PELICAN BAY STATE PRISON

Review Period: Nov 2025 – Apr 2026

Onsite: June 9-11, 2026

Receiver's Compliance Team

2026

Statewide Mental Health Program
Continuous Quality Improvement


PELICAN BAY STATE PRISON
CDCR
41.8540° N / 124.1493° W

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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 effective practices across the system. Where an institution demonstrates strength in a particular area, those practices will be documented and shared so that other facilities can learn from and adopt them.

Approach to Assessing Compliance

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

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

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

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

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

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

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

Methodology

Data Foundation

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

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

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

Data Collection

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

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

Interpreting This Report

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

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

Indicators Excluded from This Report

Part of the 2026 field-testing phase is designed to identify indicators that are not yet functioning as intended so they can be corrected before the Receiver recommends a final set of indicators to the court. During early audits, several indicators were identified as producing unreliable results due to technical issues. These

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

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

Pelican Bay State Prison (PBSP) is a multi-level, 180-degree design institution located in Del Norte County. It operates 28 housing units across two Level IV mainline facilities (A and B Yard), one Level II mainline facility (D Yard), a Minimum Support Facility (MSF), one freestanding CCCMS Restricted Housing Unit (RHU), and a 10-bed Mental Health Crisis Bed (MHCB) unit. Approximately 55% of the incarcerated population at PBSP is enrolled in mental health programming. Services are delivered across a Special Needs Yard Enhanced Outpatient Program (SNY EOP) with capacity for 96 patients, a CCCMS Restrictive Housing Unit with capacity for 125 patients, and approximately 1,090 ML CCCMS patients. PBSP's RHU contains nine intake cells (112-115, 188-192) and temporarily houses EOP patients awaiting transfer to an appropriate program. Facility B, Unit 2 is utilized for RHU overflow (101-124, 201-224). The MHCB is located within the institution's Correctional Treatment Center (CTC). The institution does not operate a Psychiatric Inpatient Program (PIP); patients requiring this level of care are transferred to other institutions.

During the review period, Facility A was converted to Level IV General Population (GP) housing on March 23, 2026 (from a previous Level II Non-Designated Programming Facility). Level II CCCMS patients were subsequently transferred to D Yard. On April 6, 2026, Facility B was converted to a Level IV Special Needs Yard (from previous Level IV General Population housing). Level IV GP residents were subsequently transferred to A Yard. Units A1, A2, B7, and B8 were temporarily closed during the review period, pending the installation of updated fire suppression systems.

Facility	Function	Mental Health Program
A (Level IV ML)	General Population (GP); eight cell housing units (180-degree design). A1 and A2 temporarily closed	ML CCCMS
B (Level IV ML)	SNY housing for GP, CCCMS, and EOP (B1 only); eight celled housing units (180-degree design). B2 is utilized for RHU overflow. B7 and B8 temporarily closed	ML EOP and CCCMS
D (Level II ML)	Non-Designated Program Facility (NDPF); 10 cell housing units	ML CCCMS
RHU CCCMS	Standalone Restricted Housing Unit for CCCMS; temporarily houses EOP patients pending transfer (nine intake cells)	RHU CCCMS and non-Hub EOP awaiting transfer
MSF	General Population; two dormitories	ML CCCMS
CTC	Correctional Treatment Center; contains 10-bed MHCB. AHU comprised of designated space within both the CTC (172-176, 178) and Specialty Clinic (102, 155, 153)	MHCB

The recent conversions of B Yard from a General Population yard to SNY and reopening A Yard as a Level IV General Population yard have been accompanied by a substantial influx of new arrivals, increased Rules Violation Reports (RVRs), safety investigations, and population redistribution. The most significant infrastructure constraint is the shortage and physical limitations of mental health treatment spaces, which limit confidentiality and safe egress for staff. PBSP has responded to increased patient intake by allocating additional resources, but there continues to be a need for expanded and improved treatment areas. The limitations of the existing treatment space have contributed to difficulties in meeting treatment expectations for

CCCMS patients as resources are prioritized for higher acuity patients. Patients with greater functional limitations in EOP require additional resources and frequently refuse program participation or seek placement in MHCB or RHU due to safety concerns.

PBSP's reliance on telehealth creates operational challenges, especially when presenter and clinician schedules do not align. Combined with mission changes and reported custody staffing shortages, access to care—particularly in the CCCMS program—is hindered, leading to frequent appointment cancellations and low rates of timely treatment contacts.

During the observation of IDTTs at PBSP with multiple remote participants, conversation did not flow freely. While IDTTs generally occur as required, treatment goals are often not discussed or documented. Conversations typically center on current symptoms and housing rather than individualized objectives, interventions, or progress toward functional improvement.

Compliance with the Custody Mental Health Partnership Plan (CMHPP) was also lacking, with daily huddles and executive rounding not occurring as required by policy. Given the challenges with timely completion of ducated appointments, the CMHPP, which is designed to improve communication amongst mental health and custody staff, is critical.

Despite these challenges, patients generally reported positive relationships with treatment team members and satisfaction with the quality of clinical interactions. Clinicians demonstrated flexibility in maintaining treatment access during periods of modified programming by utilizing additional treatment spaces, conducting weekend treatment groups, running simultaneous IDTTs to address increased demand, and redistributing patients into alternative groups when cancellations occurred.

Nearly all custody staff completed Use of Force training (99.8%), and all completed Suicide Prevention training (100%). CPR mouth shields were carried by all officers observed. Custody staff demonstrated awareness of mental health referral procedures except in one building, and 128-MH5 referral forms were available in all housing units. All transfers to MHCB, ICF, and Acute programs were completed on time throughout the reporting period.

Overall, PBSP's mission conversions have placed considerable pressure on mental health services and infrastructure. Addressing these challenges is critical to ensuring safe, confidential, and timely care for patients and staff. Priority recommendations focus on expanding treatment space, improving operational efficiency across the institution, and strengthening treatment planning.

Priority Recommendations

1. **Improve sound/visual confidentiality in identified treatment spaces and reconfigure clinical treatment spaces for safety**: Onsite assessment found 14%† of group treatment spaces, 46%† of individual treatment spaces, and 33%† of IDTT spaces met all audit criteria. The deficits are confidentiality and safety issues. Identify all treatment spaces where confidentiality issues have been documented or reported and implement remedial measures such as placing sound muffling devices, frosting windows while maintaining safety requirements, and scheduling treatment to enable confidentiality in shared spaces. Staff and patient safety are paramount. Clinical treatment spaces need to be reconfigured so that the patient is not blocking the egress and ingress route to the room.

2. **Improve appointment cancellation tracking and adherence to schedules:** Custody driven cancellations averaged 10% over the audit period per the MH reporting system, which was inconsistent with data retrieved from the correctional compliance healthcare access page, where the custody cancellation rate was reported at 1% over the review period. Seventy-nine percent of all scheduled appointments were either seen or declined by patients. Reconcile appointment cancellation reports to ensure accurate accounting for appointment cancellations. Convene a joint meeting between mental health and custody leadership to review communication and documentation regarding appointment cancellations between clinical and custody staff. Develop and implement a protocol to ensure that custody executes priority ducats and clinicians are not cancelling appointments without authorization or an allowable reason.

3. **Assess and develop a workplan to improve access to care**: Performance report data for the six-month reporting period indicate that CCCMS patients saw their PC within required timelines 76% of the time, EOP patients were seen within timelines 94% of the time, and RHU CCCMS patients were seen within timelines 82% of the time. IDTTs were completed within policy timeframes 59% of the time, while psychiatry contacts occurred as required 70% of the time. The quality management committee should conduct an analysis to determine the core reasons for missed timelines for primary clinician, psychiatry, and IDTTs. Implement changes to scheduling, oversight, and other areas responsive to the findings until consistent timeliness is achieved.
4. **Implement an IDTT quality improvement process**: Implement routine supervisory observation of IDTTs using the mental health Continuous Quality Improvement audit tool, followed by direct feedback to treatment team members after each observation. IDTT required staffing averaged 56% over six months with no improvement trend and observed IDTTs demonstrated an interactive clinical process in only 15% of presentations. The most frequent qualitative deficiencies (incomplete case formulation, treatment goals that are not measurable, no level-of-care discussion, and no discussion of Rules Violation Report mental health assessments) are clinical-practice and supervision concerns rather than staffing shortfalls. This recommendation addresses IDTT clinical quality and is distinct from the timeliness deficits addressed in Recommendation 3. The quality improvement process should focus on strengthening treatment planning, ensuring measurable treatment goals are developed and linked to diagnoses and functional impairments, and improving overall consistency across IDTTs. Institution leadership should also evaluate opportunities to strengthen patient engagement in the treatment planning process.
5. **Adhere to established CMHPP policies and procedures**: Several Custody and Mental Health Partnership Plan functions (including daily huddles, round table sessions, and executive joint rounding) have not consistently followed established policy, used the designated documentation, or sustained

required attendance from both mental health and custody staff. Unit custody officers have not regularly attended daily huddles, which is a critical component of CMHPP.

Bring CMHPP functions into conformity with policy by requiring documentation, mandating attendance at required meetings, clearly defining participant roles in daily huddles and trainings, and restoring the required Inmate Advisory Council meetings.

6. **Improve MHCB access to yard activities and Durable Medical Equipment (DME):** PBSP should ensure appropriate access to MHCB out-of-cell activities. Re-evaluate OP 1015 to ensure it supports required access to yard time. Identify cause(s) of limited yard time and inaccurate tracking, implement a plan to address these causes, and review data to determine whether access improves. Restrictions for DME by the mental health treatment team should only be implemented when there is documented evidence that the specific item has been used or attempted to be used for self-injurious behavior. Clinical justification for any DME restriction should be individualized, clearly documented, and regularly reviewed to ensure restrictions remain clinically appropriate and are discontinued when no longer indicated.

7. **Strengthen suicide prevention infrastructure – Suicide Risk Evaluation (SRE) timelines, clinical justification of inpatient orders, and completion of discharge follow ups**: The suicide prevention program at PBSP shows deficits in several areas. Suicide risk evaluations were completed within required timeframes 75% of the time, and discharge follow ups were completed as required 69% of the time. Review of inpatient orders for issue and observation revealed lack of clinical justification. Review of suicide risk management program (SRMP) tracking showed outdated information, indicating that the institution team did not enroll and remove people from the program as required by policy. Establish a reliable tracking mechanism for all discharge follow-ups and post-discharge suicide risk evaluations, with assigned responsibility for monitoring completion and escalating missed deadlines. Improve clinical justification of issue and observation orders in inpatient settings. Establish a formal process to routinely review SRMP enrollment status to ensure patients are appropriately added to and removed from the program based on current clinical criteria.

Institution's Operational Perspective

As noted in the Executive Summary, PBSP recently underwent a major mission change, impacting multiple housing units and mental health programs. The operational impacts of these changes were evident throughout the mental health delivery system. Mental health staff reported increased demands related to intake evaluations, Interdisciplinary Treatment Team (IDTT) meetings, RVR Mental Health Assessments, and treatment scheduling. To accommodate the influx of patients to B Yard, additional treatment space was obtained in the EOP Annex; however, treatment space remains limited across all programs. Limited treatment space has required some clinician-led groups to be conducted on weekends and has created scheduling challenges and delays in treatment delivery. Onsite treatment team members are also resorting to virtual treatment team meeting attendance as inadequate treatment space limits the ability of onsite treatment team members to attend in-person. These operational challenges are evident on the newly activated B Yard and in the RHU, where statewide shortages of designated RHU EOP beds resulted in prolonged RHU overflow placements.

