CALIFORNIA STATE PRISON – LA COUNTY

Review Period: Dec 2025 – May 2026

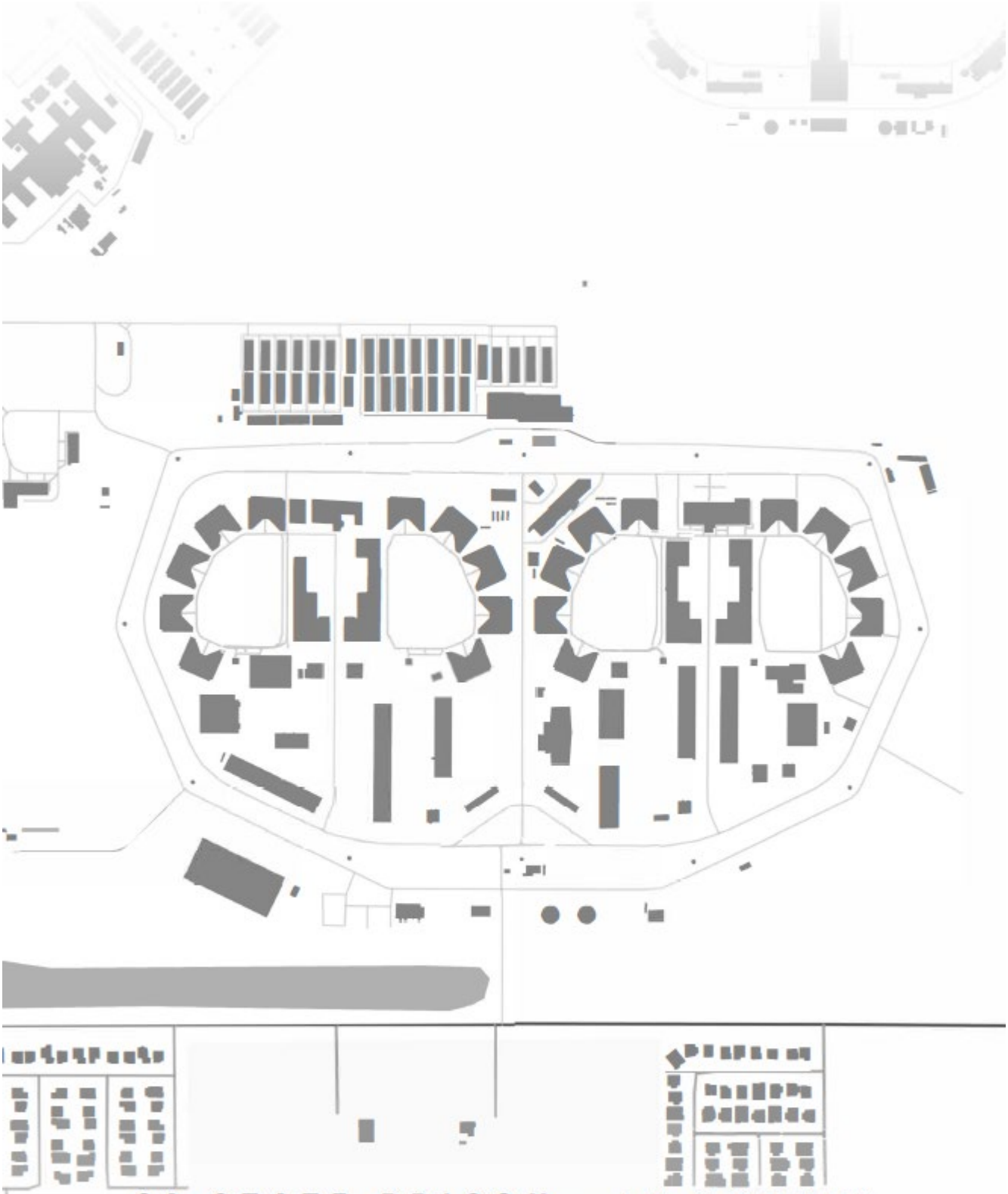
Onsite: July 14-17



Receiver's Compliance Team

2026

Statewide Mental Health Program
Continuous Quality Improvement



CA STATE PRISON - LA COUNTY

CDCR

34.6928° N / 118.2278° W

TABLE OF CONTENTS

BACKGROUND 2
GOALS 2
APPROACH TO ASSESSING COMPLIANCE 3
METHODOLOGY 4
RECOMMENDATIONS 5
EXECUTIVE SUMMARY 6
INSTITUTION'S OPERATIONAL PERSPECTIVE 9
ACCESS TO CARE 10
CUSTODY AND MENTAL HEALTH PARTNERSHIP PLAN 14
PSYCHIATRY 17
PATIENT SAFETY 18
QUALITY OF CARE 19
RVRS, SENTINEL EVENTS, AND SPECIALIZED CUSTODY 21
SENTINEL EVENTS AND SPECIALIZED CUSTODY 22
RESTRICTED HOUSING 23
SUICIDE PREVENTION 26
SUSTAINABLE PROCESS AND UTILIZATION REVIEW 30
STAFFING 31
APPENDIX A: ACRONYMS AND INITIALISMS 34
APPENDIX B: SUICIDE PREVENTION REPORT 38
APPENDIX C: MAPIP 45
APPENDIX D: SUSTAINABLE PROCESS REPORT 49
APPENDIX E: EXCLUDED INDICATORS 56

Background

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

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

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

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

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

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

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

Goals

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

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

Approach to Assessing Compliance

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

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

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

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

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

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

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

Methodology

Data Foundation

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

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

As a result, each indicator used in this report 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 early audits, several indicators were identified as producing unreliable results due to technical issues. These

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

Compliance Color Coding

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

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

Recommendations

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

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

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

Executive Summary

California State Prison – Los Angeles County (LAC) is a multi-mission institution serving male patients across several levels of care. Services are delivered across a general population program, a restricted housing unit, and a Mental Health Crisis Bed. The RHU CCCMS population is housed in Z-Unit, and an RHU EOP overflow population is housed in C5. Approximately 64% of the incarcerated population is enrolled in mental health programming.

Facility	Function	Mental Health Program
Minimum Support Facility	General Population Housing	ML CCCMS
Facility A Yard	General Population Housing	ML CCCMS
Facility B Yard	General Population Housing	ML CCCMS
Facility C Yard	General Population Housing, RHU EOP Overflow	ML CCCMS, RHU EOP Overflow
Facility D Yard	General Population Housing, Enhanced Outpatient Program, Restricted Housing Unit	ML EOP, RHU EOP, ML CCCMS
Central Services Building (CTC/MHCB)	Correctional Treatment Center; Mental Health Crisis Bed	MHCB
Z-Yard	Restricted Housing Unit	RHU CCCMS

The audit identified areas of compliance. Custody staff knew when and how to refer patients to mental health, and referral forms were available in every housing unit reviewed. Individual treatment spaces were confidential and adequate in 58 of 61 rooms reviewed. Psychiatric technician rounds in all restricted housing units met every audit criterion, and patients across the institution spoke well of their psychiatrists. Suicide prevention, CPR, use-of-force, and CMHPP training were all at or above 92%. Emergent referrals resulted in a suicide risk evaluation 98% of the time. Transfers to the MHCB and EOP met timeliness requirements in 96% and 100% of cases, respectively. Staff were engaged and well prepared throughout the visit, and the institution corrected several issues while the team was onsite.

The deficiencies fall into six areas. First, treatment planning: IDTTs showed an interactive process in 13% of observations and required staffing in 44%, treatment goals were measurable in 8 of 30 observed IDTTs, higher level of care considerations were discussed in 7 of 30, and only 36% of cases flagged for consideration of a higher level of care and that did not result in a referral had adequate Higher Level of Care documentation to support the decisions. Second, timely access: timely IDTTs (63%), psychiatry contacts (68%), mental health referrals (73%), and primary clinician contacts (77%) were all below threshold, and LAC offered EOP patients with the required number of structured treatment hours in only 59% of the cases. Third, medication management: timely response to non-adherence notifications was 45% for non-critical and 70% for critical medications, and a number of mood stabilizer laboratory monitoring metrics were low, with the six-month average for timely lithium level laboratory monitoring the lowest at 22%.Fourth, MHCB and crisis practices: MHCB patients were offered an average of 33 minutes of yard or dayroom per week against a 10-hour requirement, issue and observation orders lacked justification in all 10 charts reviewed, only 1 of 15 rescinded MHCB referrals had an adequate safety plan, 43 patients were held in temporary holding cells for more than four hours, timely clinical follow-ups were conducted in 45% of cases, and the SPRFIT meeting lacked a quorum in all six months reviewed. Fifth, restricted housing: transfers to RHU CCCMS were timely 42% of the time, patients remained in intake cells past 72 hours because of capacity issues, the C-5 overflow unit provided no yard or telephone unless the patient had tablet access, and the mental health clinician did not provide relevant clinical information in any of the 10 Institution Classification Committees (ICCs)observed. Sixth, RVR mental

health assessments were conducted in a private setting 48% of the time, met documentation requirements 44% of the time, and were requested in a timely manner 37% of the time.

These findings fall into structural, operational, and clinical-quality issues. Structural issues include the shortage of RHU EOP beds that drives overflow housing and long intake stays and the C-5 overflow unit's physical plant. Operational issues include scheduling and escort processes that result in missed appointments and groups, failure of supervisors to review safety plans, and ineffective workflows for non-adherence notifications and RVR assessments. Clinical-quality issues include incomplete treatment planning, level of care decisions, and safety planning. The priority recommendations below address the operational and clinical-quality issues the institution controls and identify the structural barriers the Receiver will address.

Priority Recommendations

1. Raise the clinical quality of IDTTs and treatment planning: Across 30 IDTTs observed in the MHCB, mainline CCCMS, mainline EOP, and both restricted housing programs, there were widespread deficiencies related to an interactive process, staffing, case formulation, treatment goals, and higher level of care appropriateness and documentation as described above. Patients on three yards described goals as general, could not recall an IDTT, or felt the meeting was scripted. Psychiatric input, patient engagement through open-ended questions, and access to the record were consistent strengths to build on.

Bring the quality of every IDTT up to meet the statewide Mental Health Program Guide policy requirements. Standardize case formulation (symptoms, functional impairment, strengths, areas of distress), set measurable goals with specific interventions, and strengthen level of care justification that addresses each HLOC consideration. Maintain a tracking system of the quality of HLOC Considerations documentation assessed by the Inpatient Coordinator (IPC) during monthly local audits to identify barriers and trends, provide feedback to clinicians based on the reviews, and modify interventions as needed. Assign supervisors to observe IDTTs in every program monthly using the statewide criteria and give clinicians individual feedback. Track performance monthly until all IDTTs meet audit requirements.

2. Provide timely access to clinical contacts, referrals, and structured treatment: LAC is not currently offering timely access to mental health services, as described above. In the RHU CCCMS, group assignment was made by the office technician and not based on clinical needs. Appointments were cancelled for custody reasons 15% of the time. During the audit we observed that appointments started late or did not occur because patients were not ducated or escorted. Patients on Facility C described referrals as a waiting game and said they had to go man down to be seen.

Map the scheduling, ducat, and escort workflow for mental health contacts, referrals, and groups in each program, fix the points where contacts are lost, and assign a responsible staff person to track mental health treatment timeliness in that program and address barriers to care. Assign patients to groups during IDTT based on their individual clinical needs. Review overdue referrals and contacts daily at the huddle. On a monthly basis, track timely-access and treatment offered indicators until sustained at threshold.

3. Respond to medication non-adherence and complete mood stabilizer monitoring: Timely response to non-critical medication non-adherence notifications averaged 45% across 2,925 instances, and timely response to critical notifications averaged 70%. MAPIP data show valproic acid level monitoring at 39%, lithium level monitoring at 22%, and lithium thyroid monitoring at 45%. Psychiatry staff reported that lab draws conducted outside of housing units drive refusals of medication monitoring appointments.

Map the workflow for receiving, triaging, and scheduling non-adherence responses, assign responsibility at each step, and revise procedures so notifications are not lost or delayed. Complete a retrospective review of every patient on valproic acid, lithium, carbamazepine, and oxcarbazepine to confirm required labs are done or scheduled and use the available registries and EHRS reminders prospectively. Address lab draw location to reduce refusals. Track response timeliness and mood stabilizer monitoring monthly by provider until sustained at threshold.

4. Bring MHCB and crisis-continuum practices into compliance: MHCB access to the yard and dayroom, issue and observation justification, safety plans, and timely clinical follow ups were all well below the required performance. Patients were held in temporary holding cells for over four hours on many occasions. Other suicide prevention practices, including reviewing serious suicide attempts and meeting quorum in the SPRFIT committee, also were not implemented.

Offer and document a minimum of 10 hours of out-of-cell activity per week for every MHCB patient and have the MHCB supervisor review weekly totals. Require daily, individualized justification for issue and observation levels. Audit records of temporary holding cell stays monthly and address the causes of any stays that extend beyond four hours. Restore SPRFIT quorum, correct designees, and complete case reviews for serious suicide attempts. Track each measure monthly until sustained at threshold.

5. Reduce stays in RHU to align with policy, resolve overflow conditions, and improve effectiveness of the clinician's role in ICC: Timely transfers to RHU CCCMS averaged 42%. Patients remained in intake cells past 72 hours in both restricted housing units because of insufficient capacity. One captain reported sending about 10 patients a week to the RHU EOP for safety concerns or pending investigations, and some remained longer than 30 days after having been made NDRH status. The C-5 overflow unit had no intake cells, no Guard One, and no yard or telephone access (except via tablet), and clothing and linen exchange was inconsistent. In all 10 ICCs observed, the mental health clinician did not provide information about the patient's current condition, so the chair did not have a basis for incorporating clinical needs into the decision-making; clinicians treated their role as clearing the patient to proceed with the meeting.

