CALIFORNIA INSTITUTION FOR WOMEN

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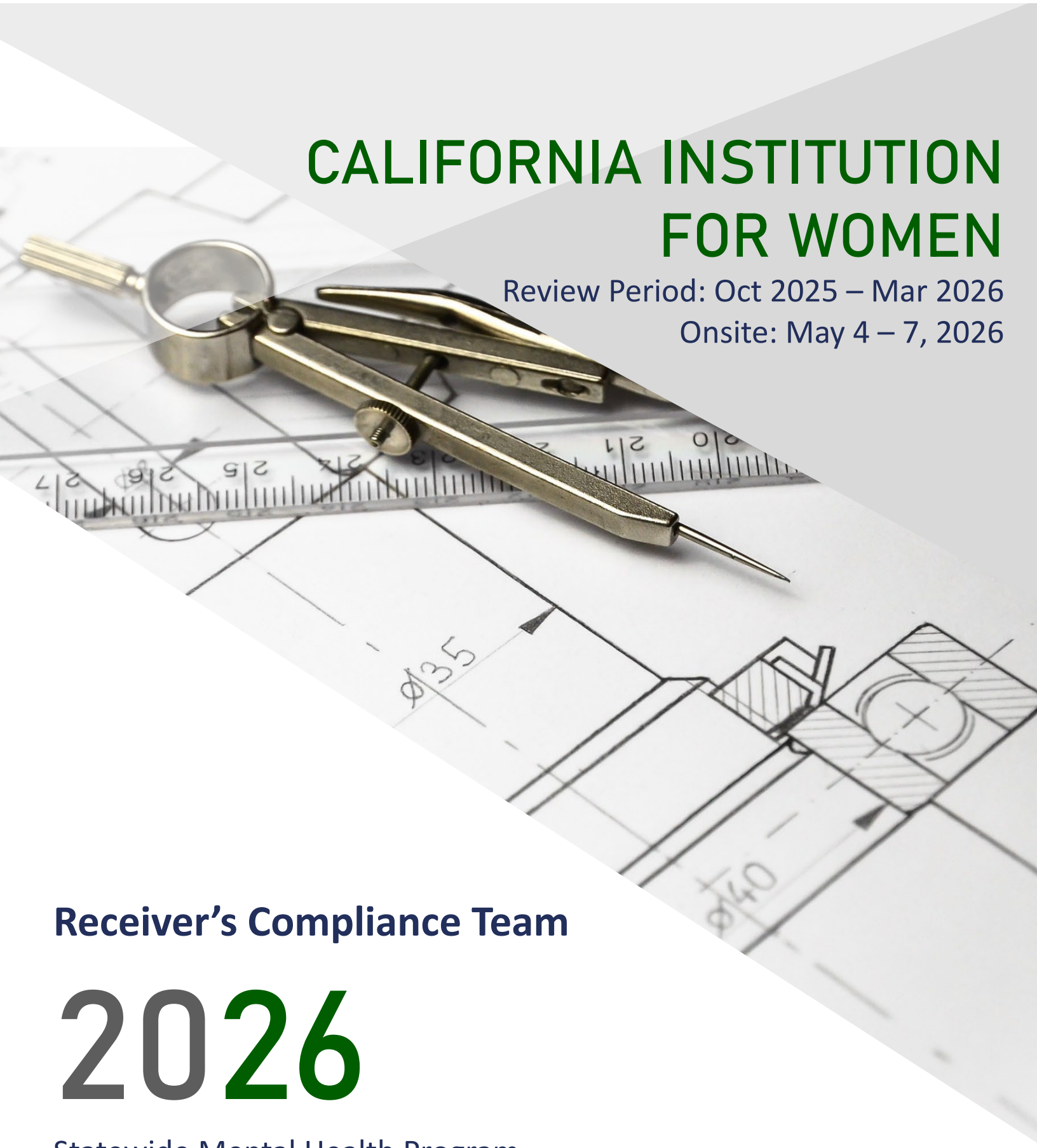

Receiver's Compliance Team

2026

Statewide Mental Health Program

Continuous Quality Improvement

CALIFORNIA INSTITUTION FOR WOMEN

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. 7283 at 4 (internal quotations omitted).

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

Goals

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

The Receiver seeks to use the audit process not only to assess compliance but also to identify barriers to compliance that she can address and 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 be in compliance 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 of 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. A majority 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 draw 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 early audits, several indicators were identified as producing unreliable results due to technical issues. These

indicators have been excluded from this report while we work to resolve the issues and can be found in Appendix D.

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

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

Executive Summary

California Institution for Women (CIW) is a multi-mission institution serving female patients across the Correctional Clinical Case Management System (CCCMS), Enhanced Outpatient Program (EOP), Mental Health Crisis Bed (MHCB), Acute, and Intermediate Care Facility (ICF) levels of care, with approximately 63% of the incarcerated population enrolled in mental health programming. Services are delivered across a general population program, a restricted housing unit, and a Psychiatric Inpatient Program.

Facility	Function	Mental Health Program
Facility A Yard	General Population housing; Restricted Housing Units; unlicensed MHCB	ML CCCMS, ML EOP, RHU CCCMS, RHU EOP, MHCB
Central Services Building (CTC/MHCB)	Correctional Treatment Center; Mental Health Crisis Bed	MHCB
Central Services Building (PIP)	Psychiatric Inpatient Program	Acute, ICF

CIW's defining characteristic is a well-resourced program that is not yet consistently converting that capacity into timely and high-quality care. The institution's strengths are real and worth preserving. Non-supervisory clinical staffing is at or above 95% of allocation, psychiatry is at 79% with additional hires in process that will bring it to 100%, and the program operates entirely with onsite personnel without reliance on daytime telemental health. Training compliance exceeds 91% across every required curriculum, including the Custody and Mental Health Partnership Plan, use of force, annual suicide prevention, CPR, suicide risk evaluation, safety planning, and the Suicide Risk Management Program. CIW sustains strong training and educational partnerships for employees, serving as a clinical training site for practicum students, interns, and medical students, and it incorporates mental health considerations thoughtfully into its Rules Violation Report process to balance patient accountability with clinical need.

The deficiencies identified in this report are not driven by staffing of non-psychiatry positions. They are procedural, cultural, and supervisory, and they cluster in the gap between the institution's capacity and its actual performance. Despite clinician staffing above 95%, timely primary clinician contacts averaged 82%, timely Interdisciplinary Treatment Teams (IDTTs) averaged 82%, and timely mental health referrals averaged 81%, with none meeting the required threshold during the review period. Patients in the Psychiatric Inpatient Program did not receive a minimum of 20 hours of treatment weekly, including at least 10 hours of core treatment. IDTT required staffing averaged 56% with no improvement trend, and observed IDTTs demonstrated an interactive clinical process only 43% of the time. Several Custody and Mental Health Partnership Plan (CMHPP) functions deviated from required documentation and attendance. Inpatient restraint practices showed deficits in face-to-face assessment, order-to-implementation timing, checklist use, and documentation across 121 incidents in six months. This volume is significantly higher than that observed at other institutions. Safety plans were signed within required timeframes 51% of the time, and the institution's Suicide Prevention and Response Focus Improvement Team (SPRFIT) governance did not meet audit criteria. The CCCMS restricted housing unit lacks confidential treatment space and one of the group treatment spaces in the EOP RHU is also not confidential.

These areas of concern relate to key themes: suicide prevention infrastructure, inpatient safety, clinical timeliness and treatment adequacy, treatment-team function, CMHPP procedural adherence, and the treatment environment in restricted housing. The Priority Recommendations below address each theme. Most fall squarely within CIW's authority to resolve through supervision, scheduling, and accountability. Because the institution is well-staffed, the principal task is to direct existing capacity at the points where it is not currently reaching patients. Where a recommendation depends on physical plant improvements (e.g., confidential

treatment space in the restricted housing unit) the report identifies the near-term institutional action and flags the capital component as a structural matter for the Receiver to review.

Priority Recommendations

1. **Strengthen Suicide Prevention Infrastructure – Safety Plan Timeliness, SPRFIT Governance, Clinical Justification of Inpatient Orders, and Discharge Continuity**: The suicide prevention continuum at CIW shows deficits at several clinical junctions. Safety plans were signed within required timeframes an average of 51% of the time (range 38%–67%), and supervisory reviews of MHCB/PIP discharge safety plans averaged 66%. The institution's SPRFIT meetings and minutes did not satisfy all audit criteria in any month, indicating that the governance body responsible for overseeing the prevention program is not functioning as designed. Review of inpatient orders for issue and observation revealed significant challenges in clinical justification. Onsite observation found no discussion of patients at high risk for suicide during the second-watch morning meeting, and the Specialized Bed Complete Care Model (SBCCM) huddle was improperly integrated into that meeting rather than conducted separately as CMHPP policy requires in the outpatient setting. These deficits are notable because CIW's underlying clinical capacity in this domain is strong: SRE mentoring training is at 100%, urgent and emergent referrals were completed timely, and SREs were completed when clinically indicated. The gap is therefore one of timeliness, oversight, and process discipline rather than clinical competence.

   Establish a reliable tracking mechanism for all safety plans, discharge follow-ups, and post-discharge suicide risk evaluations, with assigned responsibility for monitoring completion and escalating missed deadlines. Improve clinical justification of issue and observation orders in inpatient settings. Reconstitute SPRFIT so that meetings and minutes meet all audit criteria, conduct the SBCCM huddle separately from the morning meeting, and ensure high-risk patients are discussed at the second-watch meeting.

2. **Conduct a Focused Quality Review of Inpatient Restraint Use**: Restraint practices in the inpatient setting showed gaps across the full sequence of the intervention: inconsistent face-to-face assessments, delays between the order for restraint and its implementation, absent checklist use, and incomplete documentation. There were 121 restraint incidents over the six-month review period, and more than 60% involved only two patients. That concentration is a central clinical signal: a small number of patients accounting for the majority of restraint events indicates that their individual treatment and behavioral plans, not restraint procedure alone, require review.

   Initiate a focused quality review of restraint use that pairs a procedural component with a clinical one. On the procedural side, require checklist use for every restraint episode, monitor the clinical appropriateness of the interval between the restraint order and patient placement, and audit restraint logs weekly. On the clinical side, conduct an interdisciplinary review of the two patients driving the majority of incidents to develop individualized behavioral and treatment plans aimed at reducing restraint reliance and review the remaining uses of restraints to identify any patterns in use, where alternative approaches should be considered.

3. **Ensure Timely Clinical Contacts and Adequate Treatment Delivery**: The most consequential finding in this report is that no patients in the Psychiatric Inpatient Program consistently received the required minimum of 20 weekly structured treatment hours, including the required 10 hours of core treatment, during the review period; in the non-PIP setting, 63% of patients were offered treatment minimums. The average number of hours of treatment offered to PIP patients was 10.21. Timeliness of routine clinical contact was likewise below the compliance threshold across the board: timely primary clinician contacts averaged 82%, timely IDTTs averaged 82%, and timely mental health referrals averaged 81%, with clinical contact for patients returning from temporary departures at 74%. Because primary clinician, psychologist, and clinical social worker staffing each exceeded 95% throughout the period,

these deficits cannot be attributed to clinical resources; they reflect how existing capacity is scheduled and deployed. Operational interference compounds the problem: appointments cancelled due to custody factors averaged 25% and reached 44% in January 2026.

