NORTH KERN STATE PRISON

Review Period: Oct 2025 – Mar 2026

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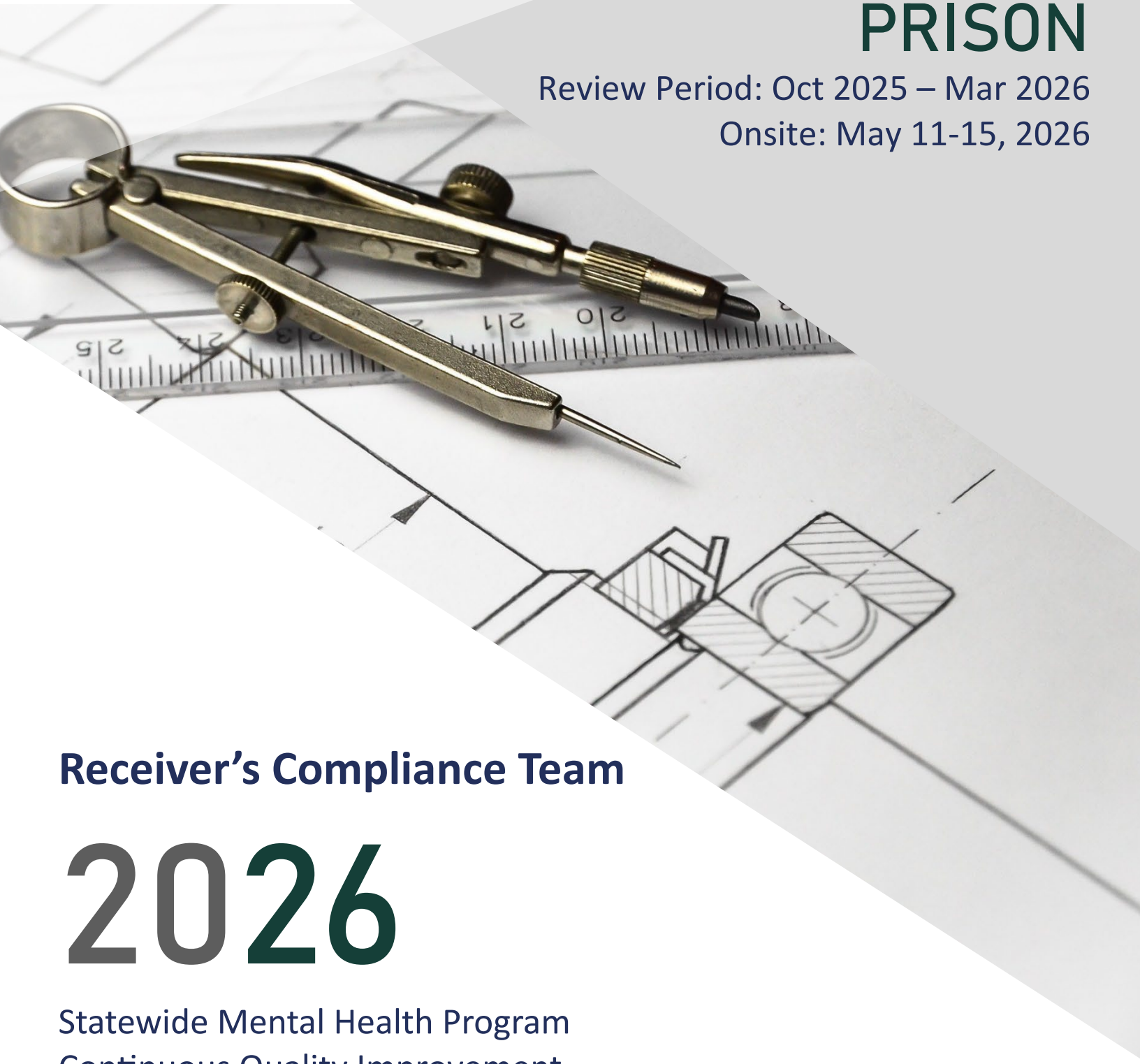

Receiver's Compliance Team

2026

Statewide Mental Health Program

Continuous Quality Improvement

NORTH KERN STATE PRISON

CDCR

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Background

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

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

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

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

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

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

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

Goals

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

The Receiver seeks to use the audit process not only to assess compliance but also to identify barriers to compliance that she can address and identify effective practices that could be replicated 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 comply with 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 leaders confer frequently with other team members to ensure the accuracy of all information included in the report. Reports reflect the team's combined expertise and are intended to help institutional leadership prioritize issues and improve performance. Draft reports are reviewed and approved by several members of the Receiver's team, including the Senior Advisor and the Deputy Receivers. The Receiver reviews and approves final reports for issuance.

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

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

Methodology

Data Foundation

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

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

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

Data Collection

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

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

Interpreting This Report

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

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

Indicators Excluded from This Report

Part of the 2026 field-testing phase is designed to identify indicators that are not yet functioning as intended so they can be corrected before the Receiver recommends a final set of indicators to the court. During the early audits, several indicators were identified as producing unreliable results. These indicators have been excluded from this report and are summarized in Appendix D.

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

Compliance Color Coding

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

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

Recommendations

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

Certain deficiencies 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

North Kern State Prison is one of two male reception centers in CDCR. It houses about 2,600 people, roughly 1,500 of them in the reception center. About 650 people in the reception center and 600 people in the mainline yards are CCCMS patients. The institution also includes a general population restricted housing unit and a ten-bed Mental Health Crisis Bed unit. The Receiver's Compliance Team conducted a review onsite May 11 through 13, 2026, covering October 2025 through March 2026. While onsite, experts also completed a suicide prevention review. Mental health clinical positions were filled above 90% during the period (96% of primary clinicians and 90% of psychiatry), so the deficiencies in this report are not driven by a shortage of clinicians. Most of the identified issues result from systems, scheduling, supervision, and documentation problems.

NKSP is meeting its core reception-center mission, with mental health screening and initial assessments being completed timely. Custody and nursing functions were at or above standard in nearly every area reviewed, custodial leadership is strong and responsive, with good collaboration across disciplines; and executive leadership joint rounding was consistent. The Mental Health Crisis Bed program is a clear strength, with out-of-cell time, yard, showers, and phone access exceeding policy requirements, and that program is supported by two recreation therapists. Suicide prevention practice has improved since the last visit, including the quality of crisis-bed discharge safety plans.

The deficiencies that were identified cluster in a few areas. First, patients are not receiving the required amount of timely, confidential treatment. Timely access to care fell below threshold across the board despite adequate staffing: primary clinician contacts at 82%, psychiatry at 77%, mental health referrals at 65%, and IDTTs at 71%. Structured treatment hours met the minimum in only 53% of patient-weeks, driven by groups that do not start or end on time, frequent cancellations, and check-in practices that do not reflect the time patients spend in treatment. The institution has inadequate scheduling protocols to maximize the use of the treatment and office space it has. This leads to confidentiality and treatment access problems across all yards.

Second, IDTT quality is weak: patients attended 39% of their IDTT meetings, required staff attended 65%, and observed meetings showed an interactive process 52% of the time. Documentation failures compound this, with level-of-care decisions appropriately documented in 67% of flagged cases.

Third, medication safety practices are not working well. Psychiatrist response to medication non-adherence was not timely; doctors took timely action in response to 29% of critical and 41% of non-critical notifications. The institution has no Chief or Senior Psychiatrist to oversee that work, which may contribute to the failures.

Fourth, the suicide prevention process broke down at several of its highest-risk moments. Half the safety plans for rescinded crisis-bed referrals were clinically deficient. Neither crisis-team response observed onsite produced the required suicide risk evaluation. Patients were also held in temporary holding cells beyond the four-hour limit, one for more than eight hours.

There are also two deficiencies identified that may require statewide action to resolve, the shortage of designated RHU EOP beds and a physical plant that may not support current demand. However, NKSP must analyze its ability to transfer EOP patients who need RHU placement as well as the space available within the facility to determine the extent to which they can be remedied within existing resources and make every effort to resolve them. Where the evidence confirms a barrier the institution cannot resolve on its own, the Receiver will engage on the structural component.

The remaining operational and clinical quality deficits can be resolved locally. The priority recommendations below target the operational and clinical-quality themes, where treatment adequacy and patient safety are most directly at stake, and are sequenced so the institution attacks the root causes first. The additional recommendations in each section feed up to them.

Priority Recommendations

1. **Treatment Space Accounting and Utilization.** NKSP has designated treatment and office space but lacks an adequate system for managing and scheduling its use. This results in treatment access and confidentiality deficiencies across the yards: we observed rooms that are not visually confidential, offices without enough furniture, nonfunctioning alarms, substandard cleanliness, and clinicians competing for rooms with custody. Adequate individual treatment space scored 64% and IDTT space 67%. Substantially improving the space and its use is possible within the existing footprint.

   Conduct a facility-wide treatment-space assessment documenting every individual, IDTT, and group space, the hours each are available for mental health programming, and the staff and times assigned to it. Build a scheduling system that assigns space by clinician and time. Remediate the confidentiality, furniture, alarm, and cleanliness deficiencies within the existing footprint, and escalate any true infrastructure gap to the Receiver.

2. **Scheduling and Timeliness of Clinical Contacts**. Timely access fell below threshold for primary clinician (82%), psychiatry (77%), referral (65%), and IDTT (71%) contacts while staffing was filled above 90%. That combination points to scheduling and workflow challenges, which is what makes this both a priority and something the institution can resolve.

   Schedule all timeframe-bound services ahead of their due dates and complete them as scheduled unless a supervisor approves the cancellation or a Modified Program Order justifies a stoppage. Review clinical caseloads and schedules to ensure necessary coverage. Establish regular supervisory review of treatment timeliness indicators so misses are caught and corrected in the month they occur.

3. **Suicide Prevention Clinical Process & Post-Crisis Continuity**. The suicide prevention process broke down at several of its highest-risk moments: half the safety plans for rescinded crisis-bed referrals were clinically deficient, four lacked adequate justification for the rescission, neither crisis-team response observed onsite produced the required suicide risk evaluation, and patients were held in temporary holding cells beyond the four-hour limit, one for over eight hours. These are points where a missed step may result in irreversible harm.

