



R.J. DONOVAN CORRECTIONAL FACILITY

Review Period: Oct 2025 – Mar 2026

Onsite: May 19-22, 2026

Receiver's Compliance Team

2026

Statewide Mental Health Program
Continuous Quality Improvement



RJD CORRECTIONAL FACILITY

CDCR

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Background

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

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

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

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

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

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

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

Goals

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

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

Approach to Assessing Compliance

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

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

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

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

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

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

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

Methodology

Data Foundation

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

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

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

Data Collection

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

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

Interpreting This Report

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

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

Indicators Excluded from This Report

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

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working on resolving the issues with these indicators. These indicators have been excluded from this report. A list of the specific indicators excluded from this report can be found in Appendix E.

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. 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 out-of-cell activity within the current MHCB configuration (institutional) while also pursuing yard reconfiguration and an additional custody position (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

From May 19 – May 22, 2026, the mental health programming at Richard J. Donovan Correctional Facility (RJD) was assessed on-site using the Continuous Quality Improvement Tool, with a focused Suicide Prevention and Response Focused Improvement Team (SPRFIT) assessment occurring just prior from May 14-15, 2026. The CQIT and SPRFIT reviews considered data covering a reporting period of October 1, 2025 – March 31, 2026. The audit evaluated mental health service delivery across access to care, treatment planning, medication management, suicide prevention, custody partnership, restricted housing, staffing, and institutional oversight. This extensive evaluation has identified areas of both strengths and deficits.

Key strengths identified during this review include: effectiveness of observed psychiatric technician rounding, intake screening, and R&R screenings; responsiveness to identified deficiencies; maintenance of suicide prevention and response equipment; housing unit custody staff's knowledge of Mental Health policies and procedures; training compliance; use of CIT and alternative housing; quality of morning meetings, the SPRFIT meeting, and the Mental Health Program Subcommittee meeting; and timely transfers to EOP and MHCB LOC. The mental health department has also steadily increased their fill rate in most civil service classifications over the course of the reporting period.

There were several deficiencies identified during the audit. IDTT quality, overall, is lacking. The RVR process was deficient in several areas, including confidentiality and timeliness of mental health assessments. Use of Force incidents involved mental health patients at a high frequency. A high rate of appointments are cancelled due to custody (13%). Some local operating procedures are inconsistent with statewide policy. Medication non-adherence notification performance is substantially below target. There remain longstanding treatment space concerns in Facility A EOP, Facility B CCCMS, and MHCB. Data entry error and documentation deficiencies were noted in areas such as RHU Hub certifications and controlled uses of force and did not meet requirements in any of the audited months. Moreover, several suicide prevention discharge-continuity indicators (timely clinical follow-ups, supervisory review of discharge safety plans) fell well below requirements.

The deficiencies documented in this report are driven by a combination of structural, operational, and clinical-quality factors. The structural barriers — the MHCB yard configuration that limits out-of-cell activity and the treatment-space limitations in Facility B CCCMS and Facility A EOP — cannot be resolved through institutional corrective action alone. The Receiver will need to address space needs that are beyond the control of the institution. The operational barriers (Facility C movement practices, custody-driven cancellations, local operating procedure misalignment, and data-entry errors affecting the RHU EOP Hub certification) are within institutional control. The clinical-quality deficits — IDTT treatment planning, RVR-MHA processes, medication non-adherence response, diagnostic monitoring, and suicide prevention documentation — are supervision and training problems that do not require additional resources to fix. RJD noted that remedying staffing deficiencies was a priority for the institution and they have made progress in filling state mental health classifications. As the fill rate for mental health clinician positions increases, it is important for the institution to allocate the staff to account for appropriate coverage in each of their mental health treatment programs. The six priority recommendations below are organized by urgency and target the areas where patient safety, treatment adequacy, or both are at stake.

Priority Recommendations

1. **Conduct a quality review of IDTT processes across programs:** IDTTs were rated positively in some domains, however, the IDTTs generally struggled with lack of participation by members, which could be a function of lack of required staffing (62%), and is evidenced by an observed interactive process only 21% of the time. Qualitative review identified deficits in case conceptualization, diagnostic formulation,

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measurable treatment goals, level-of-care justification, and in the EOP programs: discussion of assignments and accommodations. Treatment interventions were difficult to recognize, it was difficult to determine progress for the patients who had an annual IDTT in CCCMS, and clinical summaries were brief. Patients confirmed during interviews that they do not know their treatment plans and that the composition of treatment team members changes frequently.