Track intake cell stays over 72 hours daily. Provide yard and telephone access, intake cells or an equivalent safeguard, Guard One, and documented clothing exchange in any unit operating as a RHU. Reduce the length of stay for those patients included in the RHU EOP for protective placement through the classification process. Develop a standardized ICC clinical summary template specifying the minimum information the mental health clinician must present which includes: patient’s current participation in treatment, medication compliance, suitability of single celling or double celling, risk assessment of self-injurious or assaultive behavior, status of Activities of Daily Living (ADL), ability to understand Due Process proceedings, likelihood of decompensation if retained in RHU including through review of records of prior RHU placements, recommendations for alternative placement, and any other clinical issues that have impact on patients’ mental health treatment. Provide remedial training for the MH clinicians who attend ICCs to improve the functioning of the ICC overall and the quality of input provided to the committee. The Region IV staff can support this training endeavor.

Structural Issue: The shortage of RHU EOP beds statewide is outside the institution's control. The Receiver is working to address the insufficient space for treating MHSDS patients who are placed in RHUs. The institution has taken action within its control to relocate patients who were placed in a RHU overflow unit without access to yard or telephones to another unit. If further assistance is needed to support this transition, the institution should document the needs and escalate them through the Receiver’s Compliance Team.

Institution's Operational Perspective

California State Prison, Los Angeles County provides mental health services across four Level IV facilities, a minimum support facility, a mainline EOP hub on Facility D with a new mental health treatment building, restricted housing programs for CCCMS (Z-Unit) and EOP (D-5) patients, and a licensed CTC mental health crisis bed unit. Approximately 64% of the population is enrolled in the MHSDS.

Leadership identified capacity in the EOP restricted housing unit as its central operational constraint, and the RHU EOP hub has not met all requirements for operating since June 2024. LAC staff and leadership are working to bring the RHU EOP into compliance. Placements for safety concerns and pending investigations exceed the unit's designated beds, which has required overflow housing in C-5 and extended stays in intake cells. The institution is evaluating relocating overflow housing to C-1 with gate access to the CCCMS RHU exercise yards, and the Classification and Parole Representative is expediting transfers through special transports to reduce overflow occupancy.

Physical plant issues during the review period included the loss of hot water in Facility D housing because of mechanical failures during roof construction, with replacement parts on order, and non-functioning air conditioning in several group treatment spaces used by recreation therapists. Three Z-Unit cells previously identified as not suicide resistant were removed from intake designation by local operating procedure addendum on the first day of the audit.

Clinician-led therapeutic groups resumed after a period during which staffing shortages impeded their ability to offer this service. LAC now also offers recreational therapy groups and nursing- led therapeutic groups, expanding the programming offered to patients.

Leadership reported vacancies in supervisory positions, including the Senior Psychiatrist (Supervisor), though the institution had an acting Senior Psychiatrist Supervisor during the on-site audit who was in the process of becoming a permanent staff member. There were several Senior Psychologist (Supervisor) position vacancies, and the Health Program Manager I remained vacant during the reporting period. There is continued reliance on telemental health and registry staff to maintain service delivery at LAC.

LAC has recently completed its first year of hosting a clinical psychology practicum program, during which students provided therapeutic and ancillary services to the EOP population with clinical supervision. LAC looks forward to continuing this program in the next school year. LAC also operates an APA accredited clinical psychology internship program.

Access to Care

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

Appointments

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg	Onsite Audits
Appointments Cancelled Due to Custody [i]	20%	15%	9%	12%	23%	13%	15%	
Scheduled MH Appointments Completed or Refused	71%	67%	70%	72%	75%	77%	72%	

Confidential and Effective Communication

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg	Onsite Audits
Effective Communication Achieved	99%	99%	99%	99%	99%	99%	99%	
Group treatment in a confidential setting	83%	85%	86%	85%	76%	80%	82%	
IDTTs in a confidential setting	98%	98%	97%	99%	99%	98%	98%	

Timely Access

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg	Onsite Audits
Daily PC Interactions – RHU EOP High Refusers	98%	95%	99%	97%	98%	97%	97%	
IRU Reviews Completed Timely	83%†	67%†	50%†	83%†	100%†	86%†	74%	
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure		0%†	80%†	33%†		100%†	69%†	
RC MH Screens				0%†			0%†	
RHU GP Screens	94%	94%†	92%	92%	85%	93%	92%	
RHU Pre-Screen	89%	90%	85%	92%	87%	90%	89%	
Timely IDTTs (v2.0)	56%	54%	67%	67%	71%	67%	63%	
Timely MH Referrals (v2.0)	63%	62%	77%	75%	77%	85%	73%	
Timely MHMD Contacts (v2.0)	74%	65%	69%	74%	63%	61%	68%	

Timely PC Contacts (v2.0)	76%	73%	79%	79%	77%	76%	77%	
Custody MH Referrals								100%
Housing Units Where 128-MH-5s Are Available And Accessible to Housing Unit Staff								100%†

Timely Transfers

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg	Onsite Audits
Timeliness of Acute/ICF Referral Submission to IRU	71%†	67%†	100%†	100%†	67%†	80%†	84%	
Timely Transfer to MHCB (v2.0)	100%	93%	97%	100%	100%	89%	96%	
Timely Transfers to EOP (v2.0)	100%†	100%†	100%†	100%†	100%†	100%†	100%	
Timely Transfers to PIP	60%†	33%†	60%†	100%†	75%†	83%†	70%	
Timely Transfers to RHU CCCMS	24%†	31%†	39%†	46%†	53%†	64%†	42%	
Timely Transfers to RHU EOP				100%†	100%†	100%†	100%†	

Treatment Offered

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg	Onsite Audits
Treatment Offered (Structured): non-PIP	60%	60%	75%	55%	53%	53%	59%	
Adequate Group Treatment Spaces								76%†
Adequate IDTT Spaces								83%†
Adequate Individual Treatment Spaces								93%

Space by Space Assessment

LAC	Space-by Space Assessment		July 14 - 17, 2026	
Space / Location	**Type**	**Assessed**	**Compliant**	**Primary Deficiencies**
ML CCCMS	IDTT	2	Yes	
	Group	2	Yes	
	Individual	11	Partial	**Fac A** (rm 126) - patient sits close to the door. * **MSF** (Counselor's Office) - Clinician sits in the back of the room and patient sits near the door limiting staff egress.
ML EOP	IDTT	1	Yes	
	Group	9	Partial	**Fac D** (Gym) & (Visiting) The space was non confidential as others use the space during treatment. *Holding Cells in the space are being used during group time * The gym space is not well ventilated or temperature controlled. While there are fans being utilized to aid in circulation of air, the room was described by the RT as still "unbearable". The visiting area is not well-ventilated, or temperature controlled as the A/C is not functional. There are multiple large fans to attempt to improve the ventilation. The RTs interviewed described it as currently the most unbearable of all the RT group areas. *__Fac D__ (Vocational Room) Does not have A/C.
	Individual	21	Yes	

RHU CCCMS	IDTT	1	Yes	
	Group	2	Partial	No working A/C; AC Unit is unreliable for adequate ventilation.
	Individual	7	Partial	**Fac Z** (Group room) No working A/C. The AC Unit is unreliable for adequate ventilation.
RHU EOP	IDTT	1	Yes	
	Group	6	Yes	
	Individual	21	Yes	
CTC / MHCB	IDTT	1	Yes	
	Individual	1	Yes	

✓ **Strengths**

Effective communication and confidentiality: Effective communication was achieved 99% of the time every month, and IDTTs were held in a confidential setting 98% of the time. All 61 individual treatment spaces reviewed were confidential and adequately sized, and 58 of 61 were safely configured.

Custody referral readiness: Custody mental health referrals scored 100%, 128-MH-5 forms were available in all 13 housing units reviewed, and every housing officer interviewed knew when and how to refer a patient to mental health.

Restricted housing screening and contacts: RHU GP screens averaged 92%, RHU pre-screens 89%, and daily primary clinician interactions with RHU EOP high refusers 97%.

Timely transfers to MHCB and EOP: Transfers to the MHCB were timely 96% of the time and transfers to EOP 100% (based on a small sample). Transfers to RHU EOP were timely in each month reported.

⚠ **Concerns**

Timely access below threshold: Timely IDTTs averaged 63%, timely psychiatry contacts 68%, timely mental health referrals 73%, and timely primary clinician contacts 77%. Patients interviewed on Facility C described the referral process as slow, a waiting game, and said they had to go man down to be seen. CCCMS patients on Facility B reported minimal individual contacts during lockdowns and inconsistent primary clinicians. Contacts after a temporary departure averaged 69% (based on a small sample). See Priority Recommendation 2.

IRU reviews and referral submissions: Based on the sustainable process review, 100% of the 43 referrals to Acute/ICF were submitted timely to IRU. The performance report shows that Acute/ICF referrals were submitted to the IRU in a timely manner 84% of the time. Six cases were traced/counted late due to data entry (for example, four of the inpatient review orders were not initiated in EHRS). These were reviewed with the IPC onsite.

Transfers to RHU CCCMS and PIP: Timely transfers to RHU CCCMS averaged 42%, improving from 24% in December to 64% in May based on small monthly samples. Timely transfers to PIP averaged 70% (based on a small sample). See Priority Recommendation 5.

Structured treatment offered: The required number of hours of structured treatment was offered to EOP patients 59% of the time. In the RHU CCCMS, groups are scheduled based on how many patients indicate in the officer's morning poll that they plan to attend treatment. The first patients to accept treatment were placed in

the first group, regardless of the group's content. If more patients accepted treatment than there were modules in the treatment room, the remaining patients were placed in the next available group that day. Group assignment was based on convenience rather than clinical needs. One RHU EOP group started 20 minutes late because escorts were conducted by room number, so the first patients escorted fill the first group room, the next set of patients fill the second, and so forth. Each group begins when the room is filled. Therefore, groups often start late, and patients do not receive the full treatment time allotment. CCCMS patients on Facilities A and C reported that no mental health groups are offered in their units and requested access to group treatment. See Priority Recommendation 2.

Custody cancellations and escorts: Appointments were cancelled for custody reasons 15% of the time. Patient surveys on Facilities B and D began 25 to 30 minutes late because patients had not been ducated, and auditors could not observe one Facility D EOP group after a 45-minute wait for escorts during yard alarms.

Treatment environment: Of 17 group treatment spaces reviewed, 15 were confidential and 13 had adequate ventilation and temperature control (76% adequate). The Facility D gym and visiting room, both used for recreation therapy groups, are not confidential, as others use the space while groups are ongoing. Those spaces also had no working air conditioning; staff described them as unbearably hot. Vocational room 137 has no air conditioning and no working wall thermometer, and staff were therefore unsure when the space had reached a temperature that would require group cancellation because the heat plan had gone into effect. The Z-Unit group room air conditioning was out of order with a work order pending during our visit. Rooms 3 and 7 on Facility C have an echo that made IDTTs difficult to hear for both the telehealth clinician and the patient. The two MSF treatment rooms and Facility A room 126 are not configured safely to ensure a path for clinician egress. Facility D housing had been without hot water for more than a month during the audit. Working with the Receiver's team in response to concerns raised during the audit, the institution's leadership was able to secure a portable water heater on 7/18/2026, and on 8/13/2026 the original issue with the provision of hot water was fixed.

Recommendations

1. Timely access, structured treatment, and RHU transfers: See Priority Recommendations 2 and 5.
2. Custody escorts and ducats: Review and consider modifications to custody staffing for mental health ducats and escorts to improve treatment access, such as assigning a custody lead in each program, confirming daily at the huddle that scheduled patients were ducated, and tracking custody cancellations weekly, working to minimize custody cancellations.
3. Repair and configure treatment space: Restore air conditioning in the Facility D gym, visiting room, vocational room 137, and the Z-Unit group room. Treat the acoustics in Facility C rooms 3 and 7, review the configuration of MSF rooms 107 and 108 and Facility A room 126 to ensure safe egress. Track completion of each work order monthly at the MHPS.
4. Identify sufficient confidential group space: Identify group treatment space on Facility D and maximize use of available spaces. The institution is expected to maximize compliance within existing constraints and to document and escalate structural barriers to the Receiver's office.

Custody and Mental Health Partnership Plan

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

Indicator	6-Month Avg	Onsite Audits
CMHPP MH Daily Huddles		78%
CMHPP MH Huddle Documentation of Required Attendees		94%
CMHPP MH Huddle Documentation of Supervisor Attendees		57%
CMHPP Monthly Executive Leadership Joint Rounding		75%†
CMHPP Monthly Executive Leadership Joint Rounding Attended by Required Executives		75%†
CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH Program		0%†
Custody Staff CMHPP Annual Training		97%
Healthcare Staff with CMHPP Annual Training		92%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours		67%†
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours with Required Attendees		100%†
ML CCCMS and RC CCCMS CMHPP Weekly Supervisor Meetings		63%
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees		100%
ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings		0%
Quarterly Partnership Round Table Training Completed as Required		80%†
Required Staff Attendance of Quarterly Partnership Round Table Training		30%†

✓ Strengths

Annual CMHPP training: During the review period, LAC's custody staff were compliant at 97% (726 of 749) and healthcare staff at 92% (300 of 327) with annual CMHPP training.

Required attendees when meetings occur: When huddles were held, required attendees were documented as present 94% of the time. Joint supervisory program tours and weekly supervisory meetings that did occur had all required attendees (100%).

⚠ Concerns

Daily huddles: During the review period, MH daily huddles were completed 78% of the time. These huddles are not occurring on weekends in the MHCB as required by policy. During the on-site review, some huddle documentation was not provided, and it is unclear whether the huddles occurred and the documents were lost or the huddles did not occur. In addition, while attachment B was utilized to document the huddles in all programs, RHU CCCMS utilizes the same attachment B document for both second and third watch. Policy requires separate attachments for second and third watch.

Supervisor participation: Supervisor attendance was documented in 57% of huddles. With the exception of ML EOP, MH supervisors were not attending huddles once a week as required by policy across MH programs. Custody supervisors attended huddles weekly as required in all areas except for sporadic attendance in MHCB. Supervisory presence at daily huddles provides oversight and awareness of the information exchanged between custody and clinical staff and enables real-time supervisory input and mentorship. Weekly CCCMS supervisory meetings between the Sergeant and the MH Program supervisor occurred 63% of the time.

