Conduct a daily review of all assigned CCI casework to ensure compliance with the casework time frames.
b. The CCII will have (2) business days from the date the casework is completed to conduct a review and approve or return the case for corrections.
c. If the casework is returned to the CCI for corrections the CCI will have (2) business days from the date of return to make the corrections and resubmit it back to the CCII.

C. Program effectiveness, quality of services and compliance requirements for this LOP will be monitored and reported through the Warden and CEO to the RC Associate Director and the Regional Health Care Executive.

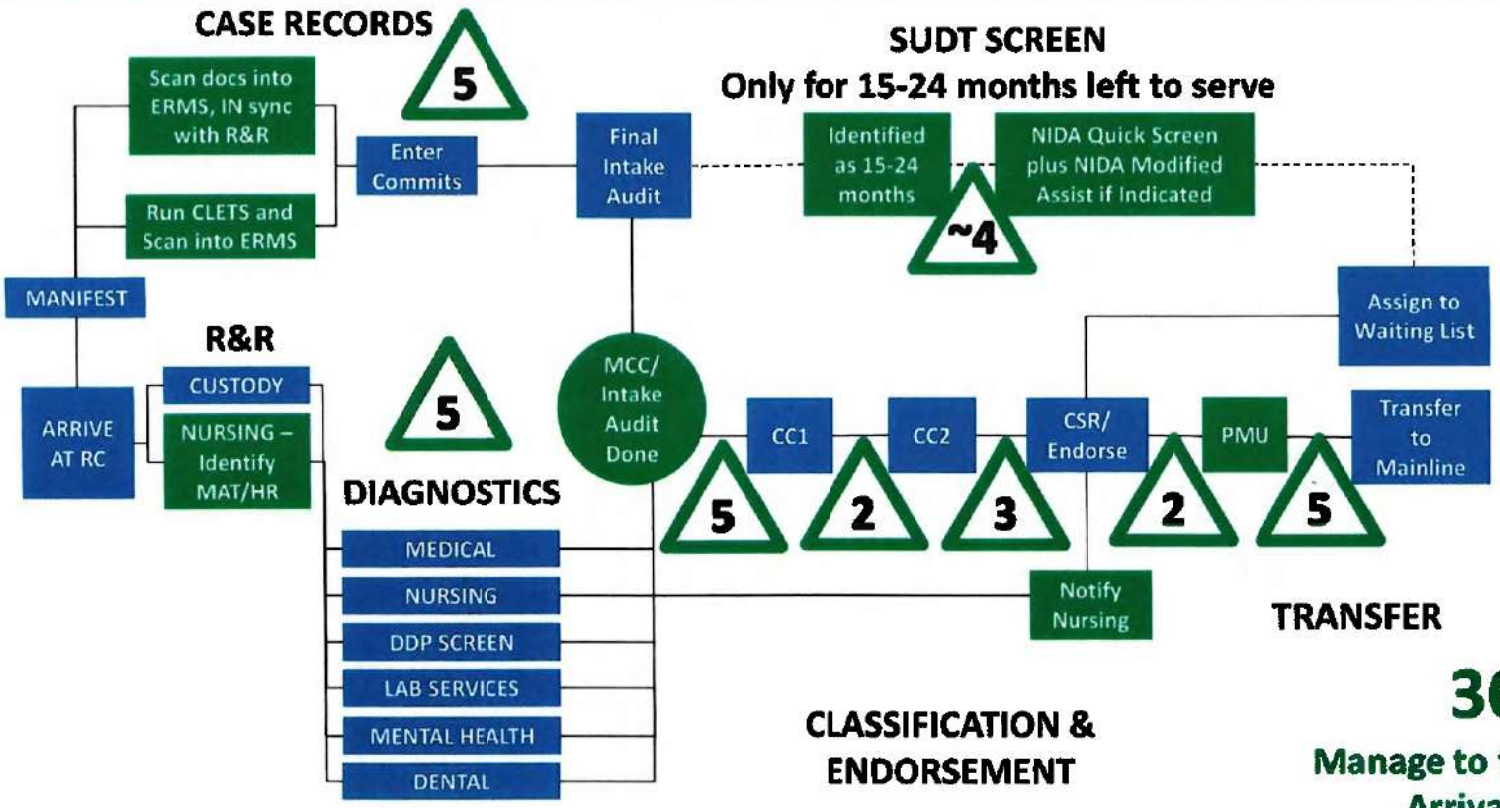
_____ _____

(Name) Date
Chief Executive Officer

_____ _____

(Name) Date
Warden

RECEPTION CENTER PROCESSING



30 Days

Manage to this timeframe from Arrival to Departure

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ATTACHMENT B

Mental Health Services Delivery System (MHSDS) Management Information Summary (MIS) Report

June 29, 2020

MENTAL HEALTH SERVICES DELIVERY SYSTEM (MHSDS)
MANAGEMENT INFORMATION SUMMARY (MIS) REPORT
6/29/2020

Level of Care	Housing Program	MALES			FEMALES		
		Capacity	Census[1]	Awaiting Placement[2]	Capacity	Census[1]	Awaiting Placement[2]
Correctional Clinical Case Management System (CCCMS)		**27,000**	**23,296**		**2,250**	**1,917**	
CCCMS	Reception Center (RC)		1,169			96	
	General Population (GP)		20,178			1,693	
	Enhanced Outpatient Program (EOP)		101			0	
	Mental Health Crisis Bed (MHCB)		3			0	
	Psychiatric Inpatient Program (PIP)		4			0	
	Specialized Medical Beds Housing		565			29	
	Administrative Segregation Unit (ASU)		406			71	
	Condemned		142			14	
	Long Term Restricted Housing Unit (LTRH)[6]	270	170			0	
	Non-Disciplinary Segregation (NDS)		0			0	
	Psychiatric Services Unit (PSU)		5			0	
	Security Housing Unit (SHU)		0			14	
	Short Term Restricted Housing Unit (STRH)[6]	1,125	553			0	
Enhanced Outpatient Program (EOP)		**7,075**	**6,521**		**225**	**173**	
EOP	Reception Center (RC)		75			1	
	General Population (GP)		153			42	
	Enhanced Outpatient Program (EOP)	6,318	5,388		195	119	
	Mental Health Crisis Bed (MHCB)		17			0	
	Psychiatric Inpatient Program (PIP)		16			0	
	Specialized Medical Beds Housing		191			1	
	Administrative Segregation Unit (ASU)	585	428	96	20	7	0
	Condemned		65			0	
	Long Term Restricted Housing Unit (LTRH)		0			0	
	Non-Disciplinary Segregation (NDS)		0			0	
	Psychiatric Services Unit (PSU)	172	115	60	10	3	1
	Security Housing Unit (SHU)		0			0	
	Short Term Restricted Housing Unit (STRH)		73			0	

Level of Care	Capacity	Census[1,7]	Awaiting Placement[2]	Capacity	Census[1,7]	Awaiting Placement[2]
Mental Health Crisis Bed (MHCB)[7]	**424**	**272**	**3**	**41**	**11**	**1**
Psychiatric Inpatient Programs: Intermediate Care Facility (ICF)	**1,166**	**1,043**	**53**			
Low Custody	390	335	10			
Atascadero State Hospital (ASH)	256	224	5			
Coalinga State Hospital (CSH)	50	45	1			
California Medical Facility (CMF)	84	66	4			
High Custody	776	708	43			
California Health Care Facility (CHCF)	354	353	13			
CMF Single Cells	106	105	1			
CMF Multi Cells	70	45	4			
SVPP Single Cells	202	170	21			
Salinas Valley Psychiatric Program (SVPP) Multi Cells	44	35	4			
Acute Psychiatric Program (APP)	**369**	**284**	**17**			
ASH	0	0	0			
CHCF	163	103	11			
CMF	206	181	6			
Psychiatric Inpatient Program (PIP)	**40**	**30**	**0**	**75**	**40**	**0**
California Institution for Women (CIW)				45	30	0
Patton State Hospital (PSH)				30	10	0
SQ	30	23	0			
SQ (Non-condemned)	10	7	0			
Penal Code 2974s (Parolees)[5]		**2**				
Metro State Hospital (MSH)		0				
Napa State Hospital (NSH)		2				
Patton State Hospital (PSH)		0				
TOTALS (excluding Parolees)	**36,074**	**31,446**	**229**	**2,591**	**2,141**	**2**

	Total Capacity	Total Census[1]	Total Awaiting Placement[2]	Total Over Timeframes[3]	CENSUS PERCENTAGES % MHSDS	% CDCR[4]
CCCMS	29,250	25,213			75.07%	22.12%
EOP	6,513	6,068			18.07%	5.32%
EOP-ASU/NDS/STRH	605	508	96	61	1.51%	0.45%
EOP-PSU/LTRH/SHU	182	118	61	20	0.35%	0.10%
MHCB	465	283	4	1	0.84%	0.25%
PSYCHIATRIC INPATIENT	1,650	1,397	70	32	4.16%	1.23%
GRAND TOTAL	**38,665**	**33,587**	**231**	**114**	**100.00%**	**29.47%**

[1] Census sources: HCODS for CCCMS, EOP; HEART for MHCB; RIPA reports for ICF, APP, and PIP programs.
[2] Awaiting Placement = The sum of inmates waiting to be placed in a bed at a specific level of care. Those awaiting placement to ICF, APP, and PIP include referrals that have been custodially reviewed by HCPOP and are awaiting bed availability, inpatient program acceptance, or transfer to the inpatient program as of the reporting date (based on the Referrals to Inpatient Programs Application (RIPA)).
[3] Total Over Timeframes = The number of referrals that are beyond Mental Health Program Guide transfer timeframes: EOP-ASU includes cases in non-hubs waiting > 30 days, PSU includes cases with an original CSR endorsement date > 60 days, MHCB includes referrals > 24 hours, Psychiatric Inpatient includes Intermediate referrals > 30 days and Acute referrals > 10 days.
[4] CDCR pop as of 6/24/20 (OISB). Based on Total In-State Institution Population and Out of State (COCF).
[5] Census numbers are tracked and updated by Department of State Hospital (DSH).
[6] LTRH and STRH capacity numbers obtained from the PMU Weekly Population Summary Report dated March 6, 2020.
[7] In response to CDCR COVID-19 Guidelines some patients may be housed outside of their level of care and/or in a Temporary Mental Health Unit.

Exhibit Y

From:	Weber, Nicholas@CDCR
To:	Melissa Bentz; Coleman Team - RBG Only; Steve Fama; Angie Cooper; Braxton Medlin; Brian Main; Cindy Radavsky; Henry D. Dlugacz; Jamas DeGroot; Jeffrey Metzner; Joseph Sorah; Kahlil Johnson; Karen Rea; Kerry Courtney Hughes, MD; Kerry F. Walsh; Kristina Hector; Lindsay Hayes; Latricea McClendon-Hunt; Lana Lopez; Maria Masotta; Matt Lopes; Michael Ryan; Mohamedu Jones; Mary Perrien; Patricia M. Williams; Rachel Gribbin; Regina Costa; Rod Hickman Gmail; Sharen Barboza; Sofia Millham; Tim Rougeux; William Trezvant; Zelia M. Tavares
Cc:	Elise Thorn; Tyler Heath; lucas.hennes@doj.ca.gov; Kyle Lewis; Dillon Hockerson; Stafford, Carrie@CDCR; Ryan, Amanda@CDCR
Subject:	Coleman Tier Report and TMHU Patient List
Date:	Monday, July 06, 2020 4:53:57 PM
Attachments:	Tier Report 06222020 - 06262020 .pdf TMHU Patient List 0622-06262020.pdf

All,

Attached is the Tier Report and TMHU/Treat in Place List for the week of June 22nd.

Nick Weber
Attorney
Department of Corrections & Rehabilitation
1515 S Street, Suite 314S
Sacramento, CA 95811-7243
(916) 323-3202

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Region	Institution	Last Name	First Name	CDCR#	Housing Location	Level of Care	Date of Arrival	Date of Release	Level of Care When Released
I	FOL	[redacted]	[redacted]	[redacted]	Max	MHCB	6/23/2020	Pending	
I	MCSP				Max	MHCB	6/17/2020	6/23/2020	MHCB
I	MCSP				Non-Max	MHCB	6/17/2020	6/23/2020	EOP
I	MCSP				Non-Max	MHCB	6/22/2020	6/24/2020	EOP
I	MCSP				Non-Max	MHCB	6/23/2020	Pending	
I	MCSP				Max	MHCB	6/24/2020	Pending	
I	MCSP				Non-Max	MHCB	6/25/2020	Pending	
I	SAC				Max	Acute	5/29/2020	Pending	
I	SAC				Max	MHCB	6/21/2020	6/24/2020	EOP
I	SAC				Non-Max	MHCB	6/20/2020	Pending	
I	SAC				Max	ICF	5/27/2020	Pending	
I	SAC				Non-Max	Acute	5/20/220	6/25/2020	MHCB
I	SAC				Max	MHCB	6/16/2020	6/22/2020	EOP
I	SAC				Max	MHCB	6/15/2020	6/22/2020	MHCB
I	SAC				Non-Max	MHCB	6/20/2020	Pending	
I	SAC				Max	ICF	6/22/2020	Pending	
I	SAC				Non-Max	Acute	6/18/2020	6/22/2020	EOP
I	SAC				Max	ICF	4/24/2020	Pending	
I	SAC				Non-Max	MHCB	6/21/2020	Pending	
I	SAC				Non-Max	MHCB	6/21/2020	6/24/2020	MHCB
I	SAC				Max	ICF	6/15/2020	6/22/2020	ACTUE
I	SAC				Max	MHCB	6/18/2020	6/23/2020	MHCB
I	SAC				Max	MHCB	6/22/2020	6/25/2020	EOP
I	SAC				Non-Max	MHCB	6/19/2020	Pending	
I	SAC				Max	MHCB	6/16/2020	6/23/2020	MHCB
I	SAC				Max	MHCB	6/17/2020	6/23/2020	MHCB
I	SAC				Non-Max	MHCB	6/21/2020	Pending	
I	SAC				Max	MHCB	6/20/2020	Pending	
I	SAC				Max	CCCMS	6/16/2020	Pending	
I	SAC				Max	MHCB	6/16/2020	Pending	
II	CTF				Non-Max	MHCB	6/23/2020	Pending	
II	SCC				Non-Max	MHCB	6/21/2020	Pending	
II	SCC				Non-Max	MHCB	6/25/2020	Pending	
II	SCC				Non-Max	MHCB	6/26/2020	Pending	
II	SVSP				Non-Max	MHCB	6/21/2020	6/24/2020	EOP
II	SVSP				Max	MHCB	6/22/2020	6/25/2020	CCCMS
II	SVSP				Non-Max	MHCB	6/21/2020	6/24/2020	CCCMS
II	SVSP				Non-Max	MHCB	6/22/2020	6/24/2020	EOP
II	SVSP				Max	MHCB	6/22/2020	Pending	
II	SVSP				Max	MHCB	6/19/2020	Pending	
II	SVSP				Non-Max	MHCB	6/22/2020	6/25/2020	EOP
II	SVSP				Max	MHCB	6/22/2020	6/25/2020	EOP

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II	SVSP	[redacted]	Max	MHCB	6/22/2020	6/24/2020	CCCMS
II	SVSP		Non-Max	MHCB	6/16/2020	Pending	
II	SVSP		Max	MHCB	6/13/2020	6/22/2020	EOP
II	SVSP		Max	MHCB	6/22/2020	Pending	
II	SVSP		Non-Max	MHCB	6/21/2020	6/22/2020	EOP
II	SVSP		Max	ICF as of 6/22/2020	6/12/2020	Pending	
II	SVSP		Max	MHCB	6/23/2020	Pending	
II	SVSP		Max	MHCB	6/23/2020	Pending	
II	VSP		Non-Max	MHCB	6/21/2020	Pending	
II	VSP		Non-Max	MHCB	6/17/2020	Pending	
II	VSP		Non-Max	MHCB	6/23/2020	Pending	
II	VSP		Non-Max	MHCB	6/23/2020	Pending	
III	ASP		Treatment in Place	MHCB	6/14/2020	6/26/2020	CCCMS
III	ASP		Treatment in Place	MHCB	6/16/2020	6/24/2020	EOP
III	ASP		Treatment in Place	MHCB	6/11/2020	Pending	
III	CCI		Non-Max	MHCB	6/19/2020	6/25/2020	CCCMS
III	CCI		Non-Max	MHCB	6/22/2020	6/23/2020	CCCMS
III	LAC		Max	MHCB	6/12/2020	Pending	
III	LAC		Non-Max	MHCB	6/16/2020	6/23/2020	EOP
III	LAC		Max	MHCB	6/16/2020	Pending	
III	LAC		Max	MHCB	6/22/2020	Pending	
III	LAC		Max	MHCB	6/22/2018	Pending	
III	LAC		Max	MHCB	6/23/2020	Pending	
III	PVSP		Non-Max	MHCB	6/20/2020	6/24/2020	MHCB
III	PVSP		Non-Max	MHCB	6/21/2020	6/24/2020	MHCB
IV	CAL		Non-Max	MHCB	6/18/2020	Pending	
IV	CRC		Non-Max	MHCB	6/24/2020	Pending	
IV	RJD		Treatment in Place	ICF	3/11/2020	Pending	
IV	RJD		Treatment in Place	ICF	5/18/2020	Pending	
IV	RJD		Treatment in Place	ICF	6/8/2020	pending	
IV	RJD		Treatment in Place	ICF	4/30/2020	Pending	
IV	RJD		Treatment in Place	ICF	6/4/2020	pending	
IV	RJD		Treatment in Place	ICF	3/27/2020	Pending	
IV	RJD		Non-Max	MHCB	6/24/2020	Pending	
IV	RJD		Non-Max	MHCB	6/24/2020	Pending	
IV	RJD		Non-Max	MHCB	6/24/2020	Pending	
IV	RJD		Non-Max	MHCB	6/24/2020	Pending	
IV	RJD		Non-Max	MHCB	6/24/2020	Pending	

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Exhibit Z

Memorandum

Date: March 16, 2020

Subject: DEPARTMENT DIRECTIVE ON SUSPENSION OF PATIENT ADMISSIONS FROM THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION (CDCR)

Pursuant to Governor Gavin Newsom's Proclamation of a State of Emergency dated March 4, 2020, the Director of the Department of State Hospitals issues this Directive in accordance with the Director's authority to execute laws relating to the care and treatment of persons with mental health disorders placed with the State Department of State Hospitals (DSH). To ensure that patients with mental health disorders currently in DSH's custody continue to receive the services and support that are threatened by disruptions caused by COVID-19, and to protect the health, safety and welfare of those patients, the Department is suspending admission of patients placed at DSH facilities pursuant to Penal Code section 2684 (*Coleman* patients).

All *Coleman* patients presently in DSH's custody will not be discharged until DSH rescinds the suspension of *Coleman* patient admissions, unless an emergency discharge is required for patients who cannot be safely maintained in DSH's unlocked dorm setting.

This suspension of *Coleman* patient admissions will remain in effect for 30 days, unless extended by the Director of the Department.

STEPHANIE CLENDENIN
Director

Exhibit AA

From: Nina Raddatz
To: Kerry F. Walsh; Michael W. Bien; Lisa Ells; Jessica Winter; Cara Trapani; Amy Xu; Marc Shinn-Krantz; Donald Specter; Steve Fama; Toche, Diana@CDCR; Bick, Joseph@CDCR; Neill, Jennifer@CDCR; Daye, Eureka@CDCR; Ponciano, Angela@CDCR; Nick Weber; Matt Lopes; Mohamedu Jones; Kristina Hector; Angie Cooper; Rachel Gribbin; Lana Lopez; Tim Rougeux; Jeffrey Metzner; Kerry Courtney Hughes, MD; Mary Perrien; Henry D. Dlugacz; Lindsay Hayes; Mary Perrien; Karen Rea; Jamas DeGroot; Brian Main; Kahlil Johnson; Sharen Barboza; Sofia Millham; Melissa Bentz; Barney-Knox, Barbara@CDCR; Golding, Michael@CDCR; Mehta, Amar@CDCR; Kyle Lewis; Elise Thorn; Lucas Hennes; Ed Swanson; "Silberfeld, Roman M."; Ed Swanson; Barrow, Roscoe@CDCR
Cc: Kent, Kristopher@DSH-S; Ciccotti, Christine@DSH-S; Clendenin, Stephanie@DSH-S; Hendon, Catherine@DSH-S; Warburton, Katherine@DSH-S
Subject: Coleman COVID Task Force Meeting: DSH Reports
Date: Monday, May 11, 2020 4:16:41 PM
Attachments: 1 Coleman Patient Census and Waitlist Report 5-8-2020.pdf
2 Census by Unit Coleman Units 5-11-20.pdf
3 Coleman Discharges 5-3-20 to 5-9-20.pdf
4 OMD Admissions 5-3-20 to 5-9-20.pdf

Good Afternoon, All:

Please see the attached DSH reports for our Task Force meeting tomorrow:

1. Coleman Patient Census and Waitlist Report
2. Census by Unit for Units with Coleman Patients
3. Coleman Discharges
4. OMD Admissions

Respectfully,

Antonina (Nina) Raddatz
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DIVISION OF HOSPITAL STRATEGIC PLANNING AND IMPLEMENTATION
Patient Management Unit
1600 Ninth Street, Room 420
Sacramento, CA 95814

DSH CDCR Patient Census and Waitlist Report

Data as of: 5/8/20

Acute Care Patients

DSH Facility - Acute - Female	Bed Capacity	Census	Beds on Hold[1]	Beds Redlined[2]	Medical Isolation Rooms[3]	Available Beds	Waitlist			Total Patients Awaiting Admission
							Referrals Pending Review	Accepted Referrals		
								CDCR Prison[4]	CDCR PIP[5]	
Patton[6]	-	0	0	0	0	0				0
Total	**-**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(Includes 0 Waiting >10 Days)**

Intermediate Care Low Custody - Unlocked Dorms

DSH Facility - Unlocked Dorms	Bed Capacity	Census	Beds on Hold[1]	Beds Redlined[2]	Medical Isolation Rooms[3]	Available Beds	Waitlist			Total Patients Awaiting Admission
							Referrals Pending Review	Accepted Referrals		
								CDCR Prison[4]	CDCR PIP[5]	
Atascadero	256	231	1	0	0	24				1
Coalinga	50	45	0	0	0	5				
Total	**306**	**276**	**1**	**0**	**0**	**29**	**0**	**0**	**1**	**(Includes 0 Waiting >30 Days)**

Intermediate Care Low Custody - Unlocked Dorms - Female

DSH Facility - Unlocked Dorms - Female	Bed Capacity	Census	Beds on Hold[1]	Beds Redlined[2]	Medical Isolation Rooms[3]	Available Beds	Waitlist			Total Patients Awaiting Admission
							Referrals Pending Review	Accepted Referrals		
								CDCR Prison[4]	CDCR PIP[5]	
Patton[6]	30	13	0	0	0	17				0
Total	**30**	**13**	**0**	**0**	**0**	**17**	**0**	**0**	**0**	**(Includes 0 Waiting >30 Days)**

[1]Beds on hold are assigned for internal patient movement and patients waiting to transfer to DSH. When allocated *Coleman* beds are at maximum capacity within the facility, beds with patients pending discharge may be placed on hold for accepted patients to maximize bed utilization. This may result in negative totals for available beds, but does not necessarily imply exceeding capacity.

[2]Redlined beds are temporarily unavailable due to repairs.

[3]Medical isolation rooms are required for licensing and physically differ from the other housing in the program, i.e., have showers or restricted sightlines into the cell, and are deemed inappropriate for everyday use.

[4]Direct referrals from a CDCR prison for patients awaiting transfer to DSH for inpatient treatment.

[5]Referrals for patients currently receiving inpatient treatment within a CDCR PIP referred to DSH for stepdown of LRH or Level of Care change.

[6]Beds at DSH-P are for female patients only.

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Exhibit BB

From: Kent, Kristopher@DSH-S

To: Kerry F. Walsh; Michael W. Bien; Lisa Ells; Jessica Winter; Cara Trapani; Amy Xu; Marc Shinn-Krantz; Donald Specter; Steve Fama; Ciccotti, Christine@DSH-S; Bachman, Ellen@DSH-S; Hendon, Catherine@DSH-S; Nina Raddatz; Toche, Diana@CDCR; Bick, Joseph@CDCR; Neill, Jennifer@CDCR; Daye, Eureka@CDCR; Ponciano, Angela@CDCR; Nick Weber; Melissa Bentz; Barney-Knox, Barbara@CDCR; Golding, Michael@CDCR; Mehta, Amar@CDCR; Kyle Lewis; Elise Thorn; Lucas Hennes; Ed Swanson; "Silberfeld, Roman M."; Barrow, Roscoe@CDCR; Tyler Heath

Cc: Matt Lopes; Mohamedu Jones; Kerry F. Walsh; Kristina Hector; Angie Cooper; Tim Rougeux; Jeffrey Metzner; Kerry Courtney Hughes, MD; Mary Perrien; Henry D. Dlugacz; Lindsay Hayes; Mary Perrien; Maria Masotta; Karen Rea; Jamas DeGroot; Brian Main; Kahlil Johnson; Sharen Barboza; Sofia Millham; Dan Potter

Subject: DSH Coleman COVID-19 Task Force Reports

Date: Monday, July 13, 2020 6:43:30 PM

Attachments: 1 Coleman Patient Census and Waitlist Report 7-10-20.pdf
2 Census by Unit Coleman 7-10-20.pdf
3 Coleman Discharges 7-5-20 to 7-11-20.pdf
4 OMD Admissions 7-5-20 to 7-11-20.pdf
Coleman COVID-19 Referral Progress for 7-14-20 Task Force Meeting.pdf

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Hello All,
Please find attached the DSH reports for this week. Thanks, Kris

DIVISION OF HOSPITAL STRATEGIC PLANNING AND IMPLEMENTATION
Patient Management Unit
1600 Ninth Street, Room 420
Sacramento, CA 95814

Draft

DSH CDCR Patient Census and Waitlist Report

Data as of: 7/10/20

Acute Care Patients

DSH Facility - Acute - Female	Bed Capacity	Census	Beds on Hold[1]	Beds Redlined[2]	Medical Isolation Rooms[3]	Available Beds	Waitlist			Total Patients Awaiting Admission
							Referrals Pending Review	Accepted Referrals		
								CDCR Prison[4]	CDCR PIP[5]	
Patton[6]	-	0	0	0	0	0				0
Total	**-**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(Includes 0 Waiting >10 Days)**

Intermediate Care Low Custody - Unlocked Dorms

DSH Facility - Unlocked Dorms	Bed Capacity	Census	Beds on Hold[1]	Beds Redlined[2]	Medical Isolation Rooms[3]	Available Beds	Waitlist			Total Patients Awaiting Admission
							Referrals Pending Review	Accepted Referrals[7]		
								CDCR Prison[4]	CDCR PIP[5]	
Atascadero	256	220	0	0	0	36				30
Coalinga	50	46	0	0	0	4				
Total	**306**	**266**	**0**	**0**	**0**	**40**	**12**	**7**	**11**	**(Includes 2 Waiting >30 Days)[8]**

Intermediate Care Low Custody - Unlocked Dorms - Female

DSH Facility - Unlocked Dorms - Female	Bed Capacity	Census	Beds on Hold[1]	Beds Redlined[2]	Medical Isolation Rooms[3]	Available Beds	Waitlist			Total Patients Awaiting Admission
							Referrals Pending Review	Accepted Referrals[7]		
								CDCR Prison[4]	CDCR PIP[5]	
Patton[6]	30	10	0	0	0	20				4
Total	**30**	**10**	**0**	**0**	**0**	**20**	**3**	**1**	**0**	**(Includes 0 Waiting >30 Days)**

[1]Beds on hold are assigned for internal patient movement and patients waiting to transfer to DSH. When allocated *Coleman* beds are at maximum capacity within the facility, beds with patients pending discharge may be placed on hold for accepted patients to maximize bed utilization. This may result in negative totals for available beds, but does not necessarily imply exceeding capacity.

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[5]Referrals for patients currently receiving inpatient treatment within a CDCR PIP referred to DSH for stepdown of LRH or Level of Care change.

[6]Beds at DSH-P are for female patients only.

[7]Accepted referrals include 19 referrals that are on a facility hold.

[8]Patients are waiting >30 days due to COVID-19 holds on referring facilities.

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Exhibit CC

MHCB Referrals Report

About this Report

All MHCB referrals initiated between 6/7/2019 and 7/7/2019 at CDCR
Generated on 7/8/2020 2:24:11 PM
Time spent out to Court or Medical. Medical hold. Refusal to transfer included.

Summary of all MHCB referrals initiated between 6/7/2019 and 7/7/2019 at CDCR

All Times in Days

		Alt Housing LOS			Transport Time			Total Transfer Time		
Status	Count	Avg	Max	>1440 min	Avg	Max	>480 min	Avg	Max	>1440 min
Rescinded	306	0.4	4.3	2	0.0	0.0	0	0.4	4.3	2
Admitted	850	0.3	1.9	8	0.1	0.4	3	0.3	1.9	21
All	**1156**	**0.3**	**4.3**	**10**	**0.0**	**0.4**	**3**	**0.4**	**4.3**	**23**

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Exhibit DD

MHCB Referrals Report

About this Report

All MHCB referrals initiated between 6/7/2020 and 7/7/2020 at CDCR
Generated on 7/8/2020 2:18:24 PM
Time spent out to Court or Medical. Medical hold. Refusal to transfer included.

Summary of all MHCB referrals initiated between 6/7/2020 and 7/7/2020 at CDCR

All Times in Days

		Alt Housing LOS			Transport Time			Total Transfer Time		
Status	Count	Avg	Max	>1440 min	Avg	Max	>480 min	Avg	Max	>1440 min
Pending	37	4.5	18.9	33	0.0	0.0	0	4.5	18.9	33
Rescinded	338	1.8	15.9	106	0.0	0.0	0	1.8	15.9	106
Admitted	391	1.0	17.0	77	0.0	0.3	1	1.0	17.0	77
All	**766**	**1.5**	**18.9**	**216**	**0.0**	**0.3**	**1**	**1.5**	**18.9**	**216**

Case 2:90-cv-00520-KJM-DB Document 6768-4 Filed 07/15/20 Page 4 of 89

Exhibit EE

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
July 1, 2019

Monthly Report of Population
As of Midnight June 30, 2019

Total CDCR Population

Population	Felon/ Other	Change Since Last Month	Change Since Last Year	Design Capacity	Percent Occupied	Staffed Capacity
A. Total In-Custody/CRPP Supervision	125,472	-359	-3,945			
I. In-State	125,472	+13	-1,100			
(Men, Subtotal)	119,781	+42	-885			
(Women, Subtotal)	5,691	-29	-215			
1. Institution/Camps	117,682	+95	-1,183	89,763	131.1	125,575
Institutions	114,831	+448	-432	85,083	135.0	121,331
Camps(CCC, CIW, and SCC)	2,851	-353	-751	4,680	60.9	4,244
2. In-State Contract Beds	6,405	-82	+108			
Private Community Correctional Facilities	1,939	-45	-66			
Public Community Correctional Facilities	1,761	-11	-16			
Community Prisoner Mother Program	22	0	0			
California City Correctional Facility	2,441	-8	+219			
Female Community ReEntry Facility, McFarland	242	-18	-29			
3. Department of State Hospitals	190	+4	-42			
4. CRPP Supervision	1,195	-4	+17			
Alternative Custody Program	160	+3	+2			
Custody to Community Treatment Reentry Program	383	-2	+3			
Male Community Reentry Program	628	-5	+17			
Medical Parole	24	0	-5			
B. Parole	50,822	+754	+3,452			
Community Supervision	48,950	+759	+3,544			
Interstate Cooperative Case	1,872	-5	-92			
C. Non-CDCR Jurisdiction	1,083	+10	+72			
Other State/Federal Institutions	323	+2	-6			
Out of State Parole	717	+11	+99			
Out of State Parolee at Large	13	-1	-1			
DJJ-W&IC 1731.5(c) Institutions	30	-2	-20			
D. Other Populations	6,247	-90	+468			
Temporary Release to Court and Hospital	1,536	+9	+263			
Escaped	199	0	+2			
Parolee at Large	4,512	-99	+203			
Total CDCR Population	183,624	+315	+47			

This report contains the latest available reliable population figures from SOMS. They have been carefully audited, but are preliminary, and therefore subject to revision.

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
July 1, 2019

Monthly Report of Population
As of Midnight June 30, 2019

Monthly Institution Population Detail

Institutions	Felon/ Other	Design Capacity	Percent Occupied	Staffed Capacity
Male Institutions				
Avenal State Prison (ASP)	3,744	2,920	128.2	4,370
Calipatria State Prison (CAL)	3,493	2,308	151.3	3,333
California Correctional Center (CCC)	3,853	3,883	99.2	4,762
California Correctional Institution (CCI)	3,739	2,783	134.4	4,120
Centinela State Prison (CEN)	3,515	2,308	152.3	3,333
California Health Care Facility - Stockton (CHCF)	2,704	2,951	91.6	2,951
California Institution for Men (CIM)	3,665	2,976	123.2	4,186
California Men's Colony (CMC)	3,540	3,838	92.2	4,398
California Medical Facility (CMF)	2,539	2,361	107.5	2,847
California State Prison, Corcoran (COR)	3,179	3,116	102.0	4,270
California Rehabilitation Center (CRC)	2,933	2,491	117.7	3,210
Correctional Training Facility (CTF)	5,492	3,312	165.8	4,887
Chuckawalla Valley State Prison (CVSP)	2,741	1,738	157.7	2,478
Deuel Vocational Institution (DVI)	2,249	1,681	133.8	2,353
Folsom State Prison (FOL)	2,995	2,066	145.0	2,895
High Desert State Prison (HDSP)	3,127	2,324	134.6	3,361
Ironwood State Prison (ISP)	2,693	2,200	122.4	3,200
Kern Valley State Prison (KVSP)	3,604	2,448	147.2	3,522
California State Prison, Los Angeles County (LAC)	3,207	2,300	139.4	3,300
Mule Creek State Prison (MCSP)	4,035	3,284	122.9	4,009
North Kern State Prison (NKSP)	4,246	2,694	157.6	3,911
Pelican Bay State Prison (PBSP)	2,663	2,380	111.9	3,250
Pleasant Valley State Prison (PVSP)	3,416	2,308	148.0	3,333
RJ Donovan Correctional Facility (RJD)	3,980	2,992	133.0	3,942
California State Prison, Sacramento (SAC)	2,112	1,828	115.5	2,449
California Substance Abuse Treatment Facility (SATF)	5,454	3,424	159.3	5,111
Sierra Conservation Center (SCC)	3,918	3,936	99.5	4,570
California State Prison, Solano (SOL)	4,533	2,610	173.7	3,882
San Quentin State Prison (SQ)	4,243	3,082	137.7	3,984
Salinas Valley State Prison (SVSP)	3,148	2,452	128.4	3,409
Valley State Prison (VSP)	2,885	1,980	145.7	2,954
Wasco State Prison (WSP)	5,023	2,984	168.3	4,351
Male Total	**112,668**	**85,958**	**131.1**	**116,931**
Female Institutions				
Central California Women's Facility (CCWF)	2,781	2,004	138.8	2,964
California Institution for Women (CIW)	1,798	1,398	128.6	1,877
Folsom State Prison (FOL)	434	403	107.7	530
San Quentin State Prison (SQ)	1	3,082	0.0	3,273
Female Total	**5,014**	**3,805**	**131.8**	**8,644**
Institution Total	**117,682**	**89,763**	**131.1**	**125,575**

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
July 1, 2019

Monthly Report of Population
As of Midnight June 30, 2019

Notes

- Felon/Other counts are felons, county contract boarders, federal boarders, state boarders, safekeepers, county diagnostic cases, Department of Mental Health boarders, and Division of Juvenile Justice boarders.
- Interstate Cooperative Cases are parolees from other states being supervised in California.
- Non-CDCR Jurisdiction are California cases being confined in or paroled to other states or jurisdictions.
- Welfare and Institution Code (W&IC) 1731.5(c) covers persons under the age of 21 who were committed to CDCR, had their sentence amended, and were incarcerated at the Division of Juvenile Justice for housing and program participation.
- Other Population includes inmates temporarily out-to-court, inmates in hospitals, escapees, and parolees at large.

Exhibit FF

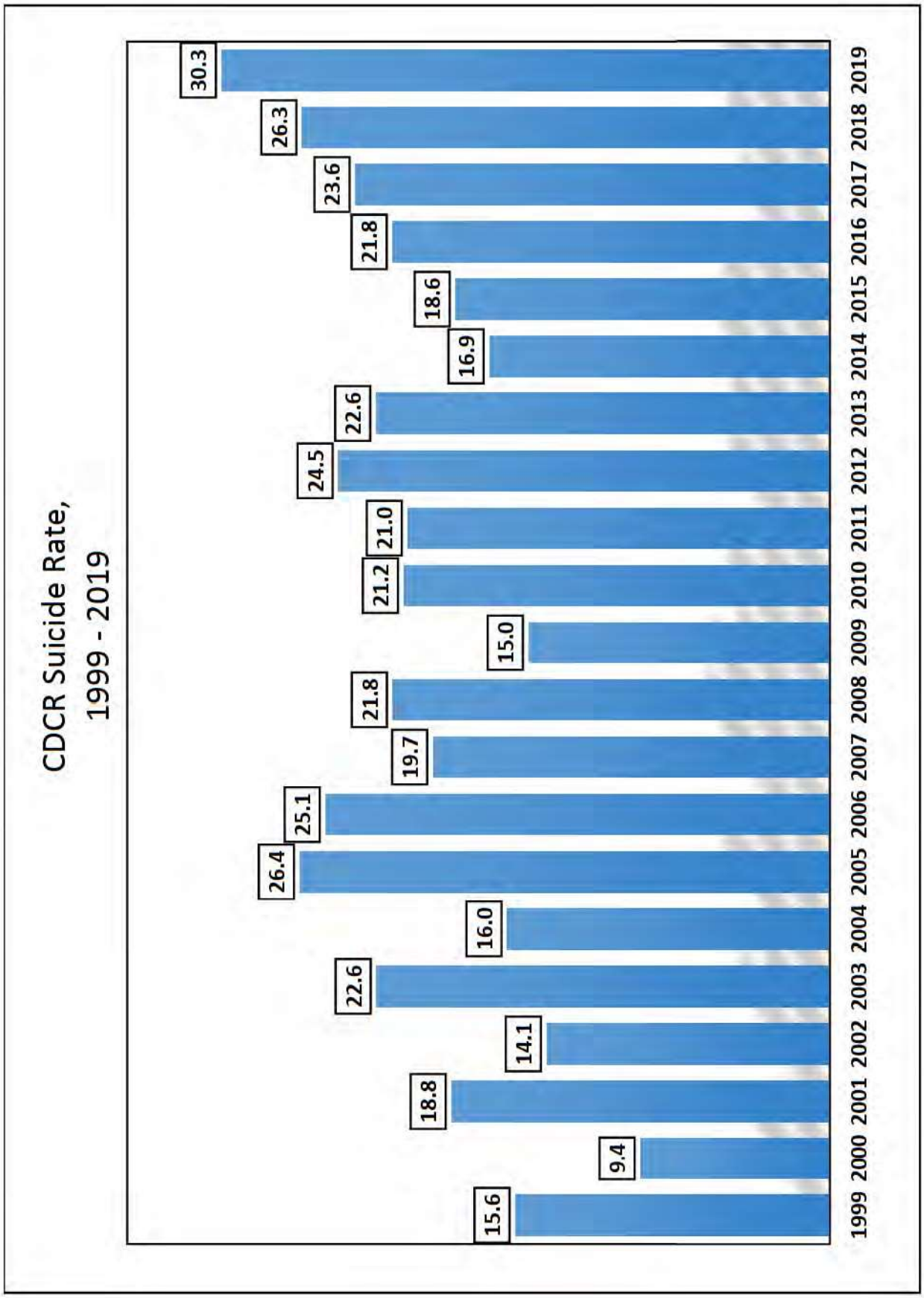

CDCR Suicide Rate,
1999 - 2019
15.6
9.4
18.8
14.1
22.6
16.0
26.4
25.1
19.7
21.8
15.0
21.2
21.0
24.5
22.6
16.9
18.6
21.8
23.6
26.3
30.3
1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019

Exhibit GG

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

Conducted per Penal Code 2064.1
October 1, 2019

Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

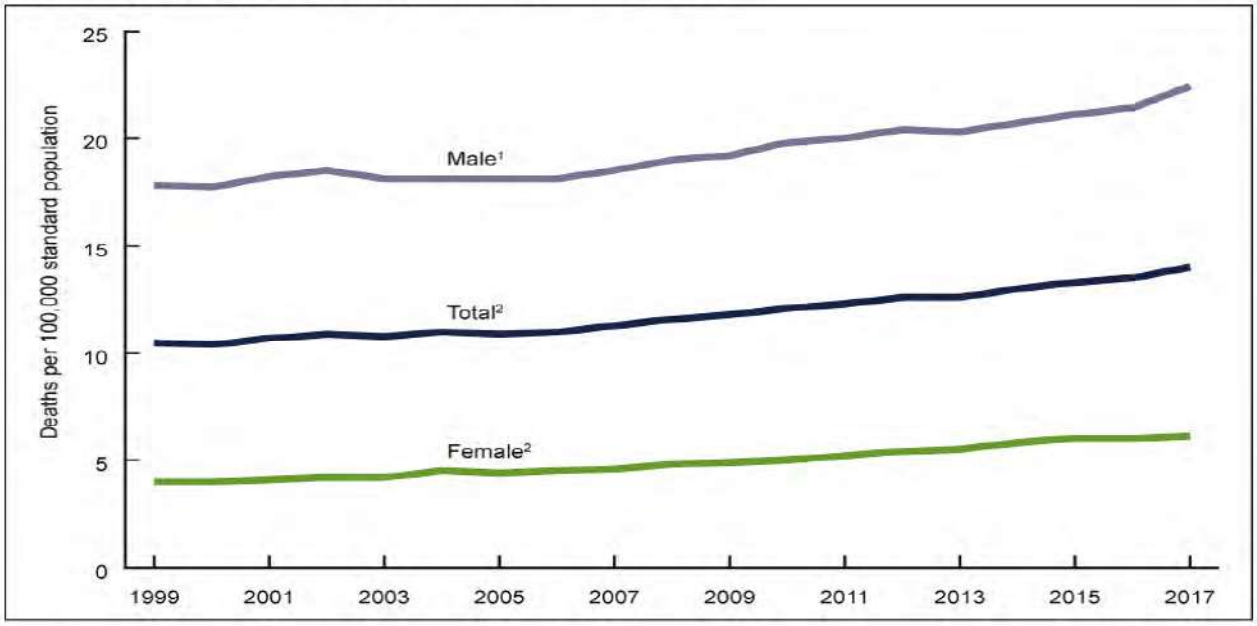
changes, many inmates report a greater feeling of hope, which is a protective factor against suicidality.

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

Introduction

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

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



¹Stable trend from 1999 through 2006; significant increasing trend from 2006 through 2017, $p < 0.001$.
²Significant increasing trend from 1999 through 2017 with different rates of change over time, $p < 0.001$.
NOTES: Suicides are identified using *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes U03, X60–X84, and Y87.0. Age-adjusted death rates were calculated using the direct method and the 2000 U.S. standard population. Access data table for Figure 1 at: https://www.cdc.gov/nchs/data/databriefs/db330_table-508.pdf#1.
SOURCE: NCHS, National Vital Statistics System, Mortality.

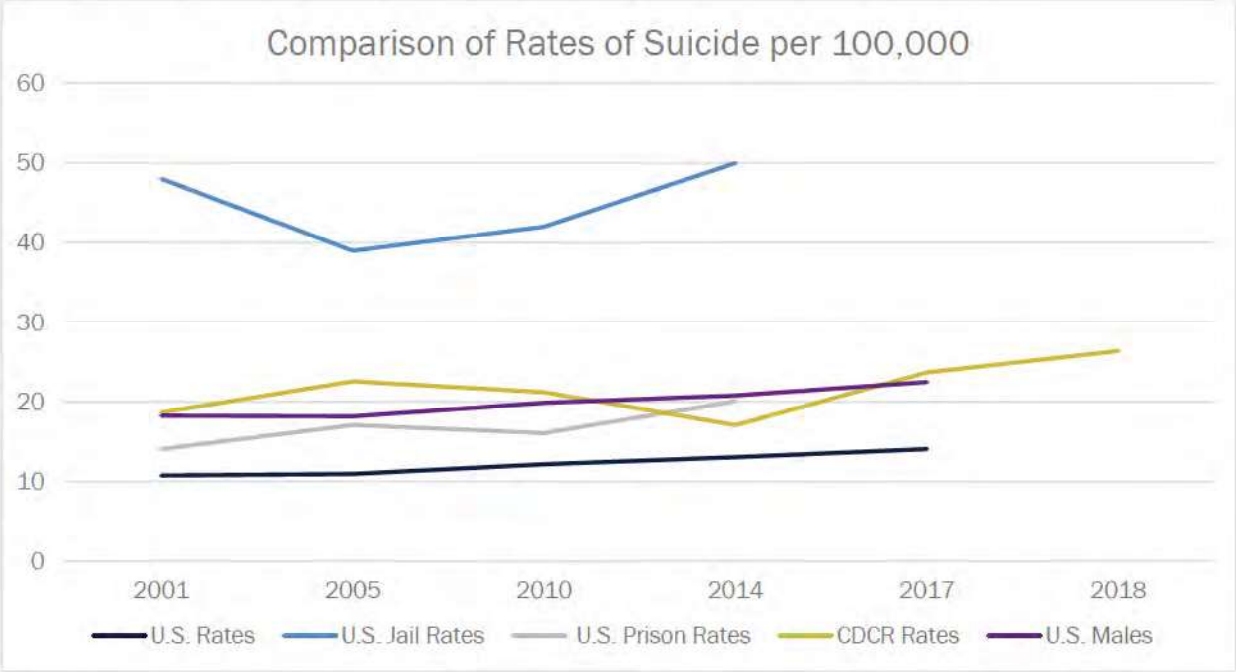
Suicide is a society-wide problem that has frustrated the efforts of federal, state, and local agencies to prevent suicides. Despite the implementation of a revised national strategy in 2012 for suicide prevention, suicide rates have continued to rise, with suicide rates increasing in most demographics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

[1]https://afsp.org/about-suicide/suicide-statistics/

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

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

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

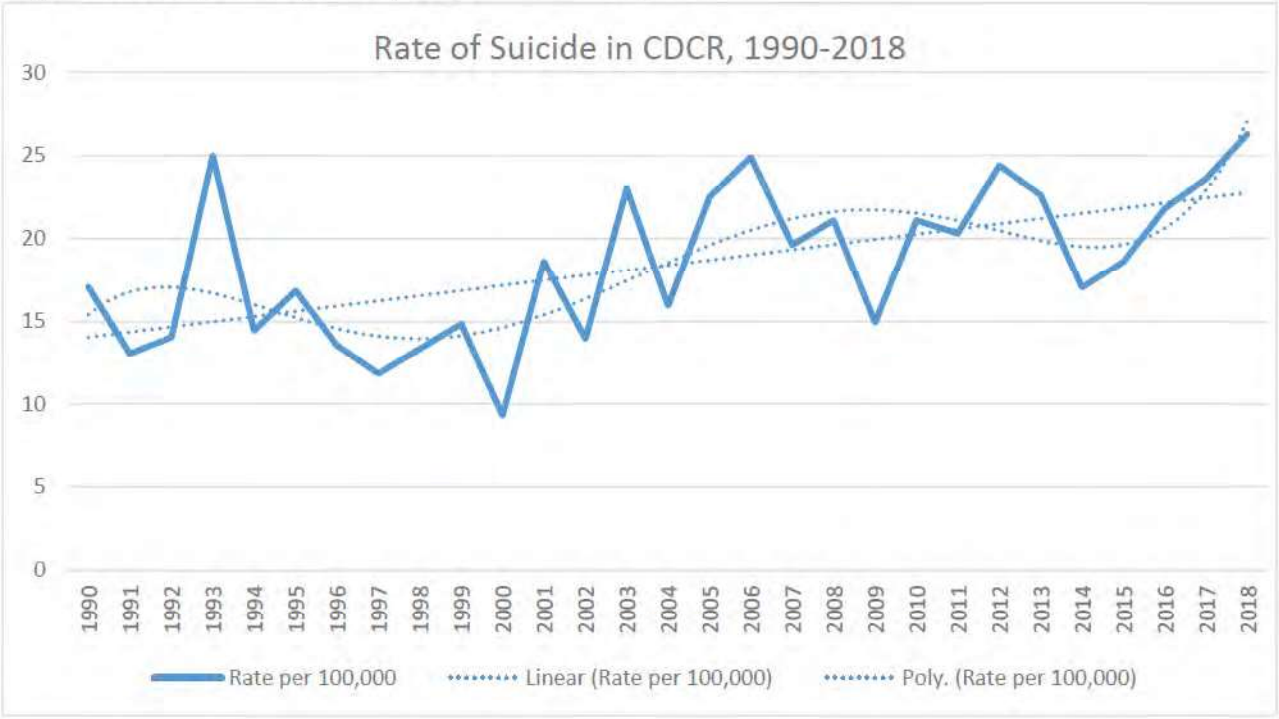


In prison systems, suicide rates are multifactorial, with contributing factors that can include medical and mental health issues, court and sentencing issues, as well as those involving family, lack of purposeful activity, conditions of the specific prison environment, and the stress of adjusting to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

[2] https://www.bjs.gov/content/pub/pdf/mlj0014st.pdf
[3] Noonan, M. *Mortality in Local Jails and State Prisons*, 2000-2013 – Statistical Tables, August 2015, Website, U.S. Department of Justice, Bureau of Justice Statistics.
[4] https://www.psychiatryadvisor.com/home/topics/suicide-and-self-harm/preventing-suicide-in-prison-inmates/

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

Figure 3: Rate of Suicide per 100,000 from 1990-2018, CDCR7



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

[5] One death in 2018 is under additional review. The outcome of the review, which will determine whether or it was a suicide vs. accidental death could impact the rate of suicides reported in this report. If determined not to be a suicide, the number of suicides for 2018 would change to 33 suicides and a suicide rate of 25.5 per 100,000.
[6] Suicide rates for large samples are standardly summarized as the number per 100,000, calculated by dividing the number of suicides by the total size of the population times 100,000. The CDCR rate of suicide uses the mid-year inclusive CDCR inmate population (in state and out-of-state totals on June 30 of each year).
[7] A linear trend line is most appropriate when data increases or decreases at a steady rate, whereas a polynomial trend line is used when data fluctuates over data or time points, as in this case.