   Audit the safety plans and justifications for rescinded crisis-bed referrals, the completion of suicide risk evaluations for crisis-team responses, and the holding-cell logs weekly and report monthly to the Mental Health Program Subcommittee through the SPRFIT committee. Retrain relevant staff on the current suicide risk evaluation requirements. Continue audits and reporting until at least ninety days of sustained compliance are observed.

4. **IDTT Quality**. Patients attended 39% of their own treatment-team meetings, assigned psychiatrists and primary clinicians attended 65%, and observed meetings showed an interactive, collaborative process only 52% of the time, with case formulations and higher-level-of-care discussion frequently thin.

   Have supervisors observe IDTTs and use the CQIT criteria to give clinicians direct feedback, , with a focus on encouraging patient attendance and engagement, required-member presence, complete case formulation, and full analysis to support level-of-care decisions. Endeavor to ensure that assigned providers attend their patient's IDTTs.

5. **Clinical Documentation**. Check-in and check-out times did not reliably reflect the time patients spent in treatment, which undermines the accuracy of recorded treatment hours; level-of-care appropriateness was fully documented in 67% of flagged cases; and work and education accommodations were not addressed in the EOP IDTTs reviewed.

   Retrain all clinical staff on documentation standards, including check-in and check-out practices that reflect face-to-face time, and issue a policy memorandum prohibiting the removal of patients from groups for individual sessions unless the program supervisor and Chief of Mental Health approve it.

Have supervisors review documentation quality on a recurring basis until sustained and acceptable improvement is observed, including all higher level of care consideration justifications and rationales for non-referral when patients meet criteria for consideration but are not being referred.

6. **Medication Monitoring and Non-Adherence Response**. Psychiatry response to medication non-adherence notifications was low, at 29% for critical and 41% for non-critical. Diagnostic monitoring was uneven, with AIMS at 66% and therapeutic-level monitoring for mood stabilizers in the 49% to 67% range. The institution has no Chief or Senior Psychiatrist to oversee this work.

   Review non-adherence weekly and report monthly to the Mental Health Program Subcommittee, prioritizing the lowest-performing and/or highest risk components, and put a process in place for cross-covering electronic notifications during absences. As psychiatry leadership is recruited, assign oversight of this review to that role.

Institution's Operational Perspective

North Kern State Prison (NKSP) serves as one of two male Reception Center (RC) facilities within the California Department of Corrections and Rehabilitation (CDCR). Their primary role and responsibility is to process those remanded to the custody of the State prison system.

In addition to approximately 650 RC CCCMS and 80 RC EOP patients, the institution includes a Minimum-Security Facility (MSF), and Level 1 and Level 2 Mainline yards. These three facilities house approximately six hundred mental health patients receiving CCCMS level of care. NKSP also operates a General Population Restricted Housing Unit (GP-RHU) for individuals who receive serious Rules Violation Reports or who are being housed in Restricted Housing for Non-Disciplinary Segregation (NDS) purposes. Participants at the CCCMS, and EOP levels of care may be temporarily housed in GP-RHU pending transfer. The Correctional Treatment Center (CTC) houses a ten-bed Mental Health Crisis Bed (MHCB) unit for patients requiring acute temporary inpatient psychiatric care.

Centralized Intake and Diagnostics Clinic

NKSP maintains a centralized intake process, providing evaluations by Mental Health, Nursing, Dental, and Medical Providers. This system supports comprehensive clinical assessment, interdisciplinary coordination, and consistent, patient-centered care throughout the reception process.

Staffing and Workforce Development

During the review period, NKSP had 96% of mental health primary clinician positions and 90% of psychiatry positions filled through a combination of civil service, tele-providers, and registry staff. Critical staffing shortages exist in recreation therapist and psychiatry leadership positions, which impact the supervision and quality management associated with psychiatric services and the program's ability to offer recreation therapy to patients across levels of care.

NKSP, with support from the Acting CEO and Headquarters, is collaborating with Chief Psychologists from other institutions to establish a Psychology Internship Consortium. The Consortium is implementing an Association of Psychology Postdoctoral and Internship Centers (APPIC) accredited internship program as a foundational step toward APA accreditation. This provides structured clinical training, with the goal of hiring qualified interns upon completion of their training. NKSP has concluded the internship interview process and is currently conducting interviews for practicum-level students. All Memorandums of Understanding (MOUs) with partner universities have been finalized, allowing practicum-level psychology students to be placed and supervised across multiple CDCR institutions to support recruitment and workforce development.

Timeliness of Mental Health Evaluations

NKSP is meeting required timeframes for mental health screening and initial primary clinician evaluations. During the review period, all mental health screenings and 99% of Mental Health Primary Clinician (MHPC) Assessments were completed on time. Administrative processing by Correctional Counselors, from the custody start date to endorsement (including initial review and approval), averages 21 days. The overall timeline from custody start date to final transfer of patients averages 32 days.

Treatment and Office Space

The Health Care Facility Improvement Program (HCFIP) project on A Yard has been completed, resulting in the allocation of one office for mental health services, specifically for ML CCCMS patients in the clinic. Mental Health staff shares the M Yard clinic space with medical staff. When the clinic is unavailable for ML CCCMS contacts, clinicians provide treatment in alternative locations such as offices in the housing units and work change area, while Interdisciplinary Treatment Team (IDTT) meetings are conducted in the visiting room.

The HCFIP project for the RC Diagnostics areas was completed, providing six designated spaces for mental health services. Since then, one space was given to medical, leaving mental health with five spaces in this area,

which are utilized for conducting initial mental health screenings and Developmental Disability assessments on the date of arrival and are not available for other mental health contacts or follow-up appointments. As a result, other contacts for RC patients are completed in multipurpose rooms located on the housing units. Additional confidential treatment space has been acquired in the D Chapel area and in the B Yard Mental Health Clinic. These spaces allow for confidential sessions by both telehealth providers and onsite clinicians.

Access to Care

This section examines whether patients sustain meaningful contact with mental health services across custody settings, levels of care, and transition points. Effective access to care 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, measuring whether patients receive care of the frequency, timeliness, and clinical adequacy the Program Guide requires, in spaces that protect confidentiality, safety, and dignity.

Effective Communication

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Effective Communication Achieved	99%	98%	98%	99%	98%	98%	98%	
Group treatment in a confidential setting	83%	97%	96%	93%	95%	100%	94%	
IDTTs in a confidential setting	99%	99%	96%	100%	96%	98%	98%	
Observed Reception Center MH Screens in a Confidential Setting								100%†

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Timely Access

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
IRU Reviews Completed Timely		100%†	100%†	100%†	100%†	100%†	100%†	
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure	0%†	25%†	40%†	0%†	0%†	33%†	19%	
RC MH Screens	95%	94%	96%	98%	97%	98%	97%	
RHU GP Screens	94%	100%†	89%†	89%†	95%†	93%†	93%	
RHU Pre-Screen	88%	70%	96%	84%	97%	91%	88%	
Timely IDTTs (v2.0)	67%	68%	63%	78%	79%	84%	71%	
Timely MH Referrals (v2.0)	65%	61%	61%	63%	72%	72%	65%	
Timely MHMD Contacts (v2.0)	74%	68%	67%	80%	82%	90%	77%	
Timely PC Contacts (v2.0)	84%	82%	81%	78%	82%	83%	82%	
Custody MH Referrals								100%
Housing Units Where 128-MH-5s Are Available And Accessible to Housing Unit Staff								100%†

Timely Transfers

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Timeliness of Acute/ICF Referral Submission to IRU		50%†	80%†	100%†	67%†	100%†	80%†
Timely Transfers from RC to CCCMS (v2.0)	94%	93%	93%	91%	92%	95%	93%
Timely Transfers to EOP (v2.0).	77%	77%	74%	76%	67%	83%	76%
Timely Transfers to PIP	100%†	100%†	50%†	80%†	0%†	67%†	69%†

Appointments

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Appointments Cancelled Due to Custody [i]	1%	1%	1%	5%	26%	21%	9%

Treatment Offered

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Treatment Offered (Structured): non-PIP	56%	45%	55%	41%	54%	71%	53%

Treatment Environment

Indicator	Onsite Audits
Adequate Group Treatment Spaces	75%†
Adequate IDTT Spaces	67%†
Adequate Individual Treatment Spaces	64%

Space-by-Space Assessment

Space / Location	Type	Assessed	Compliant	Primary Deficiencies
ML CCCMS	IDTT	2	Partial	M Yard IDTT: The space is shared by Peer Support who hold their meetings while IDTT meetings are ongoing.
	Individual	7	No	A1, A2, A3, A4: These rooms are in the housing units. The bottom portion of the windows are frosted but incarcerated people on the top tier can see into the treatment space. The patient's chair is closest to the door, compromising egress for the clinician. M1, M2: The offices are not confidential visually as the open space is shared with the housing unit day room. The patient chair is closest to the door, compromising egress for the clinician.
RC EOP	IDTT	2	Yes	RC D Yard: The IDTT space is a shared space with custody officers' office and must be re-arranged weekly to accommodate IDTTs.
	Group	2	Yes	
	Individual	27	Partial	RC EOP B yard B Side: Part of the ceiling looked like it was caved in, the smoke alarm was hanging by wires from the ceiling, and there was a laundry cart parked in the space. RC EOP B yard Room 1 & 2: Rooms have an open ceiling, which allows both the officer and fellow patients waiting in the lobby to overhear patients in session.
RC	Individual	27	No	B2 A Side, B3 A Side, B6 B Side, D1 B Side, D5 B Side: Hot temperature discourages patient participation.

				B4 B Side: Flooding caused multiple ceiling tiles to be missing/stained, also large laundry cart in the space while the clinician and patient were in the room together which could compromise egress. D5 A Side: Office was completely flooded, water was covering the floor and running out of the door. Not able to be used for MH contacts at this time.
RHU GP	IDTT	1	Yes	
	Group	2	Partial	RHU D6 Dayroom B Side: There are rolling partitions available for visual privacy. However, there was no sound privacy as treatment occurred in the dayroom.
	Individual	1	Yes	
MHCB	IDTT	1	Yes	
	Individual	2	Yes	

✓ **Strengths**

Effective communication and confidential screening: Effective communication held at or above 98% and every observed reception-center screen was confidential.

Reception-center access infrastructure: RC mental health screens were timely in 97% of cases, and the custody referral pathway was fully in place, with custody mental health referrals and 128-MH-5 availability both at 100%. The reception center mental health mission of providing initial mental health screening and assessment is working.