Conduct a structured assessment of staffing distribution and scheduling practices across all programs, with particular urgency on the PIP treatment-hour deficit, and adjust schedules and workflows so that existing clinical capacity reaches patients within Program Guide timeframes. Coordinate with custody leadership to reduce custody-driven cancellations.

4. **Implement a Structured IDTT Quality Improvement Initiative**: IDTT required staffing averaged 56% over six months with no improvement trend and observed IDTTs demonstrated an interactive clinical process in only 43% of presentations. A specific scheduling defect contributes directly: two programs share an assigned psychiatrist and their IDTTs are scheduled concurrently, which prevents timely starts and consistent psychiatric representation. The most frequent qualitative deficiencies (incomplete case formulation, treatment goals that are not measurable, no level-of-care discussion, and no discussion of Rules Violation Report mental health assessments) are clinical-practice and supervision concerns rather than staffing shortfalls. This recommendation addresses IDTT clinical quality and is distinct from the timeliness deficits addressed in Recommendation 3.

   Assess local barriers to improving IDTT quality, conduct regular supervisory observation of IDTTs, and provide direct feedback to treatment teams. Work with the Receiver's team to implement and distribute improvement tools aimed at IDTT quality improvement (currently being developed by the Receiver's team). Resolve the concurrent-scheduling conflict so that the shared psychiatrist can attend both teams and IDTTs begin on time with full representation.

5. **Adhere to Established CMHPP Policies and Procedures**: Several Custody and Mental Health Partnership Plan functions (including daily huddles, round table sessions, and executive joint rounding) have not consistently followed established policy, used the designated documentation, or sustained required attendance from both mental health and custody staff. CIW has also substituted Patient Advisory Council meetings for the Inmate Advisory Council meetings the CMHPP requires. These are process-fidelity gaps in a partnership structure that is otherwise well-supported by the institution's strong training compliance.

   Bring all CMHPP functions into conformity with policy by requiring the designated documentation forms, mandating attendance at required meetings, clearly defining participant roles in daily huddles and trainings, and restoring the required Inmate Advisory Council meetings.

6. **Establish Confidential Treatment Space in Restricted Housing**: The CCCMS restricted housing program has no confidential treatment space; patients who decline to be seen on the dayroom floor are offered the yard as the only alternative, and the group space, though partitioned, is not confidential to sight or sound. The RHU EOP program has one non-confidential treatment space. The institution's overall rate of group treatment in a confidential setting, 88%, is depressed specifically by these restricted housing deficits, and patients in the CCCMS RHU report dissatisfaction with treatment opportunities in part for this reason. This recommendation has both an institutional and a structural component.

   As a near-term institutional action within CIW's control, identify and convert space, inside or outside the housing unit, where individual contacts and structured group treatment can be conducted confidentially, applying sound-masking and visual barriers where safety protocols and the existing footprint allows. Where confidential space cannot be achieved within the existing footprint, the institution should engage with the Receiver's Office and the Receiver will evaluate options.

Institution's Operational Perspective

The California Institution for Women (CIW) continues to provide a Joint Commission–accredited continuum of mental health services, with approximately 63% of the incarcerated population enrolled in mental health programs. CIW maintains a comprehensive range of inpatient, outpatient, crisis, and specialized services.

Significant programmatic enhancements have strengthened clinical quality and patient engagement. The Curriculum Review Committee now evaluates therapeutic groups using patient satisfaction data, and the Mental Health Event Planning Committee has expanded facility-wide programming that supports wellness, education, and community connection.

CIW has launched several innovative initiatives, including monthly digital mental health education and expanded therapeutic gardening projects that serve multiple levels of care and supply produce for inpatient dietary services.

While recruitment and hiring processes have been streamlined under regional oversight, the shift has reduced local control and added procedural challenges. To support staff morale, CIW has enhanced monthly department meetings and expanded appreciation activities, themed events, and team-building efforts across the Mental Health Department.

In response to the Round 31 Coleman Review, CIW implemented improved documentation practices for clinician to clinician contacts and strengthened discharge compliance monitoring. Ongoing challenges remain, including insufficient confidential treatment space in RHU areas and persistent physical plant deficiencies that require significant capital investment.

Overall, CIW continues to expand program quality, staff engagement, and therapeutic innovation despite structural and operational constraints.

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	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Effective Communication Achieved	98%	97%	97%	98%	99%	98%	98%
Group treatment in a confidential setting	91%	88%	91%	84%	87%	84%	88%
IDTTs in a confidential setting	98%	99%	98%	98%	97%	99%	98%

Timely Access

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Daily PC Interactions – RHU EOP High Refusers				100%†			100%†	
IRU Reviews Completed Timely	100%†	100%†	100%†	88%†	100%†	100%†	97%	
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure	100%†	50%†	33%†	75%†	100%†	50%†	74%†	
RHU GP Screens		100%†	100%†	100%†	100%†	100%†	100%	
RHU Pre-Screen	100%†	100%†	84%†	56%	96%	90%	77%	
Timely IDTTs (v2.0)	82%	82%	77%	81%	79%	89%	82%	
Timely MH Referrals (v2.0)	82%	86%	84%	80%	73%	80%	81%	
Timely MHMD Contacts (v2.0)	82%	75%	81%	72%	68%	77%	76%	
Timely PC Contacts (v2.0)	86%	85%	83%	83%	76%	82%	82%	
Custody MH Referrals								100%
Housing Units Where 128-MH-5s Are Available And Accessible to Housing Unit Staff								100%†

Timely Transfers

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Timeliness of Acute/ICF Referral Submission to IRU	63%†	40%†	57%†	47%†	20%†	50%†	49%
Timely Transfers to EOP (v2.0).	100%†		100%†	67%†	100%†	100%†	91%†
Timely Transfers to PIP	80%†	100%†	100%†	91%†	100%†	100%†	95%

Appointments

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Appointments Cancelled Due to Custody [i]	21%	10%	19%	44%	31%	25%	25%

Least Restrictive Housing

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
PIP ICF Patients Housed Outside of their LRH	0%†	17%†	13%†	11%†	10%†	20%†	13%

Treatment Offered

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Treatment Offered (Core and Supplemental): PIP	0%	0%	1%	0%	0%	1%	0%
Treatment Offered (Core and Supplemental): PIP Evaluation Period	0%†	0%	4%	0%	0%	0%	1%
Treatment Offered (Specified Core Subset and Supplemental): PIP	0%	0%	0%	0%	0%	0%	0%
Treatment Offered (Specified Core Subset and Supplemental): PIP Evaluation Period	0%†	0%	0%	0%	0%	0%	0%
Treatment Offered (Structured): non-PIP	58%	65%	69%	61%	52%	71%	63%

✓ **Strengths**

RHU daily interactions and screenings for GP individuals are largely compliant: Both the RHU daily PC interactions with EOP high refusers and the GP screens for non-MHSDS patients placed in RHU were compliant 100% of the time. While RHU pre-screens averaged 77% over the review period, this was due to two months of outlier data; all other months scored at or above 90%. The RHU specific contacts being mainly compliant indicates that the system in RHU is working according to the Program Guide.

Custody staff demonstrate awareness of the referral process: Custody staff throughout the institution demonstrate strong coordination for access to mental health services. Onsite audit findings confirm that 128-MH-5 referral forms are available and accessible across housing units, and all custody staff interviewed demonstrated awareness of their responsibility to initiate mental health referrals.

Timely transfers to EOP are compliant: During the review period, patient transfers to EOP demonstrated an average compliance rate of 91%. The January 2026 timeliness metric was influenced by placements in the

Outpatient Housing Unit (OHU) due to medical needs and limitations in the automated reporting system, which did not account for patients entering EOP after OHU discharge. While the automated metric indicated a 67% compliance rate for January, the actual compliance, including OHU placements, was 100%.

⚠ Concerns

Confidential treatment space is not available in RHU: The CCCMS RHU program does not have any confidential treatment space. If patients do not want to be seen on the dayroom floor, they are given the option of being seen on the yard. The group space in CCCMS RHU has partitions around the areas but is not confidential to sight or sound. RHU EOP has one confidential group space and one non-confidential group treatment space. The six-month average for group treatment in a confidential setting, 88% (ranging from 84%-91%), is driven by the lack of confidential space in RHU CCCMS and RHU EOP. Patients in the CCCMS RHU program are largely unsatisfied with treatment opportunities in part due to the lack of confidential treatment space.

Timeliness deficits across contacts is incongruent with current staffing: Timely PC contacts averaged 82% (range 76-86%), timely IDTTs averaged 82% (range 77%-89%), and timely mental health referrals averaged 81% (range 73-86%) across the review period. Despite relatively low numbers of returns from a temporary departure, clinical contacts for returning individuals averaged 74%. Treatment offered in both the PIP and non-PIP settings did not meet minimum requirements for any month within the review period. In the PIP, though they are offering both core and supplemental treatment, they are not offering the required minimum hours of treatment to the patient. During this reporting period no patients were offered at least 20 hours of treatment, including at least 10 hours of core treatment. The EOP program also did not provide the required number of treatment hours consistently; 63% of non-PIP patients were offered treatment minimums. In the non-PIP context, staff frequently use the "no show" close-out code instead of the "refused" resolution for appointments where the patients choose not to participate and this significantly reduced the compliance rate. The "no show" designation does not contribute to offered hours; consequently, although many patients were offered group sessions and declined participation, these instances are not being counted toward compliance. Non-compliance with timely contacts is incongruent with the staffing for primary clinicians, psychologists, and clinical social workers which exceeded 95% throughout the review period.

Appointment cancellations due to custody factors was significant: Cancellations of mental health appointments due to custody factors averaged 25% (range was 10%-44%) during the six-month review period, with the rate of custody-driven cancellations as high as 44% during January 2026.

Recommendations

1. See Priority Recommendations.

Custody and Mental Health Partnership Plan

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	Oct 2025	6-Month Avg	Onsite Audits
CMHPP MH Daily Huddles			73%
CMHPP MH Huddle Documentation of Supervisor Attendees	0%†	47%	
CMHPP Monthly Executive Leadership Joint Rounding			92%
CMHPP Monthly Executive Leadership Joint Rounding Attended by Required Executives			50%
CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH Program			100%†
Custody Staff CMHPP Annual Training			91%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours			100%†
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours with Required Attendees			100%†
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees			100%
ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings			0%†
Quarterly Partnership Round Table Training Completed as Required			100%†
Required Staff Attendance of Quarterly Partnership Round Table Training			50%†

✓ Strengths

Multiple components of CMHPP were observed to be compliant: Monthly executive joint rounding, custody staff annual CMHPP training, and ML CCCMS joint supervisory program tours and supervisory meetings all scored 91% or better for CMHPP documents reviewed during the review period.

