SENATE COMMITTEE ON PUBLIC SAFETY

Senator Nancy Skinner, Chair
2017 - 2018 Regular

Bill No:	SB 960	**Hearing Date:**	April 24, 2018
Author:	Leyva		
Version:	April 16, 2018		
Urgency:	No	**Fiscal:**	Yes
Consultant:	SJ		

Subject: ***Department of Corrections and Rehabilitation: Suicide Prevention: Reports***

HISTORY

Source: Author

Prior Legislation: None

Support: California Catholic Conference; California Coalition for Women Prisoners; California Prison Focus; California Public Defenders Association; Californians United for a Responsible Budget; Depression and Bipolar Support Alliance; Ella Baker Center for Human Rights; Fair Chance Project; National Association of Social Workers, California Chapter; Steinberg Institute

Opposition: None known

PURPOSE

The purpose of this bill is to: 1) require the California Department of Corrections and Rehabilitation (CDCR) to submit an annual report on CDCR's efforts to respond to and prevent suicides and attempted suicides among inmates to the Legislature; 2) make this report available on CDCR's website; and 3) require CDCR to notify an inmate's contact person within 24 hours by telephone in the event of a serious injury, serious illness, or death, if a contact person is listed on record.

Existing law establishes a system of state prisons under the jurisdiction of CDCR. (Pen. Code, § 2000 et seq.)

Existing law requires CDCR to develop and implement a plan to obtain additional rehabilitation and treatment services for prison inmates and parolees. The plan is required to include, among other things, plans to fill vacant state staff positions that provide direct and indirect rehabilitation and treatment services to inmates and parolees. (Pen. Code, § 2061.)

This bill requires CDCR to annually submit to the Legislature, on or before April 1 of each year, a report on CDCR's efforts to respond to and prevent suicides and attempted suicides among inmates. The information contained in the report must include, but is not be limited to, all of the following:

- An identification of all recommendations that, if implemented, would affect CDCR's efforts to respond to and prevent suicides and attempted suicides among inmates and that

were made to CDCR or to a prison or institution as the result of an audit, assessment, or other review, whether internally or externally conducted, mandated, or court-ordered.

- A description of CDCR's progress in implementing each recommendation identified in an audit or other review, as described above, including the expected timeline for full implementation for each recommendation and the activities undertaken to address each recommendation. If CDCR does not intend to fully implement a recommendation, the CDCR must describe in sufficient detail its reasons for not fully implementing the recommendation.
- A description of the results of any audit or review CDCR conducts that measure the success of changes it implements as a result of the recommendations made by an audit or other review.
- A description of the CDCR's progress in identifying and implementing mental health programs that may ameliorate risk factors associated with suicides at the prisons and institutions.
- A description of CDCR's progress in meeting its goals for completing suicide risk evaluations and comprehensive mental health treatment plans in a sufficient manner, including identifying the number of suicide risk evaluations and comprehensive mental health treatment plans completed, describing the criteria CDCR uses to assess the quality of the suicide risk evaluations and comprehensive mental health treatment plans, and reporting on the results of its assessments of the suicide risk evaluations and comprehensive mental health treatment plans. CDCR must present the information regarding its progress in meeting its goals for completing suicide risk evaluations separately from the information regarding the department's progress in meeting its goals for completing comprehensive mental health treatment plans.
- A description of CDCR's efforts to ensure that all mental health staff receive required training and mentoring related to suicide prevention and response, including describing the trainings and mentoring required and identifying the number of individuals required to take each training or to participate in mentoring, and the number of individuals who completed each required training or participating in required mentoring.
- A description of CDCR's efforts to fill vacancies in its mental health treatment programs, including its efforts to hire and retain psychiatrists.

This bill requires that the report be posted on CDCR's website in an easily accessible format.

This bill requires CDCR to notify the contact person of an inmate, if one is listed on record, within-24 hours by telephone-in the event of the inmate's serious illness, serious injury, or death.

This bill provides that "serious injury" includes attempted suicide, and "serious illness" includes a new mental health diagnosis.

COMMENTS

1. Need for This Bill

According to the author:

> SB 960 imposes efforts to prevent and respond to inmate suicides at state prisons in California. High suicides rates at the California Institution for Women prompted an audit by the State Auditor which concluded that the California

Department of Corrections and Rehabilitation (CDCR) needs to report annually to the legislature about their efforts to improve its suicide response and prevention programs. Inmate suicides in California's prisons have been higher, on average, than those of all U.S. state prisons for several years. From 2005 through 2013, the average suicide rate in California's prisons was 22 per 100,000 inmates compared to the average 15.66 per 100,000 in state prisons in the United States.