PBSP has implemented several QM initiatives aimed at improving access to care, suicide prevention, and quality management oversight. Improvement efforts included staff workflow training to ensure patients are seen during their ducated time, timely signing of inpatient follow up forms, supervisor monitoring of overdue appointments, and redistribution of clinical resources to address appointment backlogs. These efforts coincided with improved performance in several indicators during the latter months of the review period.

During the review period, primary clinician fill rates increased slightly. Psychiatry staffing increased from 83% at the beginning of the review period to 109% by the end. Recruitment for on-site staff remains difficult, primarily due to the physical location of the institution. PBSP has relied heavily on the use of telehealth staff, beginning the review period with 15 telehealth MHPCs and 9 on-site MHPCs, and ending with 15 telehealth MHPCs and 11 on-site MHPCs. While telehealth is an important resource, there are limitations to the duties performed by telehealth providers that must be absorbed by on-site staff. This includes coverage of the MHCB, which only allows for the use of telehealth in the absence of on-site staff. Currently, 5 on-site providers are assigned to the MHCB, leaving the remaining on-site providers to run 21 treatment groups (EOP and CCCMS) while also managing caseloads. In addition, duties such as conducting PREA evaluations, providing on-call support, covering holidays, and responding to Use of Force (UOF) incidents are all handled by on-site providers. The absence of even one on-site provider can result in delays or modifications to programming.

Access to Care

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

Environment of Care and Effective Communication

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
Effective Communication Achieved	99%	99%	99%	99%	99%	99%	99%	
Group treatment in a confidential setting	100%	100%	99%	100%	100%	100%	100%	
IDTTs in a confidential setting	100%	100%	100%	99%	98%	98%	99%	
Adequate Group Treatment Spaces								14%†
Adequate IDTT Spaces								33%†
Adequate Individual Treatment Spaces								46%

Timely Access

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
IRU Reviews Completed Timely		100%†	100%†	100%†	100%†	50%†	86%†	
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure		0%†					0%†	
RHU GP Screens	93%†	80%†	82%†	95%	91%†	100%†	91%	
RHU Pre-Screen	89%	86%	91%	90%	83%	80%	86%	
Timely IDTTs (v2.0)	51%	39%	70%	68%	67%	65%	59%	
Timely MH Referrals (v2.0)	83%	88%	91%	92%	90%	87%	88%	
Timely MHMD Contacts (v2.0)	57%	55%	67%	75%	88%	82%	70%	
Timely PC Contacts (v2.0)	81%	75%	80%	86%	94%	85%	83%	
Custody MH Referrals								92%
Housing Units Where 128-MH-5s Are Available And Accessible to Housing Unit Staff								100%

Timely Transfers

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
Timeliness of Acute/ICF Referral Submission to IRU		100%†	100%†	100%†	100%†	100%†	100%†
Timely Transfer to MHCB (v2.0)	100%	100%	100%†	100%†	100%†	100%	100%
Timely Transfers to EOP (v2.0).			50%†	100%†			67%†
Timely Transfers to PIP	100%†	0%†	100%†	100%†	100%†	100%†	90%†
Timely Transfers to RHU EOP	20%†	22%†	0%†	20%†	38%†	17%†	21%

Appointments

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
Appointments Cancelled Due to Custody [i]	8%	3%	5%	23%	14%	13%	10%
Scheduled MH Appointments Completed or Refused	76%	78%	84%	79%	78%	81%	79%

Treatment Offered

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg
Treatment Offered (Structured): non-PIP	76%	84%	79%	80%	88%	77%	81%

Space-by-Space Assessment

Space / Location	Type	Assessed	Compliant	Primary Deficiencies
ML CCCMS	IDTT	3	Partial	On D Yard CCCMS IDTTs are via tele MH in offices with windows which compromises confidentiality. There is insufficient space to hold in-person IDTTs.
	Group	4	No	On D Yard CCCMS group space has a window that allows other patients and staff to see inside during treatment.

	Individual	7	Partial	Individual treatment spaces are not confidential on D yard and MSF, as there are windows that look out onto the main facility.
CCCMS RHU	IDTT	1	Yes	
	Group	1	Yes	
	Individual	5	Yes	However, one office does not have a ventilation system.
ML EOP	IDTT	1	Yes	
	Group	2	No	B EOP hub space group room becomes hot when at full capacity, unless the door is open. Open hub space within treatment center is utilized for recreational activity groups. No audio, nor visual privacy.
	Individual	9	Partial	Patient is seated next to the door. There is no safe egress to the exit for clinicians in 4 of the 9 offices.
MHCB	IDTT	1	Yes	
	Group	N/A		
	Individual	3	Yes	

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

✓ **Strengths**

Group treatment and IDTT spaces for EOP patients are confidential: Patients are consistently seen confidentially for IDTT and group treatment in the EOP unit.

RHU screenings for GP individuals are largely compliant: The GP screens for non-MHSDS patients placed in RHU were compliant 91% of the time.

Custody staff demonstrate awareness of the referral process: Custody staff throughout the institution demonstrated an understanding of how to access mental health services for people who demonstrate mental health needs. Onsite audit findings confirmed that 128-MH-5 referral forms are available and accessible across all housing units, and all custody staff interviewed, except for those in D5, demonstrated awareness of their responsibility to initiate mental health referrals.

Provision of group treatment in EOP: Twelve clinician and 17 recreation therapist facilitated groups are offered in the EOP program each week.

Transfers to inpatient: All patients referred to ICF, Acute and MHCB level of care were admitted to inpatient treatment within policy required timelines. The "timeliness of transfers to PIP" indicator, where there is a 0% in December, measures if patients left the referring facility within 72 hours of acceptance to the PIP; in this case, one patient from the MHCB did not leave within 72 hours of acceptance; however, he was admitted to the PIP within overall policy required timeframes (from referral to admission).

Transfers to EOP: Two of the three patients requiring transfer to EOP during the audit period were transferred within policy required timeframes. The one patient who did not transfer in time refused to get on the transport bus on two separate occasions; the C&PR had detailed tracking of required transfers, demonstrating the first attempt was within policy timelines.

⚠ Concerns

Confidentiality and safety concerns in individual treatment areas: While data reflect high compliance for confidential completion of groups and IDTT, onsite observation revealed physical conditions in several treatment areas that compromise confidentiality for individual treatment. The individual treatment spaces in the Healthcare Annex, which is utilized as treatment space for any patients in RHU overflow (B2) and D yard CCCMS, are not confidential as there are windows that look out onto the main facility, enabling other incarcerated people to see into the treatment space. Patients on ML CCCMS A yard also reported during the patient interviews that the door to their treatment spaces are left open with custody staff standing at the door, which compromises confidentiality.

On ML CCCMS A yard, B Yard EOP, CCCMS (SNY), and treatment space within the Healthcare Annex, there are safety considerations regarding seating arrangements. Rooms should not be arranged with the patient blocking clinician egress from the room.

Limited individual and IDTT space in CCCMS RHU: There are five treatment rooms available for individual treatment; however, custody plans to repurpose Room 128 for ICC meetings, reducing available mental health treatment space from five rooms to four. Room 119, a small, converted closet, lacks temperature control and can become warm.

Group treatment spaces/IDTT spaces: On ML CCCMS A Yard and D yard CCCMS the IDTT is conducted in individual offices by telehealth staff. The IDTT spaces in both locations are not large enough to conduct in-person IDTTs.

On CCCMS RHU, room 109 is typically utilized for IDTT meetings. While adequate for groups and individual treatment, it is not ideal for IDTTs as it lacks a conference table. The treatment team members sit in the restart chairs while the patient sits in the center of the room. On B Yard EOP and CCCMS (SNY), there is no additional room in which to convene IDTTs and individual treatment.

Access to Care: PBSP offers two Start Now groups per week. Patients are referred by their individual primary clinician to the clinician who facilitates the groups. This contrasts with the typical process for referrals to groups through the IDTT. Additionally, no groups are offered for CCCMS patients; however, the institution leadership has plans to start CCCMS groups in the coming months.

Inconsistent documentation and reporting of custody-driven cancellations: Custody driven cancellations averaged 10% over the audit period per the MH reporting system, which was inconsistent with data retrieved from the correctional compliance healthcare access page, where the custody cancellation rate was reported at 1% over the review period. The rate of cancellations in the MH reporting system ranged from 3% in December to 23% in February. The volume of cancellations does not align with information provided by the healthcare lieutenant that priority ducats are not cancelled for custody reasons. During patient interviews, patients reported that they are unable to have confidential sessions due to doors remaining open and the proximity of

custody members to the doors. Patients also reported inconsistency of mental health services due to PSR's, short staffing, codes, and general delays. There was feedback from the healthcare lieutenant that patients frequently decline priority ducats if they must be escorted in restraints.

Compliance with Mental Health Program Guide treatment timelines: Primary clinician, IDTT, and psychiatry contacts are not consistently completed within mental health program guide timeline requirements. Each of these access to care areas is already a PBSP quality management priority. The facility is completing regular data analysis and developing plans to address the lack of compliance. Because non-confidential appointments are not counted as "seen" in the access to care measures, patient by patient analysis is required to determine if these timelines were truly missed, or if patients were seen but not in a confidential setting.

Performance report data for the six-month reporting period indicate that CCCMS patients saw their PC within required timelines 76% of the time, EOP patients were seen within timelines 94% of the time, and RHU CCCMS patients were seen within timelines 82% of the time. The report reflects a small number of patients in RHU overflow who were seen by their PC within timelines 20% of the time. An additional access to care challenge is that, on April 20, 2026, medical assistants were required to move from four ten-hour shifts to five eight-hour shifts; this resulted in a mismatch with the schedules of telehealth staff, which is most of the clinical staff at PBSP. Telemental health staff now cannot see patients after 3 p.m.

Lack of adherence to ducat times: During patient group interviews and interactions with patients across the facility, patients reported they do not consistently get ducats for appointments and have difficulty consistently getting to appointments due to a short time period to vacate the cell for appointments. Patients also described being discouraged by some custody staff from attending treatment, which causes them to not go. While adherence to schedules was noted to be better in B EOP, lack of adherence to ducated appointment times and difficulty getting out of cells for appointments was a common theme across all yards.

Transfers to RHU EOP: PBSP had 37 patients listed on the QM Timely Transfers to EOP RHU report; with 7 in compliance and 30 out of compliance. These missed timelines were due to a lack of available EOP RHU beds statewide.

Recommendations

1. **Treatment Space:** See Priority Recommendations above.
2. **Start Now Groups**: Develop a Local Operating Procedure that establishes a clear and standardized referral process for Start Now groups through the IDTT.
3. **Appointment Scheduling:** Consider redistribution of caseload assignments, allocating onsite resources to the provision of group treatment and other duties that must be performed onsite, while re-distributing individual appointment contacts and other telemental health appropriate contacts for the telemental health clinicians. Reconcile appointment cancellation reports. See priority recommendations above.
4. **Access to Care:** See priority recommendations above.
5. **EOP RHU Patient Transfers**: Continue to track patient transfer requirements and elevate patients requiring expedited priority transfer to the regional mental health administrator when clinically indicated.

