FOLSOM STATE PRISON

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Receiver's Compliance Team

2026

Statewide Mental Health Program
Continuous Quality Improvement

F O L S O M   S T A T E   P R I S O N

CDCR

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Background

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

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

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

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

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

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

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

Goals

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

The Receiver seeks to use the audit process not only to assess compliance but also to identify barriers to compliance that she can address and expand effective practices across the system. Where an institution demonstrates strength in a particular area, those practices will be documented and shared so that other facilities can learn from and adopt them.

Approach to Assessing Compliance

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

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

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

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

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

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

Institutional leadership is responsible for developing a corrective action plan to address the high-priority recommendations identified in the executive summary of each report within 30 days of its issuance. The facility is also responsible for acting on the remaining recommendations, and the RCT will assess the steps taken to address them on the following CQIT visit. Leadership is then responsible for implementing those plans and certifying their completion. Throughout this process, the Senior Advisor and other members of the RCT are actively involved in reviewing plans and tracking implementation. Moreover, the Senior Advisor is developing a process to confirm that recommendations have been implemented in a way that achieves compliance and that institutions maintain compliance in those areas. All these actions are designed to ensure that these reviews drive measurable changes, rather than producing a document that goes unread.

Methodology

Data Foundation

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

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

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

Data Collection

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

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

Interpreting This Report

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

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

Indicators Excluded from This Report

Part of the 2026 field-testing phase is designed to identify indicators that are not yet functioning as intended so they can be corrected before the Receiver recommends a final set of indicators to the court. During the audit process, several indicators were identified as producing unreliable results due to technical issues in the CQIT platform, or a need for clarification in instructions or document production. These indicators have been

excluded from this report and are listed in Appendix D. 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

Recommendations

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

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

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

Executive Summary

Folsom State Prison (FSP) is a Level II/III institution located in Represa, California. It operates a general population A Yard (Buildings 1, 2, 3, and 5), a Minimum Support Facility (MSF), and a single Restricted Housing Unit (RHU). FSP provides mental health treatment to Correctional Clinical Case Management System (CCCMS) patients across the general population and the RHU. The institution does not operate an Enhanced Outpatient (EOP), Mental Health Crisis Bed (MHCB), or Psychiatric Inpatient Program (PIP); patients requiring these levels of care are transferred to other institutions. During the reporting period (August 2025–January 2026), FSP reportedly processed a higher than expected volume of new arrivals through MSF.

FSP's staffing fill-rate is a foundational strength. All mental health positions are filled with no functional vacancies. All supervisory positions (Chief Psychiatrist, Senior Psychologist Supervisor, and Supervising Psychiatric Social Worker) are staffed. Staff interviews reflected positive engagement, with clinicians citing creative freedom to design treatment programming, responsive leadership, and strong custody-mental health collaboration. Custody and mental health partnership functions are operating: annual Custody Mental Health Partnership Program (CMHPP) training was completed by 99–100% of custody and healthcare staff, weekly supervisory huddles and monthly joint supervisory tours were compliant throughout the reporting period, and all custody staff interviewed could identify Non-Disciplinary Restricted Housing (NDRH) patients and demonstrate knowledge of the mental health referral process.

Medication administration is strong. Overall medication timeliness averaged 94%, with psychiatry-prescribed medications at 97%. No controlled use-of-force incidents were required for involuntary medication. Antipsychotic diagnostic monitoring averaged 91%. MHCB transfers were completed within 24 hours in 100% of cases across all six months. No heat-related illness incidents occurred among Mental Health Services Delivery System (MHSDS) patients on heat alert medications. Psychiatric technician rounds in the RHU met all audit criteria. Patient surveys on A Yard showed universal satisfaction with access to care, treatment planning, and clinician quality.

The deficits documented in this report fall into three categories, each requiring a different remedy.

FSP operates with 2.5 staff psychiatrists on a 2.0 allocation. The FSP leadership team has noted challenges with coverage given the small number of staff and distance of the MSF to the main facility. MSF treatment space is also structurally constrained, with four providers sharing two offices and a pending modular request that has not been approved.

Clinical-quality deficits account for the treatment planning and suicide prevention findings. The Interdisciplinary Treatment Team (IDTT) interactive process standard was met in 31%† of observed IDTTs. Measurable treatment goals were discussed in 1 of 13 IDTTs. Treatment outcomes appeared predetermined in 8 of 13 observed IDTTs. HLOC documentation for patients flagged by the 7388B form was present only 23%† of the time. None of the four patients discharged from MHCB with a Danger to Self referral had the required safety plan in their SRE. Clinical follow-ups and safety plan timeliness both averaged 50%†. These deficits do not require additional resources to fix. They require supervisory oversight, training, and accountability for clinical practice standards.

Operational and configuration issues account for two findings with straightforward solutions. Twelve of 13 non-RHU individual treatment rooms have patient seating that blocks the clinician's exit path, producing a 7%† score on the individual treatment space indicator. This is a furniture arrangement problem remediable without capital investment. ICC clinician participation scored 20%† not because clinicians were absent (they were present at all five ICCs) but because they provided substantive clinical information in only one of five cases. This is a preparation and role-comprehension deficit addressable through training.

Priority Recommendations

1. **Address Suicide Prevention Clinical Process Deficits**: Of four patients discharged from MHCB with a Danger to Self referral during the audit period, none had the required safety plan in their SRE. Clinical follow-ups averaged 50%† (January at 0%†). Safety plans were signed within required timeframes 50%† of the time (January at 0%†). Two of four MHCB discharges did not receive required post-discharge suicide risk evaluations. SRE mentoring and biennial training averaged 78%, with a December drop to 24%. The eight randomly selected MSF patients who attended the patient survey reported hesitation to disclose crisis symptoms due to fear of being taken out of the program, placed on suicide watch and being placed in a suicide smock.

   Create a procedure to identify and track all patients discharged from MHCB, with due dates for required safety plans, 5-day follow-ups, and 30- and 90-day suicide risk evaluations. Assign responsibility for monitoring completion and reporting missed deadlines. Determine why January produced 0%† on both clinical follow-ups and safety plan timeliness and implement a work plan targeting the identified cause. Investigate MSF patient-reported barriers to crisis disclosure and, if institutional practices create disincentives, develop modifications that reduce barriers while maintaining clinical safety. Track all suicide prevention clinical process indicators monthly and report to the SPRFIT subcommittee until sustained compliance is achieved.

2. **Conduct a Psychiatric Scheduling and Capacity Assessment**: Timely MHMD contacts averaged 57% and declined from 78% to 43% over six months. IDTT timeliness averaged 81% (declining from 95% to 68%), driven in part by psychiatry availability. Primary clinician contact timeliness averaged 82% (declining from 85% to 69% in January).

   Initiate a focused review of MHMD scheduling practices, documenting cancellation and no-show patterns, the volume and impact of MSF intake evaluations on routine contact capacity, and the operational effect of staffing at 2.5 psychiatrists. Identify specific workflow changes that can increase completed contacts within existing capacity. If the assessment confirms the deficit cannot be resolved within current allocation, document the finding and coordinate with the regional mental health administrator and regional chief psychiatrist to pursue alternative solutions. Track MHMD, IDTT, and PC contact completion rates monthly and report to the Mental Health Program subcommittee.

3. **Implement a Structured IDTT Quality Improvement Initiative**: The IDTT interactive process standard was met in 31%† of observed IDTTs. Measurable treatment goals were discussed in 1 of 13 IDTTs. Treatment outcomes appeared predetermined in 8 of 13 cases. Case formulation was inadequate in the majority of observed IDTTs. HLOC documentation for patients flagged by 7388B screening was present 23%† of the time. IDTT Required Staffing averaged 55%, though the trajectory improved from 25% to 70%. The program supervisor was absent from all five RHU IDTTs. MSF patient surveys corroborated the quality concern: only 2 of 8 knew their treatment plan and 3 of 8 agreed with it.

   Begin supervisory observation of IDTTs using CQIT criteria, with direct feedback to the treatment team after each observation. Provide training on case formulation and treatment goal development for all clinical staff, with emphasis on linking treatment goals to diagnosis and functional impairments. Ensure the program supervisor attends or assigns a designee to attend RHU IDTTs. Connect HLOC documentation improvement to this initiative. Track the interactive process indicator through internal supervisory audits.

4. **Reconfigure Individual Treatment Room Layouts**: One of 15 individual treatment spaces met all audit criteria (7%†). The deficit is driven by a single remediable issue: in 12 of 13 non-RHU rooms, the patient is seated between the clinician and the doorway, obstructing the egress path. Two RHU treatment rooms met the safety criterion but were described by staff as lacking sufficient ventilation, citing it is often too cold in the winter and hot and stuffy in summer months. This is the highest-impact, lowest-

cost improvement available: rearranging furniture in rooms where the layout permits would substantially improve the score without capital investment.

Assess all individual treatment rooms where patient seating currently obstructs the clinician's exit path and reconfigure those rooms where the layout permits. Evaluate and address the ventilation deficiency in RHU treatment offices. Track the number of rooms meeting all audit criteria.

5. **Retrain Clinical Staff on ICC Participation and RVR-MHA Recommendation Formulation**: Mental health clinicians were present at all five observed ICCs but provided relevant clinical information in only one (20%†). Clinicians defaulted to stating the patient's level of care or asking generic screening questions rather than presenting the substantive clinical information required by the Program Guide.

   Distribute the Program Guide requirements for clinician participation at ICC hearings to all staff who attend RHU ICCs. Initiate supervisory observation of ICC clinician presentations. Retrain all staff responsible for RVR assessments on mitigation recommendation formulation using statewide standard materials, with emphasis on recommendations that reference penalties within the hearing officer's authority. Conduct supervisory review of sample RVR-MHAs to verify recommendation language is actionable.