SB 960 also establishes a notification timeline requiring CDCR's prisons to contact the next of kin of an inmate, within 24 hours, when that inmate commits suicide or attempts suicide. Reports have included long delays of notification or no notification at all following an inmate suicide or suicide attempt.

2. Background

CDCR has a long history of inmate suicides. In 1995, the U.S. District Court for the Eastern District of California ruled that CDCR was not providing adequate mental health care in violation of inmates' Eighth and Fourteenth Amendment rights. (*Coleman v. Wilson* (1995) 912 F. Supp. 1282 (now *Coleman v. Brown*).) As part of that ruling, the court identified six areas where CDCR needed to make improvements, including suicide prevention. The court appointed a Special Master to monitor and report on CDCR's progress toward providing an adequate level of mental health care. That remedial process has been ongoing.

CDCR's continued difficulty in remedying the deficiencies of its mental health care system is well documented. A 2013 report to the court by the Special Master criticized CDCR for failing to follow many of the recommendations he had made to the department over a 14-year period. (https://rbgg.com/wp-content/uploads/Coleman-Report-on-Suicides-Completed-in-the-CDCR-in-Calendar-Year-20111.pdf ; <http://articles.latimes.com/2013/mar/13/local/la-me-ff-court-expert-prison-suicide-rate-20130313> [as of Apr. 17, 2018].) In recent years, an increase in the number of inmate suicides led the Joint Legislative Audit Committee (JLAC) to request that the California State Auditor prepare an audit report concerning CDCR's 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. (*See* <http://www.sacbee.com/news/local/crime/article41246670.html>; <https://www.theguardian.com/us-news/2016/may/10/suicide-california-womens-prison-mental-health> [as of Apr. 17, 2018].) The findings and recommendations of that report are summarized in Comment 4.

3. CDCR Policies

Mental Health Generally

CDCR regulations require the department to provide a broad range of mental health services to inmates by assessing the needs of its population and developing specialized programs of mental health care, to the extent resources are available for that purpose. (Cal. Code of Regs., tit. 15, § 3360, subd. (a).) Necessary and appropriate mental health services must be provided to inmates, and adequate staff and facilities must be maintained for the delivery of such services. (*Id*.) When an inmate is found to require mental health care that is not available within those resources, but which is available in the Department of Mental Health, the case will be referred to the director for consideration of temporary transfer to that department pursuant to Penal Code section 2684. (Cal. Code of Regs., tit. 15, § 3360, subd. (b).)

All required mental health treatment or diagnostic services must be provided under the supervision of a psychiatrist licensed to practice in the state, or a psychologist licensed to practice in the state and who holds a doctoral degree and has at least two years of experience in the diagnosis and treatment of emotional and mental disorders. (Cal. Code of Regs., tit. 15, § 3361, subd. (a).) When an inmate or an inmate's guardian or relative, or an attorney or other interested party desires to have an inmate examined by a private psychiatrist or other mental health professional, a request must be submitted in writing to the warden. (Cal. Code of Regs., tit. 15, § 3361, subd. (b).) The warden will grant the request after consulting with the institution's chief psychiatrist or, in his or her absence, the chief medical officer, unless there are specific case factors which, in the judgment of the warden, warrant denial. (*Id.*) Private consultants are not permitted to order mental health treatment for any inmate, but may be asked to make a report of findings and recommendations to the warden. (*Id.*) All persons committed to CDCR must be informed that mental health services are available to them, and that, upon an inmate's request, an evaluative interview will be provided within a reasonable period of time by a licensed practitioner, or a specially trained counselor supervised by a licensed practitioner. (Cal. Code of Regs., tit. 15, § 3362.) Upon request, an inmate will be provided with information as to what specialized treatment programs may be available in the department and how such treatment may be obtained. (*Id.*)

Suicide Prevention and Response

Each institution head is required to ensure that all employees whose assignments routinely involve inmate contact are trained to recognize signs and symptoms associated with suicide risk, the appropriate procedures for staff intervention, and the appropriate procedures to be followed in response to emergency situations resulting from self-injurious or suicidal actions. (Cal. Code of Regs., tit. 15, § 3365, subd. (a).) Specifically, peace officer classifications are required to complete annual training on suicide prevention. (Department Operations Manual (DOM) § 32010.15)

Each institution head is required to implement a Suicide Prevention Program for inmates who display self-injurious or suicidal behavior or symptoms. These programs must include the following components:

- Suicide Watch. When medical staff determine that an inmate is actively suicidal, a licensed physician or psychologist must order placement of the inmate on suicide watch in a General Acute Care Hospital (GACH), Correctional Treatment Center (CTC), Skilled Nursing Facility (SNF), Outpatient Housing Unit (OHU), or other appropriate health care facility, for continual observation.
- Suicide Precaution. When medical staff determine that an inmate is at high risk of attempting self-injurious behavior, a licensed physician or psychologist shall order placement of the inmate on suicide precaution in a GACH, CTC, SNF, OHU, or other appropriate health care facility, for periodic monitoring.
- Follow-up Treatment. Discharge from suicide watch or suicide precaution must occur when an interdisciplinary team of clinicians determines that the inmate no longer presents a suicide risk. A written treatment plan and follow-up outpatient treatment must be provided by a mental health clinician. (Cal. Code of Regs., tit. 15, § 3365, subd. (b).)

When a suicide attempt is discovered in progress, medical assistance must be summoned immediately to provide emergency medical care. (Cal. Code of Regs., tit. 15, § 3365, subd. (c).)

Security and safety procedures must be followed, including the use of required equipment and procedures to deal with bodily fluids. (*Id.*) A cut-down kit must be immediately accessible on each unit and must be used by staff in case of an attempted suicide by hanging. (*Id.*) All subsequent activities and procedures must comply with local institutional emergency plans. (*Id.*) Additional protocols regarding suicide prevention and response are detailed in Chapter 10 of the Mental Health Program Services Delivery System Program Guide. (https://www.cdcr.ca.gov/DHCS/docs/Mental%20Health%20Program%20Guide.pdf)

Finally, the DOM requires that "incidents, events and activities that occur within the jurisdiction of institutions of immediate interest to the Department, other governmental agencies or the news media" be reported to the Director or the departmental Officer-of -the-Day, or the Deputy Director, DAPO. (DOM § 51030.1.) Certain incidents are required to be reported, including attempted suicides. (DOM § 51030.3.)

Inmate Death, Serious Injury, or Serious Illness: Notification Requirements

The DOM provides that CDCR must treat the death, serious injury, or serious illness of an inmate with dignity and respect as is regularly accorded persons who are not incarcerated. (DOM § 51070.2.) The procedures to be followed after death, serious injury, or illness must comply with the requirements of all applicable laws. (*Id.*) The DOM includes detailed protocols for prison staff after an inmate's death. Among the responsibilities and duties for prison staff following an inmate's death, include pronouncement of death, preparing a written summary of the circumstances surrounding the inmate's death, signing the death certificate, and identifying the decedent. (DOM §§ 51070.4-51070.8.)

The DOM also provides the notification requirements following an inmate's death. For example, an inmate's death must be reported to the county sheriff and coroner within two hours of the death. (DOM § 51070.9.) The inmate's death must be reported to the district attorney in the county in which the prison as well as specified CDCR officials within 24 hours. The DOM specifies that Receiving and Release staff in Reception Centers obtain primary and alternate emergency contact information for each incoming inmate. (DOM § 51070.10.) This information is stored in two CDCR databases and is required to be updated:

- Annually as part of the classification review process.
- Upon recommendation of transfer by a classification.
- Whenever an inmate advises his or her correctional counselor of a desire to change the information.

DOM section 51070.10 lays out the protocol that CDCR staff must follow with respect to notifying an inmate's emergency contact in the event of the inmate's death, serious injury, or serious illness. In the event of a death, serious injury, or serious illness, the Warden or designee at the level of Correctional Lieutenant or Correctional Counselor II or above is required to use all reasonable means to contact the person identified on the notification form. CDCR is required to notify the emergency contact person as soon as possible. Notification via phone must be used whenever possible. If notification cannot be immediately made, the Warden or designee at the level of Correctional Lieutenant or Correctional Counselor II or above must use all reasonable means to make contact with family members, including but not limited to: assigning Investigative Services Unit staff to utilize telephone signup sheets, Inmate Monitoring and Recording Systems, searching the inmate's personal property, reviewing the inmate's visiting

file, contacting the previous parole agent, if any, contacting the local coroner's office, contacting the arresting agency, reviewing social media, or contacting the Office of Correctional Safety (OCS) to locate contact information. All efforts made to notify the next of kin must be documented on a specified form.

The DOM further provides that if notification with the contact listed cannot be made within 72 hours, the Warden must notify their respective Associate Director that all reasonable means for obtaining contact information have been exhausted. The Associate Director is then required to make contact with the OCS for any additional assistance in locating the next of kin.