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

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

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

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

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

SRASHE Revisions

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

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

SRASHE Audits Using the Chart Audit Tool

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

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

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

Table 1. Results of CAT SRE and/or SRASHE Audits, 2017-2019[10]

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

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

Live SRASHE Training

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

[10] 2019 data from Performance Report run 9/10/19

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

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

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

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

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

[11] MHSDS Program Guide page 12-5-11
[12] MHSDS Program Guide page 12-5-12
[13] Other IDTT Trainings currently exist, such as "IDTT: An overview of the clinical thinking and process," a 7-hour training for treatment planning for all levels of care.

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

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

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

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

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

Table 2: Results of MHCB IDTT Audits, 2018[14]

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

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

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

[15] Number of treatment plan audits for MHCB admissions in 2018; data validated via comparison of performance report on 5/23/19 and data analysis completed on 7/9/19; 2019 data run 9/10/19

[16] MHSDS Program Guide, page 12-5-12

[17] Data based on completed IDTT appointments while housed in MHCB; data run 7/9/19

Table 3. Timeliness of MHCB IDTTs, 2018

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

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

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

A number of efforts are underway to improve how training is tracked for employees of CDCR. These efforts range from granular, institution-specific generation of compliance data and tracking, with supervisors expected to ensure compliance of staff members in completing training, to broad efforts to adopt sophisticated training compliance tools using the Learning Management System (LMS). The LMS is a computer-based teaching and tracking tool that provides online training with options for offering recorded video and for requiring embedded knowledge checks.

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

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

compliance for potential first responders (custody and nursing), psychiatrists, and psychiatric nurse practitioners.[18]

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

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

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

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

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

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

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

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

Table 5. Required Suicide Prevention Training, Mental Health Staff

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

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

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

Table 6. Mental Health Staff Compliance in Required Suicide Risk Training[19]

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

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

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

[19] Data received from SMHP Mental Health Training Unit on May 9, 2019.
[20] Electronic Court Filing (ECF) 5259, Filed 1/14/15, An audit of suicide prevention practices in the prisons of CDCR; and ECF 5271, Filed February 3, 2015, ORDER regarding first Hayes audit.
[21] Electronic Document Filing (EDF) 5762, Filed January 25, 2018; ORDER regarding the second re-audit.

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

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

- Initial Health Screening and Receiving and Release Environment: Some intake forms included compound questions, making it difficult to know if a patient was, for example, expressing depression, suicidal thoughts, or both. Per recommendations by Mr. Hayes, these paper forms were modified. All CAPs in this area were completed by the end of 2018.

- Psychiatric Technician (PT) Practices: PTs at three institutions were found not to meet standards for administrative segregation rounds in 2017. CAPs were developed and the issues were not found during Mr. Hayes' 2018 audit. A process of ongoing fidelity checks of PT rounding was in place at each site under the supervision of the Chief Nursing Executives.

- Retrofitted Cells in MHCB Units: In 2018, Mr. Hayes reported that three institutions did not meet all specifications for retrofitted cells in the MHCB units. Retrofitting was completed at one institution on April 2, 2018, another on September 17, 2018, and the final unit was completed on January 31, 2019.

[22] ECF 5396, Filed 1/13/16, A re-audit and update on suicide prevention practices in the prisons of CDCR
[23] ECF 5672, Filed 9/7/17, A re-audit and update on suicide prevention practices in the prisons of CDCR
[24] ECF 5994, Filed 11/5/18, ibid

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

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

- In regards to the provision of out-of-cell activities and privileges, an instructive memorandum was released on February 14, 2017, with MHCB staff members trained on the policy. The memorandum detailed that inmates would attend out-of-cell activities consistent with their security level designation, with therapeutic recreational goals pursued, that telephone access would be given as consistent with policy, that non-contact visiting privileges would be considered whenever appropriate based on the patient's condition, and that all out-of-cell activity would be documented. Out-of-cell activities and privileges were also included as part of the CQIT auditing of MHCBs. Institutional CAPs were developed for units where improvements were not seen in 2018.

- 30-Minute Welfare Checks in Segregated Housing: Mr. Hayes recommended CAPs for any institution with a less than 90% compliance rate for 30-minute checks within segregated housing facilities. All institutions were found to meet or surpass this compliance rate in 2018.

- Suicide Risk Evaluation Trainings: In 2017, low training compliance rates were noted for mental health clinicians on the Suicide Risk Evaluation and Suicide Risk Evaluation Mentoring courses at eight audited facilities. To address this issue, all institutions were tasked with sending training compliance data to the SMHP Training Unit and with monitoring compliance within SPRFIT. Institutions who did not meet training compliance standards were instructed to develop internal CAPs. In 2018, compliance had improved in required suicide risk evaluation trainings, with only two institutions not meeting the 90% benchmark.

- Completion of Suicide Risk Assessments as Required: A number of institutions were below 90% compliance rates in their completion of suicide risk evaluations when required, such as for emergency mental health referrals or upon discharge from Alternative Housing, which is described in detail in page 19. SMHP and local SPRFIT committees began to monitor suicide risk evaluation compliance, and institutions who were out of compliance in this area developed internal CAPs. In 2018, the number of institutions who failed to meet compliance standards fell from twelve institutions to six institutions.

- Safety Planning for Suicidal Inmates: In both 2017 and 2018, Mr. Hayes noted difficulties with the quality of safety plans written within suicide risk evaluations. During discussions, CDCR and Mr. Hayes agreed to the supervisorial[26] monitoring of all safety plans written in suicide risk evaluations at the time of discharge from MHCB. The supervisory reviews were designed to ensure that MHCB

[25] Memorandum dated 6/1/2018, Reminder-Level of Observation for Patients in Mental Health Crisis Beds
[26] While MHCB program supervisors are the most likely reviewers of discharge safety plans, at times a qualified designee, such as a SPRFIT coordinator or covering Sr. Psychologist, Supervisor or Specialist may act as a reviewer.

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

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

- Identifying warning signs that indicate a crisis may be developing
- Listing internal coping strategies that can be used independently
- Listing external situations or supports that can provide distraction
- Listing people who are available sources of support
- Listing the names of staff members that can be contacted during a crisis
- Taking steps to make the environment safe (means restriction)
- Listing reminders of things that make life worth living

- MHCB and Alternative Housing Discharge and Efficacy of Custody Welfare Checks: When patients are discharged from either Alternative Housing or MHCB, custody officers in housing units must check on their welfare every half-hour for at least 24 hours. Following 24 hours, a mental health clinician must evaluate the patient and speak with the housing officers about the patient's adjustment to the unit. This process can re-occur at 24-hour intervals up to 72-hours. In both 2017 and 2018, Mr. Hayes noted problems with the documentation of 30-minute welfare checks, with such issues as clinicians discontinuing checks in less than 24 hours, custody conducting 60-minute checks instead of 30, and so forth. A CAP was developed in 2017 for all institutions not in compliance with the process or form, known as the Discharge Custody Check Sheet (CDCR 7497). These CAPs were used again in 2018 for any institution with less than 90% compliance in correct documentation. An automated report monitors the required daily follow-ups on these welfare-

[27] https://www.sciencedirect.com/science/article/pii/S1077722911000630?via%3Dihub
[28] https://www.sciencedirect.com/science/article/pii/S1551714414001013

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

- MHCB and Alternative Housing Discharge and Efficacy of Five-Day Follow-Up: When patients are discharged from either Alternative Housing or MHCB, mental health clinicians must re-evaluate the patient daily, recording their assessment on a five-day follow-up form. The form requires clinicians to ask about suicidal thoughts, signs of distress, while instructing the clinician to review MHCB discharge documents, and to review and/or revise the patient's safety plan. In 2017 and 2018, Mr. Hayes found the five-day follow-up forms completed adequately in most of the institutions he visited.

- Local SPRFITs: Mr. Hayes observed local SPRFIT meetings at institutions in 2017 and 2018, and/or reviewed the minutes from these meetings. In general, his impression was that meetings consisted of mostly quantitative reports, such as monitoring of training compliance and prevalence of self-harm incidents, with minimal discussion of qualitative elements relevant to institutional suicide prevention, or of progress on CAPs in place to remediate concerns raised by the his audits. In response, in 2018, a memorandum was issued designed to improve the structure of local SPRFITs to help them fulfill their mission.[29] Institutional SPRFIT meeting minutes are also provided to institutional and Headquarters Mental Health Quality Management Committees on an ongoing basis and an audit was revised to ensure compliance.

- Continuous Quality Improvement (CQI): CDCR, in consultation with Mr. Hayes and the *Coleman* Special Master, has agreed to monitor nineteen (19) suicide prevention audit items through a CQI process. In 2018, the Department worked with the *Coleman* Special Master on a final CQI report format. This format integrates suicide prevention audit findings with other CQI assessments, with the comprehensive group of findings detailed in a written report. The CQI tool, or CQIT, involves reviewers from multiple disciplines within each institution (e.g., custody, nursing, and mental health disciplines) to ensure that the audit is done comprehensively. A self-audit guidebook containing these items was distributed to institutions. The CQIT-SP is also undergoing revision, to include new items audited by the *Coleman* Special Master.

- Suicide Prevention Training: Mr. Hayes attended selected IST annual suicide prevention classes held within audited institutions. He opined that the course content was too large for a 2-hour class, yet missed important topics. Mr. Hayes made recommendations for course content that have been since integrated into a revised training. The revised training has been reviewed by Mr. Hayes. The training was sent to the Office of Training and Professional Development (OTPD) for review and will be implemented at institutions in early 2020. Mr. Hayes made similar observations while attending suicide prevention classes at the Training Academy at Galt, noting again the course

[29] Memorandum dated 2/2/18, "Enhancements to the Suicide Prevention and Response Focused Improvement Teams," is found in Attachment A.

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

- Reception Center Suicides: Reception centers are prisons where inmates committed to the Department are received from county jails for initial processing. When a patient arrives at the reception center, each patient shall have a thorough initial health screening completed by a licensed health care staff. The patient is screened for medical and mental health needs and is evaluated for suicidal ideation. If the patient is identified as requiring mental health services they will be referred as clinically indicated. The issue of reception center suicides was raised in 2018, due to a cluster of suicides in reception center institutions during the year. Some of the issues identified as impacting suicide prevention in reception centers included inconsistent posting of suicide prevention posters and difficulties receiving jail mental health records in a timely manner. Regional Mental Health Compliance Teams are directed to inspect reception center institutions for suicide prevention posters on a routine basis. The SHMP is drafting a memorandum providing direction to reception center mental health clinicians regarding expectations for obtaining and reviewing jail records for newly received inmates. In addition, a Transitional Help and Rehabilitations in a Violence-Free Environment (THRIVE) program is under development. The THRIVE program consists of 12 training modules created by the Division of Rehabilitative Programs for reception center inmates, with each module containing short videos and pamphlets that provide new inmates information regarding available services, how submit requests, and "what you should know" about each area. The THRIVE program is still under development.

- Use of Alternative Housing for Suicidal Inmates: A number of initiatives have been developed and implemented to reduce the time needed to move patients in crisis from their current location to MHCB; this temporary housing is called Alternative Housing. Patients housed in Alternative Housing are to be transferred to MHCB units within 24 hours, unless their referrals to MHCBs are rescinded. In 2017, Mr. Hayes commented on the location of Alternative Housing cells, stating that some types of cells were more appropriate than other types. He asked SPRFIT committees to identify appropriate Alternative Housing cells within their institutions. In response, a policy was developed to re-enforce the Mental Health Program guide requirements for prioritization of certain types of cells, with some cells listed only when all other locations have been filled. A memorandum related to SPRFIT monitoring of Alternative Housing use was also distributed in early 2018. In 2018, Mr. Hayes noted that the majority of institutions (82%) were in compliance with transfer from Alternative Housing within 24 hours, while four institutions (18%) continued to have stays that, on average, surpassed the 24 hour mark.[30] In 2019, compliance with transfer from Alternative Housing was at 99% for quarters 1 and 2.[31]

[30] In response, institutional CAPs were written at each of the four institutions.
[31] Per Performance Report run 8/21/19, Indicator "Alternative Housing Stays"

- MHCB Transfer Timelines: CDCR has initiated several statewide initiatives for oversight and improvement of timelines for transfer from Alternative Housing to MHCB. A specific Quality Management report was developed to help ensure timely transfers. Assigned headquarters staff members in the Inpatient Referral Unit send out alerts, review missed transfer timelines, and ensure institutional action plans are developed to prevent future missed timelines. Barriers to timely transfer were identified and addressed through a number of actions impacting CDCR transportation staff practices, medical clearance procedures, and improved communication between centralized population management staff members and local classification representatives at institutions. This improvement is noted in Table 7.

- Improving Transfer Timelines for Female Patients: CDCR has established an additional unlicensed MHCB facility for female inmates that has dramatically decreased the number of female patients waiting over 24 hours for transfer. This unit, located at California Institution for Women (CIW), has had the desired impact of providing additional beds and allowing for compliance with mandated transfer timelines.

- Flex Units: Flex units are designed to adjust as needed between different levels of inpatient care. Three levels of inpatient care are available to meet patient needs: Intermediate Care Facility (ICF), Acute Psychiatric Program (APP), and MHCB. The existence of flex units ensures no one inpatient program has on-going problems with wait lists or delays in admissions. Thus, these units adjust to patient needs in order to address any possible wait time issue in MHCB. As of this date, this project is anticipated to be implemented by the end of 2019.

- Referral Timeline Alerts: In 2018, the Inpatient Referral Unit implemented alert systems that warned institutional Chiefs of Mental Health of pending deadlines regarding timely transfers of patients in Alternative Housing. A specific Quality Management report was also developed to help ensure timely transfers. Barriers to timely transfer were identified and addressed through a number of improvements in CDCR transportation staff practices, medical clearance procedures, and communication between centralized population management staff members and local classification representatives at institutions. These changes were implemented in 2018, along with institutional self-monitoring strategies. Progress in meeting referral timelines by policy are noted in Table 7.

Table 7: Compliance with Timely Admissions to MHCB, 2017-2019[32]

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

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

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

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

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

[32] Data per Mental Health Performance Report, data pulled on 7/5/2019
[33] https://www.auditor.ca.gov/pdfs/reports/2016-131.pdf
[34] *Ibid*
[35] ECF 5994, Filed 11/5/18, The third re-audit and update on suicide prevention practices in the prisons of CDCR

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

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

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

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

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

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

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

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

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

[36] CCHCS Memorandum dated 11/19/2014, Over the Counter Products Test Procedure—Clarification of Accessibility.
[37] https://www.auditor.ca.gov/pdfs/reports/2016-131.pdf

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

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

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

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

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

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

- Improving the CDCR 7497 process: The CDCR 7497 records a process involving custody checks and mental health evaluation following a patient's return from a psychiatric hospitalization. This project was completed in 2018 and resulted in a 75% decrease in failed discharge custody checks from baseline measurement to post-project implementation at the California State Prison - Sacramento.

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

- Improving compliance with pre-placement screening for segregated housing intakes: A pre-placement screening form is used that includes direct questions about suicidal thoughts or behaviors. This project improved compliance rates at the California Correctional Institution (CCI) from a baseline of 75% compliance to 99% compliance by improving notification of nursing of segregated housing arrivals, adding a checklist for new placements, updating local operating procedures, and clarifying the requirement to complete the screen with nursing staff.

- Increasing timely completion of suicide risk assessment mentoring: This project took place at the California State Prison, Los Angeles County (CSP-LAC) in 2018. At baseline, the average completion time of suicide risk evaluation mentoring for new staff or staff due renewal mentoring was 332 days "to complete a cycle of proctor/mentoring." Following development of a local operating procedure, the average time for completing mentoring was reduced to 36 days.

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

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

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

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

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

[39] https://www.govtech.com/products/Californias-Prisons-Have-New-Training-Software.html

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

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

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

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

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

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

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

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

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

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

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

[43] https://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463
[44] https://cchcs.ca.gov/wp-content/uploads/sites/60/2018/04/MAT-AnnualReport-2018.pdf
[45] https://westcarecalifornia.wordpress.com/2019/01/03/a-story-by-paul-sudt-program-participant-at-sierra-conservation-center/
[46] https://www.cdcr.ca.gov/adult-operations/fops/reentry-services/

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

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

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

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

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

1. Confidentiality and patient consent issues: Contacting next of kin may be complicated by issues related to whether the inmate has completed a Release of Information (ROI), particularly if the notification is to be made by a physician or mental health clinician. Release of health information can be construed as a violation of the Health Insurance Portability and Accountability Act of 1996 if personal medical information is disclosed without the patient's consent.[48]

2. Release of Information forms: CDCR is reviewing whether the current release of information form used by the department is adequate for suicide attempts. The use of a 'blanket' ROI form may not conform to privacy laws.

3. Guidelines for self-harm incidents: The department is working on establishing guidelines and criteria that would be utilized to notify family members of a possible suicide attempt.

[47] Dear, et al., 2008. Ten years of research into self-harm in the Western Australian Prison System: Where to Next? Psychiatry, Psychology, & Law, 15 (3), 469-481.
[48] https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2013.301845

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

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

Conclusion

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

Exhibit HH

Sign In

LOCAL // CRIME

California prisons head acknowledges 'inmate suicide crisis' after reports

Jason Fagone and **Megan Cassidy**
Oct. 8, 2019 | Updated: Oct. 8, 2019 6:17 p.m.



FILE - In this Feb. 26, 2013, file photo, inmates walk through the exercise yard at California State Prison Sacramento, near Folsom, Calif. California arrest rates have dropped nearly 60 percent since 1989, yet blacks are three times more likely to be arrested than whites, according to a report released by the Public

Sign In

The number of inmates killing themselves in California prisons is "far too high," the state admitted in a new report on the worsening suicide problem in California's correctional system.

The report confirms a Chronicle investigation that revealed the inmate suicide rate in California prisons has climbed four years in a row and reached an unprecedented peak last year with 26.3 suicides per 100,000 prisoners — substantially higher than the suicide rate in other large prison systems across the country. A total of 34 California inmates killed themselves last year in a system with about 129,000 prisoners overall.

Ralph Diaz, the state's top prison official, acknowledged in an interview Monday that California has "an inmate suicide crisis."

"Staff do care, and staff are trying to work to try and get ahead of these suicides — try to figure out why they're occurring," said Diaz, secretary of the California Department of Corrections and Rehabilitation.

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Suicides in California prisons haven't been this frequent since 1990, when the state first began tracking the deaths. Previously, the department had only released data stretching back to 2006.

This month's report — mandated by a 2018 state law — is the first of its kind, and it forces prison officials to share information about the suicide problem and explain how they are trying to fix it.

State correctional officials argue in the 34-page report that they have made significant reforms since 1990, when the department had "no formal suicide prevention program whatsoever and mental health services were available only at a handful of institutions."

In 1995, a federal court decided that poor mental care in California prisons endangered inmates and violated their constitutional rights. The court stepped in and forced changes, and since the 1990s, corrections officials say, the state has spent tens of millions of dollars creating "a robust suicide prevention program" and "a comprehensive system of quality mental health care for inmates that few other state correctional systems can boast of."

The federal case — now known as Coleman vs. Newsom — remains active and the court regularly dispatches psychiatric expert Lindsay Hayes to inspect state prisons, analyze their suicide-prevention programs and make recommendations. Diaz told The Chronicle that many of California's estimated 38,000 inmates who participate in mental health programs are being successfully treated.

Yet federal judges, state politicians and experts in the Coleman case have long disagreed, sounding the alarm about the elevated suicide rate, documenting staff's repeated failures in following their own suicide-prevention policies and questioning the commitment of prison leaders to make meaningful progress.

Last November, after performing his latest audit of state prisons, Hayes wrote that while the California system was making "continued progress at varied speeds" in

Sign In

fixing its approach to suicide prevention, "certain problematic practices continued to fester."

As recently as July, a federal district judge presiding over the Coleman case, Kimberly J. Mueller, wrote that the state was delaying important fixes ordered by the court.

"While some progress is being made," she wrote, "a substantial amount of work remains, and implementation is dragging out and taking too long."

The state's new report emphasizes that suicide is rising in the general United States population — the national rate climbed by a third between 1999 and 2017 — and that many prison systems, from federal to state to local, are struggling to stop inmates from killing themselves. Last year in Texas, for example, 40 inmates killed themselves in state prisons, the highest number in 20 years, according to the Houston Chronicle.

However, critics of the analysis say California prison officials left out key facts about the inmate suicide crisis here.

Michael Bien, an attorney who represents a class of 30,000 state prisoners with mental illness, said the state's new report gives a "misleading or deceptive picture" of the suicide problem, exaggerating the state's progress and minimizing its failures.

"It's still a system in crisis, and my clients are still very much at risk," Bien said.

The report glosses over California's record on inmate suicides and how it compares poorly to other large prison systems. The 2018 rate of 26.3 suicides per 100,000 inmates is higher than the last recorded national average for state prisons (20 suicides) and the federal rate (about 15). Although the federal prison system is larger than California's, only half as many people killed themselves in federal prisons between 2001 and 2014, according to the Bureau of Justice Statistics. The federal system counted 222 inmate suicides in that period, while California had 448.

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"The State of California has consistently led the nation in the number of suicide deaths in its prisons by a large margin," a court-appointed psychiatrist in the Coleman case wrote in 2013.

Coleman psychiatrists have discovered numerous lapses in mental care and suicide-prevention practices by California prison staff, contributing to "either foreseeable or preventable" inmate deaths.

The state report also does not mention the ongoing shortfall of psychiatrists to treat mentally ill prisoners. The system has only 72% of the psychiatrists it needs, according to the state's own tally.

"Staffing is one of our top priorities," Diaz said, "but we're operating against the background where there's an acute nationwide shortage of psychiatrists. And it is getting worse every year."

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Exhibit II

U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Statistics

February 2020, NCJ 251920

Mortality in State and Federal Prisons, 2001-2016 – Statistical Tables

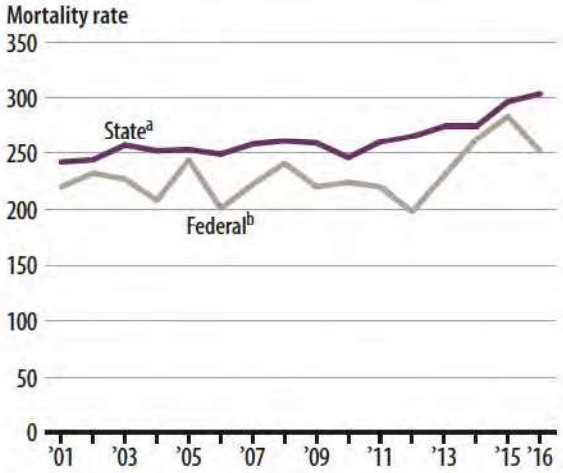
E. Ann Carson, Ph.D., *BJS Statistician*
Mary P. Cowhig, *former BJS Statistician*

In 2016, a total of 4,117 state and federal prisoners died in publicly or privately operated prisons. The number of deaths in state prisons rose 1.3% from 2015 to 2016 (from 3,682 to 3,729), while the number of deaths in federal prisons fell 15% (from 455 to 388). This marked the first decrease in deaths in federal prisons since 2012.

While the total number of state prisoners dropped 5% from 2006 to 2016, the number of deaths in state prisons rose 15% over that same period. Each year from 2001 to 2016, an average of 88% of deaths in state prisons were due to natural causes, ranging from 89% in 2001 to 86% in 2016. Over that same span, an average of 11% of deaths in state prisons were due to unnatural causes (suicide, drug or alcohol intoxication, accidental causes, or homicide), ranging from 9% in 2001 and 2008 to 13% in 2016.

Mortality rates, or the annual number of deaths per 100,000 prisoners, dropped from 2001 to 2016 for all four age groups of state prisoners

FIGURE 1
Mortality rate per 100,000 state and federal prisoners, 2001-2016



Note: Based on the annual number of deaths and the one-day custody population on December 31. See appendix table 9 for rates.
[a]Includes deaths in private state facilities.
[b]Excludes deaths in private federal facilities.
Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001-2016; and Federal Bureau of Prisons, 2001-2016.

Highlights

- From 2015 to 2016, deaths in state prisons increased from 296 to 303 deaths per 100,000 state prisoners.
- From 2015 to 2016, deaths in federal prisons decreased for the first time since 2012, from 283 to 252 deaths per 100,000 federal prisoners.
- Illness-related deaths made up 86% of deaths in state prisons in 2016, with more than half of those being due to cancer (30% of all deaths) or heart disease (28%).
- Homicide deaths, which include deaths due to injuries sustained before imprisonment, accounted for 2.5% of deaths in state prisons and 3.6% of deaths in federal prisons in 2016.
- More than half of all deaths in state prisons in 2016 (55%) were of white prisoners, who made up less than one-third (31%) of the state prison population.
- From 2001 to 2016, mortality rates dropped for all four age groups of state prisoners age 25 or older; however, the portion of prisoners age 55 or older tripled, and they have the highest mortality rates.

Bureau of Justice Statistics • **Statistical Tables**

BJS 40 YEARS OF STATISTICS

age 25 or older (25-34, 35-44, 45-54, and 55 or older). However, the portion of state prisoners who were age 55 or older roughly tripled from 2001 to 2016 (from 4% to 12%), and that subpopulation had the highest mortality rate (more than three times as high as any other age group in each year).

Suicides represented an average of 6% of deaths in state prisons from 2001 to 2016, ranging from 5.5% to 7.1% per year (6.8% in 2016).

Findings in this report are from the Mortality in Correctional Institutions (MCI) data collection (formerly the Deaths in Custody Reporting Program), developed by the Bureau of Justice Statistics (BJS). The MCI is the only national statistical collection that obtains comprehensive information about deaths among prisoners and jail inmates in the custody of adult correctional facilities. This report reviews deaths in state and federal prisons from 2001 to 2016. Until 2015, BJS received aggregated mortality data from the Federal Bureau of Prisons (BOP). In 2015, BJS began receiving individual-level data on deaths from the BOP.

Data on mortality in local jails can be found in *Mortality in Local Jails, 2000-2016 – Statistical Tables* (NCJ 251921, BJS, February 2020).

Other key findings

- A total of 59,036 prisoners died in state and federal prisons from 2001 to 2016, with about 90% of the deaths occurring in state prisons (53,051) and 10% occurring in federal prisons (5,985) **(table 1)**.
- A total of 255 state prisoners committed suicide in 2016, marking a 16-year peak in the number of suicides **(table 2)**.
- From 2015 to 2016, suicides increased from 5.9% to 6.8% of all deaths in state prisons, down from 7.1% in 2014 **(table 3)**.
- In 2016, 96% of those who died in state prisons were male (3,586) and 4% were female (143) **(tables 6 and 7)**.
- The annual average rate of suicides from 2001 to 2016 was 17 deaths per 100,000 male state prisoners and 13 deaths per 100,000 female state prisoners **(table 10)**.
- On average from 2001 to 2016, male state prisoners died from cancer, heart disease, or liver disease at about twice the rate of females **(table 10)**.
- From 2001 to 2016, eight states (Texas, California, Florida, Pennsylvania, New York, Michigan, Ohio, and Georgia) accounted for more than half of all deaths in state prisons (27,204 of 53,051), with Texas (6,628) and California (5,796) accounting for 23% of all deaths **(table 13)**.

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TABLE 1
State and federal prisoner deaths, by cause of death, 2001-2016

Cause of death	State prisoners[a] Number of deaths	State prisoners[a] Percent of deaths	State prisoners[a] Mortality rate per 100,000	Federal prisoners[b] Number of deaths	Federal prisoners[b] Percent of deaths	Federal prisoners[b] Mortality rate per 100,000
All causes	53,051	100%	262	5,985	100%	230
Illness	46,824	88.3%	231	5,441	90.9%	209
Cancer	14,525	27.4	72	...	...	...
Heart disease	13,695	25.8	68	...	...	...
Liver disease	4,940	9.3	24	...	...	...
Respiratory disease	3,315	6.2	16	...	...	...
AIDS-related[c]	1,873	3.5	9	161	2.7	6
All other illnesses[d]	8,476	16.0	42	...	...	...
Suicide	3,300	6.2%	16	260	4.3%	10
Drug/alcohol intoxication	781	1.5%	4	...	...	...
Accident[e]	530	1.0%	3	81	1.4%	3
Homicide[f]	1,024	1.9%	5	160	2.7%	6
Other causes	345	0.7%	2	0	0.0%	0
Missing/unknown	247	0.5%	1	43	0.7%	2

Note: Data may have been revised from previously published statistics. Details may not sum to totals due to rounding. Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). See *Methodology*.

...Not available.

[a]Includes deaths in private state facilities.

[b]Data on cause of death for federal prisoners were not available for all causes. Excludes deaths in private federal facilities.

[c]Includes persons who died of illness and were identified as HIV-positive or having AIDS at the time of death.

[d]Includes other specified illnesses (such as cerebrovascular disease, influenza, and other non-leading natural causes of death) and unspecified illnesses.

[e]Includes deaths by intoxication among federal prisoners.

[f]Includes homicides committed by other prisoners, incidental to the use of force by staff, and resulting from injuries sustained prior to incarceration.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001-2016; and Federal Bureau of Prisons, 2001-2016.

TABLE 2
Number of state and federal prisoner deaths, by cause of death, 2001 and 2006-2016

Cause of death	2001	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	3,170	3,561	3,757	3,851	3,793	3,620	3,738	3,707	3,879	3,927	4,137	4,117
Federal[a]	301	328	368	399	376	387	387	350	400	444	455	388
State[b]	2,869	3,233	3,389	3,452	3,417	3,233	3,351	3,357	3,479	3,483	3,682	3,729
Illness	2,567	2,830	2,980	3,036	3,029	2,869	2,980	2,959	3,082	3,031	3,225	3,191
Cancer	691	806	772	907	978	927	1,028	1,024	1,066	1,046	1,122	1,128
Heart disease	743	854	840	845	848	830	854	804	897	890	985	1,025
Liver disease	307	303	316	318	332	288	339	304	355	313	301	260
Respiratory disease	147	193	207	251	200	211	205	223	198	238	242	222
AIDS-related[c]	275	132	120	99	98	73	57	74	52	64	45	31
All other illnesses[d]	404	542	725	616	573	540	497	530	514	480	530	525
Suicide	168	219	215	197	202	215	185	205	192	249	219	255
Drug/alcohol intoxication	35	56	41	58	50	40	58	33	56	50	81	104
Accident	22	32	28	26	32	32	38	50	34	39	39	41
Homicide[e]	39	55	57	40	54	70	70	85	90	83	84	95
Other causes	0	41	16	95	16	4	11	14	18	10	20	22
Missing/unknown	38	0	52	0	34	3	9	11	7	21	14	21

Note: Data may have been revised from previously published statistics. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). See *Methodology*. For data from 2002 to 2006, see the *Mortality in Correctional Institutions* page on the BJS website.

[a]Until 2015, federal deaths were submitted as an aggregate count by the Federal Bureau of Prisons. Excludes deaths in private federal facilities.

[b]Includes deaths in private state facilities.

[c]Includes persons who died of illness and were identified as HIV-positive or having AIDS at the time of death.

[d]Includes other specified illnesses (such as cerebrovascular disease, influenza, and other non-leading natural causes of death) and unspecified illnesses.

[e]Includes homicides committed by other prisoners, incidental to the use of force by staff, and resulting from injuries sustained prior to incarceration.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001 and 2006-2016; and Federal Bureau of Prisons, 2001 and 2006-2016.

TABLE 3

Percent of state prisoner deaths, by cause of death, 2001 and 2006-2016

Cause of death	2001	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
All causes	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Illness	89.5%	87.5%	87.9%	87.9%	88.6%	88.7%	88.9%	88.1%	88.6%	87.0%	87.6%	85.6%
Cancer	24.1	24.9	22.8	26.3	28.6	28.7	30.7	30.5	30.6	30.0	30.5	30.2
Heart disease	25.9	26.4	24.8	24.5	24.8	25.7	25.5	23.9	25.8	25.6	26.8	27.5
Liver disease	10.7	9.4	9.3	9.2	9.7	8.9	10.1	9.1	10.2	9.0	8.2	7.0
Respiratory disease	5.1	6.0	6.1	7.3	5.9	6.5	6.1	6.6	5.7	6.8	6.6	6.0
AIDS-related[a]	9.6	4.1	3.5	2.9	2.9	2.3	1.7	2.2	1.5	1.8	1.2	0.8
All other illnesses[b]	14.1	16.8	21.4	17.8	16.8	16.7	14.8	15.8	14.8	13.8	14.4	14.1
Suicide	5.9%	6.8%	6.3%	5.7%	5.9%	6.7%	5.5%	6.1%	5.5%	7.1%	5.9%	6.8%
Drug/alcohol intoxication	1.2%	1.7%	1.2%	1.7%	1.5%	1.2%	1.7%	1.0%	1.6%	1.4%	2.2%	2.8%
Accident	0.8%	1.0%	0.8%	0.8%	0.9%	1.0%	1.1%	1.5%	1.0%	1.1%	1.1%	1.1%
Homicide[c]	1.4%	1.7%	1.7%	1.2%	1.6%	2.2%	2.1%	2.5%	2.6%	2.4%	2.3%	2.5%
Other causes	0.0%	1.3%	0.5%	2.8%	0.5%	0.1%	0.3%	0.4%	0.5%	0.3%	0.5%	0.6%
Missing/unknown	1.3%	0.0%	1.5%	0.0%	1.0%	0.1%	0.3%	0.3%	0.2%	0.6%	0.4%	0.6%

Note: Data may have been revised from previously published statistics. Details may not sum to totals due to rounding. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). See *Methodology*. Includes deaths in private state facilities. For data from 2002 to 2006, see the *Mortality in Correctional Institutions* page on the BJS website.

[a]Includes persons who died of illness and were identified as HIV-positive or having AIDS at the time of death.

[b]Includes other specified illnesses (such as cerebrovascular disease, influenza, and other non-leading natural causes of death) and unspecified illnesses.

[c]Includes homicides committed by other prisoners, incidental to the use of force by staff, and resulting from injuries sustained prior to incarceration.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001 and 2006-2016.

TABLE 4

Mortality rate per 100,000 state prisoners, by cause of death, 2001 and 2006-2016

Cause of death	2001	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
All causes	242	249	258	261	259	246	260	265	274	274	296	303
Illness	217	218	226	229	230	218	231	234	243	239	259	260
Cancer	58	62	59	68	74	71	80	81	84	82	90	92
Heart disease	63	66	64	64	64	63	66	63	71	70	79	83
Liver disease	26	23	24	24	25	22	26	24	28	25	24	21
Respiratory disease	12	15	16	19	15	16	16	18	16	19	19	18
AIDS-related[a]	23	10	9	7	7	6	4	6	4	5	4	3
All other illnesses[b]	34	42	55	47	43	41	39	42	40	38	43	43
Suicide	14	17	16	15	15	16	14	16	15	20	18	21
Drug/alcohol intoxication	3	4	3	4	4	3	4	3	4	4	7	8
Accident	2	2	2	2	2	2	3	4	3	3	3	3
Homicide[c]	3	4	4	3	4	5	5	7	7	7	7	8
Other causes	0	3	1	7	1	<1 !	1 !	1	1	1 !	2	2
Missing/unknown	3	0	4	0	3	<1 !	1 !	1 !	1 !	2	1	2

Note: Data may have been revised from previously published statistics. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. See *Methodology*. Includes deaths in private state facilities. For data from 2002 to 2006, see the *Mortality in Correctional Institutions* page on the BJS website.

! Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.

[a]Includes persons who died of illness and were identified as HIV-positive or having AIDS at the time of death.

[b]Includes other specified illnesses (such as cerebrovascular disease, influenza, and other non-leading natural causes of death) and unspecified illnesses.

[c]Includes homicides committed by other prisoners, incidental to the use of force by staff, and resulting from injuries sustained prior to incarceration.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001 and 2006-2016; National Prisoner Statistics, 2001 and 2006-2016.

TABLE 5

Mortality rate per 100,000 federal prisoners, by cause of death, 2001 and 2006-2016

Cause of death	2001	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
All causes	220	328	222	241	220	224	220	198	230	262	283	252
Illness	196	294	195	217	198	203	204	182	213	238	249	220
AIDS-related[a]	16	12	6!	8	4!	4!	2!	3!	2!	0	1!	1!
Suicide	13	12	11	13	12	6!	10	11	8	14	12	12
Accident[b]	4!	2!	0	4!	3!	1!	1!	2!	2!	1!	10	9
Homicide	6!	8!	7	8	4!	10	5!	3!	7	8	10	9
Other/unknown	0	0	9	1!	4!	3!	1!	1!	1!	0	2!	2!

Note: Until 2015, federal deaths were submitted as aggregate counts by the Federal Bureau of Prisons, with limited details regarding cause of death. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. Excludes deaths in private federal facilities. For data from 2002 to 2006, see the *Mortality in Correctional Institutions* page on the BJS website.

! Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.

[a]Includes persons who died of illness and were identified as HIV-positive or having AIDS at the time of death.

[b]Includes deaths due to drug or alcohol intoxication.

Source: Bureau of Justice Statistics, Federal Bureau of Prisons, 2001 and 2006-2016; and National Prisoner Statistics, 2001 and 2006-2016.

TABLE 6

Number of state prisoner deaths, by decedent characteristics, 2001 and 2006-2016

Characteristic	2001	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	2,869	3,233	3,389	3,452	3,417	3,233	3,351	3,357	3,479	3,483	3,682	3,729
Sex												
Male	2,769	3,103	3,252	3,289	3,267	3,116	3,208	3,244	3,338	3,329	3,533	3,586
Female	100	130	137	163	150	117	143	113	141	154	149	143
Race/ethnicity												
White[a]	1,340	1,627	1,719	1,822	1,774	1,680	1,912	1,789	1,902	1,920	2,040	2,063
Black[a]	1,161	1,148	1,225	1,157	1,199	1,121	1,037	1,113	1,104	1,108	1,189	1,200
Hispanic	322	404	383	400	372	359	329	379	402	368	367	383
Other[a,b]	41	50	54	73	58	61	61	70	70	87	84	80
Age												
17 or younger	2	1	1	3	0	3	2	0	0	2	0	1
18-24	86	60	68	67	69	69	50	69	69	56	68	72
25-34	256	250	226	222	210	217	200	190	221	221	226	244
35-44	656	561	513	468	467	382	397	360	335	335	341	380
45-54	893	1,061	1,031	1,063	1,039	956	930	876	861	821	795	721
55 or older	972	1,300	1,550	1,629	1,631	1,606	1,771	1,862	1,993	2,048	2,251	2,297

Note: Data may have been revised from previously published statistics. Details may not sum to totals due to missing data. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). Includes deaths in private state facilities. For data from 2002 to 2006, see the *Mortality in Correctional Institutions* page on the BJS website.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001 and 2006-2016.

TABLE 7

Percent of state prisoner deaths, by decedent characteristics, 2001 and 2006-2016

Characteristic	2001	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sex												
Male	96.5%	96.0%	96.0%	95.3%	95.6%	96.4%	95.7%	96.6%	95.9%	95.6%	96.0%	96.2%
Female	3.5	4.0	4.0	4.7	4.4	3.6	4.3	3.4	4.1	4.4	4.0	3.8
Race/ethnicity												
White[a]	46.7%	50.4%	50.7%	52.8%	51.9%	52.0%	57.1%	53.3%	54.7%	55.1%	55.4%	55.3%
Black[a]	40.5	35.6	36.1	33.5	35.1	34.7	30.9	33.2	31.7	31.8	32.3	32.2
Hispanic	11.2	12.5	11.3	11.6	10.9	11.1	9.8	11.3	11.6	10.6	10.0	10.3
Other[a,b]	1.4	1.5	1.6	2.1	1.7	1.9	1.8	2.1	2.0	2.5	2.3	2.1
Age												
17 or younger	0.1%	<0.1%	<0.1%	0.1%	0.0%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%	<0.1%
18-24	3.0	1.9	2.0	1.9	2.0	2.1	1.5	2.1	2.0	1.6	1.8	1.9
25-34	8.9	7.7	6.7	6.4	6.2	6.7	6.0	5.7	6.4	6.4	6.1	6.5
35-44	22.9	17.4	15.1	13.6	13.7	11.8	11.8	10.7	9.6	9.6	9.3	10.2
45-54	31.1	32.8	30.4	30.8	30.4	29.6	27.8	26.1	24.7	23.6	21.6	19.3
55 or older	33.9	40.2	45.7	47.2	47.7	49.7	52.9	55.5	57.3	58.8	61.1	61.6

Note: Data may have been revised from previously published statistics. Details may not sum to totals due to missing data. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). Includes deaths in private state facilities. For data from 2002 to 2006, see the *Mortality in Correctional Institutions* page on the BJS website.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001 and 2006-2016.

TABLE 8

Mortality rate per 100,000 state prisoners within each demographic group, by decedent characteristics, 2001 and 2006-2016

Characteristic	2001	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	242	244	258	261	259	246	260	265	274	274	296	303
Sex												
Male	250	251	266	267	266	255	267	275	283	282	306	315
Female	131	151	146	173	163	128	160	131	159	171	167	161
Race/ethnicity												
White[a]	345	323	389	413	412	396	461	439	468	473	515	535
Black[a]	234	219	244	230	243	233	222	245	246	254	282	293
Hispanic	139	200	138	147	134	129	121	145	153	141	142	144
Other[a,b]	59	151	57	67	49	47	45	49	45	53	50	48
Age												
17 or younger	68 !	33 !	41 !	115 !	0	140 !	111 !	0	0	206 !	0	120 !
18-24	39	29	35	34	35	35	26	38	40	35	47	53
25-34	64	62	52	51	48	50	47	46	53	53	55	61
35-44	181	182	140	131	136	114	123	113	105	104	106	118
45-54	584	554	444	442	427	389	384	368	364	349	347	321
55 or older	2,032	2,004	1,927	1,859	1,737	1,580	1,632	1,615	1,619	1,563	1,619	1,578

Note: Data may have been revised from previously published statistics. Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. See *Methodology*. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). Includes deaths in private state facilities. For data from 2002 to 2006, see the *Mortality in Correctional Institutions* page on the BJS website.

! Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001 and 2006-2016; National Prisoner Statistics, 2001 and 2006-2016; Survey of Inmates in State Correctional Facilities, 2004; and Survey of Prison Inmates, 2016.

TABLE 9
Number of deaths in state prisons, by cause of death and decedent characteristics, 2001-2016

		Illness									
Characteristic	All causes[a]	Cancer	Heart disease	Liver disease	Respiratory disease	AIDS-related[b]	All other illnesses[c]	Suicide	Drug/alcohol intoxication	Accident	Homicide[d]
Total	53,051	14,525	13,695	4,940	3,315	1,873	8,476	3,300	781	530	1,024
Sex											
Male	50,885	13,976	13,235	4,768	3,149	1,779	8,017	3,120	747	513	1,017
Female	2,165	549	460	172	166	94	459	180	34	17	7
Race/ethnicity											
White[e]	27,748	7,988	7,300	2,746	1,886	417	3,980	1,951	436	299	462
Black[e]	18,454	5,069	5,113	1,113	1,073	1,240	3,268	672	148	149	359
Hispanic	5,764	1,220	1,065	949	306	196	1,063	522	161	67	172
Other[e,f]	997	224	203	123	45	19	150	142	36	14	29
Age											
17 or younger	21	3	2	1	1	0	1	11	0	1	1
18-24	1,081	66	132	13	62	19	133	425	53	38	121
25-34	3,706	341	626	81	190	238	493	1,059	212	95	283
35-44	7,740	1,294	1,800	602	367	734	1,229	930	265	131	276
45-54	14,907	4,097	3,505	2,234	715	639	2,464	607	184	115	200
55 or older	25,568	8,719	7,626	2,006	1,979	243	4,153	266	67	149	141

Note: Data may have been revised from previously published statistics. Details may not sum to totals due to missing data. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). See *Methodology*. Includes deaths in private state facilities. There were 88 prisoners whose race/ethnicity was unknown, 28 whose age was unknown, and 1 whose sex was unknown.

[a]Includes other causes not specified and missing and unknown causes.

[b]Includes persons who died of illness and were identified as HIV-positive or having AIDS at the time of death.

[c]Includes other specified illnesses (such as cerebrovascular disease, influenza, and other non-leading natural causes of death) and unspecified illnesses.

[d]Includes homicides committed by other prisoners, incidental to the use of force by staff, and resulting from injuries sustained prior to incarceration.

[e]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[f]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001-2016.

TABLE 10

Average annual mortality rate per 100,000 state prisoners within each demographic group, by cause of death and decedent characteristics, 2001-2016

		Illness									
Characteristic	All causes[a]	Cancer	Heart disease	Liver disease	Respiratory disease	AIDS-related[b]	All other illnesses[c]	Suicide	Drug/alcohol intoxication	Accident	Homicide[d]
Total	262	72	68	24	16	9	42	16	4	3	5
Sex											
Male	270	74	70	25	17	9	43	17	4	3	5
Female	154	39	33	12	12	7	33	13	2	1	<1 !
Race/ethnicity											
White[e]	416	120	109	41	28	6	60	29	7	4	7
Black[e]	243	67	67	15	14	16	43	9	2	2	5
Hispanic	138	29	25	23	7	5	25	12	4	2	4
Other[e,f]	54	12	11	7	2	1	8	8	2	1	2
Age											
17 or younger	66	9 !	6 !	3 !	3 !	0	3 !	35 !	0	3 !	3 !
18-24	36	2	4	<1	2	1	4	14	2	1	4
25-34	55	5	9	1	3	4	7	16	3	1	4
35-44	140	23	33	11	7	13	22	17	5	2	5
45-54	429	118	101	64	21	18	71	17	5	3	6
55 or older	1,722	587	514	135	133	16	280	18	5	10	9

Note: Data may have been revised from previously published statistics. Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). See *Methodology*. Includes deaths in private state facilities.

! Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.

[a]Includes other causes not specified and missing and unknown causes.

[b]Includes persons who died of illness and were identified as HIV-positive or having AIDS at the time of death.

[c]Includes other specified illnesses (such as cerebrovascular disease, influenza, and other non-leading natural causes of death) and unspecified illnesses.

[d]Includes homicides committed by other prisoners, incidental to the use of force by staff, and resulting from injuries sustained prior to incarceration.

[e]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[f]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001-2016; National Inmate Survey, 2007-2009, 2011, and 2012; National Prisoner Statistics, 2001-2016; Survey of Inmates in State Correctional Facilities, 2004; and Survey of Prison Inmates, 2016.

