CORRECTIONAL TRAINING FACILITY

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Receiver's Compliance Team

2026

Statewide Mental Health Program
Continuous Quality Improvement

CORRECTIONAL TRAINING FACILITY

CDCR

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Background

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

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

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

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

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

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

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

Goals

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

The Receiver seeks to use the audit process not only to assess compliance but also to identify barriers to compliance that she can address and 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 confers 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 compliance 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 greater compliance. To incorporate inverse indicators into aggregate compliance scores, the individual KPI percentage is subtracted from 100 (e.g., 100 – 2% = 98% compliance).
- Indicators that do not have a specified compliance threshold are excluded from the calculation of aggregate compliance scores.

- Blank boxes in the summary tables are the result of those indicators not being applicable to the institution or program being audited, or data unavailability.

Indicators Excluded from This Report

Part of the 2026 field-testing phase is designed to identify indicators that are not yet functioning as intended so they can be corrected before the Receiver recommends a final set of indicators to the court. During the CTF audit, several indicators were identified as producing unreliable results due to technical issues in the CQIT platform. These indicators have been excluded from this report and are summarized below by category.

- Coding logic errors: Certain indicators allow auditors to select "N/A" (not applicable) as a response. The underlying coding logic converts this selection to a negative value, which distorts the indicator's calculation. This affects indicators where an "N/A" response is a valid and expected answer based on the circumstances under review.
- Quarterly reporting structure: Some indicators are designed to be entered as separate quarterly audits within CQIT. Because this was the first CQIT+ audit cycle at CTF, historical quarterly data had not yet been entered into the system. Auditors entered data for the full reporting period in a single entry, which in some cases produced a numerator larger than the denominator, which is an arithmetic result that cannot yield a valid compliance percentage.
- Suicide prevention training: The audit questions for custody staff suicide prevention training in CQIT do not match the corresponding questions on the data remediation documentation page (in SharePoint) used to verify training completion. This inconsistency produces inaccurate results.
- Use of force training: The audit instructions for use of force training (both custody and healthcare staff) referenced an incorrect training code, directing auditors to the wrong training records. As a result, the data collected does not reflect actual training completion.

The development team is working to resolve these issues in time for subsequent audit reports.

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

Executive Summary

Correctional Training Facility (CTF) is a large, medium-security institution that provides Correctional Clinical Case Management System (CCCMS) level of care to a growing mental health population, 836 patients at the start of the review period, 937 at the time of the site visit. Within CTF there are two operational units, Central and North. CTF does not operate an onsite Mental Health Crisis Bed (MHCB) unit.

CTF's institutional strengths are notable. Clinical staffing is among the strongest in the state, psychiatry is at 96% capacity, non-supervisory clinical positions are at or above 90%, and the entire mental health program is staffed with onsite personnel; the facility does not rely on telemental health for daytime operations. The Mental Health Referral Chronos (CDCR 128-MH5) were available across all housing units and custody staff demonstrated consistent awareness of referral responsibilities. Appointment completion rates are at 100%, custody-driven cancellations are near zero, and timely MHCB transfers averaged 95% despite the logistical complexity of external transport. Emergency response infrastructure is strong, all housing units had compliant cut-down kits, all officers carried CPR mouth shields, and all RHU intake cells were suicide-resistant. The RHU consistently emerged as an area of operational strength across multiple audit domains. Treatment team members were observed to be empathic, patient-focused, and responsive to patient concerns, and patients who attended IDTTs reported feeling listened to by their providers. CTF's emphasis on continuity of care through team-based assignments when primary clinicians are unavailable reflects thoughtful program design.

The deficiencies documented are not driven by resource scarcity. With adequate staffing, strong custody cooperation, and an institutional culture that values patient engagement, the barriers to compliance are primarily procedural, clinical-quality, and environmental. The six priority recommendations below target the areas where the gap between institutional capacity and actual performance is widest and where patient safety, constitutional adequacy, or both are at stake.

Priority Recommendations

1. **Conduct Immediate Retrospective Review of Mood Stabilizer and Antipsychotic Diagnostic Monitoring and Implement Prospective Safety Tracking**. These medications have narrow therapeutic indices where missed monitoring can result in toxicity, organ damage, or subtherapeutic dosing. Depakote therapeutic level monitoring was at 0% for three consecutive months; lithium level and EKG monitoring showed similar gaps. The Chief Psychiatrist should conduct a retrospective review of all patients prescribed mood stabilizers during the reporting period to confirm required labs have been completed or are now scheduled, identify the root cause of the monitoring gap (ordering failure, lab completion failure, or documentation error), and implement a prospective tracking system (whether through standing lab order review, automated Electronic Health Records System (EHRS) reminders, or a manual monitoring calendar) to prevent recurrence. Extend this review to the antipsychotic metabolic monitoring measures showing significant variability (blood sugar 60–100%, lipids 33–100%, thyroid as low as 33%). Demonstrate sustained compliance at or above 90% across all diagnostic monitoring measures within six months.
2. **Improve RVR-MHA Clinical Quality and Documentation**. Of 228 Rules Violation Report-Mental Health Assessments (RVR-MHA) completed for MHSDS patients during the reporting period, only one recommended alternative discipline or mitigation, a rate below 1%. Documentation met requirements 0% of the time. Onsite leadership should conduct a retrospective clinical review of a representative sample (minimum 20 cases) to determine whether clinicians are conducting individualized assessments or completing the form by rote, interview clinicians to identify barriers to recommending mitigation, and provide written clinical guidance with case examples (after removing all identifying information).

3. **Address Suicide Prevention Clinical Process Deficits: Safety Planning Quality, Timely Clinical Follow-Up, and SRE Mentoring Completion**. Two HQ Suicide Prevention and Response Focus Improvement Team (SPRFIT) corrective action plans have been assigned for safety planning deficiencies. Timely clinical follow-ups after MHCB discharge declined to 0% in the final two months of the reporting period. These findings converge on the clinical processes most directly responsible for preventing suicide in a population with established risk, and they are failing at the moments of highest risk (post-crisis discharge, transition from acute to routine care). The CMH or designee should respond to both CAPs within the 45-day deadline, implement the required random sample audits and monthly SPRFIT committee reporting, and ensure all current safety plans are individualized to the patient's specific risk factors. Clinical supervisors should identify and resolve the specific barrier causing the 0% follow-up compliance trend. Reconcile the Suicide Risk Evaluation (SRE) mentoring data discrepancy and achieve mentoring completion at or above 90%.
4. **Implement a Structured IDTT Quality Improvement Initiative**. Interdisciplinary Treatment Team (IDTT) required staffing averaged 31% over six months with no improvement trend. None of the eight IDTTs observed across three settings met all quality criteria. The most frequent deficiencies (absent case formulation, no measurable treatment goals, no level-of-care discussion, no RVR review, and limited MHMD engagement) are not staffing problems; they are clinical practice and supervision problems. Clinical supervisors should develop and distribute a standardized IDTT checklist aligned with the audit criteria, conduct regular supervisory observations of IDTTs using the checklist, and provide direct feedback to treatment teams. Address the specific barrier preventing MHMD attendance at IDTTs (which is a scheduling or expectations issue given 96% psychiatry staffing). Pre-release planning documentation (3% six-month average) should be integrated into this initiative through a prospective tracking mechanism that identifies patients approaching release. Achieve IDTT required staffing at or above 75% and demonstrate measurable improvement in observed IDTT quality within six months.
5. **Establish Facility-Wide Language Access Compliance for All Mental Health Contacts**. The audit identified a systemic pattern of inadequate language access across IDTTs, ICC hearings, and PT rounds. Certified interpreters were not utilized for Spanish-speaking patients in clinical encounters where staff served as informal interpreters, resulting in incomplete translation of both patient statements and team discussions. This is not an isolated finding in one program area, it is a facility-wide pattern that affects the constitutional adequacy of treatment delivery, the validity of clinical assessments, and patients' ability to participate meaningfully in decisions about their care, housing, and discipline. Institutional leadership should identify all limited-English-proficient (LEP) patients in the current MHSDS population, confirm certified interpreter services (telephonic or in-person) are available and accessible for all clinical contact types, and issue clear written guidance that staff interpretation without certification does not satisfy the effective communication requirement. Include language access compliance as a standing element in supervisory observations of IDTTs, ICCs, and PT rounds.
6. **Develop and Begin Executing a Treatment Space Remediation Plan**. Treatment space adequacy is the most significant environmental deficiency. Auditors found that few spaces met audit criteria, with 0% for group spaces, 33% for IDTT spaces, and 38% for individual treatment spaces. The primary driver for these low ratings is a ventilation-confidentiality tradeoff created by physical plant limitations, staff must choose between adequate airflow and treatment privacy. Institutional leadership, in coordination with Plant Operations, should conduct a systematic assessment of all mental health treatment spaces, identify which can be remediated through HVAC modification or reconfiguration versus those requiring capital improvement, and submit a Mental Health Expenditure Request for spaces requiring infrastructure work. Implement interim measures for the highest-volume treatment spaces (sealed-window ventilation, relocation to compliant spaces) and complete remediation of at least the most frequently used individual treatment spaces and both IDTT rooms within six months.

Institution's Operational Perspective

Correctional Training Facility (CTF) is an institution with two facilities, Central and North, each operating a mental health clinic. CTF provides only the Correctional Clinical Case Management System (CCCMS) level of care. During the review period, the CCCMS population grew from 836 on August 3, 2025, to 890 on January 31, 2026, and reached 937 at the start of the site visit, March 3, 2026.

A cornerstone of CTF's mental health program is a focus on continuity of care. If a patient's assigned clinician is unavailable, the next assignment is to another member of the patient's MH care team. This practice helps to ensure the focus is on the therapeutic relationship between clinicians and patients as much as possible.

Throughout most of the review period, mental health primary clinician (MHPC) positions were filled at 87% with civil service staff and 91% including registry providers. Psychiatry positions were filled at 33% with civil service staff and 100% including registry psychiatrists. Recruitment remained challenging due to competition from a nearby psychiatric inpatient program that offers a 15% pay differential and opportunities within the telemental health program.

For all but the final two weeks of the review period, CTF operated with one vacant full-time clinical supervisor position, leaving a single senior psychologist to oversee both mental health clinics. The vacancy was created when the long-term supervising psychiatric social worker transferred to the telemental health program. After six months of recruitment challenges, CTF hired a second senior psychologist supervisor on a limited-term basis effective January 20, 2026, through an internal promotion.

CTF hired two unlicensed MHPCs in July 2025, with no additional hires during the review period. Because only one clinical supervisor was available, new clinicians met with the quality management (QM) senior psychologist specialist during onboarding to review documentation and IDTT requirements. They also had ongoing access to the QM psychologist for consultation. New clinicians received guidance materials on documentation, treatment planning, and continuous quality improvement (CQI) audit criteria. CTF leadership and QM staff work to maintain a mentoring approach to implementing mental health program guidelines.