Institution's Operational Perspective

FSP is a multi-level institution located in Represa, California. The facility includes an A Yard with three Level II buildings and one Level III building, a Restricted Housing Unit (Building A4), and a Minimum Support Facility (MSF) with 11 dormitories and a firehouse dormitory. FSP does not operate an Enhanced Outpatient Program (EOP), Mental Health Crisis Bed (MHCB) unit, Psychiatric Inpatient Program (PIP), or Acute/ICF program. Patients requiring these levels of care are transferred to other institutions.

Facility	Function	MH Population
A Yard, Units 1–3 (Level II)	General Population housing	ML CCCMS
A Yard, Unit 5 (Level III)	General Population housing	ML CCCMS
A Yard, Unit 4 (RHU)	Restricted Housing Unit (three tiers; includes 8 intake cells)	CCCMS Awaiting Transfer
MSF (Level I)	Minimum Support Facility (11 dormitories + firehouse dorm; outside secure perimeter)	ML CCCMS
A Facility, 2nd Floor Med Admin Bldg	Mental health treatment center (individual treatment rooms, group rooms, IDTT space)	Clinical operations

ML = Mainline.

Mental Health Program Scope: As of April 2, 2026, FSP housed 2,650 individuals, of whom 559 were mainline CCCMS patients (261 Level II, 92 Level III, 197 Level I MSF, and 9 CCCMS pending transfer). Approximately 100 individuals were housed in the RHU. FSP provides treatment at two levels of care: ML CCCMS across all yards including the MSF, and RHU CCCMS for patients awaiting transfer in Building A4. The RHU has one assigned licensed psychologist and a half-time psychiatrist. A recreational therapist provides virtual reality sessions individually as needed in the RHU.

MSF Intake Volume: The MSF serves as a receiving facility for CCCMS patients transferring from reception centers. The MSF CCCMS population grew from 139 in September 2025 to 197 by April 2026. Due to the level I designation, patients frequently leave MSF and new arrivals continually come. This intake volume, in addition to the turnover rate for incarcerated individuals, can contribute to the psychiatry and primary clinician timeliness deficits.

Clinical Programs and Initiatives: In addition to mandated mental health programs, FSP operates a General Resource Center (GRC), governed by Local Operating Procedure No. 97, which provides drop-in services to non-MHSDS residents. The GRC offers Personal Insight Exploration (PIE) groups, regular seminars on mental health topics, and wellness programming, serving approximately 100 to 150 residents per month. FSP also continues to complete a Columbia-Suicide Severity Rating Scale (C-SSRS) for each initial PC assessment in response to feedback from The Joint Commission.

Infrastructure: Treatment space is constrained at both the A Facility treatment center and the MSF. The A Facility treatment center occupies the second floor of the Medical Administration Building, where individual treatment rooms are retrofitted cells with barred doors and plexiglass. Twelve of thirteen non-RHU individual treatment rooms are configured with patient seating obstructing the clinician's exit path. The MSF has limited office space: four providers share two offices for individual appointments, and a modular request for additional space has been submitted but not approved. The RHU IDTT room serves as a multipurpose space (IDTT, ICC, staff breakroom, and overflow individual treatment).

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
Effective Communication Achieved	97%	98%	97%	96%	97%	97%	97%
Group treatment in a confidential setting	100%	100%	99%	100%	100%	100%	100%
IDTTs in a confidential setting	100%	100%	100%	100%	100%	100%	100%

✓ Strengths

Indicators at or Above 96%: Data shows stable, high compliance across all three indicators over the six-month period. IDTTs and group treatment were held in confidential settings in all or nearly all cases, and effective communication was documented in at least 96% of encounters each month.

Onsite Observations Consistent with Healthcare Record Data: Onsite observations were consistent with the data entered by staff into the healthcare record. All three group treatment spaces audited (A Facility group room, Room 202, and MSF library) met confidentiality standards. All three IDTT spaces (A Facility, MSF, and RHU) were rated confidential. All 15 individual treatment spaces audited across A Facility, MSF, and RHU were rated confidential for sound and visual privacy.

Patient Surveys Confirm Confidential Settings: Patient surveys corroborated these findings. All eight A Yard patients, all eight MSF patients, and both RHU patients surveyed reported being seen by mental health clinicians in a confidential setting.

Psychiatry and PC Appointment Confidentiality Rates: Of 1,777 psychiatry appointments during the reporting period, 96% were completed in a confidential setting. Of 4,488 primary clinician appointments, 95% were completed confidentially.

⚠ Concerns

Inaccurate Confidentiality Logging for Cell-Side Appointments: Twenty-two appointments documented as confidential in the electronic health record were conducted at cell-side (a setting that does not meet the standard for confidential treatment delivery). This indicates that a small number of encounters are documented as confidential when the physical setting does not support that designation. While the volume is low relative to the total appointment count, inaccurate documentation erodes the validity of the automated indicator.

Recommendations

1. Align Electronic Health Record Documentation with Actual Encounter Settings: Direct clinical staff to carefully consider if the encounter was confidential and then document the encounter setting in the electronic health record at check-in and check-out accordingly. Establish a periodic supervisory review of a random sample of appointment check-in/check-out entries to verify coding accuracy and correct systematic errors.

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	Onsite Audits
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure					0%†		0%†	
RHU GP Screens	100%	100%	100%	100%†	100%	97%	99%	
RHU Pre-Screen	97%	92%	92%	96%	95%	92%	93%	
Timely IDTTs (v2.0)	95%	96%	89%	75%	80%	68%	81%	
Timely MH Referrals (v2.0)	98%	89%	87%	88%	88%	82%	88%	
Timely MHMD Contacts (v2.0)	78%	68%	50%	56%	59%	43%	57%	
Timely PC Contacts (v2.0)	85%	85%	87%	84%	84%	69%	82%	
Custody MH Referrals								100%
Housing Units Where 128-MH-5s Are Available And Accessible to Housing Unit Staff								100%†

✓ **Strengths**

Custody-Mental Health Referral Infrastructure: Custody-mental health referral infrastructure is functioning. All custody staff interviewed demonstrated knowledge of when and how to refer to mental health using the CDCR 128-MH5 Mental Health Referral Chrono (100%). CDCR 128-MH5 forms were available in housing units audited.

RHU Screening Timeliness: RHU screening processes are above compliance thresholds. RHU GP Screens averaged 99% and RHU Pre-Screens averaged 93% over the reporting period.

A Yard Patient-Reported Access to Care: Patient surveys on A Yard confirmed access to care: all eight patients reported being seen as often as needed, and all reported knowing how to make appointments with their clinician or psychiatrist.

⚠ **Concerns**

Psychiatry Contact Timeliness (57%, Declining): Timely MHMD Contacts averaged 57% over six months and declined from 78% in August to 43% in January. FSP operates with 2.5 filled psychiatrist positions.

IDTT Timeliness (81%): Timely IDTTs averaged 81% but declined from 95% in August to 68% in January (a 27% drop over the reporting period), January is 68%. The IDTT timeliness deficit is linked in part to the psychiatry backlog, since MHMD participation is a required IDTT component.

Primary Clinician Contact Timeliness (82%): Timely PC Contacts averaged 82% with a decline from 85% to 69% in January. Patient surveys at MSF corroborated access concerns. Only three of eight patients reported being seen as often as needed, and patients reported that providers often started late, creating conflicts with work and education commitments. Patients in Building 3 on A Yard reported that Non-Designated Programming Facility (NDPF) movements delayed timely unlocks to attend appointments.

Contacts Following Temporary Departure (0%†): Contacts for patients returning from temporary departure were completed 0% of the time. The small denominator warrants caution in interpretation, but a 0% rate on any

timely-access indicator is a concern. The institution should confirm that a process exists to identify and schedule contacts for this population upon their return.

Recommendations

1. Conduct a Psychiatric Scheduling and Capacity Assessment: Initiate a focused review of MHMD scheduling practices, documenting cancellation and no-show patterns, the volume and impact of MSF intake evaluations on routine contact capacity, and the operational effect of staffing at 2.5 psychiatrists. Identify specific workflow changes that can increase completed contacts within existing capacity. Track MHMD contact completion rates monthly and report results to the Mental Health Program subcommittee. If the assessment confirms that the deficit cannot be resolved within current staffing, document this finding and coordinate with the regional mental health administrator and regional chief psychiatrist to pursue alternative solutions.
2. Address the Declining Trajectory in IDTT and PC Contact Timeliness: Identify the specific causes of the January declines in IDTT timeliness (68%) and PC contact timeliness (69%), distinguishing between staffing-driven delays, scheduling workflow barriers, and program interruptions. Develop a plan targeting the identified causes, implement and track monthly to reverse the trajectory and increase compliance.

Access to Care: Timely Transfers

The Program Guide establishes timeframes for transferring patients to the appropriate level of care once a clinical determination has been made. These indicators measure whether patients referred to a Psychiatric Inpatient Program (PIP), to a designated RHU CCCMS program, or out of a GP RHU standalone unit are transferred within required timeframes, and whether referral submissions to the Institutional Review Unit (IRU) are timely.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	6-Month Avg
Timely Transfers to EOP (v2.0).	100%†	100%†	50%†	100%†	100%†	88%†
Timely Transfers to RHU CCCMS	100%†	100%†	100%†	100%†	33%†	88%†

No transfers were due in January.

FSP does not operate an onsite EOP, MHCB, or PIP; patients requiring these levels of care are transferred to other institutions. Timely MHCB transfer data is reported in the Sustainable Process and Utilization Review section of this report.

