

MULE CREEK STATE PRISON

Review Period: Dec 2025 – May 2026

Onsite: July 28-31, 2026



Receiver's Compliance Team

2026

Statewide Mental Health Program
Continuous Quality Improvement



M U L E C R E E K S T A T E P R I S O N

CDCR

38.3705° N / 120.9532° W

TABLE OF CONTENTS

BACKGROUND	2
GOALS.....	3
APPROACH TO ASSESSING COMPLIANCE	3
METHODOLOGY	4
RECOMMENDATIONS.....	6
EXECUTIVE SUMMARY.....	7
INSTITUTION’S OPERATIONAL PERSPECTIVE.....	10
ACCESS TO CARE.....	11
CUSTODY AND MENTAL HEALTH PARTNERSHIP PLAN	15
PSYCHIATRY	17
PATIENT SAFETY.....	18
QUALITY OF CARE	18
RVRS, SENTINEL EVENTS, AND SPECIALIZED CUSTODY	21
RESTRICTED HOUSING	24
SUICIDE PREVENTION.....	26
STAFFING	29
RECEIVER’S SIGNATURE PAGE.....	31
APPENDIX A: ACRONYMS AND INITIALISMS	32
APPENDIX B: MAPIP	35
APPENDIX C: SUICIDE PREVENTION REPORT	38
APPENDIX D: EXCLUDED INDICATORS	45

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.

MCSP CQI Report | 2026

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	$\geq 89.5\%$
Yellow	$\geq 74.5\%$ 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

Mule Creek State Prison (MCSP) is a multi-level, 270-degree design institution located in Amador County. Approximately 2,179 of the 3,707 (59%) incarcerated residents at MCSP are enrolled in mental health programming. At the time of the audit, 779 mental health patients were enrolled in EOP and 1,384 enrolled in CCCMS.

Residents are housed across six large mainline facilities and an eight-bed Mental Health Crisis Bed (MHCB) located within the institution's Correctional Treatment Center (CTC). Enhanced Outpatient Care (EOP) is offered across three mainline facilities (A, B, and D Yard) and Correctional Clinical Case Management System (CCCMS) services are offered across all six mainline facilities (A, B, C, D, E, and MSF). MCSP's Restricted Housing Unit (RHU) is a designated EOP HUB and currently accommodates EOP patients and CCCMS patients awaiting transfer. The RHU (C12) contains 16 intake cells (126-133, 226-233). Thirty cells within Facility C13 are utilized as RHU overflow space (101-115, 201-215). The institution does not operate a Psychiatric Inpatient Program (PIP); patients requiring this level of care are transferred to other institutions. The Alternative Housing Unit (AHU) for patients waiting for licensed mental health bed placement is comprised of prioritized space within C12 (147-150), C13 (113-115, 118-121), two holding modules within the Triage and Treatment Area (TTA), four modules within Receiving and Release (R&R), and two modules within Central Services.

In January and February 2026, there was a conversion of B and C Yard. Specifically, B8 and B9 were converted to Level III NDPF (from Level III SNY previously). C11, C13, C14, and C15 were converted to Level II NDPF (from Level III SNY previously). These conversions resulted in increased intakes into the mental health program.

Facility	Function	Mental Health Program
Facility A (Level IV ML)	SNY housing for GP, CCCMS, and EOP (A5 only); five cell housing units (270-degree design).	ML EOP and CCCMS
Facility B (Level III ML)	NDPF housing for GP, CCCMS, and EOP (B6 & B7 only); four cell housing units currently (270-degree design); B10 deactivated July 2024.	ML EOP and CCCMS
Facility C (Level II ML)	NDPF housing for GP and CCCMS; four ML cell housing units (270-degree design)	ML CCCMS
Facility D (Level II ML)	NDPF housing for GP, CCCMS, and EOP (D18 only); three dormitories	ML EOP and CCCMS
Facility E (Level II ML)	NDPF housing for GP and CCCMS; three dormitories	ML CCCMS
MSF	NDPF housing for GP and CCCMS; one dormitory currently; Dorm #1 deactivated July 2024	ML CCCMS

MCSP CQI Report | 2026

CTC	Correctional Treatment Center; contains eight-bed MHCB; AHU comprised of designated space within C12, C13, TTA, R&R, and Central Services	MHCB
RHU (C12)	Restricted Housing Unit with both EOP Hub and CCCMS LOC (two tiers; 16 intake cells). 30 cells within C13 are utilized for RHU overflow	RHU EOP Hub

The review found that MCSP consistently excelled in several areas. Staff in the Restricted Housing Unit Enhanced Outpatient Program (RHU EOP) completed timely primary clinician (PC) and psychiatry contacts 99% of the time during the audit period. The team held interdisciplinary treatment team meetings (IDTTs) on schedule 98% of the time. RHU nursing staff completed screening of people entering the RHU on time at high rates. Staff offered RHU EOP patients 10 hours of structured treatment 96% of the time.

The MCSP quality management (QM) team consistently identifies performance opportunities and initiates improvement plans. One example of the impact of this work is the improving trend in compliance with emergent, urgent, and routine referral timelines. Compliance with referral timelines increased from 77% in December to 89% in May. Additional mental health QM initiatives included reducing custody-related appointment cancellations and securing confidential spaces for urgent and emergent appointments, ensuring patients receive care privately.

Custody knowledge of MH referral processes, adherence to carrying CPR mouth shields, thermometer checks and availability of a thermometer with accurate reading was 100% across all housing units.

Mental health staffing and timely appointments, including those affected by custody cancellations, need improvement. Although staffing for primary clinicians and psychiatrists has increased, recreation therapist staffing dropped from 92% in December to 66% in May, which reduced the ability to hold group treatment hours. MCSP continues to face challenges with onsite primary clinician staffing. Primary clinician staffing averaged 65% across the review period, with about 19% provided by in-person staff, which further limited group treatment hours. MCSP maintains a triage plan tailored to each facility, ensuring EOP primary clinicians conduct contacts every two weeks, while EOP modified patients, SRMP, and ICF level of care patients on EOP D yard receive weekly contacts. Staffing shortages also impacted IDTTs, which were held at the prescribed timelines only 68% of the time during the audit period. Quality management minutes document a backlog caused by previous staffing deficits, but they expect improvement as primary clinician staffing increases.

Appointment cancellations due to custody reasons were at 25% in December 2025, increasing to 43% in February, and improved to 6% or less for three consecutive months but in June 2026 there was another increase in appointment cancellations due to custody to 18%. Quality improvement minutes reflect analysis of the reasons for these cancellations, with workplans intended to address the documented barriers; however, the improvement was not sustained. These findings are consistent with patient reports regarding access to care, where challenges getting to appointments were described on most yards. This is also consistent with data regarding mental health appointment completion data, which show that 65% of scheduled mental health appointments were completed or documented as refused in June 2026.

Additionally, except for RHU EOP patients, most individuals did not feel adequately supported by custody and mental health staff during a mental health crisis. Some patients reported that staff responses to requests for assistance were perceived as dismissive or resulted in being returned to their cells. There were also accounts,

particularly on D yard, of behaviors that may discourage patients from seeking treatment. These concerns merit further review and consideration by the institution team.

Priority Recommendations

- 1. Improve attendance at confidential appointments:** Analyze the factors impeding attendance at confidential appointments and develop a plan to increase attendance in confidential settings. Site observations and patient reports indicate that rushed unlock times prevent patients from attending confidential visits, resulting in brief cell-front encounters or missed appointments. Custody reasons contributed to 18% of appointment cancellations during the audit period. The Quality Management team should continue the plan to reduce custody-related cancellations and set clear expectations for standard unlock times—such as a ten-minute unlock for each appointment block—to ensure staff and patients understand these procedures. Mental health and custody staff must receive refresher training, so they consistently offer confidential appointments when possible. To ensure there is accurate data to track and address the issue, include a review of appointment coding and cancellation reasons and train clinicians to ensure they document confidentiality and reasons for non-confidential appointments accurately. Use the findings to develop a workplan as indicated that addresses the primary barriers for completion of confidential appointments.
- 2. Develop a Facility-Wide Treatment Space Remediation Plan:** Institution leadership should continue implementing space remediation. Plans for improvements to facility A are in progress pending labor and plant operations approval and completion. Action is recommended to address treatment and office space needs facility wide. This plan should include improvements to confidentiality and safety in identified treatment spaces. Onsite assessment found 79%† of group treatment spaces, 89%† of individual treatment spaces, and 78%† of IDTT spaces met all audit criteria. The deficits are predominately confidentiality and safety. Specifically, the CCCMS IDTT room on facility A has a window where other incarcerated individuals can see into the room. Implement remedial measures to ensure visual confidentiality, such as frosting windows, while maintaining safety requirements. Reconfigure clinical treatment spaces so that the patient is not blocking the egress and ingress route to the room.
- 3. Improve quality of safety planning:** Provide refresher training on individualized safety planning to all clinical staff, with mandatory participation for clinicians routinely assigned to MHCB recissions 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.
- 4. Improve mental health emergent response procedures:** Custody staff demonstrated knowledge of what to do when an incarcerated individual reports they have a mental health emergency, however patients in mainline EOP reported lack of response when reporting a mental health emergency. Institution leadership should further review these patient reports to determine whether staff members are responding as required by policy. If necessary, develop plans to educate patients and staff about expectations regarding mental health emergencies. Plans should be designed to ensure patients understand expected response times and that staff follow policy regarding responding to mental health emergencies.

Institution's Operational Perspective

MCSP has continued to address changes in its mental health operations while managing increased service demands. During the review period, housing conversions on B and C Yards resulted in an increase in new arrivals and growth in the CCCMS population across several facilities. The increase in patient movement and population changes placed additional demands on CCCMS treatment teams and contributed to challenges in meeting required timeframes for initial appointments and Interdisciplinary Treatment Team meetings (IDTTs). The Minimum Support Facility also experienced an increase in CCCMS patients without corresponding increases in staffing and treatment space.

MCSP has made progress in addressing several longstanding operational barriers. Mental Health Primary Clinician staffing improved during the review period after several years of significant vacancies. The institution expanded telehealth capacity and increased provider availability. The institution has also improved coordination between disciplines through the resumption of Custody Mental Health Partnership Plan roundtables and has maintained focus on identified quality improvement priorities, including Restricted Housing Unit intake cell compliance and Custody Discharge Observation Checks.

Despite these improvements, MCSP continues to face challenges that affect the delivery of consistent mental health services. Ongoing operational challenges include reliance on telehealth clinicians who do not offer groups, use of registry clinicians that may reduce continuity of care, recreation therapist vacancies, and limited office and treatment space. Recreation therapist vacancies have limited structured treatment capacity for the EOP population. In addition, treatment space has become increasingly constrained as staffing levels, particularly medical assistant staffing, have expanded. MCSP leadership has identified space modifications to address these limitations, with implementation pending completion of the required approval processes.

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 (formally 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.