Access to Care: Confidential and Effective Communication

These indicators assess whether mental health treatment is delivered in settings that protect patient privacy and whether communication barriers are addressed so that patients can meaningfully participate in their own care.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Trended View	On-site Audits
Effective Communication Achieved	98%	98%	99%	99%	97%	99%	98%		⚠
Group treatment in a confidential setting	100%	100%	100%	100%	100%	100%	100%		✓
IDTTs in a confidential setting	100%	100%	99%	99%	98%	100%	99%		⚠

Automated data shows stable, high compliance across all three indicators (98–100%). However, onsite observations revealed gaps between documented compliance and the conditions patients experience. The RHU individual treatment space met all audit criteria for privacy. The RHU and Central IDTT rooms and the North Facility group treatment space were all confidential. Receiving and Release (R&R) initial health screenings were conducted by nursing staff in a confidential setting.

⚠ **Concerns**: Of 25 individual treatment spaces surveyed in CCCMS, most were configured in ways that are both unsafe and non-confidential. The North CCCMS IDTT space was not confidential and had distracting noise. Clinician interviews across the facility revealed inconsistent understanding of what constitutes a "confidential" setting, suggesting a training gap that likely contributes to the divergence between automated data and onsite observations.

When non-English-speaking patients were identified during IDTT, ICC, and PT rounds, at times, the RCT observed staff arranging interpretation services, demonstrating awareness of the Effective Communication (EC) requirement.

Although EC forms consistently documented "EC reached: Yes," auditors observed that when interpretation was used during clinical encounters, patient statements were not fully conveyed to the treatment team and team discussions were not fully translated for the patient (regardless of whether a certified interpreter or uncertified clinician provided the interpretation).

One mainline CCCMS group was observed, a voluntary pre-release group with a rotating membership based on the 60-day pre-parole window. The group leader demonstrated strong engagement with participants, and patients facilitated supportive interactions among themselves. Note: Patients interviewed on both facilities reported a perceived lack of group treatment availability; however, structured group treatment is not required at the CCCMS level of care.

Recommendations:

1. Documentation Accuracy. Direct staff to document any clinical encounter conducted in a non-confidential setting (including encounters with windows open to occupied spaces) as "non-confidential." Conduct follow-up self-audits of treatment space confidentiality and documentation accuracy.
2. Treatment Space Remediation: Complete a systematic assessment of all individual and group treatment spaces in CCCMS, documenting each space's compliance with confidentiality and safety criteria. Implement feasible modifications (closing windows during sessions or adding noise machines to mask sound, adding visual barriers, relocating treatment to compliant spaces) and submit a remediation plan for deficiencies requiring capital improvements.

3. Effective Communication Quality: Identify barriers preventing clinicians and custody from implementing translation services where needed and accurately documenting that effective communication is reached when interacting with patients. Address identified barriers, and direct QMSU to conduct a targeted review of a sample of interpreted clinical encounters to assess communication quality.

Access to Care: Timely Access

The Program Guide requires that patients receive timely access to mental health services. These indicators measure institutional capacity to deliver scheduled contacts within mandated timeframes and to maintain accessible referral pathways between custody and mental health staff.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Trended View	On-site Audits
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure		0%†					0%†		
RHU GP Screens	100%	86%	94%	97%	100%	97%	95%		
RHU Pre-Screen	81%	95%	98%	96%	91%	96%	94%		
Timely IDTTs (v2.0)	93%	82%	89%	92%	92%	86%	89%		
Timely MH Referrals (v2.0)	88%	88%	87%	87%	83%	88%	87%		
Timely MHMD Contacts (v2.0)	92%	89%	68%	76%	68%	75%	77%		
Timely PC Contacts (v2.0)	86%	80%	80%	90%	93%	90%	87%		
Custody MH Referrals									100%
Housing Units Where 128-MH-5s Are Available And Accessible to Housing Unit Staff									100%†

The facility demonstrates strong custody-mental health coordination for referral access. 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. RHU screening processes are functioning at or near compliance thresholds. Primary clinician contact rates have trended upward over the reporting period.

⚠ **Concerns**: MHMD contacts averaged 77% over six months, with the lowest rates occurring in October and December 2025 (68% each). Notably, psychiatry staffing data for this facility reflects a functional vacancy rate of only 4% for Staff Psychiatrist positions (2.88 of 3.00 FTE filled). This divergence between adequate staffing levels and below-threshold contact rates suggests that scheduling workflows, competing clinical demands, or operational barriers are primary contributors to the deficit.

Interviews with patients on both North (n = 8) and Central (n = 6) facilities identified operational barriers to timely appointment attendance. Patients on both facilities reported that modified programming schedules and limited unlock periods contribute to late or missed mental health appointments. Patients on Central specifically noted conflicts with competing obligations, including other appointments, work assignments, visiting, and canteen. Both patient and staff interviews identified concerns with ducat distribution procedures, including reports that porters handle ducats and may have access to patient protected health information, a practice inconsistent with policy. For urgent and emergent access, patients on North reported response times consistent with Program Guide timeframes (within four hours for emergencies, 24 hours for urgent matters, five

business days for routine). Patients on Central, by contrast, reported delays in officer response to urgent mental health requests and difficulty being seen within emergency timeframes.

Recommendations:

1. Conduct a Psychiatric Scheduling Workflow Assessment: Conduct a focused review of MHMD scheduling practices to identify causes of below-threshold contact rates. Complete workflow mapping of current psychiatric scheduling, including documentation of no-show rates, scheduling conflicts, and average appointment duration. Implement and monitor improvements with monthly tracking of MHMD contact completion rates.
2. Address Operational Barriers to Patient Movement for Mental Health Appointments: Coordinate with custody operations to review ducat distribution and patient movement procedures for mental health appointments. Convene a joint custody-clinical meeting to identify specific scheduling conflicts and modified-program restrictions affecting mental health appointment attendance; confirm that ducat handling complies with institutional policy and that porters do not have access to patient ducats or protected health information. Implement revised movement protocols and track appointment attendance rates.
3. Assess Urgent and Emergent Access Disparities Between Facilities: Review custody post orders and mental health on-call protocols on Central to identify gaps in urgent referral response procedures. Ensure after-hours resources are well known and used appropriately. Align Central facility urgent and emergent response protocols with those functioning effectively on North, document and monitor compliance.

Access to Care: Appointments

These indicators measure whether scheduled appointments are completed or refused on the day scheduled and the rate at which custody-related factors result in appointment cancellations. Appointments Cancelled Due to Custody is an inverse indicator, a lower percentage reflects fewer custody-driven cancellations. Automated data for both indicators reflect near-perfect compliance throughout the reporting period.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Trended View	On-site Audits
Appointments Cancelled Due to Custody [i]	0%	0%	0%	1%	1%	0%	0%		
Scheduled MH Appointments Completed or Refused	100%	100%	100%	100%	100%	100%	100%		

Automated data for both indicators reflect near-perfect compliance throughout the reporting period: custody-related cancellations averaged 0% and 100% of scheduled appointments received a same-day disposition of completed or refused. However, onsite findings reveal operational barriers to appointment access that these automated metrics are not designed to capture. Neither indicator captures delays in arrival, modified programming schedules, or the frequency of limited unlock periods. Patients reported more frequently experiencing delays in reporting to appointments than outright cancellations, a distinction the current indicators do not differentiate.

Custody and Mental Health Partnership Plan

The Custody and Mental Health Partnership Plan (CMHPP) establishes the framework for collaborative care delivery between custody and mental health staff. These indicators assess both whether required activities occur and whether mandated participants are present.

Indicator	On-site Audits
CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH Program	100%†
Custody Staff CMHPP Annual Training	93%
Healthcare Staff with CMHPP Annual Training	97%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours	89%†
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours with Required Attendees	100%†
ML CCCMS and RC CCCMS CMHPP Weekly Supervisor Meetings	100%
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees	81%
ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings	78%†

CTF demonstrates strong structural compliance with most CMHPP requirements: training rates are high, executive leadership rounds and joint supervisory tours are occurring, and weekly supervisory meetings are being held. However, quantitative compliance with meeting schedules masks qualitative deficiencies in collaborative engagement, particularly at the weekly supervisory huddles, and a significant disparity between Central and North facilities in meeting attendance.

⚠ **Concerns**: While weekly supervisory meetings were held consistently (100% completion), the onsite observation of a huddle revealed that the meeting was not functioning collaboratively as intended. Custody staff did not participate in discussion until directly prompted with specific questions. Additionally, the mental health supervisor reviewed medication adherence information by relying on information provided by custody rather than by consulting the treating psychiatrist.

Weekly supervisory huddle attendance with all required staff varied substantially between facilities: Central facility achieved 62% compliance while North achieved 92%, yielding the overall rate of 81%. The Central facility rate alone falls below the 74.5% threshold and represents the primary driver of the aggregate deficit. The lack of collaboration between disciplines at Central may be connected to the challenges that patients in Central experienced in getting to their appointments on time and in accessing urgent and emergent care.

A CCCMS mental health program supervisor attended the monthly IAC meeting once on Central facility and three times on North facility during the reporting period, yielding an overall rate of 78%. While this falls within the yellow compliance range, the imbalance again points to Central facility as the area of concern.

Recommendations:

1. Strengthen Collaborative Engagement at Weekly Supervisory Huddles: Develop a structured huddle agenda that includes designated sections requiring active custody input (e.g., housing unit observations, programming concerns, safety issues) and a standing medication update provided by or confirmed with the MHMD rather than relayed through custody staff. Supervisory staff should evaluate huddle quality quarterly using a brief structured observation tool assessing active participation by all required attendees.

2. Address Central Facility Attendance Deficits for Weekly Supervisory Meetings and IAC: Central facility leadership need to identify the specific barriers preventing required staff attendance at weekly huddles (scheduling conflicts, competing duties, staffing gaps) and the CCCMS supervisor's absence from IAC meetings; develop a remediation plan with designated alternates when primary attendees are unavailable. Achieve and sustain required-attendee compliance for weekly supervisory meetings and IAC attendance on both facilities, with monthly tracking reported to institutional leadership.

Facility and Environment of Care

Treatment spaces used for individual contacts, IDTT meetings, and group sessions should meet standards for confidentiality, safety, adequate size, and environmental controls including ventilation and temperature. These indicators assess whether the physical environments in which mental health care is delivered support therapeutic engagement and protect patient privacy. Compliance is determined through direct observation during onsite audits.

Indicator	On-site Audits
Adequate Group Treatment Spaces	0%†
Adequate IDTT Spaces	33%†
Adequate Individual Treatment Spaces	38%

Treatment space adequacy is the most significant environmental deficiency identified at this facility. None of the three indicators meet minimum compliance thresholds. The primary driver across all space types is a ventilation and temperature control deficit that creates a forced trade-off: staff must choose between adequate airflow (opening windows) and treatment confidentiality (keeping windows closed). The breakdown below shows the facility-specific distribution of findings.

Space Type / Location	Assessed	Compliant	Non-Compliant	Primary Deficiencies
Individual — CCCMS	25	9	16	Ventilation, safety, confidentiality
Individual — RHU	1	1	0	None
IDTT — RHU	1	1	0	None
IDTT — Central	1	0	1	Noise, no table, ventilation
IDTT — North	1	0	1	Not confidential, noise
Group — North	1	0	1	Ventilation / temperature

The RHU IDTT space was the only fully compliant IDTT environment observed. The space was appropriately sized with a conference table, sufficient seating, four working computers, adequate ventilation, controlled temperature, and no distracting noises. The single RHU individual treatment space also met all audit criteria. The RHU was noted as the cleanest observed during an audit.