Develop IDTT processes that produce individualized, evidence-based treatment plans through collaborative clinical team discussion with documented patient participation to ensure that the patient has an understanding of the process and results, addressing deficits in attendance, staffing, interactive process, and clinical content quality. The Region IV Mental Health team can be accessed for support in developing a plan to resolve these deficiencies.

2. **Review and Revise Local Operating Procedures (LOP):** LOPs for Custody and Mental Health Partnership Plan (CMHPP), Clinical Seclusion and Restraint, and High Refuser Processes are not currently compliant with statewide policy and/or are not providing clear direction for staff. The CMHPP LOP omits quarterly round table training in the MHCB on third watch and in the RHU CCCMS and does not include the required documentation upload process. Perhaps as a result of these policy problems, round table training was completed 58% of the time, with required-staff attendance documented in 17%† of audited cases. The clinical seclusion and restraint LOP lacks clear RN assessment requirements (see Patient Safety). The EOP High Refusers LOP does not include reference to the requirement for creation of 128B forms that address the most recent high refusal event or required mental health–custody meetings.

Revise the CMHPP LOP to include quarterly round tables in all required areas and watches, and use of the correct attendance tracking tool for partnership trainings. Strengthening the CMHPP will support other recommended actions in this report, as concepts such as Effective Communication and De-Escalation Strategies for Mentally Ill Inmate-Patients are included in the training materials. Revise the LOP for clinical seclusion and restraint, to include updates that provide clearer guidance regarding RN assessment requirements when restraints are initiated. Revise the LOPs with regard to completion of 128Bs and required meetings for EOP high refusers in RHU. Once LOPs have been revised, train staff on the revisions with documentation of attendance included.

3. **Introduce Medication Non-Adherence Safeguards:** Timely response to medication non-adherence notifications averaged 31% for critical and 24% for non-critical notifications during the review period.

Ensure adherence to required appointment and/or documentation requirements for medication non-adherence within the required timeframe. Discontinue the practice of combining non-critical medication non-adherence appointments with routine follow-up when this causes untimely response.
4. **Identify and Remove Barriers to Attending Confidential Mental Health Treatment Services:** Patients on Facility C face movement barriers to attending treatment, with 13% of mental health appointments cancelled due to custody, and onsite ratings of treatment-space confidentiality by the Receiver's Compliance Team diverged from the institution's 99% self-reported confidentiality ratings during their own on-site audits. On facility A, there is a clinical office that is accessed by walking through group treatment space, which disrupts and compromises the confidentiality of groups. Furthermore, treatment happening in either space can be heard from the other treatment space.

Work with on-site custody partners to review processes that ensure timely movement to treatment activities and confidentiality of treatment spaces.
5. **Strengthen Suicide Prevention Clinical Processes and MHCB Out-of-Cell Access:** Suicide prevention clinical processes show deficits at several crisis-transition points. Suicide Risk Evaluations (SREs) upon MHCB referral for danger to self were completed in 71% of cases (299 of 426); timely

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clinical follow-ups happened 34% of the time; safety plans were signed within the required timeframe 73% of the time; and the supervisory-review indicator for discharge safety plans averaged 8%. The onsite review found supervisory reviews were completed on time in all 93 cases examined (see Appendix B); this divergence between the automated indicator and the onsite review requires reconciliation. Appendix B chart reviews similarly found completed follow-ups in sampled cases, indicating documentation-timing and data-capture issues may be depressing automated scores.

No sampled MHC patient was offered the required ten hours of weekly out-of-cell activity (average three hours), which is intended to support suicide prevention efforts. These deficiencies are driven by structural conditions, wherein the actual yard space is large enough that multiple patients could have out of cell time at once, but the way that it is currently structured, with one large open space and no small management yards for max-custody patients or other separations, only one patient is able to access out of cell/yard time at a time.

With support from the regional SPRFIT coordinator, perform a focused review of the SREs for referrals to MHC for Danger to Self (DTS), followed by training based on the findings. Identify the source of discrepancies between low automated report numbers and onsite documentation and resolve the discrepancies. Elevate MHC yard configuration and staffing issues to regional leadership for assistance addressing these issues. If unsuccessful, elevate these issues to headquarters and the Receiver for resolution.