Custody and Mental Health Partnership Plan

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

Indicator	Nov 2025	6-Month Avg	Onsite Audits
CMHPP MH Daily Huddles			84%
CMHPP MH Huddle Documentation of Required Attendees			16%
CMHPP MH Huddle Documentation of Supervisor Attendees	100%†	100%†	
CMHPP Monthly Executive Leadership Joint Rounding			25%
CMHPP Monthly Executive Leadership Joint Rounding Attended by Required Executives			25%
CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH Program			100%†
Healthcare Staff with CMHPP Annual Training			98%
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			0%
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees			100%
ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings			0%†
Quarterly Partnership Round Table Training Completed as Required			100%†
Required Staff Attendance of Quarterly Partnership Round Table Training			100%†

✓ **Strengths**

CMHPP Supervisory Engagement: Supervisors attended more often than required across most programs; the expectation is that a supervisor attends huddle at least one time weekly. Healthcare staff achieved 98% compliance with CMHPP Annual training. Several activities had full (100%) compliance, including completion of Monthly Executive Leadership Joint Rounds in the Mental Health Program, Supervisory Program Tours with required attendees, Weekly Supervisor Meetings, Quarterly Partnership Round Table Training, and required staff attendance for the round tables.

⚠ **Concerns**

Daily huddles were not conducted in compliance with program requirements. Compliance with required huddle attendance was 16%, primarily due to the absence of custody officers. EOP huddle documentation did not reflect the substance of communication among participants. The standardized Mental Health Huddle Report form was not completed; instead, staff attached the QM Daily Huddle Report, which exceeds 20 pages and does not identify the topics discussed during huddles. Similarly, MHCB huddle documentation consisted primarily of attendance signatures and the weekly SRMP list, with no documentation of discussions held. RHU huddle documentation also relied on report attachments without documenting the substance of huddle discussions. As a result, there was insufficient evidence of what communication occurred during daily huddles. Documentation for RHU 3rd watch huddles was unavailable for December 2025. A memorandum was attached and stated that the records had been lost due to a computer error. Documentation for EOP 2nd watch huddle was unavailable for January 2026. A memorandum was attached and stated that the power outage prevented the huddle documentation from being saved.

Executive rounding did not meet all of the requirements: The CMHPP Monthly Executive Leadership Joint Rounding did not occur consistently or with the required attendees. There was also no demonstrated compliance with ML CCCMS and RC CCCMS CMHPP weekly supervisor meetings or with the ML CCCMS Monthly Incarcerated Person Advisory Council meetings. The lack of consistency of supervisory meetings limits opportunities for regular communication across programs. The monthly incarcerated person advisory council meetings are an integral part of maintaining dynamic security and ensuring that the incarcerated person population is able to share concerns and problem solve within the facility.

Recommendation

1. **Adhere to established CMHPP policies and procedures.** See priority recommendations above.

Psychiatry

There are required timelines for psychiatric response to medication non-adherence notifications, appropriate use of involuntary medication procedures under Penal Code §2602, and systematic monitoring of medication safety and continuity through the Medication Administration Process Improvement Program (MAPIP). MAPIP tracks the percentage of patients prescribed select medications or classes of medications who received appropriate diagnostic monitoring consistent with clinical guidelines across all transfer types, administration methods (keep-on–person (KOP), nurse-administered, directly observed therapy), prescription types, medication categories, and provider types and provides an overall metric as a composite. MAPIP also tracks the percentage of medication doses provided in a timely manner across all transfer types, administration methods (KOP, nurse-administered, directly observed therapy), prescription types, medication categories, and provider types.

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
Timely Response to Critical Non Adherence Notification (v2.0)	25%†	40%†	0%†	50%†	100%†	0%†	33%†	
Timely Response to Non-Critical Med Non-Adherence Notification(v2.0)	29%	35%	31%	49%	61%	58%	44%	
Controlled Use of Force Incidents Required to Administer PC2602 Medication								0%†

✓ **Strengths**

There were no controlled Use of Force incidents for patients on PC2602 medications.

⚠ Concerns

Diagnostic Monitoring: This measure ranged from 79% to 88% overall. Lipid monitoring for antipsychotics ranged from 60% - 70%. Mood stabilizers ranged from 55% - 87%. The institution cited patient refusals, lack of an institutional Chief Psychiatrist (who has since been hired), and scheduling and workflow challenges as contributing factors.

Response to medication non-adherence notifications: This measure, for both critical and non-critical medications, remains well below the 90% threshold. PBSP has not prioritized these responses and appointments.

Recommendations

1. Conduct a systematic analysis to determine the factors contributing to missed diagnostic monitoring: Explore challenges from the areas of patient refusals, psychiatry workflows, scheduling, lab, nursing, and custody. Once barriers are identified, implement a system to consistently and reliably deliver diagnostic monitoring to the patients. Prioritize recruitment and retention of psychiatry leadership.

2. Clarify policy and implement process changes to improve response to medication non-adherence: Implement education regarding requirements and changes in process to create a sustainable operation for timely response to both critical and non-critical medication non-adherence notifications.

Patient Safety

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

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

✓ Strengths

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

⚠ Concerns

None.

Quality of Care

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

Care Access

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
IDTT Patient Attendance	25%	26%	15%	11%	26%	15%	19%	
IDTT Required Staffing	58%	56%	77%	74%	41%	35%	56%	
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available								100%
IDTTs with Observed Interactive Process								15%

Documentation

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
Cases w/documentation of appropriateness of LOC discussed for patients identified by 7388B as potentially requiring HLOC								55%
EOP IDTTs Addressing Accommodations and Clinical Appropriateness for Work and Education								0%†
IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT								100%†
IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT								100%†

✓ **Strengths**

IDTT Fundamentals: Onsite observed IDTTs across multiple levels of care demonstrated participation from treatment team members and generally reflected a collaborative process. Treatment teams were familiar with patients and were able to provide historical data regarding psychiatric history, treatment needs, medication management, and level-of-care considerations. In EOP, the clinician provided a detailed case formulation, clearly describing patient history, diagnoses, and needs. Psychiatrists were actively engaged during observed IDTTs and consistently provided clinically relevant information regarding psychiatric symptoms, medication management, and discharge planning.

Discussions generally addressed current clinical presentation, housing considerations, and treatment participation. Patients were provided opportunities to participate in discussions, ask questions, and provide input regarding their treatment. During patient interviews, most patients reported positive relationships with their treatment team members and expressed satisfaction with the quality of their clinical interactions.

Observed MHCB IDTTs demonstrated multidisciplinary discussion and familiarity with patient history, current functioning, and treatment needs. Across programs, treatment teams generally discussed level-of-care appropriateness when making treatment recommendations.

Consideration for higher level of care: Observed higher-level-of-care discussions generally incorporated relevant clinical information and demonstrated consideration of patient symptom severity, functional impairment, treatment engagement, and housing needs. Psychiatry intake evaluations reviewed during onsite observations were completed prior to initial treatment planning meetings, supporting informed treatment team discussions regarding medication management and psychiatric stabilization.

Treatment plan documentation: Clinical documentation generally reflected ongoing treatment participation, psychiatric monitoring, and multidisciplinary involvement in treatment planning. Treatment plans reviewed during the audit typically included diagnostic information, current treatment interventions, and documentation supporting the patient's assigned level of care.

⚠ Concerns

IDTT staff attendance by primary providers: Although all disciplines were present during the onsite observed IDTTs, the clinicians present were not consistently the assigned primary provider; this is supported by performance data trends, which indicate that assigned clinicians are only present during half of the IDTTs conducted in the last 6 months.

Measurable Treatment Goals: Measurable treatment goals were not consistently discussed or documented. Discussions often focused on current symptoms and housing status without sufficient attention to individualized treatment objectives, progress toward previously identified goals, or interventions designed to address functional impairments.

Interactivity During Telehealth IDTTs: Although telehealth clinicians consistently used open-ended questions to encourage patient participation, patient engagement and in-person staff participation remained limited during the virtual telehealth IDTTs.

Completion of Safety Planning: Safety planning was inconsistently incorporated into IDTT discussions. Although safety plans were broadly acknowledged during some treatment team meetings, clinicians did not consistently review specific safety plan content, patient coping strategies, or progress toward identified risk-reduction goals. Similarly, discharge planning discussions varied across programs and were not consistently individualized.

Correctional counselor input in IDTT: Although correctional staff generally provided relevant information when requested, their involvement was often limited to responding to direct questions rather than actively contributing information regarding institutional adjustment, disciplinary history, or release planning. Custody-related factors and Rules Violation Report history were not consistently incorporated into treatment planning discussions when clinically relevant.

Documentation supporting level-of-care determinations: Although level-of-care appropriateness was generally discussed during IDTTs, clinical justification for these determinations was not always clearly documented. Similarly, documentation of higher-level-of-care considerations did not consistently reflect the rationale for retaining patients at their current level of care. Only half of the cases reviewed included documentation of higher level of care considerations to assess for higher level of care need.

Discussion for work and education assignments in EOP: None of the cases reviewed addressed accommodations and clinical appropriateness for work assignments and education enrollment. This was corroborated during the patient interviews in the EOP, where patients indicated that there was limited to no opportunity to obtain a work assignment or enroll in educational programs due to long wait lists.

Recommendations

1. Implement an IDTT quality improvement process: See priority recommendations above.

RVRs, Sentinel Events, and Specialized Custody

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

Rules Violation Report

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
RVR MH Assessments Conducted in a Private Setting	53%	67%	64%	75%	70%	68%	66%	
RVR MH Assessments where Documentation Requirements were Met	100%†	100%†	100%†	100%†	100%†		100%	
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality	100%†	100%†	100%†	100%†	100%†		100%	
Timely RVR MH Assessment Request	17%	24%	34%	28%	28%	29%	27%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	72%	94%	95%	98%	98%	89%	91%	
RVRs Issued								774†
RVRs Issued to Non-MHSDS Participants								29%
RVRs Issued to Patients at the Acute Level of Care								0%
RVRs Issued to Patients at the CCCMS Level of Care								53%
RVRs Issued to Patients at the EOP Level of Care								15%
RVRs Issued to Patients at the ICF Level of Care								0%
RVRs Issued to Patients at the MHCB Level of Care								2%
RVRs recommended for mitigation that were mitigated								100%†
RVRs Recommended for Mitigation with Custody Documentation								67%†

Sentinel Events, and Specialized Custody

Indicator	Onsite Audits
The Use and Documentation of Mechanical Restraints Among Non-MAX Custody Patients in MHCB Units	0%†
Thermometer Checks completed and accurate	100%

Sentinel Events and Specialized Custody: Use of Force

Indicator	Onsite Audits

Custody Staff Attendance at UOF Training	100%
Health Care Staff Required to Attend UOF Training	97%
Use of Force Involving MH Patients	87%

✓ **Strengths**

RVR MH assessments met documentation requirements: All of the 34 audits of RVR assessments conducted by institution senior clinicians described how mental illness influenced the patients' behavior related to the RVR, described any difficulties the patient might have in understanding the hearing, and addressed developmental disability needs when relevant.

Mitigation of RVRs: When clinicians recommended mitigation, the hearing officer mitigated 100% of the time.