TABLE 11

Number of prisoner deaths in state and federal facilities, 2001 and 2006-2016

State/Federal	2001	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Federal[a]	301	328	368	399	376	387	387	350	400	444	455	388
State[b]	2,869	3,233	3,389	3,452	3,417	3,233	3,351	3,357	3,479	3,483	3,682	3,729
Alabama	87	61	54	75	80	66	104	86	107	102	112	118
Alaska[c]	8	6	10	14	7	13	12	11	8	12	15	10
Arizona	64	72	61	77	85	85	86	87	95	99	105	126
Arkansas	42	37	46	41	50	54	50	43	56	57	54	71
California	287	424	395	371	395	414	388	368	366	317	353	334
Colorado	42	31	42	38	49	48	37	48	40	35	51	57
Connecticut[d]	30	25	27	32	29	21	19	24	20	24	23	17
Delaware[d]	16	13	15	15	12	23	15	10	14	18	17	14
Florida	182	261	249	291	278	275	297	324	305	346	354	356
Georgia	93	103	143	128	125	112	121	103	122	120	130	132
Hawaii[d]	7	5	13	14	11	12	6	12	14	8	4	9
Idaho	17	18	14	18	13	13	13	9	10	23	18	16
Illinois	86	94	104	71	75	94	97	85	78	88	120	90
Indiana	46	70	54	70	91	69	74	59	66	70	85	70
Iowa	9	12	17	21	14	13	12	20	16	15	19	29
Kansas	21	16	20	24	20	22	25	17	28	21	25	35
Kentucky	36	46	46	68	57	42	60	55	40	44	60	42
Louisiana	71	72	82	117	108	100	108	116	118	118	113	123
Maine	6	6	1	2	4	3	5	2	3	7	5	5
Maryland	70	61	57	69	56	40	41	46	58	43	62	49
Massachusetts	29	39	39	29	29	39	33	42	39	45	34	34
Michigan	114	138	117	99	148	93	119	124	124	121	118	106
Minnesota	13	9	13	17	12	16	19	14	20	14	11	18
Mississippi	36	58	77	54	52	52	47	41	68	50	45	65
Missouri	57	66	78	87	81	88	74	71	92	97	106	99
Montana	6	5	5	9	3	2	6	11	7	19	13	16
Nebraska	7	8	12	6	11	12	17	11	16	13	17	9
Nevada	27	23	39	35	35	41	34	37	35	44	47	43
New Hampshire	2	6	6	5	9	4	10	5	8	5	8	9
New Jersey	69	70	60	66	58	56	66	48	46	50	52	49
New Mexico	11	13	22	29	21	16	16	14	17	24	19	16
New York	175	131	148	133	142	124	117	115	142	123	115	147
North Carolina	66	90	99	117	86	87	71	79	81	94	90	127
North Dakota	3	1	0	0	0	1	1	3	1	0	0	4
Ohio	115	106	123	101	120	116	111	126	124	111	138	133
Oklahoma	51	80	98	88	79	60	85	79	87	107	107	93
Oregon	24	40	36	31	34	39	40	26	30	31	37	47
Pennsylvania	122	124	150	145	165	141	157	157	157	145	167	171
Rhode Island[d]	3	8	9	6	7	7	10	6	4	7	5	2
South Carolina	69	65	72	83	49	70	55	58	66	66	76	79
South Dakota	4	4	8	6	4	8	11	9	6	7	7	5
Tennessee	51	84	73	74	69	74	59	84	82	83	94	102
Texas	408	443	435	469	426	375	417	462	438	409	418	403
Utah	5	7	7	11	17	13	12	15	23	23	16	21
Vermont[d]	3	7	1	3	3	5	0	2	8	6	4	7
Virginia	71	78	103	86	87	93	99	86	82	90	90	90

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TABLE 11 (continued)
Number of prisoner deaths in state and federal facilities, 2001 and 2006-2016

State/Federal	2001	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Washington	29	36	39	35	44	35	21	33	39	38	42	28
West Virginia	17	13	19	19	18	20	23	24	26	24	28	26
Wisconsin	48	45	43	44	42	25	48	46	43	58	46	66
Wyoming	5	3	8	9	7	2	3	4	4	12	7	11

Note: Data may have been revised from previously published statistics. Details may not sum to totals due to missing data. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). For data from 2002 to 2006, see the *Mortality in Correctional Institutions* page on the BJS website.

[a]Excludes deaths in private federal facilities.

[b]Includes deaths in private state facilities. Includes nine prisoner deaths reported by the District of Columbia in 2001. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons.

[c]Prisons and jails form one integrated system. Counts include deaths only in state-operated prisons and jails and exclude deaths in 14 locally operated jails.

[d]Prisons and jails form one integrated system. Data include total jail and prison population.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001 and 2006-2016; and Federal Bureau of Prisons, 2001 and 2006-2016.

TABLE 12
Mortality rate per 100,000 state and federal prisoners, 2001 and 2006-2016

State/Federal	2001	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Federal[a]	220	201	222	241	220	224	220	198	230	262	283	252
State[b]	242	249	258	261	259	246	260	265	274	274	296	303
Alabama	352	253	214	296	294	241	388	321	399	390	444	497
Alaska[c]	175!	119!	194!	280	128!	242	193	174!	157!	190	286	228!
Arizona	231	201	162	195	210	212	215	217	232	235	249	298
Arkansas	366	288	347	312	375	380	355	306	392	374	342	448
California	183	246	230	217	234	254	263	277	272	236	276	258
Colorado	243	141	185	164	216	211	169	236	198	171	256	293
Connecticut[d]	171	132	139	161	153	113	106	140	115	143	144	113
Delaware[d]	234	185	211	216	182	361	229	149!	206	267	264	221
Florida	251	289	262	291	274	269	294	325	302	343	356	363
Georgia	202	195	264	243	233	212	229	187	227	228	250	247
Hawaii[d]	137!	91!	238	257	227!	227	110!	227	271	148!	74!	174!
Idaho	323	270	198	256	181	180	174	117!	139!	307	249	222
Illinois	194	208	230	156	166	194	200	172	160	182	260	206
Indiana	234	281	215	265	340	253	270	210	232	215	320	278
Iowa	113!	136	196	241	157	137	132	229	184	170	214	320
Kansas	245	181	229	281	231	243	268	179	291	220	262	363
Kentucky	336	295	299	446	380	290	429	423	329	363	502	354
Louisiana[e]	361	346	401	561	543	526	573	624	628	631	613	817
Maine	358!	288!	47!	98!	193!	154!	253!	101!	145!	318!	228!	212!
Maryland	295	269	246	298	254	175	178	211	267	202	296	242
Massachusetts	284	362	352	260	260	349	288	377	367	431	358	376
Michigan	233	268	233	203	325	211	277	284	284	279	277	258
Minnesota	203	102!	141	188	126	170	204	149	213	146	115!	189
Mississippi	238	354	441	302	302	316	305	260	436	383	322	474
Missouri	199	219	262	289	265	288	239	228	292	304	328	305
Montana	215!	170!	172!	309!	97!	64!	192!	355!	224!	609	409	500
Nebraska	179!	182!	273	134!	245!	260	365	233!	319	249	331	174!
Nevada	274	180	293	272	278	336	280	294	274	347	355	309
New Hampshire	83!	224!	217!	175!	309!	153!	413!	195!	305!	184!	301!	346!
New Jersey	265	274	237	266	241	229	279	208	207	234	256	252
New Mexico	194!	196	342	459	319	240	239	211	251	345	267	229
New York	259	206	236	221	243	220	212	213	266	235	223	290

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TABLE 12 (continued)
Mortality rate per 100,000 state and federal prisoners, 2001 and 2006-2016

State/Federal	2001	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
North Carolina	205	239	259	293	214	215	179	211	218	252	244	353
North Dakota	276 !	75 !	0	0	0	71 !	72 !	212 !	63 !	0	0	244 !
Ohio	256	219	247	198	236	224	218	248	240	215	264	255
Oklahoma	235	350	412	372	328	248	358	324	343	404	392	353
Oregon	219	303	269	229	248	281	291	184	205	214	252	322
Pennsylvania	324	282	329	298	327	293	316	313	314	295	342	354
Rhode Island[d]	89 !	215 !	240 !	160 !	205 !	222 !	330 !	197 !	126 !	223 !	168 !	69 !
South Carolina	318	283	305	350	207	304	246	265	306	315	372	388
South Dakota	143 !	121 !	244 !	179 !	118 !	236 !	309 !	250 !	166 !	200 !	198 !	133 !
Tennessee	292	435	379	382	346	369	298	424	395	399	475	474
Texas	275	279	274	295	269	234	261	298	282	265	274	266
Utah	121 !	139 !	136 !	214 !	324	239	227	283	427	433	331	466
Vermont[d]	214 !	316 !	47 !	142 !	135 !	241 !	0	98 !	385 !	303 !	229 !	403 !
Virginia	226	253	312	264	281	291	324	289	273	300	296	301
Washington	190	214	231	204	255	206	123	195	220	221	244	163
West Virginia	500	298	387	388	356	394	447	450	456	409	473	441
Wisconsin	231	199	188	197	189	113	214	205	192	257	201	285
Wyoming	336 !	147 !	415 !	528 !	402 !	96 !	139 !	183 !	175 !	507	292 !	468 !

Note: Data may have been revised from previously published statistics. Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. See *Methodology*. Mortality rates are not adjusted for demographic differences among states. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). For data from 2002 to 2006, see the *Mortality in Correctional Institutions* page on the BJS website.

! Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.

[a]Excludes deaths in private federal facilities.

[b]Includes deaths in private state facilities. Includes nine prisoner deaths reported by the District of Columbia in 2001. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons.

[c]Prisons and jails form one integrated system. Counts include deaths only in state-operated prisons and jails and exclude deaths in 14 locally operated jails.

[d]Prisons and jails form one integrated system. Data include total jail and prison population.

[e]In 2016, Louisiana held 57.8% of its prison population in local jails. Since the calculation of mortality rates is based on the custody populations, which exclude prisoners held in local jails, the mortality rates for Louisiana prisoners will be high, because the prisoners held in jails are generally healthier according to the Louisiana Department of Corrections.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001 and 2006-2016, and National Prisoner Statistics, 2001 and 2006-2016; and Federal Bureau of Prisons, 2001 and 2006-2016.

TABLE 13
Number of prisoner deaths in state and federal facilities, by cause of death, 2001-2016

		Illness									
State/Federal	All causes[a]	Cancer	Heart disease	Liver disease	Respiratory disease	AIDS-related[b]	All other illnesses[c]	Suicide	Drug/alcohol intoxication	Accident	Homicide[d]
Federal[e]	5,985	...	...	...	...	161	5,280	260	...	81	160
State[f]	53,051	14,525	13,695	4,940	3,315	1,873	8,476	3,300	781	530	1,024
Alabama	1,360	364	326	129	97	37	262	30	4	17	32
Alaska[g]	156	23	38	17	2	1	23	27	10	8	4
Arizona	1,343	352	308	178	80	32	182	102	50	12	36
Arkansas	743	204	260	57	39	25	85	42	2	12	13
California	5,796	1,418	986	601	414	115	1,207	496	238	44	233
Colorado	709	147	134	121	52	1	125	62	27	14	26
Connecticut[h]	430	56	104	64	25	11	89	66	3	6	6
Delaware[h]	248	57	60	24	13	20	30	29	4	0	2
Florida	4,392	1,347	928	366	299	295	813	135	23	51	98
Georgia	1,872	481	627	110	153	78	233	87	3	15	59
Hawaii[h]	152	41	26	17	7	4	21	25	4	0	5
Idaho	228	56	60	22	12	3	31	29	4	5	3
Illinois	1,403	437	399	73	73	64	188	123	11	13	16

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TABLE 13 (continued)
Number of prisoner deaths in state and federal facilities, by cause of death, 2001-2016

		Illness									
State/Federal	All causes[a]	Cancer	Heart disease	Liver disease	Respiratory disease	AIDS-related[b]	All other illnesses[c]	Suicide	Drug/alcohol intoxication	Accident	Homicide[d]
Indiana	1,030	274	273	94	65	22	152	68	35	15	26
Iowa	255	90	54	15	24	5	32	27	2	1	2
Kansas	377	118	95	44	22	2	54	24	6	8	3
Kentucky	767	242	237	62	43	28	123	18	2	4	4
Louisiana	1,577	491	461	127	67	104	205	35	2	14	7
Maine	62	15	17	6	5	1	7	4	2	0	4
Maryland	925	196	227	76	37	102	106	68	54	7	43
Massachusetts	543	140	146	57	27	10	82	50	10	8	3
Michigan	1,939	662	594	157	106	39	182	118	24	24	18
Minnesota	223	65	45	32	10	1	41	23	4	1	1
Mississippi	848	218	326	43	45	24	104	37	3	9	18
Missouri	1,271	382	357	141	66	25	195	62	10	7	23
Montana	143	38	27	21	8	2	24	17	3	1	2
Nebraska	169	35	39	24	8	4	18	16	4	3	3
Nevada	548	116	128	37	16	9	127	34	6	3	9
New Hampshire	106	39	23	11	3	3	11	12	4	0	0
New Jersey	914	217	282	58	52	83	124	50	14	10	12
New Mexico	278	71	54	52	17	3	36	25	7	1	11
New York	2,318	666	617	186	100	217	212	204	38	26	25
North Carolina	1,383	457	362	120	95	69	188	47	4	21	15
North Dakota	18	5	4	2	0	0	3	3	1	0	0
Ohio	1,875	627	537	108	133	31	275	107	16	8	26
Oklahoma	1,276	318	330	142	79	30	170	75	29	27	54
Oregon	544	172	112	84	25	7	75	34	13	7	9
Pennsylvania	2,384	667	681	225	141	34	455	121	15	14	17
Rhode Island[h]	99	18	25	2	4	5	8	21	5	3	1
South Carolina	1,041	226	394	69	49	36	170	51	8	4	32
South Dakota	110	21	30	16	11	1	9	15	1	3	3
Tennessee	1,234	329	373	130	66	40	175	50	21	11	29
Texas	6,628	1,603	1,683	705	520	166	1,364	417	20	66	60
Utah	208	42	47	18	8	0	39	34	3	3	8
Vermont[h]	63	11	16	10	1	3	10	9	3	0	0
Virginia	1,387	472	374	140	69	53	183	48	12	5	11
Washington	561	158	136	66	43	9	87	38	4	10	7
West Virginia	303	87	110	22	15	6	49	6	1	2	4
Wisconsin	713	239	190	45	60	11	77	73	8	5	1
Wyoming	90	15	31	13	8	1	13	6	2	1	0

Note: Data may have been revised from previously published statistics. Details may not sum to totals due to missing data. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). See *Methodology*.

...Not available.

[a]Includes other causes not specified and missing and unknown causes.

[b]Includes persons who died of illness and were identified as HIV-positive or having AIDS at the time of death.

[c]Includes other specified illnesses (such as cerebrovascular disease, influenza, and other non-leading natural causes of death) and unspecified illnesses. Includes natural and illness-related federal prisoner deaths for which the Federal Bureau of Prisons could not provide details.

[d]Includes homicides committed by other prisoners, incidental to the use of force by staff, and resulting from injuries sustained prior to incarceration.

[e]Excludes deaths in private federal facilities.

[f]Includes deaths in private state facilities. Includes nine prisoner deaths reported by the District of Columbia in 2001. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons.

[g]Prisons and jails form one integrated system. Counts include deaths only in state-operated prisons and jails and exclude deaths in 14 locally operated jails.

[h]Prisons and jails form one integrated system. Data include total jail and prison population.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001-2016; and Federal Bureau of Prisons, 2001-2016.

TABLE 14

Average annual mortality rate per 100,000 state and federal prisoners, by cause of death, 2001-2016

		Illness									
State/Federal	All causes[a]	Cancer	Heart disease	Liver disease	Respiratory disease	AIDS-related[b]	All other illnesses[c]	Suicide	Drug/alcohol intoxication	Accident	Homicide[d]
Federal[e]	230	...	...	...	...	6	203	10	...	3	6
State[f]	262	72	68	24	16	9	42	16	4	3	5
Alabama	330	88	79	31	24	9	64	7	1!	4	8
Alaska[g]	190	28	46	21	2!	1!	28	33	12!	10!	5!
Arizona	226	59	52	30	13	5	31	17	8	2	6
Arkansas	343	94	120	26	18	12	39	19	1!	6	6
California	235	58	40	24	17	5	49	20	10	2	9
Colorado	214	44	40	36	16	<1!	38	19	8	4	8
Connecticut[h]	150	20	36	22	9	4!	31	23	1!	2!	2!
Delaware[h]	231	53	56	22	12	19	28	27	4!	0	2!
Florida	296	91	62	25	20	20	55	9	2	3	7
Georgia	227	58	76	13	19	9	28	11	<1!	2	7
Hawaii[h]	178	48	30	20	8!	5!	25	29	5!	1!	6!
Idaho	211	52	56	20	11	3!	29	27	4!	5!	3!
Illinois	191	60	54	10	10	9	26	17	1!	2	2
Indiana	255	68	67	23	16	5	38	17	9	4	6
Iowa	182	64	39	11	17	4!	23	19	1!	1!	1!
Kansas	259	81	65	30	15	1!	37	16	4!	5!	2!
Kentucky	360	114	111	29	20	13	58	8	1!	2!	2!
Louisiana[i]	513	160	150	41	22	34	67	11	1!	5	2!
Maine	190	46	52	18!	15!	3!	21!	12!	6!	0	12!
Maryland	257	54	63	21	10	28	29	19	15	2!	12
Massachusetts	324	84	87	34	16	6!	49	30	6!	5!	2!
Michigan	260	89	80	21	14	5	24	16	3	3	2
Minnesota	159	46	32	23	7!	1!	29	16	3!	1!	1!
Mississippi	337	87	129	17	18	10	41	15	1!	4!	7
Missouri	259	78	73	29	13	5	40	13	2!	1!	5
Montana	297	79	56	44	17!	4!	50	35	6!	2!	4!
Nebraska	232	48	54	33	11!	5!	25	22	5!	4!	4!
Nevada	282	60	66	19	8	5!	65	17	3!	2!	5!
New Hampshire	255	94	55	26!	7!	7!	26!	29	10!	0	0
New Jersey	238	57	74	15	14	22	32	13	4	3!	3
New Mexico	266	68	52	50	16	3!	34	24	7!	1!	11!
New York	245	70	65	20	11	23	22	22	4	3	3
North Carolina	234	77	61	20	16	12	32	8	1!	4	3
North Dakota	81	23!	18!	9!	0	0	14!	14!	5!	0	0
Ohio	239	80	68	14	17	4	35	14	2	1!	3
Oklahoma	332	83	86	37	21	8	44	20	8	7	14
Oregon	254	80	52	39	12	3!	35	16	6	3!	4!
Pennsylvania	325	91	93	31	19	5	62	16	2	2	2
Rhode Island[h]	187	34	47	4!	8!	9!	15!	40	9!	6!	2!
South Carolina	292	63	110	19	14	10	48	14	2!	1!	9
South Dakota	206	39	56	30	21!	2!	17!	28	2!	6!	6!
Tennessee	393	105	119	41	21	13	56	16	7	4!	9
Texas	266	64	68	28	21	7	55	17	1	3	2
Utah	262	53	59	23	10!	0	49	43	4!	4!	10!
Vermont[h]	205	36!	52	33!	3!	10!	33!	29!	10!	0	0
Virginia	280	95	76	28	14	11	37	10	2	1!	2!

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TABLE 14 (continued)
Average annual mortality rate per 100,000 state and federal prisoners, by cause of death, 2001-2016

		Illness									
State/Federal	All causes[a]	Cancer	Heart disease	Liver disease	Respiratory disease	AIDS-related[b]	All other illnesses[c]	Suicide	Drug/alcohol intoxication	Accident	Homicide[d]
Washington	208	59	50	24	16	3 !	32	14	1 !	4 !	3 !
West Virginia	394	113	143	29	19	8 !	64	8 !	1 !	3 !	5 !
Wisconsin	200	67	53	13	17	3 !	22	20	2 !	1 !	<1 !
Wyoming	282	47	97	41	25 !	3 !	41	19 !	6 !	3 !	0

Note: Data may have been revised from previously published statistics. Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. Mortality rates are not adjusted for demographic differences among states. Details may not sum to totals due to missing data. Excludes executions. For execution data, see *Capital Punishment, 2016 – Statistical Brief* (NCJ 251430, BJS, April 2018). See *Methodology*.

...Not available.

! Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.

[a]Includes other causes not specified and missing and unknown causes.

[b]Includes persons who died of illness and were identified as HIV-positive or having AIDS at the time of death.

[c]Includes other specified illnesses (such as cerebrovascular disease, influenza, and other non-leading natural causes of death) and unspecified illnesses. Includes natural and illness-related federal prisoner deaths for which the Federal Bureau of Prisons could not provide details.

[d]Includes homicides committed by other prisoners, incidental to the use of force by staff, and resulting from injuries sustained prior to incarceration.

[e]Excludes deaths in private federal facilities.

[f]Includes deaths in private state facilities. Includes nine prisoner deaths reported by the District of Columbia in 2001. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons.

[g]Prisons and jails form one integrated system. Counts include deaths only in state-operated prisons and jails and exclude deaths in 14 locally operated jails.

[h]Prisons and jails form one integrated system. Data include total jail and prison population.

[i]In 2016, Louisiana held 57.8% of its prison population in local jails. Since the calculation of mortality rates is based on the custody populations, which exclude prisoners held in local jails, the mortality rates for Louisiana prisoners will be high, because the prisoners held in jails are generally healthier according to the Louisiana Department of Corrections.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001-2016, and National Prisoner Statistics, 2001-2016; and Federal Bureau of Prisons, 2001-2016.

Methodology

Data collection coverage

The Mortality in Correctional Institutions (MCI), formerly the Deaths in Custody Reporting Program (DCRP), is an annual Bureau of Justice Statistics (BJS) data collection. The MCI obtains national-, state-, and incident-level data on persons who died while in the physical custody of the 50 state departments of corrections (DOCs) or of the approximately 2,800 local jail jurisdictions with adult populations nationwide. This methodology pertains to the prison portion of the MCI collection only. See *Mortality in Local Jails, 2000-2016 – Statistical Tables* (NCJ 251921, BJS, February 2020) for the methodology on deaths in local jails.

The DCRP began in 2000 in response to the Death in Custody Reporting Act of 2000 (P.L. 106-297) and was the only national statistical collection providing comprehensive information about deaths in adult correctional facilities. Starting in 2001, BJS has annually collected data directly from state prison systems, maintaining a 100% response rate. BJS uses these data to track national trends in the number and causes or manners of deaths occurring in state prisons. Until 2015, the Federal Bureau of Prisons (BOP) submitted aggregate counts of the number of male and female deaths to BJS, by cause of death. The BOP started reporting decedent-level data to BJS in 2015, including individual demographic and criminal-justice characteristics. In 2017, BJS changed the name from the DCRP to MCI to more accurately describe the data collection.

Mortality data measured by the MCI include the location and type of facility where the prisoner died, decedent characteristics (sex, race or ethnicity, and age), admission date, conviction status, and admission offense. The MCI also collects data on the circumstances surrounding the death (the cause, time, and location of death), whether an autopsy was conducted, and the availability of autopsy results to the respondent. Data on executions are excluded from this report but are accessible on the BJS website.[1] Statistics for 2001 to 2016 presented in this report are current as of October 30, 2019.

For more information on mortality in correctional settings, see—

- *Assessing Inmate Cause of Death: Deaths in Custody Reporting Program and National Death Index* (NCJ 249568, BJS, April 2016)
- *Mortality in Local Jails, 2000-2014 – Statistical Tables* (NCJ 250169, BJS, December 2016)
- *Mortality in State Prisons, 2001-2014 – Statistical Tables* (NCJ 250150, BJS, December 2016)
- *Suicide and Homicide in State Prisons and Local Jails* (NCJ 210036, BJS, August 2005).

The MCI instruments for collecting data from state prisons are administered annually to state DOCs. Respondents provide an aggregate count of the number of deaths that occurred during the referenced calendar year (NPS-4) and provide forms describing individual deaths (NPS-4A). The prison survey instruments are available on the BJS website. Respondents can submit individual records on decedents at any time during a collection cycle through a BJS web-based collection system. The BOP submits federal prison data directly to BJS.

Determining eligibility for reporting to the Mortality in Correctional Institutions

In the MCI, custody refers to the physical holding of a person in a facility or to the period during which a correctional authority maintains a chain of custody over a prisoner. For instance, if a prison transports an ill prisoner to a hospital for medical services and that prisoner dies while in the chain of custody of the prison, then that death is counted as a death in custody. A death that occurs when a prisoner is not in the custody of a correctional authority is considered beyond the scope of the MCI. Deaths were considered out-of-scope for prisoners who were on escape status or under the supervision of community corrections, such as on probation, parole, or home electronic monitoring. For state prisons responding to the survey, prisoners in physical custody include those held in any private prison facility under contract to the responding states' DOCs or in any of their state-operated facilities, such as halfway houses, prison camps or farms, training or treatment centers, and prison hospitals. BOP data submitted to the MCI exclude deaths of federal prisoners that occurred in privately operated facilities.

State and federal prison officials were asked to exclude deaths of prisoners serving sentences in the custody of local jails while under the jurisdiction of the state or federal DOCs. The MCI obtains information about such deaths through the jail reports.

[1]See *Capital Punishment, 2017: Selected Findings* (NCJ 253060, BJS, July 2019).

Identifying and excluding duplicate records

Duplicate and out-of-scope records are excluded from analysis in this report. Duplicate death records may occur in the MCI due to overlapping correctional populations or overlapping duties within correctional facilities. For example, a state prison system may report the death of a prisoner who was transferred to a local jail while serving a prison sentence. This death would be counted by the local jail that had custody of the prisoner at the time of death. The duplicate record from the prison would be deleted.

To identify duplicate records, BJS reconciles the aggregate summary counts of deaths that occurred during a calendar year with the number of individual records of death that were obtained from a reporting prison system. When discrepancies are identified, reporting prison systems are contacted for clarification.

Information on cause of death

MCI respondents are instructed to report on the cause of death as determined by autopsy or another official medical investigation. For this collection, deaths due to intoxication, accidents, suicides, and homicides are considered discrete causes of death. Although the manner and cause of death are distinct from one another, no such distinction is made in the MCI. When reporting a death due to illness, accident, suicide, intoxication, or homicide, BJS requests that respondents describe the events surrounding these deaths. Clinical-data specialists convert text entries that describe illness-related deaths into standard medical codes from the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10).

Homicides include all types of intentional homicide and involuntary manslaughter as determined by a medical examiner or pathologist at autopsy. Homicide counts include legal-intervention homicides committed while the prisoner was trying to escape. Homicides also encompass cases that are ruled a homicide at autopsy when events that led to the death occurred prior to incarceration, such as a prisoner who was shot outside of custody and who later died from complications of the gunshot wound while in custody.

Other BJS sources of correctional mortality data

BJS collects other data reported to the MCI on prisoner mortality. These other collections include—

- Capital Punishment, which provides data on legal executions. Additional details on executions are available on the BJS website.
- the National Prisoner Statistics (NPS) program, which collects counts of deaths by cause of death, including deaths due to execution; illness; AIDS and AIDS-related causes, such as HIV; suicide; accident; or homicide. Detailed counts by cause of death were discontinued in 2007. The NPS currently collects a total count of deaths as a type of release from prison. After 2006, the BOP submitted counts of deaths by cause of death to the DCRP but discontinued submitting counts to the NPS. Additional details on the NPS are available on the BJS website.

Reported statistics

Mortality data in this report include the number of deaths and mortality rates by year, the cause of death, selected decedent characteristics, and the state where the death occurred.

Mortality rates are calculated per 100,000 prisoners, with the denominators providing estimates of the number of person-years of exposure in custody in institutional corrections. The mortality rate for state or federal prisoners is calculated as the number of deaths per year divided by the December 31 population of state or federal prisoners in custody, with the resulting quotient multiplied by 100,000. The population of state prisoners used in rate calculations includes prisoners held in privately operated facilities, while the population in federal prisons does not. To improve comparability between years, this report includes mortality rates of state prisons that were re-estimated for prior years using updated year-end custody populations, including privately operated facilities.

Data on the source of the denominator allow annual mortality rates to be calculated separately by group or characteristic. The National Center for Health Statistics (NCHS) calculates crude mortality rates as the number of events for a period (such as one year), divided by the population estimate at the midpoint of the period. For statistics on mortality in the general population, the NCHS uses the midyear population as an approximation of the average population that is exposed to risk of death during any given year.[2]

[2]See Siegel, J. S., & Swanson, D. A. (Eds.). (2004). *The methods and materials of demography* (2nd ed., p. 269). San Diego, CA: Elsevier Academic Press.

The crude mortality rates that are reported in the MCI annual statistical tables use a year-end, rather than midyear, population for the denominator. The composition of the general population (sex, race or ethnicity, and age) differs from the population in state and federal prisons, which in turn differs from the population in local jails.

Estimating population characteristics of prisoners to calculate mortality rates by demographic subgroups

Age and sex distributions of the state prison population are estimated using the NPS and National Corrections Reporting Program (NCRP) collections. Rates for race or ethnicity are also derived from these collections, and they have been updated from previous years and will not match previously reported rates. Race or ethnicity reported in the NPS and NCRP come from administrative records of prisoners and may not reflect self-reporting by prisoners. Distributions of race or ethnicity were adjusted to reflect statistics that were reported in BJS's prisoner surveys. Previously, distributions of race or ethnicity were derived from BJS's 2004 Survey of Inmates in State and Federal Correctional Facilities. In 2017, BJS updated estimates of prisoners' race or ethnicity using new data from the 2016 Survey of Prison Inmates. Annual distributions of race or ethnicity were weighted by the number of years from the most recent prisoner survey (2004 or 2016). For complete details on the methodology used to estimate distributions of race or ethnicity, see *Prisoners in 2016* (NCJ 251149, BJS, January 2018).

Rolling averages

Rolling averages were computed to examine trends for certain causes of death in prisons while smoothing short-term fluctuations. Data were divided into 10 overlapping 3-year periods spanning 12 years. The rolling averages in this report describe some changes in cause-specific mortality rates over time, such as whether the overall rise in the mortality rate for cancer was steady, or the increase in unnatural deaths was recent. Rolling averages were not computed for all causes of death in custody due to small cell-sizes.

Interpreting rates among small populations

MCI data on deaths in state prisons are not subject to sampling error because the data represent a full enumeration of deaths. However, according to Brillinger and NCHS, mortality data from a complete enumeration may be subject to random error because "the number of deaths that actually occurred may be considered as one of a large series of possible results that could have arisen under the same set of circumstances."[3,4] The random variation can be large when the number of deaths is small. Therefore, caution is warranted when interpreting statistics that are based on small numbers of deaths.

Continuing to use the NCHS and Brillinger methods, BJS quantified random variation by assuming that the appropriate underlying probability distribution for the number of deaths was a Poisson distribution. This provided a simple and reasonable approach for estimating variances in mortality statistics when the probability of dying is low. Variances were calculated based on the assumption of a Poisson process. From these variances, estimates of relative random error were calculated. These estimates are comparable to the relative standard error because the relative random error is the ratio of random error derived from the Poisson variance to the number of deaths. Following NCHS practice, when the relative random error exceeded 30%, estimated mortality rates were flagged with an "!" symbol to show the instability of the rate. (Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.)

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[3]See Brillinger, D. R. (1986). The natural variability of vital rates and associated statistics. *Biometrics, 42*(4), 693-734.

[4]See Xu, J., Kochanek, K. D., Murphy, S. L., & Tejada-Vera, B. (2010). *Deaths: Final data for 2007* (National Vital Statistics Reports, Vol. 58, No. 19). Hyattsville, MD: National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf

APPENDIX TABLE 1

Estimated number of state and federal prisoners in custody, by prisoner characteristics, 2001 and 2006-2016

Characteristic	Custody population, 2001-2016	2001	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	22,869,200	1,322,600	1,460,300	1,482,100	1,489,800	1,490,600	1,487,500	1,466,400	1,443,500	1,444,100	1,439,200	1,405,800	1,382,900
Federal[a]	2,600,100	137,100	163,100	166,000	165,300	171,000	173,100	176,200	176,500	173,800	169,500	160,700	154,200
State[b]	20,269,100	1,185,500	1,297,200	1,316,100	1,324,500	1,319,600	1,314,400	1,290,200	1,267,000	1,270,300	1,269,700	1,245,100	1,228,700
Sex													
Male	18,860,000	1,109,400	1,205,100	1,222,500	1,230,600	1,227,500	1,222,900	1,201,100	1,180,600	1,181,500	1,179,400	1,156,000	1,139,900
Female	1,409,100	76,100	92,200	93,600	93,900	92,100	91,500	89,100	86,400	88,800	90,300	89,100	88,800
Race/ethnicity													
White[c]	6,670,600	387,900	475,000	441,600	441,100	430,400	424,700	414,600	407,800	406,100	406,300	396,100	385,400
Black[c]	7,584,200	495,400	523,300	502,700	502,800	493,200	481,800	467,900	454,600	448,200	437,000	421,000	409,600
Hispanic	4,179,400	232,200	189,900	277,200	272,400	277,400	278,600	270,900	260,900	262,100	261,800	258,300	266,100
Other[c,d]	1,834,900	70,000	33,700	94,600	108,300	118,600	129,300	136,800	143,700	153,900	164,700	169,600	167,600
Age													
17 or younger	31,600	2,900	2,800	2,400	2,600	2,500	2,100	1,800	1,400	1,100	1,000	900	800
18-24	3,030,100	218,000	227,500	196,700	197,900	198,700	196,000	189,100	180,400	173,700	161,300	145,500	134,800
25-34	6,712,900	401,700	429,500	437,700	439,200	437,300	434,800	424,400	413,800	415,300	417,700	407,700	400,000
35-44	5,534,900	362,000	384,500	366,600	356,600	343,700	334,200	324,100	318,200	320,500	323,700	322,500	322,600
45-54	3,475,200	153,000	185,600	232,200	240,600	243,500	245,600	242,300	238,000	236,500	235,000	229,400	224,900
55 or older	1,484,400	47,800	60,400	80,400	87,600	93,900	101,700	108,500	115,300	123,100	131,100	139,100	145,600

Note: Data rounded to the nearest 100. Data may have been revised from previously published statistics. State data include prisoners in the custody of state correctional facilities, including private prison facilities. Federal data include prisoners in the custody of federal prisons, excluding private federal facilities. All populations are based on a custody count as of December 31.

[a]Excludes prisoners in private federal facilities.

[b]Includes prisoners in private state facilities.

[c]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[d]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001-2016, National Prisoner Statistics, 2001-2016, Survey of Inmates in State and Federal Correctional Facilities, 2004, and Survey of Prison Inmates, 2016; and Federal Bureau of Prisons, 2001-2016.

APPENDIX TABLE 2

Illness mortality rate per 100,000 state prisoners within each demographic group, by decedent characteristics, 2007-2016 (3-year rolling averages)

Characteristic	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	223	225	228	226	226	227	236	238	247	252
Sex										
Male	230	231	235	232	233	235	243	246	255	261
Female	133	136	144	137	132	122	132	133	143	142
Race/ethnicity										
White[a]	325	337	353	357	372	381	403	404	425	439
Black[a]	217	213	218	216	215	213	217	225	236	248
Hispanic	115	122	119	115	107	110	116	120	120	115
Other[a,b]	48	49	46	42	35	36	36	39	38	37
Age										
17 or younger	14 !	27 !	13 !	41 !	47 !	56 !	23 !	29 !	33 !	73 !
18-24	13	14	15	15	14	14	15	15	16	14
25-34	32	29	26	25	25	24	24	23	24	24
35-44	120	110	107	99	94	86	81	75	71	70
45-54	435	416	397	382	364	346	338	324	315	298
55 or older	1,791	1,777	1,765	1,658	1,598	1,558	1,567	1,538	1,544	1,528

Note: Based on 3-year rolling averages. Labels show the most recent year only (for example, 2005-07 is shown as 2007). Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. See *Methodology*. Includes deaths in private state facilities.

! Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2007-2016; National Prisoner Statistics, 2007-2016; Survey of Inmates in State Correctional Facilities, 2004; and Survey of Prison Inmates, 2016.

APPENDIX TABLE 3

Cancer mortality rate per 100,000 state prisoners within each demographic group, by decedent characteristics, 2007-2016 (3-year rolling averages)

Characteristic	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	62	63	67	71	75	77	81	82	85	88
Sex										
Male	64	65	70	73	77	79	84	85	88	91
Female	31	33	35	40	48	44	45	43	51	53
Race/ethnicity										
White[a]	97	103	114	119	130	134	146	144	149	154
Black[a]	58	58	62	66	68	71	75	79	83	89
Hispanic	23	24	23	28	30	31	32	34	36	38
Other[a,b]	15	15	13	15	11	12	11	11	11	10
Age										
17 or younger	0	14 !	13 !	14 !	16 !	19 !	23 !	0	0	37 !
18-24	2 !	1 !	2 !	3	4	4	3	2	2 !	2 !
25-34	5	4	4	4	5	5	6	5	6	6
35-44	22	22	20	22	21	21	22	22	21	19
45-54	119	113	115	117	118	113	116	114	113	104
55 or older	580	577	592	584	584	573	572	552	549	556

Note: Based on 3-year rolling averages. Labels show the most recent year only (for example, 2005-07 is shown as 2007). Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. See *Methodology*. Includes deaths in private state facilities.

! Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2007-2016; National Prisoner Statistics, 2007-2016; Survey of Inmates in State Correctional Facilities, 2004; and Survey of Prison Inmates, 2016.

APPENDIX TABLE 4

Heart-disease mortality rate per 100,000 state prisoners within each demographic group, by decedent characteristics, 2007-2016 (3-year rolling averages)

Characteristic	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	65	64	64	64	65	64	67	68	73	77
Sex										
Male	68	67	66	66	67	67	69	71	76	81
Female	32	33	36	30	29	27	31	31	35	37
Race/ethnicity										
White[a]	98	99	99	101	107	107	114	116	126	136
Black[a]	65	62	63	64	65	66	67	69	76	82
Hispanic	27	30	29	28	25	23	24	23	25	25
Other[a,b]	12	12	12	9	7	9	11	13	12	11
Age										
17 or younger	0	0	0	14 !	16 !	19 !	0	29 !	33 !	37 !
18-24	5	4	4	4	4	3	5	5	7	5
25-34	10	8	8	8	8	7	7	8	9	10
35-44	34	31	31	32	33	30	28	25	23	24
45-54	112	106	98	94	90	86	82	79	81	82
55 or older	572	550	525	487	468	448	455	448	466	470

Note: Based on 3-year rolling averages. Labels show the most recent year only (for example, 2005-07 is shown as 2007). Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. See *Methodology*. Includes deaths in private state facilities.

! Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2007-2016; National Prisoner Statistics, 2007-2016; Survey of Inmates in State Correctional Facilities, 2004; and Survey of Prison Inmates, 2016.

APPENDIX TABLE 5

Liver-disease mortality rate per 100,000 state prisoners within each demographic group, by decedent characteristics, 2007-2016 (3-year rolling averages)

Characteristic	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	24	24	24	24	24	24	26	26	26	23
Sex										
Male	25	25	25	25	26	25	27	26	26	24
Female	12	10	10	10	9	9	13	14	16	13
Race/ethnicity										
White[a]	37	37	40	42	44	44	47	46	46	44
Black[a]	15	14	14	14	15	14	15	14	15	14
Hispanic	25	25	24	21	19	20	23	25	25	19
Other[a,b]	10	8	8	5	5	5	6	5	5	5
Age										
17 or younger	0	0	0	14 !	16 !	19 !	0	0	0	0
18-24	1 !	1 !	1 !	1 !	1 !	<1 !	<1 !	1 !	1 !	1 !
25-34	1	1 !	1	1	1	1	1 !	1	1 !	1 !
35-44	11	11	11	9	10	7	7	5	5	5
45-54	75	69	67	63	58	53	54	50	47	41
55 or older	137	136	136	129	137	139	156	150	146	125

Note: Based on 3-year rolling averages. Labels show the most recent year only (for example, 2005-07 is shown as 2007). Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. See *Methodology*. Includes deaths in private state facilities.

! Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2007-2016; National Prisoner Statistics, 2007-2016; Survey of Inmates in State Correctional Facilities, 2004; and Survey of Prison Inmates, 2016.

APPENDIX TABLE 6

Respiratory-disease mortality rate per 100,000 state prisoners within each demographic group, by decedent characteristics, 2007-2016 (3-year rolling averages)

Characteristic	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	16	17	17	17	16	17	16	17	18	19
Sex										
Male	16	17	17	17	16	17	17	18	19	19
Female	15	16	14	12	10	7	10	9	10	11
Race/ethnicity										
White[a]	25	28	28	28	29	31	32	32	34	36
Black[a]	15	14	14	15	13	13	12	14	15	16
Hispanic	7	8	8	9	7	7	7	8	8	9
Other[a,b]	1 !	1 !	1 !	1 !	1 !	2 !	3	3	3	3
Age										
17 or younger	14 !	14 !	0	0	0	0	0	0	0	0
18-24	2	3	2	2	1 !	2 !	2 !	2 !	2 !	1 !
25-34	3	3	3	3	2	3	3	3	2	2
35-44	9	8	8	7	6	5	4	4	4	4
45-54	22	23	21	21	20	19	18	16	16	16
55 or older	144	143	140	137	121	127	120	125	126	126

Note: Based on 3-year rolling averages. Labels show the most recent year only (for example, 2005-07 is shown as 2007). Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. See *Methodology*. Includes deaths in private state facilities.

! Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2007-2016; National Prisoner Statistics, 2007-2016; Survey of Inmates in State Correctional Facilities, 2004; and Survey of Prison Inmates, 2016.

APPENDIX TABLE 7

Mortality rate due to all other illnesses per 100,000 state prisoners within each demographic group, by decedent characteristics, 2007-2016 (3-year rolling averages)

Characteristic	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	45	48	48	44	41	40	40	40	40	41
Sex										
Male	46	49	49	44	42	41	41	41	41	42
Female	34	36	39	39	32	31	30	32	29	26
Race/ethnicity										
White[a]	61	65	67	61	59	60	61	61	65	66
Black[a]	46	48	50	45	43	41	40	40	40	41
Hispanic	28	32	30	27	24	26	27	28	25	24
Other[a,b]	9	12	12	10	9	7	6	6	6	8
Age										
17 or younger	0	0	0	0	0	0	0	0	0	0
18-24	4	4	5	4	4	5	4	4	4	4
25-34	9	9	9	7	7	6	6	5	5	5
35-44	29	28	28	22	19	17	16	14	14	14
45-54	85	84	78	72	65	64	58	55	50	47
55 or older	338	350	352	303	274	255	250	246	245	240

Note: Excludes cancer; heart, liver, and respiratory diseases; and AIDS-related illnesses. Based on 3-year rolling averages. Labels show the most recent year only (for example, 2005-07 is shown as 2007). Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. See *Methodology*. Includes deaths in private state facilities.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2007-2016; National Prisoner Statistics, 2007-2016; Survey of Inmates in State Correctional Facilities, 2004; and Survey of Prison Inmates, 2016.

APPENDIX TABLE 8

Rate of unnatural deaths per 100,000 state prisoners within each demographic group, by decedent characteristics, 2007-2016 (3-year rolling averages)

Characteristic	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	27	26	25	26	27	28	29	31	32	36
Sex										
Male	28	27	26	26	27	29	29	31	33	37
Female	14	15	15	16	18	18	17	20	22	23
Race/ethnicity										
White[a]	43	43	44	44	47	49	50	53	57	63
Black[a]	16	15	15	16	16	18	18	20	22	26
Hispanic	23	21	19	20	20	21	23	25	25	26
Other[a,b]	14	13	10	11	11	11	10	10	11	12
Age										
17 or younger	29 !	41 !	40 !	41 !	31 !	38 !	23 !	29 !	33 !	37 !
18-24	21	18	19	19	18	19	19	22	24	30
25-34	23	23	22	23	23	23	24	26	29	30
35-44	29	27	26	26	29	30	31	30	33	38
45-54	32	30	30	30	32	33	32	35	36	39
55 or older	38	40	36	38	39	46	46	51	46	47

Note: Unnatural deaths include deaths caused by suicide, accident, homicide, and drug or alcohol intoxication. Based on 3-year rolling averages. Labels show the most recent year only (for example, 2005-07 is shown as 2007). Mortality rates are based on the annual number of deaths and a one-day custody population on December 31. See *Methodology*. Includes deaths in private state facilities.

! Interpret with caution. Estimate is based on 10 or fewer cases, or coefficient of variation is greater than 50%.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes Asians, Native Hawaiians, Other Pacific Islanders, American Indians, Alaska Natives, or persons of two or more races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2007-2016; National Prisoner Statistics, 2007-2016; Survey of Inmates in State Correctional Facilities, 2004; and Survey of Prison Inmates, 2016.

APPENDIX TABLE 9

Rates for figure 1: Mortality rate per 100,000 state and federal prisoners, 2001-2016

State/ Federal	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Federal[a]	220	232	227	208	244	201	222	241	220	224	220	198	230	262	283	252
State[b]	242	244	257	252	253	249	258	261	259	246	260	265	274	274	296	303

Note: Based on the annual number of deaths and the one-day custody population on December 31.

[a]Excludes deaths in private federal facilities.

[b]Includes deaths in private state facilities.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001-2016; and Federal Bureau of Prisons, 2001-2016.

The Bureau of Justice Statistics of the U.S. Department of Justice is the principal federal agency responsible for measuring crime, criminal victimization, criminal offenders, victims of crime, correlates of crime, and the operation of criminal and civil justice systems at the federal, state, tribal, and local levels. BJS collects, analyzes, and disseminates reliable statistics on crime and justice systems in the United States, supports improvements to state and local criminal justice information systems, and participates with national and international organizations to develop and recommend national standards for justice statistics. Jeffrey H. Anderson is the director.

This report was written by Mary P. Cowhig and E. Ann Carson. Scott Ginder and Amy Couzens of RTI International conducted statistical analyses. Jennifer Bronson, E. Ann Carson, and Stephanie Mueller verified the report.

Eric Hendrixson and Jill Thomas edited the report. Morgan Young produced the report.

February 2020, NCJ 251920

BJS 40 YEARS OF STATISTICS

NCJ 251920

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Exhibit JJ

DIVISION OF HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 588500
Elk Grove, California 95758

August 14, 2019

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes Devereaux & O'Gara LLC
Northwoods Office Park
1301 Atwood Avenue, Suite 215 N
Johnston, RI 02919

via: Elise Owens Thorn, Esquire
Deputy Attorney General
Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550

RE: *COLEMAN* MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the *Coleman* Monthly Report reflective of June, 2019, data (or as otherwise noted). The following is the list of enclosures:

1. California Department of Corrections and Rehabilitation (CDCR) Staffing Report.
   a. Mental Health Executive Summary.
   b. Mental Health Institution Vacancy by Classification.
   c. Mental Health Institution Vacancies Summary by Classification.
   d. Mental Health Month to Month Registry Usage.
   e. Mental Health Six-Month Vacancy Summary.
   f. Mental Health Program Institution Vacancies - Summary by Classification.
   g. Statewide Mental Health Program Compliance Summary Report.
   h. Enhanced Outpatient Program Administrative Segregation Unit (EOP ASU) Case Manager Positions and Vacancies.
   i. Mental Health Hiring Progress Report.
   j. Mental Health Statewide Hire Tracking Summary - Clinical Positions Only.
   k. Mental Health Telepsych Allocated and Filled Positions Report.
   l. Psychiatric Inpatient Program (PIP) Staffing Data.
   m. Department of State Hospitals (DSH) Staffing Data.

2. Reception Center Monthly Reports.
   a. Reception Center Mental Health Screening Report.
   b. Reception Center Transfer Timelines Report.

3. Continuous Length of Stay Counts for Mental Health Services Delivery Systems (MHSDS) ASU, Secured Housing Unit (SHU), and Psychiatric Services Unit (PSU) report.

4. EOP Inmates Waiting Transfers to PSU.

5. EOP ASU Hub Trends.

6. Population and Census Reports.
   a. Health Care Placement Oversight Program (HCPOP) Information Report, Summary of Mental Health Population by Institution and Level of Care (H-1).
   b. MHSDS Management Information Summary (MIS).
   c. Weekly EOP/Outpatient Psychiatric Program Report.

7. Mental Health Crisis Bed (MHCB) Reports.
   a. MHCB Referrals report.
   b. MHCB Stays report.
   c. MHCB Wait List.

8. DSH and Inpatient Program Referral Reports.
   a. Referrals for Transfer to Inpatient Programs Report.
   b. DSH Monthly Report of CDCR Patients in DSH Hospitals, Summary of PC 2684s Report.