Executive joint rounding: During the review period, there was no documentation of rounds conducted in RHU EOP, and only one round was completed in ML EOP rather than the two required by policy. While joint rounding was completed only 75% (9 of 12) of the time, during the nine months where rounding occurred, all required executives were in attendance. Because documentation for June and August 2025 could not be located, no program received the minimum number of required executive joint rounds. Joint rounding provides visibility and access to leadership, and particularly in ML EOP and RHU EOP, facilitates awareness of program issues that might not otherwise rise to the level of top leadership and allows these problems to be addressed and solved expeditiously.

Joint supervisory tours and IAC: Monthly ML CCCMS joint supervisory program tours occurred in 4 of 6 required months (67%). The mental health program supervisor did not attend any of the required monthly Incarcerated Person Advisory Council meetings; the Warden's monthly IAC meeting was completed in lieu of the Facility Captain's IAC meeting. The Warden's IAC meeting is not part of the CMHPP policy and therefore cannot be substituted for the Facility Captain's meeting.

Quarterly Partnership Round Table Training: While quarterly roundtables occurred 80% of the time during the review period, only a small proportion of the required staff attended the roundtables. In some cases, the required custody or MH staff were not present, in others, the MH and custody supervisors were not present. The presence of both MH and custody supervisors is essential to delivering the training materials effectively and modeling partnership.

Recommendations

1. Restore huddle and supervisory participation: Ensure huddles occur daily in required programs and set clear expectations for supervisor attendance once a week as required by policy with required documentation. Hold daily huddles seven days a week in the MHCB, keep a separate Attachment B for each watch, and file every huddle sheet. Hold the weekly CCCMS supervisory meeting every week. Initiate audits of huddle occurrence and required attendance across all programs and address barriers to achieving compliance.

2. Complete executive rounds and program tours as scheduled: Schedule executive leadership joint rounds so every mental health program, including the EOP RHU, receives the required number each period. Prioritize MH program areas with known compliance concerns or reports suggesting a need for increased leadership attention. Hold the ML CCCMS joint supervisory tour monthly. Retain documentation for each event.

3. Round table training attendance: Communicate attendance expectations and track attendance using training sign in sheets. Identify and address specific barriers preventing required staff from attending and preventing program supervisors from delivering the training.

4. Attend Facility Captain's IAC meeting: Communicate expectations that the CCCMS mental health program supervisor attends the monthly facility IAC meeting where CCCMS patients are housed as required by policy rather than the Warden's IAC meeting.

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. It also tracks the required diagnostic monitoring for psychiatric medications. These indicators assess whether patients receive timely access to prescribed medications and whether prescribing practices include appropriate safety monitoring.

Medication Management

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg	Onsite Audits
Timely Response to Critical Non Adherence Notification (v2.0)	75%†	89%†	50%†	67%†	75%†	67%†	70%	
Timely Response to Non-Critical Med Non-Adherence Notification(v2.0)	52%	40%	41%	45%	42%	46%	45%	
Controlled Use of Force Incidents Required to Administer PC2602 Medication								0%†

✓ **Strengths**

Patient regard for psychiatric care: Patients on every yard spoke well of their psychiatrists during interviews, describing them as approachable, efficient, and responsive to medication concerns. Psychiatric input was a consistent strength in observed IDTTs.

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

Vital signs for all medication classes: MAPIP vital-sign monitoring ranged from 96% to 100% across medication classes, and medication administration timeliness ranged from 85% to 100%.

⚠ **Concerns**

Timely response to med non-adherence notifications: Psychiatrists did not respond in a timely manner to notifications that patients were not adhering to medications. Timely responses to non-critical medication non-adherence notifications averaged 45% for the reporting period across 2,925 instances. Timely response to critical medication non-adherence notifications averaged 70% (small monthly samples), also below threshold.

Mood stabilizer monitoring is critically low: MAPIP data show required laboratory monitoring is missed for a large share of patients on mood stabilizers. These medications have narrow therapeutic indices where missed monitoring can result in toxicity, organ damage, or subtherapeutic dosing. On average, patients had their valproic acid levels checked 39% of the time. The blood count (CBC) and metabolic panel (CMP) tests associated with valproic acid are completed 65% and 64% of the time. For lithium, level monitoring is done 22%

of the time, thyroid checks are done 45% of the time, and the CBC and CMP tests are completed 59% and 40% of the time.

Medication Monitoring Adherence: Thyroid monitoring ranged from 45% (mood stabilizers) to 82% (antipsychotic) across medication classes, below the 89.5% threshold in every class. Overall laboratory monitoring adherence was 86% for the period; staff attributed refusals in part to lab draws being located away from housing units.

Training for Office Technicians (OTs): Conversations with staff revealed that OTs were not appropriately trained on how to use the most up-to-date reports for appointment scheduling and were unaware of appointment scheduling timelines that apply to each appointment type and level of care.

Recommendations

1. Non-adherence response and mood stabilizer monitoring: See Priority Recommendation 3
2. Ensure providers are aware of current resources for tracking monitoring requirements: t Headquarters provided a review of the due dates report to schedulers at LAC after the visit. Encourage staff to routinely utilize these resources to identify, order, and complete laboratory studies and assessments as required. Track individual provider rates of timely follow up and engage individually with psychiatrists as needed.
3. Ensure OTs have access to information they require for appropriate scheduling of appointments: Confirm Mental Health Medical Doctor (MHMD) appointment guidelines are posted and training on using the most up-to-date reports for accurate information for appointment scheduling is provided to the OTs within 30 days of receipt of this report. Audit scheduling accuracy and provide the results within 60 days following receipt of this report.

Patient Safety

This section examines patient safety indicators including heat-related illness prevention, seclusion and restraint events, and the availability of alternative programming during environmental restrictions. Patient safety metrics measure whether institutional protocols protect patients from physical harm, particularly for clinically vulnerable subpopulations such as those prescribed heat-alert medications.

Indicator	May 2026	6-Month Avg	Onsite Audits
Heat Related Illness Incidents for MHSDS Patients Prescribed Heat Alert Medications	0†	0†	

✓ **Strengths**

Heat plan readiness: No heat-related illness incidents were recorded among MHSDS patients on heat-alert medications. In all 13 housing units reviewed, staff knew the heat plan procedures, working thermometers were mounted correctly, the daily heat-alert medication list was posted, officers carried CPR mouth shields, and cut-down kits were complete and inventoried.

Mechanical restraint reviews: There were no restraint or seclusion incidents during the review period. All five non-max custody MHCB patients had a completed mechanical restraint review documenting that restraints were not required.

⚠ **Concerns**

Heat log timeliness: Indoor heat logs were current in 10 of 13 housing units (77%); late entries were found in D-2 and the MHCB.

Cut-down kit bags: Every housing unit and the MHCB, except the MSF, still stores cut-down kits in plastic bags rather than durable response bags, as required by policy. Leadership is working to replace the plastic bags with a more durable canvas bag.

Alternative activities during heat alerts: See the RVRs, Sentinel Events, and Specialized Custody section.

Recommendations

1. Heat logs: Have the area supervisor verify the indoor heat log each shift in D-2 and the MHCB.
2. Cut-down kit bag replacement: Complete the replacement of plastic cut-down kit bags with canvas bags in every unit. Confirm completion at the next Mental Health Program Subcommittee (MHPS).

Quality of Care

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

Care Access

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg	Onsite Audits
IDTT Patient Attendance	73%	71%	71%	71%	73%	76%	72%	
IDTT Required Staffing	42%	38%	40%	45%	49%	47%	44%	
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available								93%
IDTTs with Observed Interactive Process								13%

Documentation

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg	Onsite Audits
MHSDS Patients Released from CDCR With Pre-Release Planning Forms Signed	25%	17%	6%	11%	9%	22%	15%	
Cases w/doc. of appropriateness of LOC discussed for pts identified by 7388B as potentially requiring HLOC								23%
EOP IDTTs Addressing Accommodations and Clinical Appropriateness for Work and Education								0%†

IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT								95%
IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT								100%

✓ **Strengths**

Intake evaluations and record access: Primary clinician intake evaluations were completed before the initial IDTT 95% of the time, and psychiatry intake evaluations were completed before the initial IDTT 100% of the time. Team members had access to the health record and SOMS in 93% of observed IDTTs, and a psychiatrist attended all 30.

Patient engagement and IDTT clinical strengths: Patients were invited to participate and asked open-ended questions in 26 of the 27 IDTTs they attended, and psychiatrists consistently addressed diagnosis, medications, and side effects. Mainline EOP IDTTs on Facility D, led by the Senior Psychologist Supervisor, showed interactive discussion in most cases, and MHCB IDTTs met all criteria in 4 of 5 cases.

⚠ **Concerns**

Interactive process and treatment planning: Most IDTTs observed did not demonstrate a fully interactive process, and the required assigned staff only attended 44% of observed IDTTs. Across the 30 IDTTs observed, a succinct case formulation was presented in seven, interactive discussion among all staff about the plan occurred in 12, measurable goals were discussed in eight, higher level of care and appropriateness of level of care were discussed in seven, and progress toward goals was discussed in six of 13. Restricted housing IDTTs were presented largely in silo, with the correctional counselor and psychiatric technician contributing little in the RHU CCCMS. On Facility C, three of four initial assessments had been completed by a clinician other than the assigned primary clinician, one of them seven months earlier and at cell front. See Priority Recommendation 1.

Level of care documentation: Appropriateness of level of care was documented for 23% of cases identified on the 7388-B Higher Level of Care Considerations form as potentially requiring a higher level of care. Level of care justification in observed IDTTs was often limited to stating the patient would remain at the current level.

Patient attendance and accommodations: IDTT patient attendance averaged 72%. During on-site observation, one patient's IDTT was held in absentia because he was not ducated, rather than because of a refusal. EOP IDTTs did not address work and education accommodations at all (small sample).

Patient experience: Patient views of IDTTs were mixed. Some patients described honest staff, efficient group assignment, and appropriate meeting space; others felt unheard, said the team did not know them, and described the meeting as predetermined and scripted. Several CCCMS patients on Facilities A and C could not recall having an IDTT, and patients on three yards described goals as general and primary clinician changes as frequent.

Recommendations

1. IDTT quality, level of care documentation, and continuity: See Priority Recommendation 1.
2. Patient attendance at IDTT: Confirm at the daily huddle that patients scheduled for IDTT have been ducated, and document the reason whenever an IDTT is held in absentia.

RVRs, Sentinel Events, and Specialized Custody

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

Rules Violation Report

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg	Onsite Audits
RVR MH Assessments Conducted in a Private Setting	48%	55%	44%	54%	47%	43%	48%	
RVR MH Assessments where Documentation Requirements were Met	75%	44%†	38%†	43%†	26%†	31%†	44%	
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality	100%	100%†	100%†	100%†	95%†	100%†	99%	
Timely RVR MH Assessment Request	28%	32%	38%	39%	37%	48%	37%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	93%	91%	94%	93%	89%	86%	91%	
RVR MHAs where Captain Disagreed with Documenting in an Alternative Manner								50%†
RVRs Issued								1,929†
RVRs Issued to Non-MHSDS Participants								24%
RVRs Issued to Patients at the Acute Level of Care								0%
RVRs Issued to Patients at the CCCMS Level of Care								52%
RVRs Issued to Patients at the EOP Level of Care								22%
RVRs Issued to Patients at the ICF Level of Care								0%
RVRs Issued to Patients at the MHCB Level of Care								2%
RVRs recommended for mitigation that were mitigated								89%†
RVRs Recommended for Mitigation with Custody Documentation								89%†

✓ **Strengths**

Custody use of clinical input: Senior hearing officers documented consideration of the clinician's mitigation recommendation in 18 of 20 RVRs reviewed. In each of those 18 cases, the hearing officers mitigated the penalty. Three of the cases reviewed involved patients who were found guilty, resulting in an RHU term. In these cases, the ICC considered the mental health assessment (MHA) when determining the RHU term. Patients were informed of the limits of confidentiality 99% of the time, and assessment results were submitted in a timely manner 91% of the time.

⚠ Concerns

RVR mental health assessments: RVR assessments were documented as taking place in a private setting 48% of the time. However, this was based on patient refusals of confidential assessments. Of the 20 cases reviewed, two patients refused the contact altogether. Nine additional IPs refused a confidential setting, and these MHAs were conducted at cell front. While a patient may refuse a confidential assessment, it is valuable to offer and encourage participation in the process through a confidential assessment given the potential for mitigating an RVR. Documentation requirements were met 44% of the time, declining to 26% and 31% in April and May on small samples. Timely assessment requests averaged 37%. There is a discrepancy between custody and mental health RVR MH assessment policies regarding timeframes. Mental health policy requires all RVR MHA requests to be submitted within 48 hours of the violation, while reporting staff (those writing the RVR) have up to 15 days from the date of discovery to issue the RVR. As a result, the 48-hour timeframe for RVR MHA requests may lapse before the necessary custodial steps to submit the assessment request are completed. This is a known statewide issue for which a resolution is being discussed.

RVR distribution: Of 1,929 RVRs issued in the prior quarter, 76% went to MHSDS patients (52% CCCMS, 22% EOP, 2% MHCB) against an MHSDS share of the population of about 64%.

Recommendations

1. Improve RVR mental health assessments: Offer and encourage participation in the process through a confidential assessment given the potential for mitigating an RVR. Train clinicians on the documentation requirements for the assessment and have supervisors audit a sample monthly for quality. Track documentation requirements in practice and timeliness monthly until sustained at the required threshold. Address the discrepancy between custody and mental health RVR assessment policies regarding timeframes for assessment requests, a known statewide issue for which a resolution is being discussed.

