CENTRAL CALIFORNIA WOMEN'S FACILITY

Review Period: Sept 2025 – Feb 2026
Onsite: April 6 – 9, 2026

Receiver's Compliance Team

2026

Statewide Mental Health Program
Continuous Quality Improvement

CENTRAL CALIFORNIA WOMEN'S FACILITY

CDCR

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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. 7283at 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 F. 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

This report presents the findings of the Comprehensive Quality Improvement Team audit of the Central California Women's Facility (CCWF) for the period September 2025 through February 2026, with an onsite review conducted April 6–9, 2026. The audit evaluated twelve substantive domains of mental health service delivery. CCWF has successfully built the operational infrastructure that forms the base for providing mental health care (training completion, direct-care staffing, crisis transfers, structural compliance in restricted housing). The institution shows deficits, however, in clinical quality, and in the institution's capacity to resolve findings identified in prior audit cycles

Documentation completeness masks clinical content deficits: The institution completes clinical documentation using the required templates across psychiatric, psychological, and interdisciplinary domains. However, the clinical content within those templates is deficient. Higher level of care documentation quality was insufficient in 89% of the cases reviewed by headquarters staff. Crisis care, Rules Violation Report (RVR) mental health assessments, and interdisciplinary documentation each met form-completion requirements while the clinical substance fell below audit standards. This is a pattern across disciplines, not a handful of program-specific gaps. This pattern coexists with long-standing vacancies in the supervisory positions most responsible for clinical documentation oversight. Training completion for these activities reached near-universal rates, indicating that the gap between process completion and clinical content is not attributable to untrained staff.

Efficient crisis operations do not ensure safe transitions: The Mental Health Crisis Bed (MHCB) processes patients through crisis care at rates that reflect functioning operational infrastructure: daily clinical contacts, transfers, and clinical stay management all exceeded compliance thresholds during the review period. Nonetheless, key aspects of clinical quality of care in crisis services are deficient. Safety plan adequacy at the rescission point (the transition from crisis-level to lower-level care) was very low (3%). MHCB admission and observation orders, discharge summaries, and post-discharge follow-up each fell below compliance standards. Patients remained on suicide precaution at discharge, without clinical justification, a practice previously observed in October 2021 and documented in October 2022.[1] Additionally, patients were held in temporary holding cells beyond the permitted maximum time period, a condition previously observed in July 2025 and documented in December 2025.

Adequate staffing has not produced timely clinical contacts: Non-supervisory clinical positions are filled at rates that are near the staffing allocations. However, timeliness of clinical contacts consistently fails to meet compliance thresholds. Psychiatrist (MHMD) contacts, Interdisciplinary Treatment Team (IDTT) timeliness, and primary clinician contacts each fell below threshold during multiple months of the review period, with MHMD and IDTT timeliness failing to meet the compliance threshold in any month. The timeliness failings also impact medication safety: timely response to critical medication non-adherence notifications averaged 13%, and pregnancy monitoring for medications fell below threshold across all three monitored medication classes.

Sustained operational strengths coexist with unresolved recurring deficits: CCWF has not experienced an incarcerated person death by suicide in more than 8 years. During the review period, no heat-related illness incidents occurred among patients prescribed heat-alert medications. No clinical seclusion or restraint events occurred. Restricted housing structural indicators achieved full compliance across daily rounds, electronic health record availability, and access provisions. Executive leadership rounding achieved full participation. Enhanced Outpatient (EOP) structured treatment hours exceeded Program Guide minimums, supported by recreation therapy fill rates exceeding allocated positions. Emergent and urgent mental health referrals with completed suicide risk evaluations are at above-threshold rates. These many areas of consistent compliance

[1] The CCWF MHCB was closed for renovations from November 2021 through October 2023. A corrective action plan was assigned to the institution following a headquarters SPRFIT Coordinator site visit in February 2024.

indicate that patient safety, crisis logistics, restricted housing infrastructure, and treatment programming are functioning at or above the level the Program Guide requires.

At the same time, several findings in the current audit were first documented in prior cycles and have not been resolved. Suicide precaution practices, confidential assessment access, temporary holding cell violations, and custody follow-up form deficits each persist from prior audits. The coexistence of sustained strengths with unresolved recurring findings indicates an institution that maintains its areas of performance but struggles to close its areas of deficit.

Four Priority Recommendations follow, addressing the cross-cutting themes developed above: supervisory oversight and documentation quality, MHCB clinical quality at crisis transition points, clinical contact timeliness, and the corrective action process for persistent findings.

Priority Recommendations

1. **Restore supervisory oversight capacity**: Documentation quality deficits across multiple areas (psychiatry, psychology, interdisciplinary documentation, and sentinel event assessments) result from a shared upstream condition: limited supervisory infrastructure responsible for clinical documentation review. The Chief Psychiatrist position has been vacant since January 2023. Senior Psychologist fill rates stand at 57% and 67%. These vacancies and absences impact compliance in Staffing, Quality of Care, Suicide Prevention, and Sentinel Events. Filling the supervisory gap could advance compliance in multiple areas simultaneously.

   Work collaboratively with the Office of the Coleman Receiver and CCHCS HR to fill these supervisory positions as quickly as possible. Filling these positions will restore supervisory infrastructure sufficient to sustain clinical documentation review across clinical domains to support supervisory oversight, mentorship, and technical assistance sufficient to identify and correct the identified clinical deficits.

2. **Establish MHCB clinical quality**: The MHCB operates at compliance threshold rates for daily clinical contacts, transfer timeliness, and clinical stay management. The clinical quality within those operations is deficient at the points where patients are most at risk. Safety plan adequacy at the crisis rescission point was extremely low (1 of 30 met audit criteria). MHCB admission and observation orders were adequately justified in 20% of reviewed cases. Post-discharge clinical follow-up averaged 43%. The constellation of clinical quality deficits within the crisis care unit, concentrated at patient transition points, raises patient safety concerns.

   Improve clinical practices and documentation and timely post-discharge follow-up for patients admitted to and discharged from the MHCB, with particular attention to safety plan adequacy at crisis transitions and individualized order justification.

3. **Achieve contact timeliness thresholds**: Clinical contact timeliness fell below threshold across multiple contact types during the review period despite non-supervisory clinical fill rates above 85%. MHMD contacts averaged 67%, IDTT timeliness averaged 72%, and critical medication non-adherence response averaged 13%. The persistence of below-threshold timeliness alongside adequate direct-care staffing indicates that the constraint is operational rather than workforce-driven, and that resolution requires coordinated action across scheduling, oversight, and clinical delivery functions.

   Achieve compliance-threshold timeliness for each clinical contact type (including critical medication non-adherence response and post-crisis clinical follow-up) to close gaps between staffing capacity and contact delivery rates.

4. **Implement durable solutions to cross-cycle findings**: Four findings documented in the current audit period were first identified in prior cycles: suicide precaution maintained at MHCB discharge without documented clinical justification (first identified October 2021), denial of confidential assessments in alternative housing (first identified July 2025), temporary holding cell violations beyond the permitted

maximum (first identified July 2025), and custody follow-up form completion at 72% and 68% (first identified May 2023). The persistence across audit cycles indicates that institutional corrective action has not produced a durable resolution, warranting a Priority Recommendation targeting the corrective action process itself rather than the individual clinical findings.

Implement durable resolution and verified closure of findings that have persisted across two or more audit cycles, with specific measurable benchmarks and a timeline for interim review consistent with the remedial action plan requirement, to demonstrate measurable progress toward resolution within the remedial timeline.

Institution's Operational Perspective

CCWF is a multi-mission female institution operated by the California Department of Corrections and Rehabilitation (CDCR) in Chowchilla, Madera County. CCWF serves as the Reception Center (RC) for all newly committed female incarcerated persons and provides mental health services across three levels of care within the Mental Health Services Delivery System (MHSDS): Correctional Clinical Case Management System (CCCMS), EOP, and MHCB. CCWF also holds the statewide mission for the Developmentally Disabled Program (DDP) for female offenders.

The institution delivers mental health programming through seven treatment programs: Mainline CCCMS, Mainline EOP, Reception Center CCCMS, Reception Center EOP, Restricted Housing Unit (RHU) CCCMS, RHU EOP, and the MHCB.

At the time of the April 2026 site visit, CCWF's mental health caseload comprised approximately 1,365 patients at the CCCMS level of care, 100 patients at the EOP level of care, and 8 patients at the MHCB level of care. The Closed Custody (C/C) population, designated work group C / privilege group C, housed in Facility A, Building 503 represents a substantial share of the Mainline CCCMS caseload; 81% of C/C patients are MHSDS participants.

Physical Plant and Capacity

CCWF comprises five operational areas: Facility A Yard, Facility B Yard, Facility C Yard, Facility D Yard, and the Central Health Building. The physical plant accommodates reception center processing, general population housing, restricted housing, and crisis-level care.

Facility	Function	Mental Health Program
Facility A Yard (Building 503)	General Population housing; Closed Custody (C/C) patients; Alternative Housing	ML CCCMS, including C/C
Reception Center, Facility A Yard (Buildings 501, 502)	Intake processing for newly admitted patients	RC CCCMS, RC EOP
Restricted Housing Unit, Facility A Yard (Building 504)	Restricted Housing Unit; 12 designated intake cells; Alternative Housing for RHU	RHU CCCMS, RHU EOP
Facility B, C, D Yards	General Population housing	ML CCCMS, ML EOP
Central Health Building	Skilled Nursing Facility (SNF); 12-cell Mental Health Crisis Bed unit	MHCB
Building 805	Three wet holding cells (A-145, A-73, A-20) for Alternative Housing; out-of-cell MHCB treatment room (Room 68)	Alternative Housing; MHCB out-of-cell treatment

The Restricted Housing Unit in Building 504 is organized into three designations: General Population RHU (GP RHU) for incarcerated persons not in the MHSDS, CCCMS RHU for MHSDS participants at the CCCMS level of care, and EOP RHU for MHSDS participants at the EOP level of care. Three exercise yards are adjacent to the RHU. Two exercise yards serve GP and CCCMS RHU patients and one serves EOP patients. Cells 118, 120, and 126 in Building 504 are designated Disability Placement Program (DPP) cells. The GP RHU Control Booth provides visual coverage of the unit and exercise yards via video surveillance and operates the electronic control panel for cell doors and building access.

The MHCB is an 8-cell unit (with 12 beds) within the Central Health Building, licensed as a Skilled Nursing Facility. An out-of-cell treatment room (Room 68) in Building 805 was placed in service in February 2024 to

provide a confidential out-of-cell environment for primary clinician and psychiatric contacts with MHCB patients.

Alternative Housing

Alternative Housing provides placement for patients who require special housing for mental health reasons based on Danger to Self, Danger to Others, or Significant Impairment/Dysfunction Due to Mental Illness, while pending transfer to a higher level of care such as the MHCB. Alternative Housing is maintained in Building 503 (Reception Center housing), in Building 504 (RHU), in two rooms in Building 703, and in two wet holding cells in Building 805 (A-145, A-73). While pending mental health and nursing assessment, patients are placed in Temporary Holding Cells (THCs) at each yard and at Building 805, with a 4-hour maximum placement duration. Patients in Alternative Housing are furnished with beds and observed on a 1:1 basis.

Programs and Services

CCCMS: The CCCMS program serves the largest segment of the mental health caseload. Mainline CCCMS is provided across Facilities A through D. The C/C population in Building 503 receives an expanded service model that includes daily afternoon rounds, individual contacts available upon request, therapeutic groups on the unit, and distribution of packets for in-cell activities.

EOP: The Enhanced Outpatient Program provides structured therapeutic programming for patients requiring a higher level of care than CCCMS. Mainline EOP is provided on Facilities B. RHU EOP is provided in Building 504. EOP structured treatment hours during the review period averaged 13.4 hours per week for mainline EOP patients, exceeding the Program Guide minimum of 10 hours.

MHCB: The Mental Health Crisis Bed program provides inpatient-level mental health services for patients in acute psychiatric crisis. The 8-cell unit operates 24 hours per day, 7 days per week within the Central Health Building.

Reception Center: CCWF's Reception Center processes all newly committed female incarcerated persons through mental health screening and clinical assessment. Patients identified as requiring MHSDS services are placed at the CCCMS or EOP level of care through the reception center screening process.

Developmentally Disabled Program: CCWF holds the statewide DDP mission for female offenders. The DDP provides adaptive support services and accommodations for incarcerated persons with developmental disabilities.

Crisis Intervention Team: CCWF operates a Crisis Intervention Team (CIT) on Monday, Tuesday, and Wednesday from 1600 to 2200 hours. Yard clinicians respond to crisis calls during all other hours. The CIT provides responsive crisis intervention directed toward resolving patient crises, operating under Local Operating Procedure MH-019.

Palliative Care and Memory Care: The institution has developed a Palliative Care Program that includes a Memory Care Unit serving the aging CCWF population.

Operational Context

CCWF's operational geography involves a split-campus configuration in which the Central Health Building (Building 805) is located apart from the general population yards. Patient movement between housing units and clinical treatment spaces only involves transport coordination between custody and mental health staff for RHU and C/C patients.

The institution has consolidated nonclinical staff into pooled workspaces during the review period to make additional confidential office and group-treatment space available for clinical programming. A monthly mental health newsletter has been implemented.

The institution monitors internal performance indicators for continuous quality improvement, including MHCB confidential out-of-cell contacts, appointment scheduling accuracy, clinical encounter quality, use of THCs

and Therapeutic Treatment Modules, caseload distribution, EOP discharges, safety plan completeness, clinical contact timeliness, and Suicide Risk Evaluation completion for emergent and urgent referrals.

Access to Care

This section examines the timeliness, availability, and quality of clinical mental health contacts, including scheduled appointments, reception center screening, restricted housing access, transfer processes, and treatment programming. Access to care encompasses the operational mechanisms through which patients initiate and sustain contact with mental health services across custody settings, level-of-care designations, and transition points. The indicators in this section measure whether patients receive clinical contact at the frequency and within the timeframes the Program Guide requires.