9. Milestone Credits Report.

10. Work Assignments Report.

11. Out of Level Housing Report.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

Eureka C. Daye

EUREKA C. DAYE, Ph.D, MPH, MA, CCHP
Deputy Director (A), Statewide Mental Health Program
California Department of Corrections and Rehabilitation

Enclosures

cc: Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Kerry F. Walsh, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert

Kerry C. Hughes, M.D., *Coleman* Expert
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Angela Ponciano, Associate Director, Statewide Mental Health Program, DHCS
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Wendy Worrell, Psy.D, Chief Psychologist, (A), Quality Management and Informatics Statewide Mental Health Program, DHCS
Teresa Owens, Health Program Specialist I, Quality Management, Statewide Mental Health Program, DHCS

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE (H1)

CONFIDENTIAL

Date Refreshed: 6/24/19 6:09 AM

Mental Health Summary by Level of Care

Institution	Correctional Clinical Case Management System (CCCMS)				Enhanced Outpatient Program (EOP)						Mental Health Crisis Bed (MHCB)				Intermediate Care Facility (ICF)				Acute Psychiatric Program (APP)				Total Mental Health Population
	Operational Capacity	Population	% Occupied	Vacant Beds	EOP Operational Capacities			Population	% Occupied	Vacant Beds	Operational Capacity	Population	% Occupied	Vacant Beds	Operational Capacity	Population	% Occupied	Vacant Beds	Operational Capacity	Population	% Occupied	Vacant Beds	
					General Population (GP)	Administrative Segregation Unit (ASU)	Psychiatric Services Unit (PSU)																
ASP	1,100	935	85 %	165				5		-5													940
CAL		7		-7																			7
CCC		5		-5								1		-1									6
CCI	1,850	1,523	82 %	327				7		-7		1		-1									1,531
CEN																							
CHCF	550	629	114 %	-79	375	50		516	121 %	-91	98	63	64 %	35	300	302	101 %	-2	214	176	82 %	38	1,686
CIM	1,050	1,085	103 %	-35				37		-37	34	22	65 %	12		7		-7					1,151
CMC	750	651	87 %	99	552	100		478	73 %	174	50	29	58 %	21		12		-12		9		-9	1,179
CMF	600	554	92 %	46	391	58		489	109 %	-40	50	26	52 %	24	284	270	95 %	14	182	120	66 %	62	1,459
COR	1,000	1,123	112 %	-123	366	100		381	82 %	85	24	20	83 %	4		2		-2		3		-3	1,529
CRC	1,150	1,353	118 %	-203				1		-1		1		-1									1,355
CTF	1,500	1,607	107 %	-107				3		-3													1,610
CVSP		6		-6																			6
DVI	500	470	94 %	30				14		-14													484
FOL	500	458	92 %	42				5		-5													463
HDSP	1,050	956	91 %	94				4		-4	10	4	40 %	6									964
ISP	0	9		-9																			9
KVSP	900	950	106 %	-50	96			107	111 %	-11	12	8	67 %	4						1		-1	1,066
LAC	1,000	875	88 %	125	750	100		557	66 %	293	12	4	33 %	8		2		-2		4		-4	1,442
MCSP	1,350	1,419	105 %	-69	774	50		669	81 %	155	8	4	50 %	4		2		-2		5		-5	2,099
NKSP	1,000	792	79 %	208				62		-62	10	6	60 %	4									860
PBSP	300	272	91 %	28				1		-1	10	1	10 %	9									274
PVSP	700	432	62 %	268				8		-8	6	1	17 %	5									441
RJD	1,500	1,379	92 %	121	894	63		765	80 %	192	14	12	86 %	2		3		-3		1		-1	2,160
SAC	500	501	100 %	-1	642	64	236	683	73 %	259	44	18	41 %	26		2		-2		4		-4	1,208
SATF	2,000	1,952	98 %	48	660			577	87 %	83	20	15	75 %	5		4		-4		4		-4	2,552
SCC	400	565	141 %	-165				1		-1													566
SOL	1,000	786	79 %	214				4		-4	9	3	33 %	6						1		-1	794
SQ	1,250	1,082	87 %	168	200			222	111 %	-22	7	5	71 %	2	33	26	79 %	7					1,335
SVSP	850	1,005	118 %	-155	492			312	63 %	180	10	4	40 %	6	246	164	67 %	82		3		-3	1,488
VSP	1,350	1,003	74 %	347	372			351	94 %	21		1		-1									1,355
WSP	1,300	1,239	95 %	61				45		-45	6	5	83 %	1						2		-2	1,291
DSH-ASH								4		-4		2		-2	256	130	51 %	126		3		-3	139
DSH-CSH								1		-1					50	37	74 %	13					38
Male Subtotal	27,000	25,623	95%	1,377	6,564	585	236	6,309	85%	1,076	434	256	59%	178	1,169	963	82%	206	396	336	85%	60	33,487
CCWF	1,350	1,231	91 %	119	120	10		87	67 %	43	12	8	67 %	4		5		-5		1		-1	1,332
CIW	750	833	111 %	-83	75	10	10	65	68 %	30	29	22	76 %	7	45	37	82 %	8					957
FWF	150	155	103 %	-5				1		-1													156
DSH-PSH		1		-1				1		-1					30	10	33 %	20					12
Female Subtotal	2,250	2,220	99%	30	195	20	10	154	68%	71	41	30	73%	11	75	52	69%	23	0	1		-1	2,457
Grand Total	29,250	27,843	95%	1,407	6,759	605	246	6,463	85%	1,147	475	286	60%	189	1,244	1,015	82%	229	396	337	85%	59	35,944

NOTES:

1. This report provides operational capacities, population, and vacant beds detail by mental health level of care and institution. Level of care is based on Current Mental Health level of care code in SOMS. For each level of care, a summary of patients by SOMS housing program and institution is provided. Data Source is HCODS, as of the "Data Refreshed" time stamp.
2. Definitions:
   - Operational Capacity = indicates the number of beds available in the program based on factors such as treatment space and staffing, as determined by CCHCS headquarters. A blank value indicates the institution does not have a designated program available. Any corresponding population must be moved to an institution with a designated program.
   - Population = total census per SOMS as of the "Data Refreshed" time stamp shown on the report.
   - % Occupied = ([Population] / [Operational Capacity]) x 100.
   - Vacant Beds = the number of beds available after subtracting the Population from the Operational Capacity.
   - The "PIP" column in the "Psychiatry Inpatient Program (PIP) Housing" refers to programs that have the ability to provide multiple levels of care.
3. PIP capacities:
   - SQ PIP is for male condemned patients only, and has a total capacity of 40 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF, APP, and MHCB level of care.
   - CIW PIP has a total capacity of 45 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF and APP level of care.
   - DSH-PSH has a total capacity of 30 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF and APP level of care.

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SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 6/24/19 6:09 AM

Correctional Clinical Case Management System (CCCMS) Level of Care Population by Housing Program

Institution	RC Reception Center	GP General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total CCCMS Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP		932								3								935
CAL		7																7
CCC		4									1							5
CCI		1,499									24							1,523
CEN																		
CHCF		224	1	2				158		243	1							629
CIM	78	962								13	32							1,085
CMC		634						10			7							651
CMF		502	4			1		16	1	19	11							354
COR		847	5					8		3	28		119			5	108	1,123
CRC		1,349								4								1,353
CTF		1,586								6	15							1,607
CVSP		4									2							6
DVI	296	147								7	20							470
FOL		457									1							458
HDSP		882						5									69	956
ISP		9																9
KVSP		840						6									104	950
LAC		741	30					1									103	875
MCSP		1,393	3								23							1,419
NKSP	627	150		1				2			12							792
PBSP		212						1									59	272
PVSP		396															36	432
RJD		1,329	3					5			42							1,379
SAC		300	30							5	5			3	56		102	501
SATF		1,850	4	1				9									88	1,952
SCC		554								1	10							565
SOL		776						3			7							786
SQ	217	685						4			27	149						1,082
SVSP		928	6			2											69	1,005
VSP		988								13	2							1,003
WSP	1,100	129						3			7							1,239
DSH-ASH																		
DSH-CSH																		
Male Subtotal	**2,318**	**21,316**	**86**	**4**	**0**	**3**	**0**	**231**	**1**	**317**	**277**	**149**	**119**	**3**	**56**	**5**	**738**	**25,623**
CCWF	227	912						15			63	14						1,231
CIW		766		2						7	22					36		833
FWF		155																155
DSH-PSH		1																1
Female Subtotal	**227**	**1,834**	**0**	**2**	**0**	**0**	**0**	**15**	**0**	**7**	**85**	**14**	**0**	**0**	**0**	**36**	**0**	**2,220**
Grand Total	**2,545**	**23,150**	**86**	**6**	**0**	**3**	**0**	**246**	**1**	**324**	**362**	**163**	**119**	**3**	**56**	**41**	**738**	**27,843**

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SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

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Enhanced Outpatient Program (EOP) Level of Care Population by Housing Program

Institution	RC Reception Center	GP General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total EOP Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP		5																5
CAL																		
CCC																		
CCI		5									2							7
CEN																		
CHCF			366	5		2		34		82	27							516
CIM	33	1									3							37
CMC		3	444					1			30							478
CMF		1	422	3	6	3		16	2	9	27							489
COR		16	278					16		2	69							381
CRC		1																1
CTF		3																3
CVSP																		
DVI	12	1									1							14
FOL		5																5
HDSP		2															2	4
ISP																		
KVSP		5	94					1									7	107
LAC			476					1			80							557
MCSP		1	627					1			40							669
NKSP	56			1							5							62
PBSP								1										1
PVSP		8																8
RJD		1	727					2			35							765
SAC			467					1		12	58				145			683
SATF		1	561					7									8	577
SCC		1																1
SOL		2									2							4
SQ	27	8	145								9	33						222
SVSP			293			7											12	312
VSP		2	340							3	6							351
WSP	42										3							45
DSH-ASH		1	2			1												4
DSH-CSH			1															1
Male Subtotal	170	73	5,243	9	6	13	0	81	2	108	397	33	0	0	145	0	29	5309
CCWF		30	45					4			8							87
CIW			59							1					5			65
FWF		1																1
DSH-PSH		1																1
Female Subtotal	0	32	104	0	0	0	0	4	0	1	8	0	0	0	5	0	0	154
Grand Total	170	105	5,347	9	6	13	0	85	2	109	405	33	0	0	150	0	29	5463

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SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

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Mental Health Crisis Bed (MHCB) Level of Care Population by Housing Program

Institution	RC Reception Center	GP General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total MHCB Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC		1																1
CCI											1							1
CEN																		
CHCF				60	2					1								63
CIM		4		18														22
CMC		1		28														29
CMF				25	1													26
COR		3		17														20
CRC		1																1
CTF																		
CVSP																		
DVI																		
FOL																		
HDSP				4														4
ISP																		
KVSP				8														8
LAC				4														4
MCSP			1	3														4
NKSP				6														6
PBSP				1														1
PVSP		1																1
RJD				12														12
SAC				14										4				18
SATF			1	14														15
SCC																		
SOL				3														3
SQ				5														5
SVSP		1				3												4
VSP		1																1
WSP	1			4														5
DSH-ASH				2														2
DSH-CSH																		
Male Subtotal	1	13	2	228	3	3	0	0	0	1	1	0	0	4	0	0	0	256
CCWF	3			4							1							8
CIW				22														22
FWF																		
DSH-PSH																		
Female Subtotal	3	0	0	26	0	0	0	0	0	0	1	0	0	0	0	0	0	30
Grand Total	4	13	2	254	3	3	0	0	0	1	2	0	0	4	0	0	0	286

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SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

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Intermediate Care Facility (ICF) Level of Care Population by Housing Program

Institution	RC Reception Center	GP General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total ICF Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI																		
CEN																		
CHCF					35	262		4		1								302
CIM				7														7
CMC			4	6							2							12
CMF			2	9	20	239												270
COR				2														2
CRC																		
CTF																		
CVSP																		
DVI																		
FOL																		
HDSP																		
ISP																		
KVSP																		
LAC			2															2
MCSP			1								1							2
NKSP																		
PBSP																		
PVSP																		
RJD			1	1				1										3
SAC			2															2
SATF			2	1													1	4
SCC																		
SOL																		
SQ				1			25											26
SVSP			8			156												164
VSP																		
WSP																		
DSH-ASH		4	32	19	36	36		1		2								130
DSH-CSH		2	7	9	14	5												37
Male Subtotal	0	6	61	55	105	698	25	6	0	3	3	0	0	0	0	0	1	963
CCWF		1	2	2														5
CIW				1			35	1										37
FWF																		
DSH-PSH		1	1	1			7											10
Female Subtoal	0	2	3	4	0	0	42	1	0	0	0	0	0	0	0	0	0	52
Grand Total	0	8	64	59	105	698	67	7	0	3	3	0	0	0	0	0	1	1015

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SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

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Acute Psychiatric Program (APP) Level of Care Population by Housing Program

Institution	RC Reception Center	GP General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total APP Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI																		
CEN																		
CHCF				7	164	4		1										176
CIM																		
CMC				9														9
CMF				4	113	2		1										120
COR				3														3
CRC																		
CTF																		
CVSP																		
DVI																		
FOL																		
HDSP																		
ISP																		
KVSP				1														1
LAC				4														4
MCSP				5														5
NKSP																		
PBSP																		
PVSP																		
RJD			1															1
SAC				3										1	1			4
SATF			1	3														4
SCC																		
SOL				1														1
SQ																		
SVSP						3												3
VSP																		
WSP				2														2
DSH-ASH					2	1												3
DSH-CSH																		
Male Subtotal	0	0	2	42	279	10	0	2	0	0	0	0	0	1	1	0	0	336
CCWF				1														1
CIW																		
FWF																		
DSH-PSH																		
Female Subtotal	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Grand Total	0	0	2	43	279	10	0	2	0	0	0	0	0	1	1	0	0	337

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Exhibit KK

ANNUAL REPORT ON SUICIDES IN THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
JANUARY 1, 2015 – DECEMBER 31, 2015

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Executive Summary of the Annual Suicide Report

In 2015 a total of 24 inmate suicides occurred within the California Department of Corrections and Rehabilitation (CDCR). This number is an increase of one from 2014. The frequency of suicides in 2014 and 2015 are the lowest consecutive yearly number of suicides in the CDCR since 2002. The rate of suicide in the CDCR was 18.6 suicides per 100,000 inmates in 2015 and 17.0 per 100,000 in 2014. The suicide rate in U.S. state prisons ranged from 14-17 per 100,000 per year between 2000 and 2013[1] and 20 per 100,000 in 2014.[2] Male prisoners in the CDCR had a lower rate of suicide rate than U.S. males in the community in 2014 and 2015.[3]

Suicides in 2015 largely match prior year's patterns with respect to time of year, prevalence in spring and fall months, greater frequency in high custody inmates (75% in Level III and Level IV housing), and a relatively high percentage of suicides in inmates involved in mental health programming (typically 50-60%). Suicides in 2015 were somewhat unlike prior year's patterns in that there were two female suicides and three suicides of inmates aged 70 and older.

Both the frequency and the rate of suicide have declined in the CDCR over the past 10 years (2006-2015). The frequency of suicide in the CDCR decreased from 43 in 2006 to 23 in 2015, while the rate of suicide in the CDCR declined from 24.9 per 100,000 in 2006 to 18.6 per 100,000 in 2015. The decline in suicide rate in the CDCR in 2015 compared to the prior 10 years can be attributed to fewer suicides within segregated housing units, lower rates of suicides in Caucasian and Hispanic/Latino inmates, and fewer suicides in inmates aged age 35-54.

Many suicide prevention initiatives are underway and/or continuing in the CDCR. These initiatives have emerged from Quality Improvement Plans (QIP) on deaths by suicide, from recommendations generated by tours, reviews, and audits, from advances in the field of Suicidology, from opportunities arising from the Mental Health Tracking System and the Electronic Health Record System, and so forth. These initiatives are meant to enhance a comprehensive, integrated system of suicide prevention and are detailed in the report that follows.

[1] Noonan, M, Rohloff, H., & Ginder, S., Mortality in Local Jails and State Prisons, 2000-2013 Statistical Tables, US DOJ, Bureau of Justice Statistics, August, 2015 NCH 248756
[2] Noonan, M. Mortality in Local Jails and State Prisons, 2001-2014 Statistical Tables, US DOJ, Bureau of Justice Statistics, December, 2016, NCJ 250150
[3] http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2015/2015datapgsv1.pdf?ver=2017-01-02-220151-870

I. Introduction and Review of Findings

This report reviews the 24 suicides by inmates of the CDCR which occurred during 2015. The report is submitted as part of joint efforts by the CDCR and the Office of the Special Master's (OSM) experts to work together to reduce the number of suicides within California's state prisons and is part of the CDCR's compliance with court-ordered remediation specified by the Special Master as part of the continuing review in the matter of *Coleman v. Brown*, No. (CIV S-90-0520 KJM KJN E.D.Cal.).

This report is unlike prior reports in that the report is generated by the SMHP with consultation by *Coleman* court experts. Prior reports submitted to the Special Master were written by the *Coleman* court's experts. The purpose of the report remains the same: To report on ongoing efforts to monitor suicides in the CDCR, to identify any trends in suicide that may indicate targets for suicide prevention efforts, and to provide recommendations for continued improvement. Additional detail is provided in this report as to the definitions, response efforts, monitoring, and other improvement processes and programs implemented by or used by the SMHP to prevent suicide. The report is prepared for the Special Master and has implications for the CDCR and for the work of the *Coleman* court's experts.

The primary source of data used for this report is the suicide case reviews completed by members of the SMHP who are trained in conducting these reviews. Additional sources include data obtained from the CDCR Office of Research, information garnered from reports by the CDCR Death Review Committee, information from prior annual suicide reports, and publically available information regarding suicide rates in community and incarcerated settings. Each suicide was also independently reviewed by this author in order to assess trends in data or findings. Input made by the OSM's experts, who attend each suicide case review by teleconference and consult on case review, provided added information for this report. Finally, members of the Quality Management unit, a separate unit within the SMHP, provided input through auditing each suicide case review report.

A. Suicide definitions and terms used

The CDCR is in the process of adopting definitions related to suicide that were developed by the Centers for Disease Control and the World Health Organization and have been widely-adopted in community settings. As these changes are pending, the definitions used in the MHSDS Program Guide, 2009 Revision are listed below. Terms and definitions now considered obsolete are omitted from the listed provided here. Additionally, the term self-injurious is synonymous with self-harm. The term self-harm is used frequently in this report as it conforms to both existing definitions and proposed definitions and is routinely qualified by the phrases "with intent" or "without intent."

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

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

3. Suicidal Ideation: Thoughts of suicide or death, which can be specific or vague, and can include active thoughts of committing[4] [that is, dying by] suicide or the passive desire to be dead.

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

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

   [Note: The terms self-injurious behavior, self-mutilation, and suicide gesture are found in the MHSDS Program Guides, 2009 Revision, but are not used in this report. The term 'self-harm without intent' is used instead as the meaning is the same, self-harm for other reasons than death by suicide, and does not have the potentially negative connotations of terms such as 'gesture.']

B. Review of findings

Section 1: Current Year

Number and rate of suicide in reporting year: There were 24 suicides in the CDCR in 2015. This represents an increase of one over the total in 2014, or an increase of 4%. The suicide rate in the CDCR for 2015 was 18.6 per 100,000. Rates of suicide are standardized by the number per 100,000 in order to make standardized comparisons between samples and populations. The total number of suicides in 2015 corresponds to a suicide on average every 15.2 days.

Demographic Factors: In 2015, 22 men and 2 women died by suicide in the CDCR. The rate of suicides in the CDCR was 17.8 per 100,000 for men and 35.5 per 100,000 for women. The rate of suicide for women fluctuates more dramatically than the rate for men, as there are many more males (123,268) than females (5,632) in the CDCR. To illustrate, one fewer female suicide would have lowered the female rate in 2015 by one-half, from 35.5 to 17.6 per 100,000. The same decline of one suicide in males would have lowered the frequency by 1 in 22, or from a rate of 17.8 to a rate of 17.0 per 100,000. A listing of suicides by gender, per year over 10 and 20 year periods is found in Table 15 in this report.

[4] The term 'committing' has fallen out of favor with Suicidologists, as the term implies some sort of success in carrying out a pledge or obligation. The favored term is rather straightforward—'died by suicide.'

The racial and ethnic backgrounds of inmates who died by suicide are represented in Table 1. Caucasians represented over half of all suicides despite comprising only 22% of the population within the CDCR. This finding has been typical of the racial breakdowns of suicides within the CDCR for many years.

Table 1. *Racial/Ethnic Groupings of Suicides in the CDCR, 2015*

Racial Group	Frequency	Percent of Suicides	Percent of race within the CDCR
African-American	5	21%	29%
Caucasian	13	54%	22%
Hispanic/Latino	4	17%	42%
Other*	2	8%	6%

**1 Chinese American female, 1 Japanese American male*

Table 2 contains a listing of age groupings within the CDCR, with the number and percentage of suicides for each group compared with the prevalence of the age group within the CDCR. Of note, four age groups had higher rates of suicide than their corresponding representation within the CDCR population during the reporting year (2015): Inmates ages 30-34, 45-54, 60-64, and 65 and older. The overrepresentation of older inmates in the year's suicides may bear further monitoring as a possible emerging trend. The three suicides of older inmates occurred in individuals aged 70-73. The average age of those who died by suicide was 42.9.

Table 2. *Age Groupings of Suicides in the CDCR, 2015*

Age Group	Frequency	Percentage of 2015 Suicides	Percentage of CDCR Population
18-24	2	8	12
25-29	3	13	16
30-34	5	21	16
35-39	2	8	14
40-44	2	8	11
45-54	4	17	10
55-59	1	4	6
60-64	2	8	3
65 +	3	13	3

Marital Status: Marital relationships are thought to be a protective factor for inmates. This variable is protective for males in community studies and may function in a similar way for inmates as these relationships may offer support during incarceration.[5] In 2015, two suicides (one male, one female) occurred in married individuals, whereas nine suicides occurred in separated or

[5] Kposowa, A. (2000). Marital status and suicide in the National Longitudinal Mortality Study. *Journal of Epidemiology and Community Health,* 54, 254-261.

divorced inmates (including the second female) and 13 suicides occurred in single or never-married inmates.

Education, Juvenile History, and Work History: Three suicides occurred in inmates with some college education. The remaining 21 inmates had secondary educations, ranging from the 8th to 12th grade. Fifty-seven percent had a history of juvenile arrest, with 33% having a history of gang involvement. The majority of suicides occurred in inmates with limited employment history, typically in work classified as "unskilled labor." None of the suicides occurred in inmates who were in the Developmental Disability Program (DDP), though two inmates had some history of special education involvement.

Languages Spoken: One female inmate who died by suicide spoke Mandarin as her primary language. All others were primarily English-speaking.

Health Factors: Nearly half (46%) of the inmates who died by suicide in 2015 were considered to have serious and/or chronic medical problems. This ranged from problems with low back pain or headaches to cases of liver disease, diabetic neuropathy, cardiac problems, and legal blindness. In all cases, medical needs were determined to be adequately addressed according to nursing reviews. Implications of this finding for service delivery are explored later in this report.

Temporal Factors: Suicides occurred within the CDCR in nine months in 2015. That is, zero suicides occurred in three months. Four suicides occurred in one month (March) and five suicides occurred in each of two months (May and October). The prevalence of suicides in spring and fall months has been noted in prior years as well (*Figure 2* contains a breakdown of suicides by month over the current year and by a 10-year average).

In 2015, time of day of discovery did not vary significantly, with seven suicides occurring during first watch (2200 hours to 0600 hours), seven during second watch (0600 hours to 1400 hours), and ten during third watch (1400 hours to 2200 hours). This finding is similar to prior years.

Custodial and Correctional Factors: In 2015, suicides occurred at 13 institutions including an out-of-state facility. Table 3 lists suicides by institution. Any institutions that are not listed did not have a death by suicide in 2015.

Table 3. *Frequency of Suicide by CDCR Institution, 2015*

Institution	Frequency
California State Prison, Sacramento	3
San Quentin State Prison	3
Duel Vocational Institute	3
California Men's Colony	3
California Institution for Women	2
California State Prison, Corcoran	2
RJ Donovan Correctional Facility	2
California Medical Facility	1
California Correctional Institution	1
California Institution for Men	1
Folsom State Prison	1
California Health Care Facility	1
Tallahatchie County Correctional Facility	1
Total	24

As can be seen, one-half of the suicides in 2015 occurred in four institutions, and 18 (75%) of the suicides occurred within seven institutions.

During 2015, 9 of the 24 suicides occurred in segregated housing settings (37%); seven in Administrative Segregation Units (ASU), one in a Security Housing Unit (SHU), and one in Short-Term Restricted Housing (STRH). Two inmates were in Reception Centers, one in a Correctional Treatment Center (CTC), and one in a Sensitive Needs Yard (SNY). The remaining 11 suicides occurred in general population settings. This information is depicted in Table 4.

Table 4. *Frequency of Suicide by Housing Type, 2015*

Housing Type	Frequency	Percent
Administrative Segregation	7	29
Security Housing Unit	1	4
Short-Term Restricted Housing	1	4
Reception Center	2	8
Correctional Treatment Center	1	4
Sensitive Needs Yard	1	4
General Population	11	46
Total	24	99

A common finding in prison and jail settings is a preponderance of suicides in violent inmates and in inmates with higher level security needs; violent inmates have nearly three times the risk of suicide as non-violent inmates[6]. The commitment offenses of inmates who died by suicide in 2015 are listed below in Table 5. Notably, half of suicides occurred in individuals who had committed murder. Four other inmates had commitments for assault resulting in great bodily injury, one inmate had a commitment for battery, and two had a commitment for armed robbery (and thus the threat of assault was implied). Of the five commitment offenses considered non-violent, two resulted in significant injury but were seen as unintentional (driving under the influence resulting in injury or death). The remaining three suicides occurred in inmates who were committed for vehicle theft, burglary, or drug charges.

Table 5. *Commitment Offenses in Inmate Suicides, 2015* Type of Commitment Offense	N	Percent
Violent Crimes Overall	**19**	**79**
Murder	12	50
Assault w/ Great Bodily Injury	4	17
Armed Robbery	2	8
Battery	1	4
Sex Offense	0	0

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

Non-Violent Crimes Overall	**5**	**21**
DUI with injury/vehicular manslaughter	2	8
Vehicle theft	1	4
Burglary	1	4
Drug Charges	1	4

In regards to security level, suicides occurred predominantly in higher security (Level III and Level IV) settings in 2015. Table 6 lists the number of suicides by security classification level. Level IV suicides have traditionally represented more than half of all suicides within CDCR. Of note, the classification system used by the CDCR was modified prior to 2015, with fewer inmates classified at the highest level, Level IV, which may account for some of the decline in Level IV inmate suicides in 2015.

Table 6. *Suicides per Security Level, 2015*		
Security/Classification Level	N	Percent
Level IV	9	37.5
Level III	9	37.5
Level II	6	25
Level I	0	0

Another variable unique to correctional settings is the issue of sentence length: Total length of sentence, how much time an inmate has served prior to a suicide, and how much time an inmate had left to serve in prison prior to a suicide. These variables are captured in Tables 7, 8, and 9.

Table 7 shows that a slight majority of suicides (54%) occurred in inmates with Life sentences (including condemned individuals) in 2015. Inmates with Life sentences have historically made up roughly 20% of the population within the CDCR and are overrepresented in individuals who die by suicide. No suicides occurred in inmates with medium length sentences (11 to 20 years) in 2015.

Table 7. *Suicides in the CDCR by Length of Sentence, 2015*

Sentence Length	Frequency	Percent
1-5 years	7	29
6-10 years	3	13
11-20 years	0	0
20+ years	1	4
Life with Possibility of Parole	11	46
Life without Possibility of Parole	1	4
Condemned	1	4
Total	24	100

As seen in Table 8, individuals early within their sentence represent a high risk group. Five inmates died by suicide within their first year of incarceration; this included two individuals who died within 30 days of imprisonment. Three inmates who had served 20 years or more were among those who died by suicide in 2015.

Table 8. *Suicides in the CDCR by Amount of Time Served, 2015*

Sentence Length	Frequency	Percent
0-1 year	5	21
1-5 years	5	21
6-10 years	7	29
11-20 years	4	17
21+ years	3	12
Total	24	100

The length of time remaining in sentences for those who died by suicide are shown in Table 9. There was nearly an even split between those with short to moderate sentences left to serve (46%) and those with lengthy sentences or indeterminate/life sentences (54%).

Table 9. *Suicides in the CDCR by Time Left to Serve, 2015*

Sentence Length	Frequency	Percent
0-1 year	0	0
1-5 years	10	42
6-10 years	1	4
11-15 years	0	0
16 years or more (including Lifers)	13	54
Total	24	100

The implications for the findings represented in Tables 7, 8, and 9 are considerable, suggesting the need to discuss the unique risk associated with life sentences and long prison stays as well as the risks associated with being early within a sentence. These considerations will be discussed later in this report.

Cell Occupancy: In 2015, 25% of suicides occurred in inmates housed in designated double cells and 75% of suicides occurred within designated single cells. Of the six suicides in designated double cells, two suicides occurred in cells without a currently assigned cellmate, two inmates waited for a cellmate to leave for work or other programming before dying by suicide, one occurred outside of the cell (by jumping from a tier), and one occurred with a cellmate present but asleep. Of the nine suicides occurring in segregated housing settings, eight of the suicides occurred in single-person cells. The ninth suicide occurred in a double cell but without an assigned cellmate. Overall, 23 of the 24 suicides occurred within a single cell or within a solely occupied (at the time) double cell.

Job Assignment: The majority of inmates (62.5%) who died by suicide in 2015 did not have a job assignment or educational placement. Of the nine inmates who had program assignments, two were placed in educational settings, one (female) in a substance abuse program, and six were in traditional jobs (e.g., as a porter).

Means or Method of Suicide: Correctional settings necessarily limit the methods or means inmates can use to die by suicide. For example, suicides by firearms or carbon monoxide poisoning are unheard of in correctional systems. As with most correctional systems, hanging is the primary means used by inmates in the CDCR to die by suicide. Inmates have ready access to clothing and linen items that can be used for nooses and ligature points can be found in nearly all cells. In 2015, both female suicides were by hanging and 20 of the 24 suicides overall were by hanging (83%).

The remaining four inmates (males) died by intentional overdose (2), asphyxiation (1), and jumping from a high place (1).

Mental Health Factors: The number and percentage of inmates who died by suicides in the CDCR in 2015 who were participants in the Mental Health Services Delivery System (MHSDS) is listed in Table 10. Mental health patients continue to be overrepresented in the year's suicides, a pattern that is typical in correctional and community settings.

Table 10. *Suicides in the CDCR by MHSDS Participation, 2015*

Sentence Length	Frequency	Percent
No MHSDS participation	10	42
Correctional Clinical Case Management System	9	37
Enhanced Outpatient Program	5	21
Total	24	100

Ten inmates were not in the MHSDS at the time of death. Six of these inmates (25% of the total number of suicides) had no history of participation in the MHSDS. Four inmates who were not in the MHSDS system at the time of death had previously been in the MHSDS at the Correctional Clinical Case Management System (CCCMS) level of care.

In 2015, 15 (62.5%) of the inmates who died by suicide had a history of mental health treatment prior to incarceration. Of these, 11 were in the MHSDS at the time of death, with one other having previously participated in the MHSDS. Eight cases (33%) had a family history of mental illness and/or family history of substance abuse treatment.

Upon entrance to the CDCR, inmates are screened for the possible presence of significant mental health disorders. Thirteen (55%) of the inmates who died by suicide in 2015 were identified as possibly having significant mental health disorders during initial screening. On subsequent mental health evaluations, 69% of those positive on screening were also found to have mental health conditions qualifying them for MHSDS services.

At the time of suicide, 14 inmates (58%) were on psychiatric medications. Three individuals (13%) had involuntary medication orders in place per Penal Code 2602. Eleven of the 24 (46%) had a history of Mental Health Crisis Bed placement or inpatient hospitalization. Eight (33%) had been psychiatrically hospitalized in the year prior to their suicide.

Diagnoses: The mental health diagnoses of individuals who died by suicide in 2015 are summarized in Table 11 and are listed by frequency. Please note that people can have multiple mental health diagnoses, thus the frequency of diagnoses in Table 11 exceeds the number of annual

suicides. Additionally, all inmate suicides in 2015 involved individuals with some history of substance use or abuse. However, the diagnoses listed in Table 11 include substance use disorders *only* if formally reported as a diagnosis. All diagnoses are based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 4th Edition or 5th Edition (DSM-IV or DSM-5).

When present, mood disorders and psychotic disorders were listed as the primary diagnosis of record. Of the individuals diagnosed with mood disorders, five were diagnosed with Major Depressive Disorder and four with Bipolar I Disorder. Five individuals were diagnosed with psychotic disorders; three with Schizophrenia, one with Delusional Disorder, and one with Psychotic Disorder NOS. Six inmates were diagnosed with Antisocial Personality Disorder and two of these six inmates were concurrently diagnosed with Narcissistic Personality Disorder.

Table 11. *Mental Health Diagnoses of Suicides in the CDCR, 2015*

Diagnostic Category	Frequency	Percent
Any DSM Disorder	20	83
Substance Abuse or Dependence	13	54
Mood Disorder Major Depressive Disorder (5) Bipolar I Disorder (4) Psychotic Disorder (5)	9	38
Personality Disorder	6	25
Psychotic Disorder Schizophrenia (3) Delusional Disorder (1) Psychotic Disorder NOS (1)	5	21
Adjustment Disorder	4	17
No Diagnosis	4	17
Anxiety Disorder	1	4

Suicide Attempt History: A history of suicide attempts was found in 16 (67%) of the 24 cases of suicide in 2015. Of the group of 16, ten had made multiple past suicide attempts (42% of the overall total). Of those that had prior suicide attempts, 10 had reported at least one suicide attempt while in the community and eight had at least one suicide attempt while incarcerated. For the eight individuals who had suicide attempts during incarceration, a range of one to five prior attempts in prison were noted. The finding of 10 suicides within *Multiple Attempters,* a term indicating the

presence of two or more suicide attempts with the intent to die, is significant as this is a group with known high chronic risk.[7] Implications of this finding are discussed later in this report.

Suicide Precipitants and Behavior: Seven of the 24 individuals (29%) who died by suicide in the CDCR in 2015 wrote suicide notes. This is a bit higher than the rate (one in six or 17%) found in community samples.[8] A small percentage (17%) of the deaths occurred in inmates who reported having no interpersonal supports, while two reported having one person in their support system. The majority (75%) endorsed two or more supports during their most recent mental health or suicide risk evaluations. Only one of the 24 (4%) of the suicides occurred in a patient who was believed to be feigning distress or suicidality. Five of the 24 inmates who died by suicide in 2015 did so on a holiday, with one each on Christmas Eve, Memorial Day, 4th of July, Halloween, and Chinese New Year.

Suspected precipitants are event(s) that precede a death by suicide. These events may also be referred to as potential triggers to one's decision to end their life. The precipitants to the current year suicides listed or suspected by Mental Health Suicide Reviewers (MHSRs) in their suicide case review reports were examined, and are presented in Table 12.

Table 12. *Suspected Precipitants to Suicides in the CDCR by frequency, 2015*

Precipitant Category	Frequency	Percent of Total
Receipt of new charges, convictions, disciplinary actions, or added time in prison	9	17
Safety concerns, drug debts, fears of victimization, gang pressures	8	15
Mental health symptoms, e.g. anxiety, psychosis	7	13
Medical illness and/or pain issues; medical disability	6	11.5
Holidays or anniversaries of losses, crimes, etc.	6	11.5
Disruption in prison 'program;' e.g., transfer between facilities, cellmate change, loss of single cell housing	4	8
Conflict or losses of external supports	5	10

[7] Rudd, Joiner, & Rajab (1996). Relationships among suicide ideators, attempters, and multiple attempters in a young-adult sample. *Journal of Abnormal Psychology*, 105, 541-550.
[8] Gelder, Mayou, and Geddes (2005). Incidence of note-leaving remains constant despite increasing suicide rates. *Psychiatry and Clinical Neurosciences,* 4 (1).

Table 12. *Suspected Precipitants to Suicides in the CDCR by frequency, 2015*

Conflict or losses of within prison supports	4	8
Receipt of or anticipation of negative outcomes with the Board of Prison Hearings	2	4
Loss of parole to the community (e.g., due to added sentence, finding of MDO or SVP)	1	2
Totals:	52	100

The precipitants listed in suicide case review reports can be divided roughly into ten categories as represented in Table 12. The frequency of precipitants is greater than the total number of suicides, as nearly all suicide case reviews listed more than one hypothesized precipitant. In many cases, the precipitants were not entirely clear. Rather, the precipitants identified by suicide case reviewers are marked by each inmate's idiosyncratic reasons for ending one's life. The frequency of certain categories of suicide precipitants has implication for prevention efforts as explored later in this report.

Additionally, Table 13 indicates the precipitant factors for suicides occurring in the CDCR in 2015 on a case by case basis. As is apparent, the majority of inmates had multiple potential triggers for the action. Also, in-prison events or stresses are noted in most, but not all, cases. Greg Dear and colleagues reported similar findings in Australian prisons with suicide attempters. When interviewed, prisoners reported two or more of five categories related to precipitants for attempts, with the most common category (71% of incidents) being termed "stressful event that occurred within the prison" and second most common category (43% of incidents) being a consequence of imprisonment (e.g. placing a strain on family).[9] These themes are mirrored in the 2015 suicides within the CDCR and have been presented to CDCR clinicians in monthly suicide prevention videoconferences and in revised trainings in suicide risk evaluation. The precipitants listed in Table 13 are those suspected by Mental Health Suicide Reviewers (MHSRs) within each suicide case review reports.

[9] Dear, Thomson, Hall, & Howells (2001). Non-fatal self-harm in Western Australian prisons: Who, where, when, and why. *Australian & New Zealand Journal of Criminology*, 34, 47-66.

Table 13: *Individual Precipitants for Suicides within the CDCR, 2015*[10]

Case	**Precipitants Noted**
A	Interpersonal losses/estrangement; notified of additional charges (rape case pending investigation); holiday (Halloween)
B	Received 3 year sentence extension (assault on peace officer) with long ASU stay
C	Safety concerns/fears of victimization (went into protective custody)
D	Gang pressures/attempted to debrief; conflict with custody officers
E	Health concerns and complaints of pain; panic attacks and tearfulness around "no hope" of getting better medically; holiday (Chinese New Year)
F	Concerned about losing single cell and a large amount of personal property in a pending transfer and reported he could not cell with others
G	Serious medical disabilities; distress regarding possible transfer
H	Parole denied by BPH; argument with main family support (daughter); of hoarded medication (for overdose) was found and charged for possession for sales
I	Dysphoria/hopelessness about the possibility of parole, thus requested/given CCCMS discharge; disciplinary infraction at work (faced losing assignment)
J	Health concerns (headaches); close custody status due to RVR; holiday (4th of July)
K	Paranoia/belief that family or other inmates intended to have the inmate stabbed
L	Multiple disciplinary actions with time added to sentence; anniversary of step-son's suicide; accrual of drug debt;; cellmate moved out of cell; told of positive lab test (Hepatitis C); familial estrangement
M	Interpersonal problems/perceived rejection from other inmates on living unit
N	Medical illness (terminal) and pain issues; housing issues (SNY status/safety concerns); conflict with spouse
O	Convicted of murder of another inmate (incident occurred in 2012), thus received 45 years to life sentence and 25-month SHU term
P	Concern about drug debts and substance use relapse; familial estrangement; bothersome hallucinations/depression; holiday (Memorial Day)
Q	Fought with inmate and reported safety concerns; transferred during 5-day follow-up period after MHCB stay rescinded
R	Chronic illness/pain, 'bad news' about medical condition (liver cancer), and researched Christian beliefs about suicide and the 'unforgiveable sin' prior to suicide
S	Safety concerns, thus requested Sensitive Needs Yard (SNY); complained of hallucinations and reported delusional beliefs
T	Concern about transfer (to a different prison) and feared losing single cell status; feelings of depression/worthlessness
U	Interviewed for Mentally Disordered Offender (MDO) status and found to meet MDO criteria—upset by this; somatic delusions; holiday (Christmas)
V	Inability to move in with in-prison romantic partner; reported having an enemy to move 'yards' and was taken to ASU rather than desired 'yard'

[10] Precipitants tabulated for Table 12 are separated by semicolons in Table 13 (when more than one precipitant was determined by the Suicide Case Reviewer).

W	Delusions/hallucinations; less faith that legal appeal would be won with the result being serving a long sentence.
X	Agitation from hallucinations and delusions, increasing depression, facing SHU term

C. Review of findings

Section 2: Current Year vs. Prior Years

Comparison of suicide rate between current and prior years: The suicide rate in the CDCR in 2015 was 18.6 per 100,000. This rate is higher than in 2014, when the rate was 17.0 per 100,000, reflecting both one more suicide in 2015 than in 2014 and a decrease in the inmate population of a little over 6500 from 2014 to 2015. The rate of 18.6 per 100,000 is the third lowest rate in the past 10 years. During the ten-year period, 2006 to 2015, the rate of suicide in the CDCR was 20.5 per 100,000.

Table 14, presents two mid-year (June 30th) frequency and rate of suicide calculations, by gender. The first calculation is in-state only and does not include the out-of-state CDCR inmate population; this is provided in order to ensure consistency with past reports prepared by members of the OSM. The second rate includes the out-of-state population and is consistent with past internal methods used by CDCR. The rate including the out-of-state population is the more meaningful number, as out-of-state-suicides, when they occur, are included in rate calculations. Furthermore, these individuals were remanded to CDCR custody and the CDCR maintains responsibility for their welfare.

Table 14. *2015 In-state, Out-of-state and Overall Mid-year Frequency and Rate of Suicide, by Gender*

	Male			Female			Total		
	Population	Freq	Rate	Population	Freq	Rate	Population	Freq	Rate
Mid-year In-state only	115,835	22	19.0	5,632	2	35.5	121,467	24	19.8
Mid-year In-state and out-of-state total	123,268	22	17.8	5,632	2	35.5	128,900	24	18.6

Table 15 shows the rate and frequency of suicide in the CDCR for the past 20 years. The table shows the rate and frequency of suicides by gender during each year as well. Of note, the frequency of suicides over the period has ranged from a low of 15 in 2000 to a high of 43 in 2006.

As mentioned earlier, the rate of suicide in female inmates fluctuates considerably compared to a relatively stable rate in male inmates. In 11 of the past 20 years, there were no female suicides.

The number of suicides in female institutions has ranged from a low of 0 to a high of 4 within the time period; with 2 occurring in 2015.

For reference, population figures in all years were garnered from the CDCR's Offender Information Services Branch. The population figures are reflective of mid-year (June 30th) of the respective year, following the previous practice of reports prepared by members of the OSM, the practice of the Federal Bureau of Justice Statistics and to remain consistent in CDCR's methodology for calculating suicide frequency and rate.

Table 15. *Annual Frequency and Rate of Suicide in the CDCR for 20 years, by Gender and Overall, 1996-2015*[11]

Year	Male			Female			Total		
	Population	Freq	Rate	Population	Freq	Rate	Population	Freq	Rate
1996	131,273	19	14.5	9,744	0	0	141,017	19	13.5
1997	141,669	18	12.7	10,837	0	0	152,506	18	11.8
1998	147,001	21	14.3	11,206	0	0	158,207	21	13.3
1999	150,581	24	15.9	11,483	0	0	162,064	24	14.8
2000	150,793	15	9.9	11,207	0	0	162,000	15	9.3
2001	150,785	29	19.2	10,712	1	9.3	161,497	30	18.6
2002	148,153	22	14.8	9,826	0	0	157,979	22	13.9
2003	150,851	37	24.5	10,080	0	0	160,931	37	23.0
2004	152,859	23	15.0	10,641	3	28.2	163,500	26	15.9
2005	153,323	37	24.1	10,856	0	0	164,179	37	22.5
2006	160,812	39	24.3	11,749	4	34.0	172,561	43	24.9
2007[12]	161,424	33	20.4	11,888	1	8.4	173,312	34	19.6
2008	159,581	36	22.6	11,392	0	0	170,973	36	21.1

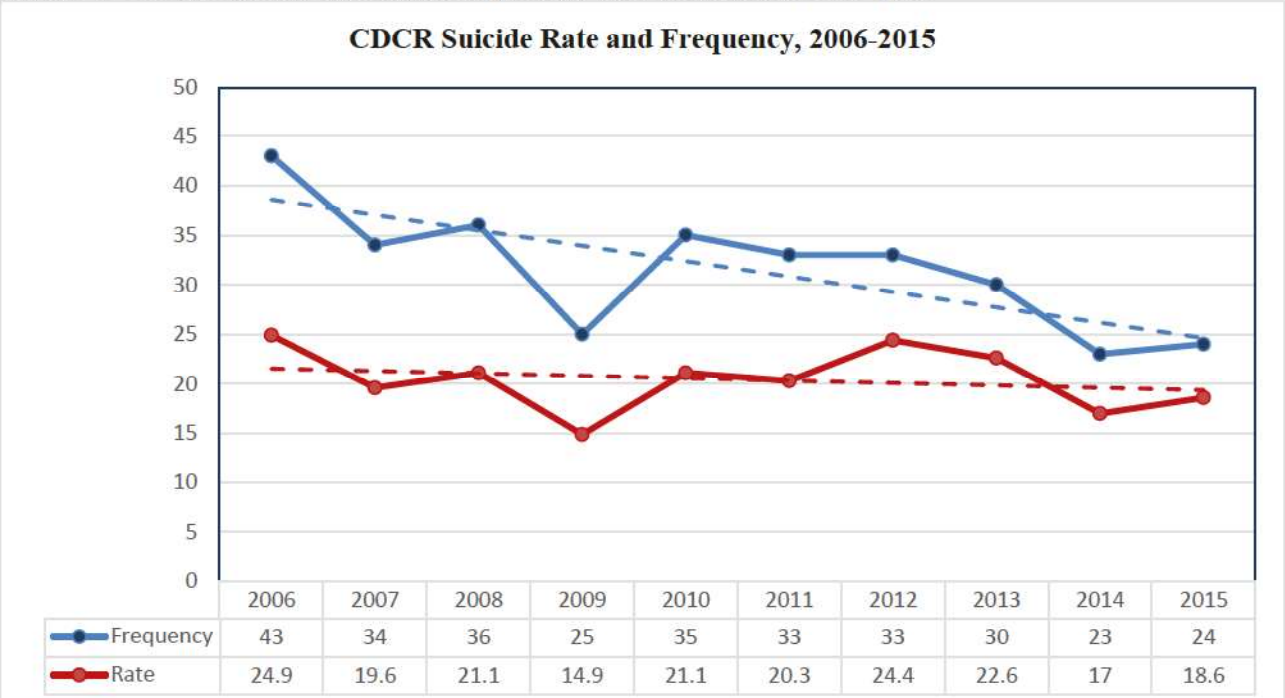
[11] Population figures are from the Offender Information Services Branch. From 1996 through 2010 the population figures are as of June 30, following the practice of the federal Bureau of Justice Statistics, and reflecting relatively stable institutional populations. From 2011 through 2014 the figures are average daily population which better reflects the institutional population during years with large declines of population (due to AB 109). In 2015, and reflecting a more stable census, population figures returned to mid-year (June 30) counting. Caution should be exercised when making comparisons of suicide rates between California and national or state estimates published by the Bureau of Justice Statistics since these rates are not adjusted for demographic factors.

[12] California state law (AB 900) enacted in 2007 allowed for CDCR inmates to be housed in Out-of-State Correctional Facilities. The population figures above include out-of-state and in-state inmates for all years.

2009	156,805	25	15.9	11,027	0	0	167,832	25	14.9
2010	155,721	34	21.8	10,096	1	9.9	165,817	35	21.1
2011	152,803	33	21.6	9,565	0	0	162,368	33	20.3
2012	128,829	32	24.8	6,409	1	15.6	135,238	33	24.4
2013	126,992	29	22.8	5,919	1	16.9	132,911	30	22.6
2014	129,268	21	16.2	6,216	2	32.2	135,484	23	17.0
2015	123,268	22	17.8	5,632	2	35.5	128,900	24	18.6
1996-2015	2,932,791	549	18.7	196,485	16	8.1	3,129,276	565	18.1
2006-2015	1,455,503	304	20.9	89,893	12	13.3	1,545,396	316	20.5

Notably, the rate of suicide within the CDCR has trended downward over the past 10 years (2006-2015). The trend line can be seen in Figure 1.

Figure 1: *CDCR Suicide Rate and Frequency, with trend line, 2006-2015*



Suicides by institution, current year vs. 15-year average: Whereas Figure 1 represents suicides throughout the whole of the CDCR; the frequency of suicides by institution is a less stable variable. The higher frequency of suicide at some facilities versus others has many explanations. Variables such as the number of patients in the institution's mental health program, the mental health mission

of the facility, the predominance of violent offenders at the site, and the total number of inmates at the institution are just some of the factors that contribute variance to *where* suicides occur. Fluctuations can occur in the number of suicides at an institution in given years due to cluster effects[13], changes in the use or mental health mission of the institution, and other factors. There are also subsets of suicides that occur during or upon transfer of an inmate from one institution to another, further complicating the interpretation of *why* suicides occur at certain institutions more frequently than others.

Table 16 lists the number of suicides at CDCR Institutions in 2015 along with the total and average number of suicides at each institution over a 15-year period. The inclusion of 15-years of data allows current year data to be compared to averages over a significant period of time. The range of suicides on average per year for all facilities was 0.0 to 2.1. The mean for suicide for all institutions from 1999-2014 was 30.2 suicides per year.