Sentinel Events and Specialized Custody

Indicator	6-Month Avg	Onsite Audits
Days Alternative Out-of-Cell Activities were Offered to Patients on Heat Alert Medications when Indicated		0%
The Use and Documentation of Mechanical Restraints Among Non-MAX Custody Patients in MHCB Units		100%†
Thermometer Checks completed and accurate		77%†

Use of Force

Indicator	6-Month Avg	Onsite Audits
Custody Staff Attendance at UOF Training		95%
Health Care Staff Required to Attend UOF Training		92%
Use of Force Involving MH Patients		94%

✓ Strengths

Use-of-force training and restraint documentation: Custody staff were current with annual use-of-force training at 95% (743 of 779) and healthcare staff at 92% (301 of 326). No controlled use of force was required to administer PC 2602 medication, and mechanical restraint reviews for non-max MHCB patients were complete in all five cases.

⚠ Concerns

Alternative activities during heat alerts: Thirty-three Stage I heat alerts occurred in May and June 2026. None of the six facility Daily Activity Reports reviewed documented alternative out-of-cell activities for patients on heat-alert medications, and not every report reflected that a heat alert had been activated. Indoor heat logs were current in 10 of 13 units (77%).

Use of force involving mental health patients: Patients in the MHSDS were involved in 204 of 217 immediate use-of-force incidents (94%) and 8 of 9 controlled incidents (89%) during the review period, well above their share of the population.

Recommendations

1. Provide and document alternative activities during heat alerts: Offer alternative out-of-cell activities to patients on heat-alert medications during every heat activation and record the activation and the activities on the Daily Activity Report. Have the facility captain verify the entries after each alert and report compliance monthly to the MHPS.

Restricted Housing

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

Timeliness

Indicator	Apr 2026	May 2026	6-Month Avg	Onsite Audits
CC II, Captain, and Warden Reviews of RHU EOP Patients with LOS Over 90 Calendar Days	100%†	100%†		100%
ICCs with Mental Health Clinicians Present and Relevant Information Provided				0%†
Initial ICCs Reviewed that were Held within 10 Calendar Days of Arrival to Restricted Housing Placement				100%
MH Patients on Max Custody Over 150 Calendar Days with a Timely Initial MHCBC				73%†
MH Patients on Max Custody Over 180 Calendar Days with Timely Initial LTSCC				100%†

Documentation

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg	Onsite Audits
Controlled Use of Force MH Assessments Meeting Documentation Requirements	0%†	0%†	0%†	0%†	25%†	50%†	15%†	
Observation of Psych Tech Rounds Where EC, Interaction, and Referrals Met All Audit Criteria								100%†

Psychiatric Technician Rounds Documentation Audited Meeting All Audit Criteria								100%†
PT Rounds Completed in Restricted Housing Units								100%†

Out-of-Cell Activities/Care

Indicator	6-Month Avg	Onsite Audits
Custody Staff who can Identify all NDRH Patients		100%†
NDRH Patients Provided Personal Property		100%†
Observed RHU Screening Questionnaire Conducted in Confidential Settings		100%†
Patients in restricted housing with working entertainment appliances		100%
Peace Officers Observed to Carry Their CPR Mouth Shield		100%
RHU CCCMS Out of Cell Time Offered		90%
RHU EOP Out of Cell Time Offered		100%
RHU Shower Access		98%
Staff Who Report Unclothed Body Searches Conducted in a Private Area		100%†
Weeks where NDRH Patients are Offered Required Phone Calls		90%

✓ **Strengths**

Psychiatric technician rounds and screening: Psychiatric technician rounds in all restricted housing units met every audit criterion for observation, interaction, and referrals (100%), and quarterly fidelity audits were complete. RHU intake and pre-placement screenings observed were compliant. All documentation was completed at cell front in real time, and in the Z-Unit, the psychiatric technician used a flashlight to see into darkened cells.

Custody timelines and reviews: Initial ICCs were held within 10 calendar days in all 40 cases reviewed, and reviews of RHU EOP patients who remained in the unit for more than 90 days by the CC II, captain, and warden were complete in every case reviewed. MH patients who remained in restrictive housing for more than 180 days also had a timely initial review by the Long-Term Segregated Case Conference Team 100% of the time. Guard One welfare checks were completed per policy in both units, and NDRH property tracking was accurate in SOMS.

Out-of-cell time and showers: RHU EOP patients met the 10-hour out-of-cell requirement in 20 of 20 weeks reviewed, and RHU CCCMS patients met the 18.5-hour requirement in 18 of 20; showers were offered every other day in 39 of 40 cases. Intake cells were used appropriately, and the three Z-Unit cells previously found not suicide resistant were removed from intake designation on the first day of the visit.

Second watch huddles: Morning huddles in both units had full attendance and participation and covered new arrivals and high-risk patients.

⚠ **Concerns**

Mental health role in ICC: In all 10 ICCs observed, initial input from the MH clinician at ICCs was lacking and did not support ICC decision-making. Instead of providing useful and relevant information for the committee to consider, the clinician only asked the patient if they had any issues that would affect their understanding of the ICC. The clinician did not communicate the patient's mental health status, treatment progress, clinical needs, or mental health considerations relevant to the committee's placement decision. The chair therefore could not

effectively weigh the patient's clinical needs. When the clinician does not provide this information, the ICC leader should seek the information proactively from participants, including the MH clinician. If the ICC does not have this information, it makes housing and program decisions without the clinical context necessary to evaluate whether the patient's mental health needs are being met in their current placement. See Priority Recommendation 5.

Initial MH case by case reviews were completed out of timeframes: During the review period, a total of eleven (11) Mental Health Case by Case Reviews were examined for timeliness and compliance with established CDCR and DOM requirements. The audit focused on adherence to the mandated 150-day maximum custody timeframe for completion outlined in the priority case-by-case review of MHSDS long term segregated inmates policy. Under this policy, a Priority Case-By-Case Review shall be completed within 150 days of max custody placement to evaluate the risk for decompensation from extended restricted housing and whether continued placement is appropriate. The ICC shall conduct a priority case-by-case review of all available case factors, disciplinary history, and mental health treatment plan. All MHSDS cases retained in restricted housing following the institution priority case-by-case review shall be referred for a long-term segregated case conference (LTSCC) within 30 days of completing the institutional priority case-by-case review. Of the eleven reviews assessed, eight (8) were completed within the required timeframe, resulting in a 73% timeliness compliance rate. These cases demonstrated appropriate documentation, follow-through, and processing aligned with departmental expectations. The remaining three (3) reviews exceeded the 150-day requirement (8, 5, and 1 days past the requirement). Delays were associated with scheduling constraints, case complexity, or lapses in case tracking. These instances should be evaluated further to identify procedural gaps and ensure proactive actions can be implemented.

Capacity, intake stays, and overflow: Patients remained in intake cells past 72 hours in both units because of inadequate capacity in non-intake cells. Although LAC had non-intake IPs in intake cells past 72 hours, they are in overflow and at max capacity. During the audit, IPs over 72 hours had pending bed moves in SOMS. One captain reported sending about 10 patients a week to the EOP RHU for safety concerns or pending investigations, and some remained for more than 30 days in NDRH status. During the audit, the C-5 overflow unit held up to eight patients but had no retrofitted intake cells inside the unit. No patients in the housing unit were within the 72- hour intake period. The unit had no Guard One system (rounds were documented on paper), no yard or telephone access, and inconsistent clothing and linen exchange. In the C-5 overflow unit, phone calls via patient tablets were activated for patients who had tablets, ultimately providing them increased access to phones, but those without tablets had no phone access. Timely transfers to RHU CCCMS averaged 42%. See Priority Recommendation 5.

Group scheduling in the RHU: In the RHU EOP, groups are filled by room number, starting at the first room moving to the last, rather than assigning patients to groups based on clinical indications. Escorting to the groups begins around 8:30, and the groups begin at various times during the week, with the earliest starting at 9 am. Given the slow escort process, some participants arrive at the group 15 minutes before the group is scheduled to end. One group observed during the site visit started 20 minutes late because escorted participants arrived late. Group attendance in the RHU CCCMS was arranged via a process in which the officer speaks to each patient on the AQR list, asking if they want to go to a group, but not explaining the time or group topic. Patients who agree to go out for group treatment on any given day are pulled for the first available group rather than being assigned to clinically indicated groups. See the Access to Care section and Priority Recommendation 2.

Physical plant: Facility D housing units had been without hot water for more than a month because of mechanical failures during roof construction. Replacement parts were on order and expedited, and the RCT began to work with the institution to obtain a temporary hot water trailer for the area[1].

[1] On 7/18/2026 LAC received the portable water heater, and on 8/13/2026 the original issue with hot water provision was fixed.

Morning Huddle Content: The Z-Unit RHU clinician at the second watch huddle did not discuss patients in the Suicide Risk Management Program, which is a requirement.

Controlled use of force mental health assessment documentation was non-compliant: Documentation requirements were not met in any of the audited cases in four of the six months with data, overall reaching only 15% compliance over the course of the reporting period. Every controlled use of force is scrutinized for appropriate application. Appropriate assessment and documentation prior to a controlled use of force provides vital information to staff involved in the use of force. The information is particularly important when the incident extends over multiple shifts and to the reviewing officials who assess the appropriateness of force and may mitigate any consequences for the patient based on actions during the application of force.

RHU EOP has not met hub certification requirements during the review period: During each month, LAC was below 90% for treatment offered (See Access to Care) with the main driver being the monthly institutional program shutdown for training two days each month. Despite attempts by institutional leadership from both custody and mental health to add additional groups and shorten training by two hours on one of the days, this measure did not reach compliance. Other core measures below the 90% threshold during the review period include: Timely MH Referrals for December 2025 and January 2026, Out of Cell Time for all months except March 2026, and RHU Pre-Screens for all months except April 2026.

Recommendations

1. ICC participation, intake stays, and overflow conditions: See Priority Recommendation 5.
2. Group Scheduling: See Priority Recommendation 2.
3. Huddle content: Include Suicide Risk Management Program patients in every restricted housing second watch huddle and confirm it on the huddle sheet.
4. Provide training to the mental health staff who participate in controlled use of force incidents with MHSDS participants to produce and enhance quality of documentation: Documentation of the mental health assessment prior to and during controlled use of force events is an important contribution to the overall occurrence and provides vital information to the review of each incident. Use of Force training is required by policy for all staff. Provide mental health staff with focused training on completing and documenting the mental health assessment that is performed during controlled use of force incidents, review all documentation for controlled uses of force monthly, and report the results to the Mental Health Program Subcommittee until sustained compliance is achieved.

Suicide Prevention

This section evaluates the institution's suicide prevention infrastructure, including suicide risk evaluations, safety planning, MHCB clinical practices, crisis intervention, welfare checks, temporary holding cell compliance, training delivery, and post-discharge continuity. Suicide prevention indicators measure whether the clinical, custodial, and administrative components of the prevention continuum identify, respond to, monitor, and follow up with patients at risk of self-harm.

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg	Onsite Audits
Discharges from MHCB with clinician review of d/c summary	0%†			20%†	25%†	0%†	17%†	

Documentation of Acute/ICF Discharges with Clinician to Clinician Contact within 5 days	100%†		100%†		100%†	100%†	100%†	
Emergent and Urgent MH Referrals That Result in SREs	97%	98%	97%	99%	100%	98%	98%	
MHCB clinical stays within timeframes	100%	100%	100%	100%	100%	100%	100%	
MHCB Daily Provider Contacts (v2.0)	85%	85%	83%	81%	83%	88%	84%	
MHCB/PIP Supervisory Reviews of Discharge Safety Plans	19%	16%†	38%	35%	18%	38%	28%	
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training	66%	85%	91%	92%	92%	97%	87%	
Safety Plans Signed Timely	87%	89%	81%	84%	90%	91%	87%	
Timely Clinical Follow-Ups (V2.0)	39%	36%	47%	42%	48%	59%	45%	
Audited Security Welfare Checks in Restricted Housing That Included the Required Visual Observation								100%
Custody Staff with CPR Training								97%
Custody Staff with Suicide Prevention Training								97%
Healthcare staff current with suicide prevention training								94%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories								100%†
Institution SPRFIT Meeting Minutes Reviewed that Satisfy All Audit Criteria								0%†
MHCB and Acute/ICF Out of Cell Activities - Dayroom								0%†
MHCB and Acute/ICF Out of Cell Activities – Phone Calls								100%†
MHCB and Acute/ICF Out of Cell Activities - Showers								100%†
MHCB and Acute/ICF Out of Cell Activities - Visits								0%†
MHCB and Acute/ICF Out of Cell Activities - Yard								0%†
MHCB and Acute/ICF Records with Rationale for Partial Issue								0%†
MHCB Out of Cell Activities								0%†

Nursing Staff Current with CPR Training								100%
Observed Initial Health Screenings								80%†
Onsite Review of Patient Orders for Issue and Observation								91%†
Patients referred to MHCB on continuous direct visual observation								100%†
Referrals That Received a SRE When DTS or Suspected Intentional OD was not Marked on the MH Referral								93%†
RHU Intake Incarcerated Persons Appropriately Housed								100%†
Suicide Resistant Cells								100%†

✓ **Strengths**

Second Watch RHU Huddle: With one exception, the morning huddles in the D-5 RHU (EOP) and Z-Unit (CCCMS and GP) were observed to be adequate. There was full attendance and participation by all attendees, including clinicians, nursing, PTs, and custody. All topics, including new arrivals and high-risk patients, were discussed. The exception was that the Z-Unit clinician did not discuss any SRMP patients, which is required.

Suicide prevention training complete: Annual suicide prevention training achieved at least 94% compliance for custody, healthcare, and mental health staff. CPR certification reached between 97 and 100% completion for both custody and nursing.

Emergent/Urgent MH Referrals not marked for DTS: Examination of approximately 50 charts for emergent/urgent Mental Health Referrals not marked for DTS found 15 cases that required an SRE during the review period, and 93 percent (14 of 15) of these cases had the SRE completed.