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%	100%	99%	100%	99%	
Group treatment in a confidential setting	99%	99%	89%	95%	96%	98%	96%	
IDTTs in a confidential setting	100%	100%	100%	100%	100%	100%	100%	

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	99%	98%	100%	100%	100%	100%	100%	
IRU Reviews Completed Timely	100%†	100%†	88%†	100%†	100%†		94%†	
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure					0%†		0%†	
RHU GP Screens	94%†	83%	100%†	57%†	92%	94%	88%	
RHU Pre-Screen	90%	98%	91%	94%	89%	86%	91%	
Timely IDTTs (v2.0)	68%	61%	73%	64%	71%	69%	68%	
Timely MH Referrals (v2.0)	77%	85%	82%	91%	90%	89%	86%	
Timely MHMD Contacts (v2.0)	84%	83%	91%	86%	73%	83%	83%	
Timely PC Contacts (v2.0)	53%	50%	49%	59%	63%	55%	55%	
Custody MH Referrals								98%
Housing Units Where 128-MH-5s Are Available And Accessible to Housing Unit Staff								100%

MCSP CQI Report | 2026

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	100%†	67%†	88%†	100%†	100%†		88%†	
Timely Transfer to MHCb (v2.0)	100%†	100%†	100%†	100%†	100%†	100%†	100%	
Timely Transfers to EOP (v2.0)	100%†	100%	100%†	100%	100%	100%†	100%	
Timely Transfers to PIP	100%†	100%†	86%†	50%†	100%†		88%†	
Timely Transfers to RHU CCCMS	43%	50%	27%	62%	35%	50%	45%	

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	25%	32%	43%	3%	3%	6%	18%	
Scheduled MH Appointments Completed or Refused	72%	76%	55%	68%	67%	51%	65%	

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	33%	38%	22%	37%	25%	17%	29%	
Monthly Review of EOP Modified Treatment								0%†

Treatment Environment

Indicator	Onsite Audits
Adequate Group Treatment Spaces	79%†
Adequate IDTT Spaces	78%†
Adequate Individual Treatment Spaces	89%

Space-by-Space Assessment

Space / Location	Type	Assessed	Compliant	Primary Deficiencies
ML CCCMS	IDTT	3	Partial	SE20 MH Group Room A is located on a general population housing unit. There are 2 large windows open to the IDTT room that allow others to see into the treatment space.
	Group	3	Partial	MCSP is presently not offering groups to CCCMS patients but does have treatment space to hold groups. MSF and C Yard Mod trailer group treatment spaces are not confidential; MSF space lacks sound confidentiality and C Mod lacks sight and sound confidentiality due to partitions that are not soundproof and windows that allow other incarcerated people to see into the treatment room. The space on MSF lacks ventilation and does not have air conditioning. SE20 MH Group Room A: See above
	Individual	5	Partial	MSF building 2 space is not well ventilated and is hot and humid in summer months. Interview room SE20 CE20-F107 space is not configured safely. Patient chairs block safe egress for the clinician in the event of an emergency.
RHU HUB EOP & CCCMS	IDTT	1	Yes	
	Group	1	Yes	
	Individual	6	Yes	
MLEOP	IDTT	3	Yes	
	Group	9	Yes	
	Individual	22	Partial	Two of the 22 spaces audited, D Treatment Center MH interview Room CD06-173 and A yard interview room A-2 311, are not configured safely. Patient chairs block safe egress for the clinician in the event of an emergency.
MHCB	IDTT	1	Yes	
	Group	0	N/A	
	Individual	2	Yes	

“Partial” indicates the space(s) met some but not all audit criteria or that some of the spaces in that category met audit criteria.

MCSP CQI Report | 2026

✓ Strengths

Timely Access: During the audit period, staff engaged with RHU EOP high refusers consistently as required over the review period. Additionally, staff completed IRU reviews with 94% compliance and conducted RHU Pre-Screens on time at an average rate of 91%, prioritizing high-risk patients. Custody staff referred patients for mental health care at a strong compliance rate of 98% and ensured the availability and accessibility of 128 and MH-5 forms in the housing units.

Timely Transfers: Staff transferred patients to MHCB and EOP within program timelines 100% of the time during the review period, ensuring that individuals requiring a higher level of care quickly moved to the appropriate programs. Several months showed deficits in the timely transfers to PIP placement (measuring whether patients depart the referring facility within 72 hours after referral acceptance). Institution staff review of missed physical transfer timelines within 72 hours concluded these were due to the receiving inpatient program completing clinical acceptance of the patient but requesting the patient not be sent until a later day.

Treatment spaces were predominantly compliant: All treatment spaces audited were either compliant or partially compliant. Only 3 of the 35 treatment spaces where individual treatment was held were not compliant due to room configuration. Of the 8 IDTT treatment spaces observed only 1 was not compliant due to confidentiality issues. Of the 13 group rooms observed, 3 were found to be deficient; MCSP does not conduct group treatment presently in the deficient locations.

Effective communication: Over a six-month review, MCSP staff documented that effective communication was achieved during 99% of relevant appointments.

⚠ Concerns

Timeline deficits for patient care: PC contacts occurred 55% of the time during the designated timeframe over the review period, with monthly results ranging from 49% to 63%. Staff performed IDTTs on time 68% of the time throughout the review period. Staffing deficits combined with mission change conversions, which resulted in increased intake and backlogs for IDTTs, contributed to these low percentages. Additionally, telemental health clinician patient time has been restricted due to a misalignment of tele presenter and clinician hours resulting from tele presenters' shift moving from four ten hour shifts to five eight-hour shifts, while the clinician's hours are four ten-hour shifts.

Appointment cancellations due to custody factors were significant: Cancellation of mental health appointments due to custody factors happened 18% of the time during the overall review period. The range of custody driven cancellations varied, March and April of 2026 reflected a low of 3%, while February 2026 reflected a 43% custody cancellation rate. The reasons behind the custody driven cancellations included custody staff shortages, facility wide training, limited-visibility movements (fog), with most (13%) due to custody modified program for security reasons (such as a riot, an attempted escape, and a drone sighting in the yard). The six-month aggregate percentage of the required hours of treatment offered to EOP patients at MCSP was 29%. Both the proportion of appointments cancelled based on custody factors and the low percentage of treatment hours offered are concerning indicators demonstrating that patients are not getting access to care in accordance with policy.

Factors impeding access to treatment: Patients have reported inconsistency in receiving ducats for scheduled appointments, modified programs impeding access to care, and not being let out of their housing units to attend appointments due to scheduling conflicts (such as custody count or shift change). There is a new system in place initiated by corrections services where yard ducats are posted the day before instead of patients receiving paper ducats, which has had mixed results in terms of attendance.

MCSP CQI Report | 2026

Communication during Program Status Reports (PSR) regarding whether patients will be able to attend their priority ducats has been inconsistent. Clinicians are not always clear about whether their patients will be coming to the appointments and sometimes go to see patients cell-front during a PSR even when MH appointments should proceed normally. For example, a member of the audit team observed at least one clinician checking in with a patient at the cell front and then documenting that the clinician saw the patient non-confidentially at cell front due to a modified program even though the PSR permitted the patient to attend their confidential therapy appointment. Report data regarding cancellation supports these reports of treatment barriers.

Timely Transfers: Timely transfers to RHU CCCMS were consistently out of compliance ranging from 27% to 62% over the review period with 71 of the 159 CCCMS RHU required transfers occurring on time. Staff submit a list of transfers each week, however, statewide bed availability results in missed timelines.

Confidentiality and safety in treatment spaces: A limited number of treatment spaces on C, D, E and MSF yards are deficient due to confidentiality and safety being compromised. Other incarcerated individuals can see into the IDTT and group room on A facility.

Limited treatment space: MCSP leadership faces challenges securing enough space for the growing team, including MAs, PCs, and psychiatrists, and for onsite urgent and emergent referrals. The mental health QM subcommittee is actively pursuing confidential spaces for emergent and urgent consults. Staff have installed holding cells in the treatment center in locations that will provide confidentiality, although plant operations have not yet finished work on this project. While the new space will provide confidentiality, staff must see patients in holding cells because other options do not offer both constant observation and confidentiality.

The CCCMS population on the MSF yard at MCSP continues to grow, yet mental health treatment space remains unchanged. As the population rises, the facility has not expanded available space for mental health services.

Data and observation discrepancy for confidentiality: The data indicates a high level of compliance with confidentiality standards; however, onsite observers identified physical conditions in two treatment areas that compromise confidentiality. Clinicians document encounters as confidential, but auditors found that the physical environment requires improvement to fully meet confidentiality requirements.

Recommendations

1. **Improve attendance at confidential appointments:** Refer to priority recommendation above.
2. **Develop a Facility-Wide Treatment Space Remediation Plan:** Refer to priority recommendation above.

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.

MCSP CQI Report | 2026

Indicator	6-Month Avg	Onsite Audits
CMHPP MH Daily Huddles		75%
CMHPP MH Huddle Documentation of Required Attendees		76%
CMHPP MH Huddle Documentation of Supervisor Attendees		31%
CMHPP Monthly Executive Leadership Joint Rounding		100%†
CMHPP Monthly Executive Leadership Joint Rounding Attended by Required Executives		100%†
CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH Program		100%†
Custody Staff CMHPP Annual Training		96%
Healthcare Staff with CMHPP Annual Training		98%
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		100%
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees		100%
ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings		21%
Quarterly Partnership Round Table Training Completed as Required		55%
Required Staff Attendance of Quarterly Partnership Round Table Training		20%†

✓ Strengths

Several CMHPP components demonstrated strong compliance: Teams consistently conducted monthly executive joint rounding, completed annual CMHPP training for custody and healthcare staff, and held ML CCCMS and RC CCCMS CMHPP weekly supervisor meetings, all achieving scores of 96% or higher during the review period. The CCCMS joint supervisory program tours and weekly supervisory meetings consistently included all required participants 100% of the time.

⚠ Concerns

Daily huddles do not follow established policy and procedure: Auditors reviewed one week of huddle reports for each month of the review period. Teams conducted daily huddles 75% of the time. The guidelines require a mental health supervisor and a custody supervisor to attend at least one huddle weekly per housing unit, but teams documented weekly supervisor attendance only 31% of the time.

Inconsistent compliance with CCCMS CMHPP components: The CCCMS and RC CCCMS monthly joint supervisory program tours were 67% compliant, and the CCCMS CMHPP IAC meetings occurred only 21% of the time during the review period, adversely impacting the ability for the incarcerated population to advocate for themselves with institutional leadership. The quarterly partnership round table training was at 55% completion, and of those, only 20% of round tables included the required staff.

MCSP CQI Report | 2026

Recommendations

1. **Improve daily huddle compliance across all programs:** Initiate weekly audits of huddle attendance and documentation across all programs. Provide training to supervisory and line staff regarding required attendees and purpose of huddles.
2. **Ensure required staff attend monthly executive leadership joint rounding and complete required documentation:** Identify the specific barriers preventing required staff attendance (scheduling conflicts, competing duties, unclear expectations about who is required). Implement an attendance confirmation process.
3. **Increase CMHPP compliance with round table training and IAC meeting attendance:** Identify barriers to quarterly round table training and barriers to the IAC meeting attendance. Implement a protocol to improve compliance.

Psychiatry

There are required timelines for psychiatric response to medication non-adherence notifications, appropriate use of involuntary medication procedures under Penal Code §2602, and systematic monitoring of medication safety and continuity through the Medication Administration Process Improvement Program (MAPIP).¹ MAPIP tracks the percentage of medication doses provided in a timely manner across all transfer types, administration methods (KOP, nurse-administered, directly observed therapy), prescription types, medication categories, and provider types. It also tracks the percentage of patients prescribed certain high risk medications who received appropriate diagnostic monitoring consistent with clinical guidelines and presents this as a composite of 33 component measures in the following five categories: antipsychotic, clozapine, mood stabilizers, antidepressants, and medications linked to QT prolongation. These indicators assess whether patients receive timely access to prescribed medications and appropriate safety monitoring.