✓ Strengths

EOP Transfer Timeliness: Transfers to EOP were timely in four of five months during the reporting period. All months carried small sample sizes.

RHU CCCMS Transfer Timeliness (August–November): From August through November, all required transfers to RHU CCCMS housing met policy timeframes.

⚠ Concerns

RHU CCCMS Transfer Timeliness (33%): Twenty-three patients required transfer to a CCCMS RHU during the reporting period. Compliance was 100% from August through November but fell to 33%† in December, with three transfers exceeding 30 days. Staff reported that the December delays were caused by difficulty securing bed space at designated RHU CCCMS receiving facilities (a factor outside FSP's direct control). Post-period data indicates compliance fell further to 29% in February before returning to 100% in March. The February decline, while outside the audit period, suggests the December finding was not an isolated event.

Recommendations

1. Evaluate Transfer Timeline Barriers and Establish Escalation Protocol: Evaluate the causes of missed RHU CCCMS transfer timelines in December 2025 and February 2026, distinguishing between delays attributable to local operational practices and delays caused by bed unavailability at receiving institutions. For locally driven delays, identify and implement improvements. For delays driven by statewide bed availability, establish a documented escalation process to the Division of Adult Institutions (DAI) regional Associate Director when a transfer has been pending beyond the required timeframe. Track transfer timeliness monthly and report to the Mental Health Program subcommittee.

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.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg
Appointments Cancelled Due to Custody [i]	0%	0%	0%	0%	0%	0%	0%

✓ **Strengths**

Zero Custody-Driven Appointment Cancellations: No scheduled mental health appointments were cancelled due to custody-related factors during any month of the reporting period (0% across all six months).

Custody and Mental Health Partnership Plan

The Custody and Mental Health Partnership Plan (CMHPP) established 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	Onsite Audits
CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH Program	0%†
Custody Staff CMHPP Annual Training	99%
Healthcare Staff with CMHPP Annual Training	99%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours	100%†
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours with Required Attendees	100%†

✓ **Strengths**

Annual CMHPP Training: Of 556 custody staff, 554 completed annual CMHPP Training (99.64%). All 79 nursing staff completed the training, and 21 of 22 mental health staff completed it (99% combined healthcare). The one mental health staff member who did not complete training separated from the position before the scheduled training sessions.

Weekly Supervisory Huddles: Twenty-seven weekly CCCMS supervisory huddle reports from housing units 2, 3, and 5 were reviewed. All reports met attendance requirements and used the correct form, with adequate documentation of individuals identified by custody or mental health staff as having concerns.

Monthly Joint Supervisory Program Tours (100%†): Monthly joint supervisory program tours were completed in all six months of the reporting period with all required staff present. Forms documented positive staff relationships and concerns about limited treatment space and delays in transferring EOP patients from the main line.

Monthly Advisory Council Participation: The mental health program supervisor attended all six-monthly Inmate Advisory Council meetings during the reporting period.

Monthly Executive Leadership Rounding Attendance and Completion: Six months of CMHPP rounds were reviewed. Rounds occurred and were attended by all executive staff required in each month reviewed.

⚠ Concerns

Executive Leadership Rounding Not Conducted in Housing Units: Executive leadership rounding occurred each month with required staff present; however, rounds were conducted exclusively on the second floor of the mental health building and did not include housing units where CCCMS patients reside. Policy requires executive rounds to be conducted in mental health program areas, including housing units. FSP staff reported that rounding was limited to the mental health building to protect MHSDS patient identities, citing safety concerns related to the incarcerated population's awareness of mental health program participants. This safety concern is acknowledged, but the policy requirement was not met in any month of the reporting period.

Recommendations

1. Develop and Implement an Executive Rounding Protocol That Meets Policy Requirements: Develop a plan for conducting executive leadership joint rounding in housing units in a manner that satisfies the CMHPP policy requirement while addressing the identified safety concern regarding patient identification. Implement the revised rounding protocol and document that rounds include housing units where CCCMS patients reside. If complete accommodation for the safety concern is not achievable, document the specific barrier and escalate to the Regional Mental Health Administrator for guidance.

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	100%†
Adequate IDTT Spaces	67%†
Adequate Individual Treatment Spaces	7%†

✓ Strengths

Group Treatment Spaces (100%†): All three group treatment spaces audited, the A Facility group room, Room 202 (used for recreation therapy VR sessions and groups of 6–8), and the MSF library, met all criteria for confidentiality, size, and ventilation.

Confidentiality Across All Space Types: Every treatment space audited (15 individual rooms, 3 IDTT rooms, and 3 group rooms) met the confidentiality criterion. A Facility individual treatment rooms are retrofitted cells with

barred doors lined with plexiglass, which achieve sound privacy despite the aging infrastructure. Because A Facility is designated solely for mental health treatment, only mental health patients who are passing to access their own treatment could briefly see into the spaces. MSF offices and the RHU individual treatment rooms also met the confidentiality standard.

⚠ Concerns

Individual Treatment Space Safety Configuration (7%†): One of 15 individual treatment spaces met all audit criteria. This is the lowest KPI score in the report. The deficit is driven by two specific failures:

- In A Facility, 10 of 11 individual treatment rooms are configured with the patient seated between the clinician and the doorway, obstructing the clinician's exit path. The one room that passed (Room 236, the telehealth room) has the patient seated at the back of the room. All 11 rooms met confidentiality, size, and ventilation criteria; safety configuration is the sole failing criterion. The physical layout does not meet the safe-configuration standard. In MSF, both individual treatment offices had the same deficiency (patient seating closest to the door in small offices).
- In RHU, both individual treatment rooms met the safety configuration criterion but failed ventilation. Clinical staff reported poor air circulation, with spaces that are stuffy in warm weather and cold in winter.

IDTT Space Multipurpose Use (67%†): Two of three IDTT spaces met all criteria. The RHU IDTT room failed because it functions simultaneously as the IDTT space, ICC room, staff breakroom, and overflow individual treatment space. While the room is large and confidential, the multipurpose use creates interruptions that do not meet the audit standard. The shared scheduling also contributed to IDTT delays: during the audit visit, RHU IDTTs started approximately 30 minutes late because ICCs ran over in the same room.

Insufficient Treatment Space at MSF: MSF treatment space is structurally constrained. Four providers share two offices for individual appointments. Two additional small offices accommodate two clinicians, a pre-release coordinator (who also works at Facility A), and one psychiatrist. One office was converted from a supply room. A modular request for additional space was submitted but has not been approved. The space limitation affects the institution's capacity to complete timely clinical intakes for the MSF arrivals (see Access to Care: Timely Access for related findings).

MSF IDTTs are held in a correctional counselor II's office, requiring the CCII to vacate for extended periods. The space met all IDTT audit criteria.

Recommendations

1. Reconfigure Individual Treatment Room Layouts to Address Egress Safety: Assess all individual treatment rooms where patient seating currently obstructs the clinician's exit path and reconfigure those rooms where the layout permits the patient to be seated away from the doorway. For rooms where reconfiguration is not physically possible due to room dimensions or fixed fixtures, document the constraint and implement alternative safety measures (e.g., adjusted camera monitoring, duress alarm placement). Track the number of rooms meeting the safe-configuration criterion and report progress.
2. Address MSF Treatment Space Deficit: Convene the institutional Space Committee to review MSF space requests and identify locations suitable for conversion to treatment use. Report findings and any barriers to regional healthcare and mental health administrators. Concurrently, follow up on the pending modular request with Facility Planning and Construction Management (FPCM) and, if no progress has been made, escalate to the regional level.
3. Address RHU Treatment Space Ventilation: Evaluate the ventilation and temperature control in RHU individual treatment offices and the IDTT room, determine what remediation is feasible (e.g., portable ventilation, HVAC adjustment), and implement improvements.

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). 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. MAPIP also tracks the percentage of patients prescribed categories of medications who received appropriate diagnostic monitoring consistent with clinical guidelines and presents this measure as a composite. These indicators assess whether patients received timely access to prescribed medications and appropriate safety monitoring.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Onsite Audits
Timely Response to Non-Critical Med Non-Adherence Notification (v2.0)	89%†	64%†	60%	59%†	42%†	50%	59%	
Controlled Use of Force Incidents Required to Administer PC2602 Medication								0%

MAPIP Diagnostic Monitoring

Medication Class	6-Mo Avg
Diagnostic Monitoring (All)	89%
Antipsychotics (All)	91%
Mood Stabilizers (All)	85%
Lithium (All)	81%
Valproic Acid (All)	86%
Oxcarbazepine (All)	86%
Carbamazepine (All)	100%
Antidepressants (All)	85%

MAPIP Medication Administration

Transfer/Provider Type	6-Mo Avg
Medications Received Timely (All)	94%
Psychiatry-Prescribed	97%
Stable Housing	95%
Intra-System (Within Institutions) – GP	91%
Intra-System (Within Institutions) – RHU	96%
Inter-System (Between Institutions) – GP	85%
Inter-System (Between Institutions) – RHU	86%
Return to CDCR – GP	96%
Leaving CDCR	99%

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✓ Strengths

Medication Administration Timeliness : Overall medication administration met policy timelines 94% of the time. Psychiatry-prescribed medications were administered on time in 97% of cases. Stable housing administration (95%), intra-system transfers (91–96%), and discharge-related administration (96–99%) were all above the compliance threshold.

No Controlled Use of Force for Involuntary Medication: No controlled use-of-force incidents were required to administer PC2602 medication during the reporting period.

Antipsychotic Monitoring : Antipsychotic diagnostic monitoring composite averaged 91%. Blood pressure (100%), weight (100%), CMP (100%), CBC with platelets (96%), and height (96%) were consistently strong.