A review of the CCCMS components of CMHPP demonstrated compliance with policy: Of 26 weekly huddles occurring during the review period, it was identified that both the mental health program supervisor and sergeant were present at all huddles. Monthly joint supervisor tours are consistently occurring and attended by the mental health program supervisor and sergeant. For one month, the program supervisor did not write their name at the bottom of Attachment C even though they authored the form, but this was a technical oversight that did not impact or reflect on the quality of the collaboration.

⚠ Concerns

Daily huddles are not following established policy and procedure: CMHPP huddles were reviewed for one week during each month in the review period. It was found that the institution does not use Attachment B as required by policy and as such compliance of required participant attendance and weekly supervisor attendance was deemed to be zero. Huddles are taking place, but attendance is recorded on institution-developed forms, on the job training sign-in sheets (844), or QM generated SBCCM huddle forms and it is not always clear whether a supervisor is present. Acute and ICF huddles are held together and sign-in sheets titled 'SBCCM Daily Huddle Sign In Sheet' are being utilized even though CIW does not participate in SBCCM. Furthermore, PIP huddle sign-in sheets do not indicate any mental health and custody staff in attendance and huddles are primarily made up of medical and nursing staff. MHCB and PIP are not holding huddles on weekends and holidays as required by policy. CIW's CMHPP LOP does not include ML EOP as a program that required huddles and it includes the wrong document as Attachment B.

Round table training attendance was problematic: While the CMHPP round table trainings were always completed monthly during the review period, in ML EOP, sergeants did not conduct any of the training sessions with the MH program supervisor; the only instructor listed on the attendance log was the MH program supervisor. Second watch trainings during the final quarter of 2025 were not attended by any custody staff.

Second watch trainings were well attended by custody staff in the first quarter of 2026. Because of their commitment to the goal of CMHPP, the MH program supervisor provided pizza to participants to entice attendance and that proved effective. On third watch during the fourth quarter of 2025 and the first quarter of 2026, the training was attended by one custody staff member. It was reported that relations between custody and mental health staff have been strained for the last few months due to the influence of at least one officer whose behavior does not align with expectations for a treatment culture. This has impacted unit operations and patient climate. RCT auditors interviewed two correctional officers assigned to ML EOP during the site visit, to discuss the CMHPP Round Table Training. Both indicated that they enjoy attending the meeting and learn helpful information about the patients from both medical and mental health staff during them. When asked how attendance could improve, they suggested that the training sessions occur in the unit dayroom with the unit being closed. They reported that the last training was done in the unit, and the unit was shut down for an hour, which enabled better custody staff attendance.

Executive joint rounding was not attended by the required staff: Executive joint rounding was conducted monthly in five of six months during the review period. However, four of the six months of rounding did not have the correct required staff composition. October 2025, February 2026, and March 2026 were missing the Warden/Chief Deputy Warden, and December 2025 was missing the CEO/Chief of Mental Health.

A Patient Advisory Council (PAC) meeting is attended by mental health rather than an IAC meeting: CIW is utilizing their PAC agenda/minutes in lieu of the IAC agenda/minutes. Attendance at the PAC meeting does not meet the CMHPP requirement for attendance at the IAC.

Recommendations

1. See Priority Recommendations.

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	57%†
Adequate IDTT Spaces	83%†
Adequate Individual Treatment Spaces	54%

✓ **Strengths**

Inpatient areas are well maintained: All inpatient areas were observed to be cleaned and well maintained. The cleanliness of these areas was attributed in part to the fact that they are covered by the contract with HFM, while outpatient mental health clinics do not maintain a contract for cleaning through HFM.

Most treatment spaces throughout the facility are confidential: There has been an effort made to make spaces confidential. Treatment areas that have cameras were confirmed to not have audio enabled. EIS further explained that these areas do not fall under the scope of where DAI approves audio capabilities to be installed with AVSS, so it was never enabled.

⚠ Concerns

Treatment spaces are inadequate due to poor configuration: Treatment spaces in CCCMS, EOP, and the Walker unit are not all configured in a safe manner, seating for the patient frequently blocks the door. Two group treatment spaces were noted to have staff offices embedded within the group treatment space; when staff enter or exit their office there is a disruption to the group, and when doors are left open the space is not confidential.

Prioritize cleanliness and renovations: The shower areas in the Forestry housing unit were found in disrepair and in need of cleaning. Soap scum, grout discoloration, peeling paint, and deteriorated walls were observed. Vents in all shower areas were covered. It was recommended that the shower areas be prioritized for cleanliness and renovation.

Recommendations

1. Reconfigure clinical treatment spaces for safety: Staff and patient safety are paramount. Clinical treatment spaces need to be reconfigured so that the patient is not blocking the egress and ingress route to the room.

Psychiatry

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

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Timely Response to Critical Non Adherence Notification (v2.0)	56%†	30%†	50%†	44%†	57%†	56%†	48%
Timely Response to Non-Critical Med Non-Adherence Notification(v2.0)	80%	28%	25%	57%	9%	32%	39%

✓ Strengths

Diagnostic monitoring nearing statewide average: The overall diagnostic monitoring averaged 81% which is near the current compliance rate statewide (statewide compliance is 84%). Compliance with EKGs for patients on QT prolonging medications ranged from 86% to 100% over the reporting period. Timely monitoring of blood pressure, height and weight was evident across multiple medication classes.

⚠ Concerns

Medication non-adherence response rates are low: Timely response to medication non-adherence averaged 48% for critical and 39% for non-critical medication non-adherence over the reporting period. Staff Psychiatrist positions were filled at 79% (see Staffing section), suggesting that the deficit is not wholly driven by the availability of psychiatry staff. During the audit, staff reported there is only one EOP psychiatrist and the chief psychiatrist reported providing coverage as needed.

[1] See Appendix B

Use of Force to administer psychotropic medications: There were a total of 11 immediate UOF related to PC2602 administrations noted by the institution during the reporting period. No controlled UOF to administer PC2602 medications was reported. Per policy, the process for controlled use of force should be utilized for the administration of refused PC2602 medications.

Diagnostic monitoring: Review of diagnostic monitoring (attachment C) over the review period was 81%. Completion of the Abnormal Involuntary Movement Scale (AIMS) for patients prescribed antipsychotic medications was at 67%. Lithium level monitoring averaged 62% and Valproic acid therapeutic level monitoring averaged 39%. Both medications have more narrow therapeutic windows and require careful monitoring to reduce the potential for toxicity. Pregnancy test monitoring across several medication classes was low. Denominator values varied across categories, (Antipsychotic N = 79; Antidepressants N = 86; Lithium N = 20; Valproic Acid N = 22; Oxcarbazepine N = 28) however the overall low rate suggests broader contributing factors that warrant additional understanding and remediation.

Recommendations

1. Conduct a review of timely response to non-adherence notifications: Identify contributing factors to the non-adherence response, with a targeted focus on timely responses to critical medication non-adherence appointments. Implement training of staff as needed to facilitate understanding of requirements and develop a plan to address any additional identified barriers. Track monthly compliance with a target of sustained improvement toward the compliance threshold.
2. Explore factors contributing to the type of force used to administer PC2602 medications: Per policy, the administration of refused PC2602 medications should be through a controlled use of force process. Review all use of force incidents for PC2602 to identify if the immediate use of force was in response to refusal of PC2602 medication or for other reasons for patients under PC2602. Ascertain if there is a need for training on the policy and take any necessary follow up action.
3. Conduct a review of pregnancy test monitoring and implement processes to address identified barriers: Pregnancy test monitoring across several categories was low (see above). Utilizing an interdisciplinary team, conduct a retrospective review of pregnancy tests completed timely and identify factors that contributed to their completion. Utilize this information to target identified barriers to timely completion for tests not completed timely.
4. Ensure timely AIMS completion: Conduct a retrospective review to determine factors contributing to the aggregate 67% compliance rate. Implement local workflows to address identified barriers.

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	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Heat Related Illness Incidents for MHSDS Patients Prescribed Heat Alert Medications								0†
Maximum Number Restraint Incidents	16†	14†	5†	4†	15†	5†	59	
Restraint Duration Incidents Greater than 4 Hours	3%	5%	6%†	25%†	4%	0%†	6%	
Restraint Incidents	34	22	18†	12†	23	12†	121	

✓ **Strengths**

No heat-related illness for MHSDS patients occurred during the review period: CIW did not experience any heat-related illness incidents among MHSDS patients prescribed heat alert medications during the reporting period. No Stage II or Stage III heat events occurred that required precautionary activation. The onsite audit confirmed that all interviewed custody officers were able to articulate their responsibilities during a heat alert. The facility's heat plan is current and compliant with statewide requirements, and available at each post.

⚠ **Concerns**

Restraint use in the inpatient setting: CIW demonstrated several departures from clinical standards for the use of restraints. Face to face contacts which are required prior to the expiration of an initial restraint order are not being completed consistently, there is a lapse in time between the restraint order and placing the patient into restraints, the required restraint checklist is not utilized by nursing staff, and there are multiple documentation inconsistencies across forms. During the six-month review period, there were 121 restraint events, with more than 60% of those incidents accounted for by two patients.

Recommendations

1. See Priority Recommendations.

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	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
IDTT Patient Attendance	83%	88%	76%	77%	83%	80%	81%	
IDTT Required Staffing	53%	47%	59%	66%	52%	57%	56%	
IDTTs with Observed Interactive Process								43%

Documentation

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Cases with documentation of appropriateness of LOC discussed for patients identified by 7388B as potentially requiring HLOC								52%
EOP IDTTs Addressing Accommodations and Clinical Appropriateness for Work and Education								50%†
IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT								94%†
IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT								100%†

✓ **Strengths**

Initial evaluations were completed prior to IDTT: During the observed IDTTs, nearly all PC (94%) and all psychiatry (100%) intake evaluations were completed prior to the IDTT in all programs. Completing the initial evaluation prior to the IDTT provides a basis for the treatment planning discussion and assists with the formulation of measurable treatment goals.

PIP IDTTs were patient-focused and tailored to individual treatment goals: PIP treatment teams provided compassionate, individualized care to support measurable treatment goals. Staff prioritized patient needs and IDTTs were patient-centered. ML EOP and RHU IDTTs engaged in interactive discussions, with staff demonstrating thorough knowledge of their patients. During the CCCMS IDTT, team members collaborated effectively with participants contributing spontaneously rather than relying on structured facilitation which indicates robust team cohesion and familiarity among the members.

⚠ **Concerns**

IDTT quality is deficient: IDTT patient attendance averaged 81% (range 76–88%), required staffing averaged 56% (range 47 – 66%), observed interactive process including the discussion of measurable treatment goals and case formulation achieved 43%, documentation of the appropriateness of the level of care for patients who may require a higher level of care occurred in 52% of cases, and IDTTs addressed accommodations for work and education in 50%† of observed IDTTs. When attendance, staffing, interactive process, higher level of care discussion, and discussion around work and education appropriateness are lacking, the intent of treatment planning is missed. The RHU EOP IDTT shared a psychiatrist with the ML EOP IDTT, both are held at the same time on the same day, which may contribute to deficiencies in the required staffing component. The observed RHU EOP IDTT started 30 minutes after the scheduled start time as the psychiatrist did not arrive until the conclusion of the ML EOP IDTTs. Supervisory staff in the programs participated in IDTTs and supported staff through prompting and modeling to cover key elements of the IDTT, but this support was not successful in ensuring all components of the IDTTs met audit requirements.