New intake cell usage: Review of both the D-5 RHU (EOP) and Z-Unit RHU (CCCMS/GP) found adequate practices, and all new intake IPs were housed in new intake cells. Further, there were no new intake incarcerated persons housed in the C-5 overflow unit.

MHCB IDTTs: Overall, the MHCB IDTTs were very thorough. IDTTs were observed for five patients. All required CQI criteria were met in 4/5 observed IDTTs. Safety planning was discussed in all required cases.

Safety plans: MHCB discharge safety plans scored 100% compliance. All 5 randomly selected safety plans for patients who were discharged from the MHCB unit during the audit period were found to be individualized and contained interventions that reduce risk.

Clinical justification: Justification for rescinding crisis bed placement was reviewed for 15 patients whose MHCB LOC was rescinded. All reviewed cases had adequate justification.

Suicide risk evaluations and training trajectory: Emergent and urgent referrals resulted in an SRE 98% of the time. SRE mentoring and biennial training completion rose from 66% in December to 97% in May (87% average). All 638 alternative housing placements during the period were released within 24 hours.

Provider contacts: MHCB daily provider contacts averaged 84% on the performance report during the six-month audit period. However, a chart review of ten patients was conducted during the onsite visit. The results revealed that all ten patients were seen daily.

⚠ Concerns

Clinical follow-up: Timely clinical follow-ups were found to be compliant in 12 of 15 (80%) cases reviewed. In the three deficient cases, two cases missed one day, and one case missed two days of the follow up process. The performance report indicated overall compliance of 45% over the audit period. Safety plans were included daily in all but the three cases within the 5-day follow-up documentation.

SRMP: Three of five (60%) master treatment plans included interventions and goals that relate to the reason the patient was placed in SRMP. Two patients identified on the internal list as being in the SRMP were categorized as not applicable at the time of their most recent IDTT.

MHCB Justification: MHCB issue and observation orders were not justified in daily documentation in any of the 10 reviewed cases; however, orders were updated every day in all reviewed cases. In 4 cases, vague language was used in the daily provider justification to describe the observation level.

SPRFIT Meetings: A review of six months of SPRFIT meeting minutes (December 2025 through May 2026) found that all meetings failed to have a quorum of all required members or designees due to non-attendance by the Senior Psychiatric Technician (PT) or the PT designee. Although meeting minutes included discussion on compliance data, improvement projects, and brief review of patients in the SRMP, there was a serious suicide attempt with medical severity ratings of "3" in November 2025 that was not addressed as a clinical case review and/or root cause analysis in subsequent monthly meeting minutes, and the minutes did not document attendance at either the IP Family Council or IP Advisory Council meeting (where attendance for both is required once every 6 months).

Temporary Holding Cell Logs: Examination of Temporary Holding Cell (THC) Logs for the four main yards that utilized THCs during the review period found that 43 individuals were confined in the cells for DTS in excess of four (4) hours, with most stays ranging from 4.5 to 6 hours. Approximately 86 percent (37 of 43) of THC usage over 4 hours occurred on D-Yard.

Safety Plans for Rescinded patients: An additional review of 15 rescinded MHCB cases (from alternative housing) found that the required safety plan was not completed in one case, and only one of the 14 (or 7%) remaining cases had an adequate safety plan.

Out-of-Cell Time offered: Review of out-of-cell time offered to 10 MHCB patients during the review period found that five of the patients were never offered yard/dayroom and the remaining five patients were offered limited yard/dayroom of between 45 minutes and 2 hours. The overall average for these 10 patients was 33 minutes, well below the required offering of 10 hours per week.

Crisis Intervention Team: A CIT response was initiated on the morning of July 14. A patient was referred for DTS by a substance use disorder clinician based upon an interaction earlier that morning. Prior to the CIT clinician's arrival, a yard clinician who was previously scheduled to see the patient completed a routine MH assessment without the benefit of reviewing the substance use disorder clinician's DTS referral. The patient was then cleared back to his housing unit without being assessed by the CIT. The required SRE was not completed.

In addition, although the facility's Crisis Intervention Policy was last revised in February 2024 and only listed the availability of CIT during the third shift, local leadership informed the review team that availability was also extended to the second shift. The review team, however, found that the response from the full team was inconsistent on both shifts.

MHCB discharge and supervisory reviews: Discharges from the MHCB with clinician review of the discharge summary averaged 17% (small sample), and MHCB supervisory reviews of discharge safety plans averaged 28%; the Review Team found multiple cases missing from the supervisor's review list. Records did not document a rationale for providing the patients with partial issue (limited access to normal closing and property) in any of the cases reviewed (small sample).

Provider Orders: The review ream observed a Mental Health Observations Status/Door Tag Form placed in front of the Adaptive Support Forms for each patient. Although the form was said to be an attempt to summarize the observation, possessions, and privileges allowed for each patient, the forms were not updated on a daily basis, did not contain observation level orders, and were potentially confusing because they were often inconsistent with current orders on the Adaptive Support Forms. Use of the Mental Health Observations Status/Door Tag Forms should be discontinued.

Recommendations

1. Clinical Follow-Ups, issue and observation justification, SPRFIT, holding cell stays, safety planning, and MHCB out-of-cell time: See Priority Recommendation 4.

2. RHU overflow privileges: See Priority Recommendation 5.

3. Update the CIT policy: LOP No. 30 should be updated to include availability on second and third shifts and improve consistency in deploying of the full team to include nursing and a custody supervisor.

4. Discontinue or standardize the Mental Health Observation Status/Door Tag Forms in the MHCB: Either discontinue the forms or ensure they are updated daily and are consistent with the Adaptive Support Forms (CDCR 128 C-2).

5. Remove "Intake Cell" stenciling from three cells: Cells 109-111 in the Z-Unit, previously found to be not suicide-resistant and deactivated on July 13, 2026, should have intake cell stenciling removed, or be retrofitted to be suicide-resistant by removing the metal shelves on the wall of each cell.

Sustainable Process and Utilization Review

This section evaluates MHCB utilization review processes, including clinical stay compliance with established timeframes and the timeliness of transfers to crisis-level care. Sustainable process indicators measure whether MHCB admissions proceed through acute stabilization and discharge planning at the pace the clinical model requires, and whether patients requiring crisis-level care are transferred without avoidable delays. A comprehensive report containing the detailed findings from the Regional Sustainable Process Review is provided separately and is not attached to this document.

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg
MHCB clinical stays within timeframes	100%	100%	100%	100%	100%	100%	100%
Timely Transfer to MHCB (v2.0)	100%	93%	97%	100%	100%	89%	96%

✓ **Strengths**

Referral submission and consistency: A total of 22 Acute Psychiatric Program (APP) and 21 Intermediate Care Facility (ICF) referrals were initiated at LAC's MH programs. The performance report indicated that 84% of APP/ICF referrals were submitted to the Inpatient Referral Unit (IRU) within required timeframes; however, further analysis indicated that all (N = 43), or 100%, of APP/ICF referrals were submitted to the IRU within required timeframes. Six cases reflected as overdue were due to data entry errors. All data entry discrepancies were reviewed with the Inpatient Coordinator (IPC). Master treatment plan documentation was consistent with EHRS entries in 7 of 8 non-referral cases sampled. Housing officers on every tier who were interviewed knew their patients, and no patient required an urgent referral.

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

⚠ Concerns

Non-referral decisions: During the review period, there were 1,157 IDTT decisions not to refer for HLOC despite one or more HLOC considerations being met. Consideration 7 (insufficient structured treatment hours) was cited in 80% of the non-referral decisions, and more than one consideration was cited in 22%.

MHPS minutes: The Health Program Manager I was dropped from the required-member list because the position is vacant, and the Senior Psychologist Specialist training coordinator was listed as a required member; neither change is consistent with policy. As in prior reviews, the minutes did not assess interventions or address trends and barriers.

Sustainable process data review: LAC's HQ Data Review scores for HLOC Considerations have remained below 85% since Q4 2022, ranging from 15% to 56%. For Q2 2026, HQ Data Review audit identified 36% (21 cases of 58) of non-referred cases with "good" Higher Level of Care (HLOC) Considerations documentation. The quality of HLOC Considerations documentation improved only 3% since Q1 2026.

Recommendations

1. MHPS membership and minutes: List the Health Program Manager I as a required member and record the vacancy, move the training coordinator to local committee members, and use the minutes to assess interventions and trends each month.

2. HLOC Considerations Documentation: See Priority Recommendation 1. In addition, the IPC should continue to provide feedback to Mental Health Primary Clinicians (MHPCs) on the quality of HLOC Considerations documentation according to HQ standards. Maintain a tracking system to monitor the quality of HLOC Considerations documentation assessed by the IPC during monthly local audits to identify barriers and trends and modify interventions as needed.

Staffing

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

Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief Psychologist	2.0	2.0	0%
Chief Psychiatrist	1.0	1.0	0%
Senior Psychiatrist (Supervisor)	1.0	0.0	100%
Senior Psychologist (Supervisor)	6.5	3.92	40%
Supervising Psychiatric Social Worker I	1.0	1.0	0%
Senior Psychologist (Specialist)	6.5	6.17	5%
Recreation Therapist	18.75*	11.0	41%
Staff Psychiatrist	12.75*	13.37	0%
Psychologist – Clinical	8.25*	7.75	6%

Clinical Social Worker	2.5	2.5	0%
Primary Clinician (PC)	52.25*	48.43	7%
PC: Psychologist – Clinical		22.82	
PC: Clinical Social Worker		18.99	
PC: Marriage and Family Therapist		5.46	
PC: Professional Clinical Counselor		1.17	

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

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

**Indicates a weighted average of allocated positions across different allocation periods.*

✓ Strengths

Leadership and line clinician fill: The Chief Psychologist, Chief Psychiatrist, and Supervising Psychiatric Social Worker I positions were filled. Staff Psychiatrist positions were filled above allocation (13.37 on 12.75); filled counts can exceed the allocated count when an institution over-hires to cover leave or anticipated vacancies. Primary clinician (7%), clinical social worker (0%), and Senior Psychologist Specialist (5%) vacancy rates were low.

⚠ Concerns

Supervisory vacancies: Senior Psychologist (Supervisor) positions were 40% vacant (3.92 filled of 6.5). The Health Program Manager I position was also vacant. These gaps are consistent with the supervisory findings elsewhere in this report: IDTT required staffing was 44%, supervisor attendance at huddles was 57%, and supervisory review of discharge safety plans was 28%.

Recreation therapists: Recreation Therapist positions were 41% vacant (11.0 filled of 18.75, including registry staff), consistent with structured treatment offered at 59%.

Recommendations

1. Work with CCHCS HR to fill supervisory and recreation therapy vacancies: Work with CCHCS HR to recruit for the Senior Psychologist (Supervisor), and Recreation Therapist positions, and until they are filled, assign interim supervisory coverage for IDTT observation, huddle attendance, and safety plan review so those functions do not lapse. Report fill status monthly to the MHPS. If attempts to fill these positions are unsuccessful, elevate through the RCT for assistance from the MH Receiver.

Receiver's Signature Page



Date: 10/23/26

Appendix A: Acronyms and Initialisms

Acronym List	
ARHR	Automated Restricted Housing Record
ASP	Avenal State Prison
APP	Acute Psychiatric Program
ASH	Atascadero State Hospital
AVSS	Audio Video Surveillance System
BPT	Board of Prison Terms
C&PR	Classification and Parole Representative
CAL	Calipatria State Prison
CAP	Corrective Action Plan
CBC	Complete Blood Count
CC I	Correctional Counselor I
CC II	Correctional Counselor II
CCAT	Correctional Clinical Assessment Team
CCCMS	Correctional Clinical Case Management System
CCHCS	California Correctional Health Care Services
CCI	California Correctional Institution
CCWF	Central California Women's Facility
CDCR	California Department of Corrections and Rehabilitation
CEN	Centinela State Prison
CEO	Chief Executive Officer
CHCF	California Health Care Facility
CHSA	Correctional Health Services Administrator
CIM	California Institution for Men
CIT	Crisis Intervention Team
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
CMH	Chief of Mental Health
CMHPP	Custody and Mental Health Partnership Plan
CMP	Comprehensive Metabolic Panel
CNE	Chief Nurse Executive
COR	California State Prison, Corcoran
CPR	Cardiopulmonary Resuscitation
CQIR	Continuous Quality Improvement Report
CQIT	Continuous Quality Improvement Tool
CQI	Continuous Quality Improvement
CRC	California Rehabilitation Center
CTC	Correctional Treatment Center
CTF	Correctional Training Facility
D/C	Discharge
DAI	Division of Adult Institutions
DAR	Daily Activity Report
DCHCS	Division of Correctional Health Care Services
DOT	Direct Observed Therapy
DSH	Department of State Hospitals

DTS	Danger to Self
EHRS	Electronic Health Records System
EIS	Enterprise Information Services
EOP	Enhanced Outpatient Program
ERRC	Emergency Response Review Committee
FIT	Focused Improvement Team
GP	General Population
HCPOP	Health Care Placement Oversight Program
HDSP	High Desert State Prison
HLOC	Higher Level of Care
HPS I	Health Program Specialist I
HQ	Headquarters
IAC	Inmate Advisory Council
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Interdisciplinary Treatment Team
IP	Incarcerated Person
IPC	Inpatient Coordinator
IRU	Inpatient Referral Unit
ISP	Ironwood State Prison
IST	In-Service Training
ISUDT	Integrated Substance Use Disorder Treatment
KOP	Keep On Person
KPI	Key Performance Indicator
KVSP	Kern Valley State Prison
LAC	California State Prison, Los Angeles County
LOC	Level of Care
LOP	Local Operating Procedure
LOS	Length of Stay
LRH	Least Restrictive Housing
LTSCC	Long-Term Segregated Case Conference
MA	Medical Assistant
MAPIP	Medication Administration Process Improvement Program
MCSP	Mule Creek State Prison
MERD	Minimum Eligible Release Date
MH	Mental Health
MHA	Mental Health Administrator
MHCB	Mental Health Crisis Bed
MHCBC	Mental Health Case-by-Case Review
MHCT	Mental Health Compliance Team
MHMD	Mental Health Medical Doctor
MHPC	Mental Health Primary Clinician
MHPS	Mental Health Program Subcommittee
MHSDS	Mental Health Services Delivery System
ML	Mainline
ML CCCMS	Mainline Correctional Clinical Case Management System
ML EOP	Mainline Enhanced Outpatient Program
MSF	Minimum Support Facility