⚠ Concerns

Non-Critical Medication Non-Adherence Response (59%): Timely response to non-critical medication non-adherence notifications averaged 59% and declined from 89%† in August to 42%† in December before partially recovering to 50% in January. This means that in four of six months, fewer than two-thirds of patients identified as non-adherent with non-critical medications received a timely follow-up response. FSP's chief psychiatrist has implemented a triage protocol to prioritize intake evaluations by acuity, which addresses psychiatry workload but does not directly target the non-adherence notification response process.

Inter-System Transfer Medication Timeliness (85–86%): Medications for patients transferring between institutions (inter-system) were administered on time 85% of the time for GP transfers and 86% for RHU transfers — both below the compliance threshold.

Diagnostic Monitoring Sub-Indicator Deficits: While the overall diagnostic monitoring composite (89%) is near the antidepressant threshold, antidepressant thyroid monitoring averaged 60%, valproic acid therapeutic level monitoring averaged 67%, Lithium level, CMP, and thyroid monitoring each averaged 75%, Valproic acid CBC and CMP monitoring each averaged 75%. A medical assistant now regularly reviews the healthcare registry to ensure required studies are completed upon arrival.

PRN Medication Access at Bedtime: Staff reported that patients prescribed PRN medications for bedtime use are unable to receive them because PRN prescriptions are not included on the medication list custody staff use to allow patients to access the medication line. This is an operational barrier that prevents patients from receiving prescribed medications as ordered.

Recommendations

1. Conduct a Non-Adherence Notification Response Workflow Review: Map the current workflow for how non-adherence notifications are received, triaged, and scheduled, identifying where notifications are lost, and/or responses are delayed, or not acted upon. Implement revised notification-response procedures with clear assignment of responsibility at each step. Track monthly compliance and confirm the declining trajectory reverses.
2. Nursing and Custody Barriers: Leaders should identify the cause of barriers for PRN prescription access and, if related to the medication list being used, ensure patients with PRN prescriptions are included on the list used by custody staff for patients to access PRN medications.

Patient Safety

Institutions are required to maintain safeguards against heat-related illness for all incarcerated individuals, with additional safeguards for patients prescribed medications that impair thermoregulation and to ensure that any use of clinical restraints or seclusion complies with established protocols. These indicators assess environmental safety monitoring and the quality of restraint and seclusion practices.

Indicator	Onsite Audits
Heat Related Illness Incidents for MHSDS Patients Prescribed Heat Alert Medications	0
Clinical Restraint Occurrences Meeting All of the Audit Criteria	N/A
Restraint Incidents	N/A
Seclusion Incidents	N/A

FSP does not have licensed inpatient mental health beds. Clinical restraints and seclusion are not used at this institution.

✓ **Strengths**

Zero Heat-Related Illness Incidents for MHSDS Patients: No heat-related illness incidents were reported for MHSDS patients prescribed heat alert medications during the reporting period. During this period, 38 days triggered a Stage I heat alert, 31 days triggered a Stage II alert, and 4 days triggered a Stage III alert.

Heat Plan Infrastructure and Staff Knowledge: All housing units audited had working thermometers mounted in locations consistent with policy for accurate temperature readings. All custody staff interviewed across all units (RHU, MSF, A Yard Units 1–5) demonstrated knowledge of heat plan procedures, including provisions for alternative activities during heat recall, identification of heat-risk patients, and stage-specific staff responsibilities. Alternative out-of-cell activities were documented on Daily Activity Reports for 37 of 38 heat alert days.

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 discussions involving the appropriateness of the patient's level-of-care. 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	Onsite Audits
IDTT Patient Attendance	74%	77%	87%	84%	68%	72%	78%	
IDTT Required Staffing	25%	52%	53%	53%	59%	70%	55%	
IDTTs with Observed Interactive Process								31%†

✓ **Strengths**

Improving Trend in IDTT Required Staffing: While IDTT Required Staffing averaged 55%, the trajectory improved from 25% in August to 70% in January. January's 70% approaches the compliance threshold and indicates that the institution's efforts to address staffing attendance at IDTTs are having an effect.

Patient Rapport and Engagement: Across all programs observed, clinicians demonstrated knowledge of their patients and therapeutic rapport was evident. In A Facility and the MSF, patients were consistently engaged and invited to participate with open-ended questions. All eight A Yard patients surveyed reported knowing their

treatment plan, agreeing with it, and being satisfied with their treatment team meetings. Both RHU patients surveyed reported satisfaction with treatment and appointment timeliness.

Records Access: In all observed IDTTs across all programs, primary clinicians, psychiatrists, and correctional counselors had access to and used the electronic health record and SOMS/ERMS as needed.

⚠ Concerns

IDTT Required Staffing (55%): IDTT Required Staffing averaged 55% over six months, meaning more than four in ten IDTTs did not have all required attendees. Although the improving trajectory is noted, the average remains out of compliance. In RHU, the program supervisor was absent from all five observed IDTTs. This absence affects the quality of supervision over treatment planning decisions and also affects ICC participation (see RHU: Timeliness).

Interactive Process Standard (31%†): Less than one-third of observed IDTTs met the interactive process standard. Thirteen IDTTs were observed across three programs (five A Facility, three MSF, five RHU), and the onsite audit identified deficiencies across the following clinical elements:

- Interactive team discussion was limited. In A Facility, team members presented information in isolation rather than engaging in interactive discussion toward the treatment plan. This pattern repeated across most of A Facility and some RHU IDTTs.
- Measurable treatment goals were discussed in only one of thirteen IDTTs. Treatment goals across programs were non-specific, not time-bound, and did not adhere to measurable standards. In several cases where a patient had achieved a treatment goal, the goal was not updated or replaced.
- Case formulation was inadequate in the majority of observed IDTTs. Primary clinicians in A Facility and RHU frequently did not present a succinct case formulation linking predisposing, precipitating, perpetuating, and protective factors. Diagnosis was mentioned but functional impairments, areas of distress, and strengths were inconsistently addressed.
- Level-of-care appropriateness was not discussed in most IDTTs. Even in cases where patients did not meet criteria for a higher level of care, the discussion of why the current level of care remained appropriate was absent or perfunctory.
- In eight of thirteen IDTTs, the treatment outcome appeared predetermined and unaffected by patient or team member input. All five A Facility IDTTs showed this pattern.

MSF Patient-Reported Treatment Quality Concerns: The MSF patient survey revealed some areas for focus in treatment quality. Of eight MSF patients surveyed, only three felt seen as often as needed, two knew their treatment plan, and three agreed with their treatment plan. Patients reported that PC contacts are "generic and brief" with questions "often limited to rating anxiety, depression, and sleep." They requested more individualized treatment, more time with their clinician, and self-help resources. Patients also reported hesitation to disclose crisis symptoms due to fear of negative consequences (placement in treatment modules, removal from programming).

Safety plans were not discussed in any of the five observed RHU IDTTs, including cases where suicide risk and self-harm history were addressed. This finding is discussed further in the Suicide Prevention section.

Recommendations

1. Implement a Structured IDTT Quality Improvement Initiative: Evaluate the challenges related to meeting IDTT quality requirements and develop and implement a plan to improve IDTTs to meet statewide CQI quality requirements. The plan should be specific to FSP's challenges but must result in an outcome that aligns with CQIT audit criteria including: case formulation elements, measurable treatment goal development, level-of-care discussion, safety plan review when indicated, and interactive team participation. Track the interactive process indicator through internal supervisory audits and report quarterly results to the Mental Health Program subcommittee.

2. Address Program Supervisor Attendance at RHU IDTTs: Ensure the program supervisor attends or has a designee present at RHU IDTTs as required. If scheduling barriers prevent attendance, identify and resolve them. Verify attendance through a standing review of IDTT sign-in documentation.

Quality of Care: Documentation

The Program Guide requires that clinical documentation reflect individualized treatment planning, timely completion of intake evaluations prior to the initial IDTT, appropriate consideration and documentation of higher-level-of-care (HLOC) need, pre-release planning, and accommodation assessment for EOP patients. These indicators assess whether the clinical record supports the treatment decisions being made for each patient.

Indicator	Onsite Audits
Cases w/ documentation of appropriateness of LOC discussed for pts identified by 7388B as potentially requiring HLOC	23%†
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	78%†

✓ Strengths

PC Intake Evaluations Completed Prior to Initial IDTT (100%†): Primary clinician intake evaluations were completed prior to the initial IDTT in all nine cases reviewed across all programs (A Facility, MSF, and RHU). The workflow for ensuring that a PC evaluation precedes the first treatment planning meeting is functioning consistently. The sample was small, but the result was uniform.

Psychiatry Intake Completion in RHU (100%): All five RHU initial IDTTs had psychiatry intake evaluations completed prior to the meeting. The psychiatrist attending RHU IDTTs had evaluated each patient in advance, and the clinical information was available to the team during the meeting.

⚠ Concerns

HLOC Documentation (QC2: 23%†): For patients identified by the 7388B form as potentially requiring a higher level of care, documentation of the LOC appropriateness discussion was present only 23% of the time. This means that in approximately three of four cases flagged for HLOC consideration, the clinical record does not document why the patient was or was not referred. This finding is consistent with the QC: Care Access observation that level-of-care discussions were absent or perfunctory in most observed IDTTs (see QC12 at 31%†). Without documentation, the basis for LOC determinations is absent from the clinical record.

Psychiatry Intake Completion in ML CCCMS (QC7: 78%†): Psychiatry intake evaluations were completed prior to the initial IDTT in seven of nine cases reviewed (78%†). In both A Facility and MSF, one of two initial IDTTs occurred without a completed psychiatry evaluation. In the MSF case, the patient was scheduled for a psychiatry appointment prior to the IDTT but reportedly could not be located and was rescheduled after the IDTT. In the A Facility case, a patient who arrived on March 9, 2026 had no MHMD initial assessment completed in EHRS prior to the IDTT on March 25 (a 16-day gap).