Confidential and Effective Communication

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg	Onsite Audits
Effective Communication Achieved	99%	99%	99%	99%	100%	99%	99%	
Group treatment in a confidential setting	100%	99%	92%	90%	97%	99%	96%	
IDTTs in a confidential setting	99%	99%	100%	99%	100%	99%	99%	
Observed Reception Center MH Screens in a Confidential Setting								100%†

Timely Access

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg	Onsite Audits
Daily PC Interactions – RHU EOP High Refusers	97%	100%	96%	94%†	80%	100%	96%	
IRU Reviews Completed Timely	0%†	80%†	100%†	100%†		75%†	79%†	
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure	50%†	67%†	0%†	33%†		0%†	36%†	
RC MH Screens	98%	97%	81%	98%	95%	97%	94%	
RHU GP Screens	83%†	100%†	50%†	100%†	100%†	100%†	95%	
RHU Pre-Screen	92%	99%	96%	94%	97%	95%	95%	
Timely IDTTs (v2.0)	76%	70%	72%	71%	68%	78%	72%	
Timely MH Referrals (v2.0)	85%	79%	84%	84%	80%	84%	83%	
Timely MHMD Contacts (v2.0)	64%	69%	72%	63%	70%	67%	67%	
Timely PC Contacts (v2.0)	82%	80%	85%	84%	85%	84%	83%	
Custody MH Referrals								95%
Housing Units Where 128-MH-5s Are Available and Accessible to Housing Unit Staff								100%†

Timely Transfers

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg
Timeliness of Acute/ICF Referral Submission to IRU	100%†	67%†	100%†	50%†		80%†	71%†
Timely Transfers from RC to CCCMS (v2.0)	98%	96%	96%	89%	91%	100%	95%
Timely Transfers to EOP (v2.0).	100%†	100%†	100%†	100%†	100%†	100%†	100%
Timely Transfers to PIP		50%†	100%†	100%†	0%†	100%†	73%†
Timely Transfers to RHU CCCMS	100%†	100%†	100%†	100%†	0%†	50%†	88%†

Appointments

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg
Appointments Cancelled Due to Custody [i]	1%	27%	23%	1%	9%	24%	15%

Treatment Offered

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg
Treatment Offered (Structured): non-PIP	94%	92%	83%	83%	91%	91%	88%

✓ **Strengths**

Effective communication sustained: Effective communication achieved averaged 99% across the six-month review period, indicating consistent delivery of clinical information in a manner patients can understand. Sustained performance at this level supports treatment engagement and informed participation in care decisions.

RC screening timeliness consistent: Reception center mental health screenings were completed within required timeframes at an average rate of 94% across the review period (range 81–98%), supporting the timely identification of incoming patients requiring mental health services. Consistent screening at this level supports early intervention and appropriate level-of-care assignment during the intake process.

RHU pre-screen reliability: RHU pre-screens were completed within required timeframes at an average rate of 95% across the review period (range 92–99%), supporting the timely identification of mental health needs at the point of restricted housing placement. Sustained compliance supports continuity of clinical monitoring for a population at elevated risk.

RHU high-refuser daily contact: Daily primary clinician interactions with RHU EOP high refusers averaged 96% (range 80–100%). Maintaining near-daily clinical contact with treatment-refusing patients in the most restrictive setting supports ongoing risk assessment for a high-acuity population.

Enhanced access to healthcare services for C/C individuals: Throughout the review period, improved access to healthcare services occurred for individuals identified as C/C. Strategies implemented to meet the unique needs of this population included offering group treatment sessions and assigning a dedicated nursing case manager to the unit. These interventions have been associated with a reduction in medical emergencies and urgent mental health referrals, as well as increased collaboration among mental health, custody, and nursing staff within the unit. Additionally, there was a significant decline in alarm frequency, which previously caused delays for programs involving other patients and incarcerated persons in A Yard.

Structured treatment above minimum: Mainline EOP averaged 13.4 hours per week of structured treatment, exceeding the Program Guide 10-hour minimum by 34%. RHU EOP structured treatment hours also met or exceeded minimums. Delivering treatment above required thresholds supports the clinical intensity that EOP patients' acuity level demands.

Custody MH referrals functional: Custody mental health referrals achieved 95% compliance during the onsite audit demonstrating that custody staff had acceptable knowledge of when and how to refer to mental health. Functioning referral pathways between custody and mental health are a foundational element of the partnership model and support timely identification of patients experiencing mental health decompensation. See related findings in Custody Mental Health Partnership Plan.

⚠ Concerns

Timeliness deficits across contacts: Timely MHMD contacts averaged 67% (range 63–72%), timely PC contacts averaged 83% (range 80–85%), and timely IDTTs averaged 72% (range 68–78%) across the review period. No month met the threshold for MHMD or IDTT timeliness. These deficits limit the frequency and regularity of clinical contact for the general mental health population. See related Priority Recommendation addressing contact timeliness thresholds.

Custody cancellation frequency: Appointments cancelled due to custody averaged 15% (inverse indicator), with monthly values ranging from 1% to 27%. The three-fold swing between lowest and highest months indicates episodic operational disruptions rather than a stable structural cause.

Inaccurate confidentiality reporting: While 99% of mainline EOP dayroom groups were documented by staff as confidential in the electronic health record, onsite findings indicate some areas cannot be considered confidential and should not have been recorded as such. The reported compliance rate does not accurately reflect the treatment environment as the dayroom used for treatment is accessible to all individuals housed in the EOP unit, rather than exclusively to group participants during group sessions.

Confidential assessment denial persists: Three converging findings (onsite observation and two separate staff reports) identify a practice of denying alternative housing patients access to confidential assessments in Building 805. This practice was first identified in July 2025 and is contrary to local operating procedures and may limit important disclosures by patients.

Temporary departure contacts deficient: Contacts for patients returning from temporary departure averaged 36%† (range 0–100%, all small samples). Two months recorded 0% compliance. While small samples limit generalizability, the pattern indicates a gap in clinical continuity at a significant transition point.

Acute/ICF referral submission delayed: Timeliness of Acute/ICF referral submission to IRU averaged 71%† (range 50–100%, all small samples), with 5 referrals identified as submitted late. Delayed referral submission extends the time patients awaiting higher-level care remain at an insufficient level of treatment.

Recommendations

1. Resolve confidentiality reporting discrepancy: Eliminate the discrepancy between group treatment setting conditions and electronic health record confidentiality coding to produce reported metrics that accurately reflect the treatment environment.
2. Secure confidential assessment access: Establish confidential assessment settings for patients in alternative housing. Adhere to the alternative housing local operating procedure requiring that out of cell contact will be conducted in a confidential setting to protect clinical candor during crisis and routine evaluations. See related findings in Suicide Prevention.

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 have structured input into the mental health program.

Indicator	Onsite Audits
CMHPP MH Daily Huddles	85%
CMHPP MH Huddle Documentation of Required Attendees	87%
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%
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 Supervisor Meetings	94%
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees	100%
ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings	50%†
Quarterly Partnership Round Table Training Completed as Required	100%†
Required Staff Attendance of Quarterly Partnership Round Table Training	50%†

✓ Strengths

Executive leadership rounding complete: Monthly executive leadership joint rounding achieved 100% compliance with all required executives present. Executive-level participation in rounding provides direct leadership visibility into operational conditions.

CMHPP training near-universal: Custody staff partnership training reached 99% completion. Near-universal training delivery supports a shared knowledge base for the custody-mental health partnership model. This finding is presented with the qualification that training completion is not correlated with observed practice quality in all domains measured during the audit period.

Weekly supervisor meetings consistent: Mainline CCCMS and RC CCCMS weekly supervisor meetings achieved 94% compliance with 100% of required attendees present. Regular supervisory meetings with full attendance support coordinated case management and timely identification of operational barriers.

⚠ Concerns

Supervisor huddle attendance: Daily huddle documentation of supervisor attendees scored 0%† across all programs during onsite audit. The statewide requirement is that custody and mental health supervisors must each attend a huddle at least once weekly. While records show that supervisors did attend in some weeks, none of the audited weeks in any program had documentation of both a custody supervisor and a mental health supervisor attending a huddle during that week. When supervisors do not regularly participate in huddles, there is less oversight of how the program operates. This weakens the connection between daily staff activities and

the leadership of the institution, making it harder for leaders to stay informed and guide the program effectively. See related Priority Recommendation addressing supervisory oversight capacity.

Advisory council meetings: The mental health ML CCCMS program supervisor attended monthly Inmate Advisory Council meetings 50%† of the required frequency. The advisory council is the primary formal mechanism for patient input into institutional mental health operations; attending half the required meetings diminishes patients' structured access to influence their care environment.

Training attendance below completion: Although the training was provided as scheduled, only 50%† of the required staff attended. This outcome demonstrates that the training process was not fully effective in reaching all intended participants, resulting in only half of the target audience receiving the training.

Recommendations

1. Restore supervisory huddle participation: Reinstate and document supervisory attendance at daily mental health huddles across all programs. See related Priority Recommendation in Staffing.
2. Increase IAC Supervisory Attendance: Increase attendance of ML CCCMS program supervisor to maintain the primary structured mechanism for patient input into institutional mental health operations.

Facility and Environment of Care

This section assesses the physical spaces in which mental health treatment occurs, including individual treatment rooms, group treatment areas, IDTT locations, and restricted housing environments. Adequate treatment spaces are a prerequisite for confidential, clinically effective therapeutic encounters. Environmental conditions in housing and treatment areas affect patient dignity, safety, and the quality of clinical interactions.

Indicator	Onsite Audits
Adequate Group Treatment Spaces	78%†
Adequate IDTT Spaces	100%†
Adequate Individual Treatment Spaces	98%

✓ Strengths

Individual treatment spaces adequate: Adequate individual treatment spaces scored 98% during the onsite audit, indicating that the physical plant supports confidential individual clinical encounters at nearly all assessed locations. Adequate treatment space is a prerequisite for clinically effective and legally compliant therapeutic contact. Clinicians reported that treatment spaces were reconfigured the week preceding the site visit to comply with audit requirements.

⚠ Concerns

Group treatment spaces non-compliant: 2 of 9 (22%) group treatment spaces were non-compliant during onsite audit. A CCCMS IDTT space adjacent to a restroom produced audible toilet-flush noise during observed IDTTs which suggested that communication within the IDTT space may be audible from that bathroom. Non-compliant treatment spaces compromise clinical confidentiality and therapeutic integrity.

Environmental deficiencies observed: The water fountain across from cell 101 (bldg. 504) was covered in black mold or algae. Alternative housing cells (bldg. 503) inspected during onsite audit were dirty and not prepared for intake.

Recommendations

1. Remediate non-compliant treatment spaces: Bring all group treatment spaces and IDTT locations into compliance with confidentiality and environmental standards.
2. Address environmental conditions: Remediate identified environmental deficiencies, including the water fountain contamination and the preparation of alternative housing cells prior to patient placement. See related findings in Restricted Housing.

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).[2] 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	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg	Onsite Audits
Timely Response to Critical Non Adherence Notification (v2.0)	0%†	17%†	20%†	14%†	10%†	17%†	13%	
Timely Response to Non-Critical Med Non-Adherence Notification(v2.0)	44%	32%	29%	40%	29%	21%	32%	
Controlled Use of Force Incidents Required to Administer PC2602 Medication								33%

⚠ Concerns

Critical Medication non-adherence response: Timely response to critical non-adherence notification (critical medications are medications for which missing a single dose may increase the health risk of the patient) averaged 13% (range 0–20%) and non-critical non-adherence averaged 32% (range 21–44%). Psychiatrist/Psychiatric Nurse Practitioner response to missed non – critical medications should include a timely plan for addressing medication non-adherence and an appointment with the patient to discuss missed medication doses and the potential health impacts.

Pregnancy monitoring below threshold: When patients are prescribed certain medications, where relevant, they should be tested for pregnancy at regular intervals. Oxcarbazepine pregnancy test monitoring averaged 46%, lithium pregnancy monitoring 47%, and antipsychotic pregnancy monitoring 60%.

Therapeutic drug levels subthreshold: Valproic acid level monitoring averaged 47% (range 25–58%) and lithium level monitoring averaged 45% (range 11–75%). When medications require very precise dosing, not checking blood levels often enough (less than half the time) can put patients at real risk—too high dosing can result in harm.

Recommendations

1. Strengthen pregnancy monitoring compliance: Attain compliance-threshold monitoring rates for medications prescribed to patients of childbearing potential.

[2] See Appendix C

2. Elevate non-adherence response timeliness: Elevate timely response rates for critical medication non-adherence notifications (currently 13%) and non-critical notifications (currently 32%) to compliance thresholds, with prioritization of the responsiveness to critical non-adherence.
3. Improve therapeutic drug monitoring: Raise monitoring rates for narrow-therapeutic-window medications, including valproic acid level monitoring (currently 47%) and lithium level monitoring (currently 45%), to compliance thresholds to reduce clinical risk from sub- or supratherapeutic drug levels.

Patient Safety

This section examines patient safety indicators including heat-related illness prevention, seclusion and restraint events, and the availability of alternative programming during environmental restrictions. 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	Onsite Audits
Heat Related Illness Incidents for MHSDS Patients Prescribed Heat Alert Medications	0
Clinical Restraint Occurrences Meeting All of the Audit Criteria	N/A
Restraint Incidents	0
Maximum Number Restraint Incidents	0
Restraint Duration Incidents greater than 4 hours	0
Seclusion Incidents	0
Maximum Number Seclusion Incidents	0
Seclusion Duration Incidents greater than 8 hours	0

✓ **Strengths**

Zero heat-related illness events: During the review period, no heat-related illness incidents occurred among patients prescribed heat-alert medications.

No seclusion or restraint events: No clinical seclusion or restraint events occurred during the review period. The absence of seclusion and restraint reflects utilization of least-restrictive intervention principles.

Heat-alert alternative activities provided: Alternative out-of-cell activities were documented on 7 of 8 heat-alert days (88%) during the review period. Providing structured programming alternatives when outdoor temperatures preclude yard access protects patients from heat exposure while maintaining therapeutic programming continuity.

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	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg	Onsite Audits
IDTT Patient Attendance	57%	57%	55%	61%	56%	70%	59%	
IDTT Required Staffing	50%	53%	50%	48%	55%	45%	50%	
IDTTs with Observed Interactive Process								38%

Documentation

Indicator	Onsite Audits
Cases w/documentation of appropriateness of LOC discussed for pts identified by 7388B as potentially requiring HLOC	92%
EOP IDTTs Addressing Accommodations and Clinical Appropriateness for Work and Education	75%†
IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT	100%†
IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT	69%†

⚠ Concerns

HLOC documentation critically deficient: Despite the higher level of care discussion occurring during the observed IDTTs, the documentation quality of higher level of care considerations scored 11% in the Q1 2026 headquarters review. Program-wide, the reasons why the master treatment plan documentation was considered "unacceptable" in the headquarters review included: inpatient coordinator (IPC) error (67%); insufficient narrative (21%); insufficient interventions (8%); clinical inconsistencies (4%). This is the lowest quality indicator in the audit data set. See related Priority Recommendation addressing supervisory oversight capacity.