Recommendations

1. See Priority Recommendations.

RVRs, Sentinel Events, and Specialized Custody

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

Rules Violation Report

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
RVR MH Assessments Conducted in a Private Setting	76%	86%	73%	65%	53%	70%	71%	
RVR MH Assessments where Documentation Requirements were Met	17%†	17%†	13%†	9%†	100%†	43%†	23%	
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality	100%†	100%†	100%†	100%†	100%†	100%†	100%	
Timely RVR MH Assessment Request	38%	35%	35%	33%	18%	22%	30%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	87%	98%	96%	95%	94%	88%	93%	
RVRs Issued								925†
RVRs Issued to Non-MHSDS Participants								19%
RVRs Issued to Patients at the Acute Level of Care								0%
RVRs Issued to Patients at the CCCMS Level of Care								71%
RVRs Issued to Patients at the EOP Level of Care								7%
RVRs Issued to Patients at the ICF Level of Care								1%
RVRs Issued to Patients at the MHCB Level of Care								2%
RVRs recommended for mitigation that were mitigated								100%†
RVRs Recommended for Mitigation with Custody Documentation								100%†

**MHSDS participants comprise 63% of the population at CIW.*

Sentinel Events, and Specialized Custody

Indicator	Onsite Audits
Custody Staff Attendance at UOF Training	92%
Days Alternative Out-of-Cell Activities were Offered to Patients on Heat Alert Medications when Indicated	90%
Health Care Staff Required to Attend UOF Training	97%
Thermometer Checks completed and accurate	100%†
Use of Force Involving MH Patients	93%

✓ **Strengths**

RVRs are holding patients accountable while taking mental health factors into consideration: Nearly all of reviewed RVR-MHAs where mitigation was recommended by the clinician were mitigated. Clinicians appear to be well-versed in identifying patient needs throughout the mental health assessment. Discussion of RVR-MHAs during IDTT could strengthen the IDTT and result in a decrease in the number of RVRs.

Custody was knowledgeable of policy requirements in all areas of the facility: During interviews, custody staff demonstrated fluency in the heat plan and electronic heat tracking, the mental health referral process, RHU requirements for appliances and searches, and use of the TTMs and mechanical restraints along with required documentation. Staff were also able to identify all NDRH patients and reported that all unclothed body searches occur in private areas. All observed officers were noted to be carrying their CPR mouth shield.

UOF training was compliant for custody and health care staff: Ninety-seven percent of health care staff completed the annual use of force training requirement while 92% of custody staff completed the requirement.

⚠ Concerns

RVR-MHAs had several areas of deficiency: RVR-MHAs were documented as occurring in a private setting on average 71% of the time. When patients declined scheduled RVR-MHA appointments, their consultations subsequently took place in non-private environments. Further, the documentation requirements including a patient's cognitive or adaptive functioning deficit status and the assessor's collaboration with peers and/or supervisors were met, per the chart audit tool, in 23% of cases and the RVR-MHA order was created within two calendar days from the data of the RVR an average of 30% of the time, averaging 4.8 days overdue.

Recommendations

1. Implement targeted training for staff focused on documentation standards for RVR-MHAs: Provide training to staff focusing on consistently documenting all required elements, including patient cognitive or adaptive functioning deficit status and evidence of collaboration with peers or supervisors. Regular feedback to clinicians should follow Chart Audit Tool (CAT) audits, to monitor progress and reinforce best practices, ensuring that RVR-MHAs are thorough, ultimately enhancing patient care and compliance with evaluation criteria.

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	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
ICC Review of Max Custody PIP Patients Within 10 Calendar Days of Arrival		0%†	0%†	0%†	0%†	0%†	0%†	
Timely Transfers to RHU EOP	100%†	100%†	100%†	100%†			100%†	
CCII, Captain, and Warden Reviews of RHU EOP Patients with LOS Over 90 Days								100%†
ICCs with Mental Health Clinicians Present and Relevant Information Provided								100%†
Initial ICCs Reviewed that were Held within 10 Calendar Days of Arrival to Restricted Housing Placement								100%†

Documentation

Indicator	Onsite Audits
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available	81%
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 CCCMS Out of Cell Time Offered	100%†
RHU EOP Out of Cell Time Offered	100%†
RHU Incarcerated Persons Who Received an RHU Orientation Guide	100%†
RHU Shower Access	100%†
Staff Who Report Unclothed Body Searches Conducted in a Private Area	100%†

✓ **Strengths**

RHU EOP has met Program Guide requirements throughout the review period: The CIW RHU EOP certification met Program Guide requirements in December 2025. In October 2025, November 2025, January 2026, and February 2026, CIW's RHU EOP met with explanation. October and November 2025 met with explanation due to timely mental health referrals and treatment offered (structured) non-PIP not meeting the 90% threshold. January and February 2026 met with explanation due to timely mental health referrals not meeting compliance thresholds. The failures in those months were due to a combination of errors in referral orders and cell front contacts. Training has been provided to staff who were entering inaccurate referral information.

RHU functions are occurring timely and according to policy: All of the custody functions for maximum custody patients are 100% timely with the exception of initial ICCs for maximum custody PIP patients which was 0%† all months during the review period, a function of the current methodology. Initial ICCs for "Max Custody Reduction Reviews" for PIP patients were completed timely in all nine cases and documented appropriately in the ICC Chrono narrative. However the review type "Max Custody Reduction Review" was not selected, instead various types of Psychiatric/Return review types were selected. Therefore, the data reflects this indicator as noncompliant despite the meetings occurring timely. Further, psychiatric technician rounds are occurring daily and observed rounds met all audit criteria including the requirements for documentation. RHU patients are consistently offered custody out-of-cell activities including access to showers, and access to working entertainment appliances. Patients reported that they did not actually spend significant time out of their cells, regardless of time offered.

⚠ **Concerns**

Data entry error contributed to the need for explanation in monthly certifications: Treatment offered was below threshold in October and November 2025. Lapses in treatment offered reflect data entry errors (e.g., "no show" was used instead of "refused" or, the appointment was resolved for a duration shorter than the length of the

clinical contact). Similarly, barriers to achieving a rate of 90% or greater for timely mental health referrals included data entry errors, specifically discontinuing orders rather than voiding orders.

Second watch morning meeting was deficient: Improvement is needed in the discussions occurring during the second watch morning meeting between mental health and custody staff to ensure it serves the purpose of alerting staff to key clinical and custodial information that they should consider when engaging with patients. For example, there was no discussion of patients at high risk for suicide. The SBCCM huddle discussion was integrated into the morning meeting; per CMHPP policy the SBCCM huddles should be separate in the outpatient setting.

Recommendations

1. Ensure that clinicians properly resolve appointments to minimize data entry errors: Monitor appointment completion status to reduce the likelihood of inaccurately recorded appointment times.
2. Review meeting standards for the RHU: See Priority Recommendations.

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.

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Discharges from MHCB with clinician review of d/c summary				0%†		0%†	0%†	
Documentation of Acute/ICF Discharges with Clinician to Clinician Contact within 5 days	100%†						100%†	
Emergent and Urgent MH Referrals That Result in SREs	100%†	100%†	67%†	78%†	60%†	100%†	86%	
MHCB Daily Provider Contacts (v2.0)	91%	90%	94%	83%	91%	83%	88%	
MHCB/PIP Supervisory Reviews of Discharge Safety Plans	63%†	67%†	83%†	50%†	65%	73%	66%	
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training		27%	46%	98%	100%	100%	76%	
Safety Plans Signed Timely	38%	47%	50%†	59%	44%	67%	51%	
Timely Clinical Follow-Ups (V2.0)	33%	68%†	75%†	63%†	70%	68%	61%	

Audited Security Welfare Checks in Restricted Housing That Included the Required Visual Observation	100%
Custody Follow Ups, Page 1	84%
Custody Follow Ups, Page 2	59%
Custody Staff with CPR Training	91%
Custody Staff with Suicide Prevention Training	93%
Healthcare staff current with suicide prevention training	93%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories	100%†
Institution SPRFIT Meeting Minutes Reviewed that Satisfy All Audit Criteria	0%†
Institution SPRFIT Meetings Observed 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	100%
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	47%†
MHCB Out of Cell Activities	100%†
Nursing Staff Current with CPR Training	100%
Observed Initial Health Screenings	100%†
Onsite Review of Patient Orders for Issue and Observation	100%†
PIP Out of Cell Activities	100%
RHU Intake Incarcerated Persons Appropriately Housed	100%†
Suicide Resistant Cells	100%†

✓ **Strengths**

CIW demonstrated strong operational compliance across multiple domains.

IDTTs were timely and patient-centered: Observed IDTTs in the inpatient settings followed a cohesive, multidisciplinary approach. PIP treatment teams were noted to have a compassionate treatment approach tailored to individual patients while implementing creative interventions to help patients achieve their measurable treatment goals. Staff appeared focused on patient needs.

Urgent and emergent referrals are completed timely: Urgent and emergent referrals from the review period were reviewed during the site visit and were noted to be completed within timeframes. When an SRE was clinically indicated, it was also completed timely. Safety planning was conducted or reviewed with the patient when required.

Training compliance rates were consistently high: Most suicide prevention trainings were at or near 100% compliance (including 100% for SRE Mentoring). This demonstrates the institution's level of organization and commitment to ensuring clinicians are prepared and have the necessary tools to complete their job.

SPRFIT subcommittee is professionally run: Based on a review of meeting minutes, SPRFIT holds monthly meetings to include a discussion and review of system monitoring and improvement efforts. The SPRFIT subcommittee was run professionally and systematically, with a knowledgeable and solution-focused facilitator who prompted active discussion; however, none of the reviewed committees met all audit criteria as

not all members required to achieve a quorum (including healthcare and custody) were in attendance regularly. Minutes from the subcommittee should reflect the meeting content in its entirety to capture the nature of the discussion.

Alternative housing: The alternative housing processes appeared to be compliant, and the designated unit was clean, well-maintained and appropriate for the intended purpose. However, it does not appear that CIW utilizes this unit, other than for MHCB overflow. Instead, most patients are admitted directly to the MHCB. After hours, the psychiatrist on call admits patients to the MHCB, rather than placing them in alternative housing and allowing a clinician to conduct a face-to-face assessment in the morning. This practice, although conservative, may be resulting in the overutilization of Mental Health Crisis Beds and may be prematurely placing patients in a more restrictive environment when it may not be clinically indicated.

CIT functionality and hours of operation: CIW now has two assigned CIT team members to work in the evenings, who can conduct assessments and address routine matters before they become a crisis, potentially reducing MHCB admissions. However, the CIT is not regularly utilized to address crisis in housing units or elsewhere; instead the CIT clinicians primarily complete assessments and consultations. There is an opportunity to more fully utilize the capacity these clinicians and the complete CIT teams provide.

⚠ Concerns

Second watch morning meeting in restricted housing was deficient: The joint custody and mental health meeting in RHU CCCMS was lacking in discussion and collaboration. There was a missed opportunity to review high risk patients in one of the most high-risk settings.