Recommendations

1. Address HLOC Documentation Deficit: Review the HLOC documentation process for patients identified by 7388B screening as potentially requiring a higher level of care. Ensure that IDTT documentation includes the LOC discussion, the clinical rationale for the determination, and contributions from all team members. Connect this action to the IDTT quality improvement initiative recommended in QC: Care Access, incorporating HLOC documentation as a checklist element for supervisory observation.
2. Ensure Psychiatry Intake Evaluations Precede Initial IDTTs in ML CCCMS: Establish a scheduling process that ensures MHMD initial assessments are completed before the initial IDTT is scheduled. If the initial IDTT must be held before the psychiatry evaluation due to scheduling constraints, document the reason for the delay in the IDTT record.

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	Onsite Audits
RVR MH Assessments Conducted in a Private Setting	92%	60%	77%†	93%†	94%†	76%†	82%	
RVR MH Assessments where Documentation Requirements were Met			100%†	100%†	100%†	0%†	77%	
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality			100%†	100%†	100%†	100%†	100%	
Timely RVR MH Assessment Request	29%†	43%†	43%†	55%†	69%†	53%†	48%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	100%	100%†	100%†	100%†	100%†	100%†	100%	
RVR's Issued								1,414
RVR's Issued to Non-MHSDS Participants								70%
RVR's Issued to Patients at the Acute Level of Care								0%
RVR's Issued to Patients at the CCCMS Level of Care								30%
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								0%

The RVR Analytics report (SOMS, run 3/12/2026) identified 1,414 RVRs issued during the full audit period: 442 to CCCMS patients, one to an EOP patient, and 971 to non-MHSDS individuals.

✓ Strengths

Confidentiality Notification (100%): Audited records showed patients assessed for RVR-MHAs were informed of the limits of confidentiality, with 100% compliance.

Timely Submission of MH Assessment Results (100%): Once the RVR-MHA was completed, results were submitted within the required timeframe in 100% of cases across all six months.

Improving Trajectory for Timely RVR MH Assessment Requests: Improved from 29%† in August to 69%† in December, indicating that the institution's efforts to address referral timeliness are producing results. Since

RVR-MHA referrals are now automated in SOMS once custody staff classify the RVR, the remaining timeliness gap depends on the speed of the initial RVR classification by custody.

⚠ **Concerns**

Timely RVR MH Assessment Request (48%): RVR-MHA referral timeliness averaged 48% over six months. Fewer than half of the referrals were initiated within the required timeframe. The improving trajectory (29%† to 69%†) is a positive signal, but January regressed to 53%† after the December high.

Private Setting for RVR-MHA (82%): RVR-MHA assessments were conducted in a private setting 82% of the time, with monthly rates ranging from 60% (September) to 94%† (December). In approximately one of five assessments, the patient was assessed in a setting that did not meet the confidentiality standard.

Documentation Requirements: Documentation compliance was 100%† from October through December, then dropped to 0%† in January. No data is reported for August or September.

Clinician Mitigation Recommendations: Three RVRs that required clinician assessment were reviewed. One of the recommendations from those reviews was to retain mental health programming. This is not an item that can be a disciplinary action of an RVR, hence the clinician's input was not something that the hearing officer could adopt.

Recommendations

1. Sustain and Extend RVR Referral Timeliness Improvement: Continue monitoring monthly to confirm the improving trajectory is sustained. If the primary remaining barrier is custody classification speed, coordinate with custody leadership to ensure timely RVR classification so that automated SOMS referrals are triggered within the required timeframe.
2. Retrain Clinical Staff on RVR-MHA Recommendation Formulation: Retrain mental health clinical staff responsible for RVR assessments using statewide standard materials, with emphasis on formulating mitigation recommendations that reference penalties within the hearing officer's authority and alternative discipline recommendations that clearly state the recommended alternative. Following training, conduct supervisory review of sample RVR-MHAs to verify that recommendation language is actionable.

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 ICCs 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	Onsite Audits
ICCs with Mental Health Clinicians Present and Relevant Information Provided	20%†
Required NDRH Transfers that Occurred Within 72 Hours	100%†

✓ **Strengths**

NDRH Transfer Timeliness (100%): Two incarcerated individuals were approved by ICC for transfer within 72 hours. Both were transferred within the required timeframe. NDRH transfer timelines were consistently met.

ICC Custody Participation: The ICC chairs (the Associate Warden and Warden) demonstrated thorough consideration of both clinical and custody needs. In observed ICCs, the chair clearly explained the impact of mental health factors on transfer options, verified patient comprehension by asking patients to paraphrase information, and inspected SOMS for effective communication and adaptive support needs. Effective communication was ensured for all patients observed.

⚠ Concerns

Mental Health Clinician Participation at ICCs (20%†): The clinician was physically present at all five observed ICCs. However, relevant clinical information was provided in only one of five cases (20%†). In the four non-compliant cases, clinicians limited their input to stating the patient's level of care, asking generic symptom screening questions (e.g., thoughts of suicide, auditory hallucinations), or informing the committee that the patient might not know their level of care. None of these inputs meet the standard described in the Program Guide, which requires the clinician to present information regarding the patient's current mental health condition, medication needs, tendencies, clinical contraindications, and other factors relevant to the committee's housing and program decisions.

Recommendations

1. Implement ICC Clinician Preparation and Participation Standards: Distribute the Program Guide requirements for clinician participation at ICC hearings to all clinical staff who attend ICCs in the RHU. Develop a brief pre-ICC preparation standard that requires the clinician to review the patient's chart, current treatment plan, medication status, and recent behavioral observations before each hearing. Initiate supervisory observation of ICC clinician presentations to verify that clinical input meets the information standard. Track the indicator through internal self-audits and report results quarterly.

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	Onsite Audits
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available	100%†
Observation of Psych Tech Rounds Where EC, Interaction, and Referrals Met All Audit Criteria	100%†
Psychiatric Technician Rounds Documentation Audited Meeting All Audit Criteria	100%†
PT Rounds Completed in Restricted Housing Units	100%†

✓ Strengths

PT Rounds Completion and Documentation (100%†): PT rounds were completed daily in the RHU throughout the review period. Six quarterly fidelity audits were reviewed; all six met criteria in both the observation and documentation review sections. PT initials were present on the Isolation Log for all six days in the review period.

PT Interaction Quality (100%†): The psychiatric technician interacted with each patient at cell front, ensured effective communication, and made appropriate referrals consistent with Program Guide requirements. Documentation was completed per policy during the observed round.

Records Access During IDTTs (100%†): The electronic health record and SOMS were available and actively used during all observed RHU IDTTs. Clinicians, psychiatrists, and correctional counselors had access to the systems needed to inform treatment planning

RHU: Out-of-Cell Activities/Care

The Program Guide requires that patients in restricted housing receive out-of-cell time, shower access, phone access, entertainment appliances, personal property, and orientation materials. These indicators assess whether the custodial functions that support daily living and treatment access in the RHU are functioning.

Additionally, custody staff in Restricted Housing Units should be able to identify all Non-Disciplinary Restricted Housing (NDRH) patients and know that NDRH patients receive specific protection including access to personal property, entertainment appliances, telephone calls, and timely transfers when eligible.

Indicator	On-site Audits
Custody Staff who can Identify all NDRH Patients	100%†
NDRH Patients Provided Personal Property[1]	75%†
Patients in restricted housing with working entertainment appliances	100%†
Peace Officers Observed to Carry Their CPR Mouth Shield	95%

✓ **Strengths**

NDRH Patient Identification (100%†): All ten custody staff interviewed could identify every NDRH patient in their area of responsibility. The property officer was also aware of all NDRH patients who had not yet received personal property.

Entertainment Appliances (100%†): All patients in restricted housing had a functional tablet. Since RHU cells lack electrical outlets, FSP provides large televisions on each tier and staff charge tablets for patients. Both patients surveyed during the onsite visit confirmed they had tablets and crank radios.

Phone Call Access: Weekly phone calls are available to all RHU individuals. Of twelve NDRH patients in the RHU, two were MHSDS class members. Both received initial ICC reviews and NDRH privileges within one week of placement.

Intake Cell Standards: All eight designated intake cells met suicide resistant cell criteria. No patients were housed in intake cells beyond 72 hours during the review period. Two patients on intake status were either double-celled with an appropriate cell partner or celled alone, consistent with policy.

CPR Mouth Shield Compliance (95%): Almost all officers observed carried their personal CPR mouth shield, except for one officer.

Patient-Reported Conditions: Both RHU patients surveyed reported receiving orientation guides upon entry, confirmed that unclothed body searches were conducted privately in their cells and by officers of the same or

[1] While the KPI measures whether patients had personal property at the time of the audit, there is no policy establishing when property must be issued. Therefore, the KPI is coded blue as an information-only indicator. In this instance, three individuals did not yet have their property at the time of the audit and all three were within six days of their ICC designation.

preferred gender, and reported being offered adequate out-of-cell time (three hours per day, seven days per week). Both reported satisfaction with available exercise time.

Sentinel Events and Specialized Custody

This section presents sentinel event data (deaths, self-harm, and serious incidents) alongside specialized custody indicators that assess use-of-force training, heat plan compliance, mechanical restraint documentation, and mental health participation in use-of-force events. These indicators measure whether the institution's custody infrastructure supports the safety of patients with serious mental disorders, both through emergency preparedness and through the systems designed to prevent harm.