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg
Timely Response to Critical Non-Adherence Notification (v2.0)	61%†	67%†	43%	83%†	73%	48%	60%
Timely Response to Non-Critical Med Non-Adherence Notification(v2.0)	60%	58%	65%	59%	68%	77%	65%
Controlled Use of Force Incidents Required to Administer PC2602 Medication	25%†						25%†

✓ Strengths

Quality Management: The quality management system actively monitors diagnostic requirements and ensures that staff perform most diagnostic monitoring on time.

¹ See Appendix B

 Concerns

Medication non-adherence: Staff responded to both critical and non-critical medication non-adherence notifications at rates below the compliance threshold throughout the reporting period. For critical medication non-adherence, insufficient psychiatry staffing outside of normal business hours and the requirement to see patients within 24 hours of notification contributed to delayed responses. For non-critical medication non-adherence, psychiatry teams deprioritized these appointments and processed a larger-than-usual volume of new arrivals, stemming from the conversion of Level III SNY to a Level II NDPF yard which began to impact operations in December 2025, and continued through May of 2026.

Recommendations

- 1. Develop a plan to meet timelines for critical medication non-adherence notifications:** Analyze the primary factors that cause noncompliance with timely responses to critical medication non-adherence notifications. After identifying these factors, develop a comprehensive process that ensures timely responses to critical medication non-adherence notifications. If staffing issues contribute to noncompliance, collaborate with headquarters, regional, and institutional leadership to strengthen recruitment and retention of after-hours psychiatry staff.
- 2. Develop a plan to meet timelines for non-critical medication non-adherence notifications:** Analyze the primary factors that cause non-compliance with timely responses to non-critical medication non-adherence notifications. After identifying these factors, develop and prioritize a comprehensive process that ensures timely responses to non-critical medication non-adherence notifications. Engage the Quality Management teams at MCSP to support these improvements.

Patient Safety

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

Indicator	Onsite Audits
Heat Related Illness Incidents for MHSDS Patients Prescribed Heat Alert Medications	0+

 Strengths

There were no heat-related illness incidents during the reporting period.

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	60%	61%	58%	54%	57%	50%	57%	
IDTT Required Staffing	81%	82%	83%	82%	74%	76%	79%	
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available								84%
IDTTs with Observed Interactive Process								32%

Documentation

Indicator	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	6-Month Avg	Onsite Audits
Cases w/doc. of appropriateness of LOC discussed for pts identified by 7388B as potentially requiring HLOC								76%
EOP IDTTs Addressing Accommodation and Clinical Appropriateness for Work and Education								13%†
IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT								100%†
IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT								100%†

✓ Strengths

D yard, MHCB, and RHU EOP IDTTs on time with interactive process: Staff started IDTTs on time during onsite observations and arrived prepared with relevant clinical records. D Yard EOP IDTTs demonstrated strong interdisciplinary collaboration. Treatment teams actively reviewed diagnoses, treatment history, symptoms, risk factors, protective factors, and level-of-care considerations. The correctional counselor contributed relevant case information, including RVR history, release and parole factors, and other case details. Staff consistently engaged patients by asking open-ended questions and providing opportunities for patients to discuss their treatment goals, coping strategies, and barriers to progress. MHCB IDTTs also demonstrated strong clinical collaboration and individualized treatment planning. Teams reviewed the circumstances leading to MHCB placement, current symptoms, safety concerns, diagnoses, medications, and discharge planning. The observed MHCB IDTTs included measurable treatment goals, specific interventions, and discussion of level-of-care appropriateness. The psychiatrist actively participated in treatment planning by addressing medication management, side effects, and diagnostic considerations. In RHU EOP IDTT, staff spoke with the patient rather than about the patient and routinely asked open-ended questions to support patient participation. Primary

MCSP CQI Report | 2026

clinicians were well-prepared and presented case formulations, clinical summaries, level of care history, symptoms, diagnoses, progress toward treatment, and any barriers to treatment.

Quality of group treatment: Two different recreation therapy groups were observed in mainline EOP and RHU EOP. Groups were described as excellent in the RHU, and groups in mainline EOP were interactive and well received by patients.

Concerns

Patient attendance at IDTT: Patient IDTT attendance was at 57 percent during the six-month review period and declined from 60 percent in December 2025 to 50 percent in May 2026. Patients cited conflicting appointments, modified program, and difficulty with unlock times (as discussed in the executive summary) as barriers to attending IDTT and other treatment. During onsite observations, patients who attended IDTTs were engaged and able to participate in treatment discussions; however, lower attendance limited opportunities for direct patient involvement in treatment planning.

Lack of measurable treatment goals: The most consistent treatment planning concern was the lack of measurable, individualized goals. In D Yard EOP, treatment goals were discussed during observed presentations; however, most goals lacked specific objectives, measurable benchmarks, and clear indicators of progress toward discharge. Patients on A yard reported that treatment teams typically just do a “routine check” and usually facilitate IDTTs in-absentia, further stating they would like team members to ask more about what plan of action they (the patient) wants for mental health treatment. In D EOP and across CCCMS units, patients reported that discussion of treatment interventions is rare and, when it does occur, follow through rarely occurs.

In RHU, treatment goals were also frequently broad and were not consistently linked to interventions addressing identified symptoms, behaviors, or barriers to treatment. While none of the six patients surveyed in RHU EOP reported knowing their treatment goals, two reported that their clinicians help them identify what they need to work on and how.

Multidisciplinary contribution: The quality of discipline contributions varied by program. Except for D yard, correctional counselor participation was limited primarily to reviewing the reason for RVR placement and did not consistently incorporate behavioral factors, programming opportunities, or custody observations into treatment planning. Psychiatrist contributions were inconsistent in each case. Discussion of medications, target symptoms, and diagnostic considerations was not consistently discussed without prompting.

Documentation for higher level of care consideration: Documentation reflected level-of-care appropriateness discussions in 76 percent of cases. However, onsite observations found that the rationale supporting level-of-care decisions was not always linked to measurable treatment progress, identified barriers, or specific interventions.

Discussion of work and education appropriateness: Thirteen percent of observed EOP IDTTs included consideration of accommodations and clinical appropriateness for work and education. Given the level of need that EOP patients have for support and the lower rates of participation in these programs, these discussions are an important tool for teams to increase patient access to rehabilitation.

Offering of clinical process groups: MCSP does not currently offer clinical process groups including START NOW or another structured intervention focused on personality-disordered behaviors. As a result, treatment teams do not have an available program option for patients who may benefit from targeted treatment for personality disorder behaviors. Although patients reported satisfaction with their recreation therapy groups, they consistently reported they would like more groups that relate to their treatment goals.

Pre-release planning: Patients on MSF reported they do not receive pre-release planning; patients were not aware of the pre-release planning resources available.

MCSP CQI Report | 2026

Recommendations

1. **Strengthen individualized treatment planning:** Utilize statewide training materials and develop local interventions to ensure measurable goals, specific interventions, and ensure documented progress toward those benchmarks are included in IDTTs. Connect level of care decision-making to patient progress and ensure all relevant IDTTs include a discussion of work and education.
2. **Improve IDTT consistency by clarifying expectations for interdisciplinary participation:** MCSP leadership should provide guidance and training to ensure each discipline consistently contributes relevant information, including custody observations, medication management, diagnostic considerations, and barriers to treatment.
3. **Implement clinician led groups including START NOW:** Develop a workplan to provide structured clinician led groups, including treatment for patients who require targeted programming for personality-disordered behaviors.

RVRs, Sentinel Events, and Specialized Custody

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

Rules Violation Report

Indicator	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	43%	42%	59%	52%	57%	54%	51%	
RVR MH Assessments where Documentation Requirements were Met	93%†	86%	80%†	64%†	100%†	100%†	83%	
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality	100%†	100%	100%†	100%†	100%†	100%†	100%	
Timely RVR MH Assessment Request	24%	23%	31%	29%	30%	24%	27%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	99%	98%	100%	98%	99%	99%	99%	
RVRs Issued								1,594†
RVRs Issued to Non-MHSDS Participants								21%
RVRs Issued to Patients at the Acute Level of Care								0%

MCSP CQI Report | 2026

RVRs Issued to Patients at the CCCMS Level of Care								48%
RVRs Issued to Patients at the EOP Level of Care								30%
RVRs Issued to Patients at the ICF Level of Care								0%
RVRs Issued to Patients at the MHCB Level of Care								1%
RVRs recommended for mitigation that were mitigated								100%†
RVRs Recommended for Mitigation with Custody Documentation								89%†

*At the time of the audit 2,179 patients, or 59% percent of the MCSP population, were enrolled in the mental health program at MCSP.

Sentinel Events, and Specialized Custody

Indicator	Onsite Audits
Custody Staff Attendance at UOF Training	90%
Days Alternative Out-of-Cell Activities were Offered to Patients on Heat Alert Medications when Indicated	49%
Health Care Staff Required to Attend UOF Training	95%
Thermometer Checks completed and accurate	100%†
Use of Force Involving MH Patients	93%
Controlled Use of Force Incidents Required to Administer PC2602 Medication	25%†

✓ Strengths

UOF and CMHPP Training Completion: Of 821 custody staff, 735 (90%) completed Use of Force (UOF) training. Seven hundred and sixty-three of 763 (96%) custody staff attended the annual Custody Mental Health Partnership Plan (CMHPP) training. Healthcare staff attendance of both UOF and CMHPP training courses was also in compliance. Of 198 nursing staff, 189 (95%) completed the CMHPP training. Four of the nine nursing staff who did not complete CMHPP training separated from their employment at MCSP during the review period. Seventy-six of 77 mental health staff completed CMHPP training. Ninety-four percent of nursing staff and 99% of mental health staff completed annual UOF training.

Heat Plan Infrastructure: There were four recorded heat alert days within the reporting period where outside temperatures exceeded 90 degrees. Of these, two Daily Activity Reports reflect that alternative out-of-cell activities were offered. Custody staff completed thermometer checks accurately in all housing units reviewed (100%). Custody staff maintained temperature logs electronically, with thermometers being visible on each post at the highest area where incarcerated individuals are housed. Staff recorded the highest observed temperature readings for housing units with multiple thermometers. Correctional officers on all units were interviewed regarding their knowledge of the heat plan, including months in which it is in effect, and all were able to articulate adequate knowledge of their responsibilities during a heat alert. Staff were also aware that

MCSP CQI Report | 2026

indoor temperatures are recorded every three hours, and outdoor temperatures every hour. Heat plan reference materials were posted in the officers' stations and readily available. Heat risk medication lists were up to date on each post.

Limits of confidentiality for RVR assessments: Patients were advised regarding the limits of confidentiality in all RVR assessments during the audit period.

Timely submission of mental health assessment results: Mental health staff completed the mental health RVR assessment within 8 calendar days of referral, per policy, at or above 98% of the time throughout the audit period.

Concerns

UOF Involving MH Patients: There were four controlled Use of Force incidents and 414 immediate Use of Force incidents within the reporting period. MHSDS patients were involved in all four controlled Use of Force Incidents, as well as 386 of the 414 immediate Use of Force incidents. Of the total number of controlled Use of Force incidents, one required administration of PC2602 medication. Of the total Use of Force incidents within the review period, 93% involved mental health patients. Comparatively, the overall MHSDS population at MCSP is approximately 59%.

