California Correctional Institution

Review Period: Nov 2025 – Apr 2026

Onsite: June 2 – 4, 2026

2026

Statewide Mental Health Program

Continuous Quality Improvement

CALIFORNIA CORRECTIONAL INSTUTION

CDCR

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TABLE OF CONTENTS

Background

In 1990, a class of incarcerated individuals with serious mental disorders filed a federal lawsuit alleging that mental health care in California state prisons was constitutionally inadequate. Coleman v. Wilson, No. 2:90-cv-0520 (E.D. Cal.), now known as Coleman v. Newsom. The case remains active.

Following a trial, the U.S. District Court for the Eastern District of California issued findings in September 1995 identifying systemic deficiencies in the delivery of mental health care across the prison system. The court concluded that these deficiencies, including inadequate screening and access to care, insufficient staffing and training, deficient medication management practices, incomplete medical records, and shortcomings in suicide prevention, constituted deliberate indifference in violation of the cruel and unusual punishment clause of the Eighth Amendment to the Constitution. The court further found that disciplinary and housing practices failed to adequately account for the mental health needs of incarcerated individuals. 912 F.Supp. 1282.

To remedy these violations, the court approved a comprehensive plan for mental health care delivery, now set forth in the Mental Health Services Delivery System (MHSDS) Program Guide (Program Guide), and appointed a Special Master to monitor compliance.

Over the ensuing decades, CDCR undertook efforts toward compliance with the court's remedial orders. However, in 2025, the court determined that critical components of the ordered remedy had not been durably implemented. Effective September 1, 2025, the court appointed a Receiver with authority over implementation of the outstanding remedial requirements. Among the Receiver's core responsibilities is the establishment and implementation of an effective quality assurance and improvement system.

To that end, a comprehensive quality measurement framework has been developed over the course of several years with input from the parties, the Special Master, and the court. This comprises over 250 provisional Key Performance Indicators (KPIs) designed to assess each institution's compliance with the court-ordered remedy. Approximately 150 of these indicators are automated, drawing data from electronic health records and other operational databases on a continuous basis. The remaining approximately 100 indicators require onsite data collection utilizing the Continuous Quality Improvement Tool (CQIT), including direct observation of treatment delivery, assessment of treatment environments, and interviews with clinical and custody staff and patients.

As the court has explained, CQIT is central to the transition toward self-monitoring and the durable implementation of constitutionally adequate mental health care: "[T]he key indicators in CQIT signify the material provisions of the Program Guide and the Compendium that must be durably implemented in order to satisfy the Eighth Amendment." August 25, 2021, Order, ECF No. 7283 at 4 (internal quotations omitted).

During 2026, the Receiver is field-testing CQIT and all other remediated indicators in what is being termed a "CQIT+ audit" at approximately two dozen institutions. The purpose of this testing phase is to determine whether the indicators function as intended and yield the information necessary to reliably assess compliance. Following this evaluation, the Receiver is charged with recommending a final set of indicators to the court.

Goals

The Receiver's overarching goals in implementing CQIT+ are to assess compliance with Program Guide requirements and build CDCR's capacity to monitor and sustain the quality of its own mental health care delivery. The latter is a prerequisite for durable reform and, ultimately, for the resolution of this case.

The Receiver seeks to use the audit process not only to assess compliance but also to identify barriers to compliance that she can address and expand effective practices across the system. Where an

institution demonstrates strength in a particular area, those practices will be documented and shared so that other facilities can learn from and adopt them.

Approach to Assessing Compliance

The Receiver's site visits integrate the CQIT tool with additional quality assurance activities, including reviews related to level-of-care placement and suicide prevention. The Receiver designed this integrated approach to provide a comprehensive picture of each facility's performance which "will allow her to implement targeted remedial measures soon after identifying noncompliance." ECF 8842 at 3. Moreover, this approach provides facility leadership with specific, actionable information in a single report while reducing the overall burden that multiple separate audit processes have imposed in the past.

Audits are conducted by the Receiver's Compliance Team (RCT), which is composed of independent subject-matter experts, regional clinical experts, and staff from the Office of the Receiver. This blended team reports to the Receiver's Senior Advisor for auditing and compliance. This approach enables the Receiver to exercise independent review of institutions while "assessing transfer of the knowledge and skill sets required to conduct internal auditing and maintain durability." ECF 8842 at 4.

During onsite visits, the RCT takes a collaborative, multi-method approach to assessing compliance and identifying strengths and areas for improvement. In addition to collecting data for the CQIT indicators, the team cross-references automated data that has been collected over time against direct onsite observations. The RCT also examines staff workflows to verify that the operational processes generating automated data are functioning as intended. To gain a fuller picture of institutional performance, the team conducts interviews with both clinical staff and patients. Throughout the visit, the RCT members work diligently to understand why an institution may not have met standards on a specific issue. This enhances the report findings and recommendations and will enable the Receiver to address broad themes and issues that require her attention.

Prior to arriving at each facility, an onsite audit schedule is created to ensure all areas are audited. The RCT reviews information about previously identified compliance concerns so the team can assess the status of those issues onsite. If critical issues are observed during the audit, the team addresses them in real time. Each day, the RCT convenes a team huddle to discuss emerging themes, identify areas where additional information is needed, and resolve any differences in assessment. At the conclusion of the visit, every RCT member who is on site drafts a summary of their overall observations for use in report drafting.

Using all this information, the process of drafting the audit report uses a report framework developed under the Senior Advisor's leadership. The RCT team-leads confer frequently with other team members to ensure the accuracy of all information included in the report. Reports reflect the team's combined expertise and are intended to help institutional leadership prioritize issues and improve performance. Draft reports are reviewed and approved by several members of the Receiver's team, including the Senior Advisor and the Deputy Receivers. The Receiver reviews and approves final reports for issuance.

This report is organized into thematic sections, each presenting both the automated KPI data and the audit team's onsite findings for that domain. In some sections, readers will observe that the automated data reflects high compliance while the onsite findings identify significant concerns, and the recommendations that follow may appear to conflict with the data table. Where the data and onsite observations diverge, the report presents both transparently so that the nature and extent of the gap is visible.

Institutional leadership is responsible for developing a corrective action plan to address the high-priority recommendations identified in the executive summary of each report within 30 days of its issuance. The facility is also responsible for acting on the remaining recommendations, and the RCT will assess the steps taken to address them on the following CQIT visit. Leadership is then responsible for implementing those plans and certifying their completion. Throughout this process, the Senior Advisor and other members of the RCT are actively involved in reviewing plans and tracking implementation. Moreover, the Senior Advisor is developing a

process to confirm that recommendations have been implemented in a way that achieves compliance and that institutions maintain compliance in those areas. All these actions are designed to ensure that these reviews drive measurable changes, rather than producing a document that goes unread.

Methodology

Data Foundation

A central prerequisite to implementing CQIT has been the completion of a court-ordered data remediation process. Beginning in 2019, the court directed a comprehensive review of CDCR's data collection and reporting practices to ensure the reliability and accuracy of the compliance data used in this case. The court subsequently ordered CDCR to undertake data remediation and validation of its mental health data management system, noting "CQIT cannot be implemented until the data on which it depends can be validated and verified." August 25, 2021, Order, ECF No. 7283 at 6.

The data remediation process has involved systematic validation of the electronic data sources that feed the automated indicators, including verification that the clinical and operational data recorded, and that accurate calculation rules are applied, consistent with Program Guide requirements. Most of this work was conducted under the supervision of the Special Master and with input from all parties in the case.

As a result, each indicator used in this report draws on data infrastructure that has been subject to this multi-year remediation and validation process. The Receiver's 2026 field-testing phase includes ongoing assessment of whether the validated data sources are producing reliable results at the institutional level.

Data Collection

Compliance data is collected through two primary methods. Automated indicators (approximately 150 of the over 250 total KPIs) draw data from electronic health records, operational databases, and other systems used in day-to-day operations. This data is collected continuously throughout the year and is available for review prior to and during onsite audits. Onsite CQIT indicators (approximately 100 KPIs) require data collection at the institution by the RCT through direct observation of treatment delivery, assessment of treatment environments, review of clinical documentation, and interviews with staff and patients.

During onsite audits, the RCT cross-references automated data against direct observations to assess consistency and identify discrepancies. The team also examines the operational workflows that generate automated data to verify that the underlying business processes are functioning as intended and producing accurate results.

Interpreting This Report

Each KPI in this report is presented with a percentage reflecting the proportion of cases, events, or observations that met the applicable standard. The following conventions are used throughout this report:

- A dagger symbol (†) indicates a small sample size (N < 20). Results based on small samples should be interpreted with caution, as they may not reliably represent overall institutional performance.
- The notation "i" designates an inverse indicator, where a lower percentage reflects better performance. To incorporate inverse indicators into aggregate compliance scores, the individual KPI percentage is subtracted from 100 (e.g., 100 – 2% = 98% compliance).
- Indicators that do not have a specified compliance threshold are excluded from the calculation of aggregate compliance scores.
- Blank boxes in the summary tables are the result of those indicators not being applicable to the institution or program being audited, or data unavailability.

Indicators Excluded from This Report

Part of the 2026 field-testing phase is designed to identify indicators that are not yet functioning as intended so they can be corrected before the Receiver recommends a final set of indicators to the court. During the audit process, several indicators were identified as producing unreliable results due to technical issues in the CQIT platform, or a need for clarification in instructions or document production. These indicators have been excluded from this report and are listed in Appendix E. The development team is working to resolve these issues in time for subsequent audit reports. Additionally, the indicator related to timely release planning is excluded because the documented measurement does not align with recently revised requirements regarding release planning. Any changes to the indicators to align with policy will be recommended to the Receiver's team for authorization.

Compliance Color Coding

The compliance thresholds and associated color coding used in this report reflect thresholds that were established prior to the court-ordered data remediation process and prior to the Receiver's appointment. Their use in the 2026 reports does not constitute an endorsement of these thresholds by the Receiver as the final standard for assessing compliance. Like the CQIT indicators themselves, the Receiver will be evaluating them during the 2026 field-testing phase. The Receiver will include proposed compliance thresholds when she submits recommended final indicators to the court. The thresholds in this report are defined as follows:

Color	Compliance Percentage Range
Green	≥ 89.5%
Yellow	≥ 74.5% and < 89.5%
Red	< 74.5%
Blue	No compliance threshold

Recommendations

The recommendations in this report are directed at the institution. As a result, they address deficiencies that institutional leadership has the authority and operational capacity to resolve. These include clinical supervision practices, scheduling workflows, documentation quality, staff training, internal communication protocols, and custodial procedures such as welfare check compliance and procurement. The Receiver expects institutional leadership to take action to respond to these recommendations.

Certain deficiencies identified in this report are driven by structural conditions that exceed the institution's capacity to remedy independently. These include statewide shortages of designated RHU EOP beds, insufficient physical infrastructure for group treatment, and systemwide challenges in recruiting and retaining onsite clinical staff in remote locations. Where the report identifies a structural barrier, the Receiver will take the lead in developing and implementing a resolution, whether through infrastructure investment, population management, policy revision, or coordination with CDCR and DSH leadership. Institutional leadership is not expected to solve problems it does not control, but it is expected to maximize compliance within existing constraints and to document and escalate structural barriers through the channels the Receiver's office establishes.

Where a recommendation touches both domains, for example, maximizing the use of existing treatment space (institutional) while also requesting capital investment for additional space (systemwide), the report identifies the institutional component as a near-term action item and the structural component as an issue the Receiver will address.

Executive Summary

California Correctional Institution (CCI) is a multi-mission institution located in Tehachapi, California. It operates 21 housing units across three mainline facilities (Facility A, a Level 3 facility; Facility B, a Level 4 facility; and Facility C, a Level 2 facility). In addition to its general population (GP) program, CCI operates a GP Restricted Housing Unit (RHU) on Facility B (B8), and a 16-bed Outpatient Housing Unit (OHU) on Facility B. CCI provides treatment to mainline Correctional Clinical Case Management Services (ML CCCMS) patients in all three facilities, and to Enhanced Outpatient Program (EOP) patients in Facility A (A7 and A8). CCI's EOP population is a Level 4 population housed on a level 3 NDPF GP/SNY facility. In this way, CCI is able to incentivize patients to program positively, so they are eligible for a behavior override to stay at CCIs level 3 NDPF once they graduate from EOP level of care (LOC). Approximately 54% of the incarcerated population at CCI is enrolled in mental health programming.

CCI had frequently been under Program Status Report (PSR) due to an increase in violence on both Facility A and B within the last quarter of 2025. The most recent 2026 PSRs were mostly driven by security threat group violence, requiring modification to programming.

CCI demonstrated a strong receptiveness to constructive feedback and a commitment to addressing issues identified during the review. In some cases, the team was able to immediately remedy issues we raised. The warden, the CEO, and their leadership team demonstrated a commitment to creating and maintaining a compliant and effective mental health program at CCI.