IDTT quality deficiencies: IDTT patient attendance averaged 59% (range 55–70%), required staffing averaged 50% (range 45–55%), observed interactive process achieved 38%, and psychiatry intake evaluations were completed prior to initial IDTT in 69%† of cases. When attendance, staffing, interactive process, and pre-IDTT diagnostic input are simultaneously deficient, the treatment planning apparatus does not function as the Program Guide intends.

Recommendations

1. Restore IDTT functional quality: Ensure that IDTTs across all programs adhere to quality standards including: necessary staff presence, engagement in an interactive clinical process identifying measurable treatment goals, and completion of initial clinical evaluations prior to the meeting. This will allow the team to create individualized treatment plans with all participants actively involved.

RVRs, Sentinel Events, and Specialized Custody

This section reviews rules violation report, 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 Report

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg	Onsite Audits
RVR MH Assessments Conducted in a Private Setting	50%	67%	57%	47%	71%	63%	59%	
RVR MH Assessments where Documentation Requirements were Met		100%†	100%†	100%†			100%†	
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality		100%†	100%†	100%†			100%†	
Timely RVR MH Assessment Request	24%	23%	27%	38%	38%	43%	32%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	62%	77%	82%	83%	76%	76%	76%	
RVR's Issued*								1,187
RVR's Issued to Non-MHSDS Participants								19%
RVR's Issued to Patients at the Acute Level of Care								0%
RVR's Issued to Patients at the CCCMS Level of Care								73%
RVR's Issued to Patients at the EOP Level of Care								6%
RVR's Issued to Patients at the ICF Level of Care								0%
RVR's Issued to Patients at the MHCB Level of Care								2%

**MHSDS participants comprise 69% of the population at CCWF.*
Note: Both the RVR Documentation Requirements and Limits of Confidentiality are based on the number of times CAT Audit 11 was completed in that calendar month. If they weren't completed, then the box will appear blank.

Sentinel Events, and Specialized Custody

Indicator	Onsite Audits
Custody Staff Attendance at UOF Training	100%
Days Alternative Out-of-Cell Activities were Offered to Patients on Heat Alert Medications when Indicated	88%
Health Care Staff Required to Attend UOF Training	99%
Thermometer Checks completed and accurate	100%†
Use of Force Involving MH Patients	95%

✓ **Strengths**

UOF training fully delivered: Custody staff use-of-force training achieved 100% and healthcare staff training reached 99%. Complete delivery of use-of-force training establishes the knowledge base for policy-compliant force application and post-incident mental health assessment.

Senior hearing officer mitigation acceptance complete: Senior hearing officers accepted all clinician mitigation recommendations in reviewed cases. Complete acceptance of clinical input into the disciplinary process reflects functional integration of mental health considerations into custody proceedings. This finding would be strengthened if the senior hearing officer increased documented consideration of RVR-MHA information; this documentation should reflect the hearing officer's consideration of the clinical assessment, not only quoting language from the assessment itself.

⚠ Concerns

RVR-MHA content not individualized: Throughout the year, institutions conduct self-audits of various functions, including RVR mental health assessments. The audited mental health assessments met 100%† documentation requirements. Onsite audits of RVR mental health assessments found that the documents contained verbatim language across patients in responses to questions 3 and 4. Form completion without content individualization means the assessment documents are completed but do not reflect patient-specific clinical reasoning. See related findings in Quality of Care.

RVR assessment timeliness: Timely submission of mental health RVR assessment results averaged 76% (range 62–83%).

BTI training refocused from patient trauma to staff trauma: Becoming Trauma Informed (BTI) training focus narrowed from patient care to staff trauma per staff interviews, which was confirmed through onsite staff report. The shift in training emphasis reduces the clinical applicability of BTI training to patient-facing interactions.

Recommendations

1. Individualize RVR-MHA documentation: Eliminate verbatim language patterns in RVR mental health assessment documentation to produce assessments that reflect patient-specific clinical reasoning, particularly in responses addressing the relationship between mental health status and the violation. See Priority Recommendations (supervisory oversight).
2. Accelerate RVR assessment requests: Accelerate timely RVR mental health assessment request rates (currently 32%) and timely submission of assessment results (currently 76%) to compliance thresholds, supporting integration of clinical input into the disciplinary process within policy-required timeframes.

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 both general population and enhanced outpatient program patients.

Timeliness

Indicator	Sep 2025	Nov 2025	6-Month Avg	Onsite Audits
Timely Transfers to RHU EOP	100%†	100%†	100%†	
CCII, Captain, and Warden Reviews of RHU EOP Patients with LOS Over 90 Days				100%†
Initial ICCs Reviewed that were Held within 10 Calendar Days of Arrival to Restricted Housing Placement				100%†

Documentation

Indicator	Onsite Audits
High Refusers for Whom a 128B was Completed	0%†
High Refusing EOP Patients in Restricted Housing for Whom a Meeting Between MH and Custody was Conducted	22%†
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available	100%
Observation of Psych Tech Rounds Where EC, Interaction, and Referrals Met All Audit Criteria	100%†
Psychiatric Technician Rounds Documentation Audited Meeting All Audit Criteria	100%†
PT Rounds Completed in Restricted Housing Units	100%†

Out-of-Cell Activities/Care

Indicator	Onsite Audits
Custody Staff who can Identify all NDRH Patients	100%†
Patients in restricted housing with working entertainment appliances	100%†
Peace Officers Observed to Carry Their CPR Mouth Shield	100%
RHU EOP Out of Cell Time Offered	100%
RHU Shower Access	100%
Staff Who Report Unclothed Body Searches Conducted in a Private Area	100%†

✓ **Strengths**

RHU structural compliance uniform: Restricted housing structural indicators achieved 100% across PT daily rounds, effective communication, clinical referral criteria, electronic health records and SOMS availability at IDTTs, custody identification of NDRH patients, entertainment appliances, and shower access. Uniform structural compliance establishes the operational foundation necessary for clinical programming in the most restrictive setting.

Timely RHU EOP transfers: Timely transfers to RHU EOP scored 100% in both reported months (September and November 2025). Timely placement ensures patients requiring enhanced outpatient services in restricted housing receive clinical programming without placement-related delays. Sustained transfer timeliness supports treatment continuity for patients moving between custody classifications. This finding is based on a small sample.

⚠ **Concerns**

High-refuser engagement absent: 128B forms documenting discussion between mental health and custody about high refusers were completed in 0%† of reviewed cases. Mental health/custody meetings for high-refusing EOP patients in restrictive housing occurred 22%† of the time. Collaborative meetings and documentation of the findings allows for patient-identified barriers to treatment to be resolved and increases treatment engagement for the highest need patients.

RHU CCCMS treatment gaps documented: Between September 1 and February 28, there were 61 occurrences of RHU CCCMS patients not being offered any treatment in a given week. RHU CCCMS patients were offered the 90-minute weekly minimum 85% of the time overall, but there were gaps that led 10% of patients to miss at least one week of treatment. Scheduling practices may be impacting the frequency of treatment enrollment upon admission to the restricted housing setting.

Recommendations

1. Establish high-refuser engagement mechanisms: Develop clinical engagement mechanisms for treatment-refusing patients in restricted housing to improve treatment for these patients while addressing the 22%† mental health/custody meeting rate for high-refusing EOP patients, and the 0%† 128B completion rate.

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.

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg
Discharges from MHCB with clinician review of d/c summary		100%†	50%†	50%†			60%†
Documentation of Acute/ICF Discharges with Clinician to Clinician Contact within 5 days	0%†						0%†
Emergent and Urgent MH Referrals That Result in SREs	94%†	94%	95%	87%	98%	90%	94%
MHCB Daily Provider Contacts (v2.0)	82%	87%	90%	83%	92%	86%	87%
MHCB/PIP Supervisory Reviews of Discharge Safety Plans	93%†	93%†	86%	57%†	60%†	80%†	80%
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training			13%	30%	75%	98%	55%
Safety Plans Signed Timely	71%	83%	82%	82%	81%	82%	80%
Timely Clinical Follow-Ups (V2.0)	20%	44%	43%	44%	55%	47%	43%

Onsite Audits	
Audited Security Welfare Checks in Restricted Housing That Included the Required Visual Observation	100%
Custody Follow Ups, Page 1	72%
Custody Follow Ups, Page 2	68%
Custody Staff with CPR Training	100%
Custody Staff with Suicide Prevention Training	99%
Healthcare staff current with suicide prevention training	100%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories	80%†
Institution SPRFIT Meeting Minutes Reviewed that Satisfy All Audit Criteria	0%†
MHCB and Acute/ICF Out of Cell Activities - Dayroom	100%†
MHCB and Acute/ICF Out of Cell Activities – Phone Calls	0%†
MHCB and Acute/ICF Out of Cell Activities - Showers	100%†
MHCB and Acute/ICF Out of Cell Activities - Yard	100%†
MHCB and Acute/ICF Records with Rationale for Partial Issue	0%†
MHCB Out of Cell Activities	0%†
Nursing Staff Current with CPR Training	100%
Observed Initial Health Screenings	100%†
Onsite Review of Patient Orders for Issue and Observation	100%†
Referrals That Received a SRE When DTS or Suspected Intentional OD was not Marked on the MH Referral	87%†
RHU Intake Incarcerated Persons Appropriately Housed	0%†
Suicide Resistant Cells	100%†

Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training compliance does not factor in SRE training being paused. Outside of the pause, biennial SRE training for clinicians is 98% compliant and SRE mentoring is 90% compliant.

✓ **Strengths**

Zero suicides since April 2018: CCWF has not experienced a suicide since April 2018, a period exceeding 8 years. While process-level deficits identified in this section warrant attention, the sustained absence of deaths by suicide is a significant patient-safety outcome.

Emergent and urgent referrals yielding SREs: Emergent and urgent mental health referrals resulting in suicide risk evaluations averaged 94% (range 87–98%). Reliable conversion of referrals to clinical assessment supports early identification of suicidal risk and timely intervention at the initial point of concern.

MHCB daily provider contacts: MHCB daily provider contacts averaged 87% (range 82–92%) across the review period. Daily clinician engagement with patients in mental health crisis supports ongoing risk assessment, treatment adjustment, and therapeutic rapport during the most acute phase of care.

Security welfare checks compliant: Audited security welfare checks in RHU demonstrated 100% compliance with required visual observation standards. Reliable welfare checks serve as a critical safety-net function for patients in restricted housing. Sustained compliance supports the correctional institution's ability to detect and

respond to emergent patient safety situations in the most restrictive custody settings. See related findings in Restricted Housing.

Suicide prevention training complete: Suicide prevention training was achieved for 99% of custody staff, 100% for healthcare staff, and 100% for mental health staff. CPR certification compliance reached 100% for both custody and nursing. Near-universal training completion reflects a functional training delivery infrastructure. This finding is presented with the qualification that training completion is not correlated with observed practice quality in all domains measured during the audit period. See related concern in Staffing.

⚠ Concerns

Safety plan adequacy near-zero: MHCB rescission safety plans demonstrated less than 3% adequacy (1 of 30 met audit criteria). MHCB discharge safety plans scored 38% adequate. Safety plans at crisis transitions are the primary clinical instrument for protecting patients as they move from crisis-level to lower-level care. Near-complete inadequacy at the rescission point represents a patient-safety deficit. See related Priority Recommendation addressing MHCB clinical quality.

Post-crisis follow-up inadequate: Timely clinical follow-ups averaged 43% (range 20–55%). Patients recently discharged from mental health crisis care to general population had timely clinical follow-up less than 50% of the time creating a gap in continuity during the post-crisis transition period. See related Priority Recommendations addressing MHCB clinical quality and contact timeliness.

MHCB orders lack justification: MHCB issue and observation orders were adequately justified in 20% (2 of 10) of reviewed cases. Insufficiently justified orders mean that it is not clear whether there was a clinical basis for crisis admission and observation decisions. The institution attributes the insufficient documentation to form field structure rather than clinical reasoning quality, however, adequate clinical justification can be included in the current form. See related Priority Recommendation addressing supervisory oversight capacity.

Precaution maintained without justification: During the onsite audit, a review of the records found 8 of 10 patients remained on suicide precaution at MHCB discharge but the medical records lacked the individualized clinical rationale necessary to justify these orders. Maintaining suicide precaution without documented clinical justification raises both clinical concerns and liberty concerns as patients have limited access to clothing and other personal effects while on suicide precaution.

Temporary Holding Cells (THC) violations beyond maximum: 11 patients were held in temporary holding cells beyond the 4-hour maximum between January 2026 and the audit date: Nine were held for 5–8 hours, 2 were held for 10+ hours. Holding patients beyond four hours is contrary to current policy.

SRE completion for Danger To Self referrals: SRE completion for MHCB DTS referrals reached 56% (193 of 340). Low compliance is partially attributed to after-hours referrals where SREs are often not completed at the time of referral. Without telepresenters, nightshift ability to conduct a face-to-face evaluation is limited.

Abbreviated SRE form misapplied: The abbreviated SRE form was used in 62% of reviewed cases requiring the full form (8 of 13). Use of the abbreviated instrument when the full assessment is indicated reduces the clinical information available for crisis management decisions.

Custody discharge follow-up deficient: Custody form MH-7497 completion was deficient in multiple respects. Page 1, which addresses discharge information and clinical evaluation was fully completed 72% of the time (73 of 101). The second page, which covers receiving institution and custody checks components was completed in 68% of cases (69 of 101). Insufficient documentation of discharge follow-ups impedes verification of custody's completion of required wellness checks and mental health staff's completion of the follow-up discontinuation process, which may compromise patient safety. See related Priority Recommendation addressing persistent cross-cycle findings.

SPRFIT minutes did not meet all criteria for any audited month: Institution SPRFIT meeting minutes did not meet all of the criteria in any of the six months, resulting in a score of 0%†. SPRFIT meetings occur, but

documentation does not meet all of the audit tool's requirements. The 0% score reflects a documentation gap in meeting minutes, not an absence of suicide prevention committee meetings. The institution attributes this to a template and training problem.

SRE mentoring compliance low: Required mental health clinical staff with completed SRE mentoring and biennial training averaged 55%. However, this score is being depressed by the fact that compliance requires attendance at two trainings and one of the two was paused statewide during the reporting period. This is outside the facility's control and is not an indication of failure to complete available trainings.