In addition to the notification requirements described above, CDCR is required to report inmate suicides and other critical incidents within a specified timeframe to the Office of the Inspector General, the agency tasked with providing oversight to California's correctional system.

4. Audit on CDCR Inmate Suicides

Pursuant to its duty to complete an audit requested by JLAC, the State Auditor conducted an audit of CDCR's policies, procedures, and practices for suicide prevention and reduction. The audit included visits to four state prisons, including two women's prisons and two men's prisons. The report was released in August 2017 and concluded:

> 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.
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> 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. (https://www.auditor.ca.gov/pdfs/reports/2016-131.pdf)

In order to provide additional accountability for CDCR's efforts to respond to and prevent inmate suicides and attempted suicides, the Auditor recommended that the Legislature require that CDCR report to it annually 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, as well as the results of any audits CDCR 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.

In order to remedy CDCR's deficiencies, the Auditor recommended:

- CDCR 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, CDCR 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, CDCR 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, CDCR 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, CDCR 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, CDCR 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, CDCR 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, CDCR should implement its plan to review attempts with the same level of scrutiny that it uses during its suicide reviews.

CDCR 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, CDCR 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.

This bill adopts several of the Auditor's recommendations. This bill requires CDCR to submit an annual report to the Legislature on CDCR's efforts to respond to and prevent inmate suicides and attempted suicides. The report must identify:

- All recommendations that, if implemented, would affect CDCR's efforts to respond to and prevent suicides and attempted suicides among inmates and that were made to CDCR or to a prison or institution as the result of an audit, assessment, or other review, whether internally or externally conducted, mandated, or court-ordered.
- A description of CDCR's progress in implementing each recommendation identified in an audit or other review, as described above, including the expected timeline for full implementation for each recommendation and the activities undertaken to address each recommendation. If CDCR does not intend to fully implement a recommendation, the CDCR must describe in sufficient detail its reasons for not fully implementing the recommendation.
- A description of the results of any audit or review CDCR conducts that measure the success of changes it implements as a result of the recommendations made by an audit or other review.
- A description of the CDCR's progress in identifying and implementing mental health programs that may ameliorate risk factors associated with suicides at the prisons and institutions.
- A description of CDCR's progress in meeting its goals for completing suicide risk evaluations and comprehensive mental health treatment plans in a sufficient manner, including identifying the number of suicide risk evaluations and comprehensive mental health treatment plans completed, describing the criteria CDCR uses to assess the quality of the suicide risk evaluations and comprehensive mental health treatment plans, and reporting on the results of its assessments of the suicide risk evaluations and comprehensive mental health treatment plans. CDCR must present the information regarding its progress in meeting its goals for completing suicide risk evaluations separately from the information regarding the department's progress in meeting its goals for completing comprehensive mental health treatment plans.
- A description of CDCR's efforts to ensure that all mental health staff receive required training and mentoring related to suicide prevention and response, including describing the trainings and mentoring required and identifying the number of individuals required to take each training or to participate in mentoring, and the number of individuals who completed each required training or participating in required mentoring.
- A description of CDCR's efforts to fill vacancies in its mental health treatment programs, including its efforts to hire and retain psychiatrists.

The bill additionally requires that this report be posted on the department's website, and requires CDCR to notify an inmate's emergency contact person by phone within 24 hours of an inmate's serious illness, serious injury (including attempted suicide), or death.

5. Argument in Support

According to the National Association of Social Workers, California Chapter:

> In response to an unusually high number of suicides in recent years, the Joint Legislative Audit Committee approved an audit of the prison suicide crisis in California state prisons. CDCR establishes its own policies in responding to, planning treatment for, and observing suicidal inmates. However, the State Auditor revealed in an audit released in August 2017, that the CDCR knowingly did not consistently follow their established procedures and practices for years. As a result, state prisons have failed to adequately complete required behavioral risk evaluations for inmates, inmates have been insufficiently monitored, and some mental health staff did not complete required training related to suicide prevention and response.
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> SB 960 would enact the State Auditor's recommendations to require CDCR to issue an annual report to the Legislature with the Department's progress related to:
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> - Implementation of recommendations made by internal and external audits
> - Meeting its goals for completing suicide risk evaluations and mental health treatment plans
> - Ensuring that vacancies in mental health treatment programs are filled, and that staff is adequately trained in suicide prevention and reporting
>
> …NASW-CA advocates…for the implementation and improvement of programs and policies designed to enhance human well-being and help meet the basic needs of all people.

-- END --