Institutional strengths are in custody operations, emergency preparedness, CMHPP processes, CIT functioning, and staffing for clinical positions. All custody staff completed Use of Force training (100%), and nursing staff have all completed CPR training (100%). CPR mouth shields were carried by all officers observed. Cut-down kits were complete and standardized across all housing units. Most custody staff understand the mental health referral processes, and MH5 referral forms were available in all housing units observed. Though they failed to conduct the quarterly partnership round tables during the reporting period, measures for executive and CCCMS CMHPP items are largely compliant. CCI recognized and had already implemented a plan to bring CMHPP quarterly round table trainings into compliance before our arrival on-site. For all observed CIT responses, all required members were present, patients were seen in a confidential setting, and all documentation was completed appropriately. CCI increased the fill rate in most mental health classifications over the course of the reporting period, and by the time of our visit, they had an 80% fill rate for primary clinicians and 100% fill rate for psychiatry staff.

Staff reported strong relationships and communication amongst their team. During observations of interactions between the mental health staff and the patients that they serve, patients were treated with respect, were engaged with open-ended questions and were given the opportunity to provide input into their treatment plans. In the ML EOP goals were measurable and the plans were individualized.

The deficiencies documented in this report are driven by a combination of structural, operational, and clinical-quality factors. The structural barriers, including a lack of sufficient treatment space and statewide RHU CCCMS and EOP bed shortage cannot be fully resolved through institutional corrective action alone. The operational barriers (cancellation of appointments due to custody, slow transfer of CCCMS patients who are transitioning from EOP to more appropriate housing) can be addressed with local institutional leadership and adequate resource allocation. The clinical-quality deficits, including deficiencies in IDTT quality and medication safety protocols, are primarily supervision and training issues that can be addressed at the institution level.

The five priority recommendations below are selected because of their urgency and target the areas where patient safety, treatment adequacy, or both are at stake.

Priority Recommendations

1. **Review and revise internal transfer processes to ensure timely transfer to appropriate housing and treatment settings for MH patients**: Transfers to appropriate CCCMS programs after discharge from EOP LOC are taking an excessively long time. The number of CCCMS patients recently discharged from EOP LOC housed in ML EOP housing units A7 and A8 continues to be a concern. At the start of the audit, 06/02/2026, there were 40 CCCMS patients housed in the ML EOP housing units with lengths of stay ranging from two to 322 days. Twelve or 30% of the CCCMS patients housed in EOP housing have remained in EOP housing for more than 90 days after their level of care changed. Timely transfers to a PIP averaged 33%, and timely transfers to RHU CCCMS averaged 40% over the course of the reporting period.

   Review current practices and identify barriers to the endorsement and timely transfer of patients discharged from EOP LOC and those endorsed to PIP. Remediate any practice barriers to create a more effective transfer process. The Receiver will continue to develop and implement strategies to address the challenge in not achieving timely transfers to CCCMS and EOP RHU beds resulting from insufficient beds for those placements systemwide.

2. **Identify and Remove Barriers to Mental Health Treatment Attendance:** During the reporting period, treatment offered averaged 7% while 61% of IDTTs, 52% of MHMD contacts, and 63% of primary clinician contacts met the applicable timeliness standard. Staff and patients described a layered ducat process wherein the patient needs to both have a ducat and be on a list provided to the Control Booth Officer to access care. While intended to enhance the process of moving patients to appointments as a fail-safe, this has, in practice, provided a barrier to patients arriving at appointments on time or at all.

   Review and either refine or eliminate the layered ducat process so that patients can access their mental health appointments as scheduled.

3. **Ensure Confidential and Safe Mental Health Treatment Spaces**: The onsite audit revealed several treatment spaces with confidentiality limitations and both staff and patients voiced concerns about confidentiality. These issues included treatment space without doors, treatment being provided in a dining hall, treatment being conducted in a space with audio and visual recording, and telepresenters remaining in the room during treatment even when not requested by the clinician. Despite these observed issues, the automated reports on confidentiality indicate that 84% of groups and 100% of IDTTs across the reporting period were held in confidential settings. This indicates that there are problems both with the availability of confidential treatment space and with accurate coding of appointments by staff. The space at Facility A CCCMS is of particular concern, as there are also noted safety issues regarding configuration and barriers to visual inspection by custody officers.

   Make all treatment space confidential and safe either by modifying existing treatment space or identifying alternative spaces. If an exhaustive review of all space and scheduling options reveals that there is inadequate space available to provide confidential treatment, then provide that evidence to the Receiver's Office and seek additional support.

4. **Conduct coaching and supervision to improve IDTT processes across programs**: Although IDTTs were rated positively in some domains, meaningful participation by all members was generally lacking, with an interactive process in only 25% of the IDTTs. Qualitative review identified deficits in case conceptualization, measurable treatment goals, level-of-care justification, and discussion of assignments and accommodations (for EOP patients). These deficits mean that the IDTT did not present a clear picture of the patient, their treatment needs, and how those needs will be met.

Conduct coaching and supervision that produces individualized treatment plans through collaborative clinical team discussion with documented patient participation, addressing deficits in attendance, staffing, interactive process, and clinical content quality.

5. **Develop a Local Process for ensuring Medication Monitoring Compliance and Timely Response to Medication Non-Adherence**: Based upon review of the data for the reporting period, diagnostic monitoring (all) was at 81% for the six-month average. Antipsychotic monitoring was below 85%, with lipid monitoring at 63%, thyroid monitoring at 60%, CBC at 72%, and EKG at 50%. Mood stabilizers monitoring (all) was 69% for the six-month average with particularly low lithium (62%) and valproic acid (66%) level monitoring. Antidepressants monitoring (all) was 78% for the six-month average, with antidepressant thyroid monitoring at 45% for the six-month average. Critical and non-critical medication non-adherence response was 20% and 19% respectively.

   Identify contributing factors to missed medication monitoring requirements and implement workflow changes to address these. Ensure staff are trained in the use of available registries for monitoring and tracking medication monitoring requirements. Identify barriers to a timely response to medication non-adherence and implement workflow changes and staff training as needed.

Institution's Operational Perspective

California Correctional Institution (CCI) is a multi-mission institution located in Tehachapi, California.

Facility	Function	Mental Health Program
Facility A	General Population	ML CCCMS, ML EOP
Facility B	Restricted Housing Units; Outpatient Housing Unit; Alternative Housing; General Population	ML CCCMS, RHU (GP), OHU
Facility C	General Population	ML CCCMS

Mental Health Program Scope: CCI provides treatment to ML CCCMS patients on all three facilities and to Enhanced Outpatient Program (EOP) patients located on Facility A (A7 and A8). RHU GP in B8 can temporarily accommodate CCCMS and EOP patients awaiting transfer. The 16 bed OHU is located on Facility B and accommodates medical patients, some of whom may be participants in the MHSDS at the CCCMS or EOP LOC. OHU has two cells identified for Mental Health and these are utilized as Alternative Housing, as well as two cells outside of the OHU identified as OHU overflow (clinic holding) for Alternative Housing.

Staffing and Recruitment: During the review period, CCI increased the fill rate in most classifications. Senior staff reported that the increased hiring of unlicensed staff has increased supervisory demands, limiting time available for patient care.

CCI has expanded the CIT and the hours of CIT coverage and now specific team members are scheduled seven days per week. Per the January 2026 staffing allocation, CIT positions are inadequate to staff CITs seven days a week. In April 2026, CCI received over 200 crisis calls. At CCI, this has resulted in new staff being re-assigned to CIT from other programs (EOP, RHU, and CCCMS).

Operational Environment: Since approximately October 2025, RHU custody escorts for MH have been reduced. Mental health escorts are now allotted 1.5 officers per day, and an additional .50 is allotted for IDTT. This has resulted in most RHU MH contacts taking place at cell-front.

Mental health and custody staffing shortages, continued PSRs, and lack of treatment space have impacted how patient care is provided. Cross coverage and triage of patient care is utilized to ensure that patients, especially those at the highest acuity of need, are seen. Additional treatment hours have been added to weekend days and at times during the week where more treatment space is available.

Clinical Programs and Initiatives: CCI has APPIC certification and thus access to a candidate pool open to both Ph.D. and Psy.D. interns. They currently host three psychology interns and will host four for the 2026-2027 internship year. CCI also has an MOU with California State University Bakersfield and provides second year MSW students with limited clinical training and supervision. This has created a pipeline for recruitment to state positions at the institution.

Infrastructure: Confidential treatment space is a significant infrastructure constraint. Because CCI was not initially built to serve an incarcerated MH population, nor has it had any significant physical plant projects to address MH treatment space needs, clinical treatment areas are dispersed throughout the institution. Facility A level 3 CCCMS is limited to two clinic office spaces for a population of approximately 268 patients. Facility A level 4 EOP is in a self-contained unit, with the A7 and A8 dining hall as the designated treatment area for EOP with an approximate population of 152. This space has two desks placed on opposite walls cordoned off by privacy partition and two confidential group spaces that can be used for one-on-one appointments when space is available in the alcoves. In A7 and A8, staff may use the multi-purpose spaces, however, this is a shared space with medical, custody, and correctional counselors. The two MH offices in the Facility A clinic may also be utilized for one-on-one EOP contacts when the CCCMS program does not have a provider. The R&R office may be used when nursing and CCCMS providers are not using it. Facility A boardroom is used for IDTT for both EOP and CCCMS populations. Treatment space for Facility B CCCMS is limited to two clinic office spaces for a population of approximately 461 patients. Only one of two MH offices in Facility B clinic has a treatment

module for RHU contacts and escorts are needed to access that space. As of May 29, 2026, the RHU GP held 32 CCCMS and 11 EOP patients awaiting transfer. Non-contact visiting space (non-confidential) is used, but access is limited to availability of RHU MH custody escorts and to when PSR is not in place. Facility B Boardroom is used for both ML CCCMS and the GP, RHU CCCMS, and RHU EOP populations. Treatment space on Facility C is limited to three MH offices in the old dental clinic for the population of approximately 359 patients. The Facility C program office is used for IDTTs.

Access to Care

This section examines whether patients initiate and sustain meaningful contact with mental health services across custody settings, levels of care, and transition points. Effective access has several dimensions: contact must occur within designated timeframes, communication confidential and clinically effective, scheduling and transfer processes reliable, treatment appropriate to need, and the physical environment adequate to the encounter. The subsections below assess each in turn: Confidential and Effective Communication; Timely Access; Timely Transfers; Appointments; Treatment Offered; and Treatment Environment (formerly Facility and Environment of Care), measuring whether patients receive care of the frequency, timeliness, and clinical adequacy the Program Guide requires, in spaces that protect confidentiality, safety, and dignity.

Confidential and Effective Communication

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
Effective Communication Achieved	97%	98%	98%	98%	98%	99%	98%
Group treatment in a confidential setting	87%	93%	87%	93%	86%	70%	84%
IDTTs in a confidential setting	99%	100%	98%	100%	100%	100%	100%

Timely Access

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
IRU Reviews Completed Timely		100%†	100%†				100%†	
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure	0%†						0%†	
RHU GP Screens	88%†	80%†	71%†	85%†	100%	81%	86%	
RHU Pre-Screen	83%	68%	77%	78%	82%	50%	72%	
Timely IDTTs (v2.0)	50%	63%	58%	63%	56%	69%	61%	
Timely MH Referrals (v2.0)	61%	59%	63%	69%	67%	63%	64%	
Timely MHMD Contacts (v2.0)	43%	50%	44%	66%	51%	59%	52%	
Timely PC Contacts (v2.0)	42%	67%	68%	69%	62%	71%	63%	
Custody MH Referrals								96%
Housing Units Where 128-MH-5s Are Available And Accessible to Housing Unit Staff								100%†

Timely Transfers

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
Timely Transfer to MHCB (v2.0)	100%†	100%†	100%†	100%†	100%	100%	100%
Timely Transfers to EOP (v2.0)		100%†	100%†				100%†
Timely Transfers to PIP	0%†		50%†				33%†
Timely Transfers to RHU CCCMS	43%	31%	23%	37%	44%	59%	40%

Appointments

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
Appointments Cancelled Due to Custody [i]	45%	22%	22%	20%	27%	48%	33%

Treatment Offered

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
Treatment Offered (Structured): non-PIP	5%	6%	5%	12%	11%	3%	7%

Treatment Environment

Indicator	Onsite Audits
Adequate Group Treatment Spaces	100%†
Adequate IDTT Spaces	50%†
Adequate Individual Treatment Spaces	38%

Space-by-Space Assessment

Space / Location	Type	Assessed	Compliant	Primary Deficiencies
ML CCCMS	IDTT	2	Partial	Facility B: hard to hear as the hallway was noisy
	Individual	10	Partial	Facility B: Not safe as there were storage items in the space that made it hard to exit
ML EOP	IDTT	1	Yes	
	Group	1	Yes	
	Individual	4	Partial	Facility A: Space is shared with a dining area where patients are walking around able to see and hear the treatment in the space. Available partitions are only minimally adjusted to enhance privacy; one camera with sound capability was present

RHU	IDTT	1	Partial	On Facility B in the Board room, both officers had radios that were audible
	Group	0	n/a	
	Individual	10	Partial	Facility B: No door for confidentiality

✓ **Strengths**

Timely IRU Reviews: IRU reviews of the three submitted cases were completed within timeframes 100% of the time. This completes the referral submission process so that the PIPs can begin the acceptance/rejection decision phase, which is needed to move patients to appropriate treatment programs as quickly as possible.