Indicator	Onsite Audits
Custody Staff Attendance at UOF Training	99%
Days Alternative Out-of-Cell Activities were Offered to Patients on Heat Alert Medications when Indicated	97%
Health Care Staff Required to Attend UOF Training	99%
Thermometer Checks completed and accurate	100%†
Use of Force Involving MH Patients	35%

Sentinel Events During the Reporting Period: One suicide occurred at FSP during the reporting period on December 31, 2025. The suicide case review has been completed and the resulting Quality Improvement Plan has been closed. FSP also has one outstanding QIP from a 2023 suicide by jumping, which involves a capital outlay request to augment barriers on the fifth floor of several buildings. This QIP remains open and continues to be addressed during institutional SPRFIT meetings. The self-harm rate during the reporting period was 0.2 per 1,000 (well below the statewide average of 5 per 1,000).

✓ Strengths

UOF Training Completion (99%): Of 556 custody staff, 553 completed annual Use of Force training (99%). All 79 nursing staff completed UOF training, and 21 of 22 mental health staff completed it (99% combined healthcare). The one mental health staff member who did not complete UOF training was a recreational therapist whose limited-term assignment ended before the training was administered.

Heat Plan Infrastructure (100%†): Thermometer checks were completed and accurate across all housing units audited. All custody staff interviewed across all units demonstrated knowledge of heat plan procedures, including stage-specific activation protocols, responsibilities for documenting the highest temperature reading, and identification of patients on heat-risk medications.

UOF Involving MH Patients (35%): No controlled use-of-force incidents occurred during the reporting period. There were 58 immediate use of force incidents involving 20 MHSDS patients (35%). MHSDS patients represent approximately 30% of the FSP population. The 35% involvement rate is roughly proportional to the MHSDS population share, indicating that mental health patients are not disproportionately involved in use-of-force events at FSP.

⚠ Concerns

Heat Plan DAR Documentation (97%): Alternative out-of-cell activities were documented on Daily Activity Reports for 37 of 38 heat alert days (97%). The one day without documentation represents a minor gap. Additionally, DAR entries currently record that yard access was provided or that out-of-cell activities were

offered per the local operating procedure, but do not consistently detail the specific activities offered. More detailed documentation would provide a clearer record of what alternatives were made available during heat plan activation.

Recommendations

1. Enhance DAR Documentation During Heat Plan Activation: Ensure all heat alert days have a corresponding DAR entry documenting the alternative out-of-cell activities offered to patients on heat alert medications. Direct that DAR entries specify the activities offered rather than referencing the local operating procedure by number alone. Verify compliance through quarterly review of heat plan documentation.

Suicide Prevention

The Program Guide establishes clinical requirements for suicide risk evaluation, safety planning, crisis bed management, post-discharge follow-up, welfare checks, and staff training. These indicators assess whether the institution's suicide prevention processes (from initial risk identification through crisis stabilization and return to the general population) function as intended. Detailed findings from the Receiver's Compliance Team and Regional SPRFIT Review are attached as Appendix B.

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg	Onsite Audits
Discharges from MHCB with clinician review of d/c summary			100%†		100%†	100%†	
Emergent and Urgent MH Referrals That Result in SREs		100%†	75%†	100%†	100%†	90%†	
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training	100%†	100%†		24%	95%	78%	
Safety Plans Signed Timely			100%†		0%†	50%†	
Timely Clinical Follow-Ups (V2.0)			100%†		0%†	50%†	
Audited Security Welfare Checks in Restricted Housing That Included the Required Visual Observation							100%
Custody Follow Ups, Page 1							100%†
Custody Follow Ups, Page 2							0%†
Custody Staff with CPR Training							99%
Healthcare staff current with suicide prevention training							100%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories							83%†
Institution SPRFIT Meeting Minutes Reviewed that Satisfy All Audit Criteria							100%†
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%†

✓ **Strengths**

Suicide Prevention Training Completion: All required suicide prevention trainings were completed within designated timelines. Healthcare staff suicide prevention training was 100%. Custody CPR training was 99% (533 of 537 staff). Nursing CPR training was 100% (94 of 94).

SPRFIT Program Functioning: Institution SPRFIT meeting minutes satisfied all audit criteria (100%†). The local operating procedure for suicide prevention was current and consistent with statewide policy, as was the policy on patients receiving bad news. SPRFIT meetings were conducted per policy.

Intake Screening and Referral Processes: All observed initial health screenings at R&R were conducted in a confidential setting with all required questions asked and responses entered into EHRS immediately (100%†). Suicide prevention posters in English and Spanish were displayed in all screening areas. All referrals where danger to self or suspected intentional overdose was identified received a Suicide Risk Evaluation (100%†). All 11 MHCB referrals during the reporting period had SREs completed (100%).

RHU Suicide Prevention Infrastructure: All eight designated RHU intake cells met suicide resistant cell criteria (100%†). All intake patients were appropriately housed (100%†). Security welfare checks in restricted housing met all audit criteria (100%). Custody discharge checks documentation (Page 1) was compliant (100%†), including supervisor review on each shift.

MHCB Discharge Review: Clinician review of MHCB discharge summaries was completed in all cases with available data (100%†).

⚠ **Concerns**

Timely Clinical Follow-Ups (50%†): Timely clinical follow-ups averaged 50%† over the reporting period, with November at 100%† and January at 0%†. The January score indicates that no clinical follow-ups were completed within the required timeframe during that month.

Safety Plans Signed Timely (50%†): Safety plans were signed within the required timeframe 50%† of the time, with November at 100%† and January at 0%†. The January failure, combined with the QC: Care Access finding that safety plans were not discussed in any of the five observed RHU IDTTs, indicates a broader pattern of inconsistent safety plan processes.

MHCB Discharge Suicide Risk Evaluations (50%): Of four clinical discharges from MHCB during the reporting period, SREs were completed for two (50%). Two discharged patients did not receive required post-discharge suicide risk evaluations. For patients transitioning from crisis-level care back to the general population, the post-discharge SRE is a critical assessment point.

Cut-Down Kit Inventory Documentation (0%† Page 2; 83%† Emergency Response Equipment): All housing units had approved cut-down kits with working Ambu bags. However, inventory documentation was non-compliant in the RHU. The first tier's inventory sheets were pre-signed for subsequent shifts, and the second and third tiers had missing signatures on the inventory sheet, including both first and second watch on the audit day. These findings produced the 0%† score on Custody Follow Ups Page 2 and contributed to the 83%† on Emergency Response Equipment. Custody staff received corrective training on March 31, 2026.

SRE Mentoring and Biennial Training (78%): SRE training compliance averaged 78%. September and October were at 100%†, but December dropped to 24% before recovering to 95% in January. The low score in December decreased the overall score for this indicator.

MSF Patient Reluctance to Report Crisis Symptoms: The eight MSF patients who were randomly selected and attended the patient survey expressed that they hesitate to report crisis or high-stress symptoms due to concerns about being placed in treatment modules, removed from programming, and given a smock. If patients at risk of self-harm are deterred from reporting, the intake screening, referral, and SRE processes measured by the other indicators in this section cannot function for those patients.

Alternative Housing Placement: Alternative housing placements at FSP are uncommon, and when they occur, the RHU is used. Policy does not specifically prohibit this, but the RHU is not the preferred placement from a clinical perspective given that it is the location where one is placed when they have committed a Title 15 violation. Limited space at FSP makes it challenging to identify safe, non-RHU alternatives.

Recommendations

1. Establish a Tracking System for MHCB Discharge Follow-Up Requirements: Create a system to identify all patients discharged from MHCB and track due dates for required post-discharge clinical follow-ups and suicide risk evaluations at 30 and 90 days. Assign responsibility for monitoring completion and reporting missed follow-ups. Track compliance monthly and report to the SPRFIT subcommittee until the indicator sustains performance at or above 90% for three consecutive months.
2. Identify and Correct the Cause of Safety Plan and SRE Timeliness Failures: Assess why safety plans and suicide risk evaluations were not completed within required timeframes in January (both indicators at 0%†). Determine whether the failures reflect a process breakdown, a staffing gap, or a documentation error. Implement corrective actions targeting the identified cause, incorporate safety plan review into the IDTT quality improvement initiative (see QC: Care Access), and monitor monthly.
3. Address MSF Patient Barriers to Crisis Reporting: Investigate the reported hesitation among MSF patients to disclose crisis symptoms. Determine whether institutional practices (e.g., treatment module placement procedures, programming consequences, use of safety smocks) create actual or perceived barriers to crisis reporting. If barriers are identified, develop and implement modifications that reduce disincentives while maintaining clinical safety. Communicate any procedural changes to the MSF patient population.

Sustainable Process and Utilization Review

Sustainable process reviews assess whether clinical documentation practices and level-of-care decisions meet Program Guide standards on a sustained basis, not just during audit visits. These indicators are drawn from quarterly HQ reviews, Inpatient Coordinator (IPC) audits, and the automated monitoring of MHCB utilization.

Indicator	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	6-Month Avg
Timely Transfer to MHCB (v2.0)	100%†	100%†	100%†	100%†	100%†	100%†	100%†

FSP does not operate an onsite EOP, MHCB, PIP, Acute, or ICF program. Sustainable process quarterly reviews and IPC audits are therefore not applicable. The sole applicable indicator in this section is timely transfer to MHCB for patients referred to external crisis beds.

✓ **Strengths**

Timely MHCB Transfer (100%†): All MHCB referrals during the reporting period were admitted within the required 24-hour timeframe. The indicator was at 100%† across all six months. Since FSP does not have an onsite

MHCB, these transfers require coordination with external receiving facilities and transport. Sustained 100%† compliance indicates the referral, bed-finding, and transport processes are functioning reliably.