RVRs completed in a private setting: Staff completed mental health RVR assessments in a private setting only 51% of the time throughout the audit period, which is primarily due to patient refusal to attend the evaluation in a private setting.

Timely RVR mental health assessment request: There is currently a mismatch between regulatory requirements related to timelines for issuing RVRs (15 days) and the mental health policy requirement for issuance of an RVR MHA request (within 48 hours of the violation). Before the mental health assessment can be requested, the RVR must be written, approved by a supervisor, and classified in SOMS to determine whether an assessment is required. If the RVR meets requirements for an MHA, the request is automatically generated in SOMS once it is classified. Thus, staff must complete the RVR drafting, approval, and classification well before the regulatory timeline lapses, for requests to be considered timely. This occurred in 27% of cases where an RVR MHA was required during the audit period.

Recommendations

- 1. Reinforce de-escalation techniques:** Provide staff refresher training on communication and deescalation techniques and resources available such as support from clinicians in an effort to reduce the need for force.
- 2. Improve completion of RVR assessments in a private setting:** Evaluate the reasons for declined attendance at confidential RVR assessments, as well as other reasons these evaluations are not conducted privately and develop a workplan to address the identified barriers.

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
CCII, 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				100%†
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				100%†
MH Patients on Max Custody Over 180 Calendar Days with Timely Initial LTSCC				100%†

Documentation

Indicator	Feb 2026	6-Month Avg	Onsite Audits
Controlled Use of Force MH Assessments Meeting Documentation Requirements	0%†	0%†	
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	Dec 2025	6-Month Avg	Onsite Audits
Custody Staff who can Identify all NDRH Patients			100%+
NDRH Patients Provided Personal Property			100%+
Patients in restricted housing with working entertainment appliances	100%+	100%+	
Peace Officers Observed to Carry Their CPR Mouth Shield			100%
RHU EOP Out of Cell Time Offered			100%
RHU Shower Access			100%
Staff Who Report Unclothed Body Searches Conducted in a Private Area			100%+
Weeks where NDRH Patients are Offered Required Phone Calls			100%

✓ Strengths

Custody operations: Timeliness of out of cell activity happened 100% of the time during the reporting period. All incarcerated individuals required to have an entertainment device were in possession of one, and patients on non-disciplinary segregation were offered phone calls as required. Six randomly selected patients confirmed positive custody operations by offering that, unprompted during the patient survey, “the C/O’s are good here.” Patients also reported feeling supported in crisis. One patient noted that when a loved one died, staff proactively brought him out of his cell without him asking and he felt cared for and supported.

Institutional Classification Committee (ICC): The clinician in ICC provided relevant information regarding each patient’s mental health and programming such as treatment compliance, housing, risk assessment, suicide risk, activities of daily living, understanding of due process, and potential for decompensation. The committee chair, the warden of the institution, considered both the clinical and custody needs of the patient for program review. When the patient’s mental health status had an impact on their understanding of the ICC, staff members ensured effective communication.

⚠ Concerns

Mental health documentation requirements for Use of Force evaluations: Local supervisory staff completed one audit of a mental health Controlled Use of Force evaluation during the audit period. This event occurred in the MHCB, not RHU. The clinician’s documentation met 1 of 7 audit criteria; the note did not include reason for the patient’s non-compliance with verbal orders, summary of mental health factors, documentation that consultation with nursing or custody staff occurred, rationale regarding their assessment of whether or not the patient could understand orders, documentation of whether the patient was at risk of decompensation, or start and end of cool down period that was established by the incident commander and mental health clinician before initiation of force.

Recommendations

1. Take individualized action to ensure clinicians assigned to complete mental health Use of Force evaluations understand requirements.

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%†	100%†	0%†	67%†	100%†	50%†	
Emergent and Urgent MH Referrals That Result in SREs	95%	98%	96%	97%	94%	95%	96%	
MHCB Daily Provider Contacts (v2.0)	92%	94%	98%	96%	90%	96%	94%	
MHCB/PIP Supervisory Reviews of Discharge Safety Plans	63%†	29%†	86%†	88%†	50%†	90%†	70%	
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training	65%	83%	98%	99%	100%	100%	91%	
Safety Plans Signed Timely	86%	87%	82%	89%	88%	91%	87%	
Timely Clinical Follow-Ups (V2.0)	92%	93%	93%	93%	96%	75%	90%	
Audited Security Welfare Checks in Restricted Housing That Included the Required Visual Observation								100%
Custody Staff with CPR Training								91%
Custody Staff with Suicide Prevention Training								89%
Healthcare staff current with suicide prevention training								97%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories								88%
Institution SPRFIT Meeting Minutes Reviewed that Satisfy All Audit Criteria								0%†
MHCB and Acute/ICF Out of Cell Activities - Yard								100%†

MCSP CQI Report | 2026

MHCB and Acute/ICF Records with Rationale for Partial Issue								30%†
Nursing Staff Current with CPR Training								100%
Observed Initial Health Screenings								40%†
Onsite Review of Patient Orders for Issue and Observation								75%†
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								87%†
RHU Intake Incarcerated Persons Appropriately Housed								100%†
Suicide Resistant Cells								100%†

✓ Strengths

Training and mentoring compliance: Staff completed all mandatory mental health suicide prevention training courses with 100% compliance. Medical and mental health staff achieved over 96% compliance in IST training attendance, while 89% of custody staff attended their training.

RHU Intake cells: Staff reviewed new intake cell usage in C-12 and determined that practices were adequate. They housed all new intake incarcerated individuals in new intake cells.

MHCB IDTTs: During the review, staff observed two initial IDTTs. All participants actively contributed to the discussion. In both cases, the IDTT teams conducted thorough discussions and met all required CQI criteria.

Safety plans for MHCB discharges: Staff achieved 100% compliance for MHCB discharge safety plans. They individualized all five MHCB discharge safety plans and included interventions that effectively reduce risk.

MHCB Observation and Issue order justification: Daily issue and observation orders were present in all of the reviewed patient charts; however, clinical justification for limited issue was present in only 30% of records audited as described in the concerns section below.

MHCB out of cell time: Review of the Automated Restricted Housing Record (ARHR) system demonstrates that MHCB patients received slightly over 10 hours of yard or dayroom access per week, along with offers of 3 showers and 5 telephone calls each week during the audit period.

Emergent and Urgent referrals: 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 87 percent (13 of 15) of these cases had the SRE completed.

MCSP CQI Report | 2026

Temporary holding cell logs: Examination of hundreds of Temporary Holding Cell (THC) Logs for the three main yards (A, B, and C) that utilized THCs during the review period found that nearly all were in compliance with the four hour maximum timelines; however, two individuals were confined in the cells for danger to self in excess of four (4) hours (at 4.2 and 4.9 hours respectively).

Concerns

Alternative Housing: On-site observations suggest clinicians do not encourage private, out-of-cell assessments. For example, language such as "Can we do this assessment cell front or do you prefer a private assessment", was observed. In one case, the clinician incorrectly stated in the SRE that "patient agreed to be seen cell front due to yard lockdown." This was not correct. The facility's PSR did not prohibit the opportunity for out-of-cell assessments in that unit. Officers informed the review team that clinical assessments are normally conducted cell front, and that patients in alternative housing are not typically placed in cells adjacent to each other; however, alternative housing cell 121 is adjacent to cell 122, a non-alternative housing cell that housed two incarcerated individuals who could overhear the mental health assessment, potentially decreasing the patient's candor and participation.

Safety Plans for Rescinded Patients: The review also found that only 33 percent (5 of 15) of patients rescinded from MHCB LOC had adequate safety plans. Plans were viewed as inadequate if the narrative did not identify any coping skills and/or specific interventions to assist the patient in reducing their suicide risk.

MHCB Observation and Issue Order Justification: Justification for limited issue and enhanced observation status was missing in 70 percent of patients' daily documentation.

Alternative Housing Assessments: Observation of the assessment of three (3) patients in Alternative Housing (C-13) occurred on July 28-29. The required SREs were completed in each case, however, the safety plans were very poor. In addition, there were concerns with both the brevity of the assessments, as well as the lack of opportunity for out-of-cell assessments. The clinician spent less than 5 minutes with each patient. Although subsequently completed SREs included adequate documentation of both current and prior suicide risk, there was limited engagement with the patients regarding suicide risk. In addition, despite the fact that safety plans were contained in each SRE, the clinician did not address safety planning directly with the patients.

Recommendations

- 1) **Ensure that justification for issue and observation orders is 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 to explain the patient's unique risk factors and clinical need. General statements of risk and/or providing minimal items without justification are not acceptable.
- 2) **Improve confidentiality of patient contact in alternative housing:** See priority recommendations.
- 3) **Improve quality of suicide risk evaluations:** Provide refresher training to clinicians assigned to assess patients in alternative housing to ensure understanding of requirements and the skills necessary to complete comprehensive suicide risk evaluations.

MCSP CQI Report | 2026

- 4) **Revise clinical follow-up procedures:** Recent statewide updates have been made that clarify the first day of the five day follow-up should begin on the day after the MHCB rescission, rather than on the day of the rescission; update procedures to reflect this recent change.
- 5) **Improve quality of safety planning:** See priority recommendations.

Staffing

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

Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief of Mental Health	1.0	1.0	0%
Chief Psychologist	1.0	1.0	0%
Chief Psychiatrist	1.0	1.0	0%
Senior Psychiatrist (Supervisor)	1.0	1.0	0%
Senior Psychologist (Supervisor)	7	5	29%
Supervising Psychiatric Social Worker I	1.0	1.0	0%
Senior Psychologist (Specialist)	7.5	6.0	22%
Recreation Therapist	24	15.85	24%
Staff Psychiatrist	15	13.10	10%
Psychologist – Clinical	7	7	0%
Clinical Social Worker	2	2	0%
Primary Clinician (PC)	59	42.17	35%
PC: Psychologist – Clinical		19.24	
PC: Clinical Social Worker		6.31	
PC: Marriage and Family Therapist		1.46	
PC: Professional Clinical Counselor		0.97	

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 $(\text{Average Allocated} - \text{Average Filled}) \div \text{Average Allocated}$.

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

✓ Strengths

Chief positions remained filled throughout the review period.

MCSP CQI Report | 2026

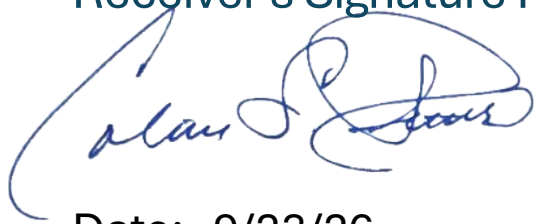
Concerns

There are vacancies in key positions with senior psychologist supervisor being filled at 71%, senior psychologist specialist filled at 78%, and senior psychiatrist supervisor filled at 17%.

Filled positions for recreation therapists have decreased considerably across the review period from 92% in December 2025 to 66% in May 2026.

Primary clinician rates across the review period were at 65%. Approximately 81% of onboard primary clinicians are telehealth or registry staff, with approximately 19% being in-person state staff.

Receiver's Signature Page

A handwritten signature in blue ink, appearing to read "Alan J. Jones", is written over the "Receiver's Signature Page" text.