Table 16. *Frequency of Suicide by CDCR Institution, 2015 and by prior 15-year total and average (1999-2014)*

Institution	2015 Frequency	Prior 15-year total (1999-2014)	Prior 15-year average (1999-2014)
California Health Care Facility	1	0	0
Tallahatchie County Correctional Facility	1	0	0
Department of State Hospitals-Salinas Valley	0	1	0.1
California Rehabilitation Center	0	1	0.1
Chuckawalla Valley State Prison	0	1	0.1
Valley State Prison	0	2	0.1
California Correctional Center	0	2	0.1
Ironwood State Prison	0	2	0.1
Atascadero State Hospital	0	4	0.3
Calipatria State Prison	0	5	0.3
Sierra Conservation Center	0	5	0.3
Centinella State Prison	0	6	0.4

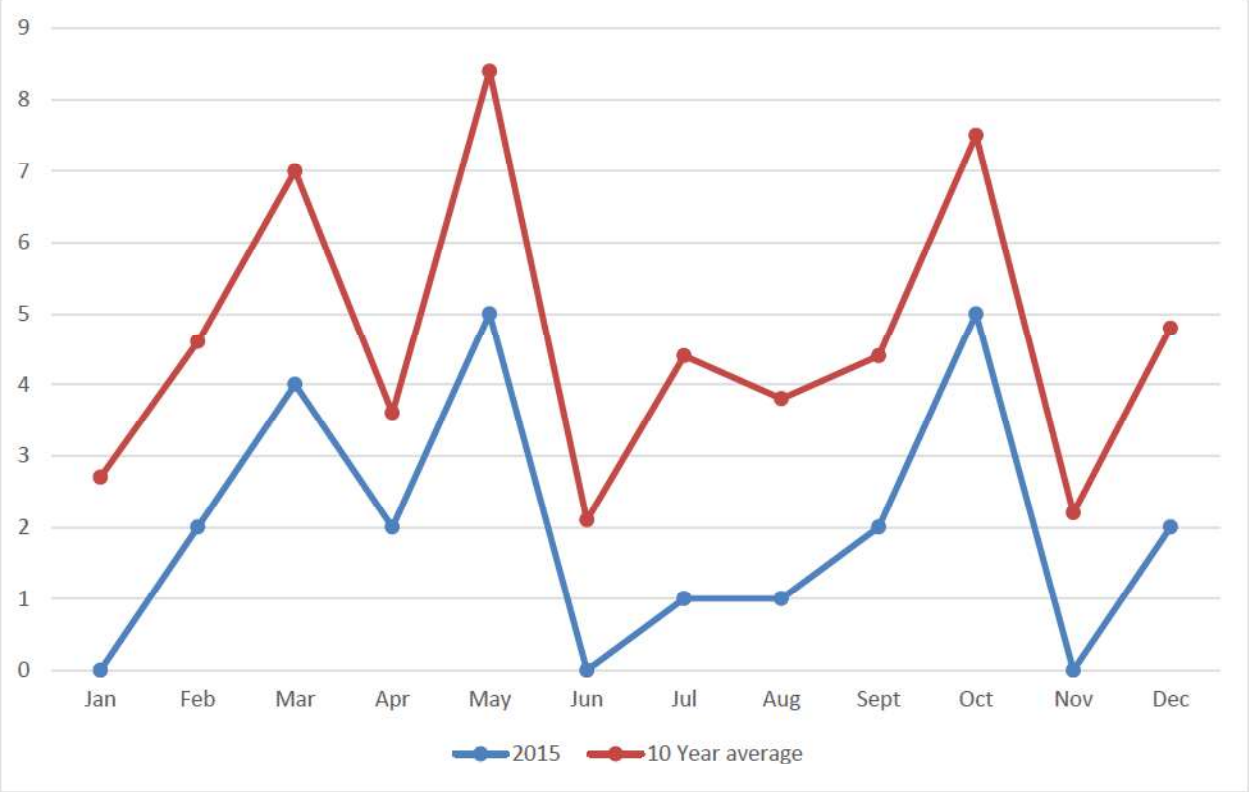
[13] Hawton, Linsell, Adeniji, Sariaslan, & Fazel (2014). Self-harm in prisons in England and Wales: An epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. *Lancet,* Vol. 383.

Institution	2015 Frequency	Prior 15-year total	Prior 15-year average
California Institution for Women	2	6	0.4
Avenal State Prison	0	7	0.5
Department of State Hospitals-Vacaville	0	7	0.5
Central California Women's Facility	0	7	0.5
California State Prison, Solano	0	10	0.7
North Kern State Prison	0	10	0.7
Kern Valley State Prison	0	11	0.7
Pleasant Valley State Prison	0	13	0.9
Wasco State Prison	0	13	0.9
Mule Creek State Prison	0	14	0.9
California Substance Abuse Treatment Facility	0	15	1.0
California Correctional Institution	1	15	1.0
California Training Facility	0	16	1.1
Pelican Bay State Prison	0	16	1.1
High Desert State Prison	0	17	1.1
Folsom State Prison	1	18	1.2
Deuel Vocational Institute	3	19	1.3
California Medical Facility	1	21	1.4
California Institution for Men	1	22	1.5
California State Prison, Los Angeles County	0	22	1.5
California State Prison, Corcoran	2	24	1.6
RJ Donovan Correctional Facility	2	24	1.6
California Men's Colony	3	27	1.8
San Quentin State Prison	3	29	1.9
Salinas Valley State Prison	0	30	2.0

California State Prison, Sacramento	3	31	2.1
Total	24	453	30.2

Suicides in the CDCR by month, current year and 10-year average: CDCR data covering a 10-year period (2006-2015) shows little or no trend in the frequency of suicides in any given month. As in 2015, suicides tend to occur in the spring and fall months of the year. Suicides in the CDCR have traditionally not been associated with specific holiday periods, though in 2015 there were five suicides on holiday days (21%) spread over five different months. See Figure 2. The prevalence of suicides in March, May, and October has not been explained. CDCR clinicians have noted this trend over several years.

Figure 2: *CDCR Frequency by Month, 2015and 10-Year Average*

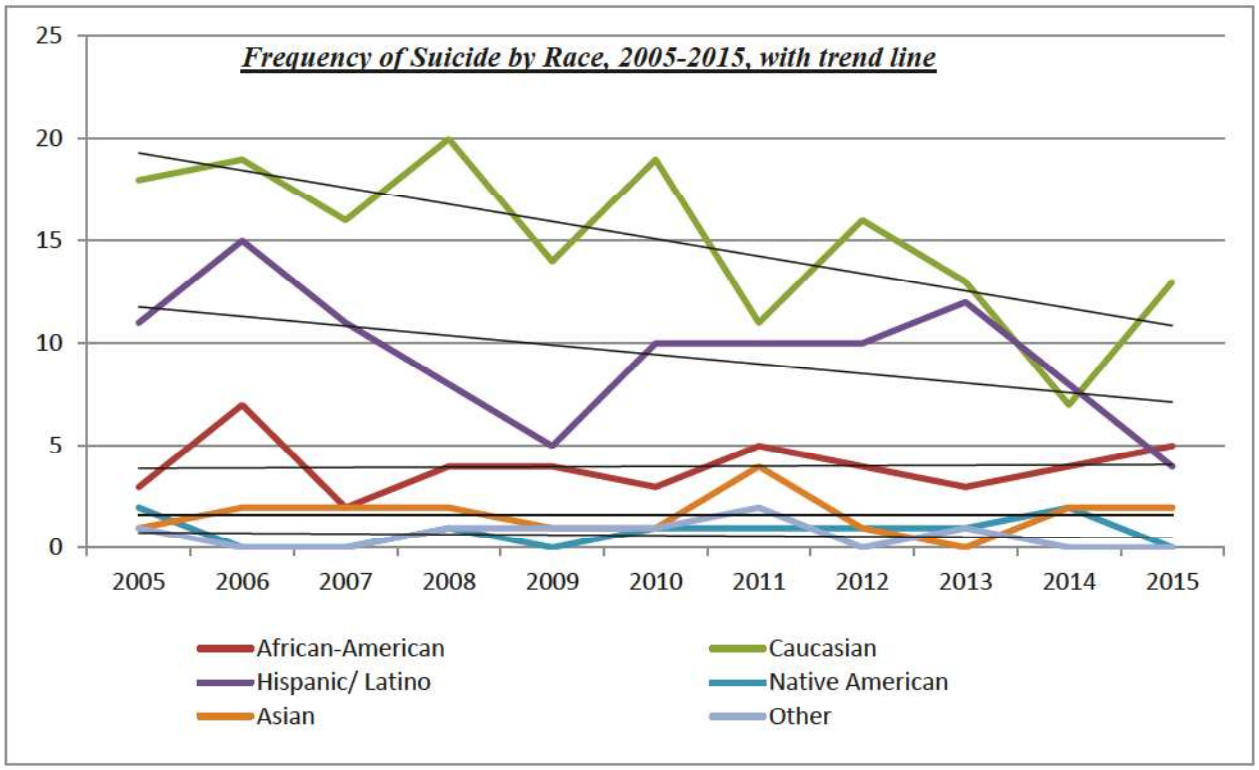


Demographic Factors: Demographic variables specific to 2015 suicides are presented earlier in this report. These factors are presented here only as a means of comparing information from prior years with 2015 suicide data.

A depiction of suicides by race in 2015 and over the past 10 years is found in Figure 3. Caucasians comprise the largest group, comprising 48% of the suicides over the 10-year period and 54% of the suicides in 2015. Caucasian suicides have consistently fallen within a range of 14 to 20 per

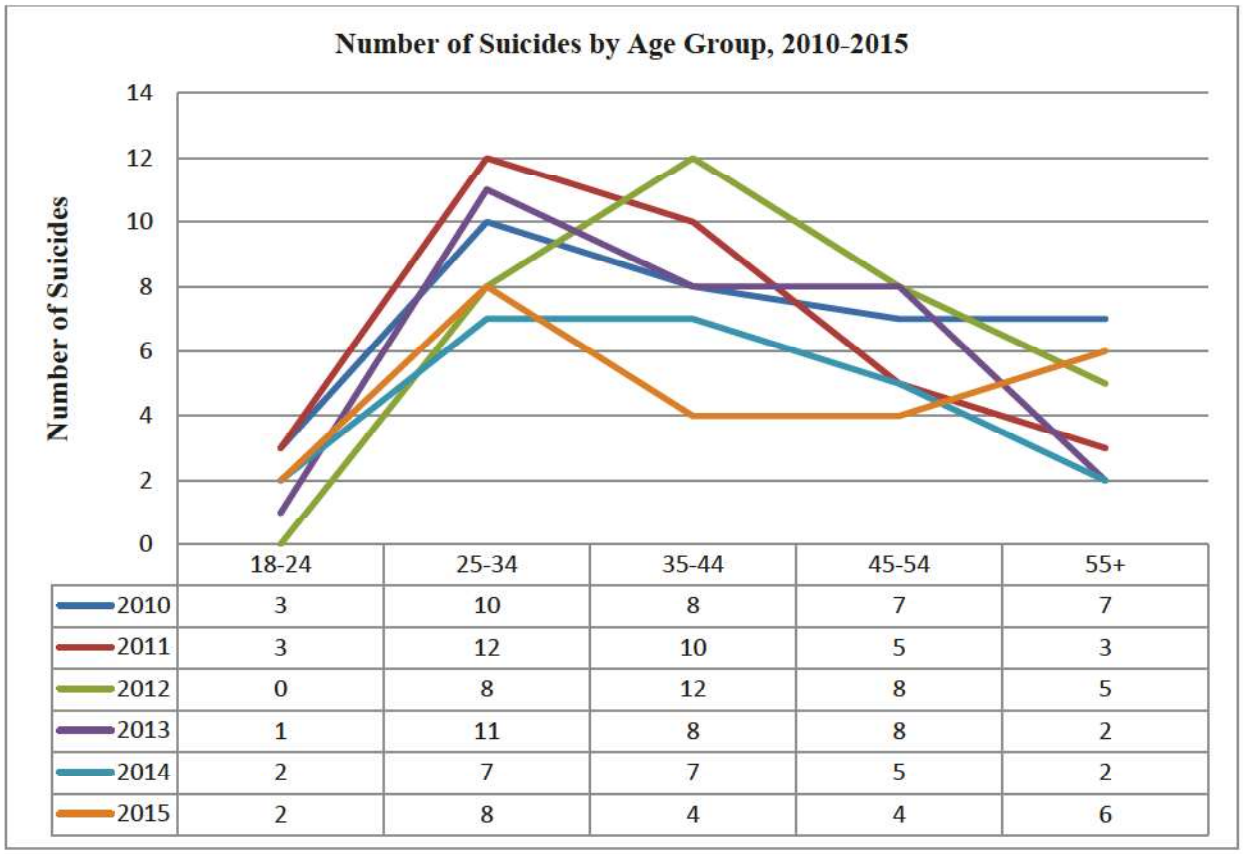
year. Hispanics/Latinos make up the second largest group, accounting for 30% of the suicides over the years represented. Hispanic/Latino suicides have a more variable range, from 5 to 15 in any given year. African-Americans account for 13% of the suicides during these years with a range from 2 to 7. The frequency of suicides in other racial groups is relatively small and typically at a range of 0 to 2 per year. The trend lines in Figure 3 suggest that the relative decline in suicides within the CDCR during 2014 and 2015 are in Caucasians and Hispanics/Latinos, the two groups who historically have the highest numbers of suicides within the CDCR.

Figure 3: *Suicide Frequency by Race, 2005-2015, with trend line*



Age is divided into five adult age brackets in Figure 4: Ages 18-24, 25-34, 35-44, 45-54, and 55 and above. In all but one year, 2012, the largest frequency of suicides in any age group was in individuals aged 25-34. Compared to the prior five years, 2010 to 2014, suicides in 2015 were somewhat lower in inmates aged 35-44 and 45-54, and slightly higher than most past years in ages 55 or older. The 55 and older age group had the second highest total in the past 6 years. In 2015, 25% of the suicides occurred in this age group, an age group that comprises 12% of the population of the CDCR. This number (25%) is similar to 2010, when 22% of suicides were in the 55 and over group, and dissimilar to other years: 9% in 2011, 15% in 2012, 7% in 2013, and 8% in 2014.

Figure 4: *Number of Suicides by Age Group, 2010-2015*



	18-24	25-34	35-44	45-54	55+
2010	3	10	8	7	7
2011	3	12	10	5	3
2012	0	8	12	8	5
2013	1	11	8	8	2
2014	2	7	7	5	2
2015	2	8	4	4	6

Suicides by housing type: Historically and in national and international studies,[14] segregated housing units have been a high-risk setting for suicide, particularly in single cell housing.[15] In the CDCR, segregated housing includes ASU, SHU, STRH, Long Term Restricted Housing (LTRH), Psychiatric Services Units (PSU), and the Condemned units at San Quentin State Prison and California Correctional Institution for Women. During 2015, nine of the year's 24 suicides occurred in segregated housing settings, representing 37.5% of all suicides. For reference, approximately 6.5% of inmates were housed in segregated housing at the mid-year point of 2015 (June 30, 2015). Calculating a rate per 100,000 in segregated housing may be misleading as the overall population is quite small and subject to wide swings in rate based on a single suicide.[16]

Of the nine suicides that occurred in segregated settings in 2015, seven were in ASU, one in a SHU, and one in STRH. The number and percentage of suicides in segregated housing settings for 2015 and over the prior five year period is found in Table 17. As can be seen, the frequency of suicides in segregated housing decreased significantly in 2015 compared to prior years (2010-2014). Whereas 47% of suicides within the CDCR occurred in a segregated housing setting in the

[14] World Health Organization (2007). *Preventing suicide in jails and prisons.* WHO Document Production, Geneva, Switzerland.
[15] *Id.*
[16] Based on a segregated housing population of 8,325 inmates on June 30, 2015.

ten year period between 2004 and 2014 and 45% of suicides occurred in segregated housing on average in the ten year period from 2010 to 2014, 37,5% of suicides occurred in this setting during 2015. This may represent changes adopted within the CDCR leading up to and occurring within the reporting year, such as implementation of safety/wellness checks using the Guard One system and initiation of enhanced mental health services for MHSDS participants in segregated settings (e.g., STRH and LTRH units). Also of note, inmates in single-cell housing accounted for eight of the nine suicides (89%) within segregated housing units in 2015. This percentage is consistent with prior years. The percentage of suicides in segregated housing units that occurred in single cell housing in the prior five years was 100% in 2010, 86% in 2011, 91% in 2012, 100% in 2013, and 86% in 2014.

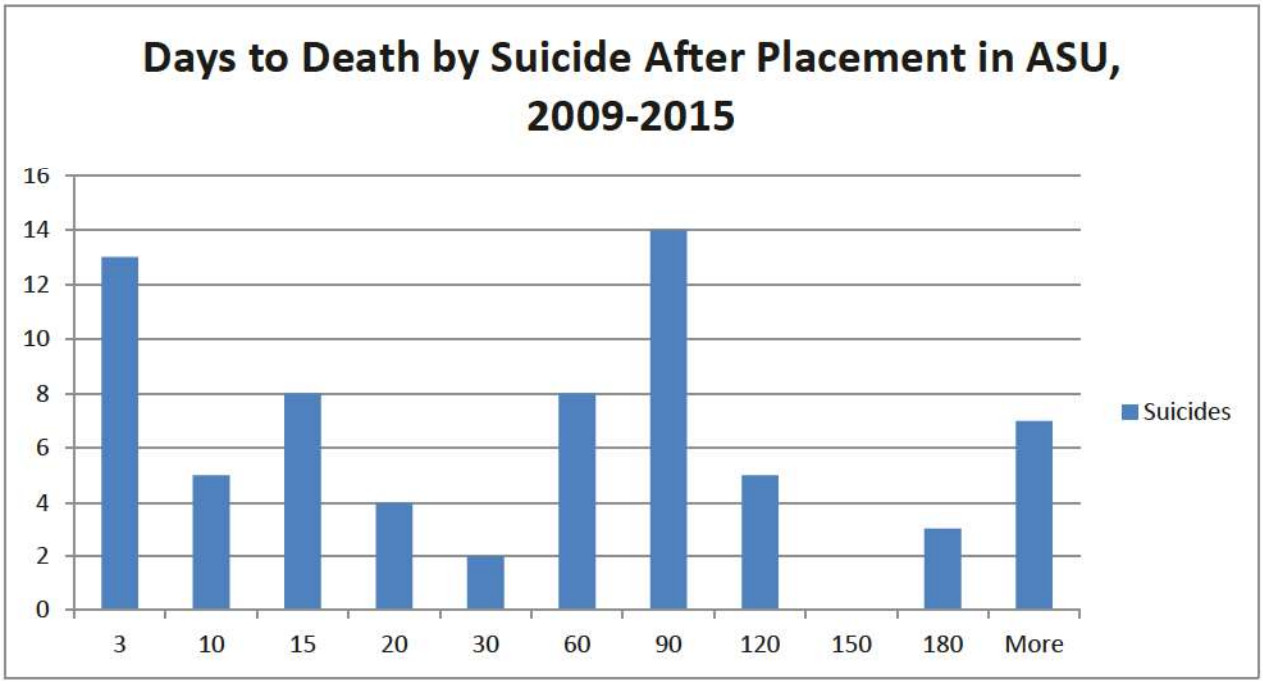
Table 17. *Frequency of Suicide within Segregated Housing, 2010-2015*

Year	Frequency	Percent of Annual Suicides
2010	13	37
2011	14	42
2012	13	41
2013	14	47
2014	13	57
2015	9	37.5

Time in Segregated Housing Prior to Death: In 2015, nearly half of the suicides that occurred in segregated housing occurred soon after placement. Three of the nine suicides occurred in intake cells, indicating stays of less than 72 hours (Cases H, K, and V). A fourth case had been in ASU for six days and had just arrived for a temporary stay at an institution while in route to another institution (Case Q). The remaining five cases were in segregated housing units for 100 days or more at the time of death (Cases B, C, D, O, and X).

Data on the number of days between ASU placement and deaths by suicide has been tracked since 2009. Over this seven-year period (2009-2015), suicides tended to occur shortly after placement, particularly in the first 72 hours after placement. Of course, fewer inmates are present in ASU as lengths of stay increase. Figure 5 shows the distribution of deaths by suicide following placement.

Figure 5: *Length of Time in ASU before suicide, 2009-2015*



Suicides by Method: The rate of suicide by hanging, easily the most frequent method for suicides in prison settings, has remained relatively stable over the past number of years. In 2015, 83% of suicides were by hanging. The percentage of suicides that were by hanging was 77% in 2010, 88% in 2011, 91% in 2012 and 2013, and 87% in 2014.

Involvement in Mental Health Services: The percentage of suicides that occur in inmates with identified mental health needs is a complex variable. Suicide is a phenomenon that can occur in individuals who do not have a traditional mental health diagnosis and in inmates with no prior identified mental health needs. Inmates can avoid mental health services by choice, such as by denying symptoms on screening or by masking symptoms in order to be discharged from the Mental Health Services Delivery System (MHSDS). It is not uncommon for suicidal individuals to distrust mental health clinicians when contemplating suicide, concerned that clinicians may in some way remove a valued option (death) should life so dictate.[17] Yet suicides occur in individuals who have been identified as meeting criteria for participation in the MHSDS and who were receiving services in the MHSDS at the time of death. Table 18 lists the numbers of suicides at each level of MHSDS involvement for 2015 and for the prior five years.

[17] Jobes, D. (2016). Managing Suicidal Risk: A Collaborative Approach (2nd Edition). Guilford Press, New York.

Table 18. *Frequency of Suicide within MHSDS Levels of Care, 2010-2015*

Year	Non-MHSDS	CCCMS	EOP	MHCB /DSH	% in MHSDS
2010	15	12	8	0	57
2011	10	10	13	0	69
2012	14	12	5	1	55
2013	14	9	6	1	53
2014	1	12	9	1	96
2015	10	9	5	0	58

Suicides in Mental Health vs. Non Mental Health Populations: Table 19 shows the suicide rate for MHSDS vs. non-MHSDS, as the average total CDCR populations over the past ten years, including 2015. This information was derived from the Health Care Placement Oversight Programs (HCPOP) monthly trends reports. The population totals may vary slightly from other referenced population totals within this report, as the data from HCPOP is collected a different points of time, and utilizes total population averages. As can be seen, the rate of suicide in those involved in the MHSDS is significantly higher than for individuals who have not been included in the MHSDS. This suggests a need to carefully work with existing mental health population members to reduce the risk of suicide. Targeted, suicide-specific interventions for individuals within the MHSDS remain an area that is potentially fruitful in preventing suicides; this will be discussed further later in this report.

Table 19. *Frequency of Suicide in mental health versus non-mental health, average total populations, 2006-2015*

Year	MH Pop	MH Freq	MH Rate	Non-MH Pop	Non-MH Freq	Non-MH Rate	Total Pop	Total Freq	Total Rate
2006	32,327	20	61.8	139,015	23	16.5	171,342	43	25.1
2007	33,148	25	75.4	138,431	9	6.5	171,579	34	19.8
2008	34,854	18	51.6	131,887	18	13.6	166,741	36	21.6
2009	35,677	19	51.0	125,201	6	4.8	160,878	25	15.5
2010	37,140	20	53.8	119,555	15	12.6	156,695	35	22.3
2011	37,140	23	61.9	113,182	10	8.8	150,322	33	20.3
2012	33,613	18	53.5	93,892	15	16.0	127,505	33	25.9
2013	34,477	16	46.4	90,098	14	15.5	124,575	30	24.1
2014	37,322	21	56.3	89,192	2	2.2	126,514	23	18.2
2015	37,146	15	43.1	92,197	9	9.8	129,343	24	18.6
Average	**35,284**	**20**	**55.5**	**113,265**	**12**	**10.6**	**148,549**	**32**	**21.1**

D. Review of Findings

Section 3: Comparison of CDCR Suicide Rates with Other State Prisons Systems and Relevant U.S. Rates

CDCR Rates vs. Other State and Federal Prison Rates: State prison suicide rates have varied little over a number of years. The rate of suicide in U.S. state prisons ranged from 14 per 100,000 to 17 per 100,000 from 1999 to 2013[18], with a rate of 15 suicides per 100,000 prisoners in U.S. state prisons in 2013. However, the U.S. prison rate jumped by 30% between 2013 and 2014, rising to 20 per 100,000 inmates.[19] No explanation for this increase has been offered. Rates for U.S. prisons for 2015 are not available at this time.

Suicide rates for all federal and state prisons were calculated by the Bureau of Justice Statistics for the years 2001-2014.[20] A listing of state rates is found in Table 19. California's rate is listed twice in Table 19. One listing is for the composite rate for the CDCR from 2001-2014 and the second rate is for the year 2015 only. California ranks in the middle one-third of states in rank and rate. In 2015, California's rate of prison suicides ranked as 20th among state prisons.

Table 20. *Rate and rank of suicides by state, 2001-2014 (14 years)*

State Name	Rank (Highest to Lowest Rate) *(t=tie)*	Suicide Rate per 100,000
Rhode Island	50	45
Utah	49	44
Montana	48	34
Massachusetts	47	32
New Hampshire	46	31
Alaska	46t	31
Hawaii	44	29
Idaho	43	28
South Dakota	43t	28
Delaware	41	26
Vermont	41t	26
Connecticut	39	24
New Mexico	38	23
Nebraska	37	21
New York	37t	21
All State Prisons, 2015		*20*
Iowa	35	20
Chart continues on next page		

[18] Noonan, M. *Mortality in Local Jails and State Prisons*, 2000-2013 – Statistical Tables, August 2015, Website, U.S. Department of Justice, Bureau of Justice Statistics.
[19] Noonan, M. Mortality in Local Jails and State Prisons, 2001-2014 Statistical Tables, US DOJ, Bureau of Justice Statistics, December, 2016, NCJ 250150
[20] *Id.*

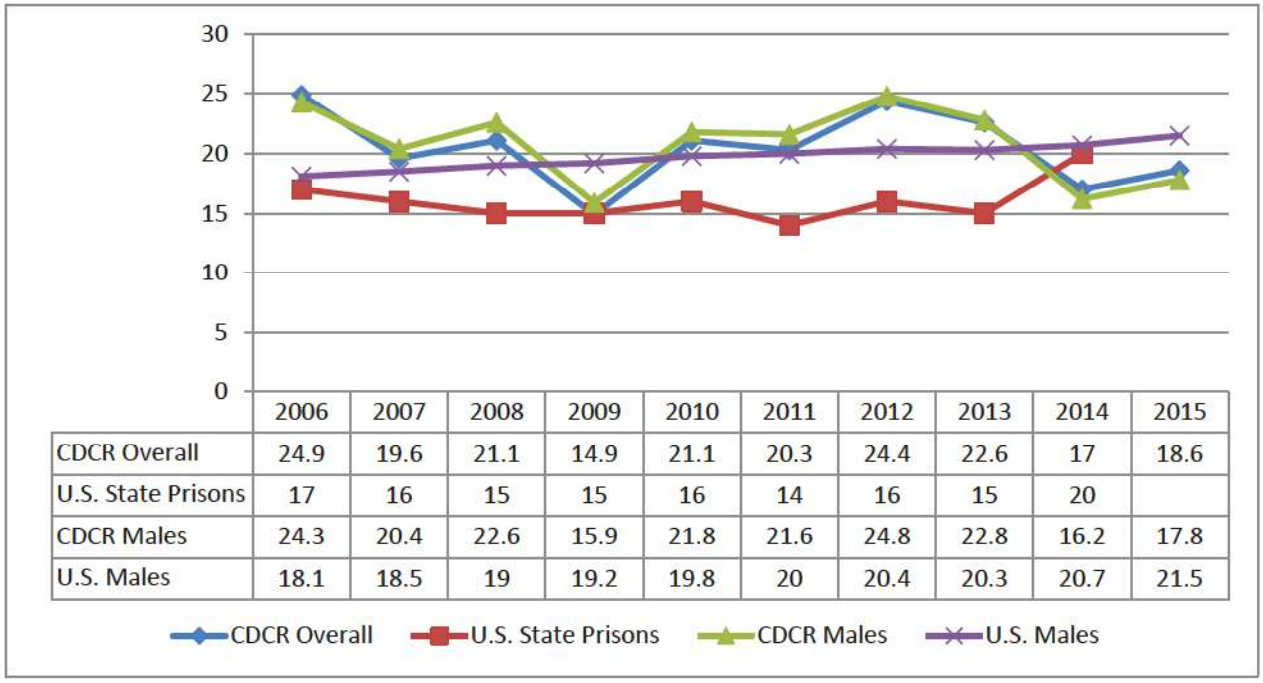
State Name	Rank (Highest to Lowest Rate)	Suicide Rate per 100,000
Maryland	35t	20
California (2001-2014)	35t	20
Wisconsin	32	19
Oklahoma	32t	19
California (2015)		*18.6*
Colorado	30	18
Minnesota	30t	18
Wyoming	30t	18
Arizona	27	17
Nevada	27t	17
Arkansas	27t	17
All State Prisons, 2001-2014		*16*
Indiana	24	16
Illinois	24t	16
Texas	24t	16
Oregon	24t	16
Pennsylvania	24t	16
Tennessee	18	15
Kansas	17	14
Ohio	16	13
South Carolina	16t	13
New Jersey	16t	13
Washington	16t	13
Mississippi	16t	13
Missouri	11	12
Maine	10	11
U.S. Federal Prisons (2001-2014)		*10*
Virginia	9	10
Georgia	9t	10
Kentucky	7	9
Louisiana	7t	9
West Virginia	5	8
Florida	5t	8
North Carolina	3	7
Alabama	2	6
North Dakota	1	5

CDCR Rates vs. Community Rates: It is notable that the rate of suicide in the community within the United States reached a 30 year high in 2014, reaching an overall national rate of 13.4 per 100,000. The rate of suicide rose 24% overall between 1999 and 2014[21]. The U.S. rate increased

[21] http://www.nytimes.com/2016/04/22/health/us-suicide-rate-surges-to-a-30-year-high.html?_r=0

again in 2015 to 13.8 per 100,000.[22] For adult males in the U.S., the rate of suicides was 21.1 per 100,000 in 2014[23] and 21.5 per 100,000 in 2015[24], topping the rate of suicides in the (mostly male) CDCR in 2014 (17.0 per 100,000) and 2015 (18.6 per 100,000). Figure 6 shows the rate of suicides in adult males in the U.S., in U.S. prisons, and in the CDCR over a ten year period from 2006 to 2015. Suicide rates for state prisons are not available after 2014.

Figure 6: *Suicide rates for adult males in the CDCR, State Prisons, and the U.S., 2006-2015*



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
CDCR Overall	24.9	19.6	21.1	14.9	21.1	20.3	24.4	22.6	17	18.6
U.S. State Prisons	17	16	15	15	16	14	16	15	20	
CDCR Males	24.3	20.4	22.6	15.9	21.8	21.6	24.8	22.8	16.2	17.8
U.S. Males	18.1	18.5	19	19.2	19.8	20	20.4	20.3	20.7	21.5

E. Summary Review of Findings and Trends

In reviewing suicides within the CDCR during the reporting year, 2015, a suicide rate of 18.6 per 100,000 is noted. The rate of CDCR suicides is below the average rate of all U.S. state prison systems combined in 2014, the last year in which such data is available. The rate of suicides in the CDCR in 2014 was also lower than the average suicide rate for state prisons in 2014. Additionally, the rise in the community rates of suicide, particularly for males, has increased significantly over the past decade. Adult males in the community in the U.S. were more likely to die by suicide than male inmates within the CDCR in both 2014 and 2015.

Some trends are noted in years 2014 and 2015. First, fewer inmates aged 25-54 died by suicide than in prior years. Second, the rates of suicide in Caucasian and Hispanic inmates in CDCR have

[22] http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2015/2015datapgsv1.pdf?ver=2017-01-02-220151-870
[23] http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2014/StatesSexTABLE2014.pdf
[24] http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2015/2015datapgsv1.pdf?ver=2017-01-02-220151-870

fallen rather significantly in the past 10 years. The majority of suicides in the CDCR have occurred within these two racial groups for many years. Third, a decline in the frequency of suicides in segregated housing units was noted in 2015; this finding may reflect the decreasing percentage of the inmate population housed in such settings as well as the many efforts implemented to improve safety from suicide in these settings. Other factors reviewed appear to simply indicate yearly and/or unstable fluctuations in suicides, such as in timing of suicides (e.g., month of suicide, time of discovery), frequency in specific institutions, and the rate of involvement in mental health systems of care.

In looking at the group of individuals who died by suicide in 2015 within the CDCR, specific risk factors remain clear: Caucasian race, single/divorced marital status, serious or chronic medical disease or pain, spring and fall months, history of violent offenses, housing in higher security settings, life or long sentences, single-cell housing, lack of job assignment, mental health treatment prior to and during incarceration, prior suicide attempts, and prior psychiatric hospitalization. Other variables seem to be possible trends to monitor, such as increased suicides in older inmates (those age 60 or above), fewer suicides within segregated housing units, and more suicides on or around holiday periods. The reasons for suicide for inmates within the CDCR remains rather idiosyncratic and complex, with most suicide reviewers determining multiple precipitants (or triggers) for suicide. Suicides most commonly occurred on account of in-prison stressors (safety concerns, receipt of additional charges, transfers, etc.); medical illness, pain or disability; acute psychiatric symptoms; conflicts with others; and important dates (anniversaries of losses or crimes, holidays).

Chapter II. Response to Suicide and Suicide Attempts

Institutional reporting of self-harm incidents and suicides: All incidents of self-harm in the CDCR are reviewed by institutional staff members (including mental health clinicians) and all incidents of self-harm are entered and tracked on a self-harm database. These processes allow for tracking patients in High Risk Management Lists or Program(s) within a facility. A sample High Risk Management Program policy is found in Appendix I. Suicides are reported by the Chief Medical Officer or designee to stakeholders, including the SMHP and the OSM. Processes involved in institutional reporting of self-harm events and suicides are found in Appendix II.

Determination of unknown causes of death: When deaths occur in a CDCR institution in which the cause of death is not immediately determined, the cases are classified as "Unknown Deaths." These cases receive special attention until the cause of death is determined, particularly as any that could possibly involve suicide need to be determined in a timely fashion. The process for reviewing these deaths and making a determination may be found in Appendix III

In 2015, a total of 44 cases were tracked as the cause of death was listed provisionally as unknown. Nineteen of the 44 cases had no provisional cause of death, whereas 25 cases had a suspected or "probable" cause of death listed. In two cases, suspicion of a suicide was present and was

confirmed by autopsy, toxicology finding, and/or coroner's report. These cases, Case T, who died of an overdose on a prescribed medication, and Case P, who died of asphyxiation during an acute intoxication illicit drug, are reviewed later in this report. Additionally, two cases were determined to be accidental overdoses due to findings of ingested balloons during autopsy; ingesting balloons filled with narcotics is a method for concealing and/or transporting illicit drugs in prison (Cases OO and PP).

Of the remaining four cases, 23 were determined by the Death Review Committee (DRC) to have died by natural causes: Pulmonary embolism, myocardial infarction, coronary artery disease, hypertension, cardiomyopathy, and so forth. Three of the remaining cases were determined to be deaths by homicide.

The 14 remaining cases met criteria for additional review, as they involved either overdose (10 cases), the case was pending further information (three cases), or the death potentially related to mental health treatment needs (one case). In this later death (Case AA), the cause of death was provisionally termed inanition secondary to acute psychosis. That is, the patient was thought to have died on account of the medical consequences of refusing to eat. His lack of intake was attributed to acute psychosis. Though the initial finding of inanition was mentioned, reviewers on the Combined Death Review Summary noted the pathologist's use of the term "well-nourished" and determined the patient had gained roughly 20 pounds in the two years prior to his death. The patient denied suicidal ideation upon evaluation six days before his death and there was no indication that he purposefully engaged in any behavior with the intention of dying or hastening his death. The category of death was changed by the DRC to natural, unexpected

The three cases pending further information were determined by the DRC to be deaths of various causes. The cause of one death was due to "excitement delirium." In this case (Case BB), the inmate struggled with officers who were trying to apply restraints; this exertion led to neuronal excitotoxic injury per autopsy. The second case (Case CC) was determined to have ingested both morphine and Citalopram, though both medications were prescribed. The inmate had multiple additional medical problems, including cardiovascular disease, and the death was determined to be accidental. The inmate's cellmate at the time reported normal mood, participation in routines, and so forth the evening of the death, with no history of suicide attempts or statements of wishes to die. The third case (Case DD) was unknown for a period of time due to the complexity of medical symptoms present prior to the death, including reports of blackouts, other neurological symptoms, and cardiovascular issues. The final cause of death was determined to be natural and secondary to cardiovascular disease.

The 10 remaining cases (Cases EE to NN) were reviewed using the guidelines noted above as the cause of death in each was overdose. Upon review of these cases, the best explanation for each was unintentional, accidental overdose. In each case, the Combined Death Review Summary determined that the cause of death was an accidental overdose. None of the cases involved ingestion of medications that do not have abuse potential (e.g., Tylenol). Rather, all ten deaths

involved intoxication/ingestion with an illicit drug or drug(s) of abuse. Specifically, three cases died due to methamphetamine intoxication (Cases EE, FF, and GG), two to Fentanyl intoxication (a powerful synthetic Opioid; Case HH and II), one case to a combination of heroin and methamphetamine intoxication (Case JJ), one to heroin intoxication (Case KK), one to morphine intoxication (Case LL), one to methadone and morphine intoxication (Case MM), and one to intoxication with an unknown or unspecified opiate (Case NN). Of these 10 cases, none left a suicide note and none made recent statements suggesting suicidal ideation or desire. Appendix IV contains additional information on the SMHP's review of overdose cases.

Suicide Attempts and Suicides Prevented: In 2015, there were a total of 502 incidents of self-harm with intent to die that did not result in death. That is, 502 suicide attempts were in some way prevented, interrupted, aborted, averted, or otherwise were not fatal during the year.

Of the 502 attempts, 285 involved incidents of self-harm with intent to die that resulted in either no injury or mild injury. An additional 217 incidents of self-harm involving moderate-to-severe injury and intent to die (suicide attempts) were reported to the CDCR's self-harm database. These 217 incidents include some combination of: The inmate used non-lethal means and intended to die but was discovered, the inmate reported having recently engaged in self-harm with the intent to die but was not discovered and did not perish, or CDCR staff members interrupted a suicide attempt in progress by an inmate that may otherwise have been lethal.

Determination and tracking of Quality Improvement Plans: Each Suicide Case Review report may include formal Quality Improvement Plans (QIPs) as applicable to the case. QIPs are developed based on the concerns raised by custody, nursing/medical, and/or mental health case reviewers. In 2015, a total of 115 QIPs were generated from Suicide Case Reviews, resulting in an average of 4.8 QIPs per suicide. Nursing QIPs are referred to the DRC. Custody and mental health QIPs are typically addressed to the institution where the deceased person resided but may also be written for prior institutions and/or for the DHCS SPR FIT. Table 20 provides a listing of responsible persons or teams for the QIPs assigned in 2015.

Table 21. *QIPs assigned within the CDCR by recipient, 2015 Suicides*

Quality Improvement Plan	Frequency	Percent of Total
Chief of Mental Health/Chief Executive Officer	53	46
Warden/Custody	32	28
Death Review Committee/Nursing/Medical	17	15
DHCS SPR FIT	11	10
Design Standards Branch	1	<1
Contract Bed Facility	1	<1
Total	115	100

As can be seen in Table 21, the Suicide Case Review process generates quality improvement plans that are multidisciplinary. The responses to an inmate's suicide are therefore addressed with a broad lens, looking at many ways of addressing what went wrong (if applicable; one case of the 24 had no listed QIPs). Notably, nearly half of the formal QIPs generated in 2015 were focused on mental health concerns, with the Chief of Mental Health and/or Chief Executive Officer of a CDCR facility tasked to address the concern(s). Mental health concerns ranged from evaluations not completed within timeframes established by policy to poor quality of suicide risk evaluation to inadequate treatment and safety planning. The specific reasons for individual QIPs are presented in the individual case review section (Chapter 3).

Determination whether a suicide is preventable or foreseeable:

Using the below definitions[25], CDCR's Statewide Mental Health Program's Suicide Case Review Committee (SCRC) originally determined that in 2015, 12 of the 24 suicides were foreseeable and

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

17 of the 24 suicides might have been preventable had some additional information been gathered or some additional interventions undertaken. As discussed in more detail below, that determination was changed to 13 foreseeable suicides as a result of this report. The SCRC in 2015 was comprised of members of the CDCR Statewide Mental Health Program, DAI's Mental Health Compliance Unit (MHCU), Nursing Executives and/or their designees, members of the CDCR Office of Legal Affairs, and medical personnel (as needed). In 2015, subject matter experts from the Office of the Special Master attended Suicide Case Reviews and participated in teleconference discussions of foreseeability and preventability with the SCRC immediately following each Suicide Case Review.

Foreseeable: A "foreseeable" suicide is one which, based upon available information reasonably known, is reasonably anticipated based upon the presence of a substantial or high risk for a suicide attempt which would require reasonable clinical, custodial, or administrative intervention. Foreseeability is assessed by determining the adequacy and accuracy of how suicide risk was evaluated. Assessment of the degree of risk may be high, moderate, or low to none. In contrast to a high and immediately detectable risk, a "moderate risk" of suicide, indicates a more ambiguous set of circumstances that requires significant clinical judgment based on adequate training, as well as a timely assessment, to determine the level of risk in the most appropriate manner and relevant interventions to prevent suicide.

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

The definitions stated above were distilled from longer definitions previously adopted by the Special Master's experts. The definitions were shortened for the purpose of facilitating discussion of the foreseeability and preventability of a suicide. The longer definitions, as used in Special Master's reports[26] on suicides, are:

The terms "foreseeable" and "preventable" are used in this report… They describe the adequacy and implications of CDCR suicide prevention policies and procedures, staff training and

be deliberately indifferent to the risk." *Rellegert ex rel. Rellegert v. Cape Girardeau County*, Mo., 924 F.2d 794, 796 (8th Cir. 1991).

[26] See for instance Report on Suicides Completed in the CDCR, January 1, 2014-December 31, 2014 by Kerry Hughes, M.D., Case 2:90-cv-00520-KJM-KJN Document 5428, filed 3/29/16.

supervision, clinical judgments, and utilization of clinical and custodial alternatives to reduce the likelihood of completed suicides.

> The term "foreseeable" refers to those cases in which available information about an inmate indicates the presence of substantial or high risk for suicide, and requires reasonable clinical, custodial, and/or administrative intervention(s). Assessment of the degree of risk may be high, moderate, or low to none. This is an important component in determining foreseeability. In contrast to a high and immediately detectable risk, a "moderate risk" of suicide indicates a more ambiguous set of circumstances that requires significant clinical judgment based on adequate training, as well as a timely assessment, to determine the level of risk in the most appropriate manner and relevant interventions to prevent suicide. Interventions may include but are not limited to changes in clinical level of care, placement on suicide precautions or suicide watch, and changes in housing including utilization of safe cells and transfers to higher levels of care, as well as clinically appropriate treatment and management services which may include but not be limited to increased contacts/assessments by mental health professionals, medication management review and changes, other therapeutic interventions and measures, and/or changes in level of care, including short-term changes such as utilization of MHCBs and/or longer term level-of-care changes including transfer to DSH programs.
>
> Individuals evaluated as a "low risk," "no risk," or "negligible risk" may continue to require some degree of clinical and custodial monitoring and subsequent evaluation with appropriate treatment and management by clinical staff of the potential for self-injury and/or suicidal ideation or activity.
>
> The term "preventable" refers to those cases in which the likelihood of completed suicide might have been reduced substantially had some additional information been gathered and/or some additional intervention(s) undertaken, usually as required by existing policy, reflected in the Program Guide and/or local operating procedures. Suicides that may have been preventable include not only cases in which additional information might have been gathered or additional interventions undertaken, but also cases involving issues with emergency response by custody and clinical staff. The emergency response is reviewed not only by DCHCS mental health staff but also by DCHCS medical staff as part of the death review summary process, as well as by this reviewer.

CDCR acknowledges slight differences between the Special Master's definitions and those used by the suicide case review committees when they reviewed the cases originally in 2015. CDCR agreed to a request by the *Coleman* plaintiffs to re-review the 2015 suicides using the Special Master's definitions. The Special Master's experts concurred with this request. After meeting and conferring with the Special Master's experts, it was agreed that all cases not previously found as both foreseeable and preventable by the SCRC would be reviewed again using the Special Master's

definition. As twelve cases had originally been found as both foreseeable and preventable, twelve cases remained for re-review.

The author of the 2015 Annual Report on Suicides in the CDCR attended SCRs and post-call SCRC discussions of foreseeability and preventability, being a voting member of this committee. The author also compiled the original committee findings of foreseeability and preventability on each case. The author then re-reviewed all twelve cases using the Special Master's definition. In cases where the finding of foreseeability and preventability fall outside of the scope of a licensed mental health professional (this author), consultation was made with custodial, nursing, and/or psychiatry representatives as to matters of appropriate discipline practice and adherence to within-discipline policies and procedures. Special attention was given to re-evaluating each case based on the official OSM definition of foreseeable and preventable. As a result of this re-review, only one change was made. One case that was previously determined to be *not* foreseeable was changed to foreseeable when using the Special Master's definition. Accordingly, 13 of the 24 suicides were foreseeable and 17 of the 24 suicides might have been preventable had some additional information been gathered or some additional interventions undertaken.

Audits of SCR Quality: The DHCS Quality Management Unit audits all Suicide Case Reviews (SCRs) for 15 items. SCRs are scored with required elements marked present or absent. In 2015, SCRs generally met audit criteria at a high rate, reported in Table 21.

Table 22: *Results of Quality Audits, 2015 Suicide Case Review reports*

Audit Item	Present	Absent	% Present
1. Does the Executive Summary describe the means of death, the emergency response taken, and the MH LOC of the patient?	23	1	96
2. Are the sources for the SCR identified?	24	0	100
3. Are substance abuse issues reported, if applicable?	24	0	100
4. Does the Institutional Functioning section include information on institutional behavior, including disciplinary history?	24	0	100
5. Does the Mental Health History review the adequacy of mental health care and screening?	24	0	100
6. Are medical concerns discussed (e.g., chronic pain, terminal illness) or is the absence of medical conditions noted?	24	0	100
7. Is the quality of the most recent SREs (past year) reviewed, with comment on risk level, safety planning, and risk and protective factors?	14	6 (4 N/A)	70
8. Does the Suicide History section review all prior attempts, as applicable?	24	0	100
9. Are significant pre-suicide events discussed (e.g., receipt of bad news or existence of a safety concern)?	23	1	96
10. Was a risk formulation offered specific as to why the person was vulnerable to suicide?	24	0	100
11. Does the review comment on the adequacy of the emergency response?	18	4 (2 N/A)	82

12. Are all violations of policy and breaches of standards of care in mental health, medical, and nursing addressed in the reviewer's concerns, if applicable?	24	0	100
13. Were custody policies followed? If not, were violations noted in the report?	23	0 (1 N/A)	100
14. Were all concerns raised by reviewers (custody, nursing, and mental health) represented in Quality Improvement Plan recommendations?	24	0	100
15. Were the Quality Improvement Plan recommendations adequate to address the concerns? (e.g., QIP should not simply say conduct an inquiry and report findings).	23	1	96
Total	339	13	96

As evident in Table 22, on most audit criteria, reviewers were found to meet quality standards with 96% of all audit items marked as present. A notable exception in quality audits appears to be in reviewing most recent SREs. In examining this finding, six SCRs did not comment on *all* aspects of the most recent SREs. For example, the reviewer discussed risk factors but did not provide an analysis of the adequacy of risk formulation. One other item was absent in four cases: Comments on the adequacy of emergency response. Emergency response timelines were reported by nursing and custody in all SCRs. In the four cases, reviewers did not specifically state that the emergency response was adequate, though this appears to be the case in each occasion.

Timeliness of Suicide Case Reviews and Suicide Reports: The process of responding to suicides, completing reviews, writing and editing reports, tracking QIP compliance, and so on is involved. Timelines for each step in suicide response have been developed and are specified in the MHSDS Program Guides, 2009 Revision. Internal deadlines have also been developed as a way to ensure timelines for each step of the suicide response process are met. The number of days specified for each step in suicide response, for both Program Guide and internal deadlines, is found in Appendix VI.

In reviewing timeliness of 2015 suicides, the assignment of a suicide reviewer and the visit of the reviewer to the institution were completed on time in all but two cases; both cases were originally "unknown deaths" (Cases P and T) and thus not determined to be suicides until further information was obtained. Due dates on Cases P and T were recalculated when the cases were determined to be suicides. Both were then reviewed in a timely manner.

Original suicide reports are generally completed within 30 to 40 days after the death. The established 30-day limit was met in nine cases (of 24 reports). Five reports (including Cases M and V) were completed 40 days or more after the death. All reports were available by the time Suicide Case Reviews were held. Fifteen of the 24 SCRs were completed within timelines. Of the nine SCRs held late, delays ranged from one day to nine days.

Once suicide reports are reviewed at the SCR, edits are made and a final report is due to be sent to institutions within 60 days of the death. Timeline compliance becomes increasingly difficult at this step, with only five of the 24 reports finalized and sent to institutions by the 60 day mark. Delays at this step can affect the ability of institutions and other recipients of QIPs to complete QIPs by the deadline (150 days after the death). However, in 13 cases, QIP response timelines were met. QIP responses also require review and approval, with a report of QIP implementation due to the OSM by 180 days after the suicide.

As the CDCR endeavors to complete all steps of the suicide review process in a timely manner, a focus on ensuring original reports are completed on time, on decreasing the number of days used for editing suicide reports after the SCR, and on accelerating the review, response, and approval of QIPs is underway. The DHCS SPR FIT will explore further ways to expedite review processes for implementation during the 2017 calendar year.

Chapter III. Findings in Individual Case Reviews

Introduction to Individual Case Reviews: The presentation of information such as suicide rates and demographic variables in suicide deaths provides a sense of data trends, comparisons between correctional systems, and so forth. That is, suicide rates and numbers give us a *macro* look at causes and contributors to suicide and to variables that require monitoring. The data presented in prior chapters has implications for practice within the CDCR, implications that will be reviewed in the Conclusions section to follow.

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

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

Commonalities in individual case reviews: Tables 22 and 23 list variables commonly found between suicides. The tables contain either factual data or qualitative determinations about the

adequacy of staff response and/or the ability of staff members to meet quality of care expectations. Narrative comments are noted after each table.[27]

Before presenting these tables, it should be noted that inadequacy of risk assessment, treatment planning, custody rounds, and so forth result in QIPs. In Suicide Case Review (SCRs) reports, reviewers *may* comment on what was done well within an institution and *may* state areas where policy was correctly followed. However, these comments are not required as it is assumed staff members will follow policy and will do a professional job in working with inmates. In contrast, reviewers *must* identify any and all departures from policy or from standards of care, creating formal Quality Improvement Plans (QIPs) applicable to each identified issue. Reviewers may also point out clinical 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. It should also be noted here that institutional responses to QIPs are sent to the SMHP and DAI leadership for review. If any QIP response is felt to be inadequate, the SMHP and/or the DAI will contact the institution to request clarification or request additional development or implementation of the QIP. QIPs are not considered finished until approved at the headquarters level.