Routine transfer timeliness: Transfers from the reception center to CCCMS were timely in 93% of cases, and all sixteen higher-level-of-care referrals were reviewed promptly once the IRU received them.

Recent space improvements: The A-Yard IDTT room now meets audit requirements after previously being held in an open common area, and the B-Yard clinic gives telemental health a confidential space for appointments.

⚠ **Concerns**

Timely clinical contacts below threshold: A significant proportion of clinical encounters were not offered within the required timelines. Primary clinician contacts (82%), psychiatry contacts (77%), mental health referrals (65%), and IDTTs (71%) all fell short, and clinical follow-ups for patients returning from temporary departure were timely in 19% of cases. Staff positions were filled above 90% during the period, so these problems flow from scheduling and workflow gaps, not a headcount shortage.

Structured treatment below the minimum: Non-PIP structured treatment met the weekly minimum in only 53% of patient-weeks. Groups did not consistently start or end on time, cancellations were frequent, and patients were checked in for the full scheduled block even when the group ran short, which both reduces treatment delivered and undermines the accuracy of the recorded hours.

Confidentiality documentation: IDTTs and group treatment were documented as being conducted in confidential settings 98% and 94% of the time by providers completing these services, despite the confidentiality issues identified for several treatment spaces as determined by onsite review.

No accounting or scheduling system for existing treatment space: Adequate individual treatment space scored 64% and IDTT space 67%. The absence of a documented system for assigning and scheduling of existing treatment space as well as the lack of efficient utilization of existing treatment space limits NKSP's ability to meet its treatment obligations, as staff who do not have assigned space to see patients often have to either wait for space or reschedule appointments.

Specific treatment space configuration and conditions issues: ML CCCMS housing-unit rooms are visible from the dayroom, M-Yard space is separated only by a non-confidential partition, D-Yard rooms have flooding problems, the B4-B office has maintenance and safety issues, RHU groups run in a nonconfidential dayroom, and chapel treatment module number seven is too small to use. Laundry carts should not be present in treatment rooms when patient care is in progress.

Higher-level-of-care transfer timeliness: Transfers to EOP (76%) and PIP (69%) were below threshold. The PIP delays were minimal, three cases exceeded the required timeframe by an hour or less and one by a day, suggesting that targeted operational changes should be sufficient to reach compliance. (Timely transfers to RHU EOP are addressed under the Restricted Housing Unit section of the Report.)

Recommendations

1. Account for and schedule treatment space. See Priority Recommendation #1.
2. Ensure treatment space integrity. See Priority Recommendation #1.
3. Schedule and protect clinical contacts. See Priority Recommendation #2.
4. Maximize and accurately record structured treatment. See Priority Recommendation #5.

Custody and Mental Health Partnership Plan

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

Indicator	Jan 2026	6-Month Avg	Onsite Audits
CMHPP MH Daily Huddles			88%
CMHPP MH Huddle Documentation of Required Attendees			75%
CMHPP MH Huddle Documentation of Supervisor Attendees	0%†		75%†
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			100%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours			100%†
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours with Required Attendees			100%†
ML CCCMS and RC CCCMS CMHPP Weekly Supervisor Meetings			96%
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees			99%
ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings			25%

Quarterly Partnership Round Table Training Completed as Required			100%†
Required Staff Attendance of Quarterly Partnership Round Table Training			0%†

✓ **Strengths**

Executive leadership engagement: Compliance with monthly executive leadership joint rounding was 100%; and required executive attendance at those rounds was also 100%. Leadership is visibly engaged in the partnership.

Custody training and supervisory cadence: Custody staff attended CMHPP annual training 100% of the time, weekly supervisor meetings occurred at 96% of the time with required attendees in attendance 99% of the time. Monthly joint supervisory program tours occurred 100% of the time and with the required attendees present. The basic governance mechanisms for the partnership have been implemented.

⚠ **Concerns**

Daily huddle documentation, especially supervisor presence: Daily huddles occurred 88% of the time, but the required attendees were only documented in 75% of the sample of records reviewed. There is no documented supervisor attendance in any of the January records reviewed, and overall supervisor attendance was only documented 75% of the time. While records reflect the huddles are happening, documentation does not reflect that key participants consistently attend.

Required attendance at quarterly round table training: The quarterly partnership round table training was held as required (100% of the time), but the required staff were not documented as present. If the key participants do not attend the training, then it will not achieve its intended impact.

Health Care and Custody Staff Training: Required health care staff attended CMHPP annual training only 80% of the time, while custody staff attnended100% of the time.

Incarcerated-person engagement: ML CCCMS monthly incarcerated person advisory council meetings were held 50% of the time, which does not reflect consistent engagement with the incarcerated population to solicit valuable feedback.

Recommendations

1. Standardize huddle attendance documentation: Set clear attendance expectations for daily huddles and a standard way to record who attends, with specific attention to documenting supervisor attendance, and audit the records periodically to ensure validity.
2. Secure required attendance at round table training: Communicate the attendance expectation, schedule sessions so the required participants can attend, and track attendance.
3. Close the healthcare training gap: Track CMHPP annual training completion for healthcare staff and follow up with those who have not completed it to ensure completion.
4. Raise advisory council participation: Use targeted outreach and clearer meeting objectives to increase participation in the incarcerated person advisory council, identify existing barriers to attendance, and resolve them.

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

[1] See Appendix C

methods (keep-on person, nurse-administered, directly observed therapy), prescription types, medication categories, and provider types. It also tracks whether required diagnostic monitoring for psychiatric medications is completed in accordance with issued guidelines. These indicators assess whether patients receive timely access to prescribed medications and whether prescribing practices include appropriate safety monitoring.

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Timely Response to Critical Non Adherence Notification (v2.0)	43%†	0%†	33%†	0%†	0%†	50%†	29%
Timely Response to Non-Critical Med Non-Adherence Notification (v2.0)	61%	43%	25%	40%	42%	41%	41%

✓ **Strengths**

No involuntary-medication force events: No controlled use-of-force incidents were required to administer involuntary medication under Penal Code §2602 during the review period.

Metabolic and anthropometric monitoring: Performance Report data shows overall diagnostic monitoring averaged 88%, with high compliance on antipsychotic lab panels (CBC and CMP at 94%, lipid at 90%, blood sugar at 93%), full compliance for carbamazepine (CBC and CMP at 100%) and clozapine (lipid, blood sugar, and CMP at 100%), and height and weight monitoring across medication classes met the compliance threshold.

⚠ **Concerns**

Non-adherence response well below threshold: Performance Report data shows timely response to non-adherence notifications which averaged 29% of the time for critical and 41% of the time for non-critical medications, where a missed critical medication requires follow-up within 24 hours. The team's record review found critical medications were most often missed over weekends or on days the primary psychiatrist was not on site, which points to a coverage gap rather than a clinical-judgment problem.

Uneven monitoring for higher-risk medications: Performance Report data shows EKG monitoring occurred 50% of the time for patients on antipsychotics and 46% of the time for those on lithium, compared with 100% for patients prescribed clozapine and tricyclic antidepressants. AIMS monitoring for patients prescribed antipsychotics was 66%, and therapeutic drug-level monitoring for mood stabilizers was low across the board (valproic acid at 49%, lithium at 66%, carbamazepine at 67%). These narrow-therapeutic-index medications carry a substantial risk of toxicity and treatment-failure when monitoring lapses.

No psychiatry leadership to oversee the work: The institution has no Chief or Senior Psychiatrist, which likely contributes to the absence of regular oversight of these indicators through the performance reports and the mental health dashboard.

Recommendations

1. Fix non-adherence coverage and workflow: See Priority Recommendation #6
2. Tighten lab and assessment ordering: Review how psychiatrists identify and order the required labs and assessments for patients on psychotropic medications, make sure staff know the resources for tracking monitoring due dates, and provide training where indicated, prioritizing the lowest-performing components (EKG, AIMS, and mood-stabilizer therapeutic levels).

Patient Safety

Institutions are required to maintain safeguards against heat-related illness for all incarcerated individuals, with additional safeguards to protect patients prescribed medications that impair thermoregulation and to ensure

that any use of clinical restraints or seclusion complies with established protocols. These indicators assess environmental safety monitoring and the quality of restraint and seclusion practices.

Indicator	Onsite Audits
Heat Related Illness Incidents for MHSDS Patients Prescribed Heat Alert Medications	00†

✓ **Strengths**

Restraint and seclusion practice: No incidents requiring clinical restraints or seclusion occurred during the review period.

Heat safety: No Stage III heat alert days were recorded, and no heat-related illnesses occurred among MHSDS patients prescribed heat-alert medications. Every building reviewed had functioning thermometers in appropriate locations, heat logs were current, and custody officers interviewed demonstrated knowledge of the Heat Plan.

Quality of Care: Care Access

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

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
IDTT Patient Attendance	45%	38%	32%	32%	45%	46%	39%	
IDTT Required Staffing	73%	75%	66%	52%	53%	69%	65%	
IDTTs with Observed Interactive Process								52%

✓ **Strengths**

RHU and initial IDTTs: RHU IDTTs met most audit standards, and the initial IDTTs observed onsite showed that appropriate level-of-care decisions were occurring and there was effective team collaboration.

⚠ **Concerns**

Patient attendance at their own IDTTs: Patients attended only 39% of their treatment-team meetings, which limits their involvement in their own treatment planning. While patients have the option to refuse attendance, clinicians should encourage participation by clearly explaining the value of the IDTT, the role the patient plays, and address any concerns in advance.

Required-staff attendance: Assigned providers attended 65% of their assigned patients' treatment team meetings. Although meetings proceeded with substitute clinicians, when necessary, the absence of assigned providers reduced continuity and limited informed participation in treatment planning.

Quality of the IDTT process: Observed meetings reflected an interactive, collaborative process 52% of the time, and initial IDTTs lacked thorough clinical case formulations in two of the five observed. Higher Level of Care considerations were not discussed in any of the five cases observed and consistent team-member engagement was lacking.

Recommendations

See Priority Recommendation #4.

Quality of Care: Documentation

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

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Cases w/documentation of appropriateness of LOC discussed for pts identified by 7388B as potentially requiring HLOC								67%
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								90%

✓ **Strengths**

Intake evaluations completed before the initial IDTT: Primary clinician intake evaluations were completed before the initial IDTT in 100% of cases and psychiatry intake evaluations in 90% of cases, so the clinical record was in place when treatment planning began.