RVR assessments where the patient was informed of the limits of confidentiality: Patients were informed of the limits of confidentiality in 100% of cases.

Timely submission of RVR MH assessment results: Results were submitted within required timeframes in five of six months reviewed.

UOF and CMHPP Training Completion: Of 643 custody staff, 642 completed Use of Force (UOF) and annual Custody Mental Health Partnership Plan (CMHPP) training. Healthcare staff attendance for both UOF and CMHPP training courses was also in compliance. Of 72 nursing staff, 69 completed UOF training at 96%. 70 nursing staff attended the annual CMHPP training at 97%. All 42 mental health staff completed the CMHPP training at 100%, and 41 completed UOF Policy Training at 97%. The nursing staff who did not complete the CMHPP training left employment at PBSP in December 2025.

Heat Plan Infrastructure: Thermometer checks were completed and accurate in all housing units reviewed (100%). Temperature logs were maintained electronically, and thermometers were visible on each post at the highest area where residents are housed. The Heat Plan was not activated during the review period (no Stage II or III heat events), and no heat-related illness incidents occurred among MHSDS patients. Thirty-four correctional officers were interviewed regarding their knowledge of the heat plan, and all were able to articulate adequate knowledge of their responsibilities during a heat alert. Heat plan reference materials were posted in the officers' stations and readily available. Heat risk medication lists were up to date on each post.

Mechanical Restraint Use and Documentation: 128B Mechanical Restraint Reviews (MRR) in the Mental Health Crisis Bed were reviewed. All MRR's were accurate and up to date. One patient was observed by the clinical observers in a TTM during IDTT, which was appropriate due to the patient's maximum custody status. These findings indicate that MHCB maintained accurate and current mechanical restraint documentation during the review period.

⚠ **Concerns**

RVR MH assessments conducted in a private setting: Rates of assessments conducted in confidential settings increased, with patients being assessed in private settings in 66% of cases. High refusal for confidential appointments and occasional lack of offering a confidential setting were identified as factors in the remaining cases.

Timely RVR MH assessment request: Timely RVR mental health assessment requests averaged 27% across the audit period. There is currently a mismatch between regulatory requirements related to timelines for issuing RVRs (15 days) and the mental health policy requirement for issuance of an RVR MHA request (within 48 hours of the violation). Before the mental health assessment can be requested, the RVR must be written, approved by a supervisor, and classified in SOMS to determine whether an assessment is required. If the RVR meets

requirements for an MHA, the request is automatically generated in SOMS once it is classified. Thus, staff must complete the RVR drafting, approval, and classification well before the regulatory timeline lapses, in order for requests to be timely.

UOF Involving MH Patients: There were three controlled use of force incidents and 76 immediate use of force incidents within the reporting period. MHSDS patients were involved in all three controlled use of force incidents, as well as 66 immediate use of force incidents. Of the total use of force incidents within the review period, 87% involved mental health patients. Comparatively, the MHSDS population share at PBSP is approximately 55%.

Recommendations

1. Conduct RVR assessments in a private setting except where there is a patient refusal: Analyze why a high number of RVR assessments are conducted in a non-confidential setting and develop a workplan to improve completion of assessments in a confidential setting.

2. Improve RVR-MHA assessment request timelines: Identify and address the barrier to assessment requests meeting timelines. Establish a quality improvement initiative to accomplish this recommendation. Workplans should include clear assignments for corrective actions.

Restricted Housing

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

Timeliness

Indicator	Onsite Audits
ICCs with Mental Health Clinicians Present and Relevant Information Provided	0%†
Initial ICCs Reviewed that were Held within 10 Calendar Days of Arrival to Restricted Housing Placement	100%
MH Patients on Max Custody Over 150 Calendar Days with a Timely Initial MHCBC	100%†

Documentation

Indicator	Jan 2026	6-Month Avg	Onsite Audits
Controlled Use of Force MH Assessments Meeting Documentation Requirements	50%†	50%†	
Observation of Psych Tech Rounds Where EC, Interaction, and Referrals Met All Audit Criteria			100%†
Psychiatric Technician Rounds Documentation Audited Meeting All Audit Criteria			100%†
PT Rounds Completed in Restricted Housing Units			100%†

Out-of-Cell Activities/Care

Indicator	Onsite Audits
Custody Staff who can Identify all NDRH Patients	100%†
NDRH Patients Provided Personal Property	50%†
Patients in restricted housing with working entertainment appliances	100%†
Peace Officers Observed to Carry Their CPR Mouth Shield	100%
RHU CCCMS Out of Cell Time Offered	100%
RHU Incarcerated Persons Who Received an RHU Orientation Guide	100%†
RHU Shower Access	100%
Weeks where NDRH Patients are Offered Required Phone Calls	100%†

✓ **Strengths**

Staff assistant for ICC: There were a total of five (5) ICCs held for MHSDS patients. All patients were CCCMS LOC and all patients were in attendance. Introductions were made and a staff assistant was made available to provide clarification, information, or resources related to patients' inability to understand any aspect of the ICC, as needed.

Out of cell time, showers, and NDRH tracking: The RHU team provided verification that all required out of cell time, showers, tracking of NDRH patients, and phone calls were provided. All staff in RHU were able to show their CPR mouth shields; data for CPR mouth shields in this section reflect high performance on this measure for the entire facility.

⚠ **Concerns**

Clinician input into ICC: For the five cases observed, the assigned MHPC was not the clinician in attendance. The clinician inquired if the patient had any "mental health concerns", indicated whether the patient had refused any recent appointments or medications, and inquired if the patient knew how to reach mental health. No other inquiries or topics regarding patients' mental health or programming were addressed (e.g. treatment compliance, housing, risk assessment, suicide risk, activities of daily living, understanding of due process, potential for decompensation, etc.). The ICC chair did not confirm the patients' level of care or review any custodial decision based on the patient's mental health status.

Controlled Use of Force Mental Health Assessments Meeting Documentation Requirements: The six-month average documentation compliance rate for controlled use of force was 50%, based on audits of two incidents that occurred during the review period. In one audit, the clinician omitted a summary of mental health factors found after chart review, such as diagnosis, symptoms, danger to self and others assessment, and cognitive or adaptive deficits.

Recommendations

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

information standard. Track the indicator through internal self-audits and report results quarterly to the mental health program subcommittee.

2. Review controlled use of force mental health assessments using the CQI audit criteria for the next quarter to ensure there are no systemic issues related to use of force mental health assessments: If further audits reveal ongoing errors, initiate a quality improvement initiative to ensure staff completing assessments meet all documentation requirements.

Suicide Prevention

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

Indicator	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	6-Month Avg	Onsite Audits
Discharges from MHCB with clinician review of d/c summary		25%†			60%†		44%†	
Documentation of Acute/ICF Discharges with Clinician to Clinician Contact within 5 days	0%†	100%†					50%†	
Emergent and Urgent MH Referrals That Result in SREs	90%	83%	81%	83%	84%	81%	84%	
MHCB clinical stays within timeframes	77%	90%	92%†	100%†	89%†	96%	89%	
MHCB Daily Provider Contacts (v2.0)	81%	86%	79%	87%	89%	88%	85%	
MHCB/PIP Supervisory Reviews of Discharge Safety Plans	4%	73%	65%†	20%†	67%†	53%†	46%	
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training	26%	38%	77%	97%	97%	97%	73%	
Safety Plans Signed Timely	79%	86%	94%†	75%†	94%†	77%	83%	
Timely Clinical Follow-Ups (V2.0)	62%	64%	63%†	75%†	61%†	92%	69%	
Audited Security Welfare Checks in Restricted Housing That Included the Required Visual Observation								100%
Custody Staff with CPR Training								100%
Custody Staff with Suicide Prevention Training								100%
Healthcare staff current with suicide prevention training								98%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories								79%
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 - Yard								100%†
MHCB Out of Cell Activities								0%†

Nursing Staff Current with CPR Training	100%
Observed Initial Health Screenings	100%†
Onsite Review of Patient Orders for Issue and Observation	100%†
Referrals That Received a SRE When DTS or Suspected Intentional OD was not Marked on the MH Referral	80%†
Restricted Housing Unit Security/Welfare Check Discrepancies with an Explanatory Memo	100%†
RHU Intake Incarcerated Persons Appropriately Housed	100%†
Suicide Resistant Cells	100%†

✓ **Strengths**

Suicide Risk Evaluation (SRE) and clinical follow-ups for MHCB rescissions: Medical chart review of the 15 rescinded MHCB referral cases found that the required SREs and five-day clinical follow-ups were completed in all cases. In addition, in most cases safety plans were completed, and most contained individualized interventions designed to reduce suicide risk.

Completion of annual suicide prevention training: Ninety-seven percent of custody, medical, and mental health staff completed annual suicide prevention training. Compliance with most required suicide prevention trainings was similarly high, including Safety Planning (100%), Suicide Risk Management Program (100%), Understanding and Assessing Suicidality (99%), SRE Mentoring (99%), Nursing CPR (100%), and Custody CPR (99%).

SPRFIT meeting minutes: Documentation demonstrated that all meetings achieved quorum with required members or designees present. Minutes included discussion of compliance data, quality improvement projects, SRMP tracking, corrective action plans, and a clinical review of a serious suicide attempt.

Collaborative RHU partnership huddles: Multidisciplinary collaboration was observed during RHU partnership huddles and MHCB IDTT meetings. Required participants attended and actively contributed to discussions regarding patient care, observation status, and treatment planning.

Self-harm rates: PBSP maintained low rates of self-harm during the review period, reporting a six-month self-harm rate of 0.1 incidents per 1,000 incarcerated persons, substantially below the statewide average of 5.0. There were no suicides during the audit period, but a suicide occurred several days following the onsite assessment.

⚠ **Concerns**

Access to yard in MHCB: Out-of-cell programming for MHCB patients is limited, with an average of three hours per week documented. OP 1015 states that the yard door remains locked, which has raised staff concerns regarding personal safety, patient safety, and patient access to yard. PBSP custody leadership informed the reviewers that patients were normally offered 1.5 hours of yard per session, but yard time was consistently recorded in ARHR as 15 minutes. Record review revealed that many patients were not approved for yard until they were placed on 30-minute observation with full issue clothing, and medical charts rarely justified withholding privileges. Additional contributing factors included limited recreational therapy staffing and limited custody supervision on the yard.

SPRFIT minute documentation of incarcerated person attendance at Inmate Advisory Council: Incarcerated person attendance at Inmate Advisory Council meetings was not documented in SPRFIT minutes.

Safety planning: Sixty percent of reviewed safety plans were completed collaboratively with patients, and documentation frequently did not explain patient refusal to participate. Safety plans were completed timely 83

percent of the time during the audit period, and supervisory review of discharge safety plans averaged 46 percent compliance.

Suicide Risk Evaluation Completion: Timely SRE completion averaged 75 percent during the audit period. Emergent and urgent mental health referrals requiring an SRE, excluding danger- to-self referrals, were complete within timelines 84 percent of the time. Most missed timeframes for required SREs were for post-MHCB discharge SREs (18% for the first follow-up and 28% for the second).

Issue and Observation Orders: Forty percent (4/10) of the reviewed charts lacked documented justification linking enhanced observation and patient restrictions to the patient's clinical condition. There was one case that involved restricting a patient's access to eyeglasses for eight days despite no evidence that they had been used for self-harm and without documented justification.