IDTTs and documentation were lacking essential components in MHCB: Observed IDTTs in MHCB lacked specific and measurable treatment goals. In the MHCB, justifications for patient issue and observation were not consistently documented in the chart and at times when issue and observation orders were mentioned the discussion lacked a connection between the patient's presentation and the level of observation and issue being ordered.

Timeliness of safety plans and supervisory reviews: Although safety plans were completed in most instances, a significant number remain in a "pending" status due to unsigned documentation; additionally, some plans were finalized after the required deadlines. Metrics indicate that safety plans were signed within mandated timeframes an average of 51% of the time (with a range of 38%–67%), while supervisory reviews of MHCB/PIP discharge safety plans reached an average completion rate of 66%.

Timely clinical follow ups were consistently non-compliant during the review period: Clinical follow ups after discharge from MHCB, Acute/ICF/DSH, and after rescinded MHCB referrals were completed timely on average 61% of the time during the review period. Discharge follow-ups were noted to have multiple days added on to ensure that a clinician completed the assessment on the final day, however with the institution being fully staffed it appears these clinical follow ups need to be better prioritized.

Suicide Risk Management Program (SRMP): Due to the unavailability of On Demand reports for SRMP currently, all institutions are tasked with manually tracking SRMP patients, however some of the patients on the log that was provided are no longer in SRMP and should have been removed.

Custody staff are not initiating holding cell logs in the Triage and Treatment Area (TTA): When patients are placed inside of holding cells or wet tanks, a holding cell log is required to document a patient's behavior for the duration of the stay. Holding cell logs are not being maintained for patients placed in the TTA holding cells pending mental health evaluation.

Recommendations

1. Suicide prevention infrastructure: See Priority Recommendations.

2. Improve documentation of issue and order justifications in inpatient settings: Direct inpatient staff to clearly document justifications for observation and issue in the health record. Ensure justifications are updated as patients' clinical presentations change, even if there is no change in privileges.
3. Maximize the CIT process: Inform the patient population and staff about the CIT process and its benefits, as there appears to be misinformation regarding the potential uses of the CIT for the de-escalation of crisis situations. Utilize assigned CIT clinicians to address crisis situations and provide de-escalation opportunities to the patient population, potentially reducing MHCB referrals.

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. A comprehensive report containing the detailed findings from the Regional Sustainable Process Review is provided separately and is not attached to this document.

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
MHCB clinical stays within timeframes	100%	100%	100%	94%	100%	100%	99%
Timely Transfer to MHCB (v2.0)	100%	96%	100%†	96%	96%	100%	98%

✓ Strengths

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

⚠ Concerns

Sustainable process data review: HQ reviewed 21 cases in this quarter's Higher Level of Care documentation audit: 62% (13 cases) were identified as "good" and 38% (eight cases) were identified as "unacceptable." CIW's HLOC documentation quality declined by 2% this quarter. Program-wide, the reasons why the cases were considered "unacceptable" included: insufficient narrative due to missing a mental status exam and/or the patient's clinical functioning (50%); documentation signed late (25%); missing documentation (12.5%); and IPC error (12.5%).

Mental Health Program Subcommittee (MHPS) minutes: January, February and March 2026 MHPS minutes did not incorporate information from the monthly higher level of care documentation review into the narrative of the minutes. Minutes were not being posted to the statewide Monthly MHPS Meeting Minutes SharePoint site but the institution has since implemented a remedy.

Recommendations

1. Increase support for writing the higher level of care section of the treatment plan: Implement feedback sessions between clinicians, supervisors, and the IPC, to address the areas of concern identified in the headquarters documentation audit and improve the quality of Higher Level of Care (HLOC) documentation. Monitor progress by conducting follow-up reviews and tracking improvement in documentation quality.
2. Establish a process to reduce gaps in MHPS meeting minutes: Ensure that meeting minutes incorporate findings from the monthly HLOC documentation reviews.

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 of Mental Health	1.0	1.0	0%
Chief Psychologist	3.0	2.67	11%
Chief Psychiatrist	2.0	2.0	0%
Senior Psychiatrist (Supervisor)	0.0	0.0	--
Senior Psychologist (Supervisor)	2.5	2.83	0%
Supervising Psychiatric Social Worker I	1.0	2.0	0%
Senior Psychologist (Specialist)	6.0	6.17	0%
Recreation Therapist	9.5	13.67	0%
Staff Psychiatrist	11.5	9.08	21%
Psychologist – Clinical	11.5	10.90	5%
Clinical Social Worker	8.5*	8.32	0%
Primary Clinician (PC)	15.0*	21.67	0%
PC: Psychologist – Clinical		12.20	
PC: Clinical Social Worker		9.47	
PC: Marriage and Family Therapist		0.00	
PC: Professional Clinical Counselor		0.00	

The figures in this table come from the monthly Mental Health Staffing, Allocated and Filled reports published on the CCHCS public website (https://cchcs.ca.gov/reports/). The institution's allocated and filled positions are pulled from each of the six monthly reports covering the review period. Table figures are six-month averages, and the functional vacancy rate is (Average Allocated – Average Filled) ÷ Average Allocated.
Filled counts include telehealth and registry providers: Staff Psychiatrist combines onsite and tele-psychiatry, MHPC combines onsite and tele-clinicians, supervisory social work combines Supervising Psychiatric Social Worker I and II, and Recreation Therapist includes registry staff. The Primary Clinician discipline breakdown is published as filled positions only, so those rows show no allocation.

✓ Strengths

Clinical Non-Psychiatry Positions Significantly Filled: Non-supervisory clinical roles, including psychologists, clinical social workers, and primary clinicians, achieved fill rates ranging from 95% to 100%. Psychiatrist positions reached a 79% fill rate with onsite psychiatrists exclusively. Additional psychiatrists are in the hiring pipeline and will eliminate the use of registry psychiatrists and is anticipated to bring civil service psychiatry staffing to 100% by September 2026. Recreation therapist positions were filled at 144%. The substantial staffing of direct-care roles establishes a robust foundation for the delivery of clinical services.

Receiver's Signature Page

Date: ___6/24/26___

Appendix A: Acronyms and Initialisms

Acronym List	
AIMS	Abnormal Involuntary Movement Scale
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	Correctional Training Facility
D/C	Discharge
DAI	Division of Adult Institutions
DCHCS	Division of Correctional Health Care Services
DOT	Direct Observed Therapy
DSH	Department of State Hospitals
EHRS	Electronic Health Records System
EOP	Enhanced Outpatient Program
ERRC	Emergency Response Review Committee
FIT	Focused Improvement Team
GP	General Population
HCPOP	Health Care Placement Oversight Program
HDSP	High Desert State Prison
HLOC	Higher Level of Care

HPS I	Health Program Specialist I
HQ	Headquarters
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Interdisciplinary Treatment Team
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
OHU	Outpatient Housing Unit
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 Clinical Case Management System
RHU EOP	Restricted Housing Unit Enhanced Outpatient Program
RHU GP	Restricted Housing Unit General Population
RJD	Richard J. Donovan Correctional Facility

RT	Recreation Therapist
RVR	Rules Violation Report
RVR-MHA	Rules Violation Report – Mental Health Assessment
SAC	California State Prison, Sacramento
SATF	Substance Abuse Treatment Facility
SCC	Sierra Conservation Center
SHO	Senior Hearing Officer
SNY	Sensitive Needs Yard
SOL	California State Prison, Solano
SOMS	Strategic Offender Management System
SPRFIT	Suicide Prevention and Response Focus Improvement Team
SQRC	San Quentin Rehabilitation Center
SRASHE	Suicide Risk and Self Harm Evaluation
SRE	Suicide Risk Evaluation
SRMP	Suicide Risk Management Program
SRN II	Supervising Registered Nurse II
SRN III	Supervising Registered Nurse III
SVPP	Salinas Valley Psychiatric Program
SVSP	Salinas Valley State Prison
T4T	Training for Trainers
TCMP	Transitional Case Management Program
TTA	Treatment and Triage Area
UM	Utilization Management
UOF	Use of Force
VPP	Vacaville Psychiatric Program
VSP	Valley State Prison
WSP	Wasco State Prison

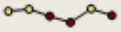
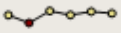
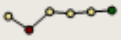
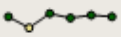
Appendix B: MAPIP

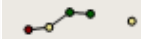
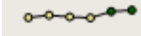
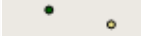
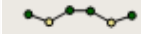
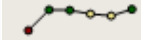
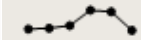
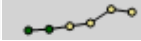
INSTITUTION 6 MONTH TREND

California Institution for Women (CIW)

March 2026

Population Health Management	6 Months	Trend	OCT	NOV	DEC	JAN	FEB	MAR
Diagnostic Monitoring (All)	**81%**		**86%**	**83%**	**79%**	**80%**	**78%**	**81%**
Antipsychotics (All)	86%		91%	86%	85%	84%	82%	85%
Lipid Monitoring	75%		88%	77%	83%	67%	65%	65%
Blood Sugar	87%		94%	89%	90%	83%	85%	79%
AIMS	67%		68%	79%	71%	72%	59%	48%
Med Consent	81%		89%	71%	69%	79%	83%	100%
Pregnancy	16%		7%	13%	13%	8%	27%	38%
Mood Stabilizers (All)	76%		77%	72%	73%	78%	75%	78%
Carbamazepine (All)	57%		-	-	-	100%	50%	50%
Carbamazepine Level	50%		-	-	-	100%	0%	-
CBC	100%		-	-	-	-	100%	100%
CMP	50%		-	-	-	-	50%	-
Med Consent	0%		-	-	-	-	-	0%
Pregnancy	-		-	-	-	-	-	-
Valproic Acid (All)	75%		66%	71%	74%	87%	72%	78%
Valproic Acid Level	39%		50%	25%	0%	71%	33%	40%
CBC with Platelets	63%		40%	50%	83%	80%	50%	50%
CMP	63%		40%	33%	83%	78%	60%	50%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	23%		40%	33%	17%	0%	0%	20%
Lithium (All)	79%		83%	83%	72%	69%	88%	78%
Lithium Level	62%		60%	89%	50%	44%	83%	25%
Thyroid Monitoring	74%		78%	67%	69%	67%	100%	75%
CMP	70%		80%	80%	70%	38%	80%	78%
CBC	78%		71%	100%	75%	67%	100%	67%
Pregnancy	30%		25%	50%	0%	50%	0%	67%