⚠ **Concerns**: Of 25 CCCMS individual treatment spaces assessed, 16 (64%) were non-compliant, with inadequate ventilation and temperature control as the most frequently cited deficiency. On North facility, treatment spaces were described as hot and stuffy. Staff reported that fans cannot be brought into treatment areas due to electrical issues. When windows are opened to manage temperature, conversations become audible from outside the space, rendering the environment non-confidential. This ventilation–confidentiality trade-off affects individual, IDTT, and group spaces across both Central and North facilities and represents the single largest contributor to the low compliance rates observed.

The Central facility IDTT space had distracting noise, lacked a conference table, and was not adequately ventilated. The North facility IDTT space was large and had a conference table but was not confidential and had distracting noise. In both cases, the group space observed was also the only one assessed and failed on ventilation and temperature, producing the 0% group compliance rate.

Several safety-related environmental findings emerged during the audit. On Central facility, staff reported that during institutional alarms, clinical staff are locked inside treatment areas with patients, a protocol that warrants safety review. Additionally, a temporary holding cell (THC) area adjacent to treatment area 112 was identified as a source of distraction during treatment as individuals are placed in that area by custody in response to behavioral issues and in doing so, it can be loud and disruptive.

Staff interviews confirmed that custody staff permit incarcerated individuals to use staff restrooms in mental health treatment areas. For safety and security purposes, the restroom door remains open during use, which disrupts clinical and support staff working in adjacent spaces. This practice raises concerns related to staff safety, patient dignity, and treatment environment disruption. No designated patient restroom facilities were available in the affected treatment areas.

Recommendations

1. Develop a Facility-Wide Treatment Space Remediation Plan: Institutional leadership, in coordination with Plant Operations, should conduct a systematic assessment of all mental health treatment spaces to identify which spaces can be brought into compliance through HVAC modification, installation of ventilation that does not compromise confidentiality (e.g., ceiling fans, sealed-window ventilation units), or reconfiguration. Spaces that cannot be remediated should be identified for potential replacement or repurposing. Submit a Mental Health Expenditure Request if capital improvements are required. Implement initial remediation for the highest-priority spaces (those used most frequently for patient contacts) and establish a timeline for remaining spaces.
2. Address Safety Concerns in Treatment Areas: Conduct a safety review of each identified concern: review the alarm lockdown protocol on Central with custody leadership to develop a procedure that does not confine clinical staff with patients; and remove the THC from treatment area 112. Implement corrective measures for each identified concern and document the resolution in the facility's corrective action plan.
3. Establish Designated Restroom Access for Patients in Treatment Areas: Custody and clinical leadership collaborate to identify designated patient restroom access options in or near mental health treatment areas that do not require the use of staff restrooms; if no existing facilities are available, develop an interim protocol that minimizes disruption to ongoing treatment activities and promotes safety. Implement the revised restroom access protocol and discontinue the practice of incarcerated persons using staff restrooms in treatment areas.

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 required diagnostic monitoring for psychiatric medications. These indicators

[1] See Appendix C

assess whether patients receive timely access to prescribed medications and whether prescribing practices include appropriate safety monitoring.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Trended View	On-site Audits
Timely Response to Non-Critical Med Non-Adherence Notification (v2.0)	75%	74%	54%	63%	86%	65%	70%		
Controlled Use of Force Incidents Required to Administer PC2602 Medication									0%

This section presents two distinct areas of concern. First, the CQIT indicator for timely response to non-critical medication non-adherence (70% six-month average) falls in the non-compliant range despite adequate psychiatry staffing. Second, MAPIP diagnostic monitoring data reveal inconsistent laboratory and safety monitoring for patients prescribed mood stabilizers and antipsychotics.

The controlled use-of-force indicator (PC2602) reflects zero incidents during the reporting period, meaning no involuntary medication administration occurred; this is a favorable finding and does not indicate non-compliance. Patients interviewed on both North and Central facilities reported that they had not experienced medication delays when transferring between housing units or yards.

⚠ **Concerns**: Timely response to non-critical medication non-adherence notifications averaged 70% over six months, with a low of 54% in October 2025 and inconsistent month-to-month performance (ranging from 54% to 86%). As noted in the Timely Access section of this report, psychiatry staffing reflects a functional vacancy rate of only 4%, suggesting that the deficit is driven by workflow or scheduling barriers rather than staffing shortages.

MAPIP data reveal a concerning pattern in laboratory monitoring for patients prescribed mood stabilizers. Depakote (valproic acid) therapeutic level monitoring reflected 0% compliance for three consecutive months (September–November 2025) before partially recovering to 50% in December. Depakote CBC and CMP monitoring were similarly inconsistent, ranging from 50% to 100%. Lithium level monitoring showed 0% when due in November, and lithium EKG monitoring dropped to 0% in September and October. While small denominators mean that individual percentage swings may reflect one or two missed labs, the pattern of missed monitoring across multiple months and multiple mood stabilizer measures raises patient safety concerns. Failure to monitor therapeutic drug levels for medications with narrow therapeutic indices (lithium, valproic acid) can result in subtherapeutic dosing, toxicity, or failure to detect organ damage.

Antipsychotic metabolic monitoring also showed significant variability. Blood sugar monitoring ranged from 60% to 100%, lipid monitoring ranged from 33% to 100%, and thyroid monitoring for antipsychotics was as low as 33%. Medication consent documentation for antipsychotics dropped from 100% to 67% in December before partially recovering to 88% in January. The antidepressant thyroid monitoring measure showed a sustained decline, falling from 80% in August to 40% in December before recovering to 78% in January. These monitoring protocols exist to detect metabolic syndrome, thyroid dysfunction, and tardive dyskinesia, conditions that develop gradually and require consistent tracking to identify.

Discussion with staff and institutional leadership revealed limited clarity regarding the updated MAPIP metric monitoring timelines. Staff were uncertain about when specific measures are due and how monitoring windows are calculated, which likely contributes to the inconsistent compliance patterns observed across the diagnostic monitoring measures.

Patients in both Central and North reported that medication distribution lines are excessively long, in part due to the time required for Suboxone administration, and that exposure to weather elements while waiting deters

some patients from obtaining medications regularly. Nursing staffing deficits were identified as a contributing factor to pill line duration. Some patients reported requesting keep-on-person (KOP) medications as an alternative to window distribution to avoid these delays.[2] The extent to which medication refusals captured in automated data are driven by distribution logistics rather than treatment refusal warrant further examination by facility leadership.

MAPIP Measures of Concern

MAPIP Measure	Aug	Sep	Oct	Nov	Dec	Jan	Pattern
Diagnostic Monitoring — Antidepressants							
Thyroid Monitoring	80%	63%	50%	60%	40%	78%	*Low; dropped to 40%*
Med Consent	92%	93%	94%	91%	88%	82%	*Downward trend*
Diagnostic Monitoring — Antipsychotics							
Blood Sugar	86%	75%	100%	60%	86%	100%	*Erratic; 60% Nov*
Lipid Monitoring	78%	60%	100%	33%	78%	83%	*Erratic; 33% Nov*
Thyroid Monitoring	50%	33%	100%	—	—	75%	*Very low; sparse N*
Med Consent	100%	100%	100%	100%	67%	88%	*Dropped Dec–Jan*
Diagnostic Monitoring — Mood Stabilizers							
Depakote Level	—	0%	0%	0%	50%	—	*0% for 3 months*
Depakote CBC/CMP	—	50%	50%	100%	67%	—	*Inconsistent*
Lithium EKG	100%	0%	0%	—	100%	—	*0% Sep–Oct*
Lithium Level	100%	—	—	0%	—	—	*0% when due*

Source: MAPIP Dashboard. Many diagnostic monitoring measures have small denominators; individual percentage swings may reflect 1–2 missed labs. Patterns across measures and months are more informative than single-month values.

Recommendations

1. Improve Non-Adherence Notification Response Workflow: The Chief Psychiatrist should conduct a workflow review of how non-adherence notifications are received, triaged, and scheduled, identifying bottlenecks in the response process. Document whether notifications are being received in a timely manner, whether response appointments are being scheduled within required timeframes, and whether competing clinical demands (e.g., crisis contacts, medication renewals) are displacing notification responses. Implement revised notification response procedures and track monthly compliance with a target of achieving and sustaining performance at or above 90%.
2. Conduct Immediate Review of Mood Stabilizer Diagnostic Monitoring: The Chief Psychiatrist should conduct a retrospective review of all patients prescribed mood stabilizers (valproic acid, lithium, carbamazepine) during the reporting period to confirm that required laboratory monitoring has been completed or is now scheduled. Identify and address the root cause of the monitoring gap, whether it is an ordering failure, a laboratory completion failure, or a documentation/data entry issue. Implement a prospective tracking system for mood stabilizer lab monitoring (e.g., standing lab order review, automated reminder through EHRS) and demonstrate sustained compliance at or above 90% across all mood stabilizer monitoring measures.
3. Evaluate Medication Distribution Logistics and KOP Eligibility: Institutional leadership should review current medication distribution window scheduling, nursing staffing during pill line hours, and the

[2] The Statewide Mental Health Program is currently in the process of updating its KOP medication policy.

impact of Suboxone administration time on overall line duration. Assess current KOP eligibility criteria and determine whether expanded KOP designation for appropriate medications could reduce line volume without compromising clinical safety. Implement adjusted distribution scheduling or staffing and track medication refusal rates to determine whether logistical changes reduce refusals attributable to distribution barriers.

Patient Safety

Institutions are required to maintain safeguards against heat-related illness for patients prescribed psychotropic medications that impair thermoregulation (heat alert medications), and that any use of clinical restraints comply with established protocols. CTF experienced no 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 the facility's heat plan is current and compliant with institutional requirements, including temperature monitoring and alert activation protocols. CTF does not operate a Mental Health Crisis Bed (MHCB) unit. Clinical restraint capacity exists within the Outpatient Housing Unit (OHU), but no clinical restraint events occurred during the reporting period.

Quality of Care: Care Access

Interdisciplinary Treatment Team (IDTT) meetings must include all required staff, follow an interactive and collaborative process, and address key clinical elements including case formulation, measurable treatment goals, and level-of-care appropriateness. These indicators assess both the structure and quality of the primary clinical processes through which treatment is planned and delivered.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Trended View	On-site Audits
IDTT Required Staffing	35%	21%	34%	34%	26%	32%	31%		
IDTTs with Observed Interactive Process									0%†

Despite the significant process deficiencies, the RCT observed that treatment team members were generally empathic, patient-focused, and responsive to patient concerns. Patients who attended IDTTs were invited to participate and given the opportunity to provide meaningful input. Seven of eight patients attended their scheduled IDTTs across all facilities. Exit interviews confirmed that patients generally feel listened to during IDTTs and that team members solicit their feedback.