Staffing

Adequate staffing is critical to compliance with many audit requirements in this report. Timely contacts, IDTT quality, treatment hours, supervisory oversight, and suicide prevention all depend on having enough qualified clinicians available to deliver services. The table includes the allocated and filled positions by classification for the reporting period, with functional vacancy rates reflecting weighted averages across months. Allocations for several classifications changed in January 2026 in response to staffing revisions.

Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief Psychologist	2.0	2.0	0%
Chief Psychiatrist	1.0	1.0	0%
Senior Psychiatrist (Supervisor)	0.0	0.0	0%
Senior Psychologist (Supervisor)	1.0	1.0	0%
Supervising Psychiatric Social Worker I	1.0	1.0	0%
Senior Psychologist (Specialist)	2.0	2.0	0%
Recreation Therapist	0.0	1.0	0%
Staff Psychiatrist	2.0	2.5	0%
Psychologist – Clinical	1.5	1.5	0%
Clinical Social Worker	2.5	2.5	0%
Primary Clinician (PC)	8.0	8.0	0%
PC: Psychologist – Clinical		5.5	
PC: Clinical Social Worker		2.5	
PC: Marriage and Family Therapist		-	
PC: Professional Clinical Counselor		-	

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

✓ **Strengths**

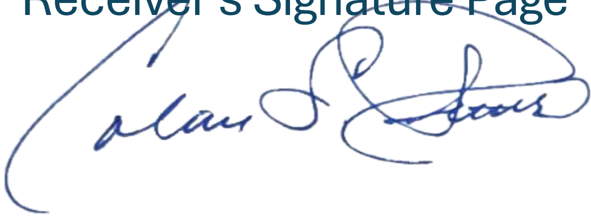
Full Staffing Across All Classifications (0% Vacancy): All allocated positions are filled. FSP has no functional vacancies in any mental health classification. Staff Psychiatrist positions are filled above allocation (2.5 on a 2.0 allocation). All supervisory positions (Chief Psychiatrist, Senior Psychologist Supervisor, and Supervising Psychiatric Social Worker) are filled. Full staffing, including 100% filled supervisory positions, is uncommon among CDCR institutions. FSP's staffing, including a full complement of permanent supervisory positions, provides a strong foundation for addressing the challenges identified in this report.

Staff Engagement and Clinical Culture: Staff interviews conducted during the onsite visit reflected positive engagement. Clinicians reported having creative freedom to design and facilitate groups, which allows for innovative and individualized treatment programming. Staff described good patient access to mental health treatment, with confidential settings available and few barriers to care. Custody-MH collaboration was described as strong, supported by consistent communication, daily huddles, and an established collaborative culture. Leadership was praised for responsiveness. For example, when psychiatry identified the lack of a backstock of crisis medications, leadership worked with the psychiatrist to identify which medications to stock and followed through.

⚠ Concerns

Psychiatry Allocation Relative to Workload: FSP operates with 2.5 staff psychiatrists on a 2.0 allocation (a 125% fill rate with no vacancies). Despite this, MHMD contact timeliness averaged 57% and declined from 78% to 43% over the reporting period.

Receiver’s Signature Page



Appendix A: Acronyms and Initialisms

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

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

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

Appendix B: Suicide Prevention Report

Institutional Changes

No changes in FSP's mission have occurred since the last visit.

Although not an institutional change, FSP's mental health department has been operating a General Resource Center (GRC) since 2021. Governed by Local Operating Procedure (LOP) No. 97, the GRC promotes well-being by offering drop-in services to non-MHSDS residents, Personal Insight Exploration (PIE) groups, and regular seminars on topics related to mental health. The facility serves roughly 100 to 150 residents per month.

Finally, in response to feedback from The Joint Commission, FSP continues to complete a Columbia-Suicide Severity Rating Scale (C-SSRS) for each initial PC assessment.

Section I: Restricted Housing Unit

FSP has a single, three-story Restricted Housing Unit (RHU).

Second Watch Partnership Huddle

All required members were in attendance, the discussion included topics such as patients new to RHU, patients leaving RHU, and patients with an increased level of care. All disciplines participated in the discussion and all staff appeared familiar with the patients.

Section II: Inpatient Units

Quality of Safety Planning:

Safety plans of four patients who were referred to and discharged from MHCB with a referral of Danger to Self during the audit period were reviewed. None of the four SREs reviewed contained the required safety plan.

Clinical Discharge Follow-Ups:

A review of the On Demand Performance Report for audit period indicated that FSP was 50% compliant for completion of the 5-Day Follow Ups.

FSP has no inpatient unit; therefore, the remaining sections typically reported on in Section II, are not applicable:

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

Section III: Alternative Housing

There are eight alternative housing cells, all in RHU (Building 4, cells 1-8). These are the same cells used for intake cells. No patients were in alternative housing at the time of the site visit.

During the audit period, there were 11 referrals to the MHCB. A review of performance data indicated that FSP was 100% compliant for timely transfers to MHCB during this period.

Section IV: Suicide Risk Management Program (SRMP)

While completing this audit, there were some inconsistencies found between information in the On Demand reports and information in EHRS. According to the OnDemand performance report, four patients were enrolled in SRMP during the audit period. However, further record review in EHRS indicated that of these, two were temporarily housed at FSP, one was removed per statewide policy in February 2024, and one was incorrectly marked as not meeting criteria in master treatment plans. This issue has been identified at other sites. As a result, the OnDemand report has been suspended while the issue is escalated to the Headquarters Reporting Unit for resolution.

Section V: Institutional SPRFIT Committee

A local SPRFIT subcommittee on February 11, 2026 was observed. All required members were present. System surveillance was conducted, and there was good multi-disciplinary participation. Similarly, monthly minutes showed good system surveillance (i.e., areas of low performance were identified and discussed), and data for non-automated measures were collected and discussed. A quorum was consistently met during this review period (August 2025-January 2026).

There were no new quality improvement projects at the time of the visit.

Section VI: Severe Self-Harm

FSP has very few incidents of self-harm. Per the Suicide Prevention and Response Focused Improvement Teams (SPRFIT) Reboot report, the 6-month average for self-harm incidents is .2 per 1000, which is well below the statewide average of five (Figure 2). There was one suicide that occurred at FSP during the audit period on December 31, 2025. The suicide case review has been completed. This suicide case review is discussed in more detail in *Section XII: Quality Improvement Plans (QIPs) Generated by Suicide Case.*

Section VII: Inmate Advisory Council and Inmate Family Council

The SPRFIT Coordinator last attended the Inmate Advisory Counsel (IAC) November 19, 2025. The date of attendance was noted in the minutes of the local SPRFIT meeting.

Inmate Family Council (IFC)

The SPRFIT Coordinator last attended the IFC on August 22, 2025. The date of the attendance was noted in the minutes of the local SPRFIT meeting.

Section VIII: Reception Center Processing

FSP is not a reception center.

Section IX: Crisis Intervention Team (CIT)

FSP does not operate a Crisis Intervention Team.

Section X: Policy

FSP has a policy on suicide prevention (LOP No. 92A), which is consistent with the memorandum "Enhancements to the Suicide Prevention and Response Focused Improvement Teams" dated 2-2-2018. FSP also has a postvention policy (LOP No. 92K). The audit also reviewed local policies to verify that FSP incorporated recent statewide memorandums related to suicide prevention into local policy. The results of this review are presented in Table 1.

Table 1. Alignment of Local Policies with Recent Statewide Policies Pertaining to Suicide Prevention

Statewide Memorandum (Date)	***In Local Policy?***
Alternative Housing (12-12-2012, 5-16-2012)	Yes (92B)
Bad News (4-28-2021)	Yes (92I)
Discharge custody checks (revised 10-10-2021)	Yes (92E)
MHCB Patient Identifier (12-03-2021)	N/A
SRMP (7-12-2021)	Yes (92J)
SRE Mentoring (revised 7-12-2022)	Yes (92H)
Cut-Down Kit (revised (8-10-2022)	Yes (92F)
Safety Concerns (revised 9-21-2022)	N/A
Security Welfare Checks (revised 10-7-2022)	Yes (OP 11)
Safety Planning (2-13-2023)	Yes (12.07.901)
Discontinue Safety Contracts (1-23-2023, 2-17-2023)	Yes (92A)
SRE Mentoring 2nd revision (6-7-2023)	Yes (92H)
Semi-annual reviews/RCAs of self-harm (6-14-2023)	Yes (92A)
Updated Process RHU Intake Cells (12-01-2023)	Yes (OP11)
Documentation Expectations for SRASHEs and Safety Plans (5-29-2024)	Yes (LOP 12.07.901)
Mandatory RN Self-Harm Assessment during PIP Admission (7-31-2024)	N/A
Update to Completion of Suicide Risk Evaluations in PIP Housing (7-31-2024)	N/A
Clarification of Appropriate Use of Safety Smocks and Blankets (8-13-2024)	Yes (LOP 12.05.301)
New Suicide Risk Evaluation Form and Expectations (8-19-2024)	Yes (LOP 12.07.901)

Section XI: Suicide Risk Evaluations

Timelines for Suicide Risk Assessment

Per the On Demand report, overall compliance with Suicide Risk Evaluation (SRE) timelines upon referral to or post discharge from MHCB was lower than the previous audit (78%, N=9). Completion percentages for Emergent or Urgent consults due to danger to self were 89% and 100%. FSP completed relatively few Suicide Risk Evaluations during the audit period, about one per month. Monthly compliance with specific SRE timelines was as follows:

- Emergent consults for danger to self: 89% (N=9)
- Urgent consults for danger to self: 100% (N=1)
- At MHCB clinical discharge: n/a
- Upon MHCB referral: 100% (N=5)
- Upon arrival from PIP: n/a
- After rescinded MHCB referral: n/a
- Following MHCB discharge (30 days post discharge): 67% (N=3)
- Following MHCB discharge (90 days post discharge): 0% (N=1)

Urgent and Emergent Consults for Danger to Self

During the audit period, FSP generated ten referrals for which the referral reason was Danger to Self (DTS). Of the ten referrals, nine were appropriately classified as emergent; however, there was one that was incorrectly classified as an urgent referral.