Completion of discharge clinical follow ups: Timely clinical follow-up contacts averaged 69 percent compliance during the six-month review period, indicating challenges with consistent completion of required follow-up activities.

Currency of SRMP tracking: Manual tracking of the SRMP identified patients who remained formally enrolled despite no longer meeting inclusion criteria, indicating deficiencies in ongoing monitoring and program management.

Recommendations

1. Improve access to and tracking of MHCB yard activities: PBSP should reinstate and actively monitor the previously closed CAP addressing MHCB out-of-cell activities. Re-evaluate OP 1015 to identify alternatives that support appropriate yard access. Identify cause(s) of limited yard time and inaccurate tracking, develop a plan to address these causes, and re-evaluate to determine if improvements are sustained.

2. Initiate a review process to improve quality of safety plans: A formal review process should be established to ensure safety plans are completed collaboratively whenever possible, contain individualized interventions, are completed within required timelines, and receive timely supervisory review. Documentation should include rationale whenever patients decline participation.

3. Establish a procedure to ensure Durable Medical Equipment (DME) and other personal property are not restricted solely based on suicide risk status: Restrictions for DME should only be implemented when there is documented evidence that the specific item has been used or attempted to be used for self-injurious behavior. Clinical justification for any DME restriction should be individualized, clearly documented, and regularly reviewed to ensure restrictions remain clinically appropriate and are discontinued when no longer indicated.

4. Initiate a plan to improve oversight of observation levels and issue orders: All orders require individualized clinical justification, ensuring provider orders support all restrictions. Plans should include routine documentation audits to ensure sustained improvement.

5. Improve compliance with SRE timelines: Targeted quality improvement monitoring through the SPRFIT subcommittee, supervisory review, and provider education should be utilized to ensure all referrals meeting criteria for an SRE receive timely evaluation and documentation in accordance with statewide policy.

6. Improve and maintain SRMP tracking and enrollment: Establish a formal process to routinely review SRMP enrollment status to ensure patients are appropriately added to and removed from the program based on current clinical criteria.

Staffing

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

Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief of Mental Health	1.0	0*	100%
Chief Psychologist	1.0	1.0	0%
Chief Psychiatrist	1.0	1.0	0%
Senior Psychiatrist (Supervisor)	0.0	0.0	--
Senior Psychologist (Supervisor)	0.00	0.00	0%
Supervising Psychiatric Social Worker I	1.0	1.0	0%
Senior Psychologist (Specialist)	3.5	2.00	43%
Recreation Therapist	4.00	3.54	11%
Staff Psychiatrist	6.5	7.09	0%
Psychologist – Clinical	5.00	5.00	0%
Clinical Social Worker	2.50	2.50	0%
Primary Clinician (PC)	23.50	18.31	21%
PC: Psychologist – Clinical		6.96	
PC: Clinical Social Worker		10.35	
PC: Marriage and Family Therapist		0.00	
PC: Professional Clinical Counselor		1.00	

** Chief psychiatrist position filled as of March 16, 2026*

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 Filled *positions for Primary Clinician sub-classifications show the discipline breakdown of the filled PC positions, so those rows show no allocations.*

✓ Strengths

The psychiatry positions are filled above the allocation rate. While it is difficult to hire on-site clinical staff, PBSP has been successful in utilizing telehealth to increase rates toward clinical staffing ratios.

⚠ Concerns

Primary clinician positions were not fully filled during the review period, with an average of 21% of positions remaining vacant. While chief and supervisor psychologist positions are filled, recent promotions left other positions vacant, resulting in vacancies across various clinical positions.

Receiver's Signature Page

Date: 8/21/26

Appendix A: Acronyms and Initialisms

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

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

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

Appendix B: MAPIP

INSTITUTION 6 MONTH TREND

Pelican Bay State Prison (PBSP)

April 2026

Population Health Management	6 Months	Trend	NOV	DEC	JAN	FEB	MAR	APR
Diagnostic Monitoring (All)	83%		84%	83%	80%	86%	79%	88%
QT Prolongation EKG 12 Months	53%		50%	75%	67%	50%	33%	33%
Antipsychotics (All)	87%		87%	90%	88%	88%	83%	88%
Lipid Monitoring	67%		64%	83%	67%	63%	60%	70%
Blood Sugar	77%		74%	94%	71%	71%	72%	79%
EKG	100%		100%	-	-	-	-	-
AIMS	87%		87%	77%	89%	100%	80%	93%
Med Consent	87%		80%	88%	85%	94%	77%	100%
CBC with Platelets	84%		80%	90%	83%	100%	50%	83%
CMP	86%		83%	89%	88%	100%	67%	86%
Thyroid Monitoring	67%		80%	67%	86%	83%	50%	50%
Blood Pressure	98%		98%	96%	100%	100%	100%	95%
Height	97%		95%	97%	97%	97%	98%	95%
Weight	98%		100%	97%	100%	97%	100%	95%
Pregnancy	-		-	-	-	-	-	-
Clozapine (All)	-		-	-	-	-	-	-
Blood Sugar	-		-	-	-	-	-	-
Lipid Monitoring	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
EKG	-		-	-	-	-	-	-
AIMS	-		-	-	-	-	-	-
Thyroid Monitoring	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Blood Pressure	-		-	-	-	-	-	-
Height	-		-	-	-	-	-	-
Weight	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-

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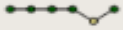
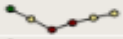
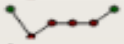
Mood Stabilizers (All)	74%		87%	64%	55%	82%	72%	86%
Carbamazepine (All)	-		-	-	-	-	-	-
Carbamazepine Level	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-
Valproic Acid (All)	72%		78%	56%	48%	93%	61%	93%
Med Consent	95%		100%	83%	-	100%	100%	100%
Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Height	96%		100%	100%	100%	100%	80%	100%
Valproic Acid Level	26%		0%	33%	0%	67%	20%	33%
CBC with Platelets	45%		50%	17%	17%	83%	33%	100%
CMP	45%		50%	17%	17%	80%	33%	100%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Lithium (All)	76%		100%	75%	50%	67%	79%	89%
Lithium Level	33%		100%	0%	25%	25%	50%	50%
Thyroid Monitoring	69%		100%	0%	50%	50%	50%	100%
CMP	53%		100%	-	33%	50%	67%	-
CBC	75%		100%	-	0%	100%	-	-
EKG	100%		100%	100%	-	100%	-	100%
Med Consent	100%		100%	100%	-	100%	100%	100%
Height	100%		100%	100%	100%	100%	100%	-
Weight	100%		100%	100%	100%	100%	100%	-
Pregnancy	-		-	-	-	-	-	-
Oxcarbazepine (All)	77%		80%	75%	80%	63%	100%	25%
CBC	82%		83%	100%	75%	67%	100%	0%
CMP	77%		83%	67%	75%	67%	100%	0%
Med Consent	67%		67%	50%	100%	50%	100%	50%
Pregnancy	-		-	-	-	-	-	-
Lamotrigine - Med Consent	100%		-	100%	-	100%	-	100%
Antidepressants (All)	78%		72%	76%	74%	84%	73%	92%
EKG (Tricyclics)	100%		100%	-	-	-	-	-
Med Consent	84%		76%	79%	75%	94%	89%	93%
Thyroid Monitoring	42%		36%	40%	54%	42%	27%	80%
Pregnancy	-		-	-	-	-	-	-
Venla Blood Pressure	100%		100%	100%	100%	100%	100%	100%

Appendix C: Excluded Indicators

- AC5.2: Monthly Review of EOP Modified Treatment
- QC5.3: MHSDS Patients Released from CDCR with Pre-Release Planning Forms Signed
- 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
- SP12.1: Custody Follow Ups, Page 1
- SP12.2: Custody Follow Ups, Page 2
- SP23: Quality of Selected SRE Documentation

Appendix D: SPRFIT Report

On June 9th-11th, 2026, the Receiver's Compliance Team conducted a review at the Pelican Bay State Prison (PBSP). Various team members contributed to the documentation within the Suicide Prevention and Response report.

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

Institutional Changes

During the review period, PBSP has had changes in facility designations. Specifically, Facility A changed from Level II Non-Designated Programming Facility (NDPF) to Level IV General Population (GP) and Facility B converted from Level IV GP to Level IV Sensitive-Needs Yard (SNY).

Restricted Housing Unit

***Second Watch Partnership Huddle*:** The second watch huddle was observed and mental health clinicians, a custody sergeant and nursing were in attendance. All required elements were discussed, including new arrivals, patients on five-day follow-ups, patients enrolled in SRMP, and patients presenting with recent concerns that contribute to high risk of suicide.

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

Intake Cells: Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

RHU Screening (Pre-Placement): Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

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

Inpatient Unit

Suicide Resistant Cells: Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

Interdisciplinary Treatment Teams (IDTT): A total of five (5) IDTT meetings were observed during the onsite review. Four of the meetings were held in the treatment space; however, one patient declined to attend and the IDTT meeting was held in absentia. Three of the meetings were initial, all for patients admitted for danger to self (DTS), one was a discharge IDTT meeting for a patient admitted for Significant Impairment Dysfunction due to Mental Illness (SIDDMI), and one follow-up meeting for a patient admitted for DTS. One patient was on max-custody status and was placed in the therapeutic treatment module during the IDTT meeting.

All the meetings started on time and all required team members were present and participated meaningfully in treatment discussion, including issue and observation. While the clinicians presented brief clinical summaries including symptomatology, diagnosis, and reason for admission, presenters did not discuss case formulation to include predisposing, perpetuating, precipitating and protective factors. The MHCB supervisor, who regularly attends the IDTT meetings, provided pertinent information in some cases that was omitted by the presenting clinician. Higher level of care and appropriateness of care were also discussed for each patient.

None of the five IDTT meeting discussions included measurable treatment goals and while the clinicians had printed copies of safety plans, there was little to no discussion of safety planning.

Two patients were on Suicide Watch and issued safety smocks. Appropriateness of issue and observation status were discussed in all cases. One patient attended the IDTT meeting in a safety smock; however, the patient was ordered partial issue. In this case, it was determined that the patient was offered clothing appropriate to his issue order, but the patient declined, choosing to stay in the safety smock. The treatment team also reviewed clinical factors and approved two of the five patients for yard.

Quality of Safety Planning: The safety plans of five (5) discharged MHCB patients admitted for suicidality and not referred to a PIP were reviewed. All had safety plans, and content was individualized. Three of the five safety plans (60%) were completed collaboratively with the patient; however, no rationale was documented within those safety plans for the patient's refusal to participate in portions of the safety planning process. Additionally, one reviewed safety plan contained stock phrasing.

It is recommended that a procedure be created to ensure safety plans are completed collaboratively with patients whenever possible, including documentation of reasons for non-participation when patients decline involvement. Also, establish a process to review safety plans for individualized content and eliminate the use of stock phrasing through routine quality assurance monitoring.

Suicide Watch and Suicide Precaution: There were eight (8) patients housed in the MHCB unit at the time of the on-site review, four patients were on a Q-30 observation, three patients were on Suicide Watch, and one patient was on Suicide Precaution. For timelines of Suicide Precaution and Suicide Watch rounds during the audit period, please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

The timeliness of Suicide Precaution rounds during this audit period was good at 95 percent over the past six months, which is in line with the current statewide average of 96 percent. Compliance with staggering was also good at 91 percent over the past six months, which is below the statewide average at 98 percent. Finally, timely completion of documentation during Suicide Watch was 94 percent, also in line with the 95 percent statewide average.