IDTT Observation Summary

Facility	IDTTs Observed	Pts Present	Met Criteria	Key Deficiencies
Central (CCCMS)	5	4 of 5	0 of 5	Limited case formulation (3/5); no measurable goals (4/5); no LOC discussion (5/5); no RVR discussion (4/5); limited MHMD/CCI engagement

North (CCCMS)	2 *	2 of 2	0 of 2	No records access; no collaboration/engagement; no measurable goals; no LOC discussion; no LOC appropriateness review
RHU	1	1 of 1	0 of 1	No case formulation; no measurable goals; no RVR discussion; predetermined outcome; no certified interpreter for Spanish-speaking patient

** Four IDTTs were scheduled on North; two were completed before the audit team arrived and could not be observed.*

⚠ **Concerns**: Over the six-month reporting period, only 31% of signed Master Treatment Plans documented the attendance of all required staff, with monthly rates ranging from 21% to 35%. This indicator has been persistently non-compliant throughout the reporting period with no discernible improvement trend. The Program Guide specifies which disciplines must be present based on housing program designation (ML CCCMS requires assigned MHPC & MHMD, and a Correctional Counselor).

None of the eight IDTTs observed across Central (5), North (2), and RHU (1) met all audit criteria for interactive process. The single RHU IDTT observed was deficient across all substantive quality criteria. The IDTT's purpose was not stated at the outset, no case formulation was presented, measurable treatment goals and RVRs were not discussed, and the outcome appeared predetermined. Most concerning, the patient's primary language was Spanish and a certified interpreter was not utilized. The auditor, whose first language is Spanish, observed that the primary clinician interpreted throughout the meeting and at times did not relay all of the patient's statements to the treatment team; some of the Spanish exchanges with the primary clinician were not shared back to the group at all before the primary clinician continued on with the discussion.

Recommendations

1. Implement Structured IDTT Quality Improvement Initiative: Clinical supervisors develop and distribute a standardized IDTT checklist aligned with audit criteria (case formulation elements, measurable goals, LOC review, RVR discussion, team participation) to use at every meeting.
2. Address Language Access Compliance for Clinical Contacts: See earlier recommendation in: Access to Care: Confidential and Effective Communication

Quality of Care: Documentation

The Program Guide requires that clinical documentation reflect the quality and completeness of care delivered. These indicators assess four documentation domains: (1) whether IDTT documentation demonstrates that appropriateness of level of care was discussed for patients flagged by the Master Treatment Plan (MTP) Higher Level of Care tab (a screening tool, formerly known as the 7388B, that identifies patients whose clinical indicators suggest they may require a higher level of care); (2) whether pre-release planning documentation is completed within the required timeframe; and (3–4) whether primary clinician and psychiatrist intake evaluations are completed prior to a patient's initial IDTT, ensuring the treatment team has foundational clinical information before developing the initial treatment plan.

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Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Trended View	On-site Audits
MHSDS Patients Released from CDCR With Pre-Release Planning Forms Signed	0%†	0%†	0%†	8%†	14%†	0%†	3%		
Cases w/doc. of appropriateness of LOC discussed for pts identified by 7388B as potentially requiring HLOC									0%†
IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT									100%†
IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT									100%†

Documentation quality at CTF presents a sharp split: intake evaluation completion prior to initial IDTT is at 100% for both primary clinician and psychiatrist, while level-of-care appropriateness documentation and pre-release planning are critically non-compliant. Supplemental audit findings (MHCB discharge summary documentation and RVR mental health assessment documentation) reveal additional documentation failures that compound the picture. These deficiencies are not simply clerical; they have clinical and legal consequences. Undocumented level-of-care discussions leave patients without evidence that their placement was evaluated. Incomplete pre-release planning leaves patients transitioning to the community without documented continuity of mental health care.

⚠ **Concerns**: The MTP Higher Level of Care tab is a screening tool that flags patients whose clinical indicators suggest they may need a higher level of care than their current placement. When a patient is flagged, the IDTT must discuss whether the current level of care is appropriate and document that discussion in the Master Treatment Plan. During the onsite audit, none of the observed IDTTs included documentation of this discussion for flagged patients.

MH Pre-Release IMHPC Preliminary Information, MH Pre-Release Planning Assessment MHPC, and MH Pre-Release Planning MHMD forms must be signed when a patient's estimated release date falls within 30 to 60 calendar days. While the small denominators mean that the absolute number of patients affected may be limited, the near-zero rate across the full reporting period indicates a systematic process failure rather than isolated lapses. Patients released from CDCR without completed pre-release planning documentation may lack documented referrals for community mental health services, medication continuity plans, and crisis resources, the elements most critical for successful reentry.

Recommendations

1. Implement a Structured LOC Documentation Protocol: Clinical supervisors should provide a focused instructional session on the MTP Higher LOC tab: how patients are flagged, what triggers a flag, and the specific documentation elements required in the Master Treatment Plan when a flag is present. Develop a brief reference guide or decision tree that clinicians can use during IDTTs. Integrate LOC documentation review into the standardized IDTT checklist recommended in the Care Access section. Supervisory staff should audit a sample of MTPs for patients flagged by the Higher LOC tab to verify that LOC appropriateness discussions are documented.
2. Establish a Pre-Release Planning Tracking and Accountability System: Clinical supervisors should implement the tracking mechanism and demonstrate that all MHSDS patients released during the quarter had pre-release planning documentation initiated within the required timeframe.

Rules Violation Reports

The Program Guide requires that when MHSDS patients receive a Rules Violation Report (RVR), a mental health assessment (RVR-MHA) is conducted to evaluate whether the patient's mental health condition contributed to the behavior underlying the violation. The RVR-MHA serves two critical functions: informing the disciplinary hearing officer about mental health factors that may warrant alternative discipline or mitigation of penalties, and protecting patients whose rule-violating behavior may be symptomatic of their mental disorder from disproportionate consequences. These indicators track the timeliness of the process (custody's submission of the MHA request and clinician's completion of the assessment), the conditions under which assessments are conducted (private setting, confidentiality advisement), and the quality of the resulting documentation.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Trended View	On-site Audits
RVR MH Assessments Conducted in a Private Setting	86%†	75%†	50%†	100%†	50%†	73%†	73%		
RVR MH Assessments where Documentation Requirements were Met			0%†	0%†	0%†		0%†		
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality			100%†	100%†	100%†		100%†		
Timely RVR MH Assessment Request	25%†	75%†	0%†	33%†	20%†	40%†	30%		
Timely Submission of MH RVR MH Assessment Results (v3.0)	75%†	100%†	50%†	71%†	78%†	73%†	77%		
RVR's Issued									838
RVR's Issued to Non-MHSDS Participants									73%
RVR's Issued to Patients at the Acute Level of Care									0%
RVR's Issued to Patients at the CCCMS Level of Care									26%
RVR's Issued to Patients at the EOP Level of Care									0%
RVR's Issued to Patients at the ICF Level of Care									0%
RVR's Issued to Patients at the MHCB Level of Care									1%

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

The RVR process at CTF shows multiple deficiencies: mental health clinicians complete and submit assessments within required timeframes 77% of the time, the assessments themselves met documentation standards 0% of the time, and only 1 of 228 MHSDS RVR-MHAs recommended alternative discipline or mitigation. This last finding is the most clinically significant issue in this section. The RVR-MHA exists to determine whether a patient's mental health condition contributed to the behavior at issue; a mitigation recommendation rate below 1% across 228 cases raises serious questions about whether the assessments are functioning as a meaningful clinical evaluation or as a procedural formality.

Patients were informed of the limits of confidentiality in 100% of RVR-MHA cases where data were available. This indicates that clinicians understand and consistently implement the disclosure requirement, which protects both the patient's rights and the admissibility of the assessment in the disciplinary process. In the single case where the clinician recommended mitigation, the senior hearing officer accepted the recommendation and mitigated the penalties. While the sample of one limits the generalizability of this observation, it suggests that when clinicians do recommend mitigation, the disciplinary process is responsive.

⚠ **Concerns**: All MHSDS patients carry a diagnosis of a serious mental disorder; the clinical question in the RVR-MHA is whether that disorder contributed to the specific behavior. A population-level mitigation rate below 1% is inconsistent with the clinical literature on the relationship between serious mental illness and behavioral dysregulation. This issue requires further investigation by institutional leadership to assess the cause of the low rate and take responsive actions. A sub-1% rate means the protective function of the RVR-MHA process is effectively inoperative at this facility.

While onsite, auditors observe and confirm data entry practices and adherence to approved workflows. One specific documentation error was noted where the clinician indicated on the form that the interview was conducted in a private setting, but the response to Question 3A stated that the patient refused the assessment. If the patient refused the assessment, there was no interview to conduct in any setting. Combined with the near-zero mitigation rate, the 0% documentation compliance reinforces the concern that RVR-MHAs are not being conducted as substantive clinical evaluations.

RVR-MHAs were conducted in a private setting 73% of the time, with wide monthly variation (50–100%). When an RVR-MHA is not conducted in private, the patient may be reluctant to disclose mental health symptoms or discuss how their mental health condition relates to the behavior at issue. This undermines the clinical validity of the assessment and may contribute to under identification of mental health contributions, further compounding the low mitigation rate.

Recommendations

1. Conduct a Clinical Review of RVR-MHA Practices and Mitigation Rates: Conduct a retrospective review of a representative sample of completed RVR-MHAs (minimum 15–20 cases) to assess the quality of clinical reasoning documented. Determine whether clinicians are conducting individualized assessments of the relationship between the patient's mental health condition and the rule-violating behavior, or whether assessments are formulaic and non-analytical. Interview clinicians who complete RVR-MHAs to identify barriers to recommending mitigation, including perceived institutional pressure, lack of clarity about when mitigation is appropriate, or insufficient access to clinical records during the assessment. Based on root-cause findings, implement corrective measures. Provide clinicians with written guidance on the clinical standard for mitigation recommendations, including de-identified case examples illustrating when a mental health contribution is and is not supported. Establish supervisory review of a sample of completed RVR-MHAs as a standing component of clinical supervision. Track mitigation recommendation rates quarterly to assess whether corrective measures produce a clinically reasonable rate.

RHU: Timeliness

Patients placed in Restricted Housing Units (RHU) must receive timely transfers to appropriate mental health housing designations and Institution Classification Committee (ICC) hearings must be conducted within required timeframes with meaningful mental health participation. Mental health clinician presence at ICC ensures that clinical needs are considered alongside custody factors, and the provision of relevant clinical information enables the committee to make informed placement decisions that account for the patient's mental health status.

Indicator	Sep 2025	Oct 2025	Dec 2025	6-Month Avg	Trended View	On-site Audits
Timely Transfers to RHU EOP	100%†	100%†	100%†	100%†		
ICCs with Mental Health Clinicians Present and Relevant Information Provided						0%†

RHU timeliness indicators show transfer and scheduling processes are functioning well, but the quality of mental health participation in ICC hearings is deficient. Timely transfers to RHU EOP housing occurred 100% of the time, and ICC hearings were held within the required 10-day timeframe. However, the composite ICC indicator scored 0% in the onsite audit. This indicator requires that four criteria be met simultaneously for each observed ICC: clinician presence, provision of relevant clinical information, chair consideration of both clinical and custody needs, and effective communication when mental health impacts patient understanding. While clinician presence was 100%, relevant information was provided in only 40% of observed ICCs, the chairperson considered both clinical and custody needs in only 60% of cases, and a language access concern was observed that implicated the effective communication criterion. Because every observed ICC failed on at least one criterion, the composite result is 0%.