MHCB discharge summaries incomplete: Discharges from MHCB with clinician review of discharge summary averaged 60%† (range 50–100%, only 3 months reported). Documentation of acute/ICF discharges with clinician-to-clinician contact within 5 days scored 0%† in the single month reported (September). Post-discharge documentation gaps compromise clinical handoff and continuity planning. See related Priority Recommendation addressing MHCB clinical quality.

Recommendations

1. Expand DTS referral SRE rates: Review records for patients for whom SRE was not completed upon referral. Determine if there are local afterhours referral pathways that require intervention (e.g., if an SRE is not completed alongside an assessment of the patient) and develop a plan to close this treatment gap.
2. Correct SRE form selection errors: Eliminate use of the abbreviated SRE form in cases requiring the full assessment instrument (currently 62% incorrect usage) to ensure clinical information sufficient for crisis management is captured.
3. Resolve custody follow-up form deficits: Attain compliance-threshold completion rates for custody follow-up form (MH-7497) Page 1 (currently 72%) and Page 2 (currently 68%), a deficit first identified in May 2023, to ensure post-discharge safety monitoring is verifiable and complete. See related Priority Recommendation addressing persistent cross-cycle findings.
4. Standardize SPRFIT meeting documentation: Bring SPRFIT meeting minutes into compliance with all audit criteria (currently 0%†) to produce documentation that demonstrates the content, deliberations, and action items of the suicide prevention committee.
5. Scale SRE mentoring completion: Scale completion rates for required SRE mentoring and biennial training (currently averaging 55%) to compliance thresholds, accounting for training pause impacts on scheduling.

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	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg
MHCB clinical stays within timeframes	89%†	88%	100%	95%	95%	86%	92%
Timely Transfer to MHCB (v2.0)	96%	93%	100%	100%	91%	97%	96%

✓ **Strengths**

MHCB stays within timeframes: MHCB clinical stays within timeframes averaged 92% (range 86–100%), with 4 of 6 months at or above 95%. Compliance with clinical stay timeframes indicates that crisis admissions proceed through the acute stabilization phase and transition to discharge without unnecessary prolongation.

Timely MHCB transfers sustained: Timely transfers to MHCB averaged 96% (range 91–100%) across the review period. Reliable transfer execution ensures patients in acute psychiatric crisis reach crisis-level care without placement-related delays.

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)	1.0*	0.0	100%
Senior Psychologist (Supervisor)	3.0*	2.0	33%
Supervising Psychiatric Social Worker I	1.5*	1.0	33%
Senior Psychologist (Specialist)	3.5	2.0	43%
Recreation Therapist	6.5	9.33	0%
Staff Psychiatrist	9.5*	9.03	5%
Psychologist – Clinical	7.5	7.5	0%
Clinical Social Worker	6.0	6.0	0%
Primary Clinician (PC)	30.0*	28.84	4%
PC: Psychologist – Clinical		6.71	
PC: Clinical Social Worker		18.5	
PC: Marriage and Family Therapist		3.09	
PC: Professional Clinical Counselor		0.54	

Allocation changed during the reporting period due to January 2026 staffing revisions (*). Vacancy rates are weighted averages. Filled positions for Primary Clinician sub-classifications show the discipline breakdown of filled PC positions. Telehealth and registry providers are included.

✓ **Strengths**

Clinical positions substantially filled: Non-supervisory clinical positions (psychologist, clinical social worker, primary clinician) achieved 94% fill. Psychiatrist positions reached 87% fill (with 36% via telepsychiatry). Recreation Therapist positions filled at 143%. Substantial fill of direct-care positions provides the workforce foundation for clinical service delivery. This finding is presented alongside timeliness deficits that persist despite adequate fill rates.

EOP programming exceeds minimums: Recreation Therapist fill supports EOP structured treatment hours that exceed Program Guide minimums. See related findings in Access to Care.

⚠ Concerns

Chief Psychiatrist vacant three years: The Chief Psychiatrist position has been vacant since January 2023 (0 of 1.0 FTE). The three-year vacancy in the position most responsible for psychiatric documentation oversight is an upstream cause for multiple downstream documentation quality deficits. See related Priority Recommendation addressing supervisory oversight capacity.

Supervisory positions chronically unfilled: Senior Psychologist (Specialist) fill at 57%, Senior Psychologist (Supervisor) at 67%, Supervising Psychiatric Social Worker at 67%. Supervisory vacancies across disciplines create a structural gap in clinical oversight that training completion alone cannot compensate for. See related Priority Recommendation.

Recommendations

See Priority Recommendations

Receiver's Signature Page

Appendix A: Acronyms and Initialisms

Acronym List	
ASP	Avenal State Prison
APP	Acute Psychiatric Program
ASH	Atascadero State Hospital
BPT	Board of Prison Terms
C&PR	Classification and Parole Representative
CAL	Calipatria State Prison
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
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
CQIT	Continuous Quality Improvement Tool
CQI	Continuous Quality Improvement
CRC	California Rehabilitation Center
CTC	Correctional Treatment Center
CTF	California 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
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 Prisons
HPS I	Health Program Specialist I
HQ	Headquarters

ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Interdisciplinary Treatment Team
ISP	Ironwood State Prison
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 Plan
MCSP	Mule Creek State Prison
MH	Mental Health
MHA	Mental Health Administrator
MHCB	Mental Health Crisis Bed
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
MSF	Minimum Support Facility
NA	Nurse Administered
NDRH	Non-Disciplinary Restricted Housing
NDPF	Non-Designated Programming Facility
NKSP	North Kern State Prison
OA	Office Assistant
OT	Office Technician
PBSP	Pelican Bay State Prison
PBST	Positive Behavior Support Team
PC	Primary Clinician
PIP	Psychiatric Inpatient Program
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 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 Camp
SHO	Senior Hearing Officer
SNY	Sensitive Needs Yard
SOL	California State Prison, Solano
SOMS	Strategic Offender Management System
SPRFIT	Suicide Prevention and Response Focus Improvement Team
SQRC	San Quentin Rehabilitation Center
SRASHE	Suicide Risk and Self Harm Evaluation
SRE	Suicide Risk Evaluation
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

Section I: Restricted Housing Unit (RHU)

***Second Watch Partnership Huddle**:* The RHU partnership huddle was observed during this review. During the huddle, mental health staff identified patients at high risk for suicide and discussed patients new to the unit. A mental health clinician and the unit sergeant were present.

Psychiatric Technician (PT) Rounds: Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

Intake Cells: CCWF's RHU Unit, Building 504, currently has twelve intake cells (123 – 131 on the bottom tier and 226 – 229 on the top tier). All intake cells were labeled "Intake". There was signage on the doors which indicated orientation start and end dates, restrictions, mental health status, and RHU program status.

At the time of the review, the RHU had four incarcerated persons arrive within 72 hours of intake, 3 were housed in designated intake cells and one incarcerated person was housed in a non-designated intake cell (cell 116L) due to required electricity for DME (CPAP) utilization. The issue of new intake patients placed in DPW cells within RHUs has been identified as requiring a statewide improvement plan.

RHU Screening (Pre-placement): Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

Welfare Check Completion (Guard One): Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

Section II: Inpatient Units

Suicide-resistant cells: All CCWF MHCB cells are retrofitted in compliance with statewide policy.

On February 26, 2024, construction was completed on the MHCB treatment room in Building 805, room 68, and staff received approval to begin utilizing the space to provide mental health treatment. This room provides a confidential out of cell treatment space for clinicians to utilize during 1:1 MHPC/MHMD contacts.

On Demand data from September 1 to February 28, 2026, indicated that out of cell, confidential MHPC treatment contacts occurred in an "office" setting 245 times out of the 331 contacts (74%). Ten MHPC notes were reviewed to determine consistency with the location setting of the contact. In all cases, the MHPC notes documented that the contact occurred in a confidential office setting, even when confidential session did not occur. This is a slight improvement from the 66% identified in the prior audit, as such, the CAP regarding this concern will remain open.

A review of the On Demand data revealed the average duration of the inpatient MHPC contacts completed during the audit period was 13 minutes for all MHPC contacts regardless of location setting.

During the current assessment, the auditors were informed that the practice of "grand rounds" (rounding with the entire treatment team) had been discontinued and patients were offered daily assessments in a confidential interview room. An auditor examined the medical charts of nine (9) patients who were on suicide observation status in the MHCB unit during February and March 2026. The review found that all of the patients were consistently seen on a daily basis by the MHMD. In addition, a MHPC was noted as seeing patients several times a week, often with the MHMD.

Interdisciplinary Treatment Teams (IDTT): A total of four MHCB IDTT meetings were observed during the onsite review. Three of the IDTTs were held in the patient's room due to the patient refusing to attend their IDTT. Three of the meetings were initial IDTTs and one was a discharge IDTT. Two patients were admitted for SI and two for Significant Impairment/Dysfunction Due to Mental Illness (SIDDMI). One of the patients was on max custody status and was placed in mechanical restraints while the IDTT meeting was conducted in the cell.

The thoroughness of the presentation varied depending on the clinician. For example, one clinician struggled with two case presentations and needed supplemental intervention from the chief psychologist/MHCB supervisor to complete the process. The chief psychologist, who regularly attends the MHCB IDTTs, provided pertinent information in some cases that was omitted by the presenting clinician. Each of the primary clinicians initiated the introductions and the purpose for each of the IDTTs. Three patients were on suicide watch observation and were issued safety smocks. Appropriateness of issue and observation status were discussed in all cases. The primary clinicians and the chief psychologist provided relevant historical and brief clinical summaries that included current symptomatology, diagnosis, reason for admission, hospitalizations, and strengths and weaknesses. Measurable treatment goals were identified and discussed in three cases. Diagnosis, medication and side effects were thoroughly discussed by the psychiatrist in all cases. The CCI was engaged and contributed relevant information for each patient along with providing support and encouragement. Nursing staff provided information regarding medical issues. The psychiatric technician and recreational therapist discussed information about out of cell time and available groups offered.

The team was interactive and all members participated in the discussion. Safety plans and issue and observation levels were also discussed in all cases. Higher level of care and appropriateness of level of care were also discussed for each patient. It is recommended that the presenting clinicians familiarize themselves with the CQIT audit criteria for IDTTs to guide the presentation and assist in providing succinct clinical information during the team meeting.

Quality of Safety Planning: A shared review performed by two auditors of MHCB rescission data found that less than 3 percent (1 of 30) of the cases had adequate safety plans containing specific interventions to reduce suicide risk, with the vast majority of remaining cases having inadequate (25) or no (4) safety plans completed. In addition, the review of MHCB discharge data found five of 13 (38%) safety plans contained specific interventions to reduce suicide risk. Very few of the safety plans were completed in collaboration with the patient. Based on observations of alternative housing mental health assessments and statements made by clinicians during the rounding, most contacts were completed in a non-confidential setting.

Areas for improvement continue to be found in documentation of identifying each patient's specific risk factors, documentation of specific interventions to reduce risk and refraining from using cut and pasted information in multiple sections. This issue was first identified in during the February 2024 HQ SPRFIT review and the CAP regarding this concern will remain open.

Suicide Watch and Suicide Precaution: There were six patients housed in the MHCB at the onset of the on-site review, one patient was on a Q-30 observation, three patients on Suicide Precaution and two were on Suicide Watch. During the on-site review, patient observation status was updated based on clinical presentation. For timeliness of suicide precaution and suicide watch rounds during the audit period, please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

As noted in previous reports, CCWF continues to maintain the practice of maintaining patients on Suicide Precaution upon discharge from the MHCB despite repeated requests to change this practice. The MHCB closed in November 2021 and reopened in October 2023; however, this issue was first documented during the fifth re-audit conduct by Lindsay Hayes while the MHCB was closed and again upon the reopening of the MHCB in October 2023. During previous reviews, leadership expressed uncertainty regarding the placement in EHRS of observation orders that allow for observations other than for Suicide Watch or Suicide Precaution. Information regarding placing alternative observation (mental health observation at Q-30 intervals or Other Frequency Monitoring) orders was provided to the chief psychologist on March 4, 2024, after the review on February 22, 2024, however this practice continues to remain in place.

Ten patients were reviewed during the months of January and February 2026, and eight patients remained on suicide precaution observation upon MHCB discharge. One was placed on a Q30 one day prior to discharge and one remained on Q30 orders for five days prior to discharge. Of the eight reviewed who were maintained on suicide precaution, three patients denied suicidal ideations for eight consecutive days prior to discharge.

Another three patients denied suicidal ideation for seven consecutive days prior to discharge and two patients denied suicidal ideation for nine consecutive days prior to discharge.

The review revealed that justification documentation for observation and issue orders were non-specific. Copy and pasted clinical justification across multiple psychiatrists and multiple patients was found in all cases. Most, if not all clinical documentation included one of the two justifications: "*Patient denying SI/TOD/DIB and therefore does not require safety smock or 1:1 sitter, will remain on staggered q11min checks and regular MHCB approved clothing issue (bra, muumuu, shirt, pants, underwear, socks).*" Or "*I/P denies any SI/HI currently, hence does not need 1:1 observation, hence cont Q15 checks for I/Ps safety.*"

CCWF's corrective action plan submitted on May 19, 2025, and updated on November 19, 2025, indicated rationale would be included if enhanced suicide observations were continued until the patient's discharge. The plan also indicated that the MHCB clinical director would randomly audit 10 MHCB patient's chart to ensure observation orders are being utilized according to policy and appropriate clinical rationale is documented in the chart. The review revealed clinical justification was missing in the reviewed documentation when patients remained on suicide precaution observation status despite no longer endorsing suicidal ideation.

In addition, CCWF's submitted corrective action plan indicated the results of their audit would be presented in the monthly SPRFIT meeting and reflected in the meeting minutes. To date, the lead reviewer was unable to locate documentation of the audit results in the reviewed SPRFIT minutes. As a result of these findings, the CAP regarding this concern shall remain open.

Observation and Issue Orders: All issue orders posted on the patients' cell doors were current and accurately matched the provider orders documented in EHRS. Clothing and personal items issued to each patient were consistent with these orders.

Privileges: Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

A separate auditor's review of a sample of 10 MHCB patients during the review period found that all were offered both yard and dayroom out-of-cell activity during seven-day time periods, ranging from six (6) to 12.75 hours per week. The overall average was 10.4 hours, and 6 of the 10 patients were offered a minimum of 10 hours out-of-cell activity during seven-day periods. In addition, all patients were offered between 2 to 4 showers and telephone calls per week.