Strong RHU GP screens: RHU GP screens averaged 86% compliance with completion in a confidential setting and and asking all questions on the form during the reporting period. During the on-site review, the observed screens were well conducted, with patients seen in a confidential space and all questions on the form asked.

Mainline EOP Group Treatment Space: Space was observed to meet all audit criteria. The space was confidential, had adequate space for seating each participant, and was well ventilated and temperature controlled.

Transfers to EOP and MHCB: Transfer timelines for patients moving to these higher levels of care were met 100% of the time.

Custody Referrals to Mental Health: On-site review of the patient referral process from custody to MH staff achieved 96% compliance, indicating that most custody staff interviewed had acceptable knowledge of when and how to refer to mental health.

⚠ **Concerns**

Treatment space confidentiality issues: In the RHU, non-contact rooms are used for treatment space. Patients in Facility A EOP program noted lack of confidential treatment space which was confirmed via observation by our team. Additionally, treatment space observed in Facility A ML CCCMS is sometimes interrupted because it includes a supply closet and staff come into this space to get things out of the closet. If signage prohibited entry during treatment sessions it would be adequate. During the staff interview, staff reported that lack of treatment space is a concern to them. Patients also raised concerns about the lack of treatment confidentiality during interviews. There appears to be a disconnect between staff documented confidentiality in treatment records and what was observed on-site.

Three cameras were found during our review of the Facility A EOP treatment space that is situated in the A7/A8 dining area. One of the cameras in this space was determined to have audio enabled. The audio was disabled while we were on-site as a temporary resolution to prevent custody staff from hearing treatment discussions.

Telepresenters remain in every telemental health session: During patient interviews the patients voiced concern that they do not view their contacts with telemental health clinicians as confidential because the telepresenter remains in the room during the session. While the telepresenter is part of the treatment team and bound by confidentiality, the practice of having a telepresenter remain in all telehealth treatment may be hindering the clinical engagement. The default for telemental health appointments, per policy, is that the telepresenter will not remain in the room unless the teleprovider states otherwise.

Translation services are not effective: While observing IDTTs on Facility C CCCMS, a custody officer was used for translation with a patient who was primarily Spanish speaking. Problems with translation services were an additional staff concern. They reported that use of translation services is especially problematic during appointments with a telemental health provider when a separate phone is used. When using the call service from a phone in the treatment space, it is difficult for the teleprovider to hear, and for the call service to, in turn,

hear the provider. Each person in the relay spends time repeating themselves, sometimes yelling so that the interpreter on the phone can hear. For this reason, telemental health providers are advised by their leadership to call the interpreter line from their WebEx call, so there are no external barriers to hearing each other. Further, some of the treatment spaces do not have phones to utilize the translation call services.

Services are often late, cancelled, or not offered: While conducting on-site observations, IDTTs in RHU GP began 30 minutes late due to codes on the unit. Further, it took four hours to see four IDTTs, due to lengthy escort processes, lock down procedures, and an MHPC performing a full initial assessment during IDTT because the patient had not been seen for initial prior to IDTT. Due to the layout at CCI, there frequently is a lengthy escort process for IDTT as they do not have TTMs to accommodate patients who are awaiting their IDTT. The MHPC performing an initial assessment during IDTT is out of the norm for the institution, and the supervisor agreed that this is not the appropriate place to perform an initial assessment. Almost none of the EOP patients were offered the minimum number of weekly treatment hours during the reporting period (range of 3%-12% per month). Thus, few patients at CCI are receiving the minimum mental health services that are commensurate with their designated level of care.

Patients and staff reported in the interviews that patients do arrive for services late due to various reasons such as PSR, not enough custody to escort, codes, pill pass, etc. Further, staff and patients spoke about a layered ducat process wherein the patient needs to have both a ducat and be on a list provided to the Control Booth Officer. While intended to enhance the process of moving patients to appointments as a fail-safe, this has, in practice, provided a barrier to patients arriving to appointments on time or at all. These reports are consistent with the Timely Access statistics provided for the reporting period: Timely IDTTs (61%), Timely MH Referrals (64%), Timely MHMD Contacts (52%), and Timely PC Contacts (63%).

Transfers to designated levels of care are not timely: Transfers to appropriate CCCMS programs after discharge from EOP LOC take an excessively long time as described in detail in the priority recommendations above.

Intake screenings for R&R are often conducted outside the official R&R Unit at Facility B: Instead, new arrivals are processed in satellite R&R areas located on the facilities where the new arrival will be housed, which do not have dedicated RN staff. This practice requires TTA RNs to leave their assigned areas to perform intake screenings, thereby reducing their availability for emergency responses in those facilities, and increasing the refusal rate of the screening. Discussions with custody leadership during the site visit revealed that it is not feasible to conduct all R&R processes at the main B facility R&R due to custody staffing limitations. CCI custody leadership indicated they plan to collect data to demonstrate the operational impact and support a proposal for nursing staff at the satellite R&Rs. Despite some intake screenings not occurring in the main R&R area of B facility, on-site observations showed that the screenings performed were of high quality.

RHU Pre-Screens are not being completed timely: During the reporting period, RHU Pre-Screens were completed on time 72% of the time, with completion rates ranging from 50%-83%. This variance was largely due to patients who were transferred back to the RHU (B8), from the B7 RHU overflow unit, which was not identified in SOMS as an RHU, thus triggering a duplicate pre-screen. Nursing collaborated with mental health clinicians to eliminate unnecessary placement orders, and the implementation of a custody RHU checklist has led to improved screening rates.

Patients returning from a temporary departure are not being seen upon return: Neither the MHPC nor MHMD is seeing their patients timely upon return from a temporary departure. This is a divergence from policy and creates a safety risk for patients who may be returning after receiving unfavorable news regarding their health and/or case factors.

Safety concerns in treatment space: Space was rated to be problematic for IDTT (50%) and individual treatment (38%). For example, space in Facility A ML CCCMS was configured with a narrow entry corridor before reaching the desk setup and therefore there is a small space before accessing the door. When looking into the space from outside the office there is a visual of staff but not the patient. Custody officers who are attempting to ensure the safety of the area would not have a clear visual of the patient and know whether a patient was in the

room with the staff member or not. There is also another office enclosed in this space where it is unsafe as there is no visual from the clinic.

Recommendations

1. Ensure Confidential and Safe Mental Health Treatment Spaces: See Priority Recommendations.
2. Require Telepresenters to exit the room during treatment: Per policy, telepresenters are not expected to be in the room with the patient for the entirety of the encounter and the patient may request that they leave the room at any point. Direct Telepresenters to exit the room unless requested by the teleprovider.
3. Provide a current list of on-site approved translators: Update as appropriate the current approved on-site translators list and provide to all clinical staff, including to telepresenters and teleproviders. Inform staff that it is a priority to utilize on-site healthcare provider staff before moving to non-healthcare staff as translators for mental health services.
4. Identify and Remove Barriers to Mental Health Treatment Attendance: See Priority Recommendations.
5. Develop and implement a plan for R&R screening: This to be staffed and occur at locations that facilitate nursing staff availability for all required functions. Elevate the issue for assistance with resolution if local solutions are not effective.
6. Review and revise internal transfer processes to ensure timely transfer to appropriate housing and treatment settings for MH patients: See Priority Recommendations.
7. Review Treatment Space for Possible Safety Enhancement: See Priority Recommendations.

Custody and Mental Health Partnership Plan (CMHPP)

This section evaluates the operational mechanisms that integrate custody and mental health functions at the institutional level. The custody mental health partnership plan encompasses executive rounding, daily huddles, supervisory meetings, training completion, and patient advisory structures. These mechanisms are designed to ensure that custody and mental health operations are coordinated, that information flows between disciplines, and that incarcerated persons (IPs) have structured input into the mental health program.

Indicator	Onsite Audits
CMHPP MH Daily Huddles	87%†
CMHPP MH Huddle Documentation of Required Attendees	86%†
CMHPP MH Huddle Documentation of Supervisor Attendees	0%†
CMHPP Monthly Executive Leadership Joint Rounding	100%
CMHPP Monthly Executive Leadership Joint Rounding Attended by Required Executives	100%
CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH Program	100%†
Custody Staff CMHPP Annual Training	99%
Healthcare Staff with CMHPP Annual Training	96%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours	100%†
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours with Required Attendees	100%†
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees	100%

ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings	83%†
Quarterly Partnership Round Table Training Completed as Required	0%†
Required Staff Attendance of Quarterly Partnership Round Table Training	0%†

✓ **Strengths**

Quarterly Partnership Round Table Training has been reinstituted: During the review period, CCI had 0% compliance with both the requirement to complete quarterly partnership round table training and the requirement for attendance at quarterly round table training. In speaking with the leadership on-site, they had already identified issues with their non-compliance with completion of the quarterly round table trainings portion of the CMHPP. They had also begun to implement a plan to include resuming partnership roundtables the week before our visit. They conducted the first roundtable for second watch prior to the audit, and third watch was to begin in June. During interviews, patients verbalized the need for staff training regarding working with individuals with mental illness. Reinstatement of the partnership quarterly round table trainings will provide this specialized training.

Executive and CCCMS CMHPP activities are largely compliant: Measures for executive and CCCMS CMHPP items are largely compliant. Bringing the quarterly round table trainings into compliance will increase awareness of the interaction of mental health and custodial operations. These trainings would also provide staff with practical tools to support their interactions with MHSDS patients.

⚠ **Concerns**

Huddle documentation is not available: Key documentation of huddle attendance is not consistently included in the records, particularly for daily huddles in EOP. Institution files include a memo stating that attachment B, the Mental Health Huddle Report, which identifies attendees and information to be discussed, is being completed consistently, however, documentation demonstrating that this practice is occurring was not available. During the reporting period, CMHPP huddles received a 0% compliance rate for supervisor attendance, as neither custody nor MH supervisors were in attendance at the observed MH huddles. Compliance with the requirement for both a custody and MH representative to attend was 86%, and overall huddle compliance was 87%.

Recommendations

1. Ensure attachment B is being utilized: To gain compliance with the CMHPP measures, CCI should use attachment B to document the huddles and huddle attendance.

Psychiatry

There are required timelines for psychiatric response to medication non-adherence notifications, appropriate use of involuntary medication procedures under Penal Code §2602, and systematic monitoring of medication safety and continuity through the Medication Administration Process Improvement Program (MAPIP).[1] MAPIP tracks the percentage of medication doses provided in a timely manner across all transfer types, administration methods (KOP, nurse-administered, directly observed therapy), prescription types, medication categories, and provider types. It also tracks the required diagnostic monitoring for psychiatric medications. These indicators assess whether patients receive timely access to prescribed medications and whether prescribing practices include appropriate safety monitoring.

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
Timely Response to Critical Non Adherence Notification (v2.0)	18%†	13%†	27%†	20%†	33%†	0%†	20%	

Timely Response to Non-Critical Med Non-Adherence Notification(v2.0)	23%	10%	8%	34%	27%	15%	19%	
Controlled Use of Force Incidents Required to Administer PC2602 Medication								0%†

✓ **Strengths**

Controlled use of force incidents required to administer PC2602 medications: was at 0%.

⚠ **Concerns**

Diagnostic monitoring is below compliance thresholds: Diagnostic monitoring (all) was at 81% for the six-month average. Antipsychotic monitoring was 85%, with lipid monitoring at 63%, thyroid monitoring at 60%, CBC at 72% and EKG at 50% completion. Mood stabilizers (all) was 69% for the six-month average with particularly low lithium (62%) and valproic acid (66%) level monitoring. Antidepressants (all) was 78% for the six-month average with antidepressant thyroid monitoring at 45% for the six-month average. These gaps matter because incomplete metabolic, hematologic, cardiac, thyroid, and serum drug-level monitoring may delay detection of medication-related adverse effects or toxicity and limit the prescriber's ability to adjust treatment safely.

Critical and non-critical medication non-adherence response compliance is problematic: Critical and non-critical medication non-adherence response was 20% and 19%, respectively. Timely response compliance averaged 20% for critical notifications and 19% for non-critical notifications; critical response fell to 0% in April and non-critical response was 15% in April. Delayed review can leave refusal, adverse effects, access barriers, or worsening illness unaddressed and may increase the risk of relapse, decompensation, crisis intervention, hospitalization, or involuntary medication procedures.

Recommendations

1. Develop a Local Process for ensuring Medication Monitoring Compliance and Timely Response to Medication Non-Adherence: See Priority Recommendations
2. Create a coverage plan: Include identification of psychiatry functions that affect access, monitoring, and medication response. Assign contingency coverage to ensure that a designated clinician reviews notifications, arranges appropriate follow-up, completes or routes necessary orders, and documents and closes the matter within the required timeframe.