Table 23 lists qualitative judgments of staff performance in suicide cases. A "no" answer can reflect anything from a singular error in the treatment or care of the patient to a pattern of poor care, whereas a "yes" finding reflects a range of actions and behaviors that were consistently professional and adequate.

Table 23: *Findings of Individual Case Reviews, part 1*

Inmate	Suicide Risk Adequately Assessed?	Adequate Suicide Risk Management?	Adequate Treatment Plan?	Good Quality Mental Health Contacts?	Adequate Nursing Rounds?	Adequate Custody Checks?	Adequate Emergency Response?	Treatment Refusal?
A	Y	Y	N/A	Y	Y	Y	Y	Y
B	Y	N/A	N/A	Y	Y	Y	Y	Y
C	N	N	N/A	N	Y	N	Y	N
D	Y	N/A	N/A	N/A	N/A	N	N	Y
E	Y	Y	Y	Y	N/A	Y	Y	Y
F	Y	Y	N/A	N*	N/A	Y	Y	Y
G	Y	N/A	N/A	N/A	N	N	Y	Y
H	N	N	N/A	Y	Y	Y	N	Y
I	Y	Y	N	N	N/A	Y	N	Y
J	Y	N/A	N/A	N/A	Y	Y	N	Y
K	Y	Y	Y	Y	N/A	Y	Y	Y
L	N	N	N	N	Y	N**	Y	Y
M	N	N	Y	Y	N	N	N	Y
N	N	N	N	N	N	Y	Y	N

[27] In order to ensure individuals referenced in this report could not be identified based on chronological sequence, cases were reordered in a more random fashion.

O	N	N	N	N	N	N	N	Y
P	N	N	N	N	N/A	Y	N	Y
Q	N	N	N	N	Y	Y	N	N
R	Y	Y	Y	Y	N/A	Y	N	Y
S	Y	Y	Y	Y	N/A	Y	Y	Y
T	N	N	N	N	Y	Y	Y	Y
U	Y	Y	N	N	N	Y	Y	Y
V	N	N	N	N	Y	Y	N	Y
W	Y	Y	Y	Y	Y	Y	Y	Y
X	Y	Y	Y	N***	Y	N****	Y	Y

*Based on poor documentation of last visit. **Based on allowance of window covering. ***Based on frequent refusal of services; HRL was provided. ****Based on allowance of an obstruction to viewing

Starting from the far left column, problems with at least one suicide risk evaluation were found in 10 cases (42%). Problems ranged from issues with reviewing or gaining access to suicide attempt histories (two cases), failing to include information already reported about suicide attempt history (two cases), poor identification or documentation of risk factors (four cases), to failure to complete suicide risk evaluations when they were required by clinical standards or policies (two cases). Issues with suicide risk evaluations are particularly problematic, as inadequate assessment most likely leads to difficulties with safety planning (e.g., not having information on what triggered past attempts) and risk management (e.g., not managing the actual level of risk as risk had been underestimated). Therefore, it is not surprising that *all* cases identified as having problems with SREs are also considered to have problems with risk management.

Issues with adequacy of suicide risk management practices were noted in 11 cases (46%). In at least one situation, risk management efforts were inadequate or failed to address the level of suicide risk indicated. Additionally, in some cases suicide risk evaluations indicated very low risk and in some cases policies were followed such that the inmate did not require evaluation; these cases are marked as not applicable (N/A). In cases marked N or No in Table 22, issues were quite varied. These included placement of a patient on suicide precautions in an unsafe cell in one case, a failure to conduct a SRE within timelines in another case, problems with full implementation of high risk management lists or programs in two cases, failure to plan for an inmate's reaction to bad news in one case, and provision of KOP medications in another case where the inmate had mentioned a previous plan to die by overdose.

Another area impacted by the quality of suicide risk evaluation is mental health treatment planning. If risk for suicide is underestimated in a case, it stands to reason that treatment planning will also miss key components of what should be addressed clinically. In six cases, adequate treatment planning was noted. In seven cases, poor treatment planning was found. In the remaining two cases, risk evaluation and treatment planning was hampered by a patient's unwillingness to engage in treatment or evaluation services. In such cases, treatment planning should focus on efforts to engage the patient, attempts to gain historical and collateral information, and so forth.

The quality of mental health contacts was rated as not applicable in three cases where there were few or no evaluations beyond mental health screening. For cases rated Y (nine cases or 43% of

applicable cases), the decided majority of clinical contacts were positive and in line with professional expectations. For the 12 cases rated N (57%), at least one clinical contact was below standards, such as incidents where poor documentation was present or where patient treatment refusals were not addressed.

Nursing rounds and/or nursing observations are required for inmates in segregated housing settings, inpatient settings, and while a patient is on suicide watch or precautions either in alternative housing or in MHCB. Cases marked N/A are those in which the inmate or patient was never in such a setting. Problems in nursing rounds were found in five of the remaining 16 cases (31%) , specifically: One case where required psychiatric technician rounds were not documented (in ASU), one case where nursing observations for a patient on 15 minute checks were not staggered, one case where a nursing check required each shift did not ensure that the patient was living/ breathing, one case of delays in starting an order for 15 minute checks, and one case where checks in alternative housing were not documented or staggered. In 11 (69%) of applicable cases nursing rounds were done adequately.

Custody checks occur in all institutions for all inmates. For example, custody conducts institutional counts multiple times in each 24 hour period. In 17 cases (71%), custody checks were rated as adequate and conducted per policy. Of the remaining seven cases, four involved situations where window coverings or draping of bunks was allowed despite custody policy forbidding the practice. In another case, an inmate kept a blanket over his head, with custody checks not ensuring living/breathing. In the remaining two cases, rounds were completed later than specified by policy around the time of the death.

Emergency response by custody officers, nursing staff, and medical staff are considered in ratings of emergency response. In 14 cases (58%), no issues with emergency response were noted. In four cases, issues with bringing complete cut-down kits were found. In three cases, issues with timely AED placement or AED functioning were reported, and in two cases delays in emergency response occurred. Other issues were rather idiosyncratic; such as the incident of an ambulance going to the wrong institution and a case where CPR was discontinued during transport to the TTA.

Issues related to patient refusal of evaluation were cited in three cases (12.5%). In these cases, patients with safety or privacy concerns declined to be brought out to confidential settings for clinical contacts while also likely withholding information when contacted at cell-front was noted. In these cases, reviewers recommended QIPs to address patient refusal and to promote treatment planning when a patient declines to come out of cell for confidential contacts. The problem of patients not wanting to be seen talking to mental health, yet needing these services, is a difficult issue to combat.

Table 24 lists additional common findings of case by case reviews.

Rigor mortis is a condition of the body postmortem that indicates a person has been deceased for at least four hours.[28] In 2015, only one case was found to be in rigor mortis at discovery. This case occurred in a CTC. By comparison, four cases were found in rigor mortis in 2014. This may suggest improvements in the quality of safety/welfare checks, the implementation and use of Guard One throughout institutions in the CDCR, or simple chance variance.

The method used for each suicide is listed for the reader's reference. As in prior years and in other prison systems, hanging is easily the most common method of suicide in incarcerated populations, accounting for the means for 83% of the suicides in the CDCR in 2015.

Table 24: *Findings of Individual Case Reviews, part 2*

Inmate	Patient Found in Rigor Mortis?	Method Used	Prior Suicide History/ # of Prior Attempts	Higher Level of Care Indicated?	Housing/ Cellmate Present?	MHSDS Status at Time of Death & LOC?
A	N	Hanging	Y/2	N	GP/Y	N
B	N	Hanging	N/0	N	ASU/N	N
C	N	Asphyxiation	N/0	Y*	ASU/N	N
D	N	Hanging	N/0	N	SHU/N	N
E	N	Hanging	Y/1	N	GP/N (out to work)	N
F	N	Hanging	Y/2	N	GP/N	N
G	Y	Asphyxiation	N/0	N	CTC(GP)/N	N
H	N	Overdose	Y/1	N	ASU/N	N
I	N	IIanging	N	Y**	GP/N	N
J	N	Hanging	N/0	N	GP/N	N
K	N	Hanging	Y/3	N	ASU/N	CCCMS
L	N	Hanging	Y/6	Y	GP/N	CCCMS
M	N	Hanging	Y/1	N	GP/N	CCCMS
N	N	Jump	Y/1	Y	SNY/N	CCCMS
O	N	Hanging	Y/1	Y	STRH/N	CCCMS
P	N	Asphyxiation/ Overdose	Y/3	N	CTC/N	CCCMS
Q	N	Hanging	Y/1-3***	Y	ASU/N	CCCMS
R	N	Hanging/ Cutting	Y/3	N	GP/N	CCCMS
S	N	Hanging	Y/1	N	GP/N	CCCMS
T	N	Overdose	Y/5	Y	GP/N	EOP
U	N	Hanging	N/0	N	GP/N	EOP
V	N	Hanging	Y/3-7	Y****	ASU/N	EOP
W	N	Asphyxiation	N/0	N	GP/N (out to work)	EOP
X	N	Hanging	Y/2	Y*****	ASU/N	EOP

[28] https://en.wikipedia.org/wiki/Rigor_mortis

*Inclusion in the MHSDS seemed warranted **Per policy, should not have been discharged from CCCMS ***Incidents on 1/7/14, 4/22/14, and 10/7/15 were without clear intent ****Recommended during Regional Team visit, December, 2014 *****Due to worsening psychosis

There is a robust literature on the heightened chronic risk of suicide for individuals with prior attempts. This risk is especially robust when a person has a history of two or more suicide attempts.[29] It is thus not surprising that 16 of the 24 cases (67%) who died by suicide in 2015 also had a history of prior attempts, with 10 cases (42%) having a history of multiple attempts. Deaths occurring on a person's first attempt are correlated with the use of a highly lethal method, such as firearms in the community and hanging in the case of prisons. Hanging is a highly accessible means for suicide in prisons. The ability of a person to abort a suicide attempt mid-way through the event is usually impossible in hanging.[30]

Clinicians can use several interventions for risk management purposes, including transfer to inpatient hospitalization, transfer to a more intensive level of care, or placement in a high risk management program. Inpatient psychiatric hospitals, for example, are able to restrict means to hanging by eliminating tie off points. In 2015, reviewers found reason to indicate that more intensive risk management may have been needed in nine cases (37.5%). Of these cases, one was recommended for a higher level of care by a visiting Regional Team, two should have been considered for placement or retention in the MHSDS, one showed signs of psychotic decompensation, two should have been considered for higher levels of care due to frequent refusal of services, two were removed from high management lists or programs, and one had received bad news and had threatened to harm himself if this news was received.

Housing status is listed next with findings regarding whether a cellmate was present or not at the time of the suicide. In 23 cases (96%), there was either no cellmate present or the deceased had been in a single cell at the time of the suicide. In the one case where a cellmate was present, the deceased hung himself during the overnight hours.

Finally, the level of care for each case at the time of death is listed. The high frequency of suicides within the MHSDS is both to be expected and a cause for continued quality improvement efforts.

Chapter IV. Review of Suicide Prevention Initiatives in 2015

Introduction: The development and implementation of Quality Improvement Plans following deaths by suicide is but one of many pieces of a comprehensive suicide prevention strategy. These plans occur too late for the deceased, but correct problems and offer training and prevention plans that may contribute to decreasing the risk of suicide in an institution and in a system in the future.

[29] E.g., Forman, Berk, Henriques, Brown, & Beck, 2004. History of multiple suicide attempts as a behavioral marker of severe psychopathology, American Journal of Psychiatry, 161, 437-443.
[30] https://www.hsph.harvard.edu/means-matter/means-matter/case-fatality/

There are many additional aspects of a comprehensive suicide prevention strategy.[31] Such a strategy includes ensuring a solid screening process occurs at various points of incarceration, establishing a referral process, written procedures and policies for suicide prevention are maintained and updated as needed, and there are effective methods for evaluating proof of practice of existing and/or on-going suicide prevention programs and initiatives. In addition, comprehensive suicide prevention programs must have a commitment to staff training, with the provision of on-going training on suicide risk detection and referral to all correctional employees. In addition, the complexities and specifics of suicide risk evaluation, risk management, and intervention training must be provided to mental health staff. Comprehensive programs also assure easily available mental health services for inmates who request and/or are referred for these services, along with a variety of care options and levels. Suicide prevention materials must be readily provided for inmates and for those who interact with inmates (e.g., family members, work supervisors). Communication between disciplines and shifts must be prioritized, particularly regarding high risk inmates.[32]

The CDCR has worked diligently to ensure that a comprehensive suicide prevention program is in place. This effort has been shared with and reviewed by the Office of the Special Master and the OSM's experts for many years. It is beyond the scope of this report to review all suicide prevention program efforts over these many years. Rather, the information provided in this section reviews advancements in the CDCR suicide prevention program during the 2015 calendar year and shortly thereafter.

Suicide prevention efforts developed, initiated, and/or implemented during the reporting year: Numerous initiatives were either under development at the close of 2015 or had been implemented during the year. Each initiative is described below with notation of the status of the project on December 31, 2015 as well as the current status of each effort.

- New Five-Day Follow-Up Form: Patients are known to be at elevated risk for suicide upon release from inpatient settings per studies conducted in the community.[33] The Five-Day Follow-Up Form (CDCR MH-7230-B) used by the CDCR is intended to ensure clinical contacts with patients returning from inpatient settings in cases where the reason for admission was danger to self. Whereas the old form had been contained on one page for all five days, leaving little room for documentation, the new form developed has two pages with sufficient room for recording the patient's comments and the clinician's assessment of the patient. The new form also contains several structured, suicide-specific questions so as to ensure clinicians and psychiatric technicians are asking about suicidal thoughts, desire, and intention. The new form also requires mental health clinicians to complete a

[31] Hayes, L.M. (2013). Suicide Prevention in Correctional Settings: Reflections and Next Steps. International Journal of Law and Psychiatry, 36, 188-194.
[32] Preventing Suicide in Jails and Prisons, World Health Organization, 2007
[33] Qin, P., & Nordentoft, M. (2005). Suicide Risk In Relation to Psychiatric Hospitalization, Archives of General Psychiatry, 62, 427

safety/treatment plan with the patient. The new form was routed and approved by all required committees by the end of 2015. Involved unions were noticed. The form was readied for distribution and materials for Training for Trainers were prepared and delivered by webinar in January, February, and May, 2016. Training for Trainers materials were co-taught by mental health and nursing staff. The form was released for use on June 10, 2016.

- ASU Post-Placement Screening Questionnaire: All inmates are screened prior to placement in segregated housing units for mental health symptoms. Once placed in segregated housing, all inmates are contacted daily by psychiatric technicians. In addition, identified mental health patients are seen on a regular basis by mental health clinicians. As inmates may experience distress upon placement, the ASU Post-Placement Screening Questionnaire is a brief measure (12 to 13 items) that is administered by a psychiatric technician to non-MHSDS inmates and assesses an inmate's level of distress and the presence or absence of suicidal thoughts or behavior. The screening questionnaire has set scoring rules that, once scored, guide the psychiatric technician regarding whether a referral to mental health is indicated, and if so, to what degree of urgency. Inmates who refuse the screen are to be referred to mental health on an urgent basis. The new form (CDCR MH-7790) was also routed and approved by all required committees by the end of 2015. Involved unions were noticed. The form was readied for distribution and trainings (co-taught by mental health and nursing staff) were prepared, again via the Training for Trainers format. The PowerPoint presentation for the form had been reviewed and approved. This form was also released for use on June 10, 2016.

- Provision of Beds for Alternative Housing Cells: Several tours and audits of suicide prevention practices at various institutions had noted the lack of a physical bed in certain alternative housing cells. These cells are used with patients who are awaiting transfer to a MHCB and patients in these cells are typically on Suicide Watch (direct, one-on-one observation). Without available beds, patients were placed temporarily in cells with mattress placed directly on the floor. As this could be experienced as punishment, the CDCR agreed to ensure beds were placed in all alternative housing cells. A bed (Norix Stack-a-Bunk) was selected and was purchased for this purpose. Beds were delivered to all institutions in need of them by the end of 2015. A Mental Health Services policy was drafted for patients pending MHCB transfer that includes provision of a Stack-a-Bunk in alternative housing. This policy remains under review currently.

- Updated Initial SRE Mentoring Training for Trainers: The SRE Mentoring training slides and webinar were updated to place more emphasis on mentoring safety/treatment planning, to develop more of an understanding of the interplay of chronic and acute risk factors in cases, to further explore the role of the mentor in assessing and expanding clinician competencies around suicide risk evaluation, and to further teach the Quality of Care Tool

for SRE Mentors. The revised training was offered on several occasions in 2015 and 2016 and was well received. Additional revisions were made to the presentation in November, 2016.

- Development of a SRE Mentoring 'Booster' Training: The requirement for an annual 'booster' training was discussed and a presentation developed for current mentors. The 'booster' training was re-cast as an advanced course in suicide risk evaluation mentoring, with a focus on risk assessment competencies, methods for competency assessment, and ways to enhance SRE skills in clinicians at all levels of proficiency. The training was undergoing revisions at the end of 2015 with a plan to implement training in 2016. This training indeed occurred in 2016, with the mentoring booster training attended live by 50 current mentors in November, 2016 and with numerous others taking the course by webinar in December, 2016.

- Memorandum Clarifying SRE Mentoring Requirements: A memorandum was drafted in 2015 outlining and revising the requirements for SRE Mentoring. Clinicians working in Mental Health Crisis Bed settings were required to complete mentoring annually, whereas other clinicians were maintained on an every two year schedule. Clinicians were also notified of two SRE audits; one to be conducted by institutional program supervisors and the other by headquarters staff. Each mental health clinician will have an audit of a completed SRE at least once every six months. Processes for corrective action when audit criteria are not met were described as well. Finally, the expectation that SRE Mentors would receive annual 'booster' training was written. This memorandum was released on March 15, 2016. Institutional program supervisors began auditing SREs using the Chart Audit Tool, reporting results through the Quality Management Portal. Headquarters audits have been modified to solely focus on inter-rater reliability checks on institutional audits.

- Memorandum Clarifying SRE Training: SRE Training is a 7-hour CME-approved course that is provided to all CDCR mental health clinicians within 180 days of hire and every two years thereafter. The SMHP updates the 7-hour SRE class annually. The updated class is provided to a large group of institutional clinicians who then teach the class at their home institutions. This process of annual updates in Training for Trainers also ensures trainers are adherent to the content and focus of the course. A memo clarifying SRE Training requirements was drafted in 2015, noting that the requirement extends to clinicians hired through a registry and to telepsychiatry. Training for Trainers occurred in October, 2014 for the 2015 training year and in October, 2015 for the 2016 training year. This memorandum was pending release at the end of 2015 and was released on March 24, 2016.

- Memorandum Clarifying SPR FIT Coordinator Duties: A memorandum was released on August 14, 2015 instructing all institutions to designate one Senior Psychologist, Specialist

to the role of institutional SPR FIT Coordinator, tasked with leading suicide prevention efforts at each facility. The role also includes coordination of mental health assessments/evaluations and mental health training/orientation. A duty statement for the position was attached to the memorandum. The memorandum and clarification of duties was designed to ensure all institutions had dedicated resources within mental health programs to coordinate suicide prevention efforts. This memorandum was released on August 14, 2015 and implemented; the memorandum is found in Appendix VII.

- Memorandum Regarding SRE Tracking: A memorandum was released on October 23, 2015 mandating that all institutions use appointment schedulers to simultaneously enter SREs completed by clinicians into the patient record and into the Mental Health Tracking System (MHTS). Clinicians were required to enter scheduled and unscheduled SRE appointments on daily work logs. This process is automated in EHRS institutions, but must be entered in this manner in institutions using the eUHR. The memorandum ensures proper tracking of suicide risk evaluations and timely scheduling and completion of follow-up risk evaluations. This memorandum is found in Appendix VIII.

- Updated Cadet Training: An update to training provided at the cadet training academy on the Mental Health Services Delivery System (MHSDS) and on Suicide Prevention was drafted and reviewed in 2015. Training for trainers on the updated version was provided on November 30, 2015. Lindsay Hayes attended the updated training as it was being given to a cadet class, providing feedback on the training in December, 2015. The training and accompanying lesson plans were undergoing revisions in light of Mr. Hayes' feedback at the end of 2015. This revised training was distributed on May 11, 2016.

- Workgroup on Keep-on-Person (KOP) Medications: In response to a headquarters QIP (from Case H in 2015) and in conjunction with a pilot program on using over the counter projects[34], a workgroup was assembled to discuss how prescribed medications should be distributed in high-risk settings, such as in ASU Intake Cells. The workgroup met several times, considering input from pharmacy, custody, nursing, medical, and mental health representatives. Suggestions for limiting KOP medications in certain settings, relying on the Complete Care Model to communicate when medications should be administered as Direct Observation Therapy (DOT), and other potential solutions were discussed. Workgroup meetings focused on integrating clinical practices with KOP medications with new policy on the use of Over-The-Counter (OTC) medications. In addition, concerns about KOP medications will be an issue to be discussed at morning huddles.[35]

[34] CCHCS Memorandum dated November 19, 2014, *Over the counter products test procedure—clarification of accessibility.*

[35] The combined efforts of this workgroup and a workgroup developed by the statewide patient safety committee (CCHCS QM) completed a document, "KOP Guideline Feedback," in November, 2016, after the drafting and initial routing of the 2015 Annual Report on Suicide.

- Training in Safety Planning: In response to reviews by regional staff, headquarters staff, and Mr. Hayes, training entitled "Safety/Treatment Planning for Suicide Risk Assessment" was created in 2014 by Dr. Robert Canning. The class was updated in 2015 with a slightly revised title, "Safety/Treatment Planning within Suicide Risk Assessment and Management." The class included new content focusing on the on-going role of safety planning in managing suicide risk within the inmate population. Continuing medical education (CME) units are available to clinicians who take this course; attendance is mandatory for all clinical staff. The revised class was provided on four occasions between August and October, 2015Safety planning training was offered on multiple occasions in 2016, with training then planned every six months in order to accommodate newly-hired clinical staff. The role of safety/treatment planning was also incorporated into other updated trainings in 2016 (e.g., in suicide prevention videoconferences, the 7-hour SRE course, and in SRE Mentoring classes).

- Training in Complex Diagnostic Cases: This training, entitled, "Differential Diagnosis in Complex Mental Health Cases" was developed to assist treatment teams in considering cases involving self-harm. Clinicians and clinical teams can err in underestimating or overestimating risk for suicide,[36] particularly when cases present with complex diagnostic presentations and when patients engage in negative [37] or positive impression management.[38] The under- or over-reporting of symptoms of distress and the within-patient variances in reporting suicidal ideation or desire for death can cause considerable clinical confusion. For example, a patient who reports self-harm behavior due to "needing to get off the yard" can be seen as manipulative and may represent little else in the case. However, for a more vulnerable patient the pressure exerted by other inmates can be a source of considerable distress and may indeed give rise to a desire to die. An approved version of this training was presented to mental health clinicians on multiple occasions in 2016.

- Training in Culturally-Competent Suicide Risk Assessment: In response to a 2015 QIP (Case E), training was designed to offer primary care physicians and mental health clinician's specific approaches and tools to assess suicide risk in patients of various cultures and belief systems. Training included introductions to the DSM-5's Cultural Formulation

[36] Horon, McManus, Schmollinger, Barr, & Jimenez (2013). A study of the use and interpretation of standardized suicide risk assessment measures within a psychiatrically hospitalized correctional population. *Suicide and Life-Threatening Behavior,* 43, 17-38.
[37] Sullivan & King (2010). Detecting faked psychopathology: A comparison of two tests to detect malingered psychopathology using a simulation design. *Psychiatry Research,* 176, 75-81.
[38] Bagby & Marshall (2003). Positive impression management and its influence… A comparison of analog and differential preference group designs. *Psychological Assessment*, 15. 333-339.

Interview,[39] the Cultural Assessment of Risk for Suicide (CARS),[40] and the Cultural and Protective Suicide Scale for Incarcerated Persons (CAPSSIP).[41] Interactive vignette-based practice of suicide risk inquiry in diverse cases was integrated within the training. The course was offered, with CME credits, on four occasions in 2015. Several hundred physicians and mental health clinicians attended the course.

- Training of Board of Prison Hearings (BPH) Commissioners: Two informational talks were developed for the BPH. First, the perception that participation in the MHSDS would cause a BPH denial (and the reaction of clinicians to this perception) was listed as a QIP in Case H. Case H requested to be taken out of the MHSDS prior to an upcoming BPH appearance, a request that was granted by his IDTT. In addition, two cases in 2015 (also Cases H and I) *may* have considered receiving a RVR as removing the possibility of parole. For these reasons, members of the SMHP met with administrators within the BPH on two occasions in 2015 to discuss the best way of going about offering information to commissioners. After these meetings, two trainings were developed. The first occurred in October, 2015, with commissioners briefed on the topic of how mental health clinicians evaluate RVRs and the role depression, psychosis, and other mental health conditions in influencing behavior temporarily or when untreated. The second training was scheduled with the intention of exploring perceptions about mental illness and future risk of violence. An area of focus for the second training was on encouraging treatment participation and treatment compliance as a way of decreasing violence risk. This second training occurred in January, 2016.

- BPH Commissioner and BPH Evaluator Access to the Urgent Response Mailbox: As a result of discussions between BPH administrators and SMHP representatives, a letter was sent to all BPH commissioners and all evaluators working for the BPH to notify them of the availability of the Urgent Response mailbox. The mailbox allows BPH commissioners or evaluators to alert headquarters mental health staff regarding any concerns for suicide in inmates or patients who are scheduled to go before the BPH or who appear distressed at or after a BPH hearing. For example, a patient who makes concerning statements during a pre-BPH evaluation can be referred to headquarters mental health personnel, who then notify the mental health program at the patient's institution. Similarly, an inmate who appears highly distressed by a parole denial during a BPH hearing can be referred by any of the commissioners present, ensuring a mental health contact occurs on that same day.

[39] Lewis-Fernandez, Aggarwal, Hinton, L, Hinton, D, & Kilmayer (2015). Handbook on the Cultural Formulation Interview. American Psychiatric Association Publishing, Washington, DC.
[40] Chu, Floyd, Diep, & Bongar (2013). A tool for the culturally competent assessment of suicide: The Cultural Assessment for Suicide (CARS) Measures. *Psychological Assessment,* 25, 424-434.
[41] Horon, Williams, & McManus (Manuscript in review). The Culture and Protective Suicide Scale for Incarcerated Persons (CAPSSIP): A measure for evaluating suicide risk and protection within correctional populations. Submitted to *Psychological Services*.

This project has been implemented. The Urgent Response Mailbox was being used by BPH commissioners and evaluators by the close of 2015.

- Suicide Prevention Pamphlets: Inmate and Family Member: Suicide prevention pamphlets were designed for inmates and for family members during 2015. The pamphlets were specifically intended for suicide prevention purposes. Inmate pamphlets provided information on how to ask for help, noted common myths about suicide, and described feelings that may go along with suicidal thoughts. The varieties of ways inmates can be referred or self-referred for mental health contact are listed. The family and friends pamphlet provides a list of warning signs for suicide, clarifies common myths about suicidal people, and provides a mental health contact number. The pamphlets were distributed in July, 2015, accompanied by a memorandum dated July 30, 2015. The memorandum specified that inmate pamphlets were to be made available in all housing units, with family/friend pamphlets available in visiting areas. The process for ordering additional pamphlets was also detailed. Both pamphlets were distributed during the year in English. Pamphlets in Spanish for both inmates and friends/family members had been prepared and were moving towards printing by the end of 2015. All pamphlets are currently available and can be reordered and redistribution at any time. The memorandum sent to institutions and the pamphlets created and distributed are found in Appendix IX.

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

- Columbia Suicide Severity Rating Scale (C-SSRS) Training and Inclusion in the EHRS: The C-SSRS is a well-established, empirically established, standardized suicide risk

measure[42] that has been incorporated as part of all suicide risk evaluations in the CDCR's Electronic Health Record System (EHRS) beginning in 2015. The primary author of the measure, Kelly Posner, Ph.D. (from Columbia University, New York), was invited to present on the measure in 2015. She accepted and presented the C-SSRS to a group of 50 CDCR clinician-trainers from over 30 institutions in October, 2015. The training was video-recorded and was just under two hours long. A group of handouts and a brief PowerPoint slideshow was constructed to aide clinicians in becoming familiar with administering the C-SSRS. The C-SSRS assists mental health clinicians by providing a structured way to inquire about suicidal history, to evaluate the intensity of suicidal ideation, and to assess the potential and actual lethality of suicide attempts. The recorded video presentation by Dr. Posner, handouts and other materials were distributed in February, 2016. Clinician trainers received two hours of approved CME credit on the C-SSRS based on the recorded (DVD) presentation. All institutions that received the EHRS in 2016 held C-SSRS training prior to their respective EHRS start dates.

- Collaborative Assessment and Management of Suicidality (CAMS) training: The CDCR began discussions with David Jobes, Ph.D., a clinical researcher at the Catholic University of America (Washington, D.C.) during 2015. Discussions centered on training a group of clinicians within the CDCR on CAMS. Dr. Jobes agreed to present on the principles of CAMS, a treatment intervention specific to working with suicidal patients, during a statewide suicide prevention videoconference in October, 2015. CAMS represents a promising intervention for mental health clinicians within the CDCR, as the therapy has wide community use, good empirical backing,[43] good support with other established treatments,[44] and flexibility to be used in a variety of settings. CAMS may be effective in targeting patients with high chronic risk for suicide, patients on high risk lists or in high risk programs, and patients with recent contemplation of or engagement in self-harm with intent. By the end of 2015, a purchase order to train an initial group of 50 clinicians in CAMS was in process. A list of clinicians was identified at all institutions with mental health missions to be the first group to receive and use CAMS. CAMS note templates were under preparation for inclusion in the EHRS. Training began in January, 2016 and continued until July, 2016. CAMS trainings occurred by using on-line training modules and a series of follow-up consultation calls with CAMS experts. A second round of clinician training is being arranged for 2017.

[42] Posner, Brown, Stanley, (2011). The Columbia-Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry*, 168, 1266-1277.
[43] Jobes, Wong, Conrad, Drozd, & Neal-Walden (2005). The Collaborative Assessment and Management of Suicidality versus treatment as usual: A retrospective study with suicidal outpatients. *Suicide and Life-Threatening Behavior*, 25, 483-497.
[44] Andreasson, et al. (2016). Effectiveness of Dialectical Behavior Therapy versus Collaborative Assessment and Management of Suicidality for reduction of self-harm in adults with borderline personality disorder and traits. *Depression and Anxiety*, 33, 520-530.

- Self-Harm Tracking and Predictive Algorithm: Self-harm incidents at every institution continue to be entered in MHTS. The data is used to identify institutions with high numbers of events and to track trends within and between institutions. In addition, using a technique called machine learning, the data will be used in developing a predictive algorithm. Machine learning algorithms can identify variables and variable combinations that may not at the surface appear related to increased short-term risk of self-harm, but can statistically establish these risks. The model allows for refinement as additional data points are entered. Work on a machine learning algorithm was begun in 2015, led by David Leidner, Ph.D., a specialist in informatics and data science. Dr. Leidner piloted an initial algorithm for predicting self-harm. Initial inquiries were made with several academic institutions regarding partnerships in developing the algorithm. More recently, a federal grant application was submitted in consultation with Drs. Ronald Kessler and Matthew Nock at the Harvard Medical School. The grant project hopes to refine the machine learning algorithm, increasing its predictive power and potentially alerting clinicians to patients with high degrees of likelihood of self-harm in the near future.

- On-Going Training through Monthly Suicide Prevention Videoconferences: Monthly suicide prevention videoconferences continue to occur. Institutional SPR FIT teams and mental health clinicians participate in the videoconference by viewing presentations in conference rooms using VTC connections or, when unable to attend in this manner, through phone lines. In 2015, the suicide prevention videoconference was used to review suicides and trends in suicides within the department, to brief staff on new or revised policies and procedures, to notify staff of suicide prevention trainings and resources (e.g., membership in the American Association of Suicidology), and to provide didactic trainings. Trainings covered during the year included:
    - Behavioral markers for suicide, even when suicide is denied
    - Introductions to evaluating suicide risk in the EHRS
    - Methods for improving safety plans
    - The use of suicide intention scales (with vignette practice)
    - Understanding chronic risk for suicide
    - Understanding the interplay between chronic and acute risk for suicide and imminent/warning signs for suicide
    - Staff self-care and monitoring of reactions to suicidal patients
    - Introduction to CAMS.

The suicide prevention videoconference is a continuing suicide prevention effort. Presentations continued in 2016.

- Revisions to the SRE and inclusion of additional suicide risk assessments in the EHRS: As noted above, the inclusion of the C-SSRS as part of every SRE conducted within the CDCR

is planned as part of EHRS implementation. The C-SSRS adds a structured set of questions inquiring about the intensity of suicidal ideation and about the range of suicide attempts and suicidal behaviors in which the patient has engaged over his or her lifetime. In addition, the SRE in the EHRS adds detailed information about past suicide attempts when applicable, noting the timing of the attempt, the means used, the potential and actual lethality/medical consequence, and so forth. These additions should help clinicians construct more accurate judgments of acute and chronic risk, while ensuring greater accuracy in considering historic vulnerability to suicide. In addition, the EHRS contains seven suicide risk assessment tools that may be used as needed by clinicians. These additional tools can help with understanding cultural protective and risk factors in cases,[45] evaluate readiness[46] and/or capability for suicide,[47] evaluate motivations for suicide attempts,[48] and so forth. Each of these tools was provided by researchers to the CDCR. All of the measures mentioned above had been included in the 'build' of the EHRS, with the C-SSRS prominently featured within the EHRS SRE. Training in the additional suicide risk assessment tools available in the EHRS occurred via webinar in 2016, with additional trainings offered in monthly videoconferences. Live and webinar trainings are planned for 2017.

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

Chapter V. Conclusions

Introduction: The numerous efforts undertaken by the CDCR to reduce suicides, aided by the consultation of the OSM, have been productive. While it may be impossible to say how many suicides were prevented in 2015, the on-going efforts and new initiatives for suicide prevention hold promise in reducing suicides within the CDCR. The rate of suicide in the CDCR in 2014 and 2015 dipped below the average rate of suicides in U.S. prisons in 2014 (the last reporting year available) and the percentage of suicides occurring in segregated housing units declined in both years. Efforts during the reporting year ranged from QIPs at the institutional level to continuing work to train clinicians in suicide risk evaluation and risk management to changes in policy and procedure to innovative projects. Yet, work remains to be done and efforts are on-going.

Summary of Findings: In 2015, 24 suicides occurred within the CDCR, 22 males and two females, at a rate of 18.6 per 100,000 inmates. Caucasian inmates and inmates in the age groups 30-34, 45-54, and over 60 died by suicide at a higher frequency then would be expected given their respective percentages within the CDCR population. Suicides occurred more commonly in

[45] CAPSSIP; *ibid*
[46] Chronic Readiness Questionnaire; Horon, McManus, & Sanchez-Barker (2013)
[47] Acquired Capability for Suicide Scales—Fearlessness About Death; Ribeiro, Witte, Van Orden, Selby, Gordon, Bender, & Joiner (2014)
[48] Reasons for Attempting Suicide Questionnaire; Holden & Delisle (2006)

unmarried inmates with limited educational and vocational experiences. Health factors were implicated in nearly half of the deaths by suicide in 2015. The frequency of suicide in segregated housing has declined, but remains an area of continued focus. Inmates sentenced to life also had a higher risk of suicide than inmates with determinant sentences. The first year of incarceration was also correlated with higher risk. Only one (4%) suicide occurred in a cell with a cellmate present (the cellmate was sleeping at the time), suggesting a protective impact of dual person or dorm housing. Suicides were more likely in individuals with past attempts (67%), a finding that is both expected and suggestive of potential interventions for (living) suicide attempters/survivors. A broad range of precipitants for suicide were found in 2015, with in-prison stresses repeatedly seen as underlying suicidal motives.

In comparison to the past 10 years, the suicide rate in the CDCR in 2015 of 18.6 per 100,000 is the third lowest rate, with 2014 (17.0 per 100,000) and 2009 (14.9 per 100,000) the years with the lowest rates. Two suicides of female inmates occurred in 2014 and 2015, higher than the number of suicides in such settings in all but two of the prior 20 years. The frequency of suicide over a 15-year period is highest in prisons with large mental health programs (1-2 suicides per year) and lowest in settings with either minimal mental health programs or predominantly inpatient missions (0.0 to 0.4 suicides per year on average). In 2015 and in the past 10 years in general, suicides occur most frequently in March, May, and October.

The frequency and rate of suicide within the CDR has declined over the past 10 years (2006-2015). In 2015, there were fewer suicides by Caucasians and Hispanic/Latinos, the two groups with the highest frequency of suicide in the CDCR, and fewer suicides in individuals ages 25-54. Suicides of inmates age 55 and over trended higher in 2015 compared to the previous five years. Suicides in segregated housing units have also declined in frequency compared to prior years, though the setting continues to have an elevated risk of suicide compared to other housing types. Inmates who qualify and have been placed in the MHSDS likewise continue to have an increased risk for suicide, with MHSDS rates of 52.6 per 100,000 in the past 10 years (2006-2015) versus a rate of 10.3 per 100,000 in non-MHSDS inmates over the same period.

As referenced above, the rate of suicide in U.S. Prisons rose to 20.0 per 100,000 inmates in 2014, the last year such statistics are available. This rate is higher than the rate of suicide in the CDCR in 2014 and in 2015. The community rate and U.S. Prison rate increased in 2014 and 2015. Men incarcerated in the CDCR had a lower rate of suicide then men in the community in 2014 and 2015.

When a non-lethal self-harm incident occurs within the CDCR, institutions are required to report the event using a database of such incidents. When a suicide occurs, a broad and intensive series of reviews is set in motion. These internal and external reviews evaluate the performance of staff members within and across disciplines, evaluate the emergency response, discuss the event in terms of procedural and policy considerations, and determine what corrective action plans must be put in place to ensure qualitative improvements to suicide prevention programs. In 2015, a total of

115 quality improvement plans were initiated and completed, addressing case-specific, institution-specific, and departmental level actions need to enhance suicide prevention efforts. Personnel at the headquarters level review all deaths within the CDCR and carefully evaluate all deaths initially listed as "unknown" or as caused by overdose in conjunction with the Death Review Committee. Suicide case reports are carefully edited and reviewed for quality, with quality audits completed by Quality Management staff. With very few exceptions, Suicide Case Reviews meet all or nearly all audit criteria. Experts working with the OSM participate in SCRs.

Suicides occurring in the CDCR in 2015 were understandably rather idiosyncratic and often multi-determined. Each of the 24 suicides in the year was reviewed to illustrate the complexities of the case and how suicidal outcomes can manifest within very different individuals. Case findings are also tabulated to look at key issues in improving suicide prevention. Among these findings are continued difficulties with suicide risk evaluations, suicide risk management, and treatment planning by mental health clinicians, manifested in a variety of ways over the 10 to 11 cases where these issues were identified. The need for higher levels of care considerations was also indicated in a number of cases. Issues with custody rounds, such as allowance of in-cell draping, concerns with emergency response, such as failing to bring full cut-down kits to an emergency, and problems with nursing/psychiatric technician checks were noted in a number of cases as well. Only one inmate was found in a state of rigor mortis in 2015, an improvement over past years.

Numerous suicide prevention initiatives continued, created, or initiated in 2015 were also reviewed. These initiatives strive to ensure a comprehensive suicide prevention strategy remains in place and continues to grow and develop as the population of the CDCR changes. Initiatives arose from many sources: QIPs, suggestions by Mr. Lindsay Hayes, audits of clinician performance, results of mentoring of clinicians trained in suicide risk evaluation and treatment planning, discussions and coordination with others (e.g., BPH commissioners), inspiration from public suicide prevention campaigns, discussions with and consultation with renowned Suicidologists, and even advances in informatics and other technologies. The development of the EHRS also set in motion a number of opportunities for innovation in the service of improving patient safety.

Report implications and future steps: A group of 10 report implications are enumerated below. The order of these implications is based on the order in which each finding was presented in the annual report. Future steps regarding each implication are to be discussed during DHCS SPR FIT meetings with updates provided in future annual reports.

1. Suicides in older adults: As was noted in Table 2, inmates over the age of 60 make up 6% of the population within the CDCR. However, 21% of suicides within the CDCR in 2015 were within this age group, making this the age group most overrepresented in number of suicides. High rates of suicide are found in the community in elderly males, particularly Caucasian males, during their mid- and late 70s and 80s. For mental health clinicians, the use of measures of connectedness with elderly patients should be discussed. The

Interpersonal Needs Questionnaire (INQ)[49] is included as an optional assessment in the EHRS and is a fine choice in such cases.

2. Suicides in inmates with co-morbid medical conditions: Nearly half (46%) of the inmates who died by suicide in 2015 were considered to have serious and/or chronic medical problems. This group of inmates had medical problems ranging from chronic low back pain or headaches to cases of liver disease, cancer, hemiparesis, diabetic neuropathy, cardiac problems, and worsening blindness. Community surveys of suicide in patients with significant medical problems have had varying results, with roughly 10% of suicides seen as attributable to medical disorder or to terminal illness.[50] In comparison, the one year (2015) total of 11 suicides of 24 in the CDCR is rather elevated and thus a potentially promising area to increase suicide prevention efforts. Several institutions have implemented pain management committees and pain management groups for inmates, and the success of these endeavors is being looked at closely.

3. Suicides in segregated housing units: Despite a decline in the frequency of suicide in segregated housing units, the rate of suicide in these units remains high compared to other housing settings within the CDCR. The three deaths occurring in dedicated intake cells is also concerning. Each of these three suicides occurred using different methods (hanging from a sprinkler head, hanging from ventilation grate holes, and overdose on KOP medications). A great deal of effort has already gone into improving safety and suicide prevention procedures in these settings, and it may be too early to fully ascertain the success of those efforts. However, further discussion of the implications of this finding may lead to new innovations.

4. Suicides in Inmates with Life Sentences: As 54% of suicides in 2015 occurred in patients with life sentences, compared with a roughly 20% proportion of the population overall, 'Lifers' represent a potential target for intervention. From a prevention standpoint, a number of efforts have been taken to try to combat this finding, including conducting training for BPH commissioners and evaluators, broadening the Urgent Response referral system to commissioners and evaluators, and training clinicians to 'bracket' BPH hearings with mental health contacts. Clinicians were advised during suicide prevention videoconference training to evaluate the degree of a patient's distress present before and after the hearing, to discuss the patient's thoughts on the outcome of the hearing, and to respond proactively to what may be experienced as bad or distressing news. Further education

[49] Cukrowicz, Cheavens, Van Orden, Ragain, & Cook (2013). Perceived burdensomeness and suicide ideation in older adults. *Psychology and Aging*, 26, 331-338.
[50] https://www.theguardian.com/society/2011/aug/23/suicide-chronic-illness-study

regarding the risk of suicide in inmates with sentences of Life without the Possibility of Parole is planned. Further interventions may also include holding "open lines" on general population lines, where inmates who do not require placement in MHSDS may seek time-limited services.

5. Suicides in Inmates during the First Year of Incarceration: In 2015, five of the 24 suicides occurred within the first year of incarceration, representing 21% of suicides. Three of the suicides occurred in inmates who were in reception centers (Cases A, M, & S). In reviewing the five cases, there is not a great deal of consistent or readily attributable commonalities between the deaths. However, based on 2015 data, additional attention to the variable 'early in sentence' is important to consider. The DHCS SPR FIT may wish to discuss ways to encourage clinicians in reception centers and those working with new arrivals to institutions (who are in their first year of incarceration) to exercise a more conservative approach to risk management with these individuals, to possibly include enhanced outreach.

6. Prevalence of Suicide in Single Cells and Double Cells without Assigned Cellmates: The CDCR has recognized the potential protective gain of cellmates for many years, noting the majority of suicides occur in cells with single occupancy. The same is true for 2015, with 96% of suicides occurring without a cellmate present at the time of the death. While it is true that inmates can wait for their cellmates to leave the cell for work or programming (this was true in two cases in 2015), there is still a preponderance of suicides in inmates with no assigned cellmate (20 of the 24 in 2015). Cellmates have interrupted suicide attempts, called for help during attempts, talked others into aborting attempts, and provided social support in many cases. The DHCS SPR FIT may discuss ways to encourage double cell or dorm placements in institutions, understanding that this is an optimal arrangement for most inmates.

7. Suicide Attempt History: Ten of the inmates who died by suicide in 2015 had made multiple past suicide attempts, with another six having made one prior attempt. Thus, two-thirds of those who died by suicide had made at least one prior attempt. The lifetime risk of death by suicide increases with single attempts and much more so after a second attempt; this is true in psychiatric and non-psychiatric samples. In psychiatric samples, the finding is particularly true in individuals with schizophrenia and bipolar disorder[51] and in patients shortly after release from hospitalization.[52] The CDCR has already instituted post-hospitalization follow-up contacts by policy, with procedures such as five-day follow-ups,

[51] Tidemalm, Langstrom, Lichtenstein, & Runeson (2008). Risk of suicide after suicide attempt according to coexisting psychiatric disorder: Swedish cohort study with long-term follow-up. *British Medical Journal*, 337.
[52] Haukka, Suominen, Partonen, & Lonnquist (2008). Determinants and outcomes of serious attempted suicide: A nationwide study of Finland, 1996-2003. *American Journal of Epidemiology*, 167, 1155-1163.

MHCB discharge custody checks, and so forth. The DHCS SPR FIT may consider and discuss additional interventions for suicide survivors, such as developing a pilot program to pilot the use of CAMS treatment with identified high risk patients; patients who have recent suicide attempts or a history of multiple prior attempts. As noted, CAMS is a targeted intervention that is specific to suicide risk. The treatment includes patient ratings of what most fuels suicidal desire for them and what has historically contributed to a wish to die by suicide, while challenging this wish for death with considerations of making life worth living.

8. Focus on Common Triggers or Motives for Suicide: Logically, in-prison stresses such as safety or enemy concerns, victimization fears, gang pressures, or new charges can be seen as sufficient to trigger or motivate suicidal contemplation. These motives were well represented in suicide case reviews conducted in 2015. However, mental health clinicians can sometimes underestimate the impact of in-prison stresses, noting either the inmate's role in the difficulty or the responsibility of custody staff in managing these issues. In other occasions, clinicians rely on reported mental health symptoms without assessing current distress. Additional highlighting of ways to integrate the role of in-prison stresses in inmate suicide within on-going suicide risk evaluation and suicide prevention trainings may be helpful.

9. Prevalence of Suicide in Mental Health Patients: The difference in rates of suicide over a 10-year period between identified mental health patients (52.6 per 100,000) and non-mental health inmates (10.3 per 100,000) is striking. While this suggests the CDCR has been doing a good job of screening and identifying inmates in need of mental health services, it also suggests that more can be done to prevent suicide in identified MHSDS participants. Of course, suicide is associated with a number of mental health disorders, and individuals who self-harm are placed in the MHSDS, suggesting that the rate in mental health populations will always be larger.[53] However, MHSDS staff members receive increasingly extensive and intensive suicide risk evaluation and suicide risk management training in the service of their patients. Increasing the focus on and training for suicide-specific interventions and suicide-specific treatment planning may be the most advantageous next step and may be carried forward by the headquarters SPR FIT. The provision of specialized training in CAMS,[54] DBT,[55] and/or CBT for Suicidality[56] is a worthwhile consideration for discussion.

[53] http://depts.washington.edu/mhreport/facts_suicide.php
[54] Jobes, D. (2016). Managing Suicidal Risk: A Collaborative Approach (2nd Edition). Guilford Press, New York.
[55] Linehan, M. (1993). Cognitive-Behavioral Treatment of Borderline Personality Disorder. Guilford Press, New York.
[56] Byran, C., Ed. (2015). Cognitive-Behavioral Therapy for Preventing Suicide Attempts. Routledge Press, New York.

10. Capitalizing on Innovations: The introduction of the Mental Health Tracking System (MHTS) in 2014 and the creation of an electronic health record system in 2015 created significant opportunities. First, in creating MHTS, critical information is entered daily into a data warehouse; this information can be used not only to track incidents of self-harm but also to correlate with other system information. The EHRS is also able to load information into the data warehouse. In this way, information is available to generate predictive algorithms for self-harm incidents in the CDCR, another way of identifying high-risk inmates that can alert clinicians to inmates in need of intervention. Additionally, the EHRS provides a way to integrate empirically-supported measures for evaluating suicide risk into clinical practice, lends tools for tracking the impact of safety and treatment planning efforts, and offers ways to evaluate the effectiveness of specific treatment interventions. These innovations should be embraced as advancements in suicide prevention.

Appendix I: Sample High Risk Management Program Policy

California Men's Colony Health Care Services
MENTAL HEALTH DEPARTMENT POLICY AND PROCEDURE MANUAL
HIGH RISK MANAGEMENT PROGRAM
10-0016
October 2015

I. **PRIMARY REVIEWER/RESPONSIBILITY:**
Chief of Mental Health

II. **PRIMARY MANUAL/MAINTENANCE:**
Mental Health Policy and Procedure Manual

III. **POLICY:** This local operating procedure establishes and describes the High Risk Management Program (HRMP) at California Men's Colony (CMC) which is designed to be consistent with the Mental Health Services Delivery System (MHSDS) Program Guide and adhere to suicide prevention and response and risk assessment / evaluation practices and policies. It is implemented to assist in identifying inmate-patients who may be at an elevated risk for self-harm or suicide, provide specific and individualized treatment for these behaviors, and to ensure that clinicians possess the knowledge and skill to adequately evaluate inmate-patients (IPs) for high risk.