Clinical Discharge Follow-Ups:

The On Demand Performance Indicator noted CCWF's overall Timely Clinical Follow Up compliance during the audit period as 38%. As of March 2025, the business rule indicates that day 1 of the clinical follow up must occur within 24 hours of discharge from the MHCB. Additionally, follow up compliance is now calculated as compliant or not compliant for the entire follow up series, whereas it was previously calculated daily. Currently if one day of the follow-up is out of compliance, the entire follow-up is now deemed out of compliance. Changes to these business rules have significantly impacted compliance for this indicator statewide and are currently in the process of being updated to reflect the intent of the statewide policy, which mandates daily follow-ups beginning the day following physical discharge, rather than within 24 hours.

A random sample of 15 patients who were rescinded from MHCB LOC was reviewed by one auditor. All five-days of the series of follow-ups were completed. In all but one case, safety plans were completed or updated during the duration of the 5 Day Follow-Up series. However, as noted above, the overall quality of safety planning was inadequate.

MHCB Supervisor Review of Discharging Safety Plans:

A review of the On Demand Performance Report during the audit period indicated that the chief psychologist or chief of mental health reviewed 80% (69 of 73) of plans. Data indicates 80% of safety plans were completed timely.

MHCB supervisory review of safety plans indicated that more plans were completed and reviewed than were clinically necessary and required. This likely occurred because of misinterpretation of policy which requires plan completion only when admission was for DTS and/or became suicidal during placement which resulted in suicide observation.

Several reviewed safety plans were completed for patients admitted for DTO and SIDDMI, and not displaying any suicidal behavior yet still placed on suicide observation.

Alternative Housing

CCWF's MH OP 012, Alternative Housing outlines the alternative housing process and specifies a prioritized alternative housing location list. Alternative Housing was primarily found in four cells in Building 503 (RC housing), Building 504 (RHU), and three wet holding cells (A-145, A-73, and A-20) in Building 805. When those cells are full, IPs are housed in Temporary Holding Cells (THCs) up to a maximum of four (4) hours throughout the facility. At the time of audit, A-145 was off-line due to a broken window. Alternative housing continued to be utilized on almost a daily basis at CCWF. The patient cells were clean and contained a bed per policy, while being monitored at 1:1 observation level.

The auditors were provided data on 399 patients placed in Alternative Housing for DTS from September 1, 2025, through February 28, 2026. Almost all were housed under 24 hours. The majority of cases (60 percent, 238 of 399) resulted in the MHCB referrals being rescinded and patients returned to their housing units. Electronic health record review of 30 rescinded cases found that all the required SREs and daily clinical follow-ups for each of the five required days were completed.

An observed Alternative Housing assessment in A-73 (Building 805) on April 9, 2026, found that the officer did not allow for a confidential assessment, informing the clinician that "we usually do it cell front." The clinician informed the auditor that the same problem occurred a few days earlier on April 6 with a different officer. Chart review of a third case indicated that an assessment on April 7, 2026, in A-73, occurred inside the cell (with the door open), with no written documentation that the patient was offered the opportunity for a confidential setting.

Examination of Temporary Holding Cell (THC) Logs from all four yards and Building 805 found 11 patients were held over the maximum 4 hours for DTS from January 2026 to April 2026. Nine (9) patients were held between 5 and 8 hours, while two (2) of these patients were held over 10 hours in the THCs. SPRFIT minutes suggested patients sometimes refused to leave the THCs, but such an explanation was not documented in the logs. This issue was first identified in the July 2025 review and the CAP regarding this concern will remain open.

During the audit period, On Demand Performance Report data revealed CCWF was 96 percent compliant with timely transfers to the MHCB. Justification documentation for 15 MHCB rescinded patients were reviewed by one auditor, with findings that two of the 15 SREs did not include clinical rationale for rescinding the patients from MHCB level of care.

Suicide Risk Management Program (SRMP)

At the time of this review, the On Demand Performance Report noted 38 patients were included in the program. There was one patient who met criteria but was not included. The SPRFIT Coordinator completes a monthly audit of the SRMP, which includes tracking of patients placed in the program and treatment plan compliance. The SPRFIT Coordinator also tracks for report accuracy. CCWF's SRMP process is included in their LOP MH-013 Suicide Risk Management Program.

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.

Discharge Custody Checks

Examination of 101 patients discharged from a MHCB or alternative housing placement from September 2025 through early January 2026 found that 72 percent (73 of 101) of page one of the two-page "Discharge Custody Check Sheet" (CDCR MH-7497) forms were completed correctly by mental health clinicians and 68 percent (69 of 101) of page 2 of the "Discharge Custody Check Sheet" (CDCR MH-7497) forms were completed correctly by custody staff. Most errors were attributable to clinicians not completing Day 1 of the form, missing custody supervisor review, and gaps in observation by custody officers. This issue was first identified in May 2023 and the CAP regarding this concern will remain open. As of January 5, 2026, CCWF began utilizing the digital custody check application process.

Local SPRFIT Committee

Review of six monthly SPRFIT meeting minutes for the reporting period found that meetings always had quorums, included discussion on compliance data, improvement projects, as well as the status of corrective actions based upon regional SPRFIT audits and/or previous recommendations from the Receiver's suicide prevention expert, tracked and provided brief review of patients in the SRMP, and provided reception center screening data. There were no serious suicide attempts with a medical severity rating of "3" that necessitated a clinical review or root cause analysis. Although a current SPRFIT local operating procedure (LOP), as well as other suicide prevention LOPs were up-to-date, the "Crisis Intervention Team" LOP (MH-019) incorrectly authorized various holding cell locations [e.g., RHU (504), EOP (508) and TTA (805)] to be utilized as confidential settings for mental health assessments.

CCWF's SPRFIT Coordinator last attended a Patient Advisory Council (PAC) meeting in September 2025, which is beyond the 6-month policy requirement. The CCWF Patient Family Council (PFC) has been disbanded and continues to search for qualified board members. The SPRFIT Coordinator will continue to monitor if/when a new Patient Family Council has been formed.

Urgent and Emergent Referrals for Danger to Self

Review of Urgent/Emergent referrals not for DTS but requiring an SRE found that 13 of 15 (87%) had SREs, but 8 of 13 (62%) incorrectly used the abbreviated SRE assessment form. A review of the On Demand Performance Report for Urgent/Emergent referrals found that SREs for emergent consults were completed in 94 percent of cases (n=219) and 100 percent for urgent consults (n=1) for DTS.

Suicide Risk Evaluations

A review of the Suicide Risk Evaluation indicator in On Demand for the time period of September 1, 2025 through February 28, 2026, resulted in an overall compliance of 75 percent for SREs completed timely.

There were 340 patients referred to the MHCB for DTS during the review period. On Demand Performance Report data indicated 56 percent (193/340) had the required SRE completed. Low compliance is mainly attributed to after-hour phone consult to the on-call or night shift psychiatrist where SREs are not completed at the time of the referral. There were 123 clinical discharges from both a MHCB or PIP and SREs were completed in 98 percent (120/123) of cases. Of the 223 MHCB rescissions, SREs were completed in 96 percent (215/223) of the cases.

The business rules for the MHCB referral indicator have changed in recent months to accurately reflect current statewide policy, and concerns regarding meeting timelines for after-hours referrals have been identified, which are negatively impacting overall compliance. As a result, actions have been taken to revise the policy language to better align with the intent of the indicator. Significant decreases in compliance for SREs following MHCB discharge were also noted. Concerns have been raised regarding the failure of these assessments to populate in the Current Due Dates report, which has impacted timely scheduling, and actions are currently underway to rebuild this report.

As noted earlier, review of data regarding MHCB discharges and MHCB recissions found timely completion of required SREs and 5-Day clinical follow-up forms.

Emergency Response

Cut Down Kits: Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

Suicide Case Review Quality Improvement Plan (QIP) Follow Up

CCWF has not had an occurrence of a suicide since April 2018.

Training and Mentoring Compliance

Review of the Court Mandated Trainings for March 2026, as well as information obtained from CCWF, indicated the following compliance rates:

- Understanding and Assessing the Presence, Severity and Risk of Suicidality: 98%
- Safety Planning Intervention: 97%
- SRE Mentoring: 90%
- Suicide Risk Management Program: 97%
- Annual IST Suicide Prevention (December 2025):
    - Custody: 99%
    - Mental Health: 100%
    - Healthcare: 99%
- CPR Certification
    - Custody: 100%
    - Nursing: 100%

Receiving and Release (R&R) Screening

Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

Reception Center Processing

Five (5) diagnostic screenings by two clinicians in the Reception Center were observed. Three screenings by one clinician were found to be adequate. Problems were encountered with observation of the second Reception Center clinician in their "mental health screening" assessments in two cases. The clinician took hand-written notes of their interactions with the two patients and did not enter patient responses into the EHRS until sometime later in the day. The clinician asked questions by memory and, therefore, did not ask all 27 questions on the Mental Health Screening form as required. In addition, the clinician did not request completion of a Release of Information form for one patient with an extensive history of mental health treatment in the community, nor complete an SRE on another patient with an extensive, yet unclear current and prior history of suicidal behavior.

Crisis Intervention Team (CIT)

CCWF has a CIT which operates on Monday, Tuesday and Wednesday from 1600 to 2200 hours. Yard clinicians respond to crisis calls during all other hours. No CIT responses were observed during the onsite assessment.

However, during the tour, one observed crisis response for DTS in Building 508 (EOP) found that a THC log was initiated for the patient, but had not been updated for approximately one hour (i.e., patient placed in the THC at approximately 8:30am, the auditor arrived at approximately 10:45am to observe assessment, and inspection of the log found it had not been updated since 9:45am.) Also, contrary to CCWF's LOP for THCs, the patient was cuffed inside THC until arrival of the clinician, when the patient was uncuffed and escorted to a private room for assessment.

Assignment of Corrective Action Plans as a Result of this Review

As a result of this review, no additional CAPs have been generated, however six recommendations have been generated. Focus should remain on the eight previously assigned and open CAPs listed below as well as the newly identified recommendations.

Problem	Current Status
1. Concerns were identified with inadequate documentation of safety plans for both patients rescinded and discharged from MHCB level of care. Specifically, Lindsay Hayes reported 70% of MHCB safety plans were adequate, although 100% of them were deemed adequate by the supervisor. He also found that only 25% of safety plans were deemed adequate for rescinded patients. **This concern was identified as a result of the HQ SPRFIT review in February 2024.**	Two separate reviews by auditors of MHCB discharge data found that five of 13 (38%) safety plans contained specific interventions to reduce suicide risk. Very few of the safety plans were completed in collaboration with the patient. It appears that most contacts were completed in a non-confidential setting. Information regarding appropriate documentation of safety planning was emailed to the Chief Psychologist and Chief of Mental Health on December 1 & 2, 2025.
2. Concerns were identified with safety plans not being completed for patients rescinded from MHCB level of care and were referred for DTS. **This concern was first identified during the May 2024 review and assigned a CAP after the December 2024 review.**	Two separate reviews by auditors of MHCB rescission data found that less than 3 percent (1 of 30) of the cases had adequate safety plans containing specific interventions to reduce suicide risk, with the vast majority of remaining cases having inadequate (25) or no (4) safety plans completed.
3. Concerns were identified with patients not receiving MHPC and MHMD confidential, out of cell clinical 1:1 treatment contacts per statewide policy. **This concern was identified during the February 2024 HQ SPRFIT Review.**	On Demand data from September 1 to February 28, 2026, indicated that out of cell, confidential MHPC treatment contacts occurred in an "office" setting 245 times out of the 331 contacts (74%). Ten MHPC notes were reviewed to determine consistency with the location setting of the contacts.

4. Concerns were identified with the continuance of the practice of maintaining suicide precaution observation for all patients who are no longer at an elevated suicide risk until MHCB discharge if they have no restrictions on issue and privileges. **This concern was identified at the reopening of the MHCB in October 2023 and identified in the last four HQ SPRFIT Coordinator reports.**	Of the ten patients reviewed during January and February 2026, eight patients remained on suicide precaution observation upon MHCB discharge. One was placed on a Q30 one day prior to discharge and one remained on Q30 orders for five days prior to discharge. Of the eight reviewed who were maintained on suicide precaution, three patients denied suicidal ideations for eight consecutive days prior to discharge. Another three patients denied suicidal ideation for seven consecutive days prior to discharge and two patients denied suicidal ideation for nine consecutive days prior to discharge. Despite CCWF's CAP response indicating that 10 cases would be audited and results would be provided during the SPRFIT meeting, no documentation of this occurring has been included in the reviewed SPRFIT meeting minutes to date.
5. Concerns were identified in the IDTT presentation. Specifically, Lindsay Hayes reported an uneven presentation, no discussion of a safety plan, privileges or diagnosis. **This concern was identified during the July 2025 HQ SPRFIT review.**	Thoroughness of the presentation varied depending on the clinician. For example, one clinician struggled with two case presentations and needed supplemental intervention from the Chief Psychologist/MHCB Supervisor to complete the process. It is recommended that the presenting clinicians familiarize themselves with the CQI audit criteria for IDTTs to guide the presentation and assist in providing succinct clinical information during the team meeting.
6. Concerns were identified in completion of SREs for Emergent and Urgent Consult orders for DTS or as a result of a positive indicator on the R&R nursing screen. Lindsay Hayes found that SREs were completed in 33/40 cases (78%). **This concern was first identified by HQ SPRFIT and Hayes during the July 2025 review.**	Review of Urgent/Emergent referrals <u>not</u> for DTS but requiring an SRE found that 13 of 15 (87%) had SREs, but 8 of 13 (62%) incorrectly used the abbreviated SRE assessment form. A review of the On Demand Performance Report for Urgent/Emergent referrals found that SREs for emergent consults were completed in 94 percent of cases (n=219) and 100 percent for urgent consults (n=1) for DTS.
7. Concerns were identified with page 2 of the 7497 Custody Discharge Wellness Checks. Specifically, 30 minute checks, failure to log when patient arrived in unit and supervisor review continue to be delinquent. This has been a long standing issue over the last few years. **This concern was first identified during the May 2023 HQ SPRFIT review.**	CCWF began utilizing the digital custody check application in early January 2026. Examination of 101 patients discharged from a MHCB or alternative housing placement from September 2025 through early January 2026 found that 72 percent (73 of 101) of page one of the two-page "Discharge Custody Check Sheet" (CDCR MH-7497) forms were completed correctly by mental health clinicians and 68 percent (69 of 101) of page 2 of the "Discharge Custody Check Sheet" (CDCR MH-7497) forms were completed correctly by custody staff. Most errors were attributable to clinicians not completing Day 1 of the form, missing custody supervisor review, and gaps in observation by custody officers.