Patient Safety

Patient safety metrics measure whether institutional protocols protect patients from physical harm, particularly for clinically vulnerable subpopulations such as those prescribed heat-alert medications.

Indicator	Nov 2025	6-Month Avg
Heat Related Illness Incidents for MHSDS Patients Prescribed Heat Alert Medications	0†	0†

No heat-related illness incidents and no seclusion or restraint events occurred during the reporting period.

Quality of Care

This section evaluates the clinical quality of treatment planning and documentation, focusing on interdisciplinary treatment team meetings, higher level of care reviews, and the individualization of clinical documentation. Quality of care indicators measure whether the treatment planning apparatus produces individualized, clinically informed plans through interactive process with required participants present.

Care Access

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
IDTT Patient Attendance	33%	31%	43%	35%	36%	37%	36%	
IDTT Required Staffing	71%	76%	80%	84%	70%	73%	75%	
IDTTs with Observed Interactive Process								25%†

Documentation

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
Cases w/doc. of appropriateness of LOC discussed for pts identified by 7388B as potentially requiring HLOC								44%†
EOP IDTTs Addressing Accommodations and Clinical Appropriateness for Work and Education								0%†
IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT								92%†
IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT								92%†

✓ **Strengths**

It is clear that staff genuinely care: IDTTs were rated positively in some domains: patients were treated with respect, patients were engaged with open-ended questions and were given the opportunity to provide input into their treatment plan. In the ML EOP, goals were measurable and plans were individualized.

⚠ **Concerns**

IDTT quality is deficient: IDTT patient attendance averaged 36% (range 31–43%), required staffing averaged 75% (range 70 – 84%), observed interactive process including the discussion of measurable treatment goals and case formulation was present in 25%† of cases, documentation of the appropriateness of the level of care for patients who may require a higher level of care occurred in 44%† of cases, and EOP IDTTs did not address accommodations for work and education in any (0%†) of the observed IDTTs. When attendance, staffing, interactive process, higher level of care discussion, and discussion around work and education appropriateness are lacking, the IDTT cannot achieve its intended impact.

Recommendations

1. Conduct coaching and supervision to improve IDTT processes across programs: See Priority Recommendations.

RVRs, Sentinel Events, and Specialized Custody

This section reviews rules violation reports, mental health assessments, use-of-force incidents and training, hearing officer integration of clinical input, and behavioral treatment interventions. Sentinel events indicators measure whether the intersection of custody disciplinary processes and mental health services functions as designed—with timely assessments, individualized documentation, private settings, and meaningful integration of clinical findings into hearing outcomes.

Rules Violation Reports

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
RVR MH Assessments Conducted in a Private Setting	40%	40%	27%	30%	22%	27%	31%	
Timely RVR MH Assessment Request	17%	16%	35%	23%	14%	24%	21%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	97%	97%	97%	94%	94%	98%	96%	
RVRs Issued								2,150†
RVRs Issued to Non-MHSDS Participants								28%
RVRs Issued to Patients at the Acute Level of Care								0%
RVRs Issued to Patients at the CCCMS Level of Care								64%
RVRs Issued to Patients at the EOP Level of Care								7%
RVRs Issued to Patients at the ICF Level of Care								0%
RVRs Issued to Patients at the MHCB Level of Care								1%
RVRs recommended for mitigation that were mitigated								46%†
RVRs Recommended for Mitigation with Custody Documentation								46%†

Sentinel Events and Specialized Housing

Indicator	Onsite Audits
Custody Staff Attendance at UOF Training	100%
Thermometer Checks completed and accurate	100%†
Use of Force Involving MH Patients	85%

✓ **Strengths**

Custody Housing Unit Audits were largely compliant: With the exception of one housing unit visited, Facility C (C1) third watch, staff were knowledgeable about the MH Referral process. In addition, required supplies including cut down kits, suicide prevention posters, CPR mouth shields, and heat risk lists were available as required throughout the institution.

⚠ **Concerns**

Documentation by the Senior Hearing Officer is deficient: Senior hearing officer (SHO) documentation of their consideration of the mental health assessment (MHA) recommendations regarding RVR mitigation was deficient. The sample MHAs created by the clinicians were adequate, but the SHO did not document the reasons for failing to mitigate several RVRs that were deemed to have been impacted by the patients' mental health conditions. Thirteen MHAs recommended mitigation of penalties and the SHO mitigated penalties in 6 cases or 46%. The SHOs failed to explain the decision not to mitigate and instead quoted the MHA response to question 4 or 5 as part of the adjudication of the RVR. According to policy, if the Hearing Officer does not accept the recommendations listed on the MHA, the Hearing Officer shall provide a rationale within the body of the RVR.

MH RVR assessments were not conducted in a private setting: Only 31% of MH RVR assessments were conducted in private/confidential settings. Providing a confidential space for the MH RVR assessment is valuable as it provides the patient with a secure forum for discussing and providing information related to the

event that led to the receipt of an RVR. Staff can encourage participation in a confidential setting by explaining the purpose of the assessment and the benefits of the confidential setting to the patient.

RVR MH Assessment Requests are Not Provided in a Timely Way: Only 21% of requests for a RVR MH assessment were provided in accordance with policy timeframes. There is a discrepancy between custody and mental health RVR MH assessment policies regarding timeframes. While MH policy requires all RVR MHA requests to be placed within 48 hours of violation, reporting staff (those writing the RVR) have up to 15 days to issue the RVR to the incarcerated person from the date of discovery. This often results in the timeline for RVR MHA requests to lapse prior to the completion of necessary custodial steps to submit the assessment request. This is a known issue statewide and is being discussed for a viable resolution.

Use of Force incidences involve mental health patients at a high frequency: There were 125 immediate Use of Force incidents during the review period. One hundred and six involved mental health patients (85%). At CCI, 54% of the population is included in the MHSDS, so mental health patients are significantly overrepresented among those who are subject to uses of force

Recommendations

1. Provide training to staff who participate in use of force incidents to enhance quality of interactions during encounters with the MHSDS participants: There were 125 Immediate Use of Force incidents during the review period. One hundred and six involved mental health patients (85%). At CCI, 52% of the population is included in the Mental Health Services Delivery System, indicating the mental health population is overrepresented in uses of force. Provide training to relevant staff on communication and de-escalation techniques when working with patients in the MHSDS in an attempt to reduce the frequency with which mental health patients are involved in use of force incidents. De-escalation training can be found in lesson five of the CMHPP roundtable trainings.

Restricted Housing

This section evaluates mental health services, out-of-cell programming, clinical engagement, and environmental conditions in restrictive housing units. Restricted housing indicators measure whether patients placed in the most restrictive custodial settings receive the clinical services, out-of-cell opportunities, and treatment engagement mechanisms the Program Guide requires. The RHU population includes general population, correctional clinical case management system and enhanced outpatient program patients.

Timeliness

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
Timely Transfers to RHU EOP	0%†	40%†	17%†	18%†	25%†	33%†	19%	
ICCs with Mental Health Clinicians Present and Relevant Information Provided								33%†
Initial ICCs Reviewed that were Held within 10 Calendar Days of Arrival to Restricted Housing Placement								100%

Documentation

Indicator	Nov 2025	Jan 2026	Feb 2026	6-Month Avg	Onsite Audits
Controlled Use of Force MH Assessments Meeting Documentation Requirements	0%†	0%†	0%†	0%†	
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available					88%†

Out-of-Cell Activities/Care

Indicator	April 2026	Onsite Audits
Custody Staff who can Identify all NDRH Patients		100%†
NDRH Patients Provided Personal Property		100%†
Patients in restricted housing with working entertainment appliances	100%†	100%†
Peace Officers Observed to Carry Their CPR Mouth Shield		100%
Weeks where NDRH Patients are Offered Required Phone Calls		75%†

✓ **Strengths**

Initial ICCs are held within timeframes: Initial ICCs were held within 10 calendar days of arrival to restricted housing placement. This function ensures that the patients in the most restrictive setting receive information about the nature of their placement within the designated timeframe and have a reasonable understanding of what to expect during their stay.

The chair of the ICC engaged with and used the mental health input he received: During observations of the ICCs at CCI, the Warden consistently considered MH input and incorporated this information into decisions to retain, release, or transfer patients.

Quality PT Rounds: During on-site observations in the RHU, PT rounding was observed to be conducted in accordance with the applicable requirements, and documentation was completed at cell front in real time.

⚠ **Concerns**

Transfers to RHU EOP are not happening in a timely manner: EOP patients who receive RVRs are moved to appropriate housing within policy timelines in only 19% of the cases. CCI is unable to provide the required mental health services for the RHU EOP population for various reasons that include limited access to confidential space for provision of services, and limited presence of custody staff to provide escort for the RHU patients to their MH treatment. The result is patients awaiting transfer do not receive clinically appropriate treatment.

ICC Input from the MH Clinician was lacking: During on-site observations, initial input from the MH clinician at ICCs was lacking and did not provide sufficient information to inform the committee's placement decision. The Warden sought additional information from the MH patients and the clinician who was present in the ICC, resulting in more complete information being considered in the placement decisions.

MH Documentation requirements in Controlled Use of Force are deficient: Not all documentation completed by the MH clinicians for Use of Force incidents included the relevant clinical information. Every controlled use of force is reviewed for appropriate application. Documentation of the mental health assessment during a controlled use of force provides vital information to change of shift team members and for the review of each of these incidences.

Recommendations

1. Provide training to MH clinicians who will participate in the ICC: Remedial training for the MH clinicians who attend ICCs could improve the clinical input provided during the ICC. The Region IV staff will reach out to the institutional MH leadership to support this training endeavor.
2. Provide training to mental health staff who participate in use of force incidents to produce and enhance quality of documentation during uses of force: Provide mental health staff focused training on completing and documenting the mental health assessment that is performed during controlled use of force incidents, review all documentation for controlled uses of force monthly, and report the results to the Mental Health Program Subcommittee until sustained compliance is achieved.

Suicide Prevention

This section evaluates the institution's suicide prevention infrastructure, including suicide risk evaluations, safety planning, MHCB clinical practices, crisis intervention, welfare checks, temporary holding cell compliance, training delivery, and post-discharge continuity. Suicide prevention indicators measure whether the clinical, custodial, and administrative components of the prevention continuum identify, respond to, monitor, and follow up with patients at risk of self-harm. Detailed findings from the Receiver's Compliance Team and Regional SPRFIT Review are attached as Appendix B.

Automated Data Collected During the Reporting Period							
Indicator	**Nov 2025**	**Dec 2025**	**Jan 2026**	**Feb 2026**	**Mar 2026**	**Apr 2026**	**6-Month Avg**
Discharges from MHCB with clinician review of d/c summary	100%†	0%†	50%†	100%†	100%†		63%
Documentation of Acute/ICF Discharges with Clinician-to-Clinician Contact within 5 days	50%†						50%†
Emergent and Urgent MH Referrals That Result in SREs	89%	87%	93%	95%	91%	94%	92%
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training	0%	44%	84%	84%	87%	96%	70%
Safety Plans Signed Timely	42%†	58%†	82%†	75%†	74%†	76%	69%
Timely Clinical Follow-Ups (V2.0)	35%	41%	32%	78%†	69%	58%	53%

Onsite Data Collected During April and June		
Indicator	**Apr 2026**	**Jun 2026**
Audited Security Welfare Checks in Restricted Housing That Included the Required Visual Observation	100%	
Custody Staff with CPR Training	100%	
Custody Staff with Suicide Prevention Training		100%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories	86%†	
Nursing Staff Current with CPR Training	100%	
Observed Initial Health Screenings	100%†	
RHU Intake Incarcerated Persons Appropriately Housed	0%†	50%†

✓ **Strengths**

SPRFIT meeting minutes: Review of the minutes for the reporting period found that, although meetings lacked a quorum in January and February 2026, the meetings included discussion of compliance data, improvement projects, as well as the status of corrective actions to address previous reviews. The minutes also documented tracking of and brief review of patients in the SRMP.

SPRFIT subcommittee observation: SPRFIT subcommittee on April 21st was observed via Microsoft Teams for CCI. Discussion was comprehensive and the team engaged in a good qualitative discussion.

Holding Cell Logs: Examination of hundreds of Temporary Holding Cell (THC) Logs for the three facilities (A, B, and C) that utilized THCs during the review period found that only two individuals were confined in the cells for danger to self (DTS) in excess of four (4) hours.

Alternative Housing: Alternative housing continued to be utilized on a daily basis at CCI. For the six-month period of November 1, 2025 through April 30, 2026, there were 215 patients placed in alternative housing. They were evenly distributed between clinic wet holding cells and designated OHU cells. All patients were released within 24 hours.

Crisis Intervention Team (CIT): Three CIT responses were observed during the onsite assessment. All CIT members were present, and the patients were seen in confidential settings. All documentation, including the required SREs, was completed appropriately.