Observation and Issue Orders: All issue orders posted on the patients' cell doors were current and accurately matched the provider orders documented in EHRS. In all but one instance, clothing and personal items issued to each patient were consistent with these orders. In the one instance that issue did not match what was ordered it was determined that the patient had declined to exchange his safety smock for partial issue.

Forty percent (4/10) of the reviewed charts lacked documented justification linking enhanced observation and patient restrictions to the patient's clinical condition. Thirty percent (3/10) lacked corresponding orders for enhanced observation and restrictions. One patient remained on enhanced observation and restricted status despite being discharged to a lower level of care, with no clinical justification based on presentation. No instances of vague or nonspecific clinical terminology were identified.

One chart contained two entries that appeared to use canned language, with documented justification that did not align with associated orders. In another case, documentation stated the patient did not meet criteria for a higher level of care, was being discharged to previous housing, and required no changes to restrictions or observation status, yet safety restrictions and Suicide Watch remained in place. A separate case involved restricting a patient's access to eyeglasses for eight days despite no evidence that they had been used for self-harm and without documented justification.

It is recommended that a procedure be created to ensure enhanced observation and issue are supported by current provider orders and individualized clinical justification that is clearly linked to the patient's presenting condition and level of care needs. It is also recommended to establish a process for routine review and monitoring to verify that restrictions and observation statuses are clinically appropriate, consistent with treatment decisions and discharge plans, accurately documented, and promptly discontinued when no longer indicated.

Privileges: During the previous assessment in August 2025, it was determined that the overall average for out-of-cell activity (yard and dayroom) for MHCB patients was only 4.6 hours per week. (This was significantly below the mandated offering of at least 10 hours per week for max-custody patients and 2 or more hours per day across five different days for non-max-custody patients.) There were several reasons for the lack of out-of-cell activity. First, a recreational therapist (RT) was only available to the CTC (for both medical and MHCB patients) Monday through Wednesday for four hours each day. Their time was restricted to providing structured activity to MHCB patients in the dayroom, and not unstructured activity in the yard. Second, although MHCB custody officers escorted patients to the yard, they did not remain in the yard to provide supervision and attempted to make rounds of the yard every 30 minutes.

During this current assessment, the Review Team asked the MHCB Supervisor to provide an update on the availability of yard/dayroom for MHCB patients, and received the following response:

> "As for your findings from last year we do have some updates. Every IP is considered for Yard at the initial IDTT no matter what their level of MH observation/issue. Yard is approved on a case by-case basis and can be approved for patients on 1:1, Q11, or Q 30 checks. Yard approval is then discussed everyday amongst the MHCB team with input with custody and medical. This way IPs do not have to wait until their next IDTT to be cleared for yard. The RT situation has not changed. The RT is only available in the MHCB M, T, W, TH from 11:00 to 1500. We currently have two RT staff on site, and they are also providing Rec therapy in EOP. The RT has not been providing out-of-cell-structured therapy on the MHCB yard due to limited staff. The responsibility of monitoring patients on the yard falls to custody. The custody officers do not remain on the yard with the patients and continue to check on them every 30 minutes. A recent directive from the HCA AW (we were informed last week), that the door leading from the MHCB is to be shut and locked at all times, even when a patient is out at yard. This leaves a patient on yard by themselves if they are q11 or q30. The officers have to unlock the door each time a nurse has to complete a q 11 check. I elevated this to both the CMH, chief psychologist, as well as CEO as it appears to be a possible safety issue. We were informed by HCA AW having the door closed and locked is policy."

Based upon this information, the Review Team then examined the Automated Restricted Housing Record (ARHR) system for documentation of out-of-cell activity for 10 MHCB patients during seven-day periods of the current review period (November 2025 through April 2026).

Similar to the previous assessment, as well as contrary to the information received above from the MHCB supervisor, the selection process at PBSP was again hampered by the fact that very few MHCB patients were cleared for yard privileges during a consecutive seven-day period. Chart review indicated that many MHCB patients are only cleared for yard following their initial IDTT meetings, as well as following placement on 30-minute observation with full issue clothing. In most of the reviewed cases, there was either no written clinical justification in Provider Notes or Patient Issue Orders to withhold such out-of-cell privileges, or boilerplate generic narrative in Provider Notes as follows: "*Rationale for continued level of care includes incarceration and ongoing mental health needs without posing an acute danger to self or others. MH observation and patient Issue d/w team to keep IP safe*."

The review eventually found 10 cases in which all patients had been cleared for out-of-cell activities by providers. The review found that none were offered the minimum of 10 hours per week of out-of-cell activity (yard and dayroom). Patients were only offered between zero and six (6) hours of out-of-cell activity, with an overall average of three (3) hours per week. (Of note, two patients with the highest number of yard hours (5.75 and 6 hours, respectively) were provided yard/dayroom by an RT.) The length of time patients were

allowed out to yard was often limited to 15 minutes. Finally, all patients averaged 3.7 showers and 4.7 telephone calls per week.

Although PBSP custody leadership subsequently informed the Review Team that patients were normally offered 1.5 hours of yard per session, and not 15 minutes as indicated by the ARHR, the ARHR data indicated otherwise. All reviewed cases displayed the exact time of the yard offering (e.g., on December 6, 2025, the officer noted at 12:56pm that the patient was offered yard from "8:00am to 8:15am"). Regardless, the fact remains that even following recalculation of those numbers to reflect yard offering at 1.5 hours, patients were still not offered the minimum of 10 hours per week of out-of-cell activity due to limited RT and custody staff availability. In addition, the fact remains that many patients were only offered yard following placement on 30-minute observation with full issue clothing, with inadequate written clinical justification to withhold such privileges.

Of note, the above findings might differ from those appearing in the CQIT report as examined by the DAI's Mental Health Compliance Team (MHCT). The differences are in methodology. The RCT's suicide prevention expert tracks clinical justification for out-of-cell activities (OCAs), 10-hour minimum offering per week of yard/dayroom (and not mental health appointments), and samples 10 patients who were recently placed on Suicide Precaution and/or Suicide Watch status during the in-patient placement. The MHCT reviews patients currently housed in the inpatient program at the time of the onsite assessment, counts the total amount of offered OCAs, and allows for mental health appointments to be included in OCAs. The final methodology of this item will be determined after additional data is gathered and recommendations presented to the Receiver.

A previous CAP to correct deficiencies in offering of out-of-cell activities to MHCB patients was prematurely closed in February 2026 by the local SPRFIT and should be reinstated to resolve continuing issues of RT and custody availability, as well as inadequate clinical justification for withholding such privileges.

Clinical Discharge Follow-Ups: Medical chart review of the 10 cases of patients discharged from the MHCB unit found that all daily clinical follow-ups were completed for each of the five required days. In addition, as detailed below, a separate medical chart review of 15 rescinded cases (from alternative housing) found that all applicable daily clinical follow-ups for each of the five required days were completed.

***MHCB Supervisor Review of Discharging Safety Plans**:* A review of the OnDemand Performance Report during the audit period indicated that the MHCB supervisor reviewed 41 percent of the required safety plans (43 of 105). Data also indicates that 83 percent (129 of 155) of safety plans were completed timely.

It is recommended that a procedure be created to monitor timely completion and supervisory review of safety plans to ensure that all required safety plans are completed within the established timeframes and reviewed by a MHCB supervisor in accordance with statewide policy.

Alternative Housing

Alternative Housing cells to temporarily house patients identified as suicidal and awaiting MHCB placement were found in six (6) CTC medical cells (172, 173, 174, 175, 176, and 178) and three (3) Specialty Clinic Cells (102, 105, and 153). For the six-month period from November 2025 through April 2026, 146 patients were held in alternative housing, a significant decrease from an August 2025 assessment when 254 patients were held in alternative housing during a comparable time period. During the current assessment, all patients were released from alternative housing within 24 hours. In addition, the overwhelming majority (90%) of patients were referred to an MHCB, with 10 percent (15 of 146) of the referrals rescinded and patients returned to their respective housing units.

Medical chart review of the 15 rescinded cases found that the required SREs were completed in all of the cases (although one incorrectly included an SRE reassessment form when the full SRE form was required), and 100 percent (13 of 13) of applicable daily clinical follow-ups for each of the five required days were completed. In addition, the review found that 87 percent (13 of 15) of the cases had safety plans completed, and most (12 of 13) of the completed plans were deemed to be adequate (i.e., containing specific interventions to reduce suicide risk).

Finally, examination of Temporary Holding Cell (THC) Logs for all four yards that utilized THCs during the review period found that only two individuals were confined in the cells for DTS in excess of four (4) hours, one of whom remained in a cell for over six (6) hours.

Suicide Risk Management Program (SRMP)

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

Currently, PBSP manually tracks patients included in the SRMP. At the time of the audit, PBSP identified 34 patients as being in SRMP. Five (5) patients were reviewed for the current audit, and it was found that 60 percent (three out of five) were noted as currently being included in SRMP with appropriate treatment plans. Treatment plans for the remaining two patients reviewed indicated that they did not currently meet criteria

for inclusion in SRMP. Both of these patients deemed inapplicable had formerly been included with goals and interventions noted for management of suicidality; however, neither of the two had ever been formally removed from the program.

Discharge Custody Checks

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

Institutional SPRFIT Committee

A review of six months of SPRFIT meeting minutes (November 2025 through April 2026) found that meetings had quorums of all required mandatory members or designees for all six months. Meeting minutes included discussion on compliance data, improvement projects, and status of corrective actions based upon prior Receiver's suicide prevention expert assessments and regional SPRFIT audits. In addition, meeting minutes included the tracking and brief review of patients in the SRMP. There was a clinical review of a serious suicide attempt in September 2025 with a medical severity rating of "3" that included the seven areas required for clinical case reviews in meeting minutes of November 2025. All required suicide-prevention LOPs were current. In sum, all 5 significant SPRFIT compliance areas were assessed as adequate.

However, although the SPRFIT meeting minutes listed the SPRFIT coordinator's attendance at Inmate Advisory Council meetings in September 2025 and March 2026, there was no attendance listed for any Incarcerated Person Family Council meetings during the review period.

Finally, as indicated above, it should be noted that the SPRFIT committee suggested in all of its meeting minutes during the review period that: "Every IP is being reviewed for yard access upon admission and/or initial IDTT and daily thereafter," as well as closed a previous CAP based upon inadequate provision of yard to MHCB patients in February 2026. Based upon the finding from this current assessment, such a decision was very premature and the CAP warrants reinstatement.

Policies

PBSP has a local suicide prevention policy (Suicide Prevention and Response, LOP MH01.102A, January 2026) that addresses required Suicide Prevention training, Discharge Custody Check requirements, and documentation of self-harm events, as well as other SPRFIT responsibilities. Other local policies, e.g., Bad News (MH01.101, December 2025), Suicide Risk Management Program (MH01.02A, revised December 2025),

and Alternative Housing (LOP MH01.102, February 2026) were reviewed to verify that recent statewide memorandums related to suicide prevention have been incorporated, and policies have been updated annually.