⚠ **Concerns**: In the three cases where relevant clinical information was not provided, the clinician was physically present but did not communicate the patient's mental health status, treatment progress, clinical needs, or mental health considerations relevant to the committee's placement decision. When the clinician does not provide this information, the ICC makes housing and program decisions without the clinical context necessary to evaluate whether the patient's mental health needs are being met in their current placement.
In two of five observed ICCs, the chairperson did not consider both the clinical and custody needs of the patient in the committee's deliberation. This is a bidirectional problem: when the clinician does not provide relevant information (3 of 5 cases), the chairperson has nothing clinical to incorporate. But in at least one case, the clinician provided clinical information and the chairperson still did not integrate it into the decision.
The fourth component of the composite indicator requires that when a patient's mental health status appears to impact their understanding of the ICC, staff ensure effective communication. During the onsite audit, a language access concern was observed at an ICC hearing: the correctional counselor (CCI) did not translate mental health input that the MHPC communicated to the patient in Spanish. This meant that clinical information presented by the mental health clinician, the very input this indicator is designed to ensure, was not conveyed to the patient in their primary language. It is also consistent with the systemic language access pattern identified in IDTT observations and patient rounds (see Care Access section), where certified interpreters were not utilized and clinicians or staff served in an informal interpreter role with incomplete translation.

Recommendations

1. Standardize Mental Health Clinician Participation at ICC: Develop a standardized ICC clinical summary template specifying the minimum information the mental health clinician must present: need for

medication, tendency for behavioral difficulties, suggested interventions, need for level of care, need for staff assistant, and clinical recommendation regarding housing placement. Distribute the template and review its use with all clinicians assigned to ICC coverage. Supervisory staff can observe a sample of ICCs to verify that clinicians are using the template and providing substantive clinical input.

2. Ensure ICC Chairpersons Integrate Clinical Input into Placement Decisions: Provide written guidance to ICC chairpersons clarifying that the Program Guide requires consideration of both clinical and custody factors in RHU placement decisions and that clinical input from the mental health clinician must be acknowledged and addressed in the committee's deliberation. Discuss this expectation with ICC chairpersons through the CMHPP supervisory structure. Include ICC chairperson integration of clinical input as an element in the supervisory ICC observation process established in Recommendation 1. Document findings and discuss opportunities for improvement during CMHPP Supervisory and Executive meetings.

RHU: Documentation

Psychiatric Technician (PT) rounds in Restricted Housing Units must be completed daily with appropriate documentation, interactions with patients must meet standards for effective communication and clinical referral, and treatment team members must have access to and actively review electronic records during IDTTs. PT rounds serve as the primary daily mental health monitoring function in RHU, where patients have limited contact with other clinical staff between scheduled appointments. These indicators assess whether rounds are being completed, whether the quality of interactions meets clinical standards, and whether documentation accurately captures the encounter.

Indicator	On-site Audits
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available	0%†
Observation of Psych Tech Rounds Where EC, Interaction, and Referrals Met All Audit Criteria	67%†
Psychiatric Technician Rounds Documentation Audited Meeting All Audit Criteria	67%†
PT Rounds Completed in Restricted Housing Units	67%†

PT rounds in the RHU show a consistent pattern across all three indicators: four of six quarterly audits met criteria, producing a uniform 67% rate across completion, observation quality, and documentation. The two non-compliant audits on the documentation indicator suggest lapses in charting thoroughness, while round completion (isolation log documentation) showed the same 4-of-6 pattern. The IDTT records access indicator scored 0% because the psychiatrist did not use the electronic health record during the observed RHU IDTT, a single-discipline failure that zeroes out the composite even though the MHPC and correctional counselor appropriately accessed their respective systems.

The PT demonstrated knowledge of the RHU pre-screen and intake screening processes. During observed rounds, the PT maintained a positive rapport with each patient and rounded on both MHSDS and non-MHSDS patients. After completing rounds, the PT experienced connectivity issues with the laptop that prevented electronic documentation. The PT appropriately completed paper charting during rounds and subsequently entered the documentation electronically, consistent with the facility's downtime policy. This demonstrates awareness of and compliance with backup documentation procedures when technology fails.

⚠ **Concerns**: Two of six quarterly fidelity audits did not meet all documentation criteria, which assess whether the PT completed all applicable EHRS sections, documented identified concerns or negative findings, recorded medication compliance observations, and documented any observed or reported medication side effects.

Additionally, two of six audited days lacked PT initials on the isolation log, producing the 67% completion rate. These documentation gaps mean that for one-third of audited encounters, the clinical record may not fully capture the PT's observations, information that subsequent clinicians rely on for continuity of monitoring.

During the observed rounds on March 5, 2026, review of the Automated Restricted Housing Record (ARHR) revealed that the PT was documenting the incorrect activity type for patient contacts. This error affects the accuracy of patient contact data, including out-of-cell time tracking. During that same observation, one patient's primary language was Spanish and the PT was not a certified Spanish interpreter. This represents another instance of the facility-wide language access pattern documented throughout this report (see Care Access: IDTT, RHU Timeliness: ICC, and patient rounds). For PT rounds specifically, the inability to confirm effective communication means that the daily mental health monitoring function, the primary clinical contact for RHU patients between scheduled appointments, may not be reliably reaching all patients.

Recommendations

1. Strengthen PT Rounds Documentation Practices Through Supervisory Review: Review the two non-compliant audits to identify which specific documentation elements (EHRS sections, concern documentation, medication compliance, side effects) were missed. Provide individualized feedback to the PT(s) responsible, with specific guidance on what a compliant entry looks like. Confirm that the corrective action regarding ARHR activity type documentation has been implemented. Nursing supervision incorporates a monthly spot-check of PT rounds documentation (minimum 2 entries per month) to verify sustained compliance.
2. Address Language Access for RHU PT Rounds: As part of the facility-wide language access remediation (see Care Access section).

RHU: Out-of-Cell Activities/Care

The Program Guide and related policies require that custody staff in Restricted Housing Units be able to identify all Non-Disciplinary Restricted Housing (NDRH) patients and that NDRH patients receive specific protections including access to personal property, entertainment appliances, telephone calls, and timely transfers when eligible. Additionally, all peace officers are required to carry CPR mouth shields as part of emergency preparedness. These indicators assess custody staff knowledge and readiness in the RHU environment.

Indicator	On-site Audits
Custody Staff who can Identify all NDRH Patients	100%†
Peace Officers Observed to Carry Their CPR Mouth Shield	100%

Both indicators in this section are fully compliant. Custody staff demonstrated knowledge of NDRH patients and their associated requirements, all peace officers were observed carrying CPR mouth shields, and NDRH patients had access to personal property and entertainment appliances. The RHU continues to emerge as an area of relative operational strength at CTF, consistent with the compliant treatment space findings (Facility and Environment of Care), strong pre-screening rates (Access to Care), and clean physical environment noted throughout the audit. Two supplemental observations outside the formal audit parameters are documented below for institutional follow-up.

The RHU property officer was issuing personal property to NDRH patients but was not logging the issuance in SOMS, instead using the former paper-based process. While all NDRH patients had received their property (substantive compliance), the lack of electronic documentation means there is no auditable system record confirming property issuance. This observation was identified outside the formal audit parameters and was communicated to the healthcare captain for corrective action during the site visit.

Incarcerated persons in the RHU reported that they were not receiving weekly towel and linen exchanges as required by policy. This report was corroborated by four RHU officers, who stated that they request the appropriate quantities from the facility laundry but consistently receive approximately half of the amount requested. The deficiency originates with the institutional laundry operation, not with RHU custody staff, who are appropriately requesting the required quantities. While this finding falls outside the mental health audit scope, inadequate access to basic hygiene supplies in a restrictive housing environment has implications for patient welfare and institutional climate. The healthcare captain was advised during the site visit.

Sentinel Events and Specialized Custody

Custody staff must complete annual use-of-force (UOF) training, use-of-force incidents must be documented and reviewed for appropriateness, and the facility must maintain heat mitigation infrastructure including accurate thermometers and alternative out-of-cell activities during heat events. These indicators assess training compliance, environmental monitoring readiness, and the rate at which use-of-force incidents involve MHSDS patients.

Indicator	On-site Audits
Custody Staff Attendance at UOF Training	99%
Days Alternative Out-of-Cell Activities were Offered to Patients on Heat Alert Medications when Indicated	—
Thermometer Checks completed and accurate	100%†
Use of Force Involving MH Patients	37%

This section reflects strong compliance with training and environmental monitoring requirements. Of 662 custody staff at CTF, 658 (99%) completed annual use-of-force policy training during the previous calendar year. This near-universal completion rate demonstrates sustained institutional commitment to training requirements. Twenty-seven use-of-force incidents were reviewed during the reporting period, one controlled and 26 immediate. All 27 were audited and determined to be appropriate with no significant findings. The low number of controlled UOF incidents (1) and the absence of any auditing concerns across the full sample are favorable indicators of custody practice.

All housing units had a working thermometer present, and all thermometer inspections confirmed that equipment was functional and providing accurate readings in appropriate locations with current logs (100%). All interviewed custody staff demonstrated knowledge of heat plan procedures. No heat-

related illness incidents were reported during the reporting period (see Patient Safety section). The alternative out-of-cell activities indicator was not assessable because no heat alert days (outside temperature ≥ 90°F) occurred during the reporting period.

Of the 27 use-of-force incidents during the reporting period, 10 involved MHSDS patients (37%). This is an informational indicator without a compliance threshold; however, the rate provides useful context when compared to other population data in this report. In the RVR section, MHSDS patients received 27% of all Rules Violation Reports. If MHSDS patients account for 27% of rule violations but 37% of use-of-force incidents, this difference (while based on small numbers and not necessarily statistically significant) may suggest that interactions with MHSDS patients are more likely to escalate to use of force than interactions with the general population. This is consistent with the clinical literature on the relationship between serious mental illness and behavioral escalation. It also underscores the importance of the CMHPP training framework (93% custody completion), UOF training compliance (99%), and the RVR-MHA process in ensuring that custody staff are equipped to recognize and de-escalate situations involving mentally ill patients before force is used. Note: This observation is offered as context for institutional quality improvement. The 37% rate does not indicate non-compliance, and the small sample size (N = 27) limits the strength of any comparative inference.