Oxcarbazepine (All)	72%		79%	59%	79%	70%	61%	79%
CBC	82%		90%	64%	100%	83%	83%	85%
CMP	81%		86%	58%	100%	86%	80%	86%
Med Consent	75%		89%	60%	100%	20%	67%	92%
Pregnancy	32%		0%	50%	0%	100%	17%	44%
Lamotrigine - Med Consent	50%		-	50%	0%	-	100%	100%
Antidepressants (All)	67%		69%	78%	57%	64%	68%	66%
EKG (Tricyclics)	-		-	-	-	-	-	-
Med Consent	73%		75%	77%	70%	64%	78%	71%
Thyroid Monitoring	87%		79%	93%	100%	82%	100%	79%
Pregnancy	15%		9%	33%	0%	24%	13%	20%
Venla Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Medication Management	**6 Months**	**Trend**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
Medications Received Timely (All)	**89%**		**89%**	**89%**	**90%**	**89%**	**89%**	**89%**
By Transfer Type								
New Arrival to CDCR (RC) – RC	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – RHU	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – MHCB	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – CTC	-		-	-	-	-	-	-
Intra-System (Within Institutions) – GP	83%		83%	74%	88%	83%	87%	85%
Intra-System (Within Institutions) – RHU	86%		83%	64%	89%	87%	89%	91%
Intra-System (Within Institutions) – MH Inpatient	86%		90%	80%	89%	82%	86%	90%
Intra-System (Within Institutions) – Specialized Medical	91%		89%	98%	86%	86%	93%	93%
Inter-System (Between Institutions) – GP	77%		73%	75%	70%	80%	75%	85%
Inter-System (Between Institutions) – RHU	89%		92%	78%	96%	90%	94%	92%
Inter-System (Between Institutions) – MH Inpatient	87%		94%	91%	83%	67%	88%	90%

Inter-System (Between Institutions) – Specialized Medical	85%		73%	76%	97%	95%	-	84%
Return to CDCR – GP	88%		85%	87%	86%	85%	91%	93%
Return to CDCR – RHU	80%		-	100%	-	-	80%	-
Return to CDCR – MH Inpatient	92%		95%	85%	100%	99%	84%	93%
Return to CDCR – Specialized Medical	88%		60%	93%	92%	86%	83%	94%
Stable Housing	89%		90%	89%	90%	89%	89%	88%
Leaving CDCR	99%		99%	99%	100%	100%	100%	100%
By Provider Type								
Psychiatry	91%		91%	91%	92%	90%	91%	91%
Psychiatry - Refused	2%		2%	2%	2%	2%	2%	2%
Non-Formulary by Psychiatrists	**4.1%**		**3.4%**	**3.5%**	**3.7%**	**4.0%**	**5.2%**	**5.0%**

Appendix C: Sustainable Process Report

Site Visit Report for California Department of Corrections and Rehabilitation
(CALIFORNIA INSTITUTION FOR WOMEN)

SITE VISIT DATES

May 4 – 7, 2026
CQIT+ Site Visit

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

Senior Psychologist, Specialist ..... Rachael Ohanian, PhD
Senior Psychologist, Specialist ..... Shanesha Sorensen, PhD
Senior Psychologist, Specialist ..... Luz Vargas, PsyD
Senior Psychologist, Specialist ..... Mark Wrathall, PsyD
Senior Psychologist, Specialist (SPRFIT Region IV) ..... Sarah Parhami, PsyD
Associate Health Program Advisor ..... Daniel Stebbins

AREAS REVIEWED

Program Area Reviewed:	Sustainable process data review – Prior review 64% – Current review 62%
On this CQIT+ site visit, the licensed MHCB unit, EOP, and both RHU areas were toured. The unlicensed Walker unit was not toured as there were no patients in the unit. The terms ”good” and “unacceptable” are utilized in the headquarters documentation review, to determine the quality of the documentation on the higher level of care (HLOC) considerations documentation. “Good” means that HLOC documentation adequately supports the decision to not refer the patient to a higher level of care even though one or more of the considerations is positive, and that the documentation adequately summarizes the specific treatment modifications that are documented in the treatment plan to improve the patient’s ability to function. “Unacceptable” means one or more of the HLOC considerations were positive, but the explanation for not referring the patient to a higher level of care is deficient, and the HLOC documentation does not adequately summarize the modifications documented in the treatment plan to improve the patient’s ability to function.	

CIW identified 57% "good" cases in this quarter's HLOC documentation review, and HQ identified 62% "good" cases. There was one case with a discrepant outcome; CIW identified the case as "unacceptable" due to insufficient interventions and HQ found it to be "good." Regional review concurred with HQ.

HQ reviewed 21 cases: 62% (13 cases) were identified as "good" and 38% (eight cases) were identified as "unacceptable."

ML EOP comprised 48% of the documentation, with 28% out of the MHCB, and 24% from RHU EOP. In ML EOP (10 cases total), 40% of the cases were considered "good" and 60% were considered "unacceptable." In MHCB (six cases total), 83% of the cases were "good" and 17% were "unacceptable." In RHU (five cases total), 80% of the cases were "good" and 20% were "unacceptable."

Program-wide, the reasons why the cases were considered "unacceptable" included: insufficient narrative due to missing an MSE and/or the patient's clinical functioning (50%); documentation signed late (25%); missing documentation (12.5%); and IPC error (12.5%).

Reasons why the cases were considered "unacceptable" were further categorized by program. In EOP (six "unacceptable" cases), the following were the reasons for unacceptable documentation: insufficient narrative (67%) and documentation signed late (33%). In MHCB, the one "unacceptable" case was due to missing documentation. In RHU, the one "unacceptable" case was due to an IPC error in completing the audit.

CIW's HLOC documentation quality declined by 2% this quarter. Within-program rates indicated that ML EOP declined by 51% to attain 40% "good" documentation, MHCB improved by 50% to 83%, and RHU improved by 30% to 80%. While none of the programs reached the 85% benchmark, MHCB was close. CIW will be required to complete the audit again for Q3 2026.

A summary of this information was provided to the IPC, program supervisors, and leadership via email prior to the conclusion of the site visit. Further investigation by the IPC into the ML EOP documents that were "unacceptable" led to the discovery that three of the documents were authored by either an intern or newer staff. Regional continues to recommend that program supervisors maintain oversight of HLOC documentation in all programs, with particular attention on newer or lesser experienced clinical staff.

The Q1 2026 follow-up action plan was: 1. Ensure that all clinical staff are provided with a summary of the overall results of the HQ audit and areas of focus for continued improvement in the quality of the HLOC documentation (i.e., MSE and clinical functioning are both required elements of the non-referral rationale). Provide 844s with dates that staff were provided with this information. 2. Provide an update on if an LOP is being considered that will identify expectations for prereview and corrective IDTTs to assist in improving documentation, particularly in the MHCB.

The institutional response was: 1. Feedback to be provided to each area supervisor by the IPC. 2. A LOP for higher level of care considerations will not be implemented. The LOP was discussed and considered. The HLOC issues in MHCB are being addressed by the Senior Psychologist Supervisor along with additional training provided by the IPC. The ML EOP supervisor, [name removed], will also cross train the MHCB supervisor on effective ways to support the line staff with both the IDTT process and documentation.

Follow-up required: YES _X__ NO____	If YES: Follow-up date: July 17, 2026

Follow-Up Action Plan: 1. Ensure that all clinical staff are provided with a summary of the overall results of the HQ audit and areas of focus for continued improvement in the quality of the HLOC documentation (i.e., MSE and clinical functioning are both required elements of the non-referral rationale). Provide 844s with dates that staff were provided with this information.

Program Area Reviewed:	Mental Health Program Subcommittee Minutes

January 2026

Meeting minutes were not posted timely to SharePoint and a quorum was met. The IPC was in attendance and presented HLOC information during the meeting. Part V was embedded in the minutes, and all sections were captured in the narrative except for Section F. There were three Acute referrals and four ICF referrals for a total of seven referrals. All four ICF referrals and two Acute referrals (67%) were noted to be submitted timely. One referral was documented as being submitted late due to a pending Vitek hearing caused by the patient receiving external medical care. No information was provided regarding whether referred patients transferred to PIP/DSH within designated timeframes. HLOC documentation quality was 75%. It was noted that the IPC has updated their reviewing process for HLOC documentation based on information provided by another institution in Region II. Additionally, the IPC has provided training to CCCMS, MHCB and EOP treatment teams, and schedules training for any new staff. No information was provided regarding whether there were any PIP/DSH returnees with the required documentation being reviewed and completed timely.

February 2026

Meeting minutes were posted timely to SharePoint and a quorum was met. The IPC was in attendance and presented HLOC information during the meeting. Part V was embedded in minutes, and all sections were captured in the narrative except for Section F. There were three Acute referrals and three ICF referrals, for a total of six referrals. In the narrative it stated that there were two rescissions, as On Demand had four Acute and four ICF referrals; however, those rescissions were not included in the total number of referrals initiated (which should have made total referrals initiated eight instead of six). All six referrals noted in Part V were submitted timely. No information was provided regarding whether referred patients transferred to PIP/DSH within designated timeframes. HLOC documentation quality was 81%. Section F in Part V noted a plan that was not captured in the narrative and was copied and pasted from the prior month with no changes. No information was provided regarding whether there were any PIP/DSH returnees with the required documentation being reviewed and completed timely.

March 2026

Meeting minutes were posted timely to SharePoint and a quorum was met as more than 50% of the required voting members were in attendance (seven plus acting CMH); however, on the face sheet of the minutes it noted a quorum was not met and only six required members plus CMH were in attendance. Additionally, on the face sheet, it noted the CMH as the chair but then further down that the outpatient chief was the acting chair. Part V was embedded in minutes, and all sections were captured in the narrative except for Section F. There was one Acute referral and two ICF referrals, for a total of three referrals. The one Acute referral was noted to be submitted late due to a pending Vitek hearing. One of the ICF referrals was submitted late due to "IRU's recommendation due to patient's medical concerns." No information was provided regarding whether referred patients transferred to PIP/DSH within designated timeframes. HLOC documentation quality was 63%. Section F in Part V noted a plan that was not captured in the narrative and was copied and pasted from the prior month with no changes. No information was provided regarding whether there were any PIP/DSH returnees with the required documentation being reviewed and completed timely.

CIW noted in the Q1 2026 institutional response to the requested follow-up action plans that the outpatient Senior Psychologist Supervisor will be responsible for drilling down all PIP/DSH returns and present the findings at the MHPS meeting and noted that this was a "carryover from previous audits" and that "interventions completed during previous audit." However, review of March minutes indicated that deficiencies continued. As a result, Regional will continue with the follow-up action plans until review of minutes indicate that all sections of Part V are discussed and documented in the narrative of the minutes, along with timeliness of patient transfers and review of PIP/DSH returnees discharge documentation requirement compliance rates.

A summary of this information was provided, along with all reviewed documentation, to the IPC, CMH, CPs, and program supervisors before the site visit and completion of this report. The IPC was informed that IRU has requested that referrals for patients pending a Vitek hearing be submitted as soon as the packet is complete absent the Vitek hearing results. The CMH was also informed of the need to have Part V Section F follow-up action plans captured in both Part V and in the body of the minutes. For PIP timely transfers, the IPC tracks this information in the internal tracking spreadsheet and will start to report on this during the MHPS meeting. Additionally, the requirements for required PIP/DSH returnee documentation were reiterated and details were provided to the IPC during the site visit. It was determined that this information was being discussed during the meeting but documented in a different section; the CMH modified the most recent minutes to be approved at the upcoming MHPS meeting with the PIP/DSH returnee information captured in the HLOC section of the minutes.