⚠ **Concerns**

Higher-level-of-care documentation: For patients flagged on the 7388B as potentially needing a higher level of care, the appropriateness of the level-of-care decision was documented in only 67% of cases. Specifically, in only two of the five cases presented were the case formulations presented, and in none of the cases were considerations for a higher level of care addressed. Also, in two cases the level of care appeared predetermined as they were not discussed among the team but simply shared with the patient.

Recommendations

See Priority Recommendation #5.

Rules Violation Reports

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

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits

RVR MH Assessments Conducted in a Private Setting	65%	83%	59%	52%	58%	76%	66%	
Timely RVR MH Assessment Request	37%	54%	31%†	35%	31%	50%†	40%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	92%	94%	92%	100%	89%	86%	92%	
RVRs Issued								975
RVRs Issued to Non-MHSDS Participants								41%
RVRs Issued to Patients at the Acute Level of Care								0%
RVRs Issued to Patients at the CCCMS Level of Care								54%
RVRs Issued to Patients at the EOP Level of Care								4%
RVRs Issued to Patients at the ICF Level of Care								0%
RVRs Issued to Patients at the MHCB Level of Care								1%

✓ **Strengths**

Timely completion of assessments: Once requested, mental health assessments for RVRs were completed and submitted timely in 92% of cases. This means they were available to the person adjudicating the RVRs and the decision-maker could consider the impact of the mental health condition on the behavior where appropriate.

⚠ **Concerns**

Timeliness of the assessment request: Only 40% of requests for an RVR mental health assessment were submitted on time, which subsequently delays the start of the entire process.

Private setting for assessments: RVR mental health assessments were conducted in a private setting 66% of the time. Some of these instances may be cases where a confidential setting was offered but declined by the patient.

Hearing-officer documentation of mitigation: In 24% of the RVRs reviewed, the senior hearing officer did not adequately document whether penalty mitigation was considered based on the mental health assessment recommendations. The purpose of the mental health assessment is to inform the hearing officer's penalty determination by identifying how the patient's mental health condition may have influenced the behavior. Accordingly, the hearing officer's decision should document whether and how that assessment was considered in determining the penalty.

Recommendations

1. Improve request timeliness: Strengthen the systems behind custody's submission of mental health assessment requests so assessments begin on time.
2. Document mitigation at the hearing: Provide remedial training for senior hearing officers on documenting the consideration given to the mental health assessment recommendations and any resulting penalty mitigation.

RHU: Timeliness

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

Indicator	Oct 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Timely Transfers to RHU EOP	100%†	17%†	0%†	100%†	100%†	46%†	
ICCs with Mental Health Clinicians Present and Relevant Information Provided							100%
MH Patients on Max Custody Over 150 Calendar Days with a Timely Initial MHCBC							†
MH Patients on Max Custody Over 180 Calendar Days with Timely Initial LTSCC							†

✓ **Strengths**

Initial ICC timeliness: All RHU initial ICC reviews were held within 10 calendar days of arrival, consistent with policy.

Mental health presence at ICC: Mental health clinicians attended all four ICCs reviewed and provided the clinical information necessary to inform committee decisions including patients' compliance with treatment and relevant mental health considerations.

⚠ **Concerns**

Timely transfers to RHU EOP: Patients were transferred within the required timelines to RHU EOP 46% of the time for the cases reviewed. This reflects the statewide shortage of designated RHU EOP beds rather than reception-center processing or ICC delays. NKSP should monitor the patients who are waiting, provide treatment to the extent possible, and work with the regional team to request expedited placement when clinically indicated and with HCPOP to move them as timely as possible as beds open.

Recommendations

1. Track and escalate RHU EOP waits: Monitor the patients awaiting RHU EOP transfer, provide regular clinical contacts to waiting patients to prevent and identify signs of decompensation, and work with the regional team to place them as beds become available.

RHU: Documentation

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

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

✓ **Strengths**

RHU documentation complete: Every RHU documentation requirement was met during the onsite audit. Psychiatric technician rounds were completed and documented to all audit criteria, the quality of the rounds (effective communication, interaction, and referral) met all criteria, and treatment teams had electronic health record and SOMS access during IDTTs.

RHU: Out-of-Cell Activities/Care

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

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

Indicator	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%†
Peace Officers Observed to Carry Their CPR Mouth Shield	100%

✓ **Strengths**

NDRH identification and provisions: Custody staff could identify all patients held on non-disciplinary restricted housing status and were ensuring those patients received their personal property and working entertainment appliances, consistent with policy.

⚠ **Concerns**

Phone access for NDRH patients: Patients held in RHU on non-disciplinary status were not consistently offered phone calls. One patient who should have been offered calls across five weeks had a single call logged; one missed offer was appropriately documented as tied to an incident, but three weeks had no offered calls logged.

Recommendations

1. Offer and log NDRH phone calls: Ensure every patient held for non-disciplinary reasons is offered phone access and that both the offers and the completed calls are logged in the ARHR.

Sentinel Events and Specialized Custody

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

Indicator	Onsite Audits
Custody Staff Attendance at UOF Training	100%
Health Care Staff Required to Attend UOF Training	70%
The Use and Documentation of Mechanical Restraints Among Non-MAX Custody Patients in MHCB Units	100%†
Thermometer Checks completed and accurate	100%†
Use of Force Involving MH Patients	54%

Use of force involving mental health patients: Mental health patients comprised approximately 50% of the institution's population and were involved in 54% of use-of-force incidents. This small difference suggests that use-of-force incidents involving mental health patients occur at a rate generally consistent with their representation in the institution.

✓ Strengths

Use-of-force and emergency training: All custody staff attended use-of-force training (100%) and all active nursing staff were current on their CPR and BLS certification.

Mechanical restraint and treatment-module practice: Mechanical restraint use and documentation for non-MAX custody patients in the MHCB was fully compliant. Restraint chronos were posted on all MHCB cell doors and accurately reflected patients' restraint status. Treatment-module use was consistent with policy, and patients observed during IDTTs were seated in chairs rather than in modules or restraints.

⚠ Concerns

Health care staff use-of-force training: Seventy percent of health care staff attended required use-of-force training. Although health care staff are not expected to use force routinely, they must be prepared to respond safely and appropriately when circumstances require the use of force. Regular training ensures they understand when and how to apply force safely and in accordance with policy.

Holding-cell logs and durations: Holding cell logs on Facility D had multiple missing entries and recorded individuals held beyond the four-hour limit without explanation, and one log on Facility B documented an individual held for more than eight hours without explanation. The clinical and patient-safety implications of these extended holds are addressed under Suicide Prevention.

Recommendations

1. Increase health care UOF training: Bring health care staff use-of-force training participation up to policy.
2. Maintain holding-cell logs: Ensure holding cell logs across Facilities A, B, and D are accurately and timely maintained, with a documented explanation for any duration that exceeds the limit.

Suicide Prevention

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

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Emergent and Urgent MH Referrals That Result in SREs	95%	95%	93%	97%	95%	95%	95%	
MHCB Daily Provider Contacts (v2.0)	94%	90%	95%	91%	95%	90%	92%	
MHCB/PIP Supervisory Reviews of Discharge Safety Plans	94%†	83%	84%†	81%†	89%†	86%†	86%	
Safety Plans Signed Timely	80%	92%	84%	60%	75%	67%	77%	
Timely Clinical Follow-Ups (V2.0)	59%†	62%	79%	85%†	71%	89%†	74%	
Audited Security Welfare Checks in Restricted Housing That Included the Required Visual Observation								100%
Custody Follow Ups, Page 1								89%
Custody Follow Ups, Page 2								81%
Custody Staff with CPR Training								100%
Custody Staff with Suicide Prevention Training								100%
Healthcare staff current with suicide prevention training								100%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories								100%†
Institution SPRFIT Meeting Minutes Reviewed that Satisfy All Audit Criteria								0%†
MHCB and Acute/ICF Out of Cell Activities – Phone Calls								100%†
MHCB and Acute/ICF Out of Cell Activities - Showers								100%†
MHCB and Acute/ICF Out of Cell Activities - Yard								100%†
MHCB and Acute/ICF Records with Rationale for Partial Issue								67%†
MHCB Out of Cell Activities								100%†
Nursing Staff Current with CPR Training								100%
Observed Initial Health Screenings								100%†
Onsite Review of Patient Orders for Issue and Observation								100%†
Patients in Alternative Housing with a Bed								100%†

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								80%†
RHU Intake Incarcerated Persons Appropriately Housed								100%†
Suicide Resistant Cells								100%†

✓ **Strengths**

SPRFIT structure and training: All SPRFIT subcommittee meetings during the period had a quorum and covered the required content. Custody, nursing, and mental health staff were current on CPR and suicide-prevention training. SRE mentoring and biennial training, while the period began well below the threshold level (due to a revision of the Statewide training), recovered to full compliance by March.

MHCB care and out-of-cell program: The nine MHCB IDTTs observed had good team representation and adequate case presentation, the five discharge safety plans reviewed were individualized and completed collaboratively. The out-of-cell program exceeded policy requirements, with sampled patients offered 16 to 30 hours of yard per week (25 on average), four showers, and six phone calls.

Crisis-bed access and monitoring: Patients referred to the MHCB were admitted on continuous direct visual observation, alternative-housing patients had beds, suicide-resistant cells and emergency-response equipment were in place, and audited security welfare checks in restricted housing included the required visual observation.

⚠ **Concerns**

Safety planning for rescinded crisis-bed referrals: Half of the safety plans for rescinded MHCB referrals (15 of 30) were clinically deficient and four lacked adequate justification for the rescission. Comprehensive safety plan development after a crisis referral is imperative during this high risk time period.

Crisis Intervention Team responses: Composition and nursing documentation were strong across 351 activations (99% and 94%), but both CIT responses observed onsite were problematic: neither produced the required suicide risk evaluation, one assessment was cursory and missed a recent suicide attempt and prior watch placement, and the D-Yard assessment space was not confidential.

Holding-cell timelines: Fifteen patients were held in temporary holding cells beyond the four-hour limit, five over six hours and one beyond eight. Holding cell number seven in the D-yard chapel was smaller than typical holding cells that the RCT has reviewed in other CDCR institutions and may be too small for retaining a patient t for up to four hours. It should be measured and compared to standard holding cells defined in the CQIT Guidebook and it should be replaced if it does not meet the standard.