Suicide Prevention

This section presents priority findings from the suicide prevention assessment. The full HQ SPRFIT Coordinator Review, which includes detailed Suicide Risk Evaluation (SRE) compliance data, corrective action plans, and section-by-section findings, is appended to this report.[3] Two HQ SPRFIT corrective action plans (CAPs) have been assigned as a result of the SPRFIT review, both addressing safety planning deficiencies. One suicide occurred at CTF on November 21, 2025; the case review identified no mental health system concerns.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Trended View	On-site Audits
Discharges from MHCB with clinician review of d/c summary			100%†	0%†			20%†		
Emergent and Urgent MH Referrals That Result in SREs	100%†		100%†	57%†	100%†	100%†	85%		
MHCB Daily Provider Contacts (v2.0)					100%†		100%†		
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training	90%	36%	36%	27%	41%	77%	51%		
Safety Plans Signed Timely	100%†			40%†	100%†	50%†	56%†		

[3] See Appendix B

Timely Clinical Follow-Ups (V2.0)	100%†	50%†	50%†	20%†	0%†	0%†	27%†		
Audited Security Welfare Checks in Restricted Housing That Included the Required Visual Observation									100%
Custody Follow Ups, Page 1	100%†	100%†	67%†	67%†	100%†	0%†	67%†		
Custody Follow Ups, Page 2	100%†	100%†	67%†	17%†	50%†	0%†	40%†		
Custody Staff with CPR Training									88%
Healthcare staff current with suicide prevention training									99%
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%†
Nursing Staff Current with CPR Training									100%
Observed Initial Health Screenings									100%†
Referrals That Received a SRE When DTS or Suspected Intentional OD was not Marked on the MH Referral									100%†
RHU Intake Incarcerated Persons Appropriately Housed									100%†
Suicide Resistant Cells									100%†

Suicide prevention at CTF presents a mixed picture. The facility's physical infrastructure, emergency response readiness, and healthcare training rates are strong. However, the clinical processes most directly responsible for suicide risk mitigation (safety planning, post-discharge follow-up, and SRE mentoring) show significant deficits. These are the processes that translate institutional preparedness into individualized patient protection, and they are the areas where the reviews identified corrective action needs. Two reviews of suicide prevention measures were conducted: the CQI audit and an earlier SPRFIT audit focused entirely on suicide prevention. The findings of the two visits were closely aligned though they occurred about three months apart.

Emergency response infrastructure. All nine audited housing units had compliant cut-down kits with completed inventory sheets and functional AMBU bags. All 20 custody officers interviewed had CPR mouth shields on their person. All 12 RHU intake cells were suicide resistant and housed patients within the first 72 hours of placement as required. These findings are consistent across both the CQI audit and the SPRFIT review.

Healthcare staff suicide prevention training was at 99% (226 of 229 staff). Custody suicide prevention training was at 95% (622 of 657, excluding long-term leave). Nursing CPR training was at 100%. The Safety Planning Intervention training was at 100% completion per the SPRFIT review. The suicide prevention local operating procedure (LOP 402) is consistent with statewide policy and incorporates procedures for notification when patients receive bad news (LOP 168).

SRE completion for urgent and emergent referrals. Of 60 urgent and emergent referrals reviewed, all patients were seen timely. Two referrals that indicated danger to self were incorrectly categorized as "worsening symptoms," but both received an SRE within 12 hours despite the classification error. The SPRFIT review confirmed that all urgent consult orders were correctly categorized and all required and clinically indicated SREs were completed. The overall SRE completion rate was 88% for the year (232 evaluations), with SREs at MHCB referral at 100% and SREs after rescinded MHCB referral at 96%.

⚠ **Concerns**: The SPRFIT review found that of ten charts reviewed for patients rescinded from MHCB, seven contained the required safety plan but six of the seven were deemed inadequate. Deficiencies included failure to identify clinical interventions and use of identical copied language across multiple sections of the form rather than individualized content. The CQI audit identified a parallel finding: of five safety plans reviewed during the audit, none met all criteria, with safety plans generally not individualized to address the patient's specific suicide risk. Two HQ SPRFIT corrective action plans have been assigned: CAP 1 addresses safety plan documentation deficiencies, specifically the lack of clinical interventions and copied language; CAP 2 addresses the absence of required safety plans within the 5-day follow-up for patients released from alternative housing following MHCB referral for danger to self. Both CAPs require the CMH or designee to develop an intervention plan, conduct random sample audits, and report monthly to the SPRFIT committee.

The percentage of required mental health clinical staff who completed SRE mentoring and biennial training averaged 51% over six months, dropping to 27% in November before recovering to 77% in January. SRE mentoring ensures that clinicians conducting suicide risk evaluations are supervised and calibrated in their clinical judgment, a function that is particularly important given the safety planning quality deficits identified above.

SRE completion gaps at MHCB discharge. The SPRFIT report identified critically low SRE completion rates for specific post-discharge triggers: SREs following MHCB discharge for CCCMS and non-MHSDS patients were completed at only 20% (first required SRE) and 33% (second required SRE), with average time-overdue of 69 and 58 days respectively. SREs at MHCB referral for DTS were completed at 52%. These gaps represent the highest-risk clinical moments (patients transitioning out of crisis care) and the low completion rates indicate that the post-discharge safety net is not functioning for a substantial proportion of patients.

Custody follow-up checks on page 2[4] averaged 40% compliance over six months, declining to 0% in January 2026. Page 1 checks averaged 67%. Of 15 custody discharge checks audited, only five met all criteria. The SPRFIT review's internal audit of discharge custody checks showed higher overall compliance (92.3% in December 2024), though with specific failures in "1st Entry Upon Arrival to Unit" (66.7%) and "30-Minute Checks" (66.7%). The discrepancy between the CQI data (40–67%) and the internal audit (92.3%) warrants investigation to determine whether the instruments are measuring different elements or whether compliance has declined since the internal audit period.

Recommendations

*Two HQ SPRFIT Corrective Action Plans (CAPs) have been assigned and are detailed in the appended SPRFIT report. The recommendations below address priority CQI findings that complement the CAP requirements***.**

[4] The Custody Follow-Ups indicator has two components, separated as page 1 and page 2, each with different audit requirements. The first page is completed by MH staff and records dates and times of clinical contacts, while the second page is completed by custody staff and contains an observation log to record their 30-minute checks.

1. Remediate Safety Planning Quality (Aligned with HQ SPRFIT CAPs 1 and 2): Both open CAPs address safety planning deficiencies: inadequate individualization, copied template language, missing clinical interventions, and absent safety plans during 5-day follow-ups for overdose-related MHCB rescissions. The CMH or designee should develop the corrective action response required by both CAPs within the 45-day memorandum deadline. Clinical supervisors review all current safety plans for patients on the SRMP or recently discharged from MHCB/alternative housing to ensure individualization. Provide clinicians with de-identified examples of adequate versus inadequate safety plans, using the SPRFIT review's findings as the basis for the comparison. Implement the random sample audit and monthly SPRFIT committee review process specified in both CAPs. Demonstrate that safety plans completed after the corrective action include individualized clinical interventions and address the specific factors identified in the patient's SRE.
2. Address the Deteriorating Trend in Timely Clinical Discharge Follow-Ups: Review all discharge follow-ups completed during the last two months (0% compliance period) to identify the specific timeliness barrier. Determine whether the issue is documentation timing (contacts occur timely but are documented late) or scheduling (contacts are not occurring within required timeframes). For overdose-related MHCB rescissions specifically, confirm that clinicians understand the safety plan requirement applies regardless of whether the referral was rescinded.

Sustainable Process and Utilization Review

The Program Guide requires that patients referred to a Mental Health Crisis Bed (MHCB) be physically transferred to MHCB housing within 24 hours of referral (excluding rescissions prior to 24 hours). This indicator measures the facility's capacity to execute timely crisis-level transfers. Because CTF does not operate an onsite MHCB, all crisis bed transfers require coordination with an external receiving facility and patient transport, adding logistical complexity beyond what facilities with onsite MHCB units face.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Trended View	On-site Audits
Timely Transfer to MHCB (v2.0)	100%†	100%†	100%†	100%†	83%†	100%†	95%		

Timely MHCB transfers averaged 95% over the six-month reporting period, with five of six months at 100% compliance. The single month below threshold was December 2025 at 83%. Given the small denominators, this likely represents one untimely transfer out of a small number of referrals. The 95% average places this indicator in the green compliance range and reflects effective crisis transfer coordination despite the logistical challenge of transporting patients to an external MHCB facility.

During the reporting period, 23 MHCB referrals were made, of which 7 were rescinded (see Suicide Prevention section). The facility's capacity to maintain near-perfect transfer timeliness across this volume is a notable operational strength.

Staffing

The 2009 Staffing Plan establishes staffing requirements for mental health programs at each institution. These include leadership and supervisory positions (Chief Psychologist, Chief Psychiatrist, Senior Psychologist Supervisor, Supervising Psychiatric Social Worker), clinical specialist and direct

care positions (psychologists, social workers, primary clinicians), and psychiatry. Staffing adequacy is assessed against allocated positions, with the functional vacancy rate indicating the gap between allocation and filled positions. CTF is notable for staffing its mental health program entirely with onsite personnel; the facility does not use telemental health services except for night-shift telepsychiatry.

Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief Psychologist	2.00	1.00	50%
Chief Psychiatrist	1.00	1.00	0%
Senior Psychiatrist (Supervisor)	0.00	0.00	-
Senior Psychologist (Supervisor)	1.00	2.00	0%
Supervising Psychiatric Social Worker I	1.00	0.00	100%
Senior Psychologist (Specialist)	2.00	2.00	0%
Recreation Therapist	0.00	1.00	0%
Staff Psychiatrist	3.00	2.88	4%
Psychologist – Clinical	1.50	1.50	0%
Clinical Social Worker	1.00	1.00	0%
Primary Clinician (PC)	11.5	9.27	19%
PC: Psychologist – Clinical		3.77	
PC: Clinical Social Worker		5.50	
PC: Marriage and Family Therapist		0.00	
PC: Professional Clinical Counselor		0.00	

CTF's overall clinical staffing is a significant institutional strength: psychiatry is at 96% capacity, non-supervisory clinical positions are at or above 90%, and all positions are filled with onsite staff. However, the facility has a notable vacancy, Supervising Psychiatric Social Worker I, which has implications for the quality-of-care deficits documented throughout this report.

Staff Psychiatrist positions are at 96% capacity (2.88 of 3.00 FTE), and the Chief Psychiatrist position is fully filled. As discussed in the Timely Access and Psychiatry sections, this staffing level is important context for the below-threshold MHMD contact rate (77%) and non-adherence notification response rate (70%), both deficits are attributable to workflow and scheduling barriers rather than staffing shortages.

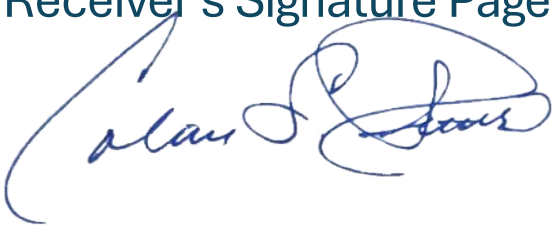
Senior Psychologist (Specialist) positions are at 100%. Psychologist—Clinical and Clinical Social Worker positions are fully filled. The Recreation Therapist limited-term position has been filled throughout the reporting period and extended by one additional year. Patients advocate to retain the Recreation Therapist, and clinical staff who lead groups were noted to know their patients well.