Date: 9/23/26

Appendix A: Acronyms and Initialisms

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

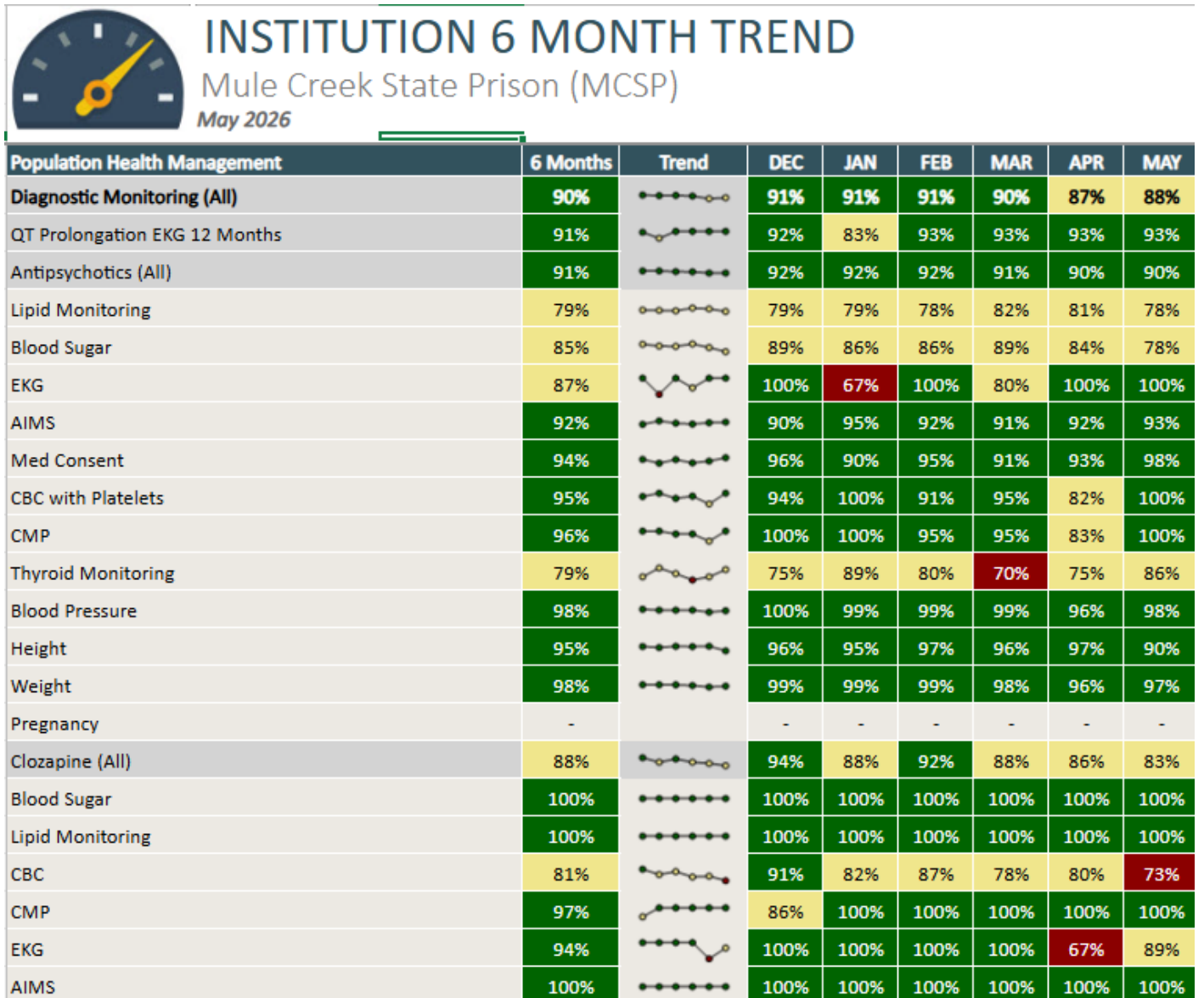
MCSP CQI Report | 2026

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

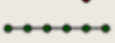
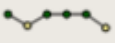
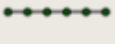
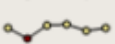
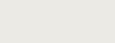
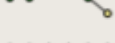
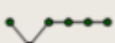
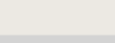
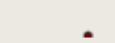
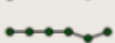
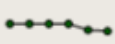
MCSP CQI Report | 2026

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

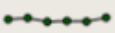
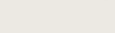
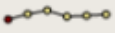
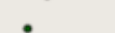
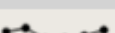
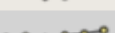
Appendix B: MAPIP



MCSP CQI Report | 2026

Lithium Level	71%		100%	100%	17%	67%	75%	100%
Thyroid Monitoring	73%		75%	60%	83%	100%	50%	67%
CMP	71%		50%	100%	63%	50%	60%	100%
CBC	88%		-	100%	75%	100%	-	100%
EKG	88%		100%	100%	67%	100%	50%	100%
Med Consent	100%		100%	100%	100%	100%	100%	100%
Height	92%		100%	83%	100%	100%	100%	80%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Oxcarbazepine (All)	82%		86%	72%	88%	88%	69%	86%
CBC	78%		81%	68%	83%	87%	69%	84%
CMP	78%		80%	67%	83%	85%	76%	80%
Med Consent	92%		100%	90%	100%	93%	50%	94%
Pregnancy	-		-	-	-	-	-	-
Lamotrigine - Med Consent	100%		100%	100%	100%	100%	100%	-
Thyroid Monitoring	92%		100%	100%	-	-	100%	75%
Med Consent	100%		100%	100%	100%	100%	100%	100%
Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Height	96%		100%	50%	100%	100%	100%	100%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Mood Stabilizers (All)	84%		85%	86%	86%	90%	72%	86%
Carbamazepine (All)	83%		-	-	-	100%	0%	100%
Carbamazepine Level	100%		-	-	-	100%	-	100%
CBC	100%		-	-	-	100%	-	-
CMP	100%		-	-	-	100%	-	-
Med Consent	0%		-	-	-	-	0%	-
Pregnancy	-		-	-	-	-	-	-
Valproic Acid (All)	85%		82%	95%	93%	90%	74%	84%
Med Consent	94%		88%	100%	100%	92%	89%	100%
Blood Pressure	99%		100%	100%	100%	100%	92%	100%
Height	97%		100%	100%	100%	100%	92%	91%
Valproic Acid Level	42%		43%	57%	50%	17%	36%	44%
CBC with Platelets	80%		67%	100%	92%	91%	62%	83%
CMP	81%		63%	100%	100%	91%	65%	81%
Weight	99%		100%	100%	100%	100%	100%	93%

MCSP CQI Report | 2026

Antidepressants (All)	91%		92%	91%	93%	89%	92%	87%
EKG (Tricyclics)	50%		-	100%	0%	-	-	-
Med Consent	94%		95%	96%	92%	93%	92%	97%
Thyroid Monitoring	71%		72%	71%	96%	66%	86%	54%
Pregnancy	-		-	-	-	-	-	-
Venla Blood Pressure	99%		100%	100%	100%	100%	96%	96%
Medication Management	6 Months	Trend	DEC	JAN	FEB	MAR	APR	MAY
Medications Received Timely (All)	86%		85%	86%	88%	86%	86%	86%
By Transfer Type								
New Arrival to CDCR (RC) – RC	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – RHU	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – MHCB	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – CTC	-		-	-	-	-	-	-
Intra-System (Within Institutions) – GP	78%		73%	79%	83%	76%	77%	78%
Intra-System (Within Institutions) – RHU	89%		91%	87%	87%	85%	92%	92%
Intra-System (Within Institutions) – MH Inpatient	82%		80%	79%	73%	89%	85%	86%
Intra-System (Within Institutions) – Specialized Medical	-		-	-	-	-	-	-
Inter-System (Between Institutions) – GP	75%		78%	74%	79%	74%	73%	77%
Inter-System (Between Institutions) – RHU	88%		82%	85%	93%	82%	90%	89%
Inter-System (Between Institutions) – MH Inpatient	92%		96%	97%	70%	100%	97%	100%
Inter-System (Between Institutions) – Specialized Medical	92%		-	92%	-	-	-	-
Return to CDCR – GP	82%		81%	70%	82%	85%	84%	83%
Return to CDCR – RHU	88%		100%	78%	96%	100%	96%	78%
Return to CDCR – MH Inpatient	-		-	-	-	-	-	-
Return to CDCR – Specialized Medical	-		-	-	-	-	-	-
Stable Housing	86%		86%	86%	88%	87%	86%	86%
Leaving CDCR	100%		100%	99%	100%	100%	99%	100%
By Provider Type								
Psychiatry	91%		91%	91%	92%	91%	90%	91%
Medications Refused (All)	6%		6%	6%	6%	5%	6%	6%
By Provider Type								
Psychiatry - Refused	5%		5%	6%	5%	5%	5%	5%
Non-Formulary by Psychiatrists	4.8%		4.6%	4.7%	4.6%	4.8%	4.9%	5.1%

Appendix C: Suicide Prevention Report

Restricted Housing Unit (RHU)

Second Watch Partnership Huddle: The morning huddle in the RHU was observed on July 29, 2026. There was full attendance and participation by a tele-health clinician, sergeant, and PT. All areas, including new arrivals, high risk and SRMP incarcerated patients, were discussed.

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

Intake Cells: There were 16 New Intake Cells (126 – 133 and 226 – 233) in the RHU (C-Yard, Building 12). Review of New Intake Call usage in C-12 found adequate practices and all new intake patients were housed new intake cells. Please refer to the CQIR for a further summary of the 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

Suicide-resistant cells: MCSP had eight (8) MHCB cells, and each had previously been retrofitted to be in compliance with statewide policy. During the onsite assessment, there were four (4) patients in the unit, three (3) of whom were on suicide observation status.

MHCB IDTT Meetings: A total of two (2) MHCB IDTT meetings were observed during the onsite review. Both were initial IDTT meetings. Both patients were admitted for suicidal ideation/danger to self. One of the patients was placed in mechanical restraints while the meeting was being conducted. The meetings began on time. The IDTT treatment room included a table and chairs. The primary clinician and psychiatrist, RN, and CC2 had access to their laptops during the meetings.

Overall, the IDTT discussions were very thorough, and information was provided in an organized and succinct manner. The MHCB supervisor initiated introductions and stated the purpose for the meetings in both cases. Both patients were on suicide precaution status and issued safety smocks. The primary clinician in both IDTT meetings provided relevant historical and brief clinical summaries that included current symptomatology, diagnosis, reason for admission, hospitalizations, and strengths and weaknesses. In both cases, adequate case formulations were presented and RVRs were discussed. Each patient was given an opportunity to provide input regarding their treatment while in the MHCB. Discharge plans were discussed during both meetings.

Measurable treatment goals were identified and discussed in both cases. Medication and side effects were discussed by the psychiatrist in both cases. The CC2 provided pertinent information for each patient. The nursing staff provided information in one case. Although both were initial IDTT meetings,

MCSP CQI Report | 2026

initial safety planning was discussed in each case. Issue and observation levels were discussed and higher level of care and appropriateness of level of care were also discussed for each of the patients.

MHCB Supervisor Review of Discharging Safety Plans: A review of the On Demand Performance Report during the audit period indicated 87 percent of safety plans were completed timely (n=301); however, only 70 percent of the required safety plans were reviewed timely by a supervisor.