SRE completed on MH Referrals when DTS is indicated: When a patient has an urgent or emergent referral, it is important to complete suicide risk evaluations if there are indicators of suicide risk during the referral contact regardless of the initial reason for referral. A sample of 15 urgent and emergent referrals that were not placed for DTS but requiring an SRE found that only 12 of 15 (80%) had SREs completed.

SPRFIT minutes and case-review quality: None of the Institution SPRFIT minutes reviewed met all audit criteria, but the deficiencies in each month's minutes were limited. The minutes met 5 of the 6 required but they did not document that suicide prevention posters were audited by the SPRFIT coordinator or designee or provided sufficient evidence that reception-center screening audits were conducted as required. As a result, the minutes did not adequately demonstrate that these required quality assurance activities had been completed

Reception-center screening: Of the five reception-center screenings observed, one was deficient because the clinician incorrectly interpreted reception-center policy regarding responsibility for requesting prior mental health records.

Recommendations

1. Audit the highest-risk steps through SPRFIT: Refer to Priority Recommendation #3.
2. Retrain on SRE requirements: Refer to Priority Recommendation #3.
3. Fix the CIT assessment space: Provide a confidential assessment space for CIT responses on D-Yard, using the chapel when it is not otherwise in use, and replacing the chapel holding cell if the current holding cell is not up to the standard size.

Sustainable Process and Utilization Review

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

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
MHCB clinical stays within timeframes	97%	96%	93%	100%	96%	96%	96%
Timely Transfer to MHCB (v2.0)	94%†	100%	93%	100%†	100%†	100%†	97%

✓ **Strengths**

MHCB utilization within timeframes: MHCB clinical stays occurred within the ten-day timeframe in 96% of the cases and transfers to the MHCB were timely in 97% of the cases, both measures sustained compliance across the review period.

Staffing

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

Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief Psychologist	2	2	0%
Chief Psychiatrist	1	0	100%
Senior Psychiatrist (Supervisor)	1	0	100%
Senior Psychologist (Supervisor)	2.3	2.0	11%
Supervising Psychiatric Social Worker I	1.3	1.1	13%
Senior Psychologist (Specialist)	2	2	0%
Recreation Therapist	3.5	2.2	37%
Staff Psychiatrist	9.8	8.8	10%
Psychologist – Clinical	16.8	16.8	0%
Clinical Social Worker	4.3	4.3	0%
Primary Clinician (PC)	23.5	21.8	7%
PC: Psychologist – Clinical		0.7	
PC: Clinical Social Worker		20.9	
PC: Marriage and Family Therapist		0.3	
PC: Professional Clinical Counselor		0	

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

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

✓ Strengths

Line clinical staffing adequate: Mental health clinical positions were filled above 90% during the review period, with primary clinician positions filled at 96% and psychiatry positions filled at 90%, including telehealth and registry. The clinical psychologist, clinical social worker, and specialist classifications were at or near full. The institution had the line staff to deliver services, which is why the access and timeliness deficiencies elsewhere in this report point to scheduling and workflow rather than headcount.

⚠ Concerns

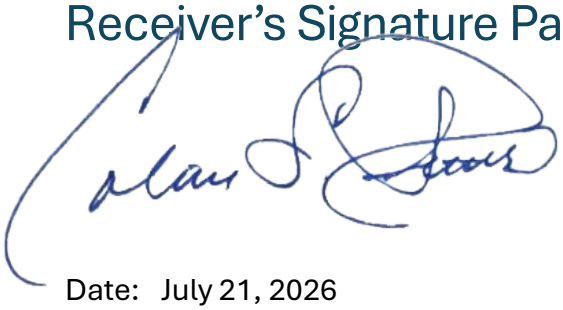
No psychiatry leadership: Both the Chief Psychiatrist and the Senior Psychiatrist (Supervisor) positions were vacant for the review period. The absence of psychiatry leadership is the likely reason the medication-monitoring and non-adherence indicators were not being overseen through the performance reports and the mental health dashboard.

Recreation therapist shortage: Recreation therapist positions were filled at 63%, which constrains structured programming, particularly for RC EOP patients.

Recommendations

1. Recruit psychiatry leadership and recreation therapists: Pursue recruitment for the Chief or Senior Psychiatrist role and the recreation therapist vacancies, and in the interim assign oversight of the medication-monitoring indicators to regional psychiatry leadership.

Receiver's Signature Page



Date: July 21, 2026

Appendix A: Acronyms and Initialisms

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

DTS	Danger to Self
EHRS	Electronic Health Records System
EKG	Electrocardiogram
EOP	Enhanced Outpatient Program
ERRC	Emergency Response Review Committee
FIT	Focused Improvement Team
GP	General Population
HCFIP	Health Care Facility Improvement Program
HCPOP	Health Care Placement Oversight Program
HDSP	High Desert State Prisons
HLOC	Higher Level of Care
HPS I	Health Program Specialist I
HQ	Headquarters
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Interdisciplinary Treatment Team
IPC	Inpatient Coordinator
IRU	Institutional Review Unit
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 Program
MCSP	Mule Creek State Prison
MH	Mental Health
MHA	Mental Health Administrator
MHCB	Mental Health Crisis Bed
MHCT	Mental Health Compliance Team
MHPS	Mental Health Program Subcommittee
MHPSC	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-Security Facility
MTP	Master Treatment Plan
NA	Nurse Administered
NDRH	Non-Disciplinary Restricted Housing
NDPF	Non-Designated Programming Facility
NDS	Non-Disciplinary Segregation
NKSP	North Kern State Prison
NLTG	Nursing Led Therapeutic Group
OA	Office Assistant

OT	Office Technician
PBSP	Pelican Bay State Prison
PBST	Positive Behavior Support Team
PC	Primary Clinician
PIP	Psychiatric Inpatient Program
PSR	Program Status Report
PT	Psychiatric Technician
PVSP	Pleasant Valley State Prison
QIP	Quality Improvement Plan
QIT	Quality Improvement Team
QMSU	Quality Management Support Unit
R&R	Receiving and Release
RC	Reception Center
RHU	Restricted Housing Unit
RHU CCCMS	Restricted Housing Unit Correctional Clinical Case Management System
RHU EOP	Restricted Housing Unit Enhanced Outpatient Program
RHU GP	Restricted Housing Unit General Population
RJD	Richard J. Donovan Correctional Facility
ROI	Release of Information
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
SI	Suicidal Ideation
SIDMI	Significant Impairment Due to Mental Illness
SNY	Sensitive Needs Yard
SOL	California State Prison, Solano
SOMS	Strategic Offender Management System
SPRFIT	Suicide Prevention and Response Focused Improvement Team
SQRC	San Quentin Rehabilitation Center
SRASHE	Suicide Risk and Self Harm Evaluation
SRE	Suicide Risk Evaluation
SRMP	Suicide Risk Management Program
SRN II	Supervising Registered Nurse II
SRN III	Supervising Registered Nurse III
SVPP	Salinas Valley Psychiatric Program
SVSP	Salinas Valley State Prison
T4T	Training for Trainers
TCMP	Transitional Case Management Program
THC	Temporary Holding Cell
TTA	Treatment and Triage Area
TTM	Therapeutic Treatment Module
UM	Utilization Management

UOF	Use of Force
VPP	Vacaville Psychiatric Program
VSP	Valley State Prison
WSP	Wasco State Prison

Appendix B: Suicide Prevention Report

On May 11 through 13, 2026, an onsite review was conducted of NKSP's compliance with statewide suicide prevention and response policies in conjunction with the Receiver's Compliance Team. This report summarizes all findings and concludes with corrective action plans and recommendations. Unless otherwise noted, this audit covered the period October 2025 through March 2026.

Restricted Housing

Intake Cells

NKSP has one restricted housing unit (RHU): Facility D-6; with eleven intake cells on the first floor (101, 109-113, and 134-138). The cells are appropriately retrofitted and had "INTAKE CELL" stenciled on the doors and none of the cells were redlined during this site visit, though cell 138 had a plumbing issue, which was reported to custody on site. The review team observed that only one IP was on new intake status and they were correctly housed in a new intake cell.

Intake cell compliance was also reviewed by MHCT lieutenants in conjunction with the Receiver's Compliance Team during this site visit. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Second Watch Morning Meeting

Second watch huddle was observed on May 13 with a mental health clinician, psychiatrist, nurse, and custody sergeant in attendance. All required elements were discussed, including new arrivals, patients who had refused medications, and patients presenting with recent concerns that contribute to high risk of suicide.

Psychiatric Technician (PT) Rounds

Morning PT rounds were observed by nursing as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Access to Entertainment Appliances

MHCT lieutenants reviewed access to entertainment appliances during this review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Welfare Check Completion (Guard One)

Guard 1 checks for RHU in March 2026 were 94.52% compliant. A portion of RHU Guard 1 checks was observed by MHCT during this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

RHU Pre-Screening (Pre-Placement)

Review of the OnDemand Performance report indicated compliance for RHU pre-placement screens completed within required timeframes during the audit period was satisfactory at 88% overall. This performance is consistent with the statewide average of 88%, and slightly below NKSP's last visit (92% overall for Q4, 2025). RHU pre-placement screenings were observed by nursing as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

RHU GP Screenings (Post Placement)

During the audit period, overall compliance with RHU GP screenings was 93%, with good compliance throughout the review period, slightly below the statewide average of 96% and NKSP's performance on this indicator during the Q4, 2025 review period (96%). RHU GP screenings were observed by nursing as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Inpatient Units

Suicide-Resistant Cells

NKSP has one licensed MHCB unit consisting of 10 beds (103-107, 110-113, 114), all of which have been previously deemed retrofitted in compliance with statewide policy. None of the ten beds were "redlined" at the time of this visit. The MHCB census was six on May 11 and nine on May 13.

Interdisciplinary Treatment Team (IDTT)

Nine full IDTT meetings were observed by reviewers May 11^{the} and 13th, including seven initial and two discharge IDTTs. Of these, seven patients were admitted for danger to self and two were admitted for Significant Impairment Due to Mental Illness (SIDMI). All required team members were present, and all participated meaningfully in the treatment discussion. Appropriately, clinical summaries and treatment goals were presented, and the team reviewed updates to the level of observation and issue. Though records reflected appropriate safety planning for patients admitted for DTS and the overall quality of IDTT meetings were generally good, review of safety planning was discussed minimally during discharge IDTTs, and it was not clear whether the patients were aware of their safety plan prior to discharge.