IV. **PURPOSE:** The identification and management of inmates presenting as high risk is critical in order to address inmate suicides and self harm behavior. Inmates who present as high risk may include those who display signs of psychiatric decomposition, unstable medical conditions, grave disability, self-harm behavior, dangerousness to others, frequent Department of State Hospitals (DSH) or Mental Health Crisis Bed (MHCB) admissions, or who have safety and/or housing or custody concerns. Those who engage in self harm behaviors, or who attempt suicide, fall into the general category of inmates who are at risk. Research reveals that prior suicide attempts correlate with risk of eventual successful suicide.

V. **REFERENCES:**

- Mental Health Services Delivery System Program Guide, 2009 Revision
- CMC Local Operational Procedure (LOP) 10-0006 Suicide Prevention and Response
- CMC Operational Procedure (OP) No. 3012: Medical Report of Injury or Unusual Occurrence CDCR Form 7219
- Memorandum dated February 5, 2013 from Timothy G. Belavich, Deputy Director Statewide Mental Health Program: "Implementation of the Suicide Risk Evaluation Mentor Program"
- Memorandum dated February 15, 2013 from Timothy G. Belavich, Deputy Director Statewide Mental Health Program: "Suicide Risk Assessment Training"
- 2010 submittal to the *Coleman* Court regarding Suicide Prevention efforts
- Memorandum dated April 12, 2013 from T. Belavich, Deputy Director(A), Statewide Mental Health Program: "Suicide Attempts Data Collection"
- Memorandum dated May 29, 2013 from E. Valenzuela, CMC Warden and T. Fox, CMC Chief Executive Officer: "Reporting Inmate Attempted Suicides and Self Harm"
- Addendum Memorandum to DOM Supplement Section 51030.3 Reportable Incidents, Sub Section 51030.6 Format and Content – Reporting Inmate Attempted Suicides and Self Harm dated January 28, 2014 signed by E. Valenzuela, CMC Warden and T. Fox, CMC Chief Executive Officer
- Memorandum dated August 13, 2013 from T. Belavich, Director (A), division of Health Care Services and Deputy Director, Statewide Mental Health Program: "Suicide Prevention and Response Focused Improvement Team Coordinator Attendance at Inmate Advisory Councils and Inmate Family Councils"
- Memorandum dated May 8, 2015 from T. Belavich, Director (A), Division of Correctional Health Care Services (DCHCS) and Deputy Director, Statewide Mental Health Program: "Consulting Staff Name Documentation in Health Care Records"
- Memorandum dated May 12, 2015 from T. Belavich, Director (A), DCHCS and Deputy Director, Statewide Mental Health Program: "Documentation of Mental Health Evaluations and Treatment Plans"

- Memorandum dated July 30, 2015 from T. Belavich, Director (A), DCHCS and Deputy Director, Statewide Mental Health Program and K. Harrington, Director, Division of Adult Institutions: "Suicide Prevention Pamphlets for Inmates and Family/Friends"
- Memorandum dated September 28, 2015 from T. Belavich, Director (A) DCHCS and Deputy Director, Statewide Mental Health Program: "Revision to the Suicide Risk Evaluation Mentoring Program"
- CMC Local Operational Procedure (LOP) 14-0004, Adverse Events and Unusual Occurrences

VI. APPROVAL AND REVIEW:

This procedure shall be updated annually. Last revision: August 2014

VII. PROCEDURE DETAILS

A. ONGOING EDUCATION AND TRAINING FOR CLINICAL STAFF

Higher Level of Care Issues and Training
Trainings are conducted as needed and ongoing with all Mental Health (MH) clinical staff regarding DSH referral and sustainability processes and monitored by Program Supervisors. Monthly and quarterly audits are additionally conducted by the DSH Coordinator (reference LOP 10-0010 DSH Referrals).

Suicide Risk Assessment Training
All MH clinical staff receives mandatory 7.0 hour training on suicide risk assessment. This is repeated every two years.

Suicide Risk Evaluation (SRE) Mentoring Program
All clinical staff is mentored by headquarters trained CMC staff on administration of the SRE. This mentoring is conducted with all new staff and is repeated every two years for all staff. Effective September 2015 SRE Mentoring will be provided on an annual basis to all MHCB staff. In addition, when an audited SRE is determined to not meet standards, additional SRE Mentoring may be required (Reference September 28, 2015 Memorandum "Revision to the Suicide Risk Evaluation Mentoring Program.")

Self Harm Behavior Reporting
All staff including nursing and custody are trained on self harm behavior reporting (see below Section D Other High Risk Management Protocols, item 7).

SRE Form 7447 Training
All clinical staff is trained locally and via Headquarters' Suicide Prevention and Response Department on completion of this form and Suicide Safety/Treatment Planning.

New Employee Orientation
All new employees are provided orientation to suicide prevention and response in the prison setting and an overview of all protocols and policies, in addition to the above trainings.

B. HIGH RISK MANAGEMENT PROGRAM

The Coordinator for the HRMP shall be a Senior Psychologist Supervisor or Senior Psychologist Specialist as appointed by the Chief of Mental Health. The HRMP Team is comprised of the HRMP Coordinator, Primary Clinician (PC) (s) and other treatment team members as indicated.

California Men's Colony Health Care Services
MENTAL HEALTH DEPARTMENT POLICY AND PROCEDURE MANUAL
HIGH RISK MANAGEMENT PROGRAM
10-0016
October 2015

1. Identification of High Risk IP

The process of identifying High Risk IPs shall be done by all MH clinical staff at CMC. Any IP requiring short or long-term intervention and treatment for high risk factors shall be considered for referral to the program.

High Utilizer Report
All IPs included on the High Utilizer Report generated from the MH Patient Registry on the Quality Improvement share site, are considered "high utilizers" of higher levels of care, and this must be documented on the IPs treatment plan as long as he is on the list. Consideration of referral to the HRMP must also be documented and referral made if clinically indicated. If a referral is not made or the clinician does not consider the IP's high utilization as indicative of high risk behavior, then the clinician must document the rational for non-inclusion on a CDCR 7230, Interdisciplinary Progress Note, and reference this note on every treatment plan as long as the IP remains on the list. This list and protocol is audited semi-annually at minimum and training is provided in all cases of non-compliance.

Other sources that may be utilized to identify high risk IPs may include the following:

a. DSH Indicator Report (generated from Mental Health Tracking System (MHTS.net)). Staff is required to document and integrate any positive criteria into Interdisciplinary Treatment Team Plans (IDTT).

b. Weekly Treatment Hours Summary (High Refusers) Report (generated from MHTS.net). Staff is required to document and address IPs refusing treatment into IDTT Plans.

c. All DSH returns and MHCB discharges remaining at CMC will be considered for referral to the HRMP.

2. Staff Referrals to the HRMP

In addition to those inmates identified through the steps above, any clinician can make a referral to the high risk program at any time.

a. The HRMP referral form (ATTACHMENT A) shall be used for referrals to the high risk program.

b. The referral is made to the HRMP group facilitators or Coordinator. The HRMP Team will perform a file review focused on review of risk factors as well as protective factors that may contribute to the IPs high risk status and conduct a screening interview with the IP. Suicide and self-harm history, methods of suicide attempts, frequency of suicide attempts or self-harm, and other relevant MH and medical conditions are among the areas focused upon in the chart review. If appropriate and in coordination with the PC, the IP will be assigned to the HRMP.

c. Final determination for inclusion is at the discretion of the HRMP Team. If placement is not appropriate for the HRMP, the reviewer will notify the PC for further assessment of the need for a possible higher level of care, or other appropriate treatment referrals or recommendations.

3. Management and Treatment of High Risk Inmates

   a. A High Risk Management Program will be provided in mainline Enhanced Outpatient Program (EOP) and Correctional Clinical Case Management System programs and in Administrative Segregation Unit (ASU).

   b. High risk factors must be documented on every treatment plan as a specific area of focus with measurable and objective goals defined and documented.

   c. The IDTT will formulate a treatment plan specific to the IPs inclusion in the HRMP including high utilization or high risk factors as applicable. The plan will include and document developmental history; criminal history, including a description of the commitment offense and past offenses; history of violence; substance abuse/dependence history; mental health history; history of suicide attempts and self harm behaviors; family history of suicide attempts or completed suicide; review of diagnoses; provision of treatment recommendation and treatment management; and frequency of clinical contact and IDTT meetings.

   d. Completion of Treatment Plans, SREs and all documentation shall be completed within all required timeframes as stipulated in the MHSDS Program Guide, 2009 Revision, and per all applicable California Correctional Health Care Services Memoranda to include: "Documentation of MH Evaluations and Treatment Plans" dated May 12, 2015 and "Consulting Staff Name Documentation in Health Records" dated May 8, 2015. Changes to the Treatment Plan due to identified high risk factors may necessitate completion of a full plan instead of an addendum or summary. SREs must also be completed as clinically indicated by presence of high risk factors.

   e. The HRMP treatment for IPs identified as high risk will be provided in a group format with ongoing consultation and involvement of the PC. The focus of the group will be on distress tolerance, affect regulation, coping skills, and suicide risk management utilizing a Dialectical Behavior Therapy informed treatment. For IPs not appropriate for group treatment, this treatment may be provided individually by the PC as determined by the IDTT and may include increased individual sessions.

4. Movement/Housing Changes

   Whenever an IP identified as "High Chronic" or "High Acute" risk on the most recent SRE, and/or is enrolled or referred to the HRMP and is re-assigned to a new PC for any reason, or moves to a different part of the institution, the PC will communicate with appropriate clinics about the arrival/departure of the IP. If the IP is transferring to a different institution, the PC will make every effort to communicate with the receiving facility to provide clinical and high risk information. Reference below for specific treatment for this population as well.

C. SUICIDE PREVENTION REVIEW - FOCUS IMPROVEMENT TEAM (SPRFIT)

The goal of CMC SPRFIT is to provide focus on appropriate suicide risk assessment and evaluation, training and education. The SPRFIT meets monthly and discusses all suicide attempts and self-harm incidents that occurred that month, and/or the previous month.

Written summaries that include all incidents of self-harm, with or without the intent to die are provided for extensive review and discussion by the multidisciplinary staff. These summaries

incorporate file reviews and clinical consultations; list identified risk and protective factors; clinical and suicide history; and relevant mental health and medical conditions.

1. A formal clinical presentation of a suicide attempt or serious incident from the previous month is made at each meeting with extensive multi-disciplinary staff discussion.

2. All self harm incidents are presented and discussed.

3. The SPRFIT Coordinator attends the Emergency Medical Response Review Committee and presents all self-harm incidents and receives information regarding medical codes. These codes are reviewed and if any mental health issues are indicated further clinical review and consultation will be conducted as applicable.

4. The SPRFIT Coordinator maintains ongoing dialogue with Facility Captains, other custody and medical staff, and shall be notified of all incidents and shall receive the Daily Briefing Report in addition to all applicable Incident Reports.

5. The SPRFIT Coordinator attends and reports to the Mental Health Program Subcommittee (MHPS) twice monthly. All relevant incidents are reviewed and discussed and reports or audits are presented as indicated. The SPRFIT Coordinator maintains monthly logs of all self-harm incidents and suicide attempts. These logs include clinical and demographic information, and track known high risk factors as well and any trends which are analyzed, reported and discussed at the SPRFIT meetings and/or in other forums as needed. The monthly data is provided to the DCHCS Suicide Prevention SharePoint site. A clinical high risk / self harm summary is provided on each case and provided to clinicians and to all Peer Review Committees for further review as indicated.

D. OTHER HIGH RISK MANAGEMENT PROTOCOLS

1. IPs with repeat admissions to higher levels of care are tracked and monitored and if clinically indicated provided specialized group and/or individualized treatment specifically regarding high utilization as described above.

2. All DSH returnees and MHCB discharges are evaluated and screened by a designated clinical staff and referred as clinically indicated to the HRMP Transitions Group Treatment program specifically designed for this purpose.

3. The Program Supervisors and/or DSH Coordinator or designee reviews all Interdisciplinary Treatment Team Level of Care Decision, CDCR MH-7388-B forms. Positive indicators are discussed including consultation with the HRMP team as needed.

4. HRMP team members attend IDTTs as requested when any IP in the HRMP is presented, or for any other consultative purpose as needed.

5. The DSH Coordinator or designee performs two 7388-B audits and presents findings to the institution MHPS and HRMP Coordinator.

6. The DSH Coordinator or designee coordinates and ensures that MHCB and DSH returnee information is provided to staff.

7. Self Harm Reporting:

a. Nursing responds to self-harm incidents and consults with the MH Clinician of the Day, assigned clinician, other responding clinician, or the Psychiatrist on Call after hours to obtain a determination if the event was a self-harm behavior with or without intent to die. Nursing then provides the Self-Harm Mental Health Chrono 128-C to the SPRFIT Coordinator or designee.

b. The responding MH clinician shall provide, no later than the following business day, a full Incident Notification of the self harm behavior to the SPRFIT Coordinator or designee. An additional follow up report may be required as well. This notification shall be made via email and shall include:
   i. The inmate's name, CDCR number and level of care
   ii. Location/cell number
   iii. A very brief description of what specifically occurred, including IP statement
   iv. Date of incident, Time of incident
   v. What the clinical determination was regarding the incident (intent to die, no intent to die, or unknown and further review required)
   vi. What the disposition was (e.g. returned to housing, admitted to MHCB, etc.)

c. The SPRFIT Coordinator or designee shall provide the Self Harm Chrono to relevant Custody and Nursing staff and the clinical information to relevant clinical staff.

d. These protocols are also defined in the Suicide Prevention LOP 10-0006 and OP No. 3012: Medical Report of Injury or Unusual Occurrence CDCR Form 7219.

e. Self harm behaviors are specifically addressed in the HRMP Group Treatment.

f. All self harm must also be reported in accordance with CMC Local Operational Procedure (LOP) 14-0004, Adverse Events and Unusual Occurrences.

8. IPs Transferring from CMC

Transfer from CMC has been identified as a high risk factor for CMC IPs. To address this risk, a specific clinical group was devised and implemented. The *Preparation for Transfer* group focuses on preparing EOP IPs for transfer to either a corresponding CDCR institution or to a DSH facility. The group is facilitated by a MH clinician (psychologist or clinical social worker) and may include a correctional counselor as indicated. The facilitators assist IPs by providing ways to reduce anxiety, discuss safety concerns, building and maintaining positive coping strategies utilizing Cognitive Behavioral Therapy (CBT), and focus on reality-based information, in order to pave the way for a smooth transition by processing concerns and incorporating psycho-education and CBT.

9. Keep on Person (KOP) Medications

KOP medications may be contraindicated for high risk IPs. The DCHCS SPRFIT is discussing possible policy changes regarding KOP medications and high risk IPs. CMC shall implement this policy as soon as it is available. In the interim, all IPs enrolled in or referred to the HRMP; who have a "High Chronic" or "High Acute" risk level determination on their last SRE; or who demonstrate significant high risk factors, shall be assessed by the PC and the IDTT regarding KOP medications as applicable. This

assessment shall include consultation with the primary medical provider. This consultation shall be appropriately documented. Through this process review an IP may be referred to medical for possible exclusion of KOP medications. This decision shall be reviewed at minimum, every IDTT.

OUTREACH

CMC will provide the following outreach and communication:

1. A Suicide Prevention DVD written and performed by CMC inmates is played on the local television system for all inmates. This DVD has been provided to all institutions statewide for utilization.
2. An outreach/referral system is integrated on general population yards including both CMC East and West Facilities.
3. Suicide prevention and general MH outreach fliers are posted throughout the institution to include chapel locations and where inmates meet with Board of Prison Terms and attorneys.
4. Outreach and communication is ongoing with non-MH staff, including custody, medical/nursing, and religious services.
5. Senior Supervisors routinely tour ASU and EOP housing units, meeting with staff and inmates to identify at-risk inmates.
6. The SPRFIT Coordinator or designee attends Inmate Family Council (IFC) and Men's Advisory Council (MAC) meetings to represent MH and provide information regarding suicide prevention.
7. Suicide Prevention information pamphlets are provided throughout the institution for visiting personnel and inmates alike, and provided at IFC and MAC meetings.

E. AUDITS

Audits on processes described above will be conducted and reported to the Suicide Prevention and Response Focused Improvement Team and to the MHPS as indicated. Reference LOP 10-0006 Suicide Prevention and Response for details.

APPROVED:

J. Meyers, MD 10/15/15
CHIEF OF MENTAL HEALTH Date

10/28/15
QUALITY MANAGEMENT COMMITTEE Date

10/28/15
LOCAL GOVERNING BODY Date

ATTACHMENT:
Attachment A – HRMP Referral

HRMP Group Referral Form (08/12/2014)

Inmate name _____ CDC#_____ DOB·_____

LOC (circle one) MHCB/ EOP/CCCMS Release Date_____ TABE score_____

Reason for referral to HRMP

_____

_____

Suicide attempt / self-harm history

_____

_____

The HRMP group utilizes a modified DBT skills model. Each group will meet twice weekly for approximately 6 months. There are currently several HRMP groups available, based on the IP's level of functioning.

_____ _____

Referring Clinician (print legibly) Today's Date

Appendix II: Self-harm and Incident Reporting

Institutional reporting of self-harm incidents: All incidents of self-harm in the CDCR are reviewed by institutional staff members, including mental health clinicians. When an incident of self-harm occurs, regardless of the severity of injury sustained, mental health clinicians discuss the event with the patient and determine whether the intent was to die (thus a suicide attempt) or if the self-harm served some other purpose, such as to relieve tension states, without any intention to die. The self-harm database also includes data on self-harm incidents that result in death.

All incidents of self-harm are entered on a self-harm database. The self-harm database serves as a way for mental health clinicians to track incidents within a facility, to allow Regional and SMHP staff members a view of the frequency of self-harm across facilities, to identify patients for High Risk Management Lists or Program(s) within a facility, and to further examine risk factors. A sample High Risk Management Program policy is found in Appendix I.

When a suicide attempt involving serious bodily injury occurs in the CDCR, the incident is documented using CDCR Form 837, Serious Incident Report, and institution mental health staff members are notified of the incident. Each incident is also relayed through one of two reporting processes; the Daily Briefing Report (DBR) or the Administrative Officer of the Day (AOD) report. The information in either report is sent to the administration of the Division of Adult Institutions (DAI) and forwarded to the CDCR's SMHP. In some cases, a suicide attempt involving serious bodily injury results in death at a later time; the DBR or AOD report are updated in this case to reflect that a death by suicide has occurred. In such cases, the DBR or AOD report is updated to inform the DAI and the DAI Mental Health Compliance Team of a death by suicide.

Institutional reporting of suicide: In the event of the discovery of a suicide attempt in progress, emergency medical interventions are made until such time as the individual is pronounced deceased by a qualified physician. Correctional officers who come upon a suicide attempt in progress are to sound an alarm and initiate life saving measures until relieved by health care personnel. Officers are trained in CPR and in procedures to respond to emergencies, including in bringing cut-down kits to the scene of a suicide in progress.[57] Custody officers will assist health care staff members, including institutional responders and paramedics, in transporting the patient to the TTA and/or ambulance. In cases in which emergency interventions are not successful, the watch commander or senior custody officer is notified of the suicide and in turn notifies the Warden or the AOD of the death.[58] A CDCR Form 837, Serious Incident Report, is completed on all suicides.

The Chief Medical Executive or physician designee makes a report of the death by suicide within eight hours of the event. Medical information is provided in the CDCR Form 7229A *Initial Inmate Death Report*. This form, once completed, is distributed internally, to the county coroner's office, and to the Death Review Coordinator at headquarters. A separate form is completed by institutional mental health staff, form CDCR MH-7229B *Inmate Suicide*. This form is typically completed by the institutional SPR FIT Coordinator and contains information on prior suicide attempts, the results of recent suicide risk evaluations, etc.[59] The form is retained at the facility and sent to the SMHP. Once received, SMHP support staff ensures the suicide is entered into a log, reports the event to nursing leadership, and alerts the SMHP Suicide Response Coordinator to the event.

[57] MHSDS Program Guides, 2009 Revision, pages 12-10-21 to 12-10-23
[58] MHSDS Program Guides, 2009 Revision, pages 12-10-24
[59] *Id.*

Appendix III: Determination of Unknown Causes of Death

Determination of unknown causes of death: On occasion, a death will occur within a CDCR institution in which the cause of death is not immediately determined. These cases are classified as "Unknown Deaths." These cases receive special attention until the cause of death is determined. In order to track these deaths, a group of employees at the SMHP are assigned to review *all* notifications of deaths within the CDCR. As noted, each institution within the CDCR is required to make a report of death and to provide documentation on the provisional cause of a death in a CDCR 7229A. A completed CDCR 7229A contains a preliminary summary of the circumstances of the death and lists any underlying/significant medical conditions. These documents are uploaded to a SharePoint site that can be accessed by members of the Death Review Committee and the SMHP. Additionally, the Death Review Coordinator for the CCHCS produces a daily report on all CDCR deaths.

In 2015, a total of 330 inmates perished in the CDCR, with 159 of the decedents (48%) involved in the MHSDS at the time of death. Whenever a *Coleman* class member dies, the OSM is notified of the circumstances and cause of the death by the SMHP. In all cases in which the cause of death is provisionally listed as a suicide, an additional mental health review is completed by the institution and documented using a CDCR 7229B. In all such cases and whenever any inmate dies from suicide, the OSM is notified of the circumstances and the specifics of the suicide. At times, notifications to the OSM may be updated with the receipt of additional information, such as results from autopsies, toxicology screens, and so forth.

In the event that a death notification lists the cause of death as unknown or undetermined, the SMHP will track the case until the death is classified. On some occasions, the cause of death is classified quickly by institutional medical review. In other cases, the cause of death remains undetermined pending the receipt of autopsy or toxicology results. In such cases, the Death Review Committee will investigate the death and produce an initial cause of death as well as a final cause of death determination. In the meantime, the SMHP communicates with the institution and with the DRC on these cases until the cause of death is determined. A member of the SMHP also sits on the DRC to ensure all unknown deaths are reviewed and, when applicable, that the possibility of suicide has been closely and objectively considered.

The SMHP reviews unknown deaths in order to ensure that all deaths are accurately identified as either due to suicide or not due to suicide. Cases are identified for this additional review when the cause of death is overdose, to determine if the overdose is most likely accidental or intentional (suicide). Other cases are identified when the cause of death is potentially related to mental health treatment needs and/or when the death may have resulted as the long-term consequence of a self-harm behavior.

The following guidelines are used to determine unknown deaths:

Reviewers Determination of Unknown Deaths Guidelines

1. Review the method of death to determine if there may have been an alternative reason (other than suicide) for the behavior (e.g., autoerotic asphyxiation, confusion and inability to form intent, purposeful intoxication, etc.).

2. If an overdose on substances is it reasonable the substance (illicit or prescribed) may have been used in an attempt to become intoxicated? (e.g., Tylenol is not likely to be used to become intoxicated; Klonopin may be).

3. Review recent mental health history and any past history of suicide attempts/self-harm behavior (check self-harm log). Did the inmate:
   - Voice suicidal ideation (including conditional suicidal ideation)?
   - Have admits to MHCB?
   - Engage in self-harm behavior?
   - Have a history of depression or mood disturbance?
   - Have a history of psychosis?

4. Review substance abuse history.
   - What substances were used?
   - Have there been any past overdoses?
     - If yes, what did the inmate say about them at the time?
   - What substance abuse treatment was offered?
   - How recent are reports of current use?

5. Review recent custodial information.
   - Was the inmate facing criminal charges?
   - Did the inmate lose an appeal?
   - Did the inmate have any recent losses?
   - Was there any bad news readily apparent?

6. Review medical information for the presence of:
   - Chronic pain
   - Terminal illness

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

Appendix IV: Review of Individual Suicide Case Reviews

Cases **EE to NN** were deaths initially classified as unknown deaths. Each of these cases was eventually determined to involve death due to drug overdose.

Case EE was provisionally determined to have had an illicit drug overdose per the CDCR 7229A completed at this death. Toxicology results indicated methamphetamine intoxication. Autopsy reports also determined no other cause of death; the death was ruled as an accidental drug overdose secondary to methamphetamine intoxication. Additionally, three baggies containing methamphetamine were found on EE during autopsy, secreted in various bodily orifices. The Combined Death Review Summary (CDRS) also determined methamphetamine overdose to be the cause of death. The case had no known history of suicide attempts, had not received recent bad news, and did not leave a suicide note. Case EE had an extensive substance abuse history as well. All evidence in the case argued for an accidental overdose and not an intentional overdose (a suicide).

Case FF was provisionally determined to have had an anoxic brain injury that occurred on account of an illicit drug overdose (per the CDCR 7229A completed at his death). Toxicology results indicated methamphetamine intoxication. Autopsy reports determined the cause of death as an accidental drug overdose secondary to methamphetamine intoxication. Case FF was known to have significant substance abuse problems and had been found by custody officers the day before his death in possession of inmate-manufactured alcohol. The Combined Death Review Summary (CDRS) also determined methamphetamine overdose to be the cause of death. The case had no known history of suicide attempts, had not received recent bad news, and did not leave a suicide note. He had a history of chronic back pain but pain medications were not implicated in his death. The evidence in this case is strong for an accidental overdose rather than for an intentional overdose (a suicide).

Case GG was listed as an unknown death per the CDCR 7229A. However, toxicology results were positive for methamphetamine intoxication. Autopsy reports determined the cause of death to be acute methamphetamine intoxication. Additionally, multiple bindles were found on Case GG during autopsy. The Combined Death Review Summary (CDRS) determined methamphetamine toxicity to be the cause of death. The case had no known history of suicide attempts, had not received recent bad news, and did not leave a suicide note. Case GG had an extensive substance abuse history as well. He had a history of knee pain for which he was treated with Tylenol; however, this medication was not implicated in his death. The evidence in the case argues for an accidental overdose and not an intentional overdose (a suicide).

Case HH was listed as an unknown death/probable overdose on his CDCR 7229A. However, toxicology results were positive for Fentanyl, a synthetic opioid. Autopsy reports determined the cause of death to be acute Fentanyl intoxication. The Combined Death Review Summary (CDRS)

determined Fentanyl toxicity to be the cause of death. Additionally, the inmate's cell was searched, with a syringe and drug paraphernalia found in his property. No suicide note was found. Case HH had an extensive substance abuse history as well and had received a RVR on 6/29/15 for Possession of a Controlled Substance for Distribution. He was placed in ASU for several weeks but had returned to general population housing. On the other hand, Case HH did have a history of suicide attempts, including an intentional overdose attempt in 1995. He had also received recent bad news three months prior to his death. He was informed that his grandmother had died and he responded by swallowing a razor blade at the time. Case HH had a history of chronic back pain for which he was treated with Tylenol and Naproxen. These medications were not implicated in his death. The evidence in the case is complex, though there appears to be stronger evidence for an accidental overdose than for an intentional overdose.

Case II was listed as possible drug overdose on the CDCR 7229A completed at his death. Toxicology results were positive for Fentanyl intoxication. Autopsy reports determined the cause of death to be accidental drug overdose/Fentanyl intoxication. The Combined Death Review Summary (CDRS) also determined Fentanyl toxicity to be the cause of death. The case had no known history of suicide attempts, had not received recent bad news, and did not leave a suicide note. He also had no known chronic pain issues. Case II had an extensive substance abuse history and was found at autopsy with multiple needle marks on his arm, with illicit drugs and syringes found in his cell as well. The evidence in the case argues strongly for an accidental overdose rather than an intentional overdose.

Case JJ was listed as an unknown death and provisionally as a death due to respiratory failure secondary to drug overdose (on CDCR 7229A). Case JJ was discovered in his cell with a syringe in his hand. The syringe was found to contain heroin, acetyl codeine, and papaverine (an opioid). Methamphetamine was not found in the tested syringe but was present per toxicology results. Prescribed medications were also found in his system but reported to "not excessive." The autopsy report determined the cause of death to be accidental drug overdose by the combined effects of acute heroin and methamphetamine intoxication and the prescribed medications. Multiple drug injection marks were found on the body. The Combined Death Review Summary (CDRS) also determined the cause of death to be overdose. The case had a history of suicide attempts, using attempted hanging and exsanguination. He was treated at the EOP level of care and had prior inpatient stays. The patient's father had passed away one month before the death. Mental health notes reported that clinicians were working with the patient on bereavement issues and that Case JJ was denying suicidal thoughts, plans, or intent. Case JJ also had known chronic back pain and an extensive substance abuse history. The evidence in the case argues is somewhat equivocal, suggesting that suicidal motive could have been present but denied by the patient. However, the evidence is stronger for ongoing IV drug use, as noted by the track marks found in many places on the body, and for an accidental overdose, as noted from the contents of the syringe found at the time of discovery.

Case KK was listed as possible drug overdose per his CDCR 7229A. Toxicology results were positive for heroin intoxication. Autopsy reports similarly determined the cause of death to be heroin intoxication. Additionally, a number of hypodermic needles were found in Case KK's cell, suggesting a pattern of illicit drug use. The Combined Death Review Summary (CDRS) determined heroin toxicity to be the cause of death. The case had no known history of suicide attempts, had not received recent bad news, and did not leave a suicide note. Case KK had an extensive substance abuse history. He had a history of back pain. The majority of evidence in the case argues for an accidental overdose rather than an intentional overdose (a suicide).

Case LL was listed as an unknown death per the CDCR 7229A. Case LL was known to have significant medical issues, including hepatic cirrhosis and Hepatitis C, prior to his death. However, toxicology results were positive for morphine intoxication. Autopsy reports determined that morphine intoxication was a tertiary cause of death with cirrhosis being the primary cause of death. The Combined Death Review Summary (CDRS) agreed with this determination; that is, that morphine ingestion was not the primary cause of death. Notably, Case LL did have a history of chronic neck and low back pain and he was treated with opiates. He also had a history of substance abuse problems. Case LL did not have a known history of suicide attempts, had not received recent bad news, and did not leave a suicide note. The evidence in the case is suggestive of a death from medical illness with secondary accidental overdose with morphine. There is little or no evidence of an intentional overdose (a suicide).

Case MM was listed as an unknown death on the CDCR 7229A completed at the time. Toxicology results were elucidating, with both morphine and methadone found. The patient did have chronic back pain and was on multiple prescribed medications for pain. However, upon Death Review Committee study, both medications were found to be elevated, suggesting acute toxicity/intoxication. Additionally, Case MM's cell was found to have syringes, despite the fact that his opioid medications were crushed for administration. The medications were crushed on account of the severity of the inmate's substance abuse difficulties. The autopsy report on the case determined the cause of death was "acute morphine and methadone intoxication (hours)." The autopsy noted left-ventricular cardiac hypertrophy, pulmonary edema, and cirrhosis of the liver as well. Case MM was known to have hypertension, diabetes mellitus, type 2, hepatitis C, and end-stage liver disease. Case MM was in the MHSDS at the CCCMS level of care. He was treated for anxiety and was in treatment groups for pain management. Mental health notes do not document concerns about suicidality and largely focus on pain symptoms. No suicide note was found in the case and there was no known receipt of bad news. The majority of evidence in the case argues for an accidental overdose rather than an intentional overdose (a suicide).

Case NN was provisionally listed as an unknown/possible drug overdose death on CDCR 7229A. His cellmate was initially suspected in his death, but no signs of trauma were found on the body. A cell search produced drug packaging materials. Case NN was known to have significant

substance abuse issues. Post-mortem toxicology findings were positive for opiates, with autopsy results indicating acute opiate toxicity as the cause of death. The Combined Death Review Summary (CDRS) concluded that opiate ingestion/toxicity was the cause of death. Case NN was in the MHSDS at the CCCMS level of care. He reportedly was placed in CCCMS after being charged with heroin possession in 2014; he reported some distress upon placement in ASU. He improved while in ASU but was retained in CCCMS. Case NN had no known history of suicide attempts. He did have back pain issues, for which he was treated with Ibuprofen. Case NN had not received recent bad news and did not leave a suicide note. The evidence in the case weighs strongly on the side of an accidental overdose of opiates. There is little or no evidence of an intentional overdose (a suicide).

Appendix V: Suicide Response Procedures

Reporting of a suicide to stakeholders: When an inmate dies by suicide, members of the SMHP complete two formal notification processes. First, a death notification is written and sent to the OSM and contains details of the suicide. Second, a summary of the suicide is composed and sent to the Deputy Director of the SMHP and the Undersecretary of the DHCS. 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 that site. The reviews are conducted first within disciplines and then within joint institutional reviews, such as during SPR FIT and emergency medical response committee meetings.

Each institution within the CDCR has a Suicide Prevention and Response Focused Improvement Team, or SPR FIT, with a Senior Psychologist-Specialist assigned to coordinate local prevention and response efforts. The institution's SPR FIT is established and maintained by the Mental Health Program subcommittee, with both committees part of local Quality Management

Committees.[60] Each institutional SPR FIT is responsible for monitoring and tracking all self-harm events, ensuring that appropriate treatment and follow-up interventions occur. When deaths by suicide occur, the local SPR FIT Coordinator is required to notify the SMHP, to provide assistance to mental health, custody, and nursing suicide reviewers, and to ensure the implementation of Quality Improvement Plans (QIPs) resulting from the suicide review.[61]

External review processes: CDCR's response to suicides includes several external reviews by trained representatives from various disciplines, including nursing, medical, custody, and mental health. Within three days of the suicide, reviewers are assigned from these disciplines at what is commonly referred to as the headquarters level. 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 look at the deceased's property, listen to recorded phone calls, check trust account records, and talk with the Investigative Services Unit (ISU) of the specific prison. Reviewers evaluate the emergency response that took place during or after the suicide 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 cellmates who may have known the patient. Reviewers may gather information from other sources as well, such as through interviews

[60] MHSDS Program Guides, 2009 Revision, pages 12-10-2 to 12-10-4
[61] *Id*

of family members. After thorough chart review, reports are generated by each discipline, with a combined report, the Suicide Report, distributed and discussed in the Suicide Case Review.

Suicide Case Review (SCR) meetings review findings in the case within and across disciplines while sharing information with institutional leadership. The Suicide Report contains quality improvement plans (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 member performance whenever such a need is 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 focuses on the performance of custody staff members related to the 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 practices and policies were followed by custody and counseling staff involved in the case. The MHCT reviewer, for example, evaluates whether custody officers followed procedure within an emergency response, how quickly the response was called once a suicide in progress has been discovered, and whether all custody staff responding to the suicide had received required training (e.g., in CPR) within set timelines (e.g., annually). The context of the suicide may necessitate additional review items. Most notably, if the individual was in a segregated or 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 inmates new to an ASU were placed in intake cells, and so forth. The MHCT reviewer also determines 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 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 health care record documentation as to the quality of nursing care in the case. Psychiatric technician practice is also covered within the nursing review. The NCPR and mental health case reviewer frequently consult 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.

Death Review Committee reviews: The CCHCS DRC reviews all causes of inmate mortality within the CDCR. When suicides occur, the DRC assigns a physician to serve as the medical

reviewer. This physician works with the NCPR to look at all aspects of medical care received by the patient and will yield an opinion as to the cause of death. As needed, the SMHP 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 case review report (discussed below) is reviewed by the Death Review Unit and addends or is integrated with the Combined Death Review Summary.[62]

Statewide Mental Health Program (SMHP) reviews: Simultaneously to custody, medical, and nursing reviews, a trained member of the SMHP is assigned to review each suicide. The assigned Mental Health Suicide Reviewer (MHSR) is typically a Sr. Psychologist, Specialist, who is tasked with completing a Suicide Case Review (SCR). The MHSR 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, a review of the deceased's personal property, and interviews of inmates, officers, medical, or mental health staff members who knew, interacted with, and/or treated the deceased. The deceased's property is inspected to see if there is any information present related to the suicide, such as a suicide note, letters to the inmate informing he/she of bad news, and so forth. Interviews focus on behavior and statements made in the days prior to the suicide, with questions about anything the deceased 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 also made available. Phone records, trust accounts, toxicology reports, and other sources of information are also made available. The MHSR 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 MHSR reviews extensive documentation from medical and custodial files. The focus of the MHSR's review will vary based on the factors in the case, though all relevant information is reviewed in each case. In some cases, the review will concentrate on mental health treatment while in the CDCR, in others on the quality of suicide risk assessment, in others on the presence or absence of distress when an inmate is placed in administrative segregation, and so on. SMHP psychiatry staff review the psychiatric care and consult with the MHSR. The MHSR 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.

Joint CDCR/DSH Suicide Reviews: When a suicide occurs of an individual who resides at a DSH facility, or when a suicide occurs within 30 days of transfer from a DSH hospital, a joint review is conducted. The DSH's Mortality Interdisciplinary Review Committee (MIRC) reviews suicides that occur within the DSH, with input from the Suicide Case Review Committee (SCRC)

[62] IMSPP Volume 1, Chapter 29.2

at the CDCR. Joint CDCR MHSRs and MIRC reviewers look at the case collaboratively to evaluate the mental health, medical, custodial, and nursing care rendered in the case. A joint report is generated in each situation, with corrective action plans developed jointly. [63] The SCRC reviews QIP responses created through this process conjointly with the MIRC.

Determination and tracking of Quality Improvement Plans: Each Suicide Case Review report may include formal Quality Improvement Plans (QIPs) as applicable to the case. QIPs are developed based on the concerns raised by custody, nursing/medical, and/or mental health case reviewers. QIPs may represent areas of deviation from policy or procedure, departures from standards of care, or systemic issues that require examination, modification or innovation. QIPs may be written for any discipline and can focus on the specific institution where the suicide occurred. If systemic issues are identified, the QIP can be directed to the DCHS Suicide Prevention and Focused Response Team (DCHS SPR FIT), a team that can address statewide policies and practices. The DCHS SPR FIT 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.

During Suicide Case Review teleconferences, the Suicide Case Review Committee (SCRC) will assemble and the case reviewer will read sections of the Suicide Report. The SCRC is made up of members of the CDCR Statewide Mental Health Program, DAI MHCU, Nursing Executives, the 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 and/or clarify concerns raised in the report, can raise additional concerns, or can discuss ways of meeting the requirements of QIPs. Since late 2015, experts from the *Coleman* court are present by phone and can raise additional concerns or issues. 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.

Audits of SCR Quality: The DHCS Quality Management Unit audits all SCRs for 15 items. SCR's are scored with required elements marked present or absent.

[63] DSH Administrative Letter AL2015-19, issued November 2015.

Appendix VI: Suicide Response Court-ordered and Internal Deadlines for Suicide Reports

Coleman Deadlines per Program Guide *		Internal Deadlines	
Assign suicide reviewer	Within 2 days		
Reviewer visits institution	Within 7 days		
Suicide report received at HQ	Within 30 days		
		Report reviewed, edited, QIPs developed and sent to all case review participants with request for feedback from reviewers	5 days prior to case review (no later than DAY 40 after DOD)
Suicide Case Review	Within 45 days		
		Final report edits	Within 1-2 days
		Signed by MH Deputy Director	Within 1-2 days
		Signed by DAI	Within 3-5 days
Final suicide report to institution	Within 60 days		
QIPs completed at the Institution	Within 120 days (**See internal deadline that requires this sooner from institution)	***Please note*: *this internal deadline is set for institutions to ensure SPR-FIT ability to comply with the Coleman deadline in the event that QIPs are inadequate and require amendment* QIPs completed and QIP report submitted to HQ	Within 45 days of institution's receipt of final report (no later than DAY 105 after DOD)
Institution's QIP Report completed and submitted to HQ	Within 150 days (**See internal deadline that requires this sooner from institution)		
		QIPs reviewed by committee	Within 10 days
		QIPs signed by MH Deputy Dir.	Within 1-2 days
		QIPs signed by DAI	Within 3-5 days
Implementation of QIP report sent to Special Master	Within 180 days		
*** deadlines are calculated from date of death (DOD)**			

Appendix VII: Memorandum "Designation of Suicide Prevention, Assessment and Training Coordinator"

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date:	8/14/2015
To:	Chief Executive Officers Chiefs of Mental Health
From:	Timothy G. Belavich, Ph.D., MSHCA, CCHP-MH Director (A), Division of Health Care Services and Deputy Director, Statewide Mental Health Program
Subject:	**DESIGNATION OF SUICIDE PREVENTION, ASSESSMENT AND TRAINING COORDINATOR**

Per the approved 2009 Mental Health Staffing Model, every institution with a mental health mission was allocated a fractional staff position for: Suicide Prevention (0.3), Mental Health Assessments/Evaluations (0.3) and Mental Health Training/Orientation (0.3) Coordination. These fractional responsibilities shall now be combined into one coordinator position.

Effective immediately, each institution must designate one Senior Psychologist, Specialist who will be responsible for the coordination of Suicide Prevention, Assessments/Evaluations, and Training/Orientation. The attached duty statement must be used for this position. No additional staff positions will be allocated for these duties.

For questions please contact Amy Eargle, Chief, Clinical Support, Statewide Mental Health Program via email at Amy.Eargle@cdcr.ca.gov.

Attachment

cc: Angela Ponciano
Amy Eargle, Ph.D.
Laura Ceballos, Ph.D.
Daryl Brown
Nancy Whitham
Regional Mental Health Administrators
Regional Personnel Administrators
Regional Health Care Executives

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES
P.O. Box 588500
Elk Grove, CA 95758

STATE OF CALIFORNIA

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

SHADED AREA TO REFLECT RECLASS POSITION NUMBER ONLY

DUTY STATEMENT

RPA | EFFECTIVE DATE:

CDCR INSTITUTION OR DEPARTMENT	POSITION NUMBER (Agency – Unit – Class – Serial)
California Correctional Health Care Services	042-XXX-9287-XXX
UNIT NAME AND CITY LOCATED	CLASS TITLE Senior Psychologist, CF (Specialist)
WORKING DAYS AND WORKING HOURS a.m. to p.m. (Approximate only for FLSA exempt classifications)	SPECIFIC LOCATION ASSIGNED TO
PROPOSED INCUMBENT (If known)	CURRENT POSITION NUMBER (Agency – Unit – Class – Serial)

YOU ARE A VALUED MEMBER OF THE DEPARTMENT'S TEAM. YOU ARE EXPECTED TO WORK COOPERATIVELY WITH TEAM MEMBERS AND OTHERS TO ENABLE THE DEPARTMENT TO PROVIDE THE HIGHEST LEVEL OF SERVICE POSSIBLE. YOUR CREATIVITY AND INGENUITY ARE ENCOURAGED. YOUR EFFORTS TO TREAT OTHERS FAIRLY, HONESTLY AND WITH RESPECT ARE CRITICAL TO THE SUCCESS OF THE DEPARTMENT'S MISSION.

Under the general direction of the Chief Psychologist, Correctional Facility (CF) or Chief of Mental Health Services, the Senior Psychologist, CF (Specialist), Suicide Prevention, Assessment, and Training Coordinator will be responsible for the Department's assessments, evaluations, suicide prevention, training, and orientation programs. Some travel is associated with this position.

% of time performing duties	Indicate the duties and responsibilities assigned to the position and the percentage of time spent on each. Group related tasks under the same percentage with the highest percentage first. *(Use addition sheet if necessary)*
	ESSENTIAL FUNCTIONS
30%	Coordinate the institution's Suicide Prevention Program, Suicide Risk Evaluation Mentor Program, and mental health screening; consult with institution health care, custodial, and management staff on improving suicide prevention policies and procedures; chair the institution's Suicide Prevention and Response Focused Improvement Team; audit the institution's suicide prevention practices; collect and interpret data and other information on the institution's suicides, remain current in the field of suicide prevention; work with institution management to develop best practices; consult with clinical, custody, and management staff regarding mental health assessments and evaluations; perform quality management functions, prepare reports, and generate action plans as related to suicide prevention duties to improve mental health services delivery.
20%	Provide training to institutional, clinical, and custody staff on suicide prevention, mental health issues and policies (e.g., completing the Mental Health Assessment for Rules Violation Reports [RVR], new employee orientation, Suicide Prevention/Crisis Intervention,) in order to ensure that inmate-patients have timely access to continuity of mental health care. Provide health care staff with the knowledge and specific strategies to interact more effectively with inmate-patients in the Mental Health Services Delivery System and Developmental Disabilities Program as directed by the Chief of Mental Health, and at the request of the In-Service Training Program; ensure training efficacy; address deficiencies as necessary.
20%	Develop and provide training on clinical topics to mental health staff; provide training on mental health policy and initiatives; maintain training logs for clinical staff; ensure mandatory trainings for mental health staff are offered as needed; work closely with the Statewide Mental Health Program Training Unit to ensure training requirements are met; ensure integrity of training; remain current in the latest research, techniques, and tools in the field of correctional mental health. Use knowledge of criminal behavior, mental health issues, correctional settings, State and Federal mental health laws and regulations, and knowledge of each classification's scope of practice, to determine training requirements.

STATE OF CALIFORNIA CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

15%	Provide coordination of mental health assessments. Maintain psychological testing library. Remain current on available psychological tests and measures and evaluation techniques. Provide training and consultation regarding assessments and testing reports as needed. Perform audits of Mental Health Assessments for RVRs and review audit results. Develop action plans to address noted deficiencies.
10%	Provide assessments and crisis interventions to inmate-patients within the program as needed. Perform special projects as assigned; interpret the objectives and procedures of the program to other staff. Implement time-limited projects in area of expertise in order to enhance existing programs, comply with departmental policies and procedures and/or court mandates, using consultations, organizational skills, communication skills, and research skills. Serve as a member of the Quality Improvement Team (QIT), as required.
5%	Other related duties as assigned.

KNOWLEDGE AND ABILITIES

Knowledge of: Principles, techniques, and trends in psychology with particular reference to normal and disordered behavior, human development, motivation, personality, learning, individual differences, adaptation, and social interaction; methods for the assessment and modification of human behavior; forensic psychology; characteristics and social aspects of mental and developmental disabilities; research methodology and program evaluation; institutional and social process, group dynamics; functions of psychologists in various mental health services; current trends in the field of mental health; professional training; and community organization and allied professional services.

Ability to: Provide professional consultation; teach and participate in professional training; recognize situations requiring the creative application of technical skills; develop and evaluate creative approaches to the assessment, treatment, and rehabilitation of mental disabilities, to the conduct of research, and to the development and direction of a psychology program; plan, organize, and conduct research, data analysis, and program evaluation; conduct the more difficult assessment and psychological treatment procedures; analyze situations accurately and take effective action; and communicate effectively.

DESIRABLE QUALIFICATIONS

Special Personal Characteristics: Empathetic understanding of patients of a State correctional facility; willingness to work in a State correctional facility; scientific and professional integrity; emotional stability; patience; alertness; tact; and keenness of observation.

SPECIAL PHYSICAL CHARACTERISTICS

Persons appointed to this position must be reasonably expected to have and maintain sufficient strength, agility, and endurance to perform during stressful (physical, mental, and emotional) situations encountered on the job without compromising their health and well-being or that of their fellow employees or that of inmates. Assignments may include sole responsibility for the supervision of inmates and/or the protection of personal and real property. Must be able to travel.

Adopted:
Revised:

STATE OF CALIFORNIA CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

SUPERVISOR'S STATEMENT: *I HAVE DISCUSSED THE DUTIES OF THE POSITION WITH THE EMPLOYEE*		
SUPERVISOR'S NAME (Print)	SUPERVISOR'S SIGNATURE	DATE
EMPLOYEE'S STATEMENT: *I HAVE DISCUSSED WITH MY SUPERVISOR THE DUTIES OF THE POSITION AND HAVE RECEIVED A COPY OF THE DUTY STATEMENT* The statements contained in this duty statement reflect general details as necessary to describe the principal functions of this job. It should not be considered an all-inclusive listing of work requirements. Individuals may perform other duties as assigned, including work in other functional areas to cover absence of relief, to equalize peak work periods or otherwise balance the workload.		
EMPLOYEE'S NAME (Print)	EMPLOYEE'S SIGNATURE	DATE

Revised:_____

Adopted
Revised:

Appendix VIII: Memorandum "Completed Contacts Associated with Suicide Risk Evaluation"

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date: 10/23/2015

To: Chief Executive Officers
Chiefs of Mental Health

From: Timothy Belavich, Ph.D., MSHCA, CCHP-MH
Director (A), Division of Health Care Services and
Deputy Director, Statewide Mental Health Program

Subject: **COMPLETED CONTACTS ASSOCIATED WITH SUICIDE RISK EVALUATIONS**

Effective immediately, when a Suicide Risk Evaluation (SRE) Assessment (CDCR MH-7447) is completed by a clinician, the appointment scheduler shall simultaneously enter the SRE and a completed contact into the patient record in the Mental Health Tracking System (MHTS). Please refer to the Suicide Risk Evaluation Completed Contact Entry Process (attached) for instructions.

Additionally, clinicians shall enter their scheduled and un-scheduled SRE appointments on their daily log. The un-scheduled SRE appointments (i.e., MHCB assessment/placement) shall be entered retroactively and include start and stop times.

If you have questions or need additional information related to this memorandum, you may contact the Mental Health Policy Unit by email: CDCR MHPolicyUnit@cdcr.ca.gov.