6. Provide training to mental health staff to ensure a comprehensive review of Use of Force events:

Controlled Use of Force mental health assessments did not meet documentation requirements during the reporting period. Appropriate assessment and documentation of the mental health assessment prior to a controlled use of force provides vital information to staff involved in the use of force when the incidence extends over multiple shifts and to the reviewing officials who assess the appropriateness and may mitigate consequences for the patient.

Provide mental health staff focused training on completing and documenting the mental health assessment that is performed during controlled use of force incidents, review all documentation for controlled uses of force monthly and report the results to the Mental Health Program Subcommittee until sustained compliance is achieved.

Institution's Operational Perspective

Richard J. Donovan correctional facility operates a large and complex mental health delivery system within CDCR, with 59% of the incarcerated population enrolled in the Mental Health Services Delivery System (MHSDS). The MHSDS programming at RJD includes four Enhanced Outpatient Programs (EOP), six Correctional Clinical Case Management Systems (CCCMS) Programs, a licensed Correctional Treatment Center (CTC) with a 14-bed Mental Health Crisis Bed (MHCB) unit, EOP and CCCMS Restricted Housing Hubs, the Developmentally Disabled Program (DDP), transgender-designated housing, and care for High-Risk medical patients. Additionally, RJD is a clozapine initiation and maintenance facility. RJD has three Level II facilities (Facility B: cell living; Facility D: cell living; Facility E: dorm living) and two Level III facilities (Facility A and Facility C), all of which are non-designated facilities (NDF).

Overall, RJD experienced a population increase during the reporting period. On October 1, 2025, RJD's census was 3,729 and at the close of the reporting period (March 31, 2026), the population had increased to 3,936. In February 2026, during the reporting period, a RHU CCCMS hub was created at RJD serving 100 incarcerated persons (IPs). A weekend psychiatric clinic was initiated on April 25, 2026, with a dedicated Health Care Access (HCA) officer to help ensure timely services are provided.

RJD is using non-traditional areas for confidential treatment. On Facility A, mental health services utilize the gym for private sessions. On Facility B, some offices within the chapel serve as treatment spaces. As a result, both the gym on Facility A and the chapel on Facility B are either unavailable or significantly limited for general population use for gym or chapel purposes.

Historically, RJD has had difficulty hiring in several classifications and has filled positions with registry staff and telepsychiatrists. Over the course of the reporting period, the institution has increased the on-site civil service fill rate in most classifications.

The combination of population pressures and staffing resource limitations at times contributed to difficulties sustaining compliance in areas such as timely contacts, program coverage, and required treatment hours for EOP services. RJD also experienced a multitude of leadership changes within the custodial administration ranks.

The mental health program achieved several meaningful successes that strengthened patient care, enhanced compliance, and improved staff morale. With the rollout of the Peer Support Specialist Program, mental health collaborated more closely with the incarcerated population on wellness and treatment initiatives incorporating the feedback and suggestions from surveys of the population. Notably, peer specialists contributed to efforts aimed at reducing group refusals—an initiative launched during the reporting period and currently in the analysis phase. The mental health program also advanced innovative therapeutic offerings, including equine-assisted therapy and specialized services for LGBTQ-identified individuals. Additional achievements included the expansion of the Association of Psychology Postdoctoral and Internship Centers (APPIC) program from six to eight post-doctoral positions, as well as a successful audit of the American Psychological Association (APA) internship program. Leadership also established a psychiatry residency rotation in collaboration with Naval Medical Center San Diego, supporting long-term recruitment efforts, enhancing clinical training, and reinforcing a culture of medical professionalism. Efforts to support staff retention and morale were also prioritized. During the reporting period, RJD mental health leadership conducted a staff satisfaction survey, which showed significant improvement compared to prior years and reflected generally positive levels of job satisfaction. Furthermore, the department hosted its first appreciation luncheon last fall, an event that was well received and contributed to a more supportive and connected team environment.

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, measuring whether patients receive care of the frequency, timeliness, and clinical adequacy in spaces that protect confidentiality, safety, and dignity.