MTP	Master Treatment Plan
NA	Nurse Administered
NDRH	Non-Disciplinary Restricted Housing
NDPF	Non-Designated Programming Facility
NKSP	North Kern State Prison
OA	Office Assistant
OCA	Out-of-Cell Activity
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
RCT	Receiver’s Compliance Team
RHU	Restricted Housing Unit
RHU CCCMS	Restricted Housing Unit Correctional Clinical Case Management System
RHU EOP	Restricted Housing Unit Enhanced Outpatient Program
RHU GP	Restricted Housing Unit General Population
RJD	Richard J. Donovan Correctional Facility
RT	Recreation Therapist
RVR	Rules Violation Report
RVR-MHA	Rules Violation Report – Mental Health Assessment
SAC	California State Prison, Sacramento
SATF	Substance Abuse Treatment Facility
SCC	Sierra Conservation Center
SHO	Senior Hearing Officer
SNY	Sensitive Needs Yard
SOL	California State Prison, Solano
SOMS	Strategic Offender Management System
SPRFIT	Suicide Prevention and Response Focused Improvement Team
SQRC	San Quentin Rehabilitation Center
SRASHE	Suicide Risk and Self Harm Evaluation
SRE	Suicide Risk Evaluation
SRMP	Suicide Risk Management Program
SRN II	Supervising Registered Nurse II
SRN III	Supervising Registered Nurse III
SUD	Substance Use Disorder
SVPP	Salinas Valley Psychiatric Program
SVSP	Salinas Valley State Prison
T4T	Training for Trainers
TCM	Timely Compliance Methodology
TCMP	Transitional Case Management Program

THC	Temporary Holding Cell
TTA	Treatment and Triage Area
UM	Utilization Management
UOF	Use of Force
VPP	Vacaville Psychiatric Program
VSP	Valley State Prison
WSP	Wasco State Prison

Appendix B: Suicide Prevention Report

Restricted Housing Unit (RHU)

LAC has two Restricted Housing Units (RHUs): one Correctional Clinical Case Management (CCCMS) RHU (RHU-1) in Z-Unit and one RHU Enhanced Outpatient (EOP) hub in D-5 Unit. There were nine (9) New Intake Cells (100-108) in the Z-Unit and seven (7) new intake cells (122-128) in the EOP RHU (D-5). Most of these cells had been previously retrofitted to be suicide-resistant. Of note, three cells (109-111) in the Z-Unit were found to be non suicide-resistant during a previous assessment because the metal shelf on the wall of each cell could be utilized as an anchoring device in a suicide attempt by hanging. The unsafe cells were finally deactivated on the morning of July 13, 2026, the first day of the onsite audit. During inspection of both units, the review team did not observe any new intake IPs housed in non-intake cells in either D-5 or the Z-Unit.

LAC currently utilizes C-5 for RHU Overflow housing. C-5 does not contain any new intake cells. There were between seven and eight patients in C-5 during the onsite assessment, and none of these individuals were on 72-hour new intake status. However, Guard One was not available on the unit and officers documented 30-minute rounds on paper. In addition, patients in RHU Overflow were not afforded either yard or telephone privileges.

There was significant improvement in the appropriate use of new intake cells at LAC since the previous assessment.

Second Watch Partnership Huddle: With one exception, the morning huddles in the D-5 RHU (EOP) and Z-Unit (CCCMS and GP) were observed to be adequate. There was full attendance and participation by all attendees, including clinicians, nursing, PTs, and custody. All areas, including new arrivals and high-risk patients, were discussed. The exception was that the Z-Unit clinician did not discuss any SRMP patients, which is a requirement.

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

Intake Cells: Please refer to the CQIR for a summary of other findings.

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

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

Mental Health Crisis Bed (MHCB) Inpatient Unit

MHCB IDTT Meetings: A total of five MHCB IDTT meetings were completed during the onsite review. Three of the five IDTT meetings were for patients discharged to a lower level of care and two were initial meetings. All patients were admitted for suicidal ideation/danger to self. None of the patients were placed in mechanical restraints while the meeting was being conducted.

Each IDTT meeting began on time. The IDTT treatment room included a table and chairs. During meetings observed on July 14th, water was leaking from the ceiling through the light fixture in the treatment room. Four waste baskets were placed around the room to catch the dripping water. However, this issue was resolved during IDTT meeting observations on July 16th. The primary clinicians, RN, and CCI had access to their

laptops during the meetings; however, in two IDTT meetings observed on July 14th, a psychiatrist did not have access to a laptop.

Overall, with one exception, the IDTT discussion in each case was very thorough, and information was provided in an organized and succinct manner. Three primary clinicians presented the five cases, with the first clinician presenting one case that was problematic, and the two other clinicians presenting the remaining four cases. In the other four cases, the primary clinicians initiated introductions and stated the purpose of the IDTT meetings. Four patients were on Suicide Precaution observation status, and one patient was on Suicide Watch. Three patients were ordered full issue, and two were issued safety smocks. Appropriateness of issue and observation status were discussed in all four cases. The primary clinicians in the four IDTT meetings provided relevant historical and brief clinical summaries that included current symptomatology, diagnosis, reason for admission, hospitalizations, and strengths and weaknesses. In four of the five cases, adequate case formulations were presented. RVRs were discussed in four cases. Each patient was given an opportunity to provide input regarding their treatment while in the MHCB unit. Safety planning was discussed during four of the five cases.

Measurable treatment goals were identified and discussed in all cases. Medication and side effects were discussed by the psychiatrist in all cases. The CCI and nursing staff were engaged and provided pertinent information for each patient. All IDTT members contributed to the discussion in all meetings. Issue and observation levels were discussed in four cases. Higher level of care and appropriateness of level of care were also discussed for each of the five patients. In sum, with the exception of one case, the IDTT meetings were comprehensive.

MHCB Supervisor Review of Discharging Safety Plans: A review of the On Demand Performance Report during the audit period indicated 87 percent of reviewed safety plans were completed timely (n=531); however, only 28 percent of the required safety plans were reviewed timely by a supervisor. The review team conducted an additional review of a list of safety plans reviewed by the MHCB supervisor or designees during December 2025 through May 2026, found that multiple cases were excluded from the list and, therefore, not reviewed as required.

Quality of Safety Planning: Five randomly selected safety plans for patients who were discharged from the MHCB unit during the audit period were reviewed. All five safety plans were deemed to be of adequate quality. All reviewed safety plans contained interventions and were individualized to address patient specific concerns.

Observation and Issue Orders: A review of daily documentation for 10 patients who were admitted to the MHCB for DTS during the audit period was completed. Daily issue and observation orders were present in all of the reviewed patients' charts. Justification for the issue and observation status were not present for all days required in the reviewed daily documentation. Four patients' documentation included vague language such as "con't obs or MH obs". The majority of patients were discharged on Suicide Precaution observation despite denying suicidal ideation for several days prior to their discharge. In several reviewed cases, the patient's observation level was changed to Q-30 only after the patient had been clinically discharged.

Provider Orders (to include level of observation, patient issue, and privileges): The review found these were placed outside each suicidal patient's door on Adaptive Support Forms (CDCR 128 C-2) and found to be current. The review team also observed a Mental Health Observations Status/Door Tag Form placed in front of the Adaptive Support Forms for each patient. Although the form was said to be an attempt to summarize the observation, possessions, and privileges allowed for each patient, the forms were not updated on a daily basis, did not contain observation level orders, and were potentially confusing because they were often inconsistent

with current orders on the Adaptive Support Forms. Use of the Mental Health Observations Status/Door Tag Forms should be discontinued.

Provider Contacts: The review team examined multiple medical charts of patients who were on suicide observation status in the MHCB unit during the review period. The review of ten patients' charts found that all of the patients were consistently seen on a daily basis by the provider, either MHMD or MHPC, during the entirety of their inpatient placement. In addition, the chart review found that most patients were consistently offered out-of-cell assessments on a daily basis by providers.

Privileges: The review team conducted an additional review of the Automated Restricted Housing Record (ARHR) system for documentation of out-of-cell activity for 10 MHCB patients during seven-day periods in April through May 2026. All patients reviewed were on suicide observation for all or most of the seven-day periods and cleared for out-of-cell activities by providers. Appointments with MH clinicians were excluded from review criteria. The review found that five of the patients were never offered yard/dayroom, and the remaining five patients were offered limited yard/dayroom of between 45 minutes and 2 hours. The overall average for these 10 patients was 33 minutes, well below the required offering of 10 hours per week. Finally, all patients averaged 2.6 showers and 1 telephone call per week.

Clinical Discharge Follow Ups: A sample of 15 clinical discharge follow ups that were completed during the audit period were selected. The results revealed that 80 percent (12/15) of cases contained five consecutive days of follow-up contacts. In the three deficient cases, two cases missed one day, and one case missed two days of the follow up process. Safety plans were included daily in all but the three cases of missing documentation. The On Demand Performance report indicated that LAC was 45 percent compliant during the audit period for completion of safety plans within the 5-Day Follow Up form. Completion of safety plans within the 5-Day Follow Up form was previously identified and is included on LAC's Improvement Priorities List.

Alternative Housing

Alternative Housing cells to temporarily house patients awaiting MHCB placement were primarily found in two locations: D-2 Unit and the two RHUs (Z-Unit and D-5). In D-2, cells 129-138 were designated for alternative housing. In the two RHUs, any cell could be utilized for alternative housing, but the new intake cells were preferred if available.

Alternative Housing was utilized on a daily basis at LAC. From December 2025 through May 2026, there were 638 patients placed in alternative housing, an average of more than three per day. All patients were released within 24 hours. The majority (384 of 638, 60 percent) of the MHCB referrals were rescinded and patients returned to their respective housing units. According to the On Demand Performance Report, 91 percent of cases were found to have SREs completed.

Medical chart review of 15 rescinded cases found that all required SREs were completed, but only 79 percent (11 of 14) of applicable daily clinical follow-ups for each of the five required days were completed. In addition, the review found that only 7 percent (1 of 15) of the cases had adequate safety plans containing specific interventions to reduce suicide risk, with the remaining cases having inadequate (14) or no (1) safety plans completed. All cases had adequate clinical justification for the rescission.

The review team observed clinical assessments of three patients housed in Alternative Housing on July 16. All three patients were offered confidential interview space, and all three patients were subsequently cleared and returned to their respective housing units. SREs and safety plans were completed in each case.

Finally, examination of Temporary Holding Cell (THC) Logs for the four main yards that utilized THCs during the review period found that 43 individuals were confined in the cells for DTS in excess of four hours, most from between 4.5 to 6 hours in the cell. Approximately 86 percent (37 of 43) of THC usage over 4 hours occurred on D-Yard. THC usage in the other yards was 1 in A-Yard, 1 in B-Yard, and 4 in C-Yard.

Suicide Risk Management Program (SRMP)

LAC maintains an internal SRMP list. A review of Master Treatment Plans for five patients enrolled in the SRMP according to the internal list revealed that 60 percent (3/5) had interventions and goals documented within the SRMP tab of the Master Treatment Plan. Two patients identified on the internal list as being in the SRMP were categorized as 'not applicable' at the time of their most recent IDTT.

Discharge Custody Checks

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

Local SPRFIT Committee

A review of six months of SPRFIT meeting minutes (December 2025 through May 2026) found that all meetings failed to have a quorum of all required members or designees due to non-attendance by the Senior Psychiatric Technician (PT) or designee PT. In addition, team members were incorrectly listed as simultaneously covering the absence of another team member; for example, the chief nurse executive listed as the designee for the supervising RN, as well as for the PT. Finally, the meeting template incorrectly listed an RN as a designee for PTs, as well as the MHCB supervisor, a non-psychiatrist, as a designee for the psychiatrist.

Although meeting minutes included discussion on compliance data, improvement projects, and brief review of patients in the SRMP, there was a serious suicide attempt with medical severity ratings of "3" in November 2025 that was not addressed as a clinical case review and/or root cause analyses in subsequent monthly meeting minutes. The status of corrective actions based upon prior Receiver's suicide prevention expert assessments and/or regional SPRFIT audits were absent from the minutes and appendices. In sum, only 2 of 5 significant SPRFIT compliance areas were adequate.

Of note, the SPRFIT minutes did not include any attendance at either the IP Family Council or IP Advisory Council meetings (where attendance for both is required once every 6 months).

Policies: LAC had a SPRFIT policy (LOP 36) that was last revised in October 2025. In addition, a "Bad News" policy was last revised in August 2025. The facility's Suicide Prevention policy (LOP 31) addressed designated housing locations for Alternative Housing and was last revised in October 2025. The SRMP policy was last revised in March 2025. Finally, and as referenced above, although the facility's Crisis Intervention Policy was last revised in February 2024 and only listed the availability of CIT during the 3rd shift, local leadership informed the review team that availability was also extended to the 2nd shift, but response from the full team was inconsistent on both shifts.

Suicide Risk Evaluations in MHCB and Outpatient

During the audit period, LAC generated 826 emergent consult orders for DTS with 98 percent compliance. SRE completion upon MHCB discharge was 99 percent compliant. However, SRE completion upon MHCB referral was noted at 73 percent. The lower compliance is attributed to MHCB referrals generated after hours and not completed until the next day when a MHPC is present, which often exceeds the 12-hour timeframe. SRE completion at the time of a MHCB rescission was 91 percent. LAC had six patients arrive from DSH during the audit period. One SRE was not completed timely, resulting in 83 percent compliance. Overall timeliness of suicide risk evaluation completion during the audit period was 79 percent.