The Q1 2026 follow-up action plan was: 1. Information documented in Part V will be captured in the narrative of the minutes. 2. (continued from Q2 2025-Q4 2025) PIP/DSH returnee required documentation with completion rates will be discussed during MHPS and captured in narrative of the minutes. 3. Confirm that the minutes are being posted to the statewide Monthly MHPS Meeting Minutes SharePoint site.

The institutional response was: 1. The scribe will ensure that Part V is captured in the narrative of the minutes. 2. The outpatient Senior Psychologist Supervisor will drill down all PIP/DSH returns each month and present the findings in MH sub. The scribe will ensure it is captured in the minutes and uploaded. This corrective action plan is carryover from previous audits. Interventions completed during previous audit. [Regional note: this will continue to be monitored until improvement in upcoming reviews shows compliance.] 3. The CMH met with the mental health OSS2 and the QM HPM 3. The QM staff were only uploading the minutes on the local CIW SharePoint, rather than the Statewide SharePoint.

Follow-up required: YES _X_ NO___	If YES: Follow-up date: July 17, 2026

Follow-Up Action Plan: 1. (Continued from Q1 2026) Information documented in Part V will be captured in the narrative of the minutes. 2. (Continued from Q2 2025-Q1 2026) PIP/DSH returnee required documentation with completion rates will be discussed during MHPS and captured in narrative of the minutes. 3. Provide whether patients referred to PIP/DSH are transferred within timelines.

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

Six referrals were initiated: two to Acute and four to ICF.

Of the two Acute referrals, neither was rescinded. Two additional entries generated on the report: one was an MHI entry error; and one was for a referral that was originally submitted before the review period. Master Treatment Plans (MTPs) were signed timely (within four hours) in both entries, the Due Process Signed column was complete in both, and no Vitek hearings were documented as being held. Both consults were submitted timely to IRU.

Of the four ICF referrals, none were rescinded. MTPs were signed timely in all entries, and the Due Process Signed column was complete. Two Vitek hearings were held; in the entry that did not populate with the Vitek date, the appointment was completed but no communication order was found. All four consults were submitted timely to IRU.

Part V of the monthly HLOC audit was consistent with the total number of referrals, but inconsistent in that it indicated three Acute and three ICF referrals. CIW's internal tracking log, however, was consistent with the On Demand data. The referral rate was 25%.

February 2026
Two referrals were initiated: one to Acute and one to ICF.

For the one Acute referral, it was not rescinded, the MTP was signed timely, and the Due Process Signed column was complete. One Vitek hearing was completed but the date did not populate in the entry; the Vitek appointment was completed but no communication order was found. The consult was submitted timely to IRU.

For the one ICF referral, it was not rescinded. There was one additional entry generated on the report for a patient already at PIP. The MTP was signed timely, the Due Process Signed column was complete, and no Vitek hearing was documented as being held. The consult was submitted timely to IRU.

Part V of the monthly HLOC audit was inconsistent with the On Demand Data. Part V reported a total of three referrals: one to Acute that was documented as not submitted timely due to needing a Vitek hearing (but the referral was submitted timely with the extended due date that is afforded when a Vitek hearing is required); and two ICF referrals where only one was noted as submitted timely due to "IRU's recommendation d/t medical concerns" being the reason why the other referral was submitted late. CIW's internal tracking log was consistent with the On Demand data, and it was unclear why discrepant data was reported. The referral rate was 7%.

March 2026
Eight referrals were initiated: four to Acute and four to ICF.

Of the four Acute referrals, one was rescinded. MTPs were signed timely in all entries, the Due Process Signed column was complete and no Vitek hearings were documented as being held. All four consults were submitted timely to IRU.

Of the four ICF referrals, one was rescinded. MTPs were signed timely in all entries, the Due Process Signed column was complete and no Vitek hearings were documented as being held. All four consults were submitted timely to IRU.

Part V of the monthly HLOC audit was consistent with the On Demand data. The referral rate was 13%.

The quarterly referral rate was 14%, a 2% increase from the previous quarter.

Prior to the March HLOC monthly audit due date, Regional contacted the IPC to share what On Demand reported for January and February and to identify where the discrepancies were coming from.

A summary of this information was provided, along with all reviewed documentation, to the IPC, CMH, CPs, and program supervisors before the site visit and completion of this report.

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

January 2026
There were 18 non-referral entries on the report, with two entries for patients already referred to Acute/ICF. Eighteen (100%) of the entries for patients not already referred to Acute/ICF were reviewed. There were 12

(67%) entries with single considerations, six (33%) with multiple considerations, five (28%) with subjective considerations, 15 (83%) with objective considerations, and the most common consideration was #5 (56%).

Three data errors were identified in the entries, and they all were for an inaccurate MHI disposition. The data error rate was 17%.

February 2026
There were 25 non-referral entries on the report, with no entries for patients already referred to Acute/ICF. All 25 (100%) entries were reviewed. There were 24 (96%) entries with single considerations, one (4%) with multiple considerations, zero (0%) with subjective considerations, 25 (100%) with objective considerations, and the most common consideration was #5 (60%).

Data errors identified included: Sustainable Process Report (SPR) was not provided and considerations could not be confirmed (five entries); missed consideration (two entries); and MTP not signed and left in an in-progress state (one entry). The data error rate was 32%.

March 2026
There were 54 non-referral entries on the report, with one entry for a patient already referred to PIP. Twenty-seven (52%) of the non-referral entries were reviewed. There were 48 (89%) with single considerations, six (11%) with multiple considerations, two (4%) with subjective considerations, 53 (98%) with objective considerations, and the most common consideration was #5 (70%).

Data errors identified included: no SPR was provided and considerations could not be affirmed (five entries); inaccurate MHI at IDTT (one entry); and considerations endorsed when they were not flagged (one entry). The data error rate was 26%.

The quarterly data error rate was 26%, a 7% increase from the previous quarter.

A summary of this information was provided, along with all reviewed documentation, to the IPC, CMH, CPs, and program supervisors before the site visit and completion of this report.

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:	Documentation Review – Higher Level of Care Tab

Quality
Eight cases were randomly selected from the March monthly HLOC audit and reviewed for quality of the rationale and intervention sections within the HLOC tab of the MTP. Three cases were found to have unacceptable documentation. In the first case, it was unclear what was driving the endorsed consideration, and it could not be determined if the interventions were tailored to the patient's specific needs. The rationale and intervention sections were also unacceptable in the second case because the MTP was edited weeks after the IDTT was held. In the third and final case, the rationale section was unacceptable because the patient's current clinical presentation was unclear.

Regional's review of outcomes was discrepant in three cases. In the first case, the institution found the intervention sections unacceptable. However, Regional review found that they were sufficient. In the second

case, the institution found that the rationale was lacking sufficient justification for the patient's appropriate level of care. Regional concluded that this was sufficiently discussed. In the last case, the institution found interventions acceptable. However, Regional noted that the MTP had been modified weeks after IDTT which resulted in an unacceptable finding.

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 corresponding SPR. All eight cases were found to be consistent.

Additional issues regarding the overall quality of the MTP documentation included: the MHMD initial assessment was not completed prior to the initial IDTT (two cases); the initial IDTT was held outside of program guidelines; the patient was assigned conflicting diagnoses; the symptoms, behaviors or endorsed consideration identified in the HLOC section of the MTP were not addressed in the problem/symptoms section of the treatment plan grid (four cases); aspects of the treatment plan grid were left blank (two cases); and, the symptoms and clinical presentation described in the HLOC section of the MTP was not captured in the patient's diagnosis (two cases).

A summary of this information was provided, along with all reviewed documentation, to the IPC, CMH, CPs, and program supervisors before the site visit and completion of this report. During the site visit, Regional reviewed with the IPC and CMH the basic requirements needed for HLOC documentation to be considered "good." Leadership will need to continue to assess and identify the barriers to improving documentation, particularly when clinicians who are known to be clinically strong writers continue to struggle with meeting the HLOC documentation requirements. Recently, CIW submitted a Solution Center ticket requesting that the HLOC document form's structure be adjusted in the EHRS to assist teams in ensuring that all required elements are met.

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. Program supervisors to provide trainings to staff. Outpatient chief to provide training to the supervisors.

Follow-up required: YES _X_ NO____	If YES: Follow-up date: July 17, 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
Six IDTTs were scheduled and observed: two initials and four follow-ups. All IDTTs started on time and all patients attended. The MHMD initial assessment and MHPC initial assessment were completed prior to the two initial IDTTs. One patient was noted to be wearing a spit mask due to recent behavioral issues, but it was removed after she was placed in a therapeutic module. None of the patients were on safety issue and had either been granted partial or full issue. The purpose of IDTT was stated and thoroughly explained by the clinicians for all six cases. All patients were invited to be active members. MHPCs provided relevant historical and current clinical summaries, as well as brief case formulations. For two of the patients, the MHPCs chose to discuss the clinical summary and case formulation prior to the patient entering the room, due to these patients having limited insight into their mental illness. Treatment goals were discussed, however in five out of six of the observations, these goals were not noted to be specific nor measurable. The MHMD discussed medications and relevant information related to each patient, including encouragement and

recommendations for mental health treatment groups and the impact of substance abuse on behavior. The CCI was actively involved throughout the IDTTs and spontaneously provided appropriate information and answered any questions asked by the patient. Nursing provided valuable information related to each patient and asked if they had any medical concerns they wanted to address. The team was interactive, and it was evident that they had good knowledge of their patients and were able to build rapport. In one case, a patient became upset as the clinician referred to her as being "assaultive" several times, rather than referring to the behavior itself. In all six cases, recent RVRs were discussed; however, only one case discussed the mental health recommendation.

Treatment plans and discharge plans were discussed. Treatment planning included progress toward treatment for the patient being seen as a follow-up, but treatment goals were not stated in a way that was measurable. Safety planning was discussed in the cases that had been referred for Danger to Self. Higher levels of care and appropriateness of level of care were discussed in all six cases. Approval for issue and observation were discussed and explained to five out of six patients. The MHCB team continues to exhibit interdisciplinary treatment planning in an empathic setting, with IDTT outcomes not appearing to be predetermined.

RHU EOP

One initial IDTT was observed. The IDTT began more than 45 minutes after the scheduled time in EHRS. The MHPC stated that the MHMD was completing IDTTs on another yard and was only available to attend the IDTT after those IDTTs were completed. Both MHPC and MHMD initial assessments were completed prior to IDTT. Required members in attendance included the assigned MHPC, the assigned MHMD, and CCI. Also in attendance was the IPC serving as an auditor, PT, RT, custody officer, and program supervisor.

The IDTT leader explained the purpose of the meeting. The patient's mental health status did not appear to impact their understanding in in the IDTT. The patient was invited to participate and asked open-ended questions. The team members also gave the patient the opportunity to provide meaningful input regarding their goals and interventions. All team members participated, were interactive with one another, and engaged with the patient in the IDTT.

The MHPC reviewed the diagnosis, precipitating, perpetuating, and protective factors, but did not include predisposing factors. The MHMD provided relevant information regarding reason for medications and discussed side effects. The CCI provided relevant information including RVR status and history, and upcoming committees.

Measurable treatment goals via self-report were discussed. Not all higher level of care considerations were reviewed, mostly objective considerations were included, and discussion of appropriateness of level of care was not discussed with all members.