Quality of Safety Planning: Five (5) randomly selected safety plans for patients who were discharged from the MHCB during the audit period were reviewed. All five safety plans were deemed to be of adequate quality. All of the reviewed safety plans contained interventions and were individualized to address patient specific concerns.

Observation and Issue Orders: A review of daily documentation for 10 MHCB patients admitted 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 in seven patients' daily documentation during the duration of orders for limited issue and observation. In half of the reviewed cases (5/10), the patients were discharged on suicide precaution status despite denying suicidal ideation for several days prior to their discharge.

Provider Orders: (to include level of observation, patient issue, and privileges) were placed outside each suicidal patient's door on Adaptive Support Forms (CDCR 128 C-2) and found to be current.

Provider Contacts: Medical chart review of the four (4) patients in the MHCB unit during the onsite audit found that all were seen by a MHMD or MHPC on a daily basis, as well as offered a confidential setting for assessment.

Privileges: The Automated Restricted Housing Record (ARHR) system was examined for documentation of out-of-cell activity (OCA) for 10 MHCB patients during seven-day periods of the review period. All had been cleared for out-of-cell activities by providers. The review found that the 10 patients were offered unstructured out-of-cell activity (yard and dayroom) during the time period, ranging from 7.5 to 13.75 hours per week. The average was slightly over 10 hours. In addition, all patients averaged more than 3 showers offered and 5 telephone calls per week.

Of note, the above findings might differ from those appearing in the CQIT report as examined by the DAI's Mental Health Compliance Team (MHCT). The differences would be in methodology. The regional suicide prevention expert tracks clinical justification for out-of-cell activities, 10-hour minimum offering per week of yard/dayroom (and not mental health appointments), and samples 10 patients who were recently placed on Suicide Precaution and/or Suicide Watch status during an in-patient placement. The MHCT adheres to the current version of the CQIT, which only reviews those patients currently housed in the in-patient program at the time of the onsite assessment, counts the total amount of offered OCAs, and allows for mental health appointments to be counted as OCAs.

Clinical Discharge Follow Ups: A random sample of 15 clinical MHCB discharge follow ups that were completed for a full five days during the audit period were selected. The results revealed that 100

MCSP CQI Report | 2026

percent (15/15) cases contained five consecutive days of follow-up contacts. Safety plans were included daily in all but the one case resulting in 93 percent compliance. The On Demand Performance report indicated that MCSP was 90 percent compliant during the audit period for timely clinical discharge follow ups.

Alternative Housing

Alternative housing cells to temporarily house individuals identified as suicidal and awaiting MHCB placement were utilized on a daily basis at MCSP. Alternative Housing was located in C-Yard, building 13 (cells 118-121) and C-Yard, Building 12 (cells 147-150) for RHU IPs. For a six-month period of December 1, 2025, through May 31, 2026, 286 patients were placed in alternative housing, with all released within 24 hours. In addition, 78 percent (224 of 286) of cases resulted in the MHCB referrals being rescinded and incarcerated persons returned to their housing units.

Further, observation of the assessment of three (3) patients in Alternative Housing (C-13) occurred on July 28-29. Although the required SREs were completed in each case, the safety plans were very poor. In addition, there were concerns with both the brevity of the assessments, as well as the lack of opportunity for out-of-cell assessments. The clinician spent less than 5 minutes with each patient and the narrative contained within each SRE was inconsistent with the observed interaction between the clinician and patients. The clinician did not encourage private, out-of-cell assessments and used language in two cases such as “Can we do this assessment cell front or do you prefer a private assessment.” In the third case (on July 28), the same clinician incorrectly stated in the SRE that “patient agreed to be seen cell front due to yard lockdown.” This was not correct. The facility's PSR did not prohibit the opportunity for out-of-cell assessments in C-13.

Due to the clinician's demeanor toward one patient, as well as their premature MHCB rescission without a thorough assessment, the Review Team requested that the patient be reassessed by another clinician. That reassessment was also inadequate. The issue was brought to the attention of the Chief Psychologist.

Officers assigned to C-13 stated that clinical assessments are normally conducted cell front, but that patients were generally not placed in cells adjacent to each other, e.g., on July 29, two patients in Alternative Housing were separated four cells away from each other (No. 118 and No. 121). However, cell 121 was adjacent to cell 122, a non-alternative housing cell that housed two patients who were observed to be overhearing the clinician's assessment on July 29. In sum, the lack of privacy for patients assessed in Alternative Housing was very problematic.

Medical chart review of 15 rescinded cases found that all had SREs, but only 47 percent (7 of 15) of applicable cases had all daily clinical follow-ups for each of the five required days. In many cases, clinicians incorrectly used the day of MHCB rescission as the first day of the five-day follow-up. Further, the review found that only 33 percent (5 of 15) had adequate safety plans. Plans were viewed as inadequate if the narrative did not identify any coping skills and/or specific interventions to assist the patient in reducing their suicide risk.

MCSP CQI Report | 2026

Finally, examination of hundreds of Temporary Holding Cell (THC) logs for the three main yards (A, B, and C) that utilized THCs found that two (2) individuals were confined in the cells for danger to self in excess of four (4) hours (at 4.2 and 4.9 hours respectively) during the review period.

Suicide Risk Management Program (SRMP)

During the audit, data discrepancies were discovered between the On Demand reports and the EHRS. As a result, the On Demand report has been temporarily suspended while the issue is escalated to the Headquarters Reporting Unit for resolution.

MCSP 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 only 20 percent (1/5) had interventions and goals documented within the SRMP tab of the Master Treatment Plan.

Discharge Custody Checks

The process by which individuals were provided Discharge Custody Checks at 30-minute intervals following release from either an MHC 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 found that all meetings except one (February 2026) had quorums of all required mandatory members or designees. (The February 2026 meeting incorrectly named the CMH as a psychiatric designee, but the CMH was not a psychiatrist.) Minutes included discussion on compliance data, improvement projects, and SRMP data. Although a summary of a serious suicide attempt was found in May 2026 minutes, it was inconsistent with the required 7-step process for conducting clinical case reviews of serious suicide attempts. The Review Team subsequently provided a copy of a comprehensive clinical case review of the incident. The SPRFIT coordinator was reminded that such reviews should be attached to the meeting minutes in the future. In addition, the status of corrective actions based upon prior Receiver’s suicide prevention expert assessments and/or regional SPRFIT audits were not included in any meeting minutes. In sum, 4 of 5 significant SPRFIT compliance areas were adequate.

In addition, the MCSP SPRFIT Coordinator and/or designee attended both the Patient Advisory Council (PAC) meetings and the Patient Family Council (PFC) meetings during the review period.

Policies: MCSP has a local suicide prevention policy (Suicide Prevention and Response, LOP MC059, revised February 2026) that encompasses various issues, including SPRFIT responsibilities, Bad News screening, and the SRMP. The Alternative Housing (LOP MC038, revised August 2025) was also reviewed, and it was consistent with the statewide memorandum. Finally, although MCSP’s Crisis

MCSP CQI Report | 2026

Intervention Policy (LOP MHL024), revised April 2024) was consistent with the statewide memorandum, the policy was not consistent with current practices because the facility has not had a full CIT since November 2024.

Suicide Risk Evaluations in MHCB and Outpatient

During the audit period, MCSP generated 638 emergent consult orders for DTS with 95 percent compliance. SRE completion upon MHCB discharge resulted in 98 percent compliance. SRE completion upon MHCB referral was noted at 79 percent. SRE completion at the time of a MHCB recission was 100 percent. Of the eight patients from DSH who arrived to MCSP during the audit period, SREs were not completed timely for two, resulting in 75 percent compliance. Overall timeliness of suicide risk evaluation completion during the audit period was 88 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 87 percent (13 of 15) of these cases had the SRE completed.

Crisis Intervention Team (CIT)

In addition, the Crisis Intervention Team was launched at MCSP in May 2019 and was previously operational seven days a week from 2:00 p.m. until 10:00 p.m., with other clinicians responding to emergency mental health referrals during other hours. In November 2024, however, the CIT was suspended due to overall staffing shortages, and yard clinicians assumed responsibility for conducting emergent referrals. During the current assessment, the Review Team was informed that the CIT remains suspended due to the lack of two clinicians posted during weekdays and weekends on the 3rd shift.

The Review Team observed a crisis response to an emergency mental health referral during the afternoon of July 29. The clinician never offered the patient the opportunity for a private, out-of-cell assessment and the interaction occurred with the patient in a THC located in the hallway of the program office in B-Yard despite the fact that the sergeant's office had been pre-arranged for a private interview. An SRE was completed as required and the patient was assessed as a moderate risk, but not imminent, for suicide and returned to their housing unit.

Quality Improvement Plans (QIPs) Generated by Suicide Case Reviews

MCSP's last suicide occurred on March 19, 2025, which resulted in no mental health QIPs.

Training and Mentoring Compliance

Compliance with the Annual IST Suicide Prevention Training for 2025 was as follows: 89 percent of custody, 96 percent for medical, and 98 percent for mental health staff. Compliance with Coleman suicide prevention training requirements as of May 2026 are as indicated below.

MCSP CQI Report | 2026

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

Assignment of Corrective Action Plan and Recommendations

The last HQ SPRFIT and Receiver's suicide prevention expert reviews were completed jointly on April 17 and 18, 2025. At that time, three CAPs were generated. Two of the previously assigned CAPs may be closed due to compliance noted during this on-site review.

	Summary of Concern	Progress	Follow Up Status
1	Psych Tech Rounds	Substantial	Close
2	Safety Planning Documentation	Minimal	Open
3	SRE Mentoring Training Compliance	Substantial	Close

As noted above, the status of corrective actions based upon prior Receiver's suicide prevention expert assessments and/or regional SPRFIT audits were not included in any reviewed meeting minutes. MCSP should ensure that all assigned open and previously assigned CAPs as well as newly generated recommendations are listed as an Issue and updated 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.

Conclusion

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

- 1) Ensure that justification for issue and observation orders is 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 that explain the patient's unique risk factors and clinical need. General statements of risk and/or providing minimal items without justification are not acceptable.
- 2) Designate a private, confidential location in or near C-Yard, Building 13, for the assessment of patients on Alternative Housing status. In addition, clinicians assigned to assess patients in Alternative Housing should collaborate with C-13 officers in the offering of out-of-cell assessments to patients.

MCSP CQI Report | 2026

- 3) Provide refresher training to clinicians assigned to assess patients in Alternative Housing to ensure that they allocate enough time with patients to ensure comprehensive SRE assessments.
- 4) Ensure that clinicians do not utilize the same day of the MHCB rescission as the first day of the five-day follow-up assessment of patients.
- 5) 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.

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

Appendix D: Excluded Indicators

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

Report for California Department of Corrections and Rehabilitation
MULE CREEK STATE PRISON

MAJOR SUSTAINABLE PROCESS REVIEW

Quarter Three, 2026

PARTICIPANTS

Program Staff

Regional Mental Health Administrator..... Laura Ceballos, Ph.D.

Senior Psychologist Specialist..... Dominique Bressi, Psy.D.

Senior Psychologist Specialist..... Andrea Ames, Psy.D.

Senior Psychologist Specialist..... Fereshte Mirzad, Psy.D.

Senior Psychologist Specialist..... Peter Madsen, Ph.D.

Senior Psychologist Specialist..... Crystal Watson, Psy.D.

Senior Psychologist Specialist..... Tyler Peterson, Psy.D.