⚠ **Concerns**: Primary clinician positions are at 81% capacity (9.27 of 11.50 FTE filled), reflecting a functional vacancy rate of 19%. The fill rate declined in January 2026 due to a staff promotion, though the six-month average remained at approximately 90%. Of the filled PC positions, all are staffed by Psychologists, Clinical (3.77 FTE) and Clinical Social Workers (5.50 FTE.

Patient interviews and observations both identified concerns regarding the clinical skill level of newer clinicians. Patients reported that some clinicians are "green" and unable to provide the type of clinical engagement patients need. While clinician experience is not a compliance metric, it interacts with the training

and supervision deficits documented in this report: less experienced clinicians are more dependent on supervisory guidance for skills like safety planning, case formulation, and RVR-MHA clinical reasoning, precisely the areas where quality deficits were identified.

Receiver's Signature Page



Appendix A: Acronyms and Initialisms

Acronym List	
ASP	Avenal State Prison
APP	Acute Psychiatric Program
ASH	Atascadero State Hospital
BPT	Board of Prison Terms
C&PR	Classification and Parole Representative
CAL	Calipatria State Prison
CC I	Correctional Counselor I
CC II	Correctional Counselor II
CCAT	Correctional Clinical Assessment Team
CCCMS	Correctional Clinical Case Management System
CCHCS	California Correctional Health Care Services
CCI	California Correctional Institution
CCWF	Central California Women's Facility
CDCR	California Department of Corrections and Rehabilitation
CEN	Centinela State Prison
CEO	Chief Executive Officer
CHCF	California Health Care Facility
CHSA	Correctional Health Services Administrator
CIM	California Institution for Men
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
CMH	Chief of Mental Health
CNE	Chief Nurse Executive
COR	California State Prison, Corcoran
CPR	Cardiopulmonary Resuscitation
CQIT	Continuous Quality Improvement Tool
CQI	Continuous Quality Improvement
CRC	California Rehabilitation Center
CTC	Correctional Treatment Center
CTF	California Training Facility
D/C	Discharge
DAI	Division of Adult Institutions
DCHCS	Division of Correctional Health Care Services
DOT	Direct Observed Therapy
DSH	Department of State Hospitals
EHRS	Electronic Health Records System
EOP	Enhanced Outpatient Program
ERRC	Emergency Response Review Committee
FIT	Focused Improvement Team
GP	General Population
HCPOP	Health Care Placement Oversight Program
HDSP	High Desert State Prisons
HPS I	Health Program Specialist I
HQ	Headquarters

ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Interdisciplinary Treatment Team
ISP	Ironwood State Prison
ISUDT	Integrated Substance Use Disorder Treatment
KOP	Keep On Person
KVSP	Kern Valley State Prison
LAC	California State Prison, Los Angeles County
LOC	Level of Care
LOP	Local Operating Procedure
MA	Medical Assistant
MAPIP	Medication Administration Process Improvement Plan
MCSP	Mule Creek State Prison
MH	Mental Health
MHA	Mental Health Administrator
MHCB	Mental Health Crisis Bed
MHPS	Mental Health Program Subcommittee
MHSDS	Mental Health Services Delivery System
ML	Mainline
ML CCCMS	Mainline Correctional Clinical Case Management System
ML EOP	Mainline Enhanced Outpatient Program
MSF	Minimum Support Facility
NA	Nurse Administered
NDRH	Non-Disciplinary Restricted Housing
NDPF	Non-Designated Programming Facility
NKSP	North Kern State Prison
OA	Office Assistant
OT	Office Technician
PBSP	Pelican Bay State Prison
PBST	Positive Behavior Support Team
PC	Primary Clinician
PIP	Psychiatric Inpatient Program
PT	Psychiatric Technician
PVSP	Pleasant Valley State Prison
QIP	Quality Improvement Plan
QIT	Quality Improvement Team
QMSU	Quality Management Support Unit
R&R	Receiving and Release
RC	Reception Center
RHU	Restricted Housing Unit
RHU CCCMS	Restricted Housing Unit Correctional Case Management System
RHU EOP	Restricted Housing Unit Enhanced Outpatient Program
RHU GP	Restricted Housing Unit General Population
RJD	Richard J. Donovan Correctional Facility
RT	Recreation Therapist
RVR	Rules Violation Report
RVR-MHA	Rules Violation Report – Mental Health Assessment
SAC	California State Prison, Sacramento

SATF	Substance Abuse Treatment Facility
SCC	Sierra Conservation Camp
SHO	Senior Hearing Officer
SNY	Sensitive Needs Yard
SOL	California State Prison, Solano
SOMS	Strategic Offender Management System
SPR FIT	Suicide Prevention and Response Focus Improvement Team
SQRC	San Quentin Rehabilitation Center
SRASHE	Suicide Risk and Self Harm Evaluation
SRE	Suicide Risk Evaluation
SRN II	Supervising Registered Nurse II
SRN III	Supervising Registered Nurse III
SVPP	Salinas Valley Psychiatric Program
SVSP	Salinas Valley State Prison
T4T	Training for Trainers
TCMP	Transitional Case Management Program
TTA	Treatment and Triage Area
UM	Utilization Management
UOF	Use of Force
VPP	Vacaville Psychiatric Program
VSP	Valley State Prison
WSP	Wasco State Prison

Appendix B: Suicide Prevention Report

MEMORANDUM

Date:	January 30, 2026
To:	Statewide Suicide Prevention and Response – Focused Improvement Team Committee
From:	Heather Stahl, Ph.D. Senior Psychologist Specialist HQ SPRFIT Coordinator for Region II- Statewide Suicide Prevention Unit
Subject:	**CALIFORNIA TRAINING FACILITY - HQ SPRFIT COORDINATOR REVIEW**

On November 20, 2025, the HQ Suicide Prevention and Response Focused Improvement Team (SPRFIT) Coordinator for Region II conducted a review at California Training Facility (CTF). Although not on-site, the Region II Mental Health Compliance Team (MHCT) Lieutenants, Ruben Loza and Humberto Gastelum, as well as the Region II nurse consultant, were consulted if warranted during the review process.

Attached is the report based upon the Suicide Prevention On-site Audit Guidebook that will be provided to the Statewide SPRFIT committee for review and follow-up.

Should you have any questions or require further clarification, please contact me at (916) 956-3406 or heather.stahl@cdcr.ca.gov

Section I: Restricted Housing Unit

Intake Cells: Intake cells 101 to 106 on the west side and 143 to 148 on the east side of the unit were observed. Intake cells were marked on the top of each cell door and identification signs are placed beside each door indicating the inmate's name, intake date and 72-hour date. Eight incarcerated persons were housed in intake cells according to policy on the day of the visit. All incarcerated persons reported, or it was observed they had an electronic device. Suicide prevention posters were placed on walls within the RHU.

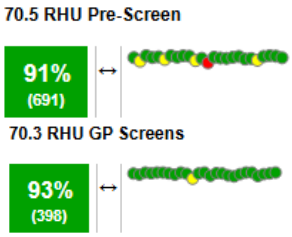
Second Watch Partnership Huddle: I was unable to observe the RHU partnership huddle during my review.

Psychiatric Technician (PT) Rounds: Psych Tech rounds were observed during second watch. The psych tech achieved direct line of sight and was familiar with the incarcerated persons. She asked each person to turn their light on so she could better assess their cell and she also utilized her flashlight when appropriate. She completed documentation in real time utilizing a laptop and asked questions regarding mental health concerns, suicidal or homicidal ideation, medication compliance, and sleep and appetite. No mental health referrals were indicated during the observed rounds.

RHU Intake Screening: RHU Pre-placement screenings were not observed.

Welfare Check Completion (Guard 1): I observed an officer complete Guard One checks. The officer stopped at each cell and looked inside and utilized a flashlight when appropriate. For the month of December 2025, there were 78321 expected checks, 74918 checks were completed timely for a compliance rate of 95.5%.

RHU Intake Screening: A review of On Demand Performance Report for January 1 to December 31, 2025, indicated that CTF was 91% compliant for completing RHU Pre Placements and 93% compliant with completing RHU Screening Questionnaires within required timeframes.



Section II: Inpatient Units

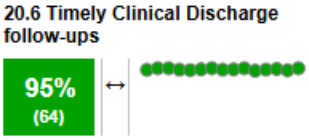
CTF does not have any inpatient units, therefore, the below sections are not applicable:

- Suicide-resistant cells
- IDTT Observations
- Suicide Watch and Suicide Precaution
- Observation and Issue Orders
- Timelines for Suicide Risk Evaluations
- Privileges

Quality of Safety Planning: I reviewed safety plans of ten patients rescinded from the MHCB level of care during the last six months of 2025. Seven of ten SREs reviewed contained required safety plans. Six safety plans were deemed inadequate, and one safety plan was deemed adequate and included

interventions specific for the patient. Most deficiencies were noted as not including clinical interventions and the same language was copied into multiple sections of the form.

Clinical Discharge Follow-Ups:



A review of the On Demand Performance Report for the year, January 1st to December 31, 2025, indicated that CTF was 95% compliant for completion of 5-Day Follow Ups.

A random sample of ten 5-Day Follow Up documentation series were reviewed. Results revealed that all 5 days of each series were completed in all cases. Safety plans were not updated during the 5 days of the follow up in two cases when the safety plan was absent within the form.

Section III: Alternative Housing

CTF's local operating procedure (OP) 400 *Infirmary- Alternative Housing* designates four cells (230 to 233) on the second floor of Facility C's Q Wing, within the Infirmary/Outpatient Housing Unit. The four designated cells are currently not suicide resistant. While not required by policy since patients are maintained on 1:1 observation, it is preferable to use suicide resistant cells for alternative housing when possible. The cells were observed and found to be clean. Suicide resistant mattresses and safety blankets were readily available in a storage closet nearby.

From January 1, 2024, to December 31, 2025, there were 57 referrals to the MHCB. A review of On Demand indicated CTF was 95% compliant for timely transfers to MHCB for all referrals during this time period.

Section IV: Suicide Risk Management Program (SRMP)

At the time of this review, On Demand report noted no patients were included in the SRMP program. There were also no patients who met criteria but were not included in SRMP.

Section V: Discharge Custody Checks

CTF provided the most recent completed internal audits of Discharge Custody Checks (MH-7497s) for November 2024. CTF has a very small number of patients on discharge custody checks for any given month. One error can result in an overall deflated compliance rate. Overall compliance for all audit elements revealed October-82.1%, November-95.2%, and December-92.3%. CTF has a go live date of February 9, 2025, for the digital custody check application.

Custody Inpatient Discharge Checks Audit					
	MEASUREMENT AREA	# Pass	# Fail	# Total	% Compliance
1	Section I Complete	3	0	3	100.0%
2	Section II Complete	5	0	5	100.0%
3	Checks Discontinued After At Least 24 Hours	3	0	3	100.0%
4	Checks Discontinued After No More Than 72 Hours	3	0	3	100.0%
5	Section III Complete	3	0	3	100.0%
6	1st Entry Upon Arrival to Unit Complete	2	1	3	66.7%
7	30-Minute Checks	2	1	3	66.7%
8	Supervisor Review	3	0	3	100.0%
	Overall Compliance for All Audit Elements	24	2	26	92.3%

Section VI: Local SPRFIT Committee

CTF's LOP 402 *Suicide Prevention* addresses institutional suicide prevention and response procedures. LOP 168 *Notification of Inmate Bad News* identifies the procedures to initiate a referral to mental health for when inmate-patients report bad news during various settings.