LOP Review: Both the suicide prevention and bad news policies are consistent with current statewide policy. All required suicide-prevention LOPs were current.

⚠ Concerns

New Intake Cell Housing: Similar to the previous assessment, the SPRFIT audit found individuals housed in RHU (B-8) new intake cells beyond the 72-hour maximum allowance, and three individuals within their first 72 hours housed in dangerous, non-intake cells in the Overflow RHU (B-7). Prior to the conclusion of the SPRFIT tour, the institution initiated bed moves for each of the three IPs housed out of compliance. Upon return to the institution, with review of the same items, the institution had made progress. There were eight IPs in intake cells, and there were no IPs in overflow housing that required an intake cell. The existing corrective action plan should remain open.

Training compliance rates were low: CCI was noted to have low completion percentages for suicide related trainings across the board. Training rates were noted to be: Understanding and Assessing the Presence, Severity, and Risk of Suicidality: 87.23%, SRE Mentoring: 67%, Safety Planning: 79.17%, Suicide Risk Management Program (SRMP): 55.32%, Complex Cases: 85%. The combined SRE Mentoring and Biennial training is at 70% compliance. The SPRFIT Power BI report indicator for SRE mentoring requires completion of both SRE mentoring and the biennial SRE training. The biennial SRE training was paused for over a year, thus, the Power BI report provides inaccurate overall compliance on this measure. Individual SRE mentoring and biennial training compliance are included in this report; the data may not be accurate due to the pause. Low staff training is of particular concern as this may result in staff being ill equipped to effectively do their job, engage in patient care, and avoid liability.

Second Watch Morning Meeting: The second watch morning meeting for the RHU was observed by the Receiver's Compliance Team (RCT) on April 29, 2026. The meeting started on time and all required members were present with representatives from custody, medical, and mental health staff in attendance. All high risk and new arrivals were discussed, however, there was very little interdisciplinary discussion noted. The meeting as observed met all requirements; however, the value of the information presented could be enhanced with more collaborative discussions amongst team members.

Safety Plans: CCI averaged 69% compliance with safety plans signed timely during the reporting period. Since January 2026, compliance scores dropped slightly and have remained in the mid-seventies for the last three months.

Clinical Discharge Follow-Ups: A review of 30 charts for patients who had their MHCB referrals rescinded found that only 53% (16 of 30) had all 5 days of the clinical follow-up consistently completed, and only 56% (17 of 30) of safety plans completed, most of which were of low quality.

Discharges from MHCB with clinician review of discharge summary: There was significant improvement in the proportion of cases where clinicians documented review of patient discharge summaries in the last two months. Though the six-month average was at 63% (N=8), February and March showed an increase from the 0% and 50% of December and January back to 100% completion.

SRMP: CCI's new SPRFIT coordinator does not have a good manual tracking system in place but was actively pursuing a way to track participants. At the time of the audit, only one individual was identified as being in SRMP. Until an effective manual tracking system is put in place, there will likely be missed opportunities to place, monitor, and remove individuals in SRMP.

Documentation of Acute/ICF Discharges with Clinician-to-Clinician Contact within 5 days: There were only two cases for review during the reporting period, one met criteria and one did not.

MHCB Daily Provider Contacts (v.2.0): Fourteen cases were included in the review period, nine did not meet review criteria. The items that were found to be non-compliant were completed, but were completed after the compliance due date.

Recommendations

1. Improve compliance and prioritize suicide related trainings: Improve compliance via attendance for suicide prevention related training, this includes SRE mentoring, safety planning, Understanding and Assessing the Presence, Severity, and Risk of Suicidality, SRMP, and Complex Cases.
2. Improve completion rates of 5-day clinical follow-ups and corresponding safety plans: Ensure that the mental health staff are aware of the importance of 5-day follow-ups as well as developing a system where these can be tracked and monitored for completion.
3. Ensure the mental health staff have a good understanding of the safety planning policy and when it is required: Provide training on the safety planning policy to the mental health staff, including documentation of attendance.
4. Reinforce existing corrective action plan: Identify and implement permanent, sustainable solutions to the inappropriate placement of RHU new intake patients in non-new intake cells.

Sustainable Process and Utilization Review

This section evaluates MHCB utilization review processes, including clinical stay compliance with established timeframes and the timeliness of transfers to crisis-level care. Sustainable process indicators measure whether MHCB admissions proceed through acute stabilization and discharge planning at the pace the clinical model requires, and whether patients requiring crisis-level care are transferred without avoidable delays. Detailed findings from the Regional Sustainable Process Review are attached as Appendix D.

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
Timely Transfer to MHCB (v2.0)	100%†	100%†	100%†	100%†	100%	100%	100%

✓ **Strengths**

IDTT quality: Overall, teams were observed to be sensitive to and knowledgeable of their patients' mental health needs despite not meeting all the CQI IDTT audit criteria and HQ standards of Higher Level of Care (HLOC) documentation quality.

⚠ **Concerns**

Sustainable process data review: HQ reviewed 22 cases in this quarter's Higher Level of Care considerations documentation audit: 27% (six cases) were identified as "good" and 73% (16 cases) were identified as "unacceptable." CCI's HLOC documentation quality declined by 11% this quarter.

Mental Health Program Subcommittee (MHPS) minutes: MHPS meeting minutes were reviewed for the months of January, February, and March 2026. The IPC was in attendance for all meetings and a quorum was met. Table V was not embedded in the minutes, and there were no documented discussions related to sustainable process. This was discussed with the Chief Psychologist and IPC prior to this on-site visit, and both reported

discussions are taking place in the MHPS meetings, however it is unclear why the discussions are not documented in the minutes. The importance of ensuring sustainable process related items are documented in the MHPS minutes was reiterated to the IPC during this on-site visit.

Recommendations

1. Continue concerted efforts in improving HLOC Considerations documentation: The IPC should continue to provide feedback to MHPCs on the quality of HLOC Considerations documentation according to HQ standards. Maintain a tracking system of the quality of HLOC Considerations documentation assessed by the IPC during monthly local audits to identify barriers and trends and modify interventions as needed.
2. Table V in MHPS Minutes: Ensure MHPS minutes contain Table V along with discussions related to sustainable process. Proof of practice will be review of the July MHPS minutes which shall be uploaded to the MHPS SharePoint site upon approval.

Staffing

This section assesses the fill rates for clinical and supervisory mental health positions, training completion across disciplines, and the relationship between staffing levels and service delivery outcomes. Staffing indicators measure whether the institution maintains the workforce capacity and competency infrastructure required to deliver clinical services at the frequency and quality the Program Guide requires.

Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief Psychologist	2.0	2.0	0%
Chief Psychiatrist	1.0	0.0	100%
Senior Psychiatrist (Supervisor)	NA	NA	NA
Senior Psychologist (Supervisor)	2.5	3.0	0%
Supervising Psychiatric Social Worker I	1.0	1.0	0%
Senior Psychologist (Specialist)	3.75	2.50	33%
Recreation Therapist	4.25	2.5	42%
Staff Psychiatrist	6.00	7.38	0%
Psychologist – Clinical	3.5	3.5	0%
Clinical Social Worker	1.0	1.0	0%
Primary Clinician (PC)	25.25	20.19	20%
PC: Psychologist – Clinical		5.47	
PC: Clinical Social Worker		11.74	
PC: Marriage and Family Therapist		2.97	
PC: Professional Clinical Counselor		0.0	

The figures in this table come from the monthly Mental Health Staffing, Allocated and Filled reports published on the CCHCS public website (https://cchcs.ca.gov/reports/). The institution's allocated and filled positions are pulled from each of the six monthly reports covering the review period. Table figures are six-month averages, and the functional vacancy rate is (Average Allocated − Average Filled) ÷ Average Allocated.

Filled counts include telehealth and registry providers: Staff Psychiatrist combines onsite and tele-psychiatry, MHPC combines onsite and tele-clinicians, supervisory social work combines Supervising Psychiatric Social Worker I and II, and Recreation Therapist includes registry staff. The Primary Clinician discipline breakdown is published as filled positions only, so those rows show no allocation.

✓ **Strengths**

Increased fill rate during the reporting period: CCI increased the fill rate in most classifications over the course of the reporting period.

⚠ Concerns

Fill rate vs. Supervision Requirements: The Chief Psychiatrist position, which was vacant during the reporting period, has been filled. The previous Chief of Mental Health retired, resulting in a Chief Psychologist vacancy. The fill rate for positions staffed by unlicensed staff who require supervision also increased, despite ongoing vacancies in the supervisory classifications needed to provide that supervision.

Recommendations

1. Prioritize filling senior psychologist specialist, mental health primary clinician, and recreation therapist vacancies: Focus recruitment efforts on obtaining interest from and qualified applicants for the recreation therapy, mental health primary clinician, and senior psychologist specialist roles. There are systemwide challenges in recruiting and retaining onsite clinical staff in remote locations. This is identified as a structural barrier, wherein the Receiver will take the lead in developing and implementing a resolution.

Receiver's Signature Page

Date: 9/11/26

Appendix A: Acronyms and Initialisms

Acronym List	
AIMS	Abnormal Involuntary Movement Scale
APPIC	Association of Psychology Postdoctoral and Internship Centers
ASP	Avenal State Prison
APP	Acute Psychiatric Program
ASH	Atascadero State Hospital
AVSS	Audio/Video Surveillance System
BPT	Board of Prison Terms
C&PR	Classification and Parole Representative
CAL	Calipatria State Prison
CAP	Corrective Action Plan
CC I	Correctional Counselor I
CC II	Correctional Counselor II
CCAT	Correctional Clinical Assessment Team
CCCMS	Correctional Clinical Case Management System
CCHCS	California Correctional Health Care Services
CCI	California Correctional Institution
CCWF	Central California Women's Facility
CDCR	California Department of Corrections and Rehabilitation
CEN	Centinela State Prison
CEO	Chief Executive Officer
CHCF	California Health Care Facility
CHSA	Correctional Health Services Administrator
CIM	California Institution for Men
CIT	Crisis Intervention Team
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
CMH	Chief of Mental Health
CNE	Chief Nurse Executive
COR	California State Prison, Corcoran
CPR	Cardiopulmonary Resuscitation
CQIR	Continuous Quality Improvement Report
CQIT	Continuous Quality Improvement Tool
CQI	Continuous Quality Improvement
CRC	California Rehabilitation Center
CTC	Correctional Treatment Center
CTF	Correctional Training Facility
D/C	Discharge
DAI	Division of Adult Institutions
DCHCS	Division of Correctional Health Care Services

DOT	Direct Observed Therapy
DSH	Department of State Hospitals
DTS	Danger to Self
EHRS	Electronic Health Records System
EOP	Enhanced Outpatient Program
ERRC	Emergency Response Review Committee
FIT	Focused Improvement Team
GP	General Population
HCPOP	Health Care Placement Oversight Program
HDSP	High Desert State Prison
HLOC	Higher Level of Care
HPS I	Health Program Specialist I
HQ	Headquarters
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Interdisciplinary Treatment Team
IRU	Inpatient Referral Unit
ISP	Ironwood State Prison
IST	In-Service Training
ISUDT	Integrated Substance Use Disorder Treatment
KOP	Keep On Person
KVSP	Kern Valley State Prison
LAC	California State Prison, Los Angeles County
LOC	Level of Care
LOP	Local Operating Procedure
MA	Medical Assistant
MAPIP	Medication Administration Process Improvement Program
MCSP	Mule Creek State Prison
MH	Mental Health
MHA	Mental Health Administrator
MHCB	Mental Health Crisis Bed
MHCT	Mental Health Compliance Team
MHMD	Mental Health Medical Doctor (Psychiatrist)
MHPC	Mental Health Primary Clinician
MHPS	Mental Health Program Subcommittee
MHSDS	Mental Health Services Delivery System
ML	Mainline
ML CCCMS	Mainline Correctional Clinical Case Management System
ML EOP	Mainline Enhanced Outpatient Program
MOU	Memorandum of Understanding
MSF	Minimum Support Facility
MSW	Master of Social Work
NA	Nurse Administered

NDRH	Non-Disciplinary Restricted Housing
NDPF	Non-Designated Programming Facility
NKSP	North Kern State Prison
OA	Office Assistant
OHU	Outpatient Housing Unit
OT	Office Technician
PBSP	Pelican Bay State Prison
PBST	Positive Behavior Support Team
PC	Primary Clinician
PIP	Psychiatric Inpatient Program
PSR	Program Status Report
PT	Psychiatric Technician
PVSP	Pleasant Valley State Prison
QIP	Quality Improvement Plan
QIT	Quality Improvement Team
QMSU	Quality Management Support Unit
R&R	Receiving and Release
RC	Reception Center
RHU	Restricted Housing Unit
RHU CCCMS	Restricted Housing Unit Correctional Clinical Case Management System
RHU EOP	Restricted Housing Unit Enhanced Outpatient Program
RHU GP	Restricted Housing Unit General Population
RJD	Richard J. Donovan Correctional Facility
RT	Recreation Therapist
RVR	Rules Violation Report
RVR-MHA	Rules Violation Report – Mental Health Assessment
SAC	California State Prison, Sacramento
SATF	Substance Abuse Treatment Facility
SCC	Sierra Conservation Center
SHO	Senior Hearing Officer
SNY	Sensitive Needs Yard
SOL	California State Prison, Solano
SOMS	Strategic Offender Management System
SPRFIT	Suicide Prevention and Response Focused Improvement Team
SQRC	San Quentin Rehabilitation Center
SRASHE	Suicide Risk and Self Harm Evaluation
SRE	Suicide Risk Evaluation
SRMP	Suicide Risk Management Program
SRN II	Supervising Registered Nurse II
SRN III	Supervising Registered Nurse III
SVPP	Salinas Valley Psychiatric Program
SVSP	Salinas Valley State Prison
T4T	Training for Trainers

TCMP	Transitional Case Management Program
TTA	Treatment and Triage Area
UM	Utilization Management
UOF	Use of Force
VPP	Vacaville Psychiatric Program
VSP	Valley State Prison
WSP	Wasco State Prison

Appendix B: Suicide Prevention Report

Restricted Housing Unit (RHU)

Psychiatric technician rounds were assessed by nursing auditors. Practices were observed to be adequate. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

Intake Cells
There were a total of 11 designated New Intake Cells (A101-A106; B101-B105) in the B-8 RHU. These cells were previously found to be suicide resistant. On April 28, the Review Team observed that one (1) of the new intake cells was empty, four (4) cells were correctly occupied with new intake patients, and the remaining six cells were being occupied by patients who were beyond their 72-hour requirement for those cells. In addition, there were eight (8) newly admitted patients on new intake status. Of those, one (1) was double-celled, one (1) was inappropriately housed in a non-intake cell in B-8, and the remaining six (6) patients were inappropriately housed in non-intake cells in B-7, the Overflow RHU that reopened in late 2025.