Of the ten referrals, only one was signed late as noted in the On Demand Performance Report. Despite being signed late, the patient was seen and a suicide risk assessment was started within compliant timeframes per Statewide policy; however, the final SRE document was completed and signed the next day, which resulted in this being out of compliance.

During the audit period, all contacts required a SRE and all SREs were completed.

According to the On Demand Performance Report, there were no urgent or emergent consult orders for reasons other than danger to self/self-harm/suicidal behavior during the audit period.

Section XII: Quality Improvement Plans (QIPs) Generated by Suicide Case Reviews

One suicide occurred at FSP during this audit period in December 2025. There was one QIP assigned to FSP; however, it was not assigned to mental health. The QIP from the December 2025 suicide has been closed.

FSP continues to have one outstanding QIP open and is independently pursuing a capital outlay in response to a previous suicide by jumping that occurred in 2023. This suicide followed three prior suicides by jumping. The outlay involves augmenting the current barriers on the fifth floor of several buildings. This QIP continues to be addressed during the Institutional SPRFIT Committee and was documented in monthly meeting minutes during the audit period.

Details of the QIP as a result of the suicide case review include: A) assess the feasibility of adding additional wire barriers to the fifth tier of Building three (and possibly Building two); and B) estimate the cost of installation. If the assessment determines results that are unattainable, the Warden or designee should develop a reasonable plan to address this issue.

Following the QIP, FSP leadership submitted a capital outlay application for Unit Three in 2024, which has been resubmitted annually. The application is currently pending approval from the CDCR Facility Planning and Management department, with the project ranked third on the priority list. While architectural plans are required due to the age of the facility, they are contingent upon approval of the capital outlay application. Furthermore, Plant Operations evaluated temporary alternatives but determined that no modifications, temporary or permanent, can be implemented without approved architectural plans. Consequently, all efforts are paused until the application is approved and the planning phase is authorized.

Section XIII: Training and Mentoring Compliance

Compliance with the Annual IST Suicide Prevention Training in 2025 was very good: custody was 98%, mental health was 100%, and nursing staff was 93%.

During the previous visit, the observation of the Annual IST Suicide Prevention Training indicated the trainer was engaging, provided real life examples and covered all required topics.

Compliance with long-standing training requirements is excellent. The SharePoint site for mandatory statewide suicide prevention training lists the following compliance percentages for FSP as of January 2026:

- SRE Mentoring: 100%
- Understanding and Assessing the Presence, Severity, and Risk of Suicidality: 95%
- Safety Planning Intervention: 100%
- Suicide Risk Management Program (SRMP): 100%
- Nursing CPR: 100%
- Custody CPR: 100%

Section XIV: Active Corrective Action Plans (CAPS)

There are no outstanding mental health CAPS.

CONCLUSION

As a result of this review, no mental health Corrective Action Plans (CAPS) are assigned to FSP.

As a result of this review, the following action was recommended to FSP:

1) Create a procedure to identify and track CCCMS and GP patients discharged from MHCB and track due dates for the 30- and 90-day clinical contacts and the requirements for completing suicide risk assessment.

2) Create a procedure to identify and track patients that require a safety plan according to statewide policy

HQ OPEN SPRFIT CAPS	CORRECTIVE ACTION PLAN	REQUIRED SUPPORTING DOCUMENTS
No open CAPS		

Appendix C: MAPIP

INSTITUTION 6 MONTH TREND

Folsom State Prison (FSP)

January 2026

Population Health Management	6 Months	Trend	AUG	SEP	OCT	NOV	DEC	JAN
Diagnostic Monitoring (All)	89%		87%	88%	90%	89%	90%	89%
QT Prolongation EKG 12 Months	-		-	-	-	-	-	-
Antipsychotics (All)	91%		87%	92%	93%	90%	91%	92%
Lipid Monitoring	78%		58%	73%	90%	100%	80%	71%
Blood Sugar	86%		69%	92%	89%	100%	88%	85%
EKG	-		-	-	-	-	-	-
AIMS	80%		100%	67%	86%	64%	100%	89%
Med Consent	85%		100%	100%	80%	75%	83%	100%
CBC with Platelets	96%		100%	100%	100%	100%	100%	88%
CMP	100%		100%	100%	100%	100%	100%	100%
Thyroid Monitoring	82%		100%	50%	67%	100%	0%	100%
Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Height	96%		89%	100%	100%	91%	100%	100%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Clozapine (All)	-		-	-	-	-	-	-
Blood Sugar	-		-	-	-	-	-	-
Lipid Monitoring	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
EKG	-		-	-	-	-	-	-
AIMS	-		-	-	-	-	-	-
Thyroid Monitoring	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Blood Pressure	-		-	-	-	-	-	-
Height	-		-	-	-	-	-	-
Weight	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-

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Mood Stabilizers (All)	85%		88%	60%	100%	89%	86%	71%
Carbamazepine (All)	100%		-	-	100%	-	-	-
Carbamazepine Level	100%		-	-	100%	-	-	-
CBC	100%		-	-	100%	-	-	-
CMP	100%		-	-	100%	-	-	-
Med Consent	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-
Valproic Acid (All)	86%		100%	100%	100%	100%	92%	58%
Med Consent	100%		100%	-	100%	100%	100%	-
Blood Pressure	100%		-	-	-	100%	100%	100%
Height	100%		-	-	-	-	100%	100%
Valproic Acid Level	67%		-	-	100%	100%	0%	0%
CBC with Platelets	75%		-	-	100%	100%	100%	33%
CMP	75%		-	100%	100%	100%	100%	0%
Weight	100%		-	-	-	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Lithium (All)	81%		100%	50%	100%	67%	50%	100%
Lithium Level	75%		-	0%	100%	-	100%	-
Thyroid Monitoring	75%		-	-	100%	-	0%	100%
CMP	75%		-	0%	100%	-	-	100%
CBC	100%		-	-	-	-	-	100%
EKG	0%		-	-	-	0%	-	-
Med Consent	0%		-	-	-	0%	-	-
Height	100%		100%	100%	100%	100%	-	-
Weight	100%		100%	100%	100%	100%	-	100%
Pregnancy	-		-	-	-	-	-	-
Oxcarbazepine (All)	86%		80%	-	-	100%	-	-
CBC	100%		100%	-	-	100%	-	-
CMP	100%		100%	-	-	100%	-	-
Med Consent	0%		0%	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-
Lamotrigine - Med Consent	-		-	-	-	-	-	-
Antidepressants (All)	85%		87%	82%	77%	87%	89%	87%
EKG (Tricyclics)	-		-	-	-	-	-	-
Med Consent	91%		90%	100%	88%	81%	93%	94%
Thyroid Monitoring	60%		63%	45%	33%	89%	71%	57%
Pregnancy	-		-	-	-	-	-	-
Venla Blood Pressure	100%		100%	100%	100%	100%	100%	100%

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Medication Management	6 Months	Trend	AUG	SEP	OCT	NOV	DEC	JAN
Medications Received Timely (All)	94%		95%	95%	95%	95%	94%	93%
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	91%		90%	94%	91%	92%	90%	90%
Intra-System (Within Institutions) – RHU	96%		90%	95%	97%	99%	92%	97%
Intra-System (Within Institutions) – MH Inpatient	-		-	-	-	-	-	-
Intra-System (Within Institutions) – Specialized Medical	-		-	-	-	-	-	-
Inter-System (Between Institutions) – GP	85%		86%	87%	89%	87%	78%	85%
Inter-System (Between Institutions) – RHU	86%		98%	87%	89%	86%	83%	87%
Inter-System (Between Institutions) – MH Inpatient	-		-	-	-	-	-	-
Inter-System (Between Institutions) – Specialized Medical	-		-	-	-	-	-	-
Return to CDCR – GP	96%		99%	99%	89%	95%	93%	96%
Return to CDCR – RHU	86%		83%	67%	100%	-	-	-
Return to CDCR – MH Inpatient	-		-	-	-	-	-	-
Return to CDCR – Specialized Medical	-		-	-	-	-	-	-
Stable Housing	95%		95%	95%	95%	95%	94%	94%
Leaving CDCR	99%		98%	99%	99%	98%	100%	100%
By Provider Type								
Psychiatry	97%		98%	97%	98%	98%	96%	96%
By Provider Type								
Psychiatry - Refused	3%		1%	3%	2%	2%	3%	4%
Non-Formulary by Psychiatrists	4.0%		3.5%	4.6%	4.4%	3.9%	3.7%	3.9%

Appendix D: Excluded Indicators

- Patients Referred to MHCB on Continuous Direct Visual Observation
- Patients in Alternative Housing with a Bed
- Scheduled MH Appointments Completed or Refused
- Mental Health Primary Clinician Continuity of Care
- Mental Health Psychiatrist Continuity of Care
- Healthcare Staff CMHPP Annual Training
- Monthly Review of EOP Modified Treatment
- ICCs with MH Clinicians Present and Relevant Information Provided
- Institution SPRFIT Meetings Observed that Satisfy All Audit Criteria
- CMHPP Monthly Executive Leadership Joint Rounding
- CMHPP Monthly Executive Leadership Joint Rounding Attended by Required Executives