8. Concerns were identified for 13/22 reviewed cases which resulted in patients who were held in TTMs over the four hour maximum time allotted. In one case, it was reported that a patient who was discharged from the MHCB was held in a TTM on the facility for 20 hours**. This concern was identified during the July 2025 HQ and Hayes review.**	Examination of Temporary Holding Cell (THC) Logs from all four yards and Building 805 found 11 patients were held over the maximum 4 hours for DTS from January 2026 to present. Nine (9) patients were held between 5 and 8 hours, while two (2) of these patients were held over 10 hours in the THCs. SPRFIT minutes suggested patients sometimes refused to leave the THCs, but such an explanation was not documented in the logs.

As a result of this review, the following actions are recommended:

1. Provide training and live auditing of the Reception Center process to ensure that clinicians consistently ask all 27 questions on the Mental Health Screening form, immediately enter patient responses into EHRS, and do not utilize hand-written notes.
2. Offering of Confidential Interview Setting: Provide training to custody officers assigned to Building 805 (A-145, A-73, A-20, and THCs) to ensure that clinicians responding to urgent/emergent referrals, as well as Alternative Housing clearances, are permitted to offer patients the opportunity of a confidential setting for assessment.
3. Ensure Daily Provider Documentation in the MHCB Justifies Issue and Observation Orders: Establish a supervisory review process focusing on the justifications for all patients prior to discharge and provide real-time training to clinicians whose documentation does not meet standards.
4. Provide Refresher Safety Planning Training: Provide refresher training on individualized safety planning to all clinical staff, with mandatory participation for clinicians routinely assigned to MHCB rescissions and MHCB discharges. Emphasize that safety plans must reflect the patient's specific risk factors, be developed collaboratively with the patient, and not consist of stock phrasing. Initiate monthly supervisory review of a random sample of ten safety plans for rescinded MHCB referrals, with individual mentoring for plans that do not meet standards.
5. Initiate Supervisory Review of Holding Cells Logs: Ensure that the maximum length of stay for patients held in Temporary Holding Cells (THCs) for DTS pending clinical assessment does not exceed four (4) hours. If a patient refuses to leave the THC, the log should note such an explanation.
6. Improve Discharge Custody Check Sheet (CDCR MH-7497) Form Completion and Accuracy: Provide targeted retraining for clinical and custody staff, emphasizing the specific error categories identified (missed Day 1 documentation by clinicians, missed supervisory reviews, and missed custody checks).

Appendix C: MAPIP

INSTITUTION 6 MONTH TREND

Central California Women's Facility (CCWF)

February 2026

Population Health Management	6 Months	Trend	SEP	OCT	NOV	DEC	JAN	FEB
Diagnostic Monitoring (All)	84%		87%	86%	87%	84%	81%	81%
QT Prolongation EKG 12 Months	100%		100%	100%	100%	100%	100%	100%
Antipsychotics (All)	87%		92%	90%	89%	86%	83%	84%
Lipid Monitoring	77%		85%	79%	79%	76%	72%	72%
Blood Sugar	87%		93%	91%	87%	82%	81%	86%
EKG	90%		100%	100%	100%	100%	50%	67%
AIMS	71%		72%	89%	75%	60%	60%	69%
Med Consent	95%		93%	95%	97%	96%	92%	95%
CBC with Platelets	87%		96%	88%	91%	87%	78%	84%
CMP	89%		100%	96%	92%	87%	77%	85%
Thyroid Monitoring	82%		91%	84%	89%	83%	74%	74%
Blood Pressure	100%		100%	99%	100%	100%	100%	99%
Height	98%		98%	98%	99%	98%	99%	97%
Weight	99%		100%	99%	100%	100%	99%	98%
Pregnancy	60%		76%	59%	55%	60%	57%	54%
Clozapine (All)	80%		88%	60%	95%	83%	82%	50%
Blood Sugar	100%		-	-	100%	-	100%	-
Lipid Monitoring	100%		-	-	100%	-	-	-
CBC	74%		80%	75%	100%	100%	50%	43%
CMP	100%		100%	-	100%	-	100%	-
EKG	100%		-	-	100%	-	100%	100%
AIMS	67%		100%	-	0%	-	100%	-
Thyroid Monitoring	-		-	-	-	-	-	-
Med Consent	100%		-	-	100%	-	-	100%
Blood Pressure	100%		-	-	100%	-	100%	-

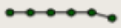
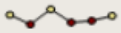
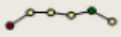
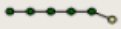
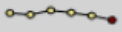
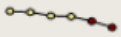
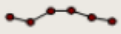
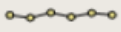
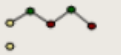
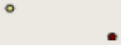
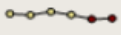
** Rate Per 1,000 Patients*

CCWF CQI Report | 2026

Height	100%		-	-	100%	-	100%	-
Weight	100%		-	-	100%	-	100%	-
Pregnancy	25%		100%	0%	-	0%	-	0%
Mood Stabilizers (All)	79%		82%	78%	83%	78%	75%	80%
Carbamazepine (All)	78%		100%	50%	89%	-	100%	50%
Carbamazepine Level	60%		-	0%	50%	-	100%	-
CBC	86%		100%	100%	100%	-	-	50%
CMP	86%		100%	100%	100%	-	-	50%
Med Consent	100%		-	100%	100%	-	100%	-
Pregnancy	33%		-	0%	-	-	100%	-
Valproic Acid (All)	82%		83%	84%	79%	83%	80%	84%
Med Consent	92%		100%	90%	100%	100%	80%	83%
Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Height	97%		92%	100%	100%	100%	100%	93%
Valproic Acid Level	47%		50%	58%	50%	25%	50%	50%
CBC with Platelets	80%		60%	86%	63%	91%	100%	83%
CMP	80%		64%	75%	67%	100%	100%	79%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	62%		100%	78%	50%	50%	40%	67%
Lithium (All)	79%		82%	83%	81%	79%	69%	78%
Lithium Level	45%		75%	58%	63%	11%	45%	13%
Thyroid Monitoring	74%		50%	89%	73%	70%	75%	85%
CMP	77%		89%	78%	89%	86%	33%	75%
CBC	86%		100%	71%	86%	100%	50%	89%
EKG	78%		75%	100%	75%	100%	67%	67%
Med Consent	94%		88%	100%	100%	89%	88%	100%

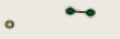
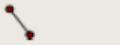
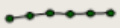
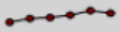
** Rate Per 1,000 Patients*

CCWF CQI Report | 2026

Height	98%		100%	100%	100%	100%	100%	93%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	47%		43%	60%	20%	100%	50%	25%
Oxcarbazepine (All)	73%		78%	64%	86%	67%	69%	76%
CBC	75%		95%	63%	93%	61%	70%	77%
CMP	74%		80%	63%	81%	65%	69%	88%
Med Consent	83%		69%	89%	89%	85%	92%	75%
Pregnancy	46%		43%	25%	75%	50%	29%	40%
Lamotrigine - Med Consent	98%		100%	100%	100%	100%	100%	89%
Antidepressants (All)	78%		80%	78%	83%	80%	77%	72%
EKG (Tricyclics)	100%		-	-	-	100%	-	-
Med Consent	91%		89%	93%	94%	90%	90%	91%
Thyroid Monitoring	78%		87%	85%	80%	78%	71%	62%
Pregnancy	56%		56%	51%	61%	62%	55%	52%
Venla Blood Pressure	99%		100%	97%	100%	100%	100%	100%
Medication Management	**6 Months**	**Trend**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**
Medications Received Timely (All)	84%		85%	85%	84%	83%	83%	83%
By Transfer Type								
New Arrival to CDCR (RC) – RC	79%		79%	77%	82%	78%	82%	80%
New Arrival to CDCR (RC) – RHU	81%		76%	97%	74%	100%	71%	-
New Arrival to CDCR (RC) – MHCB	54%		76%	-	-	-	-	11%
New Arrival to CDCR (RC) – CTC	90%		-	-	-	-	95%	77%
Intra-System (Within Institutions) – GP	77%		78%	77%	81%	77%	73%	73%
Intra-System (Within Institutions) – RHU	86%		87%	90%	85%	85%	85%	86%
Intra-System (Within Institutions) – MH Inpatient	80%		76%	79%	89%	76%	85%	80%
Intra-System (Within Institutions) – Specialized Medical	85%		86%	97%	91%	73%	93%	92%

** Rate Per 1,000 Patients*

CCWF CQI Report | 2026

Inter-System (Between Institutions) – GP	82%		84%	88%	81%	68%	76%	86%
Inter-System (Between Institutions) – RHU	89%		85%	96%	86%	100%	22%	92%
Inter-System (Between Institutions) – MH Inpatient	92%		83%	94%	-	100%	100%	-
Inter-System (Between Institutions) – Specialized Medical	89%		77%	-	-	99%	96%	-
Return to CDCR – GP	80%		80%	85%	85%	70%	76%	74%
Return to CDCR – RHU	68%		74%	7%	90%	97%	62%	33%
Return to CDCR – MH Inpatient	60%		71%	22%	-	-	-	-
Return to CDCR – Specialized Medical	88%		99%	90%	-	99%	78%	90%
Stable Housing	84%		85%	85%	84%	83%	83%	83%
Leaving CDCR	97%		93%	97%	100%	99%	100%	100%
By Provider Type								
Psychiatry	86%		86%	87%	86%	85%	85%	85%
By Provider Type								
Psychiatry - Refused	4%		4%	4%	3%	4%	5%	5%
Non-Formulary by Psychiatrists	**13.6%**		**12.2%**	**13.0%**	**13.3%**	**13.8%**	**14.8%**	**14.3%**

** Rate Per 1,000 Patients*

Appendix D: Sustainable Process Report

Site Visit Report for California Department of Corrections and Rehabilitation
(CENTRAL CALIFORNIA WOMEN'S FACILITY)

SITE VISIT DATES

April 6, 2026 – April 9, 2026
CQIT + Sustainable Process

PARTICIPANTS

Regional Mental Health Administrator
Stephanie Neumann, PsyD

Sustainable Process Leads

Senior Psychologist, Specialist (SME) .....Caitlin Chinn, PhD

Senior Psychologist, Specialist (SME) .....Shalila Douglas, PhD

Senior Psychologist, Specialist..... Emily Moresco, PsyD

Program Staff On-Site

Supervising Psychiatric Social Worker..... Elizabeth Harris, LCSW

Senior Psychologist, Specialist..... Brittany Sawyer, PsyD

Senior Psychologist, Specialist.....Mark Wrathall, PsyD

Associate Health Program Advisor.....Daniel Stebbins

AREAS REVIEWED

Program Area Reviewed:	Sustainable process data review – Prior review 11% – Current review TBD
On this major site visit, all MHCB, EOP, and RHU areas were toured. CCWF is required to complete a Q2 2026 HQ Higher Level of Care (HLOC) documentation audit due to not meeting the 85% threshold during the Q1 2026 audit. The first institutional response is due to HQ after completion of this report and is not available to review and analyze for the purposes of this review. The Q1 2026 follow-up action plan was: 1. Ensure all clinical staff are provided with a summary of the overall results of the audit and areas of focus for continued improvement in the quality of the HLOC documentation. Provide training proof of practice logs (i.e., 844s). 2. Before the HQ audit spreadsheet is submitted for Q2 2026, CMH will identify a secondary reviewer to ensure the correct Master Treatment Plan (MTP) is reviewed for all cases. The institutional response was: 1. All MHPCs were provided with the results of the HQ audit. 844s provided. 2. The Chief of Mental Health has been identified as the secondary reviewer for HQ audits prior to submission. IPC directed to submit HQ audit to CMH ahead of deadline so that entries can be reviewed for accuracy.	
Follow-up required: YES ___ NO_X__	If YES: Follow-up date: N/A
Follow-Up Action Plan: N/A	

Program Area Reviewed:	Mental Health Program Subcommittee Minutes

January 2026
Meeting minutes were posted timely to SharePoint and a quorum was met. The IPC was in attendance and presented the information during the meeting. Part V was embedded in the minutes, and all sections were captured in the narrative. There were two Acute referrals and one ICF referral, for a total of three referrals. The referrals were all submitted timely. It was unclear if patients transferred timely as it noted that "both ICF referrals were transferred within specified time frames;" however, there was only one ICF referral submitted. HLOC quality of documentation was 93%, an 8% increase from December. There were zero corrective IDTTs held in December. Two patients were discharged from PIP/DSH in January. All discharge documentation compliance rates were provided and were at 100%.

February 2026
Meeting minutes were posted timely to SharePoint and a quorum was met. An IPC designee was in attendance and the CMH presented the information during the meeting. Part V was embedded in the minutes, and all sections were captured in the narrative. There was one Acute referral that was submitted timely, and the patient transferred within designated timeframes. The were zero ICF referrals initiated/submitted. HLOC quality of documentation was 86%. It was noted that the IPC continues to remind program supervisors to audit MHPC justifications prior to submission to IPC. Additionally, the IPC will continue to train staff on documentation guidelines and HLOC justification requirements. There were three patients discharged from PIP/DSH in February. All discharge documentation compliance rates were provided and were at 100%.

March 2026
Minutes were unable to be reviewed as the due date for submission was after the site visit.

This information, as well as supporting documentation, was provided to the IPCs prior to the completion of this report. Information reported in January was noted by the IPC to be a typo regarding the ICF transfers.

The Q1 2026 follow-up action plan was: N/A.

The institutional response was: N/A.

Follow-up required: YES ___ NO_X_	If YES: Follow-up date: N/A

Follow-Up Action Plan: N/A

Program Area Reviewed:	Referral and Non-Referral Reports

Referral Reports
The On Demand Acute-ICF Referrals report was run for the review period of January through March 2026.

January 2026
One referral was initiated to Acute, and it was not rescinded. The Master Treatment Plan (MTP) was signed timely (within four hours of IDTT), the Due Process Signed column was complete, a Vitek hearing was not documented as being held and the consult was submitted timely to IRU.

Part V of the monthly HLOC audit was consistent with the On Demand data. The referral rate was 2%.