Similar to the 2025 assessment, there continued to be problematic practices at CCI regarding inappropriate placement of new intake patients in the RHU. During that previous assessment, the B-7 unit had been utilized as an RHU Overflow and did not have any new intake cells nor the capability for Guard One electronic surveillance. In addition, a practice was observed whereby when patients were designated for the RHU, but the unit was full, they would be "Confined to Quarters" (CTQ) in their existing housing unit until an RHU bed in B-8 was available. This practice was problematic for several reasons, including patients remaining housed in non-suicide-resistant new intake cells, and documentation of observation conducted without Guard One surveillance.

Of note, the use of "Confined to Quarters" (CTQ), whereby patients designated for RHU, but the unit was full, remained in their existing housing unit until an RHU bed was available, was discontinued in late 2025, and patients were transferred to either B-8 or B-7 (Overflow).

Second Watch Morning Meeting
The second watch morning meeting for the RHU GP was observed by the RCT on April 29, 2026. The meeting started on time and all required members were present with representatives from custody, medical and mental health staff in attendance. All high risk and new arrivals were discussed, however, there was very little interdisciplinary discussion noted. Required information was presented, however there was no valuable discussion or collaboration amongst the members.

Access to Entertainment Appliances
Lieutenants on the RCT reviewed access to entertainment appliances during this review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Welfare Check Completion (Guard One)
Guard 1 checks for RHU in March 2026 were within compliance at 90 percent. A portion of RHU Guard 1 checks was observed by MHCT during this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

RHU Pre-Screening (Pre-Placement)
RHU pre-placement screenings were observed by nursing as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

RHU GP Screenings (Post Placement)
RHU GP screenings were observed by nursing as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Inpatient Units

Suicide-Resistant Cells
CCI does not have an Inpatient Unit, therefore, this section was not reviewed.

Quality of Safety Planning
CCI does not have an Inpatient Unit, therefore, the quality of safety planning for patients discharged from an MHCB unit was not reviewed. However, a review of 15 patients who had their MHCB referrals rescinded found that only 47 percent (7 of 15) had safety plans completed, and most were assessed as inadequate.

MHCB Supervisory Review of Discharge Safety Plans
CCI does not have an Inpatient Unit, therefore, this section was not reviewed.

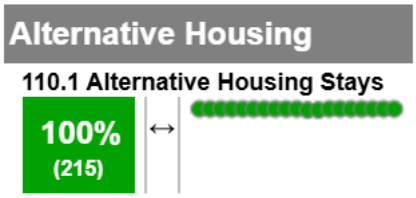
Suicide Watch and Suicide Precaution
CCI does not have an Inpatient Unit, therefore, this section was not reviewed.

Observation and Issue Orders
CCI does not have an Inpatient Unit, therefore, this section was not reviewed.

Privileges
CCI does not have an Inpatient Unit, therefore, this section was not reviewed.

Clinical Discharge Follow-ups
A review of 30 charts for patients who had their MHCB referrals rescinded found that only 53 percent (16 of 30) had all 5 days of the clinical follow-up consistently completed, and only 56 percent (17 of 30) of safety plans completed, most of which were of low quality.

Alternative Housing



Alternative Housing cells, which are used to temporarily house patients awaiting MHCB placement are located in two designated cells (No. 14. and No. 15) within the OHU or spread out in the three facilities, normally in nine (9) “clinic holding cells” within the TTAs in Facility A (No. 119 thru 122), Facility B (No. 119 thru 122, with 122 redlined), and Facility C (No. 4).

Alternative housing continued to be utilized daily at CCI. For the six-month period of November 1, 2025 through April 30, 2026, there were 215 patients placed in alternative housing, distributed amongst clinic wet holding cells and designated OHU cells. All were released within 24 hours. Similar to the previous assessment, more than one third (38 percent, 82 of 215) of the cases resulted in the MHCB referrals being rescinded and patients returned to their housing units. Medical chart review of 15 rescinded cases found that only 80 percent (12 of 15) had the required SREs (with an additional case incorrectly having the SRE reassessment form, not the full SRE),

and only 43 percent (6 of 14) of the applicable daily clinical follow-ups for each of the five required days were completed.

Finally, examination of hundreds of Temporary Holding Cell (THC) Logs for the three facilities (A, B, and C) that utilized THCs during the review period found that only two individuals were confined in the cells for DTS in excess of four (4) hours.

Suicide Risk Management Program (SRMP)

CCI'S Local Operating Policy (LOP) for the SRMP program was reviewed and found to be consistent with the most recent SRMP guidelines.

During the audit, data discrepancies were discovered between the On Demand reports and the EHRS. As a result, the On Demand report has been temporarily suspended while the issue is escalated to the Headquarters Reporting Unit for resolution. Currently, CCI's new SPRFIT coordinator does not have a good manual tracking system in place but was actively pursuing a way to track it. At the time of the audit, only one individual was identified as being in SRMP. Until an effective manual tracking system is put in place, there will likely be missed opportunities to place, monitor and remove individuals in SRMP. Additionally, this tracking system is essential as it will aid in the development of goals and interventions for suicidality in the SRMP tab of the Master Treatment Plans.

Custody Inpatient Discharge Follow-ups

The process by which patients were provided Discharge Custody Checks at 30-minute intervals following release from either a MHCB or alternative housing placement was not reviewed during this assessment because of a CCHCS directive dated June 8, 2026 that stated: "The overall audit and reporting of the MH 7497s (paper and electronic) indicators have been paused to allow for updates to the audit questions associated with the new Web-App based digital process."

Institutional SPRFIT Committee

The SPRFIT Subcommittee at CCI was observed on April 21, 2026, via Microsoft Teams. This meeting met quorum, with all required voting members being present, and started on time. Discussion was comprehensive and qualitative. They covered all main points including self-harm data, quality of SREs, 5-day clinical follow ups, safety planning, discharge custody checks, alternative housing, review of serious attempts and CAPs.

A review of six months of SPRFIT meeting minutes (November 2025 through April 2026) found that meetings had quorums of all required mandatory members or designees for four months, with psychiatric technicians absent for the January and February 2026 meetings. Meeting minutes included discussion on compliance data, improvement projects, as well as the status of corrective actions based upon prior Receiver's suicide prevention expert assessments and regional SPRFIT audits. In addition, meeting minutes included tracking and brief review of patients in the SRMP. All required suicide-prevention LOPs were current. In sum, 4 of 5 SPRFIT compliance areas were assessed as adequate.

In addition, although the SPRFIT coordinator provided data in which they attended family council and advisory council meetings within the past six months, documentation of such, including discussion, was not included in meeting minutes. Placement of suicide prevention posters were also not documented in meeting minutes.

Policies

CCI has a local suicide prevention policy (Suicide Prevention and Response, LOP No. 12.10) that addresses required Suicide Prevention trainings, Discharge Custody Check requirements, and documentation of self-harm events, as well as local policies to address receipt of bad news, and Crisis Intervention Team procedures.

It was most recently revised in December 2025. Of note, the LOP incorrectly allows a Senior Psychologist Supervisor to be a designee for the Chief Psychiatrist and should be revised. Other local policies were reviewed to verify that recent statewide memorandums related to suicide prevention have been incorporated, and policies have been updated annually. The Alternative Housing policy (LOP No. 12.5.1) was last revised in July 2025.

Severe Self-Harm

Per the On Demand Self-Harm Report, there were a total of 62 self-harm incidents at CCI during the reporting period. Of these, there were 19 incidents with no apparent injury, 35 of the incidents were noted to be rated as low injury severity, seven (7) moderate, and one (1) as severe. In addition, 29 of the incidents were noted to be as a result of lacerations, which continues to be the highest trending method of self-harm. Finally, 29 of the incidents involved patients at EOP level of care, and 27 occurred in the CCCMS program.

Suicide Risk Evaluations

Quick List: CCI
Suicide Risk Evaluation from 11/01/25 thru 4/30/26
Placement: ASU,ASU EOP Hub,Condemned,IN_TRANSIT,Institution Wide,LTRH,MHCB,ML,ML CCCMS,ML EOP,PSU,RC,RC CCCMS,RC EOP,RHU,RHU CCCMS,RHU EOP,SHU,STRH
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	Measurements	Time Overdue (Days)	Compliance
Suicide Risk Evaluation	329	10.7	69%
SRE at MHCB referral for DTS	189	0.2	76%
SRE at rescission of MHCB referral for DTS	79	3.0	89%
SRE following MHCB Discharge (CCCMS and Non-MHSDS) - 1st	29	55.3	10%
SRE following MHCB Discharge (CCCMS and Non-MHSDS) - 2nd	22	74.1	9%
SRE prior to discharge IDTT (MHCB)	8	0.0	100%
SRE upon arrival from StateHospital DSH	2	0.0	100%

Timelines for Suicide Risk Assessment

The Suicide Risk Evaluation indicator on the Performance Report for CCI was reviewed to access information related to the compliance of suicide risk evaluations for admission to, and discharge from, mental health crisis beds. It was also utilized to determine the completion of suicide risk evaluations for rescinded MHCB referrals based upon Alternative Housing Placement.

Based on the review, a total of 189 referrals for placement in an MHCB for DTS were completed during the review period. Of those, 143 had suicide risk evaluations completed timely, resulting in 76 percent compliance. Of the MHCB rescissions, 70 of the 79 required Suicide Risk Evaluations were completed timely, resulting in 89 percent compliance. Overall, the only measure that requires immediate improvement in this area is SREs when a patient is referred for placement in an MHCB. The other measure for an SRE at rescission should be monitored closely to not fall below compliance.

Urgent and Emergent Consults for Danger to Self (DTS)

A review of the Emergent and Urgent MH Referrals that Result in SREs indicator in On Demand indicated good compliance rates for referrals in which “self-harm/suicidal bx or ideation/DTS” or “intentional drug overdose” was selected as the reason for emergent referrals. From October 1, 2025, to March 31, 2026, CCI had below compliance rates for completion of a SRE (2/4 cases) after an Urgent Mental Health Consult for Self-harm/Suicidal Behavior or ideation/DTS. These SREs were signed more than 12 hours after initiation of the consult order, resulting in lowered compliance rates.

Quick List: CCI
Emergent and Urgent MH Referrals That Result in SREs from 11/01/25 thru 4/30/26
Placement: ASU,ASU EOP Hub,Condemned,IN_TRANSIT,Institution Wide,LTRH,MHCB,ML,ML CCCMS,ML EOP,PSU,RC,RC CCCMS,RC EOP,RHU,RHU CCCMS,RHU EOP,SHU,STRH
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	Measurements	Hour Overdue	Compliance
Emergent and Urgent MH Referrals That Result in SREs	648	21.1	92%
SRE after Emergent MH Consult for Self-harm/Suicidal Behavior or ideation/DTS	646	21.1	91%
SRE after Emergent MH Consult for suspected intentional drug overdose	1	0.0	100%
SRE after Urgent MH Consult for Self-harm/Suicidal Behavior or ideation/DTS	1	0.0	100%

Urgent and Emergent Consults not for Danger to Self (DTS) but Requiring an SRE
Examination of approximately 50 charts for emergent/urgent Mental Health Referrals not marked for DTS found 15 cases that required an SRE during the review period, and 87 percent (13 of 15) of these cases had the SRE completed.