Attachment

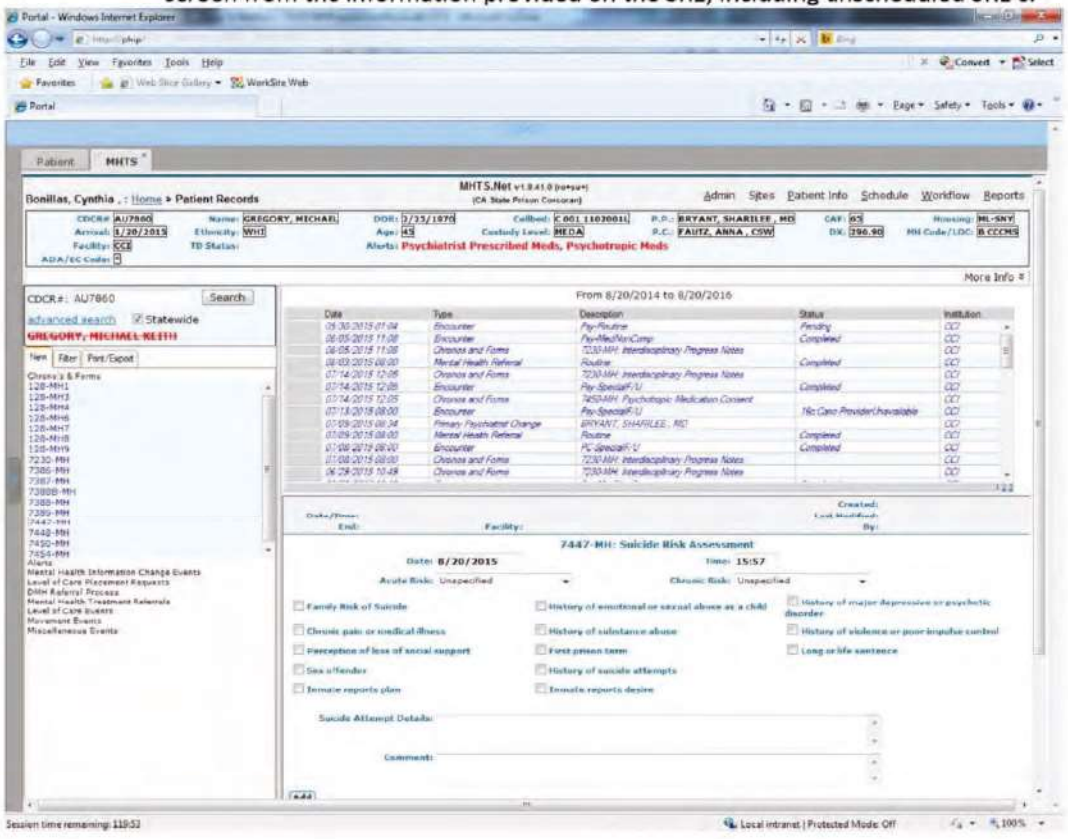
cc: Angela Ponciano
Amy Eargle, Ph.D.
Laura Ceballos, Ph.D.
Michael Golding, M.D.
Edward Kaftarian, M.D.
Jennifer Johnson
Mental Health Regional Administrators
Regional Health Care Executives

HEALTH CARE SERVICES | P.O. Box 4038
Sacramento, CA 95812-4038

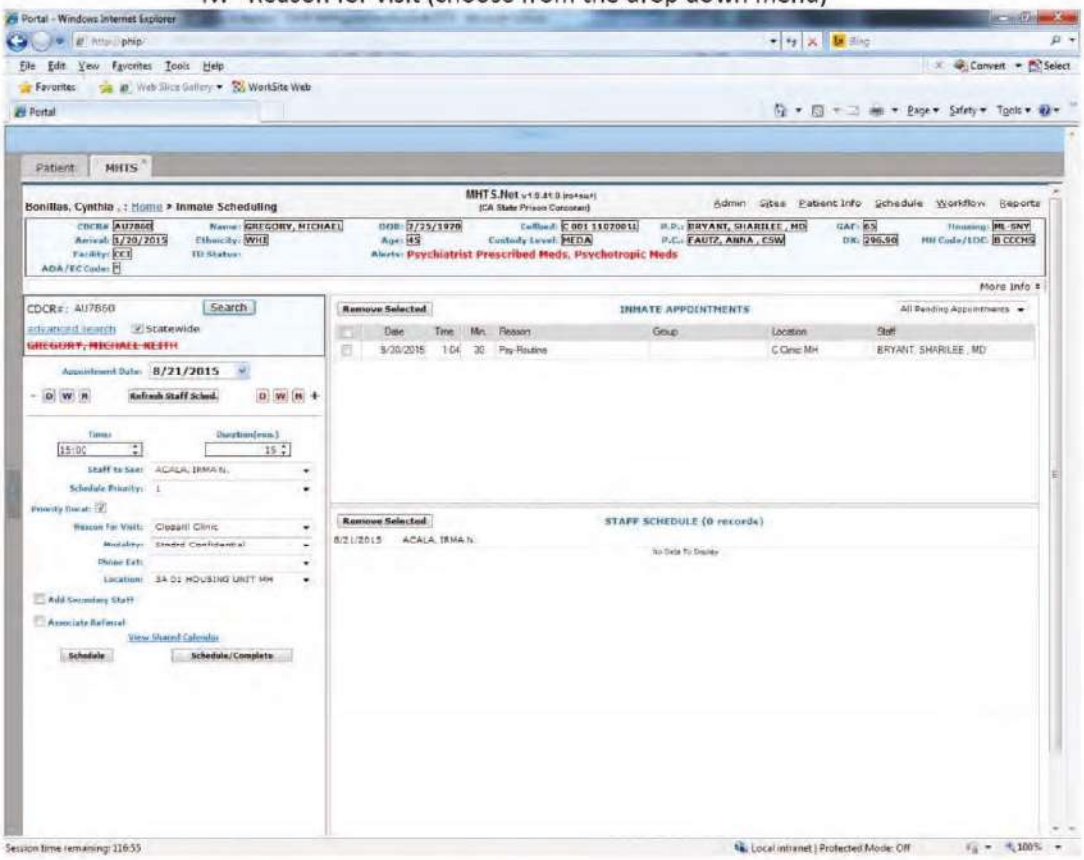
Suicide Risk Evaluation Completed Contact Entry Process

When an SRE is completed by a clinician, the appointment scheduler shall simultaneously enter the SRE and a completed contact into the patient record in MHTS.

1. **Receive** completed SRE form from clinician.
2. **Enter** information from the SRE into MHTS.
    a. **Complete** the 7447-MH: Suicide Risk Assessment portion at the bottom of the screen from the information provided on the SRE, including unscheduled SRE's.



3. **Create** a contact to correspond with SRE.
    a. **Complete** the left sections of the screen to correspond with the information provided on the SRE. Include the following:
        i. Appointment date
        ii. Start and stop time
        iii. Clinician name and classification who conducted SRE
        iv. Reason for visit (choose from the drop down menu)



4. **Close** the created contact corresponding with the SRE.

Appendix IX: Memorandum "Suicide Prevention Pamphlets for Inmates" (with pamphlets attached)

Help is Available Anytime!

The CDCR Mental Health Services Delivery System provides mental health services to all inmates. Mental health services are private and can help you when you don't know where else to turn. Our trained clinical staff are available for:

- Dealing with Change
- Adjustment & Transition Issues
- Crisis Counseling
- Medication Services
- And much more

You are not alone! We are here to offer help & hope for a better today and future.



CONTACT Mental Health

What You Should Know:

- **You are not alone!** Though sometimes you may feel like you are. Many people experience hard times and help is available.
- **Think before you act.** There are other options.
- **Keep yourself and your surroundings safe.** For example, avoid drugs, alcohol and/or storing up your medicine because they can make you feel worse and not think clearly.
- **Take all your medication as prescribed.** Don't stop or make changes to your medications unless you and your doctor decide this together.
- **Take only the medications that your doctor has prescribed to you.**
- **Know when you are not doing well and need help.** Make a list of how you are feeling and discuss it with someone you trust, like your primary clinician or psychiatrist.
- **Talk to someone you trust!** There are people who can help and support you.

CONTACT Mental Health

Warning Signs:

- Using alcohol, drugs and other substances to cope
- Feeling trapped
- Feelings of shame and/or guilt
- Feelings of anger and/or rage
- Feelings of depression and/or anxiety
- Recklessness—feeling you have nothing to lose
- Receiving bad news, such as getting more time, learning an appeal was denied, or something from home
- Feeling isolated or alone (divorce, a death of a loved one, or news of an illness)
- Getting a serious medical diagnosis or chronic pain
- Being placed in administrative segregation
- Poor sleep
- Not enjoying things you used to like to do

The following are very serious warning signs:

- Feelings of wanting to die or not wake up
- Hearing voices or seeing things that others don't
- Feeling unbearable emotional or physical pain
- Making plans to kill yourself
- Sleeping all the time or not sleeping at all
- Saying "goodbye" to loved ones—writing letters
- Giving your personal property away

CONTACT Mental Health

Cuando necesita ayuda:

- Hay ayuda disponible para Ud.
- Hable con alguien en quien tiene confianza o de quien se siente cercano
- Siga tomando todos sus medicamentos según las indicaciones
- Sea directo, abierto y honesto acerca de sus problemas
- Vaya a todas sus citas médicas y de salud mental
- Informe a cualquier miembro del personal si Ud. está teniendo dificultades

Por favor, hable con el personal de la salud mental:

- Contacte a cualquier miembro de la custodia
- Contacte a cualquier miembro del personal médico
- Contacte a cualquier miembro del personal de salud mental
- Llene un Formulario CDCR 7362 (Solicitud de Servicios *de Atención a la Salud*)

¿Verdadero o Falso?

No se puede detener a las personas que quieren suicidarse.
Falso

La mayoría de las personas con tendencias suicidas no quieren morir, solamente quieren que pare el dolor emocional.
Verdadero

Hablar sobre el suicidio sólo lo hará peor.
Falso

Hablar de sus sentimientos y de lo que está experimentando puede ayudarle a darse cuenta que necesita ayuda.
Verdadero

Si le digo a alguien que necesito ayuda, me pondrán en el programa de salud mental para siempre.
Falso

Todos necesitamos un poco de ayuda cuando tenemos dificultades. Hay ayuda a corto plazo y a largo plazo disponible para Ud.
Verdadero

ESPERANZA

¿Se siente solo? ¿Se siente desamparado? ¿Está experimentando sentimientos de pérdida? ¿Se siente temeroso? ¿Tiene apoyo familiar? ¿Tiene vergüenza? ¿Se siente deprimido? ¿Se siente culpable? ¿Se siente confundido?

¡Hay Esperanza y Ayuda!
El Programa de Salud Mental CDCR

Favor de contactar el Departamento de Salud Mental

Favor de contactar el Departamento de Salud Mental

Exhibit LL

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

March 3, 2020

VIA EMAIL ONLY

Lisa Ells (lells@rbgg.com)
Rosen Bien Galvan & Grunfeld LLP
101 Mission Street, Sixth Floor
San Francisco, CA 94105

Lisa,

I write to provide you with the requested Enhanced Outpatient Program (EOP) segregation data, which Defendants agreed to produce in Nick Weber's March 20, 2017 letter. Enclosed you will find a report showing the mean and median lengths of stay of class members in segregation, as well as a report on EOP patients and EOP patients on modified programs in segregation refusing more than fifty percent of their groups in the past month.

As of Friday, February 28, 2020, the Psychiatric Services Unit (PSU) at California State Prison-Sacramento, houses 121 PSU inmates. None are in the Step Down Program. 100 PSU inmates are currently placed in the Behavior Incentive Program as follows:

Step	Number of Inmates
Step 4	10
Step 3	10
Step 2	22
Step 1	58

The remaining PSU inmates have either finished their segregated housing term, are awaiting their initial IDTT, or have been placed in a lower or higher level of care and are awaiting transfer.

As of March 2, 2020, 3.42%, or 2,693 of the 78,790 non-class members housed in the California Department of Corrections and Rehabilitation, not counting contract beds, were in segregation.

Sincerely,

/s/ **Dillon Hockerson**

Dillon Hockerson
Attorney
Office of Legal Affairs

Exhibit MM

OFFICE OF LEGAL AFFAIRS
Jennifer Neill
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001

July 6, 2020

VIA EMAIL ONLY

Lisa Ells (lells@rbgg.com)
Rosen Bien Galvan & Grunfeld LLP
101 Mission Street, Sixth Floor
San Francisco, CA 94105

Lisa,

I write to provide you with the requested Enhanced Outpatient Program (EOP) segregation data, which Defendants agreed to produce in Nick Weber's March 20, 2017 letter. Enclosed you will find a report showing the mean and median lengths of stay of class members in segregation, as well as a report on EOP patients and EOP patients on modified programs in segregation refusing more than fifty percent of their groups in the past month.

As of Wednesday, July 1, 2020, the Psychiatric Services Unit (PSU) at California State Prison, Sacramento, houses 113 PSU inmates. None are in the Step Down Program. 108 PSU inmates are currently placed in the Behavior Incentive Program as follows:

Step	Number of Inmates
Step 4	36
Step 3	20
Step 2	19
Step 1	33

The remaining PSU inmates have either finished their segregated housing term, are awaiting their initial IDTT, or have been placed in a lower or higher level of care and are awaiting transfer.

Finally, as of July 2, 2020, 3.36% or 2,435 of the 72,485 non-class members housed in the California Department of Corrections and Rehabilitation, not counting contract beds, were in segregation.

Sincerely,

/s/ **Dillon Hockerson**

Dillon Hockerson
Attorney
Office of Legal Affairs

Exhibit NN

From: Michael W. Bien
To: Coleman Team - RBG Only
Subject: Fwd: Coleman: February 2020 Monthly Segregation Data
Date: Monday, May 04, 2020 3:52:42 PM
Attachments: ATT00001.htm
EOP Segregation Data -February 2020.pdf
ATT00002.htm
Lt DH-LE re Feb 2020 EOP Seg Data.pdf
ATT00003.htm
Segregation Length of Stay Averages -rundate 030220.xlsm
ATT00004.htm

Michael W. Bien
Rosen Bien Galvan & Grunfeld LLP
101 Mission Street
Sixth Floor
San Francisco, CA 94105

415-433-6830: Tel
415-433-7104: Fax

Mbien@rbgg.com

Begin forwarded message:

From: "Hockerson, Dillon@CDCR" <Dillon.Hockerson@cdcr.ca.gov>
Date: March 3, 2020 at 12:16:32 PM PST
Subject: Coleman: February 2020 Monthly Segregation Data

Hello,

Attached is a letter regarding the monthly EOP segregation data and two segregation reports concerning the month of February 2020. Please let me know if you have any questions.

Sincerely,
Dillon Hockerson
Attorney
California Department of Corrections and Rehabilitation
Email: Dillon.Hockerson@cdcr.ca.gov
Phone: (916) 445-2779
Cell: (916) 413-5796

Continuous Length of Stay Averages, Medians, and Counts in Segregated Housing for MHSDS Patients in ASU,

CDCR; MHIs: CCCMS, EOP, EOPMod, ACUTE, ICF
LOS calculation: Total consecutive days in any segregated housing
(1898 patients total)

	SRH-CCCMS	ASUHub-CCCMS	LRH-CCCMS	ASUHub-EOP	SRH-EOP	LRH-EOP	ASUHub-EOPMod
Average Days	109	28	249	66	34	147	113
Median Days	54	15	205.5	38	14	129	61
Inmates	770	56	250	347	44	4	37

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ASUHub-ICF	ASU-CCCMS	ASU-EOP	ASU-EOPMod	SHU-CCCMS	PSU-CCCMS	PSU-EOP	PSU-EOPMod
45	64	75	15	295	50	203	403
38	20	15	15	183.5	39	138	262
8	211	16	2	12	4	125	5

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PSU-ICF	ALL
301	119
227	54
7	1898

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Exhibit OO

From: Lisa Ells
To: Emma Cook
Subject: FW: Coleman: May 2020 Monthly Segregation Data [IWOV-DMS.FID6429]
Date: Monday, July 13, 2020 3:08:58 PM
Attachments: Copy of Segregation Length of Stay Averages - run date 060120.xlsx
EOP Segregation Data -May-FINAL.pdf
Lt DH-LE re May 2020 EOP Seg Data.pdf

From: Hockerson, Dillon@CDCR <Dillon.Hockerson@cdcr.ca.gov>
Sent: Friday, June 5, 2020 11:18 AM
To: Lisa Ells <LElls@rbgg.com>; Michael W. Bien <MBien@rbgg.com>; Steve Fama <sfama@prisonlaw.com>
Cc: Nick Weber <Nicholas.Weber@cdcr.ca.gov>; Melissa Bentz <Melissa.Bentz@cdcr.ca.gov>; Stafford, Carrie@CDCR <Carrie.Stafford@cdcr.ca.gov>
Subject: Coleman: May 2020 Monthly Segregation Data

Hello,

Attached is a letter regarding the monthly EOP segregation data and two segregation reports. Please let me know if you have any questions.

Sincerely,

Dillon Hockerson
Attorney
CDCR Office of Legal Affairs
Email: Dillon.Hockerson@cdcr.ca.gov
Phone: (916) 445-2779
Cell: (916) 413-5796

THIS DOCUMENT IS CONFIDENTIAL ATTORNEY-CLIENT COMMUNICATION AND/OR ATTORNEY WORK PRODUCT. PLEASE DO NOT FORWARD THIS EMAIL WITHOUT PERMISSION OF THE SENDER. IF YOU RECEIVED THIS DOCUMENT IN ERROR PLEASE NOTIFY THE SENDER IMMEDIATELY.

Continuous Length of Stay Averages, Medians, and Counts in Segregated Housing for MHSDS Patients in ASU,

CDCR; MHIs: CCCMS, EOP, EOPMod, MHCB, ACUTE, ICF
LOS calculation: Total consecutive days in any segregated housing
(1952 patients total)

	ASUStd-CCCMS	ASUHub-CCCMS	SRH-CCCMS	LRH-CCCMS	ASUHub-EOP	SRH-EOP	ASUHub-EOPMod
Average Days	74	61	127	328	93	78	229
Median Days	77	43	81	280	50	55	166
Inmates	9	79	661	183	396	76	15

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SRH-EOPMod	ASUHub-ICF	ASUHub-MHCB	SRH-MHCB	ASU-CCCMS	ASU-EOP	ASU-ICF	ASU-MHCB
41	107	48	13	80	71	38	25
32	65	52	13	45	50	42	25
5	12	6	1	333	65	4	2

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SHU-CCCMS	PSU-EOP	PSU-EOPMod	PSU-ICF	ALL
194	235	478	437	131
171	160	409	317	75
5	93	3	4	1952

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Exhibit PP

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

August 3, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of June, 2012 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of Mental Health (DMH) Monthly Report of CDCR Patients in DMH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.

16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0209.

Sincerely,

T. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert
Raymond F. Patterson, M.D, *Coleman* Expert
Paul Nicoll, MPA, *Coleman* Monitor
Ted Ruggles, Ph.D., *Coleman* Expert
Mary Perrien, Ph.D., *Coleman* Expert
Yong Joo Erwin, LCSW, *Coleman* Expert
Kathryn A. Burns, M.D., MPH, *Coleman* Expert
Henry A. Dlugacz, Esq., *Coleman* Expert
Kerry F. Walsh, Esq., *Coleman* Monitor
Patricia Williams, Esq., *Coleman* Monitor
Haunani Henry, *Coleman* Monitor
J. Ronald Metz, *Coleman* Monitor
Debbie Vorous, Esq., Office of the Attorney General

Heather McCray Esq., Office of Legal Affairs, CDCR
Michael Stone, Esq., Office of Legal Affairs, CDCR
Michael Bien, Esq., Rosen, Bien and Galvan
Donald Specter, Esq., Prison Law Office
Judy Burleson, Associate Director, Statewide Mental Health Program, DCHCS
Nathan Stanley, Chief, Operational Program Oversight, Statewide Mental Health Program DCHCS
Karen Higgins, M.D., Chief of Behavioral Medicine, Statewide Mental Health Program, DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

Mental Health Population By Institution

Download Date: June 8, 2012

CONFIDENTIAL

SUMMARY OF OUTPATIENT POPULATION

(ASU, GP, RC and SHU Detail on pages 2-4)

Institution	CCCMS			EOP (1)			PSU (1)			Inst Total Outpatient Pop
	Capacity	Current Pop	% of Capacity	Capacity	Current Pop	% of Capacity	Capacity	Current Pop	% of Capacity	
ASP	1099	1115	101%		8					1123
CAL		19								19
CCC		3								3
CCI	1349	1018	75%		8					1026
CCWF	899	853	95%	54	53	98%				906
CEN		25			1					26
CIM	1299	1364	105%		39					1403
CIW	499	438	88%	85	56	66%	20	19	95%	513
CMC	1099	1025	93%	634	625	99%				1650
CMF	599	517	86%	391	407	104%				924
COR	949	1215	128%	249	248	100%				1463
CRC-M	848	957	113%		1					958
CTF	845	1087	129%		4					1091
CVSP		7			1					8
DVI	649	440	68%		14					454
FOL	599	630	105%		6					636
HDSP	699	768	110%		13					781
ISP		16								16
KVSP	1000	1333	133%	96	88	92%				1421
LAC	1149	1317	115%	374	368	98%				1685
MCSP	1149	1114	97%	546	540	99%				1654
NKSP	799	1092	137%		57					1149
PBSP	349	261	75%	66	70	106%	128	115	90%	446
PVSP	1499	1658	111%		4					1662
RJD	1199	1332	111%	543	562	103%				1894
SAC	849	842	99%	458	414	90%	256	241	94%	1497
SATF	1199	1563	130%	264	276	105%				1839
SCC	499	481	96%		7					488
SOL	1199	1094	91%		9					1103
SQ	899	857	95%	36	45	125%				902
SVSP	999	1154	116%	264	222	84%				1376
VSPW	849	921	108%	9	7	78%				928
WSP	1049	1099	105%		62					1161
TOTAL	**26118**	**27615**	**106%**	**4069**	**4215**	**104%**	**404**	**375**	**93%**	**32205**

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Group	CCCMS			EOP			Subtotal MH Pop	Comments
Institution (2)	Capacity	Current Pop	% of Capacity	Capacity	Current Pop	% of Capacity		
Administrative Segregation Unit (ASU)								
ASP ASU		43					43	
CAL ASU		2					2	
CCI ASU		85			1		86	
CCWF ASU		30			1		31	
CEN ASU		14			1		15	
CIM ASU		98			2		100	
CIW ASU		9		10	7	70%	16	
CMC ASU		42		54	42	78%	84	
CMF ASU		25		58	43	74%	68	
COR ASU		164		99	82	83%	246	
CTF ASU		42					42	
DVI ASU		60			3		63	
FOL ASU		40			3		43	
HDSP ASU		53			3		56	
KVSP ASU		81			2		83	
LAC ASU		165		74	58	78%	223	
MCSP ASU		64		36	51	142%	115	
NKSP ASU		28			3		31	
PBSP ASU		107			6		113	
PVSP ASU		145			1		146	
RJD ASU		108		63	61	97%	169	
SAC ASU		101		74	46	62%	147	
SATF ASU		135			3		138	
SCC ASU		44					44	
SOL ASU		80			4		84	
SQ ASU		64		36	10	28%	74	
SVSP ASU		177		72	39	54%	216	
VSPW ASU		35		9	6	67%	41	
WSP ASU		36			5		41	

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Group	CCCMS			EOP			Subtotal MH Pop	Comments
Institution (2)	Capacity	Current Pop	% of Capacity	Capacity	Current Pop	% of Capacity		
Administrative Segregation Unit (ASU)								
Group Total for ASU		2,077		585	483	83%	2,560	

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Group			CCCMS			EOP			Subtotal	Comments
Institution (2)			Capacity	Current Pop	% of Capacity	Capacity	Current Pop	% of Capacity	MH Pop	
General Population (GP)										
ASP	II		1,099	1,072	98%		8		**1,080**	
CAL	I,IV	+		17					**17**	
CCC	I,II,III			3					**3**	
CCI	I,II,III,IV	*	1,053	690	66%		1		**691**	
CCWF			745	681	91%	54	52	96%	**733**	
CEN	III			11					**11**	
CIM	I		666	1,159	174%		27		**1,186**	
CIW			367	376	102%	75	49	65%	**425**	
CMC	I,II,III		1,099	983	89%	580	583	101%	**1,566**	
CMF	I,II,III		599	517	86%	533	407	76%	**924**	
COR	I,III,IV	+ *	499	606	121%	150	163	109%	**769**	*SNY EOP=150 beds*
CRC-M	II		848	957	113%		1		**958**	
CTF	I,II		845	1,045	124%		4		**1,049**	
CVSP	I,II			7			1		**8**	
DVI	I,II		85	108	127%				**108**	
FOL	III		599	590	98%		3		**593**	
HDSP	I,III,IV	*	608	675	111%		5		**680**	
ISP	I,III			16					**16**	
KVSP	I,IV		1,000	1,252	125%	96	86	90%	**1,338**	*SNY EOP*
LAC	I,III,IV	+	1,000	1,152	115%	300	310	103%	**1,462**	
MCSP	I,II,III,IV	+	1,149	1,050	91%	510	489	96%	**1,539**	*SNY EOP*
NKSP	I,III		80	166	208%		2		**168**	
PBSP	I,IV	*	349	143	41%	66	64	97%	**207**	
PVSP	I,III		1,499	1,513	101%		3		**1,516**	
RJD	I,III		800	1,081	135%	480	468	98%	**1,549**	*SNY EOP=150 beds*
SAC	I,IV	*	849	728	86%	384	368	96%	**1,096**	
SATF	II,III,IV	*	1,199	1,428	119%	264	273	103%	**1,701**	*SNY EOP=176 beds*
SCC	I,II,III		499	437	88%		7		**444**	
SOL	II,III		1,199	1,014	85%		5		**1,019**	
SQ	I,II		350	633	181%		25		**658**	

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Group / Institution (2)	CCCMS Capacity	CCCMS Current Pop	CCCMS % of Capacity	EOP Capacity	EOP Current Pop	EOP % of Capacity	Subtotal MH Pop	Comments
General Population (GP)								
SVSP I,IV *	999	977	98%	192	183	95%	**1,160**	
VSPW	687	886	129%		1		**887**	
WSP I,III	105	84	80%				**84**	
Group Total for GP	**20,876**	**22,057**	**106%**	**3,484**	**3,588**	**103%**	**25,645**	
Reception Center (RC)								
CCWF-RC	154	142	92%				**142**	
CIM-RC	633	107	17%		10		**117**	
DVI-RC	564	272	48%		11		**283**	
HDSP-RC	91	40	44%		5		**45**	
NKSP-RC	719	898	125%		52		**950**	
RJD-RC	399	143	36%		33		**176**	
SQ-RC	549	160	29%		10		**170**	
WSP-RC	944	979	104%		57		**1,036**	
Group Total for RC	**4,053**	**2,741**	**68%**		**178**		**2,919**	
Security Housing Unit (SHU)								
CCI-SHU	130	243	187%		6		**249**	
CIW SHU		53					**53**	
COR-SHU	450	445	99%		3		**448**	
PBSP SHU		11					**11**	
SAC SHU		13					**13**	
Group Total for SHU	**580**	**765**	**132%**		**9**		**774**	

Report Footnotes

(1) EOP, ASU-EOP, and PSU may not reflect actual program vacancies because beds can be held vacant for inmate-patients temporarily housed in MHCB and OHU.

(2) " + " is a 270 Design Facility. " * " is a 180 Design Facility.

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Exhibit QQ

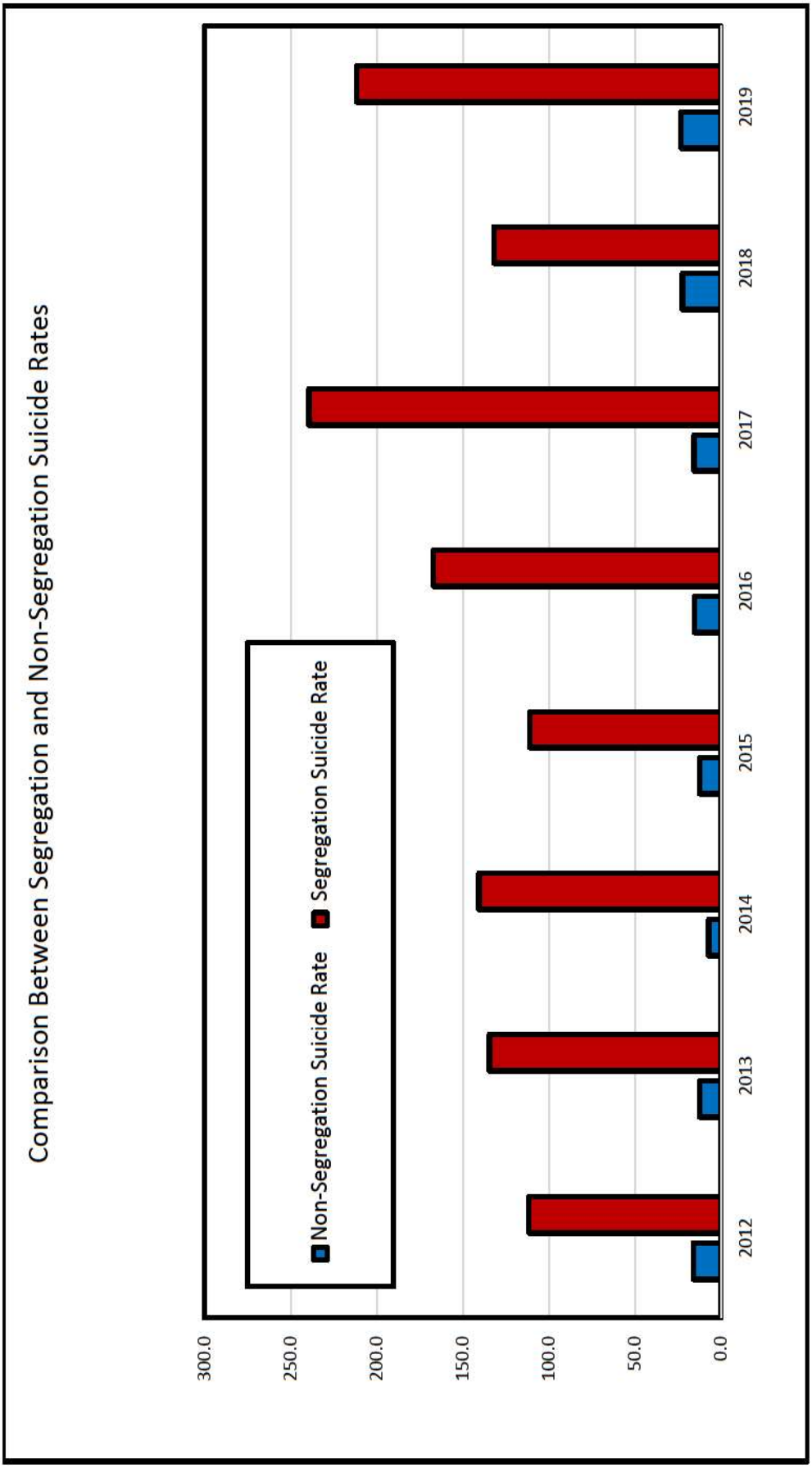

Comparison Between Segregation and Non-Segregation Suicide Rates
Non-Segregation Suicide Rate
Segregation Suicide Rate
300.0
250.0
200.0
150.0
100.0
50.0
0.0
2012
2013
2014
2015
2016
2017
2018
2019

Exhibit RR

California Department of Corrections and Rehabilitation



Offender Data Points

Offender Demographics for the 24-month period, ending June 2017

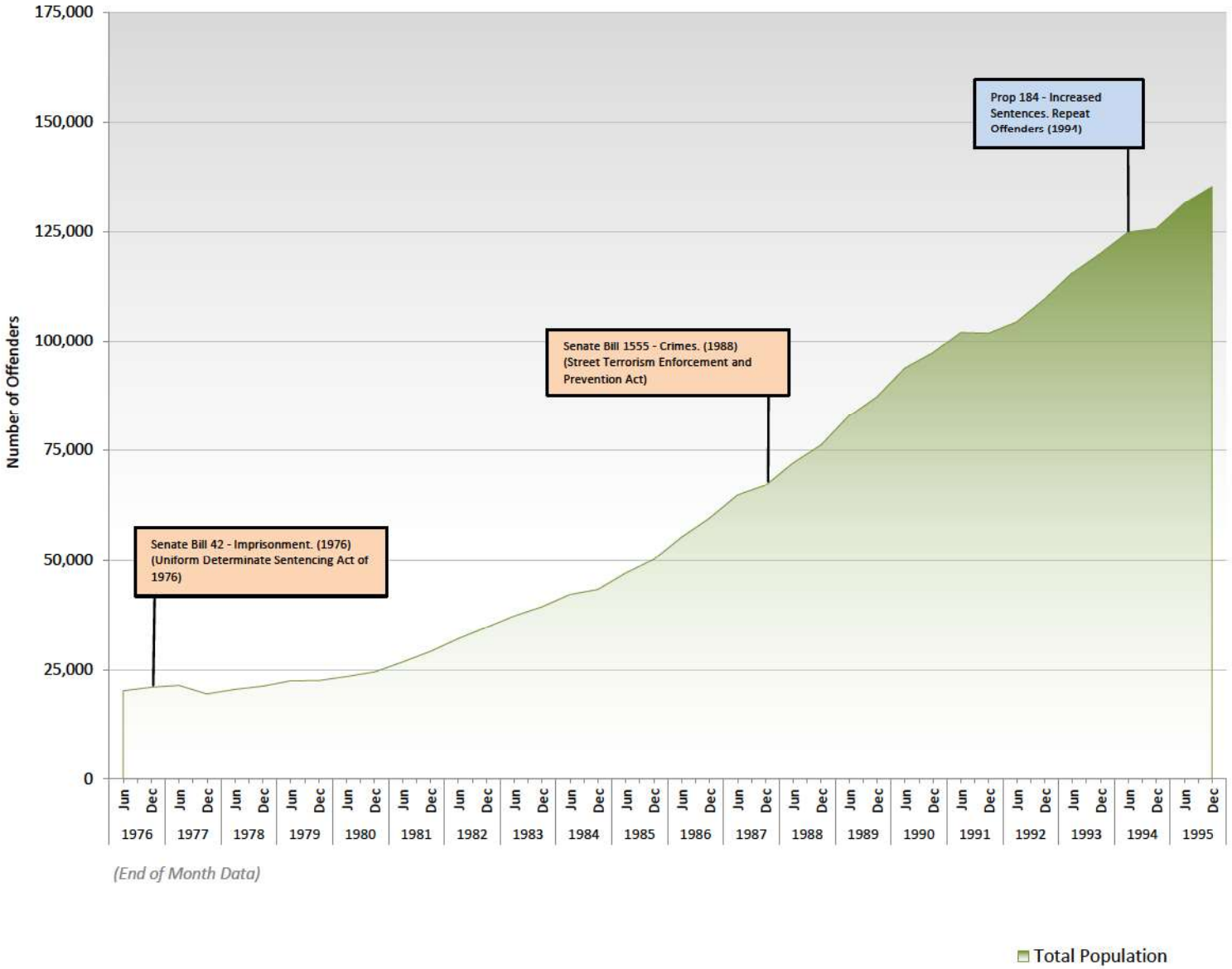
Prepared by the Office of Research, Division of Internal Oversight and Research

History of In Custody Population and Various Sentencing Policy Changes

In Custody Population		
	JUN 2015	128,900
	JUN 2016	128,643
	JUN 2017	131,260

Month-end Total

Data Source: Offender Based Information System (OBIS)/Strategic Offender Management System (SOMS)

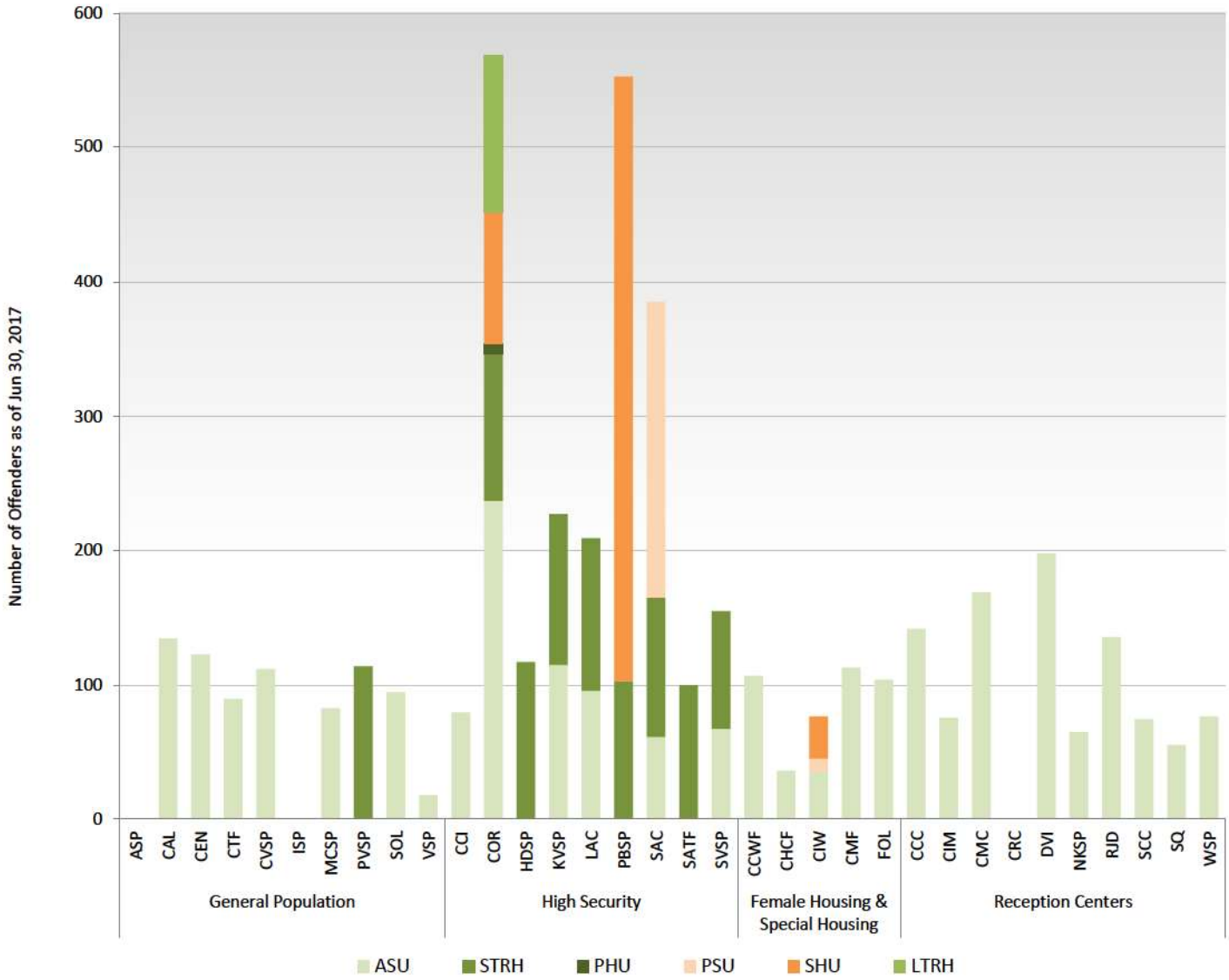


(End of Month Data)

In Custody Specialized Bed Populations

Month-end Total / % of Total Population	JUN 2015		JUN 2016		JUN 2017	
Administrative Segregation Unit (ASU)	4,369	3.4%	2,837	2.2%	2,701	2.1%
Short Term Restricted Housing (STRH)*	236	0.2%	944	0.7%	960	0.7%
Protective Housing Unit (PHU)	10	0.0%	6	0.0%	7	0.0%
Psychiatric Services Unit (PSU)	395	0.3%	309	0.2%	230	0.2%
Security Housing Unit (SHU)	3,018	2.3%	1,165	0.9%	579	0.4%
Long Term Restricted Housing (LTRH)*	77	0.1%	127	0.1%	118	0.1%
Total Offenders in Specialized Beds	8,105	6.3%	5,388	4.2%	4,595	3.5%

Data Source: SOMS



* The STRH and the LTRH house Correctional Clinical Case Management System (CCCMS) offenders who get extra time outside of their cell.

Exhibit SS



California Department of Corrections and Rehabilitation

OFFENDER DATA POINTS FOR THE 24-MONTH PERIOD ENDING IN JUNE 2018

January 2019

Division of Correctional Policy Research and Internal Oversight
Office of Research

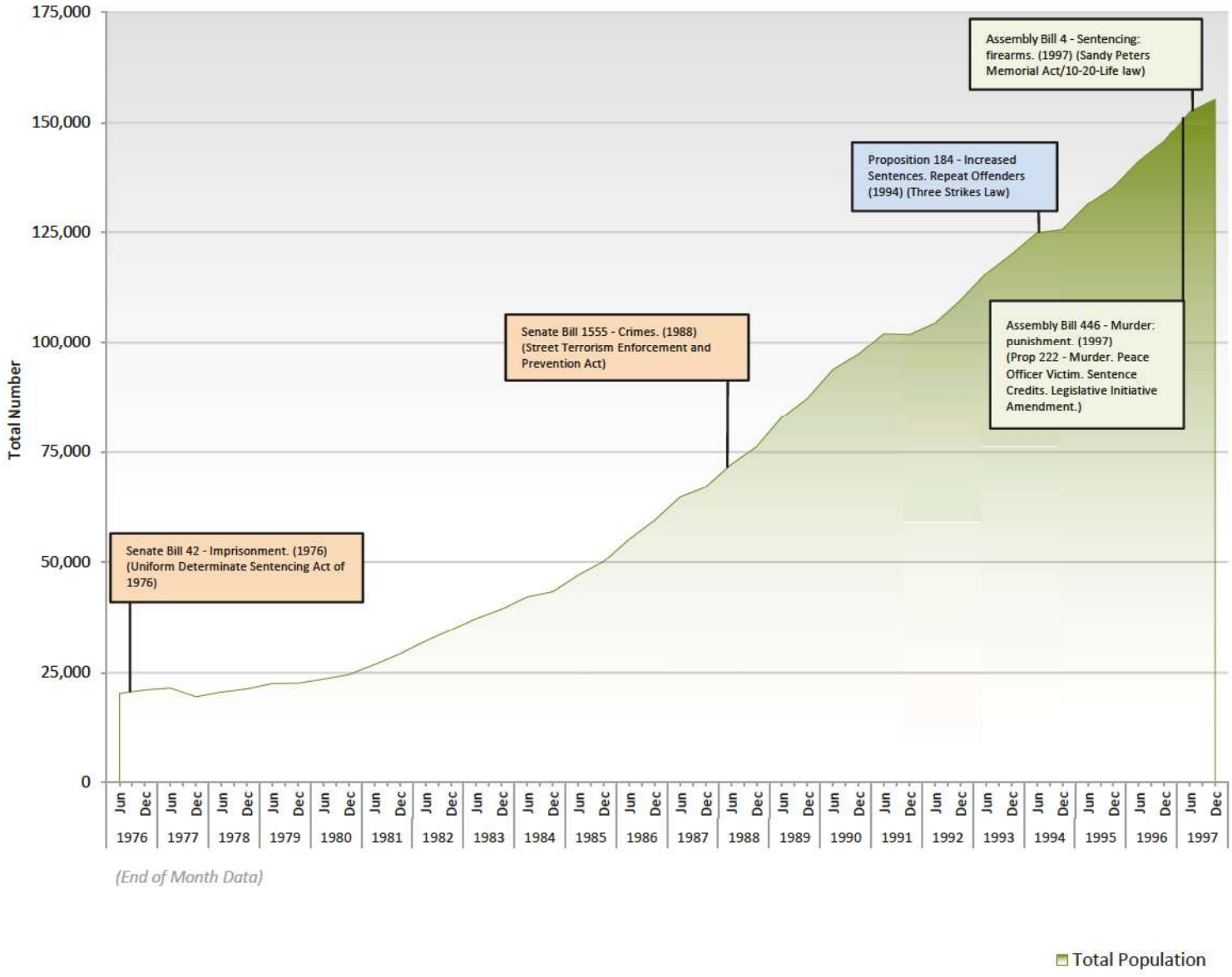


History of In-Custody Population and Various Sentencing Policy Changes

In-Custody Population		
	JUN 2016	128,643
	JUN 2017	131,260
	JUN 2018	129,417

Month-end Total

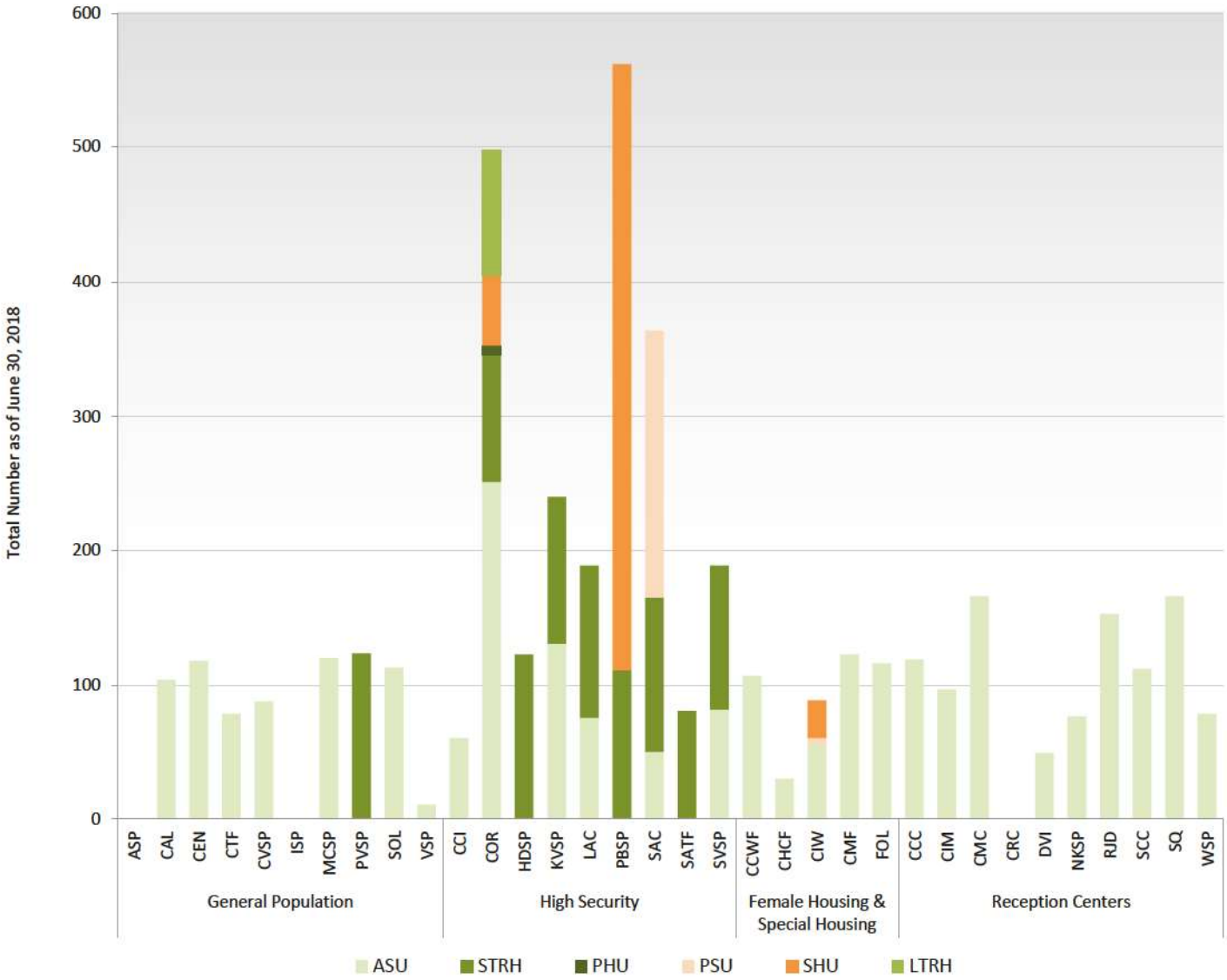
Data Source: Offender Based Information System (OBIS)/Strategic Offender Management System (SOMS)



In-Custody Specialized Bed Populations

Month-end Total / % of Total Population	JUN 2016		JUN 2017		JUN 2018	
Administrative Segregation Unit (ASU)	2,837	2.2%	2,701	2.1%	2,732	2.1%
Short Term Restricted Housing (STRH)*	944	0.7%	960	0.7%	978	0.8%
Protective Housing Unit (PHU)	6	0.0%	7	0.0%	7	0.0%
Psychiatric Services Unit (PSU)	309	0.2%	230	0.2%	204	0.2%
Security Housing Unit (SHU)	1,165	0.9%	579	0.4%	532	0.4%
Long Term Restricted Housing (LTRH)*	127	0.1%	118	0.1%	93	0.1%
Total Offenders in Specialized Beds	5,388	4.2%	4,595	3.5%	4,546	3.5%

Data Source: SOMS



* The STRH and the LTRH house Correctional Clinical Case Management System (CCCMS) offenders who get extra time outside of their cell.