February 2026
Five referrals were initiated: two to Acute and three to ICF.

Of the two Acute referrals, one was rescinded the day before the patient paroled (no rescission note was found in the EHRS). MTPs were both signed timely. One Due Process Signed entry was missing data; the chrono was found scanned under the correct title in the EHRS and it was unknown why the data did not populate. One Vitek hearing was documented as being held for the patient who was paroling and determined that the referral should stand. It was unclear why the patient's level of care was changed to EOP the next day as the patient paroled. This particular referral was not submitted to IRU. The other referral was submitted timely.

Of the three ICF referrals, one was rescinded. MTPs were signed timely in all three entries, the Due Process Signed column was complete, and one Vitek hearing was documented as being held. One MH Consult to MH UM order was not completed. All three referrals were submitted timely to IRU.

Part V of the monthly HLOC audit did not align with the On Demand data. Part V indicated that two Acute referrals were submitted timely, while the On Demand data reflected that two referrals were initiated but only one was submitted. It also reported that three ICF referrals were made with two submitted timely, whereas the On Demand data showed that all three referrals were submitted timely. CCWF noted one late referral due to the MH Consult to MH UM not being initiated in a timely manner; however, Regional has previously advised, including during the site visit, that this step does not determine whether a referral is submitted timely. The referral rate was 12%.

March 2026
Three referrals were initiated: two to Acute and one to ICF.

Of the two Acute referrals, neither was rescinded. MTPs were signed timely in one entry and not timely in the other entry. The Due Process Signed column was missing data in one entry; the chrono was found scanned in the EHRS under the wrong naming convention. One Vitek hearing was held, but the date did not populate on the report, and neither a completed Vitek appointment nor a communication order was found in the EHRS. One referral was submitted timely to IRU, and the other was submitted one day late.

For the one ICF referral, it was not rescinded. The MTP was signed timely, the Due Process Signed column was complete and no Vitek hearings were documented as being held. The referral was submitted timely to IRU.

Part V of the monthly HLOC audit was inconsistent with On Demand data. Part V was accurate with reporting three initiated referrals but indicated there was one Acute referral and two ICF referrals, and the one Acute referral was late because the "master treatment plan was signed at 4 hours and 28 minutes." Regional communicated with the IPC upon review of the inconsistent data to inform them of the discrepancies and errors and provided education again as to what determines if a referral is submitted timely (the timing of the referral being submitted to the IRU SharePoint). Regional requested that Part V be corrected – the accuracy of Part V is imperative to ensure that the correct information is being provided to the Mental Health Program Subcommittee (MHPS) so that barriers can be addressed, such as the reason why the referral was late, and the committee can identify solutions to reduce those issues in the future.

The referral rate was 7%.

The quarterly referral rate was 7%, the same as from the previous quarter. Seven of the nine referrals were submitted timely to IRU, resulting in a timely submission rate of 78%.

This information, as well as supporting documentation, was provided to the IPCs prior to the completion of this report. For both referrals that were not submitted timely, the IPC reported that they were not working on those days or the referral was managed by one of the chiefs. For the referral where the patient's level of care was changed the day before parole, the IPC indicated that the MHCB team referred the patient to a higher level of care out of an abundance of caution due to upcoming parole, but following consultation with CIW, it was determined that the patient did not

meet requirements for 5150 in the community, and as such, likely did not meet the criteria for Acute or MHCB upon release from CCWF. Regional emphasized the distinction between initiated and submitted data for Part V, clarifying that the two terms represent different stages in the reporting process. Additionally, it was reiterated that referrals should not be classified as late solely based on when the MH Consult to MH UM order is completed. This ensures that timing considerations are accurately reflected and that delays are not attributed incorrectly. Regarding the two referrals submitted late to IRU, the Acute referral in February was late because it was rescinded after it was due to IRU and the referral was never submitted, and the Acute referral in March was submitted one day late. In both instances, the IPC reported that they were either not involved in the referral process (MHCB supervisor/CP was managing the referral process) for the February referral or was off and there was a lack of communication that the referral was due when the IPC called out sick. During the site visit, Regional recommended that another column be added to their internal tracking log of the referral's due date for submission to IRU to provide more oversight on the timeliness of referral submissions. This was completed at the time of the IPC meeting. Regional continued to encourage the IPC to take primary ownership of monitoring both the internal tracking spreadsheet and the On Demand data – that this information should be reviewed frequently to identify missing or inaccurate data and to make attempts to correct this information.

Non-Referral Reports
The On Demand Acute-ICF Non-Referrals report was run for the review period of January through March 2026.

January 2026
There were 41 non-referral entries on the report, with no entries for patients already referred to Acute/ICF. Twenty-two (54%) entries were reviewed. There were 35 (85%) entries with single considerations, six (15%) with multiple considerations, zero (0%) with subjective considerations, and 41 (100%) with objective considerations. The most common consideration was #5 (61%).

Two data errors were identified; one was for a consideration that was endorsed when it was not flagged and one was for a consideration that was not endorsed when it was flagged. The data error rate was 9%.

February 2026
There were 37 non-referral entries on the report, with no entries for patients already referred to Acute/ICF. Eighteen (49%) entries were reviewed. There were 26 (70%) with single considerations, 11 (30%) with multiple considerations, one (3%) with subjective considerations, and 37 (100%) with objective considerations. The most common consideration was #5 (54%).

Data errors identified in the reviewed entries included: MTP was entered in the wrong encounter, and the entry did not populate on the report (two entries); and consideration that was endorsed when it was not flagged (one entry). The data error rate was 17%.

March 2026
There were 44 non-referral entries on the report, with one entry for a patient already referred to Acute/ICF. Twenty-one (49%) of the non-referral entries were reviewed. There were 29 (66%) with single considerations, 15 (34%) with multiple considerations, three (7%) with subjective considerations, 43 (98%) with objective considerations, and the most common consideration was #5 (64%).

Two data errors were identified in the reviewed entries; one where a consideration was endorsed when it was not flagged on the Sustainable Process Report (SPR) and one where a consideration was not endorsed when it was flagged on the SPR. The data error rate was 10%.

The quarterly data error rate was 11%, a 4% increase from the previous quarter.

This information, as well as supporting documentation, was provided to the IPCs prior to the completion of this report.

The Q1 2026 follow-up action plan was: N/A.

The institutional response was: N/A.

Follow-up required: YES _X_ NO___	If YES: Follow-up date: June 12, 2026

Follow-Up Action Plan: 1. Provide the plan on steps the IPC will take to monitor and cross-reference internal data with On Demand data – how frequently and what are the expectations of the IPC to ensure that the data in On Demand is accurate?

Program Area Reviewed:	Documentation Review – Higher Level of Care Tab

Quality

Eight cases were randomly selected from the February 2026 monthly HLOC audit and reviewed for quality of the rationale and intervention sections within the HLOC tab of the MTP. The February 2026 audit was reviewed in place of the March 2026 audit as that data was not available at the time of this review. Four cases were found to have unacceptable documentation. In two cases, the treatment team did not explicitly discuss what behaviors and/or symptoms were driving the endorsed considerations, and it could not be determined if the interventions provided were tailored to the patient's specific needs. This resulted in the rationale and intervention sections being unacceptable. In the third case, consideration #2 was endorsed but there was no discussion regarding why, which also resulted in unacceptable rationale and intervention sections. In the fourth and final case, the rationale and intervention sections were unacceptable because the MTP had not been signed.

Regional's review of outcomes was discrepant in three cases. In all three cases the rationale and intervention sections were found to be unacceptable by Regional while the institution's findings were acceptable. In the first two cases, Regional noted that the consideration was not explicitly explained by the treatment team. In the third case, consideration #2 was endorsed but not discussed in text of the document.

Consistency

The same eight cases were reviewed for consistency of the endorsed consideration in the HLOC documentation from the MTP with documentation in the EHRS and SPR. Seven cases were found to be consistent. In the case that was not consistent, the treatment team endorsed consideration #2 but there was no discussion regarding why the patient met those criteria or the clinical interventions to be implemented to address those issues.

Additional issues regarding the overall quality of the MTP documentation included: not all required members of the treatment team were present for the IDTT (two cases); the patient's diagnosis did not capture the patient's described clinical presentation in the HLOC section of the MTP; the patient was assigned multiple conflicting diagnoses (two cases); the behaviors, symptoms and/or endorsed consideration described in the HLOC section of the MTP was not addressed in the problem/symptoms in the treatment plan grid (four cases); and, the problem/symptoms targeted in the treatment plan grid conflicted with the patient's described clinical presentation in the HLOC section of the MTP.

This information, as well as supporting documentation, was provided to the IPCs prior to the completion of this report. As was reported the previous quarter, it was noted that clinicians newer to the mental health profession (as well as new to CDCR) have more recently struggled with grasping the requirements of the HLOC documentation standards as well as basic tasks such as writing a Mental Status Exam. As a follow-up to the conversations from the previous site visit, the IPC notes that there are currently no updates regarding progress on exploring additional approaches—beyond traditional training—to support clinicians facing challenges with HLOC documentation. While a variety of ideas were shared during last quarter's site visit with IPCs, chiefs, and the CEO, as well as during recent Region II IPC Support calls, at this time, alternative strategies have not been developed to address the documentation concerns.

The Q1 2026 follow-up action plan was: 1. Supervisors will review Regional's feedback on all the identified cases in this review with the respective clinicians and provide accompanying 844s.

The institutional response was: 1. Supervisors reviewed documentation feedback with respective staff. 844s provided for all staff identified in the audit.

Follow-up required: YES _X_ NO____	If YES: Follow-up date: June 12, 2026

Follow-Up Action Plan: 1. Supervisors will review Regional's feedback on all the identified cases in this review with the respective clinicians and provide accompanying 844s.

Program Area Reviewed:	Attended IDTT in MHCB, RHU, ML EOP

MHCB

Four IDTTs were observed over two days of the CQIT+ site visit; three initials and one routine that resulted in a clinical discharge. Three patients refused to attend their IDTT in the treatment room but agreed to meet with the team in their cell and one patient agreed to be seen in the treatment room. One of the patients was on max custody status and was placed in mechanical restraints. The MHPCs initiated the introductions and stated the purpose for each of the IDTTs. Patients who were on suicide watch observation and precaution were issued safety smocks. Appropriateness of issue and observation status were discussed in all cases. The MHPCs provided relevant historical and brief clinical summaries. Measurable treatment goals were identified and discussed in three cases. Diagnosis, medication and side effects were thoroughly discussed by the MHMD. The CCI was engaged and contributed relevant information for each patient along with providing encouragement. Nursing staff provided information regarding known and current medical issues. The PT and RT discussed information about out-of-cell time and available groups offered.

Safety plans were discussed. Higher level of care and appropriateness of level of care were also discussed for each patient. Each patient was given an opportunity to provide input regarding their treatment while in the MHCB. Discharge plans were discussed and one patient was clinically discharged. RVRs were discussed.

Overall, the team was interactive, and all members participated in the discussion. None of the IDTTs appeared to have pre-determined IDTT outcomes. While nearly all the criteria were met, the team's ability to do so was dependent on the clinician; the supervisor's guidance was needed for particular clinicians to ensure that the criteria were discussed.

RHU

Five IDTTs were observed with the patients present and they began on time. One was a routine IDTT and the other four were initials. All required team members were present including the MHMD, MHPC, CCI, and PT. In addition, the program supervisor, an escort officer, and an additional MHPC were present for each of the IDTTs. The MHPC initial assessment was completed for all four of the initial IDTTs, but the MHMD initial assessment had only been completed in two cases. In three cases, the clinical summary and case formulation were inadequate. In the other two IDTTs, there was a comprehensive case formulation, but this was presented after the patient left and it was not clear why. There was interactive discussion in all five IDTTs.

In all five IDTTs the MHMD discussed medications, purpose of medication, and side effects by asking the patient to recall each of these and then made corrections when the patient was incorrect. The MHMD discussed diagnosis in four of the five cases, but for the fifth case, the diagnosis was not discussed by the MHMD or the MHPC.

In two of the IDTTs, measurable treatment goals were discussed. In a third, while there were numbers attached to a general symptom, the overall goal was vague and not measurable. In the remaining two IDTTs, measurable goals were not discussed. In the one follow up IDTT it was noted that the patient had met her goals, but these were not specified.

While the HLOC considerations were discussed in three of five IDTTs, they did not appear to be used as a basis for level of care determinations. In one IDTT, there was a discussion about why the patient had not been attending groups and the patient reported that she had not been called out for groups. It was then reported that the patient was new and had not yet been placed in groups. In another IDTT, HLOC considerations were not discussed.

RVRs were discussed in four IDTTs, and in three of those, the results of the RVR MHA were discussed. In one case where mental health factors influenced the RVR, the associated symptoms were incorporated into the treatment plan.

In four of the five cases, the team appeared to be open to patient feedback and thus the IDTTs did not appear to be predetermined. In the fifth case, the patient had significant concerns that impacted her treatment plan. While she was allowed to speak to these concerns, they were not addressed in her treatment plan, and no new goals were developed in response. As a result, the outcome of this IDTT appeared to be predetermined.

ML EOP

Five IDTTs were observed with the patients in attendance for all; one initial IDTT and four routines. EOP level of care was sustained for four patients and one was referred to ICF. The first IDTT was considered to have been completed timely despite it starting 15 minutes late due to issues finding a covering MHMD, as the primary MHMD was required to attend an unexpectedly rescheduled PC2602 hearing. While all required disciplines were present for the IDTT, the person in attendance was not always the assigned treatment provider. The MHPC and MHMD initial assessments were completed prior to the initial IDTT.

The purpose of IDTT was clearly stated in three IDTTs but more explanation was necessary for two. An adequate clinical case formulation was provided for all IDTTs. Measurable treatment goals were discussed in four IDTTs, but not for the one patient referred to ICF. Progress towards treatment goals was discussed in two of the four routine IDTTs, while two provided vague updates and not in measurable terms. The patient being referred to ICF became increasingly agitated during the IDTT. Discussion of higher level of care considerations was considered adequate for all IDTTs. RVRs were discussed in all IDTTs, with no discussion of MHAs required for any of the IDTTs. Work and education assignments and reasonable accommodations were appropriately discussed in all IDTTs.