Emergency Response

Cut-Down Kits
The Mental Health Compliance Team reviewed cut down kits as part of this review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Quality Improvement Plans (QIPs) Generated by Suicide Case Reviews

There were zero QIPs that remained open from suicides which occurred prior to CCI's last site visit. Additionally, there were no deaths by suicide that resulted in a QIP at CCI during the review period.

Training and Mentoring Compliance

Compliance with the Annual IST Suicide Prevention Training for 2025 was the following: 99 percent of custody staff, 88 percent of medical staff, and 89 percent of mental health staff.

Compliance with Coleman training requirements is mostly below the expected compliance rate for suicide prevention trainings, as seen below. Training compliance for CCI as of March 2026 is as follows:

- Understanding and Assessing the Presence, Severity, and Risk of Suicidality: 87.23%
- SRE Mentoring: 67%
- Safety Planning: 79.17%
- Suicide Risk Management Program (SRMP): 55.32%
- Complex Cases: 85%
- Nursing CPR: 100%
- Custody CPR: 100%

It should be noted that the institution recently underwent a transition in coordinators and the newly assigned SPRFIT coordinator has an additional role as the training coordinator.

Annual IST Suicide Prevention Training – Observation

The annual IST suicide prevention training was not observed as part of this review.

Receiving and Release (R&R) Screening

R&R screening was observed by nursing as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Reception Center Processing

CCI does not have a Reception Center.

Crisis Intervention Team (CIT)

The Crisis Intervention Team was launched at CCI in February 2020, paused for a few years, and then reactivated in 2025. The current LOP (12.01.700, revised November 2025) indicated that the CIT was available Monday through Friday from 8:00 a.m. until 5:00 p.m. Facility clinicians responded to crisis calls outside of CIT hours.

Three CIT responses were observed during the onsite assessment. All CIT members were present and the patients were seen in confidential settings. All documentation, including the required SREs, was completed appropriately. Of note, the responding nurse in one of the cases did not have valuable input as they seemingly did not fully understand their CIT role.

Active Corrective Action Plans (CAPs)

As noted in the table below, CAPs assigned from the previous SPRFIT report in June 2025 are in various stages of completion. Unless otherwise noted, all CAPs will remain open until the next site visit. CAPs marked as "completed" are considered closed and will not be carried forward into future reports.

Problem	Current Status
1. Concerns were noted with the RHU intake process (i.e. incarcerated persons in intake cells longer than 72 hours, open intake cells, CTQ process, lack of Guard One documentation for CTQ people, etc.). **This concern was also identified in the HQ SPRFIT Coordinator report dated May 21, 2025.**	Despite long-standing efforts at corrective action, the inappropriate placement of new intake patients in dangerous, non-suicide-resistant cells within the RHU and RHU Overflow housing continues to be problematic and a permanent, sustainable solution is warranted. As noted above, the use of "Confined to Quarters" was discontinued in late 2025.
2. Previous audits noted concerns with low Guard One compliance (<90%). **This concern was also identified in the HQ SPRFIT Coordinator report dated May 21, 2025.**	The current review found that Guard One compliance was over 90 percent, therefore, this CAP **is completed.**
3. A previous audit reported 5 charts reviewed for patients in alternative housing, observation records (holding cell logs) were found for only one patient. It was identified custody staff are not utilizing the CDCR 7365 Suicide Watch/Suicide Precaution form when conducting suicide watch.	The current review found substantial improvement, i.e., examination of Temporary Holding Cell (THC) Logs found that only two individuals were confined in the cells for DTS in excess of four (4) hours. This CAP will remain open for determination of sustainability.

4. Various issues were identified with the completion of SREs when required by statewide policy (i.e. completing the abbreviated SRE for MHCB rescissions, completing abbreviated SREs when no full SRE was completed within 30 days for urgent/emergent referrals, etc.). **This concern was also identified in the HQ SPRFIT Coordinator report dated May 21, 2025.**	The current review found that SREs were not consistently completed for rescinded MHCB referrals as required. There were also concerns regarding timely SREs for MHCB placement. This CAP will remain open.
5. There were concerns identified with issue and observation orders (see alternative housing section of this report).	The current review did not find any concerns with issue and observation orders, therefore, this CAP **is completed.**
6. Previous audit revealed that, although the CIT observed on-site had nursing present, chart review indicated multiple instances of nursing not being present during CIT events. The CIT reporting tool indicated nursing was absent from 13 of 34 CIT events for May 2025. This concern was also identified in the HQ SPRFIT Coordinator report dated May 21, 2025	Although the current review found there was a nursing response to each of the three observed CIT responses, the participation of nursing in one case was concerning. This CAP will remain open for determination of sustainability.
7. A previous audit noted that of 20 charts of rescinded MHCB referrals reviewed, 4 did not have the required safety plan and 12 did not have adequate safety plans.	The current review continued to find problems with both completion and adequacy of safety planning. This CAP remains open.
8. A previous audit indicated page 1 compliance as 67% and page 2 compliance as 74% for Discharge Custody Checks for December 2024 to May 2025. This concern was also identified in the HQ SPRFIT Coordinator report dated May 21, 2025.	The process by which patients were provided Discharge Custody Checks at 30-minute intervals following release from either a MHCB or alternative housing placement was not reviewed during this assessment because of a CCHCS directive dated June 8, 2026 that stated: “The overall audit and reporting of the MH 7497s (paper and electronic) indicators have been paused to allow for updates to the audit questions associated with the new Web-App based digital process.” This CAP remains open.

As a result of this review, the following action is recommended to the California Correctional Institution (CCI):

Table 2. Status of Recommendations		***Progress***
Recommendation 1	1.Improve compliance and prioritize suicide related trainings to achieve and sustain 90% compliance or above. This includes SRE mentoring, safety planning, Understanding and Assessing the Presence, Severity, and Risk of Suicidality, SRMP, and Complex Cases.	***New recommendation***

Appendix C: MAPIP

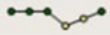
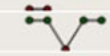
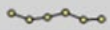
INSTITUTION 6 MONTH TREND

California Correctional Institution (CCI)

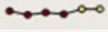
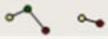
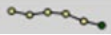
April 2026

Population Health Management	6 Months	Trend	NOV	DEC	JAN	FEB	MAR	APR
Diagnostic Monitoring (All)	**81%**		**80%**	**79%**	**82%**	**84%**	**83%**	**79%**
QT Prolongation EKG 12 Months	82%		75%	67%	60%	100%	100%	100%
Antipsychotics (All)	85%		82%	84%	86%	89%	87%	82%
Lipid Monitoring	63%		53%	65%	61%	78%	74%	51%
Blood Sugar	77%		68%	81%	81%	88%	79%	69%
EKG	50%		100%	-	-	-	0%	-
AIMS	75%		68%	65%	84%	83%	69%	88%
Med Consent	91%		90%	94%	85%	93%	91%	94%
CBC with Platelets	72%		50%	70%	73%	70%	93%	67%
CMP	82%		57%	71%	100%	91%	93%	73%
Thyroid Monitoring	60%		83%	58%	64%	75%	60%	41%
Blood Pressure	99%		98%	100%	100%	97%	100%	98%
Height	99%		100%	98%	98%	97%	100%	98%
Weight	99%		98%	100%	100%	97%	100%	98%
Pregnancy	-		-	-	-	-	-	-
Clozapine (All)	100%		-	-	-	-	100%	-
Blood Sugar	-		-	-	-	-	-	-
Lipid Monitoring	100%		-	-	-	-	100%	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
EKG	-		-	-	-	-	-	-
AIMS	-		-	-	-	-	-	-
Thyroid Monitoring	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Blood Pressure	-		-	-	-	-	-	-
Height	-		-	-	-	-	-	-
Weight	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-

CCI CQI Report | 2026

Mood Stabilizers (All)	69%		71%	63%	71%	67%	77%	67%
Carbamazepine (All)	100%		-	-	100%	-	-	-
Carbamazepine Level	100%		-	-	100%	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-
Valproic Acid (All)	66%		73%	62%	63%	55%	76%	60%
Med Consent	74%		67%	100%	100%	100%	67%	33%
Blood Pressure	97%		88%	100%	100%	100%	100%	100%
Height	100%		100%	100%	100%	100%	100%	100%
Valproic Acid Level	15%		20%	0%	0%	20%	25%	33%
CBC with Platelets	34%		50%	50%	0%	17%	50%	0%
CMP	38%		50%	50%	0%	20%	60%	0%
Weight	94%		100%	100%	100%	75%	88%	100%
Pregnancy	-		-	-	-	-	-	-
Lithium (All)	62%		71%	47%	70%	20%	81%	42%
Lithium Level	36%		0%	60%	0%	50%	100%	0%
Thyroid Monitoring	40%		50%	0%	50%	0%	60%	0%
CMP	33%		67%	0%	67%	0%	50%	0%
CBC	50%		100%	-	0%	-	0%	-
EKG	33%		-	0%	0%	-	100%	-
Med Consent	83%		-	100%	100%	0%	100%	100%
Height	100%		100%	100%	100%	-	100%	100%
Weight	100%		100%	100%	100%	-	100%	100%
Pregnancy	-		-	-	-	-	-	-
Oxcarbazepine (All)	79%		67%	76%	80%	86%	72%	86%
CBC	67%		57%	63%	67%	75%	57%	78%
CMP	74%		63%	78%	60%	78%	71%	89%
Med Consent	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Lamotrigine - Med Consent	100%		-	-	100%	100%	-	100%
Antidepressants (All)	78%		82%	75%	78%	83%	75%	76%
EKG (Tricyclics)	100%		-	-	-	-	100%	-
Med Consent	89%		88%	88%	89%	90%	89%	92%
Thyroid Monitoring	45%		41%	36%	50%	65%	43%	31%
Pregnancy	-		-	-	-	-	-	-
Venla Blood Pressure	99%		100%	100%	92%	100%	100%	100%

CCI CQI Report | 2026

Medication Management	6 Months	Trend	NOV	DEC	JAN	FEB	MAR	APR
Medications Received Timely (All)	**80%**		**82%**	**77%**	**79%**	**78%**	**80%**	**80%**
By Transfer Type								
New Arrival to CDCR (RC) – RC	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – RHU	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – MHCB	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – CTC	-		-	-	-	-	-	-
Intra-System (Within Institutions) – GP	78%		74%	82%	71%	73%	79%	82%
Intra-System (Within Institutions) – RHU	89%		95%	90%	83%	92%	88%	88%
Intra-System (Within Institutions) – MH Inpatient	-		-	-	-	-	-	-
Intra-System (Within Institutions) – Specialized Medical	84%		72%	82%	89%	73%	94%	88%
Inter-System (Between Institutions) – GP	73%		74%	70%	72%	71%	76%	76%
Inter-System (Between Institutions) – RHU	86%		88%	89%	84%	84%	96%	67%
Inter-System (Between Institutions) – MH Inpatient	-		-	-	-	-	-	-
Inter-System (Between Institutions) – Specialized Medical	77%		80%	99%	50%	-	78%	66%
Return to CDCR – GP	81%		65%	100%	82%	88%	90%	70%
Return to CDCR – RHU	78%		-	80%	-	-	-	0%
Return to CDCR – MH Inpatient	-		-	-	-	-	-	-
Return to CDCR – Specialized Medical	97%		-	-	-	-	96%	100%
Stable Housing	80%		82%	77%	79%	78%	80%	80%
Leaving CDCR	99%		100%	98%	98%	100%	97%	100%
By Provider Type								
Psychiatry	81%		84%	79%	81%	80%	81%	81%
Medications Refused (All)	**10%**		**9%**	**11%**	**11%**	**10%**	**9%**	**8%**
By Provider Type								
Psychiatry - Refused	10%		9%	12%	11%	10%	8%	8%
Non-Formulary by Psychiatrists	**3.9%**		**4.3%**	**4.1%**	**4.3%**	**4.1%**	**3.6%**	**3.3%**

Appendix D: Sustainable Process Report

Sustainable Process Report for California Department of Corrections and Rehabilitation
CALIFORNIA CORRECTIONAL INSTITUTION (CCI)

On-Site Review
June 2 – 4, 2026

Review Periods
January – March 31, 2026

PARTICIPANTS
Statewide Mental Health Program Regional Staff
Mental Health Regional Administrator (MHRA) – Rosemary Meyers, Psy.D.
Senior Psychologist, Specialist – Diana Couto da Silva, Psy.D.
Senior Psychologist, Specialist – Brian Gotterer, Psy.D.
Senior Psychologist, Specialist – Dina Khoury, Psy.D.