Supervising Psychiatric Social Worker..... Tanya Knight, LCSW

AREAS REVIEWED

Higher Level of Care Considerations Sustainable Process Data Review, Mental Health Subcommittee Minutes, Monthly Audits/Table V, Acute-ICF Non-Referral and Referral Reports, and Higher Level of Care Considerations for Internal Consistency were reviewed. IDTTs were observed in all Mental Health programs during CQIT+. The following units were visited for tier walks: ML EOP, RHU, and MHCB.

Program Area Reviewed:	Sustainable Process Data Review: 46%

MCSP CQI Report | 2026

The Sustainable Process Data Review audits Higher Level of Care Considerations documentation for quality and inter-rater reliability between the headquarters reviewer and the inpatient coordinator. The Sustainable Process Data Review results for Q3, 2026 are identified as 46% by headquarters' review and 51% by MCSP review, demonstrating a slight decrease in quality and significant increase in agreement between the headquarters reviewer and the inpatient coordinator. The Sustainable Process Data Review results for Q2, 2026 are identified as 53% by headquarters' review and 77% by MCSP review, with benchmark at 85%.

There are a total of 67 cases reviewed, with three cases in which the inpatient coordinator and the headquarters reviewer disagreed. In all those cases, the inpatient coordinator found the case "good", and the headquarters reviewer found it "unacceptable," two due to insufficient narrative supporting non-referral and one is due to being signed late. Of the 67 cases reviewed, headquarters' review found in total 31 cases "good" and 36 cases "unacceptable." Of the 36 cases found "unacceptable," 31 are due to insufficient narrative supporting non-referral, 17 due to missing or incomplete MSE; one is due to insufficient treatment interventions; two are due to missing documentation, specifically missing the positive considerations; and two are due to being completed late. Of the 36 cases found unacceptable, 32 are due to quality and four are due to documentation errors.

Follow-up required: YES X NO

If YES: Follow-Up Date:

Routine Review During CQIT

Quality Higher Level of Care Considerations are an ongoing part of quality improvement, evaluation, and training. Please see Action Plan section, Item #1.

Program Area Reviewed:

**Mental Health Subcommittee Minutes/
Monthly Audits/Table V**

Mental Health Subcommittee Minutes were reviewed for April, May, and June 2026. A quorum is met, and the inpatient coordinator or designee is present throughout. Table V is

MCSP CQI Report | 2026

embedded across the quarter. MCSP is represented on the headquarters inpatient coordinator teleconference throughout.

In April's minutes, reporting on March data, there is one initiated referral in Table V, with none rescinded, submitted timely to Acute level of care. The Documentation Review results are 95%.

In May's minutes, reporting on April data, there are two initiated referrals in Table V with none rescinded, one submitted to Acute and one submitted to Intermediate level of care. One hundred percent of referrals are submitted within timeframes. The Documentation Review results are 89%.

In June's minutes, reporting on May data, there are no initiated referrals in Table V with none rescinded. The Documentation Review results are 74%.

After validation and reconciliation, the above accounting of total submissions and timeliness aligns with the On Demand Acute-ICF Referral report. There is a total of three referrals initiated with none rescinded in the quarter reviewed, two submitted to Acute and one to Intermediate level of care. Referral submission timeliness averaged 100%. There is a total of 12 referrals initiated with none rescinded in the quarter prior, six submitted to Acute and six to Intermediate level of care. Referral submission timeliness averaged 100%.

As an ongoing practice, inpatient coordinators have been asked to reconcile and validate the On Demand Acute-ICF Referral report with the referral data they input into Table V. MCSP is completing this process as requested.

Follow-up required: YES X NO

If YES: Follow-Up Date:

Routine Review During CQIT

Follow-Up Action Plan:

These data were reviewed with the Higher Level of Care team. Quality Higher Level of Care Considerations are an ongoing part of quality improvement, evaluation, and training.

Program Area Reviewed:

Acute-ICF Non-Referral and Referral Reports

Acute-ICF Non-Referral reports were reviewed for April, May, and June 2026.

MCSP CQI Report | 2026

In April, there are 232 entries on the non-referral report in which patients met consideration for referral to a higher level of care during IDTT but were not referred. There are 15 patients with multiple entries: four due to MHCB placement and movement between programs, one due to MHCB placement, and ten due to updates. There are no erroneous entries noted.

In May, there are 175 entries on the non-referral report. There are seven patients with multiple entries: one due to MHCB placement and movement between programs, one due to MHCB placement, and five due to an update. There are no erroneous entries noted.

In June, there are 167 entries on the non-referral report. There are 11 patients with multiple entries: six due to MHCB placement and movement between programs, and five due to updates. There are no erroneous entries noted.

There are ten patients appearing on the non-referral report across all three months. Consideration number seven (participated in less than the minimum treatment hours in the last three months) continues to be the most cited over the quarter.

Acute-ICF referrals, as reported in Table V of the monthly Documentation Review audit, are reviewed in the Subcommittee Minutes Section.

Follow-up required: YES X NO

If YES: Follow-Up Date:

Routine Review During CQIT

Follow-Up Action Plan

These data were reviewed with the Higher Level of Care team. Quality Higher Level of Care Considerations are an ongoing part of quality improvement, evaluation, and training.

Program Area Reviewed:

Documentation Review:

Higher Level of Care Considerations for Internal Consistency

This audit was suspended since the implementation of CQIT.

Follow-up required: YES X NO

If YES: Follow-Up Date: N/A

Follow-Up Action Plan:

Program Area Reviewed:

Observed IDTTs: MHCB, RHU, and ML EOP IDTTs

MHCB

The IDTT started on time for one initial case presentation with the patient present in mechanical restraints due to max custody status. Staff present included the senior psychologist supervisor, a psychologist, a psychiatrist, a correctional counselor, a registered nurse, a recreation therapist, and an escorting officer. The supervisor made introductions, explained the purpose of IDTT, reviewed privileges, and justified observation and issue. The supervisor addressed the precipitant to MHCB placement utilizing open-ended questions. The correctional counselor was thorough in reviewing relevant case factors including RVRs and asked open-ended questions in a supportive manner. Effective communication was ensured.

While the clinician presented a thorough case formulation with predisposing, perpetuating, precipitating, and protective factors, she spoke fast initially and about rather than with the patient during this portion of the presentation. The clinician reviewed course of treatment, relevant history, history of mental health placement, along with diagnosis, current symptoms, and current functioning. Self-harm history and suicide risk were reviewed, including the current incident. The clinician addressed the safety plan with the patient. Details were elicited regarding precipitants with ample time given for the patient to speak. Goals were measurable and interventions were specific. Higher Level of Care Considerations were reviewed, including multiple RVRs, with current placement justified and discharge planning addressed in the overall treatment plan.

The psychiatrist contributed thoughtfully to the treatment planning process, engaged the patient, and clarified current diagnosis, taking care in addressing safety concerns and symptoms of depression. She provided information regarding current medications and invited the patient into the conversation. The recreation therapist reviewed encouraged the patient to go out to yard early due to the heat, reviewed the schedule and available

recreational activities. The nurse reviewed relevant details regarding the patients care and participation. The supervisor summarized thoroughly.

Overall, as noted in many quarters prior, this was a thoughtful and thorough treatment team. While the clinician is encouraged to speak slowly and with the patient rather than about, overall, the patient was encouraged to participate throughout, asked open-ended questions, and effective communication was ensured.

RHU

The IDTT began on time and was held in a confidential location with space for all participants. Five IDTTs were observed, two present and three held in absentia. Three were initials, one a routine update, and one an IEX review and initial following a rescinded MHCB referral. Five separate primary clinicians were observed, three in person and two via telehealth. All five cases reviewed were patients at the EOP level of care. The acting senior psychologist supervisor, primary clinicians, psychiatrist, correctional counselor, and the psychiatric technician were in attendance. It was evident that the patients had met their primary clinician and psychiatrist prior to the IDTT.

Each IDTT presentation began with an explanation of the purpose of the IDTT and team introductions by the supervisor. The correctional counselor provided limited and insufficient information, reviewing only the reason for RVR placement. In one case, he did ensure effective communication with a patient with hearing aids. While the treatment commented on RVRs, the related behaviors and mental health contributions were not always integrated into the treatment plan with individualized interventions and goals. Nor was their meaningful consideration of treatment resistance with custody input.

For patients present, staff spoke with the patient rather than about and routinely asked open-ended questions to support patient participation. While the primary clinicians were well-prepared and presented case formulations, clinical summaries, level of care history, symptoms, diagnoses, progress toward treatment, and any barriers to treatment, treatment goals were vague, not clearly tied to specific interventions, and rarely measurable. Higher Level of Care Considerations were explicitly discussed in each case observed, but not always in language meaningful to the patient. Level of care decisions were addressed in each case but not always well justified.

The psychiatrist contributed minimally to each case but did not routinely name medications or relate those medications to the target symptoms. In several cases she only provided this information after prompting from the auditor. The psychiatrist only engaged in diagnostic clarification when asked directly. The psychiatric technician offered information on rounding based on documentation in the records.

The supervisor was able to summarize the treatment plan for complex cases, prompt in several needed ways, and intervene at critical times to ensure immediate patient needs were addressed, particularly in one case where medical needed to be included due to a diabetic patient refusing their insulin for several weeks. That said, there were deficits in the IDTT and more prompting was needed.

MLEOP – A

This a combined EOP/CCCMS IDTT. Five EOP and three CCCMS case presentations were observed. Due to the recent lifting of a PSR, only two of the five EOP patients attended, with the others being held in absentia. There was one initial EOP case observed, held in absentia, and four routine EOP cases. For the CCCMS cases observed, all were initials in absentia.

The IDTT displayed multiple strengths. All patients appeared to be at the correct level of care. The primary clinician and psychiatrist knew the patient and had met with them prior to IDTT. Higher level of care indicators, including MHCB referrals, RVRs, and treatment attendance, were mostly discussed. Case formulations were presented. The CCI was particularly good at exploring the options for a behavioral override for a Level IV who had displayed good behavior for a long period of time.

Despite strengths noted above, there were significant deficits such as confusion regarding the start time and the absence of a clinical team lead. The supervisor was out, and as such, the CCI appeared to facilitate the discussion and frequently spoke first. This set a custodial tone, rather than a clinical one. Goals, when stated, were only intermittently measurable. While barriers to treatment, such as attendance, were routinely discussed, interventions targeting these barriers were missing. Additionally, while all members of the IDTT spoke, there was not a robust interdisciplinary conversation, instead having a serial presentation. Diagnoses did not always clearly link to medications, including in one PC2602 case where that patient's only diagnosis was PTSD. Also, a patient in the ISUDT program had no substance use disorder diagnosis given until prompted by the auditor.

MLEOP – B

The IDTT began on time. The IDTT leaders consistently stated the purpose of the meeting in patient-friendly language and facilitated discussion across disciplines, though there were opportunities to strengthen engagement of all team members in some cases. Primary Clinicians knew their patients well and generally provided succinct case formulations. Treatment planning and goals were lacking in clarity and measurability. Psychiatric input was inconsistent, but when present, diagnostic and medication rationale was provided in a way that was understandable to the patients.

While patients were invited to meaningfully participate in their IDTT meetings, teams would benefit from more consistent use of open-ended questions that elicit the patient's perspective on diagnosis, goals, and treatment options, rather than relying primarily on yes/no or brief confirmation questions. In some cases, treatment goals were either broad or not clearly measurable; targeted coaching could help teams consistently frame goals in observable, time-bound terms understandable to patients.