Quality of Safety Planning

Safety plans were reviewed for five discharged MHCB patients admitted for suicidality and not referred to a higher level of care. Four of those audited patients had a supervisory review prior to discharge with no modifications required. The quality of all plans reviewed was satisfactory, with all plans individualized to address triggers for suicidality. This was a significant improvement from the last site visit, and a marked strength for NKSP.

In contrast, 30 Suicide Risk Evaluations (SREs) for rescinded MHCB referrals were also audited as part of this review, and 15/30 (50%) safety plans for rescinded MHCB referrals reviewed during this visit were found to be clinically deficient. Two of the 30 SREs reviewed did not contain safety plans at all and four of the reviewed cases did not provide adequate justification for rescission. Inadequate safety plans were not individualized, relied on overly general interventions, and failed to address managing triggers for suicidality. Others failed to address patient identified safety or environmental concerns, or self-harm to effect external changes. As this was a concern noted during NKSP's last site review, the CAP related to safety planning will remain open.

MHCB Supervisor Review of Discharge Safety Plans

Of 114 MHCB discharge safety plans completed during the review period, 86 percent received timely supervisory reviews. While this is below the compliance standard for CQIT, it was a marked improvement since their November 2025 review (62.34%). All discharge safety plans should have been reviewed in accordance with the statewide policy. Four of the five MHCB discharge safety plans audited as part of this site visit had been reviewed prior to discharge and none were deemed to require modifications. Please see the *Quality of Safety Planning* section above for a review of safety plan quality.

Suicide Watch and Suicide Precaution

On May 11, the MHCB unit census was six. No patients were on Suicide Watch, four were on Suicide Precaution, and the remaining two patients in the unit were on Q-30-minute checks with full issue. On May 13, the MHCB unit census was nine, with no patients on Suicide Watch status, six on Suicide Precaution, and the remaining three patients on Q-30 checks. Suicide Watch and Suicide Precaution rounding was observed by nursing as part of this onsite review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

The timeliness of Suicide Precaution rounds during this audit period was excellent: 99% over the past 6 months, which is in line with the current statewide average of 96%. Compliance with staggering was also excellent at 99%. Timely completion of documentation during Suicide Watch was 88%, which is below the statewide average of 95%.

Observation and Issue Orders

MHCB staff posted printed issue orders on each patient's door. Observation and issue were reordered daily as required by the memorandum on state-issued clothing and bedding in the MHCB (10-29-2013 and 3-15-2016) and each patient had an up-to-date issue order posted on their door. One patient on full issue status was observed to be wearing a smock, as he had been issued full clothing, but then refused to give up his smock as he reported his full issue clothing were "too hot". Otherwise, all patients possessed items consistent with posted orders and only those items. No patients had unusual combinations of orders.

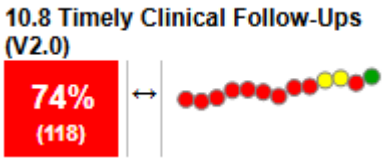
To verify whether progress notes contained justifications for orders, daily provider contact documentation of all current patients who had been on Suicide Precaution status since their arrival at MHCB (N=9) were reviewed, and of 31 documents reviewed, 29 (93%) contained adequate clinical justification for orders. The two documents that did not contain adequate justification were completed by psychiatry staff. This concern was also noted by psychiatry reviewers during this site visit, to support psychiatry staff technical assistance. Though the overall quality of issue and observation justifications was significantly improved since NKSP's November 2025 site visit, the CAP regarding justification of issue and observation orders will remain open pending training of MHCB psychiatry staff regarding documentation of issue and observation orders.

Privileges

Clinicians generally granted all privileges upon initial assessment into the MHCB unit. Review of a sample of 10 MHCB patients found that all were offered yard during seven-day time periods, ranging from 16 to 30 hours per week. The overall average was 25 hours. Patients were observed in the yard during all three onsite days. In addition, all patients averaged 4 showers and 6 telephone calls per week. There are two recreation therapists assigned to NKSP's MHCB who facilitated a significant portion of the out-of-cell activities, which is a notable strength for the institution. Overall, these MHCB practices exceeded out-of-cell activity policy requirements. Privileges were also audited by MHCT lieutenants as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Clinical Discharge Follow-ups

Compliance for clinical discharge follow-ups, which has historically been excellent for NKSP, declined significantly after the business rules changed for this indicator in March 2025. While compliance for this indicator is higher than the statewide average of 55 percent, compliance was 74 percent (N= 118) overall for October 2025 – March 2026. As of March 2025, the business rule indicates that Day 1 of the clinical follow up must occur within 24 hours of discharge from the MHCB. Additionally, follow up compliance is now calculated as compliant or not compliant for the entire follow up series, whereas it was previously calculated daily. Currently if one day of the follow up is out of compliance, the entire follow up is now deemed out of compliance. Changes to these business rules have significantly impacted compliance for this indicator statewide and are currently in the process of being updated to reflect the intent of the statewide policy, which mandates daily follow-ups beginning the day following physical discharge, rather than within 24 hours.



A random selection of 15 Clinical Discharge Follow-ups was reviewed as part of this site visit (75 follow-up days). Patients were seen for 73/75 days reviewed, though four were completed after the required 24-hour window. Follow-ups were completed exclusively by MHPCs, including the last day of each series. Review of the discharge safety plan was completed for 65/73 follow-up days.

MHCB Rescissions

During the audit period, staff rescinded approximately 29 percent (47 of 161) MHCB referrals. All patients were released from alternative housing within 24 hours.

A sample of 30 patients rescinded from alternative housing between August 2025 and January 2026 was selected for review, and a safety plan was completed in accordance with policy for 28/30 rescissions. See *Quality of Safety Planning* for a discussion of safety plan quality.

Alternative Housing

NKSP's MH OP 817, *Alternative Temporary Housing,* was revised in March 2026. It prioritizes housing locations in accordance with statewide policy and continues to designate Facility B Building 3, B-side cells 144-146, and Facility D Building 5, cells 144-146 as the first priority for patients in alternative housing with the exception of RHU (D-6) individuals, who will remain in the RHU on 1:1 observation. Stack-a-Bunk beds and safety mattresses continue to be present in each cell.

Cleanliness of Alternative Housing cells was reviewed (B-3, cells 144-146; D-5, cells 145-146). When reviewed on May 11, one cell had a torn safety blanket, and another cell had a plumbing issue. All cells were empty at the time of assessment. On May 12, the three cells in D-5 were cleaned, and a patient was housed in alternative housing in D-5 that day. The patient was observed on Suicide Watch status, and nursing staff maintained a clear visual of the patient and entered observations in EHRS in real time. Assessment for this patient was observed in a confidential setting. Suicide risk inquiry for this case was deemed adequate, and the patient was admitted to MHCB appropriately.

Examination of Temporary Holding Cell (THC) Logs from all three yards found 15 patients were held over the maximum 4 hours for DTS during the review period, including three (3) cases in May 2026 during the onsite assessment. Five of these cases exceeded 6 hours. In addition, one THC located in the chapel on B-yard was found to be very problematic in that the cell (No. 7) was triangular, placed in the corner of the room, and had an extremely small area. A patient had been placed in this cell for over 8 hours in February 2026. A regular TTM could easily fit in the room.

On Demand reflects staff referred 161 patients to the MHCB during the audit period. Of the 114 who were admitted, 98 % were admitted within 24 hours.

Suicide Risk Management Program (SRMP)

There are currently only two patients at NKSP who meet criteria for the SRMP. Both are enrolled in SRMP, and both have progress updates, interventions and goals listed in the SRMP tab of the master treatment plan. There was another patient enrolled in SRMP in October 2025 and appropriately removed in January 2026. SRMP enrollment is being tracked manually as the automated performance indicators related to SRMP are currently disabled.

NKSP's MH OP 816 *Suicide Prevention* was updated in March 2026 and is consistent with the most recent SRMP policy and procedures.

Custody Inpatient Discharge Follow-ups

These audit results are based on an institutional audit of paper 7497 forms. Audit results are compiled monthly, shared with the SPRFIT Committee, and sent to the statewide suicide prevention unit and incorporated into this CQI report.

NKSP has a variable monthly volume of 7497s: 14-31 per month during the audit period. Overall compliance was generally satisfactory: 99.3% in October 2025, 99.2% in November 2025, 90.3% in December 2025, 96.43%

in January 2026, 89.4% in February 2026, and 75.4% in March 2026, though compliance declined in March 2026 following the implementation of the Observation Tracker tool.

Examination of 101 patients discharged from a MHCB or alternative housing placement from October 2025 through March 2026 found that 90 percent (91 of 101) of page one of the forms was completed correctly by mental health clinicians and 83 percent (84 of 101) of page 2 of the "Discharge Custody Check Sheet" (CDCR MH-7497) forms were completed correctly by custody staff.

Institutional SPRFIT Committee

Observation of SPRFIT meetings was not done during the audit period due to scheduling conflicts, however, minutes for the audit period were uploaded to the Suicide Prevention SharePoint site. All SPRFIT Subcommittee meetings between October 2025 and March 2026 met quorum and included Suicide Risk Management Program (SRMP) data, improvement projects, and review of regional SPRFIT and Hayes recommended corrective actions. There was one patient who engaged in five self-harm events between December 1-2: three injuries were deemed moderate (severity level 2), and the other two were considered non-injurious (severity level 0), and this case was presented to the committee in January. A clinical review in the January meeting minutes addressed most of the seven areas required for a clinical case review. However, a clinical case summary in the October 2025 meeting minutes was of dubious value because the case did not involve a suicide attempt as the case involved a MHCB placement for SIDMI. Advisory Council meeting attendance was noted at least once in six months as required. All required suicide-prevention LOPs were current.