Institutional Mental Health Staff
Chief Executive Officer, Health Care – Penny Shank
Chief Mental Health (CMH) - Acting (A) – Aida Cairns, Psy.D.
Senior Psychologist, Specialist – Inpatient Coordinator (IPC) – John Baird, Psy.D,

Area Reviewed: Higher Level of Care Considerations HQ Review – Prior Review 55% (Q4 2025)

CCI's 2026 Sustainable Process visit took place this quarter during their CQI+ review from June 2nd to 5th, 2026. The results of the Q1 and Q2 HLOC Considerations HQ Data Review will be summarized in this report. See the MHRA's Spreadsheet, Tab *MH Subcommittee*, for further patient-specific details.

For Q1 2026, a random sample of 21 HLOC Considerations cases were reviewed by CCI's IPC and HQ's reviewer for the quality of documentation. The results of Q1's HQ Data Review were finalized and distributed to CCI and the MH Regional Team on 02/24/26. CCI's IPC identified 43% "good" cases, and the HQ reviewer identified 38% "good" cases. On 03/03/26 CCI provided institutional follow-up of all applicable "unacceptable" cases. A total of 13 cases were identified as "unacceptable": four cases were due to insufficient treatment intervention documentation; four cases were due to insufficient narrative supporting non-referral; and three cases were due to missing documentation/a missed consideration.

For Q2 2026, a random sample of 22 HLOC Considerations cases were reviewed by CCI's IPC and HQ's reviewer for the quality of documentation. The results of Q2's HQ Data Review were finalized and distributed to CCI and the MH Regional Team on 05/26/26. CCI's IPC identified 45% "good" cases, and the HQ reviewer identified 27% "good" cases. On 05/28/26, CCI provided institutional follow-up of all applicable "unacceptable" cases." A total of 16 cases were identified as "unacceptable": five cases were due to insufficient treatment intervention documentation; five cases were due to insufficient narrative supporting non-referral; three cases were due to documentation not addressing indicator specific issues; two cases were due to clinical inconsistencies or documentation completed late.

On 06/04/26, MH Regional met with the newly (as of 05/28/26) and previously assigned IPCs to discuss limitations related to improving the quality of HLOC Considerations documentation. The previous IPC reported the main setback was the inability to provide training to an influx of new staff during the reporting period. The previous IPC reported orienting the new IPC to relevant resources and will continue to be of support during the initial transition. Also, the MH Regional Specialist indicated their ability to support him in his new role. The

new IPC and MH Regional discussed important aspects of sustainable process, including providing feedback to MHPCs on the quality of HLOC Considerations documentation according to HQ standards and maintaining a tracking system during monthly local audits to identify barriers and trends and modify interventions as needed.

Improvement Opportunities

⚠ CCI's HQ Data Review scores for HLOC Considerations have remained below 85% since Q1 2024, ranging from 0% to 68%

Follow-up is not required.

Area Reviewed: Mental Health Program Subcommittee (MHPS) Minutes

MHPS meeting minutes were reviewed for the months of January, February, and March 2026. The IPC was in attendance for all meetings and quorum was met. Table V was not embedded in the minutes, and there were no documented discussions related to sustainable process. This was discussed with the Chief Psychologist and IPC prior to this on-site visit, and both reported discussions are taking place in the MHPS meetings, however it is unclear why the discussions are not documented in the minutes. The importance of ensuring sustainable process related items are documented in the MHPS minutes was reiterated to the IPC during this on-site visit. See the MHRA's Spreadsheet, Tab *MH SubCommittee*, for further details.

Follow-up is required, due on 9/1/2026.
The CMH or designee shall:

1. Ensure MHPS minutes contain Table V along with discussions related to sustainable process. Proof of practice will be review of the July MHPS minutes which shall be uploaded to the MHPS SharePoint site upon approval.

Area Reviewed: Higher Level of Care Considerations Documentation – Prior Review 100%

A random sample of eight cases were selected from the Mental Health OnDemand Acute ICF non-referral report for IDTTs completed in the month of April 2026. Consistency was reviewed between the HLOC Considerations contained in the MH MTP and the documentation in the Electronic Health Record System (EHRS) 30 days prior to the IDTT. All eight (100%) cases reviewed demonstrated consistency with the prior EHRS documentation. See the MHRA's Spreadsheet, Tab EHRS, to review specific details.

Follow-up is not required.

Area Reviewed: Referral and Non-Referral Log

The On Demand Acute-ICF Referrals and Non-Referrals reports covering January 1st–March 31st, 2026, were reviewed. See the MHRA's Spreadsheet, Tab *MH Subcommittee*, for further details.

<u>Referral Logs</u>

Total referrals: Two ICF referrals were initiated. This number is lower than the prior quarter (Q1 2026: 5) but remains similar to the number of ICF referrals initiated over the past quarters of 2025, ranging from zero to two.

- ✓ 100% of referrals were submitted to the IRU within required timeframes.
- ✓ All referrals were accepted and ultimately transferred to PIP/DSH.
- ✓ One ICF referral was rescinded due to admission to CIM's MHCB. CCI rescinded the ICF referral and CIM re-submitted the referral as APP and patient transferred to PIP timely.

Referral source trends:

- ML EOP initiated both ICF referrals this quarter. Last quarter four ICF referrals were from ML EOP and one ICF referral was from RHU.

Since the onset of 2025, after CCI was realigned to be in Region IV, MH regional had consistently met with the IPC and the ML EOP Senior Psychologist Supervisor during each on-site sustainable process visit to discuss higher levels of care decision-making and explore continued barriers in this area. A few action items had been assigned to target this area in Q2 and Q3 of 2025. In October 2025, there was a noted increase in initiated ICF referrals in outpatient settings. In March of 2026, MH regional noted a decline in initiated ICF referrals. MH regional met with the IPC on 03/11/26 to explore potential sources of the decline, discuss how staff are responding to the process of HLOC referrals, and identify any barriers to referring patients in need of HLOC. The IPC identified various contributing factors but noted all MH staff, including managerial staff, may benefit from supplemental HLOC training by regional staff. Subsequently, on 03/18/26, MH regional met with the Chief Psychologist to discuss HLOC referrals and the Chief Psychologist requested supplemental training to be provided by MH Regional. MH Regional conducted an on-site HLOC Training for staff on May 13, 2026.

Non-Referral Logs

During the review period, there were 80 IDTT decisions not to refer to HLOC despite meeting one or more HLOC Consideration(s).

- This number is consistent with the findings at CCI for the prior two quarters (2026 Q1: 81, 2025 Q4: 85).
- Use of multiple considerations is at 25% and is higher than the range of percentages found in the prior four quarters, ranging from 15% to 23%.
- Consideration #7 (high treatment refusal of structured treatment hours offered) is the most utilized consideration at 76%. This percentage is consistent with percentages of use in the last three quarters reviewed (2026 Q1: 80%; 2025 Q4 & Q3: 76%).

Pending APP/ICF Referrals

At the time of the visit, there were no pending APP/ICF referrals.

Follow-up is not required.

Area Reviewed: Interdisciplinary Treatment Teams (IDTTs)

ML EOP

Five IDTTs were observed (three initials, two routines). All patients attended.

Key Findings

- ✓ IDTTs started on time with all required staff present, including the Senior Psychologist Supervisor serving as the lead.
- ✓ Patients were engaged by being asked open-ended questions and given an opportunity to provide input into their treatment plan.
- ✓ The psychiatrist discussed medications, symptoms, and queried for side effects when applicable.
- ✓ Goals were discussed in measurable terms.
- ✓ The CCI discussed custodial factors.
- ✓ Treatment planning was individualized and included the patient's input, such as discussing best groups to place the patient into.

Improvement Opportunities

⚠ Five different MHPCs were observed and the presentation quality varied; with certain key aspects of relevant clinical information lacking.

⚠ There was use of clinical terminology and acronyms that may not be familiar to patients.

⚠ Eligibility for program assignment was not discussed in all cases.

⚠ For four cases the level of care justification, including addressing HLOC considerations, lacked clarity and connection to functional impairments.

RHU GP

Four initial IDTTs (one EOP and three CCCMS) were observed in the RHU GP. All required members were present.

Key Findings

- ✓ The MHPC completed the initial assessment before the IDTT in three of four cases.
- ✓ Patients were asked open-ended questions and given opportunities to participate in treatment planning.
- ✓ The MHMD provided detailed relevant treatment information and actively engaged each patient when discussing medications.
- ✓ The outcomes of the IDTTs did not appear to be predetermined.

Improvement Opportunities

⚠ IDTTs began 30 minutes late due to transfer and unit codes. Reduce delays and improve timeliness of IDTT start times.

⚠ Ensure clinicians utilize available electronic records during IDTTs rather than relying solely on handwritten notes.

⚠ Ensure the MHPC completes the initial assessment before IDTT.

⚠ Address functional impairments in EOP case presentations.

⚠ Consistently incorporate relevant mental health history into case presentations.

⚠ Increase engagement and participation from the CCI and PTs during IDTTs.

⚠ Develop treatment goals that are measurable and clearly related to mental health treatment needs.

⚠ Consistently discuss HLOC considerations and address appropriateness of level of care.

⚠ Ensure RVR-related behaviors are incorporated into treatment planning when clinically relevant.

⚠ Limit attendance to essential participants to reduce overcrowding to and maintain a more therapeutic and focused treatment environment. During IDTT, in addition to the required members, additional staff were present who were only observing. This has been the standard practice at CCI to ensure all staff treating the patient have full awareness of the discussion and resulting recommendations, thereby limiting attempts to split by the patients. Streamlining attendance to required team members would improve the quality of the IDTT.

No formal follow-up is needed. The regional Sr. Psychologist Specialist will work with the RHU Supervisor at CCI to provide feedback and mentoring for IDTT quality.

Area Reviewed: Psychiatric Technician (PT) Rounds and Morning Meeting

PT Rounds

PT Rounds in B8 (RHU GP) and B7 (RHU Overflow) were observed by a nursing member of the Receiver's Compliance Team during the on-site review.

Key Findings

- ✓ These rounds adhered to established policy guidelines, with staff demonstrating effective engagement with patients and promptly initiating mental health referrals when necessary.

Improvement Opportunities

NA

Morning Meeting

Morning Meeting in the RHU GP was observed by a member of the Receiver's Compliance Team during the suicide prevention audit which occurred prior to this on-site visit.

Key Findings

- ✓ Required attendees were present and started on time.
- ✓ New arrivals, five-day follow-up cases, and Suicide Risk Management Program (SRMP) patients were discussed appropriately

Improvement Opportunities

⚠ There was very little interdisciplinary discussion noted.

⚠ Though required information was presented, there was no valuable discussion or collaboration amongst the members present.

Follow-up is not required.

Area Reviewed: Patient Reviews

The Sustainable Process report was reviewed for all units (ML EOP, RHU GP). Tier walks/housing reviews were conducted with custody/nursing input to identify patients with significant MH concerns. Relevant concerns were communicated to MH Program Supervisors and/or the IPC.

At the time of the report (details appear in the MHRA Spreadsheet, Tab IP Reviews):

⚠ Two patients required an action plan with clinical intervention.

⚠ Two patients required review and consideration of clinical recommendations.

Q4 2025 Action Plan Follow-Up

On 12/15/25, MH Regional received an acknowledgement email from CCI's IPC that the action plan and/or clinical recommendation assigned in Q4 2025 for the one patient identified was reviewed and considered by the clinical team, ML EOP Senior Psychologist Supervisor, IPC, and CMH. The patient identified with a follow-up action plan was scheduled for an IDTT and clinical recommendations were shared with the patients' treatment team for proper collaboration and monitoring.

Follow-up is required and is due on July 10, 2026

The CMH or designee shall:

1. Review commentary for all four patients listed on the IP Reviews tab
   A. Submit an institutional follow-up describing actions taken for the two patients requiring clinical intervention.
   B. Provide follow-up regarding results of the review and consideration of clinical recommendations for the other two patients identified in this review to the MH Regional Team.

Site Visit Summary

The MH Regional team conducted the Sustainable Process review during the CQI+ at CCI from June 2 – 4, 2026.

Key points

- CCI's HQ's Q1 and Q2 Data Review were at 38% and 27%, respectively.
- Two ICF referrals were submitted timely to IRU.
- MHPS minutes do not include Table V or documentation of discussions related to sustainable process.
- HLOC consistency audit found all eight cases (100%) demonstrated consistency with the prior month of EHRS documentation.
- Patient reviews identified no urgent MH or higher-level-of-care needs.
- Four patients require follow-up review or action plan.
- IDTTs were observed in the ML EOP and RHU; feedback was provided to MH supervisors accordingly.

Appendix F: Excluded Indicators

- AC8: CDCR Inpatient Program Referrals: Compliance with PG Timeframes for Acute & ICF Referrals Admitted or Closed
- AC18: Scheduled MH Appointments Completed or Refused
- QC10: Mental Health Primary Clinician Continuity of Care
- QC11: Mental Health Psychiatrist Continuity of Care
- RH27: RHU Incarcerated Persons Who Received an RHU Orientation Guide
- SP3.4: Quality of Safety Planning to Reduce Suicide Risk
- SP12.1: Custody Follow Ups, Page 1
- SP12.2: Custody Follow Ups, Page 2
- SP23: Quality of Selected SRE Documentation