Severe Self-Harm

Per the local SPRFIT report, the 6-month rate for self-harm incidents at PBSP was .1 per 1,000, lower than the statewide average of 5.0, between December 2025 and May 2026. There were no deaths by suicide during the audit period. However, there was one suicide that occurred three days after the onsite assessment, on June 14, 2026.

Urgent and Emergent Referrals for Danger to Self

Examination of approximately 50 charts for emergent/urgent Mental Health Referrals not marked for DTS found 15 cases that required an SRE during the review period, and 87 percent (13 of 15) of these cases had the SRE completed.

Suicide Risk Evaluations

A review of the Suicide Risk Evaluation indicator in OnDemand for the audit period resulted in an overall compliance of 75 percent for SREs completed timely.

There were 127 patients referred to MHCB for DTS during the reviewed period and the OnDemand Performance Report data indicated that 87 percent (110 out of 127) had the required SRE completed. Although the business rules for the MHCB referral indicator have been revised in recent months to reflect current statewide policy, concerns regarding compliance with timelines for after-hours referrals persist and continue to negatively impact performance. In response, policy language has been revised to better align the referral timeframe requirements with the intended purpose of the indicator. Significant decreases in compliance for SREs following MHCB discharge were also noted, though the number of assessments required has significantly decreased. Concerns have been raised regarding the failure of these assessments to populate in the Current Due Dates report, which has impacted timely scheduling, and actions are currently underway to rebuild this report.

Emergency Response

Cut Down Kits: Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

Quality Improvement Plans (QIPs) Generated by Suicide Case Reviews

There were no suicides occurring at PBSP during the audit period and no open QIPs during the audit period. There was, however, a suicide on June 14, 2026, a few days following the onsite assessment.

Training and Mentoring Compliance

Compliance with the Annual IST Suicide Prevention Training for 2025 was the following: 99 percent of custody staff, 97 percent of medical staff, and 100 percent of mental health staff.

Compliance with *Coleman* training requirements is mostly below the expected compliance rate for suicide prevention training. Training compliance for PBSP as of April 2026 is as follows:

- Understanding and Assessing the Presence, Severity, and Risk of Suicidality: 99%
- SRE Mentoring: 99%
- Safety Planning: 100%
- Suicide Risk Management Program (SRMP): 100%
- Complex Cases: 85%
- Nursing CPR: 100%
- Custody CPR: 99%

Receiving and Release (R&R) Screening

Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

Reception Center Processing

PBSP does not have a Reception Center.

Crisis Intervention Team (CIT)

PBSP did not have a Crisis Intervention Team and utilized clinicians assigned to housing units, often tele-health clinicians, to respond to emergent/urgent mental health referrals. No crisis responses were observed during the onsite assessment.

Assignment of Corrective Action Plans and Recommendations

As a result of this review, no additional CAPs have been generated, however six recommendations have been generated as a result of this review. Focus should remain on the one previously assigned and open CAP listed below as well as the newly identified recommendations.

Problem	Current Status
Ensure all GP screenings are held in a confidential setting	Unable to assess

As a result of this review, the following recommendations were generated for PBSP:

1. The previous CAP to correct deficiencies in offering of out-of-cell activities to MHCB patients was prematurely closed in February 2026 by the local SPRFIT and should be reinstated to resolve

continuing issues of RT and custody availability, as well as inadequate clinical justification for withholding such privileges.

2. Create a procedure to ensure safety plans are completed collaboratively with patients whenever possible, including documentation of reasons for non-participation when patients decline involvement. Further, increase compliance with MHCB Supervisor Review of Discharging Safety Plans by establishing a process to timely review safety plans for individualized content and eliminate the use of stock phrasing through routine quality assurance monitoring.
3. Create a procedure to ensure enhanced observation and issue are supported by current provider orders and individualized clinical justification that is clearly linked to the patient's presenting condition and level of care needs. Further, establish a process for routine review and monitoring to verify that restrictions and observation statuses are clinically appropriate, consistent with treatment decisions and discharged plans, accurately documented, and promptly discontinued when no longer indicated.

4. Improve compliance with SRE timelines: Targeted quality improvement monitoring through the SPRFIT subcommittee, supervisory review, and provider education should be utilized to ensure all referrals meeting criteria for an SRE receive timely evaluation and documentation in accordance with statewide policy.
5. Improve and maintain SRMP tracking and enrollment: Establish a formal process to routinely review SRMP enrollment status to ensure patients are appropriately added to and removed from the program based on current clinical criteria.

Appendix E: Sustainable Process Report

Report for California Department of Corrections and Rehabilitation
PELICAN BAY STATE PRISON

MAJOR SUSTAINABLE PROCESS REVIEW

Quarter Two, 2026

PARTICIPANTS

Program Staff

Regional Mental Health Administrator…….. Laura Ceballos, Ph.D.
Senior Psychologist Specialist……...…. Dominique Bressi, Psy.D.
Senior Psychologist Specialist…..……... Andrea Ames, Psy.D.
Senior Psychologist Specialist……..……. Fereshte Mirzad, Psy.D.
Senior Psychologist Specialist……..…..…. Peter Madsen, Ph.D.
Senior Psychologist Specialist……. Crystal Watson, Psy.D.
Senior Psychologist Specialist..... Tyler Peterson, Psy.D.
Supervising Psychiatric Social Worker...Jan Underwood Bullock, LCSW
Supervising Psychiatric Social Worker..... Tanya Knight, LCSW

AREAS REVIEWED

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

Program Area Reviewed:	**Sustainable Process Data Review: 30%**

The Sustainable Process Data Review audits Higher Level of Care Considerations documentation for quality and inter-rater reliability between the headquarters reviewer and the inpatient coordinator. The Sustainable Process Data Review results for Q2, 2026 are identified as 30% by headquarters' review and 48% by PBSP review, which demonstrates no substantive change with continued low quality and discrepant interrater reliability. The Sustainable Process Data Review results for Q1, 2026 are identified as 26% by headquarters' review and 39% by PBSP review, with benchmark at 85%.

There are a total of 27 cases reviewed, with five cases in which the inpatient coordinator and the headquarters reviewer disagreed. In all those cases, the inpatient coordinator found the case "good", and the headquarters reviewer found it "unacceptable," three of which are due to insufficient narrative supporting nonreferral, one due to insufficient treatment interventions, and one due to not being completed timely, specifically beyond seven days. Of the 27 cases reviewed, headquarters' review found in total eight cases "good" and 19 cases "unacceptable." Of the 19 cases found unacceptable, 13 are due to insufficient narrative supporting non-referral, with four specifically due to missing or incomplete MSE, four due to "a lack of documentation of current adaptive clinical functioning to justify non-referral," two due to same documentation as prior, and one due to no clinical input regarding patient treatment refusal; five are due to insufficient treatment intervention documentation, with two specifically due to EOP Mod "not documented properly", and; one is due to not being completed timely. Of the 17 cases found unacceptable, 16 are due to quality and one is due to error.

Follow-up required: YES X NO	If YES: Follow-up date: Routine Review During CQIT

Follow-Up Action Plan:

These data were reviewed with the Higher Level of Care team. Quality Higher Level of Care Considerations are an ongoing part of quality improvement, evaluation, and training. Please see Action Plan section, Item #1.

Program Area Reviewed:	**Mental Health Subcommittee Minutes/ Monthly Audits/Table V**

Mental Health Subcommittee Minutes were reviewed for January, February, and March 2026. A quorum is met across the quarter, and the inpatient coordinator or designee is present throughout. Table V was embedded across the quarter as requested. PBSP is represented on the headquarters Inpatient Coordinator teleconference throughout.

In January's minutes, reporting on December data, there is one initiated referral in Table V with none rescinded, submitted 100% timely to Acute level of care. The Documentation Review results are 58%.

In February's minutes, reporting on January data, there is one initiated referral in Table V with none rescinded, submitted 100% timely to Acute level of care. The Documentation Review results are 72%.

In March's minutes, reporting on February data, there is one initiated referral in Table V with none rescinded, submitted 100% timely to Acute level of care. The Documentation Review results are 63%.

After validation and reconciliation, the above accounting of total submissions and timeliness aligns with the On Demand Acute-ICF Referral report. There are a total of three referrals, with none rescinded in the quarter reviewed, all submitted to Acute level of care. Referral submission timeliness averaged 100%. In the quarter prior, there were a total of five referrals, with none rescinded, two submitted to Acute and three submitted to Intermediate level of care. Referral submission timeliness averaged 100% for Acute and 33% for Intermediate level of care.

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

Follow-up required: YES X NO	If YES: Follow-up date: Routine Review During CQIT

Follow-Up Action Plan:

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

Program Area Reviewed:	**Acute-ICF Non-Referral and Referral Reports**

Acute-ICF Non-Referral reports were reviewed for January, February, and March 2026.

In January there are 42 entries on the non-referral report in which patients met consideration for referral to a higher level of care during IDTT but were not referred. There are six patients with multiple entries: four due to MHCB placement and movement between programs, one due to MHCB placement, and one due to updates. There are no erroneous entries noted.

In February there are 26 entries on the non-referral report. There is one patient with multiple entries due to updates. There are no erroneous entries noted.

In March there are 31 entries on the non-referral report. There are three patients with multiple entries: two due to MHCB placement and movement between programs, and one due to MHCB placement. There are no erroneous entries noted.

There are two patients who appear on the non-referral report across all three months. Consideration number seven (participated in less than the minimum treatment hours in the last three months) is the most cited over the quarter.

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

Follow-up required: YES X NO	If YES: Follow-up date: Routine Review During CQIT

Follow-Up Action Plan:

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

Program Area Reviewed:	**Documentation Review:** **Higher Level of Care Considerations for Internal Consistency**
This audit was suspended since the implementation of CQIT.	
Follow-up required: YES NO X	If YES: N/A

Follow-Up Action Plan:

Program Area Reviewed:	**Observed IDTTs for Sustainable Process:** MHCB, RHU, and ML EOP

MHCB

The treatment teams started on time, overall clinicians knew their patients, there was robust discussion among treatment team members, and the team addressed issue and observation. The treatment team broadly discussed safety plans and had copies for the patients; however, clinicians did not discuss details of the safety plan. Additionally, clinicians did not discuss measurable treatment goals, progress toward treatment goals or discharge plans.

RHU

There was a total of five RHU IDTTs observed. All patients were CCCMS LOC. There were four initial IDTTs and one routine IDTT, and all patients were present for the IDTTs. Staff present included the tele-mental health clinician, the tele-psychiatrist, the CCI, the psychiatric technician, and the program supervisor. Team introductions were completed for all cases, as was the purpose of the IDTT. For two cases, the MHPC reviewed a brief case formulation. Patient case and diagnostic history were reviewed for each patient. Higher Level of Care indicators and suicide risk were reviewed for all five cases. The patients were asked open-ended questions and engaged as part of the discussion. For all five IDTTs, treatment goals were not measurable, and safety planning was not reviewed. The psychiatrist reviewed medication as well as efficacy and side effects and, if relevant. The CCI reviewed the patient's case factors, answered questions and contributed to the discussion, as appropriate. The psychiatric technician reported patient's program status and behavior. The program supervisor inquired with the patient about their understanding of specific treatment plan components on two occasions, but there were various opportunities when the supervisor could have prompted for required topics to be discussions, as mentioned above. In all cases, the initial assessments were completed prior to the initial IDTTs, and it was clear the team was familiar with the patients. However, discussion of treatment barriers, patient strengths and treatment planning was minimal in all cases.