Relevant RVR history was reviewed and discussed. There were no applicable mental health recommendations since the last IDTT. When patient's resistance to treatment was identified, the discussion included goals and interventions to minimize resistance, including input from the custody officer present. The outcomes did not appear predetermined as the discussion appeared influenced by staff and patients' input. Overall, the IDTTs appeared patient-focused while also reviewing CQI criteria to provide a more comprehensive treatment plan. Quality of IDTT could be improved by continuing to incorporate more CQI criteria and increasing the quality of treatment goals.

ML EOP

Three routine IDTTs were observed. In attendance at each IDTT were the MHPC, program supervisor, MHMD, CCI, PT, and the unit sergeant. In one IDTT the PT arrived late, did not contribute to the discussion, and was

observed to be less than alert for a portion of the IDTT. The MHPC, MHMD, and CCI all had access to appropriate electronic records.

There was an interactive discussion that included all members in two of three IDTTs due to the program supervisor's prompting. IDTT outcomes did not appear to be predetermined. In two of the three IDTTs the case formulation was insufficient specifically lacking in a discussion of the history of mental illness and the predisposing, precipitating, and perpetuating factors. In the third IDTT, the case presentation was thorough and included all required elements; however, it was presented prior to the patient entering the room and the reason for this was not made clear. In all IDTTs the MHMD discussed the medication, uses, side effects and dosages. The CCI was knowledgeable and contributed to each IDTT. In each of the IDTTs, the patient was an active participant and was encouraged to provide input into all aspects of the IDTT.

The presence of RVRs was discussed in all IDTTs, although the RVR MHAs were not discussed in the one case in which it was required. Additionally, the behavior that led up to the RVR was not discussed. All HLOC considerations were discussed in only two of the three IDTTs

While goals were discussed in all IDTTs, only two discussed them in measurable terms. Progress toward previously established goals was only discussed in one IDTT.

The Q1 2026 follow-up action plan was: *MHCB*: N/A. *RHU*: 1. Program supervisor will ensure that all CQI criteria are covered during IDTT and prompt for missing criteria, including information related to RVRs, RVR MHAs and HLOC considerations. Provide 844s. 2. MHMD will provide side effect information for prescribed medication in all cases. Provide 844s. *ML EOP*: 1. Program supervisor will ensure CQI criteria are met in each IDTT, including discussion of measurable treatment goals, prompting for discussion of potential side effects of medications, and discussion of clinical reasonable accommodations related to work or education assignments. Provide 844s. 2. If the program supervisor cannot attend, ensure that an IDTT leader is provided with the CQI audit criteria so that all discussion topics are addressed in a succinct manner. Provide 844s. 3. Consider peer cross training with the ML EOP program supervisor.

The institutional response was: *MHCB*: N/A. RHU*:* 1. Program supervisor will train all RHU staff on all CQI criteria. Supervisor will provide all staff with the exact criteria as a reference. 2. Outpatient Chief Psychiatrist provided training to the RHU psychiatrist. Provided him with the CQI audit criteria again. *ML EOP*: 1. Program supervisor will train all RHU staff on all CQI criteria. Supervisor will provide all staff with the exact criteria as a reference. The supervisor will conduct their own audits of the criteria to ensure the effectiveness of the training. 2. Program supervisor will identify and train a delegate as IDTT leader. ML EOP Supervisor Cross Trained her back up [backup name]. 3. ML EOP supervisor conducted peer to peer training with all of the current acting, social work, and psychology supervisors on the IDTT process, HLOC, and CQI criteria.

Follow-up required: YES _X_ NO____	If YES: Follow-up date: July 17, 2026

Follow-Up Action Plan:

MHCB: 1. Program supervisor will ensure the following CQI audit criteria are met for all patients: measurable treatment goals; and RVR MHAs are discussed and considered in developing the treatment plan. Provide 844s.

RHU: 1. Program supervisor will ensure that all HLOC considerations are discussed and incorporated into the discussion regarding the resulting level of care decision. Provide 844s.

ML EOP: 1. Program supervisor will ensure that the following CQI criteria are met for all patients: discussion of all relevant RVR MHAs and if behavior leading to the RVR should be incorporated into the treatment plan; identification of measurable treatment goals; and discussion of progress toward previously identified treatment goals. Provide 844s.

Program Area Reviewed:	Housing Unit Review

MHCB

No patients were housed in the unlicensed Walker unit during the time of observation; therefore, the unit was not visited. Patients at MHCB level of care were housed in the CTC. The CTC was very clean, with HFM observed actively cleaning the unit. Most of the patients were sleeping or out of their cell programming. Empty cells were clean and ready for intake. One patient was on 1:1 suicide watch and the staff was observed to maintain continuous visual contact.

No patients were maintained on the Regional Spreadsheet who were identified during the previous quarter. No new patients were identified for further review.

RHU

Both the CCCMS RHU and EOP RHU units were toured. The RHU CCCMS was very clean and quiet. With a census of 14 patients, most of the patients were sleeping at the time of observations. Empty cells were clean and ready for intake. One patient reported that their clinician is "awesome" and has been very helpful in her ability to maintain sobriety and medication compliance. They also stated that the PT in the unit is helpful. One patient shared that during ICC, clinicians' opinions regarding mental health symptoms contributing to the RVR and corresponding recommendations are disregarded by custody and are not considered for the final decision. The RHU EOP had nine patients and all were attending group or being escorted to group during the observation. The unit was generally clean. There were several cells that were empty with no patients and had signs on the door that said "sanitized," but the cells were not clean and ready for intake. One cell was empty but had left over property that appeared to be from a patient recently moved out of the unit.

No patients were maintained on the Regional Spreadsheet who were identified during the previous quarter. No new patients were identified for further review.

ML EOP

Custody staff identified a patient they were concerned about but the staff member was unable to articulate what specifically was going on with the patient and stated, "you will know when you see her." The patient was observed to be sleeping in their bunk with the cell door open and nothing stood out regarding the state of her cell. The patient was added to the follow-up list. One patient reported that sessions with clinicians last on average between 15 and 30 minutes, which does not allow them to dive into core problems in session but instead are primarily filled with general questions about the patient's wellbeing. Additionally, she stated that she cannot express suicidal ideation or depression without being sent directly to MHCB, which is not always the help she needs. Also, group sessions were reported to not run for the allotted time and are often ended early after patients are provided with handouts to review on their own outside of the group. One patient shared that she has been at CIW a long time and has learned how to advocate for herself; therefore, she is able to receive the treatment she needs and is very happy with it. The same patient reported that they spend significant time in their cell from 1300 to 1700 hours due to EOP patients on C/C status needing programming from 1300 to 1500 hours without other patients being allowed in the same area, and count is held from 1500 to 1700 hours.

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

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 has been completed with individual action plans.

Follow-up required: YES _X_ NO____	If YES: Follow-up date: July 17, 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 – 1. Ensure that all clinical staff are provided with a summary of the overall results of the HQ audit and areas of focus for continued improvement in the quality of the HLOC documentation (i.e., MSE and clinical functioning are both required elements of the non-referral rationale). Provide 844s with dates that staff were provided with this information.

2. MHPS – 1. (Continued from Q1 2026) Information documented in Part V will be captured in the narrative of the minutes. 2. (Continued from Q2 2025-Q1 2026) PIP/DSH returnee required documentation with completion rates will be discussed during MHPS and captured in narrative of the minutes. 3. Provide whether patients referred to PIP/DSH are transferred within timelines.

3. Referral and Non-Referral Reports – N/A.

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 will ensure the following CQI audit criteria are met for all patients: measurable treatment goals; and RVR MHAs are discussed and considered in developing the treatment plan. Provide 844s. ***RHU***: 1. Program supervisor will ensure that all HLOC considerations are discussed and incorporated into the discussion regarding the resulting level of care decision. Provide 844s. ***ML EOP***: 1. Program supervisor will ensure that the following CQI criteria are met for all patients: discussion of all relevant RVR MHAs and if behavior leading to the RVR should be incorporated into the treatment plan; identification of measurable treatment goals; and discussion of progress toward previously identified treatment goals. 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

Regional thanks CIW's leadership teams for their continued warm welcome and collaboration.

HQ reviewed 21 cases in this quarter's Higher Level of Care documentation audit: 62% (13 cases) were identified as "good" and 38% (eight cases) were identified as "unacceptable." ML EOP comprised 48% of the documentation, with 28% out of the MHCB, and 24% from RHU EOP. In ML EOP (10 cases total), 40% of the cases were considered "good" and 60% considered "unacceptable." In MHCB (six cases total), 83% of the cases were "good" and 17% "unacceptable." In RHU (five cases total), 80% of the cases were "good" and 20% "unacceptable."

CIW's HLOC documentation quality declined by 2% this quarter. Within-program rates indicated that ML EOP declined by 51% to attain 40% "good" documentation, MHCB improved by 50% to 83%, and RHU improved by 30% to 80%. While none of the programs reached the 85% benchmark, MHCB was close. CIW will be required to complete the audit again for Q3 2026.
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 (CQI) audit criteria for multiple MH program areas, including IDTTs. These standards strive to exceed a constitutional threshold of quality care. Case formulations and higher level of care discussions were sufficient in MHCB, and not sufficient for all patients in RHU and ML EOP. RVRs were discussed for all patients in MHCB, RHU and ML EOP but not all the associated Mental Health Assessments (MHAs) in MHCB and ML EOP. Measurable treatment goals were identified for all patients in RHU EOP and not identified for all patients in MHCB and ML EOP. Teams were interactive for all patients in MHCB and RHU and this was not observed for all IDTTs in ML EOP. None of the IDTT outcomes in MHCB, RHU, and ML EOP appeared to be predetermined.

During the Q4 2025 site visit, custodial presence in the IDTTs was discussed with the institution's mental health leadership; the custody staff member required to attend IDTT is the CCI. Regional observed a sergeant attending the ML EOP IDTT during this site visit. Although not disruptive to the IDTT process, the sergeant did not provide information that could not be addressed by the CCI. Mental Health leadership were also reminded that custody and mental health staff should engage in a professional and collegial manner. Patients continued to report difficult interactions with some of the housing officers in ML EOP. This issue will be addressed outside of the CQIT+ processes.

Overall, teams were noted to be sensitive to and knowledgeable of their patients' mental health needs despite not meeting all the CQI IDTT audit criteria and HQ standards of HLOC documentation quality.

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

Appendix D: Excluded Indicators

- AC18: Scheduled MH Appointments Completed or Refused
- AC5.2: Monthly Review of EOP Modified Treatment
- CM2.2: Healthcare Staff CMHPP Annual Training
- QC10: Mental Health Primary Clinician Continuity of Care
- QC11: Mental Health Psychiatrist Continuity of Care
- PS3.1 Seclusion Incidents
- PS3.2 Maximum Number Seclusion Incidents
- PS3.3 Seclusion Duration Incidents Greater Than 8 Hours
- PS3.5 Restraint Occurrences
- PS3.6 Maximum Number of Restraint Incidents
- PS3.7 Restraint Duration Incidents Greater Than 4 Hours