Urgent and Emergent Referrals Not Marked for Danger to Self

Examination of approximately 50 charts for emergent/urgent Mental Health Referrals not marked for DTS found 15 cases that required an SRE during the review period, and 93 percent (14 of 15) of these cases had the SRE completed. These findings were an improvement from the previous assessment which found only 85 percent compliance.

Quality Improvement Plans (QIPs) Generated by Suicide Case Reviews

CSP/LAC's last suicide occurred on October 25, 2025, which resulted in two mental health QIPs. A QIP was issued regarding the timelines for a MHPC Initial Assessment and an Initial IDTT meeting that were completed significantly late. The other QIP was issued due to no follow up cell side contacts upon the patient's refusal of confidential clinical contacts.

Crisis Intervention Team (CIT)

The Crisis Intervention Team was initiated in May 2018, and its full activation has varied during previous years. The most recent LOP (Crisis Intervention Team, No. 30) has not been updated since February 2024 and states that "CIT operating hours shall include third watch hours and are based upon local institution utilization rates." During the current onsite assessment, local mental health leadership informed the review team that availability had also been extended to the 2nd shift, but response from the full team was inconsistent on both shifts.

During the three-day onsite assessment, the review team was only notified of one potential CIT response, and that response was aborted. In the case, the CIT response was initiated on morning of July 14. The patient was referred for DTS by a SUD clinician based upon interaction earlier that morning. The review team accompanied the CIT clinician to the yard, and the clinician, prior to gathering a nurse and custody supervisor on the yard, went to the Program Office to locate the patient's location. Upon arrival, the CIT clinician was informed by a yard clinician that the patient had already been seen, assessed, and cleared back to his housing unit. Although this clinician had completed an initial mental health assessment, the required SRE was not completed and the full CIT was never initiated.

In addition, one member of the review team came upon another emergent mental health referral for DTS that should have resulted in full CIT deployment but was instead handled by a yard clinician. The required SRE was completed in that case.

Training and Mentoring Compliance

Compliance with the Annual IST Suicide Prevention Training for 2025 revealed the following: 96 percent of custody, 100 percent for medical, and 95 percent for mental health staff. Compliance with Coleman training requirements for May 2026 found compliance for all suicide prevention trainings as indicated below.

- Understanding & Assessing Presence, Severity & Risk of Suicidality: 98%
- Safety Planning: 95%
- Suicide Risk Management Program: 100%
- CPR Certification - Custody: 97% and Nursing: 100%

Assignment of Corrective Action Plan and Recommendations

The last HQ SPRFIT review was completed on January 22 and 23, 2025. At that time, ten CAPs remained open and two additional CAPs were generated.

Please ensure all assigned open SPRFIT CAPs and new recommendations are updated on the Improvement Priorities List and Project Pipeline. All SPRFIT CAPs should be listed as an Issue and updated monthly audit data included in the comment section each month on the Improvement Priorities List and Project Pipeline. The project pipeline is to be uploaded to the Suicide Prevention SharePoint site monthly.

Should you have any questions or require further clarification, please email the suicide response and prevention unit: <m_MHProgramSuicidePr@cdcr.ca.gov >

	Summary of concern	Progress	Follow up status
1	Discharge custody checks	None	Remain open.
2	Non-confidential crisis-response contacts	None	Remain open.
3	SPRFIT meeting minutes.	Moderate	Remain open.
4	Patients denied clothing during the five day follow up process.	None	Remain open.
5	Inconsistent review of safety plans during five day follow ups.	Moderate	Remain open.
6	Inappropriate placement of patients in alternative housing.	Substantial	Close
7	RHU appliances	Minimal	Remain open.
8	Completion of SREs for emergent and urgent referrals	New	Remain open
9	Poor compliance with RHU screens	New	Remain open

Two CAPs previously assigned which addressed patients denied clothing during the five day follow up process (4) as well as inappropriate placement of patient in alternative housing (6), can be closed at this time.

Conclusion

In addition to the previously assigned and currently open CAPs, the following recommendations were generated:

1) Remove "Intake Cell" stenciling from the three cells (109-111) in the Z-Unit previously found to be non-suicide resistant and deactivated on July 13, 2026, or retrofit those cells to be suicide-resistant by removing the metal shelves on the wall of each cell.
2) Ensure that patients housed in RHU Overflow (currently in C-5) are provided access to regular yard and telephone privileges as required by Title 15.
3) Ensure that justification for issue and observation orders for MHCB patients are present in daily documentation. Justification should include the rationale for placing a patient at a particular level of observation. Justification should also be provided for patients on restricted issue which detail the patient's unique risk factors and clinical need. General statements of risk and/or providing minimal items without justification are not acceptable.
4) Discontinue use of Mental Health Observations Status/Door Tag Forms for MHCB patients or ensure the forms are updated daily to be consistent with Adaptive Support Forms (CDCR 128 C-2).
5) Ensure that MHCB patients are offered a minimum of 10 hours of out-of-cell activities per week.
6) Ensure that clinical follow-ups are completed for a minimum of 5 consecutive days.
7) Provide refresher training on individualized safety planning to all clinical staff, with mandatory participation for clinicians routinely assigned to MHCB rescissions and MHCB discharges. Emphasize that safety plans must reflect the patient's specific risk factors, be developed collaboratively with the patient, and not consist of stock phrasing. Initiate monthly reviews of safety plans for rescinded MHCB referrals and MHCB discharges who require safety plans, with individual mentoring for plans that do not meet standards.
8) Ensure that the maximum length of stay for patients held in THCs for DTS does not exceed four hours.
9) Improve the quality of requirements for SPRFIT Meeting minutes, such as maintaining quorums for all required members or designees and eliminating inappropriate designees, indicate status of corrective actions based upon prior Receiver's suicide prevention expert assessments and/or regional SPRFIT audits, document attendance at Inmate Family Council and/or Inmate Advisory Council meetings, etc.
10) Update the CIT policy (LOP No. 30) to include availability on 2nd and 3rd shifts and improve consistency for deployment of the full team to include nursing and custody supervisor.

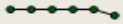
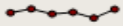
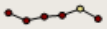
Appendix C: MAPIP

Population Health Management	6 Months	Trend	DEC	JAN	FEB	MAR	APR	MAY
Diagnostic Monitoring (All)	**86%**		**87%**	**87%**	**84%**	**86%**	**87%**	**86%**
QT Prolongation EKG 12 Months	92%		82%	90%	90%	100%	100%	92%
Antipsychotics (All)	88%		90%	88%	85%	86%	90%	88%
Lipid Monitoring	70%		77%	79%	59%	62%	71%	74%
Blood Sugar	78%		83%	79%	67%	69%	85%	88%
EKG	50%		-	-	-	100%	-	0%
AIMS	79%		85%	77%	80%	83%	77%	71%
Med Consent	91%		93%	83%	93%	94%	93%	91%
CBC with Platelets	87%		95%	82%	83%	86%	82%	93%
CMP	89%		95%	81%	83%	85%	91%	100%
Thyroid Monitoring	82%		95%	80%	76%	82%	88%	70%
Blood Pressure	99%		98%	99%	99%	100%	100%	99%
Height	97%		96%	96%	99%	97%	100%	95%
Weight	98%		97%	97%	99%	100%	100%	96%
Pregnancy	-		-	-	-	-	-	-
Clozapine (All)	100%		100%	-	-	-	100%	100%
Blood Sugar	-		-	-	-	-	-	-
Lipid Monitoring	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
EKG	-		-	-	-	-	-	-
AIMS	100%		-	-	-	-	-	100%
Thyroid Monitoring	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-

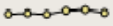
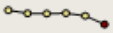
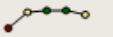
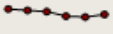
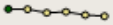
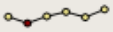
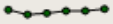
LAC CQI Report | 2026

Blood Pressure	100%		100%	-	-	-	-	-
Height	100%		-	-	-	-	100%	-
Weight	100%		100%	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-
Mood Stabilizers (All)	77%		73%	81%	74%	78%	78%	76%
Carbamazepine (All)	-		-	-	-	-	-	-
Carbamazepine Level	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-
Valproic Acid (All)	78%		65%	83%	79%	88%	74%	73%
Med Consent	88%		0%	67%	100%	100%	100%	100%
Blood Pressure	98%		100%	100%	100%	93%	100%	100%
Height	96%		100%	100%	100%	83%	100%	100%
Valproic Acid Level	39%		33%	43%	45%	50%	30%	36%
CBC with Platelets	65%		70%	70%	62%	86%	50%	57%
CMP	64%		60%	63%	69%	83%	50%	64%
Weight	98%		100%	100%	100%	93%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Lithium (All)	69%		70%	70%	72%	43%	73%	82%
Lithium Level	22%		25%	50%	0%	0%	0%	50%
Thyroid Monitoring	45%		50%	50%	50%	20%	50%	50%
CMP	59%		50%	75%	60%	25%	33%	86%
CBC	40%		100%	0%	0%	-	50%	-

LAC CQI Report | 2026

EKG	79%		100%	50%	100%	100%	50%	100%
Med Consent	85%		100%	100%	50%	100%	67%	100%
Height	100%		100%	100%	100%	100%	100%	100%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Oxcarbazepine (All)	83%		91%	90%	65%	88%	93%	79%
CBC	79%		90%	88%	58%	75%	90%	75%
CMP	75%		88%	88%	45%	83%	90%	67%
Med Consent	98%		100%	100%	100%	100%	100%	92%
Pregnancy	-		-	-	-	-	-	-
Lamotrigine - Med Consent	100%		-	100%	100%	-	-	-
Antidepressants (All)	86%		85%	87%	88%	89%	84%	85%
EKG (Tricyclics)	100%		-	-	-	100%	-	-
Med Consent	91%		90%	93%	94%	94%	91%	87%
Thyroid Monitoring	68%		68%	72%	67%	69%	62%	72%
Pregnancy	-		-	-	-	-	-	-
Venla Blood Pressure	99%		100%	100%	100%	100%	100%	94%
Medication Management	**6 Months**	**Trend**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**
Medications Received Timely (All)	**77%**		**79%**	**77%**	**77%**	**76%**	**77%**	**77%**
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	93%		-	-	-	93%	-	-
Intra-System (Within Institutions) – GP	70%		72%	62%	68%	69%	78%	65%

LAC CQI Report | 2026

Intra-System (Within Institutions) – RHU	87%		85%	85%	84%	88%	89%	86%
Intra-System (Within Institutions) – MH Inpatient	79%		86%	81%	81%	81%	78%	66%
Intra-System (Within Institutions) – Specialized Medical	86%		62%	89%	92%	92%	85%	-
Inter-System (Between Institutions) – GP	71%		74%	73%	72%	67%	66%	69%
Inter-System (Between Institutions) – RHU	86%		90%	89%	85%	86%	82%	81%
Inter-System (Between Institutions) – MH Inpatient	75%		85%	30%	76%	55%	89%	99%
Inter-System (Between Institutions) – Specialized Medical	95%		-	-	-	-	-	95%
Return to CDCR – GP	79%		77%	68%	78%	84%	76%	88%
Return to CDCR – RHU	63%		100%	100%	88%	47%	47%	87%
Return to CDCR – MH Inpatient	27%		-	-	100%	-	-	20%
Return to CDCR – Specialized Medical	91%		88%	61%	-	-	97%	98%
Stable Housing	77%		79%	77%	77%	76%	77%	77%
Leaving CDCR	97%		99%	93%	95%	98%	98%	100%
By Provider Type								
Psychiatry	77%		78%	77%	76%	76%	76%	77%
By Provider Type								
Psychiatry - Refused	3%		3%	3%	3%	3%	3%	2%
Non-Formulary by Psychiatrists	**4.0%**		**4.1%**	**3.8%**	**3.9%**	**3.9%**	**4.1%**	**4.2%**

Appendix D: Sustainable Process Report

Sustainable Process Report for California Department of Corrections and Rehabilitation
CALIFORNIA STATE PRISON, LOS ANGELES COUNTY (LAC)

On-Site Review
July 14 – 17, 2026

Review Period
March 1 – June 30, 2026

PARTICIPANTS

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

Institutional Mental Health Staff
Chief Executive Officer (CEO) – Christina Galstian
Chief Psychologist (CP) – Avetis Topchyan, Psy.D., CCHP
Chief Psychologist, Acting (A) – Armine Gevorkyan, Ph.D.
Chief Psychiatrist – Oleg Liflyandsky, M.D., CCHP-MH
Inpatient Referrals Coordinator (IPC) – Maria I. Holtrop, Psy.D.

AREAS REVIEWED

Area Reviewed:	Higher Level of Care Considerations HQ Review – Prior Review 33% (Q1 2026)

LAC's 2026 Sustainable Process visit took place this quarter during their CQI+ review from July 14th to 17th, 2026. The results of the Q2 and Q3 HLOC Considerations HQ Data Review will be addressed in this report.

For Q2 2026, a random sample of 58 HLOC Considerations cases were reviewed by LAC's IPC and HQ's reviewer for the quality of documentation. The results of Q2's HQ Data Review were finalized and distributed to LAC and the MH Regional Team on 07/06/26. LAC's IPC identified 83% "good" cases, and the HQ reviewer identified 36% "good" cases. On 07/06/26, LAC's IPC reported being in the process of addressing all relevant "unacceptable" cases, including rescheduling 12 patients for a new IDTT to appropriately address HLOC Considerations in the documentation.

A total of 37 cases were identified as "unacceptable": 11 cases were due to insufficient treatment intervention documentation; nine cases were due to the documentation not addressing indicator-specific issue, eight cases were due to insufficient narrative supporting non-referral; three cases were due to an incorrectly marked positive indicator; two cases were due to clinical inconsistencies; and four cases were due to other non-clinical reasons (i.e., IPC reviewed wrong HLOC form, the MTP was not signed).

For Q3 2026, the IPC submitted the initial institutional HQ Data Review of Higher Level of Care (HLOC) Considerations on 07/14/26. HQ's completion of LAC's Q3 2026 Data Review remained pending at the time this report was finalized.