Focus areas for continuous improvement:

1. For patients who have any history of self-harm or assaultive history, a brief note describing the patient's safety plan and, ideally, a confirmation from the patient that they are aware of the safety plan should be a regular part of each IDTT, and modified, as needed.
2. Treatment goals for each patient should be measurable.
3. A brief case formulation should be included during the review of every patient.
4. There were missed opportunities for the RHU supervisor to prompt for specific information, as needed, and/or inquire directly with the patient. Supervisors are a key part of the treatment team and are encouraged to participate in this respect to ensure all criteria are reviewed.

ML EOP - B

IDTTs were scheduled, and five observed. Of those, two were scheduled lower level of care changes and one was an initial review. Another patient observed resided at CCCMS level of care and was scheduled for a routine IDTT. Two patients refused their ducated appointments; thus these case presentations were facilitated in-absentia. IDTT started late, but within 15 minutes of its scheduled time with all required staff in attendance with access to records. The CCII was minimally engaged in discussion. He only responded to direct questions from patients regarding SNY designation and program assignment. Correctional case factors were primarily discussed by the presenting clinician. For those present, there were no factors related to mental health, nor adaptive functioning that impacted patients' ability to adequately follow and understand treatment team discussion.

The team consistently explained to patients the purpose of each meeting and afforded time for team members to introduce themselves. The team was interactive with patients and effectively solicited their

input about treatment with open-ended questions. When applicable, the assigned psychiatrist adequately reviewed/identified prescribed medications, as well as their intended therapeutic effects. Patients were provided opportunities to report any adverse side effects, followed by options to modify medication management services. Diagnoses were discussed consistently and team members appropriately utilized IDTT time to obtain diagnostic clarification and omit any inaccurate diagnoses from the healthcare chart. Treatment team discussion lacked specificity with treatment goals, case formulation, and objective benchmarks towards discharge. Personal strengths, areas of distress, and psychiatric inpatient placement histories were not consistently discussed across all presentations.

Of the five case presentations observed, four were meeting Sustainable Process indicators warranting consideration for a higher level of care. Treatment team members utilized clinical jargon that patients may not be able to understand or follow (ex: "meeting Sustainable Process indicators;" "flagging"). Two patients refused an excessive amount of offered treatment services over the previous 90 days (indicator #7). One of these patients triggered multiple indicators, having also accrued at least three or more MH RVR Assessments within the previous 90 days (indicator #6). One other patient triggered Indicator #6 only and one patient accrued three or more MHCB referrals within a six-month period (Indicator #5). When identifying contributing mental health factors, however, the team did not explicitly reference any recent MH RVR Assessment data, nor Suicide Risk Assessment data when identifying indicator-specific symptoms/behaviors to be addressed. The team identified some general treatment interventions but did not speak to relevant ways that outpatient mental health treatment would be modified to address/improve indicator-specific issues. Justification for lower level of care discharges appeared to be loosely based on patients observed functioning and not any specific or measurable treatment goal benchmarks. Otherwise, treatment team members did not refer any patients to a higher level of care and did well to adequately justify each patient's appropriateness to be retained at outpatient care, from a perspective of functional stability.

Follow-up required: YES X NO	If YES: Follow-up date: Routine Review During CQIT

<u>Follow-Up Action Plan</u>:

IDTT quality demonstrated noted strengths and deficits. Please see above for unit specific areas of strength and areas in need of improvement. Quality IDTTs are an on-going part of quality improvement, evaluation, and training.

Program Area Reviewed:	**Tier Walks/Housing Unit Reviews/Patient Follow-Ups**

During the Q2, 2026 CQIT+ Major Sustainable Process visit, tier walks/housing unit reviews/patient follow-ups were conducted in MHCB, ML EOP, and RHU. Two patients were identified for record review during the above assessments and/or carried forward from last quarter's review.	
Follow-up required: YES NO X	If YES: Follow-up Date: TBD

Follow-Up Action Plan:

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

ACTION PLAN

Higher Level of Care Considerations

Sustainable Process Data Review results: Q2, 2024 19%, Q3, 2024 0%, and Q4, 2024 6%, Q1, 2025 30%, Q2, 2025 37%, Q3, 2025 43%, Q4, 2025 53%, and Q1, 2026 26%.

The Sustainable Process Data Review audits Higher Level of Care Considerations documentation for quality and inter-rater reliability between the headquarters reviewer and the inpatient coordinator. The Sustainable Process Data Review results for Q2, 2026 are identified as 30% by headquarters' review and 48% by PBSP review, which demonstrates no substantive change with continued low quality and discrepant interrater reliability. This inpatient coordinator has now been in the role for nearly a year and a half. Resources, training, and support have been provided and are available as needed as part of an ongoing process between the regional team and institution. While the inpatient coordinator continues to report challenges with clinicians consistently submitting timely drafts for review, recommendations for elevation, consistent tracking, and routine training of clinicians, including drop-in training hours, has been encouraged to help isolate, target support, and mitigate the specific challenges.

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

- One week prior to an Interdisciplinary Treatment Team (IDTT) meeting, an office technician responsible for IDTT scheduling should utilize On Demand, Current Due Dates, to determine which patients must be scheduled for treatment team meetings. The office technician can utilize an IDTT Log spreadsheet (template available from regionals) to create a preliminary list of upcoming IDTTs for the following week. Within the preliminary IDTT Log spreadsheet, the scheduler should incorporate On Demand Sustainable Process Report (SPR) information. This can be done by generating the report

from On Demand, Sustainable Process Report, and selecting the assigned institution. From the SPR, any objective positive indicators (considerations # 4-7) highlighted in yellow should be recorded for each patient on the IDTT Log spreadsheet within the column labeled "Which PIP/DSH Criteria Met." For example, any patients on the SPR that are positive for "MHCB Admits/Referrals" should receive a "5" within the "Which PIP/DSH Criteria Met" column of the IDTT Log spreadsheet ("MH RVRs" receive a 6, and "Tx Refusal" receive a 7). Notably, an individual patient can be positive for more than one indicator, and it is important that all positive objective indicators are recorded on the preliminary IDTT Log.

- Generating a preliminary IDTT Log spreadsheet one week prior will forecast to clinicians and program supervisors any patients who may need to be considered for a higher level of care. The log will alert clinicians to prepare draft Higher Level of Care Considerations documentation for submission to the inpatient coordinator the day prior to IDTT. The preliminary period also affords opportunities to add to or modify the IDTT list prior to finalizing the schedule in the Electronic Healthcare Records System (EHRS). To ensure accountability, the preliminary IDTT Log spreadsheet should be emailed to all relevant treatment team staff (ex: clinicians, psychiatrists, program supervisors, correctional counselors), as well as senior management staff. It is also recommended to include all relevant custody staff, so they are aware of any planned level of care changes and can plan around classification committee schedules.

- On the morning of IDTT, the Sustainable Process Report must be generated again via On Demand and archived by the inpatient coordinator. A finalized IDTT Log spreadsheet should be created with any updated information from the previous preliminary log. Staff should also be informed via email whether there are any changes to the On Demand Sustainable Process Report from the previous report. This can be done through a group email. Within this email, it is further recommended that staff be reminded to submit timely referral/non-referral documentation to the inpatient coordinator to review and instructed to copy their program supervisors to help maintain accountability with correspondence. Again, draft Higher Level of Care Considerations documentation should be submitted to the inpatient coordinator the day prior to IDTT.

- The inpatient coordinator can utilize the finalized IDTT log(s) to efficiently track any higher level of care referral/non-referral documentation that must be reviewed prior to the MH Master Treatment Plans being signed in the EHRS. While drafts are due the day prior to IDTT, all documentation should be received prior to the end of IDTTs to allow sufficient time for the inpatient coordinator to review, revise, and exchange feedback with clinicians authoring MH Master Treatment Plans. Prior review is for consultation in preparation for IDTT and may change during the IDTTs treatment planning process. Subsequent review is to ensure quality and accuracy, requesting changes and/or new IDTTs as needed. The inpatient coordinator can elevate to program supervisors as needed if there are any ongoing

issues with tardiness or non-responsiveness from clinicians (as previously recommended, supervisors should be included on any email correspondence regarding required referral/non-referral documentation), elevating to the chief psychologist if needed.

- The inpatient coordinator is responsible for ensuring timely completeness, accuracy, and quality of any referral/non-referral documentation. This includes a description of justification for any non-referrals, but also interim treatment plans when patients are referred to a higher level of care and are awaiting endorsement/placement.

- For any documentation deemed inadequate by the inpatient coordinator, clinicians should be requested to adjust the Higher Level of Care Considerations documentation in the EHRS during IDTT. Timely correspondence also helps ensure appropriate discussion and integration of the Higher Level of Care Considerations into the IDTT as part of the narrative presentation. Documentation must also include thorough treatment planning/modification discussion relevant to addressing all clinical factors contributing to why the patient is being considered for a higher level of care, but ultimately not being referred.

- Program supervisors should submit a completed IDTT Log spreadsheet to the inpatient coordinator as receipt/confirmation that the Higher Level of Care Considerations documentation in the EHRS was reviewed in its entirety for everyone. A completed IDTT Log spreadsheet should include names of treatment team meeting attendees, whether any patient was referred to a lower/higher level of care, Suicide Risk Management Program (SRMP) enrollment status, and any notable comments in the space(s) provided on the IDTT Log spreadsheet. Any clinical outcomes/dispositions should be entered within the column labeled "PIP/DSH Disp. Code" utilizing the legend provided in the IDTT Log spreadsheet (i.e., A through S).

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

This Action Item is open.

MIDPOINT TELECONEFERENCE

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

SITE VISIT SUMMARY
Regional staff conducted a CQIT+ Major Sustainable Process site visit at PBSP on June 9th, 10th, and 11th 2026. Regional staff conferenced with the Higher Level of Care team to review and evaluate the Data Review processes and results, the Mental Health Subcommittee Minutes, Acute-ICF Referral and Non-Referral reports. There are a total of three referrals, with none rescinded in the quarter reviewed, all submitted to Acute level of care. Referral submission timeliness averaged 100%. The Sustainable Process Data Review results for Q2, 2026 are identified as 30% by headquarters' review and 48% by PBSP review, which demonstrates no substantive change with continued low quality and discrepant interrater reliability. Please see Action Plan Section, Item #1. In Q2, 2026, during the CQIT+ process, the team observed the MHCB, RHU, and ML EOP IDTTs. IDTT quality demonstrated noted strengths and deficits. Please see above for unit specific areas of strength and areas in need of improvement. Quality IDTTs are an on-going part of quality improvement, evaluation, and training. Tier walks/housing unit reviews/patient follow-ups were conducted in ML EOP, RHU, and MHCB. Two patients were identified for record review during the above assessments and/or carried forward from last quarter's review. Any further follow-up for identified patients after record review will be requested of the institution within two weeks, with proof of practice due within three weeks. PBSP had a mission change to EOP over two years ago with various challenges and several changes since, with the current inpatient coordinator in place for nearly a year and a half. While continuing to struggle with quality Higher Level of Care Considerations documentation, PBSP continues to work collaboratively to support prioritized patient care.