Because NKSP is a Reception Center (RC), the SPRFIT Subcommittee was required pursuant to CDCR's *Reception Center Suicide Prevention Reporting Expectations* memorandum, effective January 27, 2021, to ensure that suicide prevention placards were displayed in designated areas, including offices of the RC diagnostic clinicians. It also required diagnostic clinicians review the nurses' Initial Health Screening Forms, county jail records, and other pertinent documents within EHRS and SOMS. It required that diagnostic clinicians were requesting IPs sign Release of Information forms when reporting histories of prior mental health services in the community, and that diagnostic clinicians completed SREs when incarcerated persons presented with possible current risk for suicide. SPRFIT coordinators or designees are required to collect data and assess compliance with these four expectations, as well as report such findings during monthly SPRFIT meetings. Review of SPRFIT minutes indicated that such data or other required "proof of practice" regarding compliance with CDCR's *Reception Center Suicide Prevention Reporting Expectations* memorandum was only cursorily reported in all meeting minutes.

For example, during one of the reviewer's previous 2025 audits, the following template was utilized to report on RC responsibilities at NKSP: "Compliance for the Reception Center (RC) measures were all at 100% for February. For the month of February, 35 diagnostic screenings were audited, and no ROIs were obtained due to patients denying history of community MH treatment. The SPRFIT Coordinator and Coleman Sergeant completed the audit of the Suicide Prevention Posters. Compliance for the poster audit was 100%". During this Receiver's team current audit, "proof of practice" was scarce and the following templated wording was often used – "All reception center measures continue to be at goal. For the month of February 9/35 (26%) release of information forms were obtained by the diagnostic providers for patients who reported receiving treatment in the community" (March 2026 meeting minutes).

In summary, 5 of 6 SPRFIT compliance areas for SPRFIT Subcommittee meeting minutes were assessed as adequate.

Policies

NKSP has a local suicide prevention policy that addresses required Suicide Prevention trainings, Discharge Custody Check requirements, Suicide Risk Management Program, and documentation of self-harm events, as well as local policies to address receipt of bad news, and Crisis Intervention Team procedures. Local policies

were reviewed to verify that recent statewide memorandums related to suicide prevention have been incorporated, and policies have been updated annually. NKSP's local *Suicide Prevention* policy (OP 816) was updated in March 2026 to address discontinuing the use of safety contracts as prescribed in the *Discontinuing the Use of Safety Contracts* memorandum dated February 17, 2023, as recommended during the November 2025 site visit. Their policy addressing Alternative Housing was revised in March 2026. The results of the policy audit are presented in Table 1.

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

Statewide Memorandum (Date)	In Local Policy?
Alternative Housing (12-12-2012, 5-16-2012)	Yes (OP 817)
Bad News (4-28-2021)	Yes (OP 814)
Discharge custody checks (revised 10-10-2021)	Yes (OP 816)
MHCB Patient Identifier (12-03-2021)	Yes (OP 161)
SRMP (7-12-2021)	Yes (OP 816)
SRE Mentoring (revised 7-12-2022)	Yes (OP 801)
Cut-Down Kit (revised (8-10-2022)	Yes (OP 816)
Safety Concerns (revised 9-21-2022)	Yes (OP 816)
Security Welfare Checks (revised 10-7-2022)	Yes (OP 816)
Safety Planning (2-13-2023)	Yes (OP 816)
Discontinue Safety Contracts (1-23-2023, 2-17-2023)	Yes (OP 816)
Update to SRE Mentoring Program (6-7-2023)	Yes (OP 801)
Clinical reviews for serious suicide attempts (6-14-2023)	Yes (OP 816)

Severe Self-Harm

Per the SPRFIT report, the 6-month rate for self-harm incidents at NKSP was 4.5 per 1,000, which is below the statewide average of 5.2. No self-harm events with a severity level of 3 occurred during the current audit period, and there were no suicides. NKSP's monthly SPRFIT Subcommittee minutes include description of all self-harm events and suicide case reviews as they occur. Quarterly case conceptualizations are presented for all suicide attempts and serious self-harm events.

Suicide Risk Evaluations

Timelines for Suicide Risk Assessment

A total of 318 SREs were completed at NKSP during the audit period (October 1, 2025- March 31, 2026) with 86% overall compliance per On Demand. For this audit period, compliance for SRE sub-indicators is as follows:

- Emergent consultation for DTS: 95% (N=247)
- Urgent consultation for DTS: 100% (N=3)
- Routine consults for DTS: n/a
- At MHCB clinical discharge: 100% (N=128)
- Upon rescission of MHCB referral for DTS: 89% (N=46)
- Upon MHCB referral: 75% (N=135) **down from 99%**

- Upon arrival from a PIP: 100% (N=1)
- 30-day assessments following MHCB discharge: 0% (N=2)
- 90-day assessments post-MHCB discharge: 33% (N=6) **down from 99%**

Overall compliance for this measure decreased from 98% during the last site review, to 86%, with SREs completed upon referral to MHCB as one the primary areas of decreased compliance (75% down from 99% during the last site review). Concerns regarding meeting timelines for after-hours referrals were identified, which negatively impacted compliance during this audit timeframe. HQ is actively reviewing options to address this concern to better align with the intent of the indicator. Additionally, the Current Due Dates report was recently revised, to improve timely scheduling by better assisting schedulers with knowing who requires a ninety-day assessment post-MHCB discharge. This should provide improved visibility and subsequent higher compliance.

Urgent and Emergent Consults for Danger to Self (DTS)

NKSP classified nearly all DTS consults as emergent (247 of 250) during this audit period (October 2025-March 2026). A review of the performance report indicated an overall compliance rate of 95% for Emergent and Urgent mental health referrals that resulted in an SRE, which was generally consistent with their last review period when they were likewise compliant at 97%.

Urgent and Emergent Consults not for Danger to Self (DTS) but requiring an SRE

A sample of 15 urgent and emergent referrals that were not placed for DTS but required an SRE were audited as part of this site visit. Of 15 charts reviewed, only 12/15 (80%) had SREs completed.

Emergency Response

Cut-Down Kits

The Mental Health Compliance Team reviewed cut-down kits as part of this review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Quality Improvement Plans (QIPs) Generated by Suicide Case Reviews

There were no QIPs that remained open from suicides which occurred prior to NKSP's last site visit. There have not been any deaths by suicide since that have resulted in a QIP at NKSP.

Training and Mentoring Compliance

Compliance with the Annual IST Suicide Prevention Training for 2025 was excellent at 99.9% overall. Yearly compliance to date as of March 2026 is 97% overall.

Compliance with mandated mental health training requirements is also outstanding. Compliance for NKSP as of March 2026 is as follows:

- Understanding and Assessing the Presence, Severity, and Risk of Suicidality: 100%
- SRE Mentoring: 100%
- Safety Planning: 100%
- Suicide Risk Management Program (SRMP): 100%
- Complex Cases: 100%
- Prohibition of safety contracts: 100%
- Nursing CPR and BLS 100%
- Custody CPR: 99.7%

Annual IST Suicide Prevention Training – Observation

The annual IST suicide prevention training was not observed as part of this review.

Receiving and Release (R&R) Screening

R&R screening was observed by nursing as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Reception Center Processing

The new Reception Center (RC) building, opened in June 2023, comprises multiple private interview rooms, including four medical rooms for intake screening and four mental health rooms for diagnostic testing. At least one additional room contained a Therapeutic Treatment Module (TTM) that could be utilized by either medical or mental health personnel for the screening of a maximum custody IP or an individual deemed to be aggressive.

Regarding the RC Mental Health Diagnostic Testing process, five mental health screenings were observed by two diagnostic clinicians on May 11-12. Doors to each of the offices were closed, with custody personnel stationed outside in hallway, ensuring both privacy and confidentiality. In addition, suicide prevention placards in both English and Spanish were posted on the walls of each office. The clinicians were observed to be completing the MH Screening Interview form and correctly entering the information into the EHRS.

CDCR's *Reception Center Suicide Prevention Reporting Expectations* memorandum, released in January 2021, required RC diagnostic clinicians to review the nurses' Initial Health Screening Forms, county jail records, and other pertinent documents within EHRS and the Strategic Offender Management System (SOMS); RC diagnostic clinicians were required to request that IPs sign ROI forms when reporting a prior history of mental health treatment; and RC diagnostic clinicians were required to complete SREs when IPs' behavior suggested a possible current risk for suicide.

With one exception, the clinicians were observed to be following the above requirements. The exception was an observed case on May 12 in which the patient self-reported prior psychiatric hospitalizations, as well as prior 5150 placements. The clinician misinterpreted the above memorandum and believed that another clinician subsequently completing the full mental health assessment would be responsible for requesting the IP to sign a ROI for such records.

According to the On Demand performance report, NKSP was compliant with Reception Center diagnostic screenings at 97% (N=5481) for the audit period.

Crisis Intervention Team (CIT)

NKSP's LOP 806 *Crisis Intervention Team (CIT)* was revised in March 2026 and it serves as the institution's CIT policy. NKSP currently has CIT coverage Monday, Wednesday, and Friday from 0700-1600 and from 0700-2030 Tuesdays and Thursdays. Their policy also includes a contact system for weekends, after-hours, and holiday coverage.

Two CIT calls were observed as part of this review, and all required members were present. Both CIT calls observed on site as part of this review were problematic as neither resulted in the completion of a Suicide Risk Evaluation (SRE) as required.

One observed CIT response for DTS was observed on May 12 in D-Yard, triggered by positive findings during the intake screening process by nursing. The team met with the patient in a confidential setting. The clinician conducted only a cursory assessment and failed to query further as appropriate when the patient reported a recent suicide attempt requiring emergency room treatment. Furthermore, the clinician completed a progress note in lieu of the required SRE and simply noted the patient denied current SI and was "inconsistent with history of self-harm attempts." The note did not reference review of county jail records and recent placement on suicide watch in February 2026. Concerns regarding this clinician's performance were elevated to the CIT Supervisor on site. A second CIT was observed on May 13, again in D yard, but by a different clinician. The assessment was comprehensive and the patient was discharged to housing appropriately, however, an accompanying SRE was not completed. The CIT assessment on D yard was in the lobby of the chapel space and, while staff attempted to minimize interruptions, the space was not confidential nor well-suited to assessments and there were numerous instances of staff walking by or opening the door.

A review of the CIT quality management report indicates that for the 351 CIT events during the audit period that resulted in a MHCB referral, the correct composition of the team was present for the call 99 percent of the time. Nursing documentation was present in 94 percent of cases. 62 (17.6%) of 351 CIT calls occurring at NKSP between October 1, 2025, and March 31, 2026, were referred to MHCB.