On 07/16/26, MH Regional met with the IPC to discuss continued efforts related to improving the quality of HLOC Considerations documentation. The IPC reported all staff have received training in HLOC

Considerations documentation, but newer staff are still adjusting to adhering to documentation expectations. *Improvement Opportunities* ⚠ LAC's HQ Data Review scores for HLOC Considerations have remained below 85% since Q4 2022, ranging from 15% to 56%. The quality of HLOC Considerations documentation improved only 3% since Q1 2026.
Follow-up required: NO / If Yes, follow-up date:

Area Reviewed:	Mental Health Program Subcommittee (MHPS) Minutes
MHPS meeting minutes were reviewed for the months of April and May. A draft copy of the June minutes was reviewed as its pending review and approval by the MHPS. The IPC was in attendance for all meetings and quorum was met. Of note, the Health Program Manager I (HPMI) is no longer included in the minutes as a required member. LAC noted this was due to the HPM I position being vacant. Recommendations were provided to include the HPMI position in the required member section and reflect the vacancy to accurately account for the required members as outlined by policy. In addition, minutes list the Senior Psychologist Specialist Training Coordinator as a required member, however this is not a required member per policy and should be listed under local committee members. Table V was embedded in the minutes and minutes included some discussions related to sustainable process. As noted in prior reviews, it is recommended for the MHPS to assess interventions, improvement efforts, and address trends/barriers. See the MHRA's Spreadsheet, Tab *MH SubCommittee,* for further details.	
Follow-up required: NO	If Yes, follow-up date:

Area Reviewed:	Higher Level of Care Considerations Documentation – Prior Review 100%
A random sample of eight cases were selected from the Mental Health OnDemand Acute ICF non-referral report for IDTTs completed in the month of June 2026. Consistency was reviewed between the HLOC Considerations contained in the MH MTP and the documentation in the Electronic Health Record System (EHRS) 30 days prior to the IDTT. Seven of the eight (88%) cases reviewed demonstrated consistency with the prior EHRS documentation. See the MHRA's Spreadsheet, Tab EHRS, to review specific details.	
Follow-up required: NO	If Yes, follow-up date:

Area Reviewed:	Referral and Non-Referral Log
The On Demand Acute-ICF Referrals and Non-Referrals reports covering April 1st – June 30th, 2026, were reviewed. See the MHRA's Spreadsheet, Tab *MH Subcommittee*, for further details.	

<u>Referral Logs</u>

There were a total of 20 APP/ICF referrals (eight Acute; 12 ICF). This number is comparable to the total number of referrals made in quarters reviewed in 2026 (Q1: 24; Q2: 21).

✓ 100% of referrals were submitted to the IRU within required timeframes.

Referral source trends:

- MHCB initiated 100% of the Acute referrals and 33% (4/12) of ICF referrals.
- Outpatient settings initiated 67% (8/12) of ICF referrals, consistent with the prior quarters reviewed (2026: Q1: 69%; Q2: 63%; 2025 Q4: 71%), and maintained as a significant increase from the 26% (5/19) ICF referrals initiated in outpatient settings across the first three quarters of 2025.
- There was one ICF referral based on a PC1370 not accounted in the total number of referrals to APP/ICF.

The MH Regional team has been monitoring outpatient-initiated ICF referrals to ensure appropriate LOC assessment and prevention of avoidable decompensation.

Non-Referral Logs

During the review period, there were 583 IDTT decisions not to refer to HLOC despite meeting one or more HLOC Consideration(s).

- This is the lowest quarter of non-referrals for 2026 (Q1: 598; Q2: 601).
- Use of multiple considerations: 21%, aligned with the prior quarter's review (2026: Q2: 21%).
- Most utilized consideration: Consideration #7 (patients participating in less than minimum number of structured treatment hours per week) was at 81%. This is consistent with the prior quarters reviewed in 2026 thus far (Q2: 80%; Q1: 79%).

Pending APP/ICF Referrals

During the visit there were 13 pending APP/ICF referrals: three APP referrals in MHCB, ten ICF referrals in ML EOP, and one ICF referral RHU EOP.

- ✓ APP patients: two transferred timely, one accepted and pending transfer.
- ✓ ICF patients: All, but four, were accepted and pending transfer and within the required 10-day or 30-day transfer timelines.
    - One patient is on a medical hold, two patients were rejected due to a neurocognitive disorder or medical condition, and one patient was rejected with recommendation to refer to APP.

Improvement Opportunities

- ⚠ A review of the HLOC Considerations documentation reflected a range of adequate modified interventions to generic or lack of modified interventions.

Follow-up required: NO	If Yes, follow-up date:

Area Reviewed:	Interdisciplinary Treatment Teams (IDTTs)

MHCB

Five IDTTs were observed across two days, two initials and three routines (discharges to lower level of care). All required attendees were present. All patients were admitted for suicidal ideation/danger to self. None of the patients were placed in mechanical restraints while the IDTT was being conducted. Of note, during IDTT on July 14th, within the treatment space, water was leaking from the ceiling through the light fixture. Four waste baskets were placed around the room to catch the dripping water. However, this issue was resolved during IDTT observations on July 16th.

Key Findings

- ✓ IDTTs started on time and purpose was stated along with team introductions.
- ✓ IDTT discussions were very thorough, and information was provided in an organized and succinct manner.
- ✓ Appropriateness of issue and observation status were discussed in all cases.
- ✓ In most cases, MHPCs discussed case formulation and provided brief clinical summaries including current symptomatology, diagnosis, reason for admission, hospitalizations, and strengths and weaknesses.
- ✓ The MHMD discussed medications and side effects in all cases.
- ✓ Each patient was given an opportunity to provide input regarding their treatment.
- ✓ Active participation and input provided from CCI and nursing staff.
- ✓ Measurable treatment goals were identified and discussed in all cases.
- ✓ In most cases, RVRs were discussed.

- ✓ Safety planning was discussed in all required cases except one.
- ✓ Higher level of care, appropriateness of level of care, and discharge plans were also discussed.

Improvement Opportunities

- ⚠ The primary clinicians, RN and CCI had access to their laptops during the IDTTs, however in two IDTTs observed on July 14th, the MHMD did not have access to a laptop.

ML EOP

Five IDTTs were observed (two initials, two routines; one update). All five patients attended.

Key Findings

- ✓ IDTTs started on time with all required staff present as well as a Senior Psychologist Supervisor serving as the lead.
- ✓ All patients were engaged by being asked open-ended questions and given an opportunity to provide input into their treatment plan.
- ✓ MHMD discussed medications, symptoms, and queried for side effects when applicable.
- ✓ There were interactive discussions amongst the team members toward treatment planning in most cases.

Improvement Opportunities

- ⚠ Clinical summaries did not outline functional impairments or current areas of distress.
- ⚠ Treatment planning was generalized and goals were not discussed in measurable terms.
- ⚠ Level of care justification, including addressing HLOC considerations, was absent or lacked clarity and connection to functional impairments.
- ⚠ Eligibility for program assignment was not discussed in applicable cases.

RHU EOP

Five IDTTs were observed (two initial, three follow-up), with four patients attending and one held in absentia. The reason for refusal was not addressed.

Key Findings

- ✓ All required staff were present, including a correctional officer.
- ✓ IDTT purpose was stated for all cases.
- ✓ Patients were asked open-ended questions and given an opportunity to provide input into their treatment plan and goals.
- ✓ Clinical history, symptoms, and areas of distress were presented thoroughly, however functional impairments and strengths and weaknesses were absent in all but one case.
- ✓ The psychiatrist provided relevant information regarding diagnosis, medication, side effects, and possible adjustments; however, interactions at times resembled individual therapy rather than a team-based meeting.
- ✓ The CCI was engaged, knowledgeable, and provided meaningful information.
- ✓ RVRs were discussed in three cases, and the related behavior was addressed when clinically applicable.

Improvement Opportunities

- ⚠ PT engagement was limited to asking if the patient had “any questions for medical.”
- ⚠ Treatment goals were measurable in only one of the five cases. Across the three follow-up IDTTs, progress toward goals was discussed in only one case.
- ⚠ LOC rationales/justification for continuing level of care was discussed in only one case.
- ⚠ HLOC considerations were not addressed in two cases and the MHPC only mentioned positive considerations for the other three.

RHU CCCMS

Five IDTTs (three routine, two initial) were held with all required members present and started on time. One IDTT was held in absentia with the reason for refusal discussed.

Key Findings

- ✓ IDTTs started on time with all required staff present with the purpose explained.
- ✓ Patients were asked open-ended questions and given an opportunity to provide input.
- ✓ Diagnosis, areas of distress, and mental health history were consistently presented in all cases however strengths, weaknesses, and functional impairments were mostly absent from presentations.
- ✓ The MHMD was engaged and provided information on prescribed medication(s), possible side effects, and provided meaningful clinical input.
- ✓ RVRs or reasons for RHU placement were discussed in two cases.

Improvement Opportunities

- ⚠ Although treatment goals were addressed, they were measurable in only two cases, and progress toward goals was absent in all three follow-up IDTTs.
- ⚠ Patients were not given an opportunity to provide meaningful input or participate in their treatment planning.
- ⚠ Higher level of care considerations and appropriateness/justification of level of care was absent, often not addressed at all or the clinician stating the patient would remain at the CCCMS level of care.
- ⚠ IDTTs functioned more like presentations rather than a collaborative team meeting.
- ⚠ CCI provided minimal information unless directly asked. The PT only engaged by asking the patient if they had "any questions for medical."

Follow-up required: NO	If Yes, follow-up date:

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

PT Rounds

RHU EOP (D5)

PT Rounds in RHU EOP (D5) were observed by a nursing member of the Receiver's Compliance Team during the on-site review.

Key Findings

- ✓ The PT rounds consistently met all audit standards.
- ✓ The PT actively engaged with patients throughout the rounds.
- ✓ The PT demonstrated thoroughness during rounds by carefully reviewing each patient's appointments and group schedules.

RHU CCCMS (Z)

PT Rounds in RHU CCCMS (Z) were observed by a nursing member of the Receiver's Compliance Team during the on-site review.

Key Findings

- ✓ The PT rounds consistently met all audit standards.
- ✓ The PT actively engaged with patients throughout the rounds.
- ✓ In situations where cell visibility was limited and patients declined to turn on the lights, the PT utilized a flashlight to adequately visualize the inside of the cell, ensuring patient safety and thorough observation.

Morning Meeting

RHU EOP (D5)

Morning Meeting in RHU EOP (D5) was observed by members of the Receiver's Compliance Team during the on-site visit.

Key Findings

- ✓ The meeting was observed to be adequate.
- ✓ There were full attendance and participation by all attendees, including clinicians, nursing, PTs, and custody.
- ✓ All areas, including new arrivals and high-risk patients were discussed. Any patients on SRMP were discussed.

RHU CCCMS (Z)

Morning Meeting in RHU CCCMS (Z) was observed by members of the Receiver's Compliance Team during the on-site visit.

Key Findings

- ✓ The meeting was observed to be adequate.
- ✓ There were full attendance and participation by all attendees, including clinicians, nursing, PTs, and custody.
- ✓ All areas, including new arrivals and high-risk patients were discussed.
- ✓ The clinician did not discuss any SRMP patients, nor appear to be aware of the requirement to discuss SRMP patients.

Follow-up required: NO	If Yes, follow-up date:

Area Reviewed:	Patient Reviews

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

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

⚠ Six patients required review and consideration of clinical recommendations.

Action Plan Follow-Up

On 03/10/26, MH Regional received an email from LAC's IPC that the action plans for three identified patients were complete. All patients identified with a follow-up action plan were scheduled for an IDTT and ultimately two of the three were referred to a higher level of care and admitted into a PIP.

Follow-up required: YES	Follow-up date: **September 1, 2026**

The CMH or designee shall:

1. Review commentary for all six patients listed on the IP Reviews tab, and
2. Submit an institutional follow-up to the MH Regional Team acknowledging commentaries and clinical recommendations of the six patients were reviewed and considered.

SUMMARY
The MH Regional team conducted the Q3 Major Sustainable Process review at LAC from July 14 – 17, 2026. Key points • For Q2 2026, the HQ Data Review audit identified 36% (21 of 58) non-referred cases with "good" Higher Level of Care (HLOC) Considerations documentation. The quality of HLOC Considerations documentation improved only 3% since Q1 2026. • LAC's Initial institutional review of HQ's Q3 2026 Data Review was submitted to HQ on 07/14/26. HQ's review remained pending release at the time this report was finalized. • All 20 APP/ICF referrals were submitted timely to IRU. • MHPS minutes contain some information related to sustainable process. As noted in prior reviews, it is recommended for the MHPS to assess interventions, improvement efforts, and address trends/barriers. • HLOC consistency audit found seven out of eight cases (88%) demonstrated consistency with the prior month of EHRS documentation. • Patient reviews identified no urgent MH or higher-level-of-care needs at the time of the visit. • Six patients require follow-up review of clinical recommendations. • IDTTs were observed in MHCB, EOP, RHU EOP, and RHU CCCMS.

Appendix E: Excluded Indicators

- AC5.2: Monthly Review of EOP Modified Treatment
- AC26.2: Documentation of Clinical Barriers to Patients LRH Placement are Documented in the MTP
- AC26.3: Documentation of Correctional Counselor Review of LRH during IDTT with an Appropriate Response
- QC5.3 Pre-Release Planning Assessment Form
- QC10: Mental Health Primary Clinician Continuity of Care
- QC11: Mental Health Psychiatrist Continuity of Care
- RH24: High Refusers due to Custody Reasons with Documented Plan of Action
- RH25: High Refusers for Whom a 128B was Completed
- RH26: High Refusing EOP Patients in Restricted Housing for Whom a Meeting Between MH and Custody was Conducted
- RH27: RHU Incarcerated Persons Who Received an RHU Orientation Guide
- SP3.4: Quality of Safety Planning to Reduce Suicide Risk
- SP12.1: Custody Follow Ups, Page 1
- SP12.2: Custody Follow Ups, Page 2
- SP23: Quality of Selected SRE Documentation