MLEOP – D

Eleven routine IDTTs were scheduled, and five observed. Patients were present throughout all IDTTs observed. The IDTT started on time with all required staff in attendance with access to records. The CCI was thoroughly engaged and consistently provided information about relevant case factors, including dates patients were received into CDCR, RVR histories, and eligible dates of release and/or parole hearings. The CC1 appeared to utilize SOMS effectively across case presentations. For those present, there were no factors related to mental health, nor adaptive functioning that impacted patients' ability to adequately follow and understand treatment team discussion.

The program supervisor consistently explained to patients the purpose of each IDTT and afforded time for team members to introduce themselves. The team was interactive with patients and effectively solicited their input about treatment with open-ended questions. All presenting team members adequately discussed case formulation information (ex: theoretical orientation, individual strengths, protective/risk factors).

Diagnoses were consistently discussed and reviewed by team members. It was apparent that each team member arrived to IDTT well prepared with access to the Electronic Health Records System. The assigned psychiatrist adequately reviewed/identified prescribed medications and acknowledged good medication adherence. Patients were provided opportunities to report any adverse side effects, followed by options to modify medication management services. The psychiatrist also reminded patients of their next scheduled appointments.

The treatment team did well to encourage patients to identify effective coping strategies, protective factors, triggers/stressors, and established goals for treatment. Interventions were adequately discussed and a medical assistant in attendance provided helpful collateral observations regarding patient attendance to activities of daily living. The medical assistant proactively rescheduled a missed optometry appointment for a patient in need of new eyeglasses and appropriately advised him about the rescheduled appointment. Although treatment goals were consistently discussed across all presentations, most lacked

MCSP CQI Report | 2026

specificity and did not always adhere to a SMART format (e.g., continuing to manage depression, reducing severity of anxiety from 06/10 to 03/10. Objective benchmarks toward EOP discharge were not clearly addressed. The team consistently reviewed psychiatric inpatient placement histories and any history of suicide attempts and self-harm incidents, when applicable. Each patient observed had not accrued any RVR in over a year, thus there were no recent RVRs to address.

Of the five case presentations observed, two were meeting Sustainable Process indicators warranting consideration for a higher level of care. Both patients refused an excessive amount of offered treatment services over the previous 90 days (indicator #7). The treatment team did well to address Higher Level of Care Considerations while avoiding clinical jargon. The team utilized simple, basic language that patients could easily understand and follow. When identifying contributing mental health factors, however, the team did not speak to relevant ways that outpatient mental health treatment would be modified to address/improve indicator-specific issues. Otherwise, treatment team members did facilitate any level of care changes and did well to adequately justify each patient's appropriateness to be retained at outpatient care, from a perspective of functional stability.

Follow-up required: YES X NO

If YES: Follow-Up Date:

Routine Review During CQIT

Follow-Up Action Plan:

While the MHCB IDTT continues to show quality throughout, deficits and strengths are noted in the other IDTTs. Please see above for unit specific areas of strength and areas in need of improvement. Quality IDTTs are an on-going part of quality improvement, evaluation, and training.

Program Area Reviewed:

Tier Walks/Housing Unit Reviews/Patient Follow-Ups

During the Q3, 2026 Minor Sustainable Process visit, tier walks/housing unit reviews/patient follow-ups were conducted in ML EOP, RHU, and MHCB. In total, 11 patients were identified

for record review during the above assessments and/or carried forward from last quarter's review.

Follow-up required: YES X NO

If YES: Follow-Up Date: February 17th, 2026

Follow-Up Action Plan:

Any further follow-up for identified patients after record review will be requested of the institution within two weeks, with proof of practice due within three weeks.

ACTION PLAN

1. Higher Level of Care Considerations

Sustainable Process Data Review results had been since 2017 at or above benchmark of 85% with a significant drop in 2022: Q4, 2022 71%, Q1, 2023 52%, Q2, 2023 42%, Q3, 2023 62%, Q4, 2023 72%, and Q1, 2024 87%, Q2, 2024 70%, Q3, 2024 36%, and Q4, 2024 76%, Q1, 2025 77%, Q2, 2025 79%, Q3, 2025 57%, Q4, 2025 72%, and Q1, 2026 53%.

The Sustainable Process Data Review results for Q3, 2026 are identified as 46% by headquarters' review and 51% by MCSP review, demonstrating a slight decrease in quality and significant increase in agreement between the headquarters reviewer and the inpatient coordinator. The prior inpatient coordinator went on leave at the end of February. The new inpatient coordinator is making improvements in agreement with the headquarters reviewer, which bodes well for training line staff. It can take a year for a new inpatient coordinator to fully integrate the role; training and support are available as needed.

The ongoing process requested to be instituted by senior supervisors/team leads, in coordination with the inpatient coordinator, regarding quality Higher Level of Care Considerations documentation is as follows:

- One week prior to an Interdisciplinary Treatment Team (IDTT) meeting, an office technician responsible for IDTT scheduling should utilize On Demand, Current Due Dates, to determine which patients must be scheduled for treatment team meetings. The office technician can utilize an IDTT Log spreadsheet (template

available from regionals) to create a preliminary list of upcoming IDTTs for the following week. Within the preliminary IDTT Log spreadsheet, the scheduler should incorporate On Demand Sustainable Process Report (SPR) information. This can be done by generating the report from On Demand, Sustainable Process Report, and selecting the assigned institution. From the SPR, any objective positive indicators (considerations # 4-7) highlighted in yellow should be recorded for each patient on the IDTT Log spreadsheet within the column labeled “Which PIP/DSH Criteria Met.” For example, any patients on the SPR that are positive for “MHCB Admits/Referrals” should receive a “5” within the “Which PIP/DSH Criteria Met” column of the IDTT Log spreadsheet (“MH RVRs” receive a 6, and “Tx Refusal” receive a 7). Notably, an individual patient can be positive for more than one indicator, and it is important that all positive objective indicators are recorded on the preliminary IDTT Log.

- Generating a preliminary IDTT Log spreadsheet one week prior will forecast to clinicians and program supervisors any patients that may need to be considered for a higher level of care, alerting clinicians to prepare draft Higher Level of Care Considerations documentation to submit to the inpatient coordinator the day prior to IDTT. The preliminary period also affords opportunities to add to or modify the IDTT list prior to finalizing the schedule in the Electronic Healthcare Records System (EHRS). To ensure accountability, the preliminary IDTT Log spreadsheet should be emailed to all relevant treatment team staff (ex: clinicians, psychiatrists, program supervisors, correctional counselors), as well as senior management staff. It is also recommended to include all relevant custody staff, so they are aware of any planned level of care changes and can coordinate around classification committee schedules.
- On the morning of IDTT, the Sustainable Process Report must be generated again via On Demand and archived by the inpatient coordinator. A finalized IDTT Log spreadsheet should be created with any updated information from the previous preliminary log. Staff should also be informed via email whether there are any changes to the On Demand Sustainable Process Report from the previous report. This can be done through a group email. Within this email, it is further recommended that staff be reminded to submit timely referral/non-referral documentation to the inpatient coordinator to review and instructed to copy their program supervisors to help maintain accountability with correspondence. Again, draft Higher Level of Care Considerations documentation should be submitted to the inpatient coordinator the day prior to IDTT.

- The inpatient coordinator can utilize the finalized IDTT log(s) to efficiently track any higher level of care referral/non-referral documentation that must be reviewed prior to the MH Master Treatment Plans being signed in the EHRS. While drafts are due the day prior to IDTT, all documentation should be received prior to the end of IDTTs to allow sufficient time for the inpatient coordinator to review, revise, and exchange feedback with clinicians authoring MH Master Treatment Plans. Prior review is for consultation in preparation for IDTT and may change during the IDTTs treatment planning process. Subsequent review is to ensure quality and accuracy, requesting changes and/or new IDTTs as needed. The inpatient coordinator can elevate to program supervisors as needed if there are any ongoing issues with tardiness or non-responsiveness from clinicians (as previously recommended, supervisors should be included on any email correspondence regarding required referral/non-referral documentation), elevating to the chief psychologist if needed.
- The inpatient coordinator is responsible for ensuring timely completeness, accuracy, and quality of any referral/non-referral documentation. This includes a description of justification for any non-referrals, but also interim treatment plans when patients are referred to a higher level of care and are awaiting endorsement/placement.
- For any documentation deemed inadequate by the inpatient coordinator, clinicians should be requested to adjust the Higher Level of Care Considerations documentation in the EHRS during IDTT. Timely correspondence also helps ensure appropriate discussion and integration of the Higher Level of Care Considerations into the IDTT as part of the narrative presentation. Documentation must also include thorough treatment planning/modification discussion relevant to addressing all clinical factors contributing to why the patient is being considered for a higher level of care, but ultimately not being referred.
- Program supervisors should submit a completed IDTT Log spreadsheet to the inpatient coordinator as receipt/confirmation that the Higher Level of Care Considerations documentation in the EHRS was reviewed in its entirety for everyone. A completed IDTT Log spreadsheet should include names of treatment team meeting attendees, whether any patient was referred to a lower/higher level of care, Suicide Risk Management Program (SRMP) enrollment status, and any notable comments in the space(s) provided on the IDTT Log spreadsheet. Any clinical outcomes/dispositions should be entered within the column labeled

“PIP/DSH Disp. Code” utilizing the legend provided in the IDTT Log spreadsheet (i.e., A through S).

- Program supervisors should notify the inpatient coordinator as soon as possible if there are any last-minute or unplanned level of care decisions during IDTT (inpatient referral compliance timelines require the MH Place In Order and MH Master Treatment Plan documentation to be finalized/completed in EHRS within four hours of the patient’s IDTT check-out time). This Action Item is open.

MIDPOINT TELECONFERENCE

A teleconference was not held as Sustainable Process, since February 25th, 2026, is now subsumed into CQIT.

SUMMARY

Regional staff conducted a CQIT+ Major Sustainable Process site visit at MCSP on July 28th, 29th, and 30th 2026.

In the quarter reviewed, there are a total of three referrals initiated with none rescinded in the quarter reviewed, two submitted to Acute and one to Intermediate level of care. Referral submission timeliness averaged 100%. The Sustainable Process Data Review results for Q3, 2026 are identified as 46% by headquarters’ review and 51% by MCSP review, demonstrating a slight decrease in quality and significant increase in agreement between the headquarters reviewer and the inpatient coordinator. Please see Action Plan Section, Item #1.

In Q3, 2026 the regional team observed MHCB, RHU, and ML EOP IDTTs. While the MHCB IDTT continues to show quality throughout, deficits and strengths are noted in the other IDTTs. Please see above for unit specific areas of strength and areas in need of improvement. Quality IDTTs are an on-going part of quality improvement, evaluation, and training.

Tier walks/housing unit reviews/patient follow-ups were conducted in ML EOP, RHU, and MHCB. In total, 11 patients were identified for record review during the above assessments and/or carried forward from last quarter’s review. Any further follow-up for identified patients

MCSP CQI Report | 2026

after record review will be requested of the institution within two weeks, with proof of practice due within three weeks.

With prolonged staffing challenges for six years, responding to high and rapid turnover rates, MCSP continues to work collaboratively and efficiently toward quality patient care.