The CCI was engaged throughout IDTTs and provided helpful information about RVRs and work/education assignments. The covering MHMD engaged each patient and provided relevant information regarding diagnosis, medications to address the diagnosis, and side effects. Clinical and custodial staff had computer access, allowing them to utilize SOMS/ERMS and EHRS during the IDTT process. Discussion was interactive with each team member participating, but additional discussion of interventions would have provided further insight into the treatment plan. Additionally, the supervisor asked relevant clarifying questions, and the RT provided valuable input about each patient's participation and functioning. Patients were provided opportunities to participate in treatment planning. Effective communication was ensured when required. The IDTTs did not appear predetermined with each team members' input considered. A few of the IDTTs were long and circular at points. However, the team appeared comfortable with each other and utilized an organic process that likely provided a safe space for patients to discuss sensitive topics and participate in treatment planning.

The Q1 2026 follow-up action plan was: MHCB: 1. Program supervisor will ensure the following CQIT criteria are met for all patients: measurable treatment goals and a plan for discharge; case formulation that is consistent amongst team members; interactive team discussion that includes all participants, including integrating the patient's input; safety plan for patients admitted for danger to self; interventions and goals related to resistance to treatment; and justification for level of observation. Provide 844. RHU: 1. Program supervisor will ensure the following are met for all patients: RVRs and whether mental health played a role in the patient having received that RVR; and all members are prompted to participate. Provide 844s. ML EOP: 1. Program Supervisor will ensure that RVRs are reviewed during all IDTTs, including assessment of mental health contribution. Behaviors related to RVRs will be incorporated into

treatment plans when clinically appropriate, or that a discussion will reflect the clinical rationale when not applicable. Provide 844s.

The institutional response was: MHCB: 1. CMH will do random audits of IDTT to ensure that following criteria are met: measurable treatment goals and a plan for discharge; case formulation that is consistent amongst team members; interactive team discussion that includes all participants, including integrating the patient's input; safety plan for patients admitted for danger to self; interventions and goals related to resistance to treatment; and justification for level of observation. 844s provided. RHU: 1. CMH regularly audits RHU EOP IDTTs as part of hub certification process. CMH will provide immediate feedback to staff on whether they met criteria for adequate discussion of RVRs and whether mental health played a role in the patient having received that RVR. CMH will also provide feedback on members' participation. 844s provided. ML EOP: 1. CMH will do random audits of IDTT to ensure that following criteria are met: RVRs are reviewed during all IDTTs, including assessment of mental health contribution. Behaviors related to RVRs are incorporated into treatment plans when clinically appropriate, or that a discussion will reflect the clinical rationale when not applicable. 844s provided.

Follow-up required: YES _X_ NO____	If YES: Follow-up date: June 12, 2026

Follow-Up Action Plan:

MHCB: 1. Program supervisor, or designated IDTT team leader, will ensure that measurable treatment goals are discussed for all patients. Provide 844s.

RHU: 1. Program supervisor will provide training to RHU clinical staff that a succinct case formulation includes predisposing, perpetuating, precipitating, and protective factors that inform relevant treatment information is to be discussed with the patient present in the IDTT. If this should be presented without the patient, the reasons for such should be clearly stated. Provide 844s. 2. Supervisor will ensure the team establishes and discusses treatment goals in measurable terms. Provide 844s.

ML EOP: 1. Program supervisor will ensure the following CQIT criteria are discussed: purpose of the IDTT; measurable treatment goals; and updates to goals in measurable terms. Provide 844s.

Program Area Reviewed:	Housing Unit Review

MHCB

The unit was exceptionally clean at the time of observation with HFM actively cleaning the unit. Most patients were observed sleeping and the unit was calm. There was one patient on 1:1 suicide watch and continuous visual contact occurred.

One patient was maintained on the Regional Spreadsheet who was identified during the previous quarter. After review, no recommendations were provided but Regional will continue to monitor. No new patients were identified for further review.

RHU

Side A was active, with several patients and incarcerated individuals yelling from their cells to get the attention of staff. The unit was observed to have minimal trash on the tiers. One water fountain across from cell 101 was covered in black mold/algae. One patient shared that they would benefit from being provided with therapeutically aligned information packets, instead of puzzles or other extraneous tasks that are not related to mental health. Three patients reported that they are not pulled out for individual confidential MHPC sessions during their ducated time, even if they request to come out because they do not want to discuss their symptoms and confidential information on the tier. Patients reported that groups are being cancelled and they are not given a reason for the cancellation. Additionally, some priority ducats are not being treated as "priority" by custody. One patient shared that custody initially refused to provide the updated RHU policy regarding privileges to the incarcerated individuals and once they saw the policy,

they found certain parts that are not being followed, such as if a group is cancelled, no make-up groups are being offered. A patient reported that there is overlapping programing scheduled (yard and dayroom); therefore, they must choose which one to attend. Side B was noisy and smelled of metal/electrical smoke due to construction occurring on the unit due to removal of condemned row barrier.

Three different patients in RHU reported that they are not being seen confidentially for individual sessions by their MHPC during their ducated appointment times even if they ask to come out. This often happens week after week, with one patient reporting they have not been seen confidentially for over a month. The clinician who was identified in all three instances was the same clinician who was identified in the RHU IDTT summary where a patient confronted the MHPC about their actions being inconsistent with what they say they will do. The mental health leadership was provided this information during the site visit.

No patients were maintained on the Regional Spreadsheet who were identified during the previous quarter. Four new patients were identified for further review. Following review, it was determined that no recommendations would be provided in two of the cases. In the third case, it was recommended that the patient be referred to IDTT. In the fourth and final case, specific recommendations were provided to the institution.

ML EOP

The unit was active, with most of the patients out of their cells and in the dayroom engaging in activities or programming outside of the unit. The unit was observed to be clean, and custody did not identify any patients they felt required a higher level of care. There were two cells observed to have white sheets that covered the entirety of the bunk the patients could not be seen.

While leaving 508, a patient approached the auditors explaining that they are in building 505 and reported a variety of concerns: not getting released for yard, lack of concern from custody regarding medical concerns and in some cases had to bang on the cell door for help, cleaning materials were locked up and cannot be accessed when incarcerated individuals want to clean, and needing a ducat to attend chapel.

No patients were maintained on the Regional Spreadsheet who were identified during the previous quarter. Three new patients were identified for further review. After review, it was recommended that two of the cases be referred to IDTT. In the third case, specific recommendations were provided to the institution.

ML CCCMS 503 C/C Status Patients

The unit was observed as part of the larger CQIT+ site visit. A group was being held in the dayroom. The focus of the observation was to assess the cleanliness of the identified alternative housing cells, of which some of the empty cells that could be slated for patients in need of alternative housing had one or more of the following: unclean toilets where there appeared to be organic matter in the toilet or growing in the toilet water; dusty with debris that had not been wiped down or clean recently; and used as storage. The rest of the unit was observed to have debris and unused sanitary supplies littered about on the floor of the dayroom, and possible food remnants and spills. The floor did not appear to have been swept or mopped recently. One patient in RHU who was previously housed in 503 stated that routine mental health rounding does not occur in the unit, which was not consistent with what CCWF reported as one of the newer ways initiated to mitigate the number of alarms in the unit.

During chart reviews for patients in other units, Regional was informed of a lack of mental health services provided to the ML CCCMS C/C patients in the unit, such as confidential individual sessions. Additional completed IDTTs in March for 503 C/C ML CCCMS patients were reviewed. In these cases the following deficiencies were discovered: MTPs that did not address why the patient was placed into C/C in the clinical summary and if there were mental health issues associated with the need for the patient to be restricted to 503; MTPs missing multiple elements of the treatment plan such as clinical summary; MTP that only addressed “depressed mood” with a goal of “pt will comply with terms of contract to discharge from 503”; and lack of clinical interventions.

Four new patients were identified for further review. In all four cases, it was recommended that the patients be referred to IDTT.

The Q1 2026 follow-up action plan was: 1. Refer to the Regional Reporting Spreadsheet to review the specific information related to each patient and complete noted recommendations.

The institutional response was: 1. Spreadsheet provided and responses provided where required.

Follow-up required: YES _X_ NO____	If YES: Follow-up date: June 12, 2026

Follow-Up Action Plan: 1. Refer to the Regional Reporting Spreadsheet to review the specific information related to each patient and complete noted recommendations.

ACTION PLAN

1. Sustainable Process Data Review – N/A.

2. MHPS – N/A.

3. Referral and Non-Referral Reports – 1. Provide the plan on steps the IPC will take to monitor and cross-reference internal data with On Demand data – how frequently and what are the expectations of the IPC to ensure that the data in On Demand is accurate?

4. Documentation Review – 1. Supervisors will review Regional's feedback on all the identified cases in this review with the respective clinicians and provide accompanying 844s.

5. IDTTs – ***MHCB***: 1. Program supervisor, or designated IDTT team leader, will ensure that measurable treatment goals are discussed for all patients. Provide 844s. ***RHU***: 1. Program supervisor will provide training to RHU clinical staff that a succinct case formulation includes predisposing, perpetuating, precipitating, and protective factors that inform relevant treatment information is to be discussed with the patient present in the IDTT. If this should be presented without the patient, the reasons for such should be clearly stated. Provide 844s. 2. Supervisor will ensure the team establishes and discusses treatment goals in measurable terms. Provide 844s. ***ML EOP***: 1. Program supervisor will ensure the following CQIT criteria are discussed: purpose of the IDTT; measurable treatment goals; and updates to goals in measurable terms. Provide 844s.

6. Housing Unit Review – 1. Refer to the Regional Reporting Spreadsheet to review the specific information related to each patient and complete noted recommendations.

SITE VISIT SUMMARY

CCWF is required to complete a Q2 2026 HQ Higher Level of Care (HLOC) documentation audit due to not meeting the 85% threshold during the Q1 2026 audit. The first institutional response to the audit is due to HQ after completion of this report and it is not available to review and analyze for the purposes of this report.

Regional teams are tasked with observing IDTTs utilizing statewide quality standards determined and agreed upon by several stakeholders, which include plaintiff's attorneys, HQ leadership and staff, and external subject matter experts, which have been vetted and mandated via court processes. This has resulted in the adoption of the Continuous Quality Improvement Tool (CQIT) audit criteria for multiple MH program areas, including IDTTs. These standards strive to exceed a constitutional threshold of quality care. Discussion of case formulations, higher level of care considerations and RVRs with associated Mental Health Assessments (MHAs) were adequate in MHCB and ML EOP, and these were not observed for all patients in RHU. None of the programs discussed measurable treatment goals for all patients. All

programs were noted to have interactive processes amongst the team members. IDTT outcomes did not appear to be pre-determined in all but one RHU IDTT where the team did not develop new goals in response to a patient's significant concerns that were verbalized to the team.

CCWF continues to struggle with ensuring accurate information with the On Demand data related to the Acute-ICF Referrals report, missing referral timelines due to a lack of communication when the IPC is away from the institution, reporting accurate information to the MHPS committee via Part V data, and not identifying minor typos in MHPS meeting minutes, despite the low numbers of referrals and non-referrals over the quarter. While the HQ HLOC documentation audit was not completed at the time of this report submission, historically CCWF has not been able to attain the 85% threshold of "good" HLOC documentation. As a result, during the previous site visit, Regional was asked for multiple ideas of what could be implemented to help clinicians who are struggling to meet the HLOC documentation requirements and these ideas were discussed with the IPCs, Chiefs, and CEO during that previous site visit. Additionally, other suggestions by peer Region II IPCs were provided to CCWF during the past months of an IPC Support call that is facilitated monthly by the regional team. The IPC had no updates on whether leadership has taken steps to further discuss or implement the multiple ideas provided by the regional team and peer IPCs over the past quarter to help improve the HLOC documentation quality at the request of CCWF leadership for these ideas. Specialists continue to not be included in senior staff meetings and do not have a consistent meeting schedule with the Chiefs in which they can address questions or seek guidance. There has been, however, improvement with some clinicians in their receptiveness to the IPCs' feedback, which is attributed to support from the leadership and supervisors. Mental health leadership reported that a monthly newsletter for mental health staff has been developed.

Follow-up discussion surrounding ML CCCMS patients who are C/C status housed in 503 occurred during the site visit. Previously, the number of alarms occurring in the unit were causing delays of programming for the rest of the patients and incarcerated individuals on A Yard. Mental health leadership reported steps have been taken to reduce the number of alarms which has included the program supervisor completing routine rounds in the unit, offering individual sessions to the patients, as well as offering groups. It was reported that these measures have reduced the number of medical emergencies and emergent mental health referrals, and have improved the collaboration amongst mental health, custody, and nursing staff in the unit. Documentation of Master Treatment Plans (MTPs) show that recently completed IDTTs for ML CCCMS C/C patients housed in 503 are primarily completed in absentia leading to further questions on whether the 503 C/C patients are refusing or if they are not being offered the chance to attend in person. Additionally, the quality of some of the MTPs was inadequate and the patients were placed on Regional's patient follow-up list with the recommendation to return to IDTT. While there were no concerns about those particular patients being in need of a higher level of care, it led to questions about whether the patients are being adequately assessed and reviewed for higher levels of care if they are not able to be active participants in the IDTT process and clinical quality of the MTPs are inadequate.

Future CQIT+ site visits with a sustainable process review at CCWF are pending and the institution will be notified when those dates are identified.

QUALITY IMPROVEMENT FOLLOW-UP
Please refer to the Sustainable Process CAP Spreadsheet.

Appendix E: RHU EOP Hub Certification Letter (CCWF)

Central California Women's Facility (CCWF) met expectations with explanation due to Timely Mental Health Referrals (83%). This deficiency was due to two referrals being considered out of compliance. One routine Mental Health Medical Doctor (MHMD) consult that was completed one and half days late. The routine Mental Health Primary Clinician (MHPC) consult appears more than thirty days late because it was ordered by California Institution of Women (CIW) Mental Health staff on February 6 but backdated to January 1. The consult was completed by CIW staff on February 9. Because the order was entered incorrectly, it cannot be reset or voided. The corrected Timely Mental Health Referrals is 91%.

Appendix F: Excluded Indicators

- Patients Referred to MHCB on Continuous Direct Visual Observation
- Patients in Alternative Housing with a Bed
- Scheduled MH Appointments Completed or Refused
- Mental Health Primary Clinician Continuity of Care
- Mental Health Psychiatrist Continuity of Care
- Healthcare Staff CMHPP Annual Training
- Monthly Review of EOP Modified Treatment
- ICCs with MH Clinicians Present and Relevant Information Provided
- Institution SPRFIT Meetings Observed that Satisfy All Audit Criteria
- MHSDS Patients Released from CDCR With Pre-Release Planning Forms Signed