Active

Table 2. Status of Open CAPs

Source/Date	*Problem*	*Status*
Regional Quarter 4 2023	1) Safety plan quality was deemed poor.	Incomplete- 15/30 safety plans reviewed for rescinded MHCB referrals were deemed clinically inadequate.
Regional Quarter 2 2024	2) Justifications for observation and limited issue are clinically insufficient.	Substantial- 2/31 documents reviewed contained clinically insufficient justification for issue and observation orders.
Regional Quarter 2 2024	3) Safety plans are not being reliably reviewed during the 5-day follow-up process.	Complete- safety plans were reviewed for 65/73 (91%) follow-ups audited. This CAP can now be closed.

Corrective Action Plans (CAPS)

CAPs are in various stages of completion (Table 2). Unless otherwise noted in the tables, all CAPs will remain open until the next site visit. CAPs marked as "completed" are considered closed and will not be carried forward into future reports. CAPs marked as "substantial," indicate marked progress or that the CAP has been preliminarily met, with sustainability to be assessed at the next site visit.

Conclusion

The CAP regarding review of the safety plan during Clinical Follow-up contacts can be closed.
Two previously assigned CAPs remain open currently:

1. 15/30 (50%) of safety plans for rescinded MHCB referrals reviewed were deemed clinically insufficient. This CAP can be closed when 90% of safety plans are deemed clinically adequate.
2. 2/31 (7%) MHCB daily contacts reviewed did not contain justification for issue and observation orders. While this was a substantial improvement for NKSP, this issue appears to be exclusive to psychiatry progress notes and was also noted by psychiatry reviewers during this site visit. This CAP can be closed when psychiatry staff are provided with training to ensure consistently documented clinical justification of issue and observation orders.

In addition to the CAPs above, as result of this review, the following actions are recommended:

1. The administration should replace the THC (Cell No. 7) located in the chapel on B-yard that was triangular and extremely small.
2. The CIT assessment on D yard was in the lobby of the chapel space and, while staff attempted to minimize interruptions, the space was not confidential nor well-suited to assessments and there were numerous instances of staff walking by or opening the door. If the chapel could be used to facilitate assessments when not in use, it would minimize interruptions.
3. As an SRE was not completed as required for neither of the two observed CIT calls for DTS, it is strongly recommended that staff be retrained as soon as possible in the SRE requirements as outlined in 06.18.25 MH HQ Memo - Updated - New Suicide Risk Evaluation Form and Expectations.
4. A sample of SREs for rescinded MHCB referrals should be reviewed by the SPRFIT Coordinator or a monthly designee to ensure adequate justification for rescission and that safety plans are individualized to mitigate triggers for suicidality.
5. The administration should ensure that patients placed in Temporary Holding Cells for DTS are not held in those cells for longer than the maximum of 4 hours.

NKSP's focus should remain on resolving the above recommendations and previously assigned CAPs, as well as maintaining compliance with the closed CAP regarding review of safety plans during clinical follow-up contacts. Please ensure all assigned SPRFIT CAPs are updated on the Improvement Priorities List and Project Pipeline. All SPRFIT CAPs should be listed as an Issue and monthly audit data indicated in the Comment section each month on the Improvement Priorities List and Project Pipeline. The project pipeline is to be uploaded to the SharePoint site monthly.

Appendix C: MAPIP

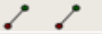
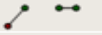
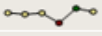
INSTITUTION 6 MONTH TREND

North Kern State Prison (NKSP)

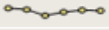
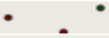
March 2026

Population Health Management	6 Months	Trend	OCT	NOV	DEC	JAN	FEB	MAR
Diagnostic Monitoring (All)	88%		89%	87%	86%	88%	90%	90%
QT Prolongation EKG 12 Months	-		-	-	-	-	-	-
Antipsychotics (All)	89%		89%	88%	87%	89%	92%	93%
Lipid Monitoring	90%		92%	91%	90%	87%	89%	91%
Blood Sugar	93%		94%	93%	91%	91%	92%	94%
EKG	50%		100%	33%	100%	50%	0%	50%
AIMS	66%		58%	53%	47%	65%	92%	91%
Med Consent	80%		83%	76%	77%	80%	81%	80%
CBC with Platelets	94%		95%	95%	93%	92%	94%	93%
CMP	94%		94%	95%	94%	93%	95%	95%
Thyroid Monitoring	77%		78%	74%	77%	74%	78%	80%
Blood Pressure	100%		100%	99%	100%	99%	99%	100%
Height	100%		99%	100%	99%	100%	99%	100%
Weight	99%		99%	99%	100%	99%	99%	100%
Pregnancy	-		-	-	-	-	-	-
Clozapine (All)	95%		100%	100%	100%	83%	96%	67%
Blood Sugar	100%		-	-	100%	-	100%	-
Lipid Monitoring	100%		-	-	100%	-	100%	-
CBC	83%		100%	100%	-	67%	83%	67%
CMP	100%		-	-	100%	-	100%	-
EKG	100%		-	-	100%	-	100%	-
AIMS	100%		-	100%	100%	100%	100%	-
Thyroid Monitoring	100%		-	-	100%	-	100%	-
Med Consent	100%		-	100%	-	100%	100%	-
Blood Pressure	100%		-	-	-	-	100%	-
Height	100%		-	-	100%	100%	100%	-
Weight	100%		-	-	-	-	100%	-
Pregnancy	-		-	-	-	-	-	-

NKSP CQI Report | 2026

Mood Stabilizers (All)	85%		87%	87%	81%	85%	86%	85%
Carbamazepine (All)	86%		50%	100%	-	80%	100%	100%
Carbamazepine Level	67%		50%	100%	-	50%	100%	-
CBC	100%		-	100%	-	100%	100%	100%
CMP	100%		-	100%	-	100%	100%	-
Med Consent	80%		50%	100%	-	100%	100%	-
Pregnancy	-		-	-	-	-	-	-
Valproic Acid (All)	85%		86%	86%	77%	86%	87%	87%
Med Consent	83%		84%	81%	84%	63%	94%	87%
Blood Pressure	99%		100%	100%	100%	100%	95%	100%
Height	99%		97%	100%	100%	100%	95%	100%
Valproic Acid Level	49%		50%	44%	31%	50%	65%	59%
CBC with Platelets	84%		89%	93%	67%	85%	81%	86%
CMP	84%		85%	93%	70%	85%	80%	86%
Weight	99%		100%	100%	100%	97%	95%	100%
Pregnancy	-		-	-	-	-	-	-
Lithium (All)	86%		86%	92%	83%	87%	83%	84%
Lithium Level	66%		54%	79%	50%	71%	70%	70%
Thyroid Monitoring	88%		100%	92%	100%	82%	90%	70%
CMP	89%		90%	94%	80%	80%	90%	90%
CBC	88%		88%	100%	75%	78%	90%	88%
EKG	46%		0%	75%	-	75%	22%	33%
Med Consent	91%		100%	90%	82%	100%	91%	86%
Height	100%		100%	100%	100%	100%	100%	100%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Oxcarbazepine (All)	88%		97%	77%	96%	72%	92%	83%
CBC	88%		100%	78%	100%	67%	89%	83%
CMP	88%		100%	75%	100%	67%	89%	83%
Med Consent	88%		91%	78%	89%	83%	100%	83%
Pregnancy	-		-	-	-	-	-	-
Lamotrigine - Med Consent	79%		100%	50%	100%	80%	100%	33%

NKSP CQI Report | 2026

Antidepressants (All)	86%		89%	84%	83%	85%	87%	86%
EKG (Tricyclics)	100%		100%	100%	-	100%	-	-
Med Consent	82%		86%	80%	78%	81%	84%	84%
Thyroid Monitoring	88%		91%	87%	87%	87%	89%	87%
Pregnancy	-		-	-	-	-	-	-
Venla Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Medication Management	**6 Months**	**Trend**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
Medications Received Timely (All)	**86%**		**88%**	**87%**	**84%**	**85%**	**86%**	**86%**
By Transfer Type								
New Arrival to CDCR (RC) – RC	87%		85%	89%	87%	88%	84%	87%
New Arrival to CDCR (RC) – RHU	90%		95%	97%	95%	66%	90%	96%
New Arrival to CDCR (RC) – MHCB	97%		100%	98%	94%	96%	100%	-
New Arrival to CDCR (RC) – CTC	84%		-	-	-	-	84%	-
Intra-System (Within Institutions) – GP	84%		88%	85%	76%	82%	85%	84%
Intra-System (Within Institutions) – RHU	87%		90%	87%	87%	88%	89%	80%
Intra-System (Within Institutions) – MH Inpatient	88%		88%	94%	77%	90%	89%	93%
Intra-System (Within Institutions) – Specialized Medical	89%		74%	96%	68%	83%	100%	92%
Inter-System (Between Institutions) – GP	79%		84%	82%	82%	79%	77%	76%
Inter-System (Between Institutions) – RHU	86%		86%	85%	85%	84%	90%	86%
Inter-System (Between Institutions) – MH Inpatient	91%		95%	90%	82%	95%	93%	91%
Inter-System (Between Institutions) – Specialized Medical	50%		60%	-	-	0%	-	100%
Return to CDCR – GP	85%		94%	78%	86%	75%	86%	83%
Return to CDCR – RHU	94%		-	94%	100%	-	90%	-
Return to CDCR – MH Inpatient	72%		-	72%	-	-	-	-
Return to CDCR – Specialized Medical	27%		100%	-	31%	2%	-	-
Stable Housing	86%		88%	87%	85%	85%	86%	87%
Leaving CDCR	97%		93%	97%	99%	98%	95%	99%
By Provider Type								
Psychiatry	85%		86%	86%	83%	83%	84%	86%
By Provider Type								
Psychiatry - Refused	10%		11%	11%	12%	10%	8%	7%
Non-Formulary by Psychiatrists	**8.2%**		**8.9%**	**9.4%**	**9.2%**	**7.3%**	**7.0%**	**7.5%**

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
- QC3: Treatment Plans with Satisfactory Documentation
- QC4: Treatment Plans with Reason for Refusal and Intervention Documented for High Refusers
- QC10: Mental Health Primary Clinician Continuity of Care
- QC11: Mental Health Psychiatrist Continuity of Care
- RH27: RHU Incarcerated Persons Who Received an RHU Orientation Guide
- SP3.4: Quality of Safety Planning to Reduce Suicide Risk
- SP23: Quality of Selected SRASHE Documentation