A review of the last six months' committee minutes was completed. SPRFIT quorum is being met. Improvement work and system surveillance topics are being discussed. SPRFIT minutes are comprehensive and well organized. SPRFIT Coordinator attended the Patient Advisory Council (PAC) on January 31, July 11, August 8 and November 6, 2025. and are documented within the SPRFIT minutes. The SPRFIT attended the Patient Family Council (PFC) meeting on July 18, 2025.

Section VII: Urgent and Emergent Referrals for Danger to Self

A review of the Emergent and Urgent MH Referrals that Result in SREs indicator from the On Demand Performance Report for January 1 to December 31, 2025, indicated the compliance rates below for completed SREs.

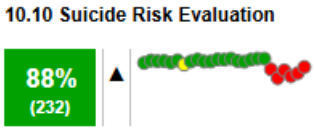
Emergent and Urgent MH Referrals That Result in SREs	59	106.6	78%
SRE after Emergent MH Consult for Self-harm/Suicidal Behavior or ideation/DTS	50	38.9	82%
SRE after Emergent MH Consult for suspected intentional drug overdose	4	483.9	50%
SRE after Urgent MH Consult for Self-harm/Suicidal Behavior or ideation/DTS	1	0.0	100%
SRE after Urgent MH Consult for suspected intentional drug overdose	4	602.6	50%

Seven of the eight deficient SREs for emergent consults were signed late as noted on the OnDemand Performance Report. Two of the four emergent and two of the four urgent consults for suspected intentional drug overdose were also signed late.

A review of all urgent and emergent consult orders for reasons other than danger to self/self harm/suicidal behavior were reviewed for the time period of January 1 to December 31, 2025. The results of the review revealed that in all cases, patients were seen timely. All urgent consult orders reviewed were correctly categorized. In instances where a SRE was clinically indicated, a SRE was completed. All emergent orders were deemed correctly categorized. All but one contact required a SRE. All required and clinically indicated SREs were completed.

Section VIII: Suicide Risk Evaluations

A review of the On Demand Performance Report for January 1 to 31, 2025, indicated that CTF had a compliance rate of 88% for required suicide risk evaluations.



December completion of

A review of On Demand indicated below the compliance numbers for completion of required SREs from January 1, 2025, to December 31, 2025:

	Measurements	Time Overdue (Days)	Compliance
Suicide Risk Evaluation	232	2.6	88%
SRE at MHCB referral	48	0.0	100%
SRE at MHCB referral for DTS	29	0.2	52%
SRE at rescission of MHCB referral for DTS	15	0.1	87%
SRE following MHCB Discharge (CCCMS and Non-MHSDS) - 1st	5	69.2	20%
SRE following MHCB Discharge (CCCMS and Non-MHSDS) - 2nd	3	58.3	33%
SREs after rescinded MHCB referral	97	0.8	96%
SREs following MHCB Discharge (admitted for DTS)	35	0.2	94%

It is important to note that compliance indicators for the new SRE timelines were not completed for all measures at the time of the review.

Section IX: Emergency Response

An audit of the cut down kits in the housing units was completed during the MHCT Lieutenant's recent review and indicated 100% compliance.

Section X: Training and Mentoring Compliance

Review of the Coleman Court Mandated Trainings SharePoint for December 2025, as well as information obtained from CTF, indicated the following compliance rates:

- Suicide Prevention and SRASHE Core Competency Building: On hold
- Safety Planning Intervention: 100%
- SRE Mentoring: 93%

- Suicide Risk Management Program: 100%
- Annual IST Suicide Prevention (End of Year 2025):
  - Custody: 96%
  - Healthcare: 97%
  - Mental Health: 100%

Annual IST Suicide Prevention Training - Observation: The annual IST suicide prevention training was not observed during this visit.

Section XI: Receiving and Release (R&R) Screening

R&R screenings were not scheduled during the on-site review. A tour of the R&R revealed there is a confidential space available for screenings. The nursing office contained a therapeutic module. The R&R nurse was interviewed, and he reported that the door is kept closed during the screens and all questions are asked. English and Spanish Suicide Prevention posters were placed in the processing and holding cell area as well as in the R&R nurse's office where the screens are conducted.

Section XII: Reception Center Processing

CTF does not have a Reception Center.

Section XIII: Crisis Intervention Team (CIT)

CTF does not have a Crisis Intervention Team at this time.

Suicide Case Review Quality Improvement Plan (QIP) Follow Up

During 2025, one suicide occurred at CTF on November 21, 2025. As a result of the review, no mental health concerns emerged.

Section XIV: Corrective Action Plans (CAPs) Generated by a Site Review Conducted by Lindsay Hayes

Lindsay Hayes has not conducted a review of CTF since March 2022. There are no open Hayes CAPs.

Section XV: Assignment of Corrective Action Plans and Recommendations Conclusions/Comments

CONCLUSION

As a result of this review, two new corrective action plans (CAPS) are being assigned at this time. The new CAP requirement process is outlined in the chart below.

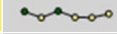
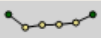
HQ OPEN SPRFIT CAPS	CORRECTIVE ACTION PLAN	REQUIRED SUPPORTING DOCUMENTS
1. CTF shall develop a corrective action plan to address the deficiencies noted in documentation within safety plans completed upon a patient's release from alternative housing when the referral reason was for danger to self as required by memorandum Safety Planning dated February 13, 2023. Specific areas noted as deficient include not identifying cliical interventions and copied language used in multiple sections.	The **CMH (or designee)** shall review this concern and identify an intervention to correct this deficiency and a plan to ensure sustainability once corrected, which may include completing a random sample audit and reviewing the results monthly in the SPRFIT committee until sustainability is achieved.	**Please provide a memorandum to the Suicide Prevention Inbox within 45 days of receipt of this report detailing a review of the factors contributing to this concern and the identified course of action.**
2. CTF shall develop a corrective action plan to address the deficiencies noted in completing required safety plans within the 5 day follow ups for patients released from alternative housing. This includes updating the safety plan during the clinical encounters when warranted as required by memorandum Safety Planning dated February 13, 2023.	The **CMH (or designee)** shall review this concern and identify an intervention to correct this deficiency and a plan to ensure sustainability once corrected, which may include completing a random sample audit and reviewing the results monthly in the SPRFIT committee until sustainability is achieved.	**Please provide a memorandum to the Suicide Prevention Inbox within 45 days of receipt of this report detailing a review of the factors contributing to this concern and the identified course of action.**

Appendix C: MAPIP

MAPIP MEASURE SUMMARY – *Trended View*

Correctional Training Facility (CTF)

January 2026

	6 Months	Trend	AUG	SEP	OCT	NOV	DEC	JAN
Diagnostic Monitoring (All)	**88%**		**92%**	**84%**	**93%**	**84%**	**84%**	**89%**
QT Prolongation EKG 12 Months	-		-	-	-	-	-	-
Antipsychotics (All)	89%		89%	79%	100%	82%	89%	91%
Lipid Monitoring	73%		78%	60%	100%	33%	78%	83%
Blood Sugar	87%		86%	75%	100%	60%	86%	100%
EKG	-		-	-	-	-	-	-
AIMS	83%		33%	100%	100%	78%	83%	100%
Med Consent	93%		100%	100%	100%	100%	67%	88%
CBC with Platelets	75%		100%	0%	-	-	-	100%
CMP	80%		100%	50%	-	-	-	100%
Thyroid Monitoring	60%		50%	33%	100%	-	-	75%
Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Height	90%		100%	75%	100%	100%	100%	70%
Weight	100%		100%	100%	100%	100%	100%	100%
Mood Stabilizers (All)	87%		100%	77%	82%	82%	86%	100%
Valproic Acid (All)	82%		100%	64%	73%	80%	80%	100%
Med Consent	100%		100%	100%	100%	-	100%	-
Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Height	100%		100%	100%	100%	-	100%	100%
Valproic Acid Level	17%		-	0%	0%	0%	50%	-
CBC with Platelets	63%		-	50%	50%	100%	67%	-
CMP	63%		-	50%	50%	100%	67%	-
Weight	100%		100%	100%	100%	100%	100%	100%
Lithium (All)	89%		100%	86%	83%	78%	100%	-
Lithium Level	50%		100%	-	-	0%	-	-
Thyroid Monitoring	100%		100%	100%	100%	-	100%	-
CMP	83%		100%	100%	100%	50%	-	-
CBC	100%		100%	-	-	-	-	-
EKG	50%		100%	0%	0%	-	100%	-
Med Consent	100%		100%	-	100%	100%	100%	-
Height	100%		100%	-	100%	100%	100%	-
Weight	100%		100%	100%	100%	100%	100%	-
Oxcarbazepine (All)	100%		100%	100%	100%	100%	100%	-
CBC	100%		100%	-	100%	100%	100%	-
CMP	100%		100%	100%	100%	100%	-	-
Med Consent	100%		100%	100%	100%	-	-	-
Lamotrigine - Med Consent	100%		-	100%	100%	-	-	100%
Antidepressants (All)	87%		91%	90%	90%	89%	79%	83%
EKG (Tricyclics)	-		-	-	-	-	-	-
Med Consent	91%		92%	93%	94%	91%	88%	82%
Thyroid Monitoring	61%		80%	63%	50%	60%	40%	78%
Venla Blood Pressure	100%		100%	100%	100%	100%	100%	100%

Medication Management	6 Months	Trend	AUG	SEP	OCT	NOV	DEC	JAN
Medications Received Timely (All)	**92%**		**93%**	**93%**	**93%**	**92%**	**92%**	**91%**
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	89%		95%	90%	95%	82%	78%	95%
Intra-System (Within Institutions) – RHU	97%		100%	100%	87%	100%	100%	99%
Intra-System (Within Institutions) – MH Inpatient	-		-	-	-	-	-	-
Intra-System (Within Institutions) – Specialized Medical	90%		94%	95%	100%	96%	94%	56%
Inter-System (Between Institutions) – GP	78%		83%	77%	78%	74%	59%	83%
Inter-System (Between Institutions) – RHU	87%		80%	87%	85%	88%	88%	91%
Inter-System (Between Institutions) – MH Inpatient	-		-	-	-	-	-	-
Inter-System (Between Institutions) – Specialized Medical	94%		78%	98%	-	98%	92%	100%
Return to CDCR – GP	88%		84%	92%	93%	84%	92%	88%
Return to CDCR – RHU	83%		-	100%	94%	62%	87%	-
Return to CDCR – MH Inpatient	-		-	-	-	-	-	-
Return to CDCR – Specialized Medical	-		-	-	-	-	-	-
Stable Housing	93%		93%	93%	93%	92%	92%	91%
Leaving CDCR	99%		99%	99%	99%	100%	100%	100%
By Provider Type								
Psychiatry	92%		92%	93%	93%	91%	90%	92%