Confidential and Effective Communication

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Effective Communication Achieved	95%	96%	96%	95%	96%	97%	96%
Group treatment in a confidential setting	96%	95%	97%	97%	97%	96%	96%
IDTTs in a confidential setting	99%	99%	99%	98%	99%	99%	99%

Timely Access

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Daily PC Interactions – RHU EOP High Refusers	99%	99%	97%	98%	97%	100%	98%	
IRU Reviews Completed Timely	100%†	100%†	100%†	100%†	90%†	100%†	98%	
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure		0%†	100%†	67%†	100%†	100%†	75%†	
RHU GP Screens	100%	100%†	96%	100%†	100%†	100%†	99%	
RHU Pre-Screen	87%	88%	81%	90%	93%	97%	89%	
Timely IDTTs (v2.0)	87%	88%	86%	83%	85%	85%	86%	
Timely MH Referrals (v2.0)	73%	75%	76%	77%	81%	82%	77%	
Timely MHMD Contacts (v2.0)	58%	61%	61%	53%	60%	72%	61%	
Timely PC Contacts (v2.0)	77%	67%	79%	75%	76%	79%	76%	
Custody MH Referrals								NA
Housing Units Where 128-MH-5s Are Available And Accessible to Housing Unit Staff								100%†

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Timely Transfers

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Timeliness of Acute/ICF Referral Submission to IRU	87%†	100%†	100%†	78%†	100%†	85%†	91%
Timely Transfers to EOP (v2.0).	100%†	100%†	100%†	100%†	100%†	100%†	100%
Timely Transfers to PIP	75%†	91%†	100%†	100%†	67%†	58%†	77%
Timely Transfers to RHU CCCMS	70%†	42%†	40%†	5%	21%†	29%	31%

*RJD converted Housing Unit B7 from Restricted Housing General Population (RHG) to Restricted Housing Correctional Clinical Case Management System (RHC) on February 1, 2026.

Appointments

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Appointments Cancelled Due to Custody ⁱ	16%	14%	11%	19%	7%	7%	13%

Treatment Offered

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Treatment Offered (Structured): non-PIP	90%	69%	87%	66%	81%	91%	81%

Treatment Environment

Indicator	Onsite Audits
Adequate Group Treatment Spaces	84%
Adequate IDTT Spaces	83%†
Adequate Individual Treatment Spaces	75%

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Space-by-Space Assessment

Space / Location	Type	Assessed	Compliant	Primary Deficiencies
ML CCCMS	IDTT	5	Partial	Others walked into the Facility B Chapel; there were noise distractions that made it hard to hear.
	Group	1	No	The space cannot comfortably accommodate enough chairs for facilitators and patients. Comfortably, the room has space for eight people to sit.
	Individual	17	Partial	Facility D: Room had a dual purpose as a copy room and break room. This room was reviewed during the CQIT+ audit, as it was listed as a treatment space, but it was not being used for treatment at the time.
ML EOP	IDTT	4	Partial	Facility A IDTT space is subject to noise and interruptions as the individual treatment space is located inside of the IDTT/Group space resulting in staff and patients walking through during active IDTT/Group treatment events. Other observed IDTT spaces on C and E are fully compliant.
	Group	31	Partial	Facility A: Noisy and subject to interruptions; staff and incarcerated people walk through space during IDTT and group treatment events.
	Individual	43	Partial	Spaces in Facilities A and C were considered non-compliant. In facility A, four individual spaces are located inside the Group/IDTT space where there is a large window between them and sound can be heard inside the individual space from the group space and vice versa. Space 16 on A-Yard is also configured in a way that does not optimize safety, as there is not equal egress to the door for both the patient and the clinician. On facility C, spaces are separated by an accordion divider, and words from the adjoining rooms can be heard in the others. Some of the spaces were rated as non-compliant due to set up of furniture not optimizing safety.

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RHU CCCMS	IDTT	1	Yes	
	Group	3	Yes	
	Individual	10	Yes	
RHU EOP	IDTT	1	Yes	
	Group	3	Yes	
	Individual	10	Yes	
CTC / MHCB	IDTT	1	Yes	
	Individual	1	Yes	

✓ Strengths

IDTT timeliness was approaching compliance: During the reporting period RJD conducted IDTTs on time 86% of the time, overall.

Screening and high-refuser contacts are timely: Daily primary clinician interactions with RHU EOP high refusers averaged 98%, IRU reviews were on time 98% of the time, and RHU GP screens averaged 99%.

⚠ Concerns

Confidential treatment space is limited in Facility B and Facility A EOP: There are long standing confidentiality issues on Facility B CCCMS where IDTT takes place in the Chapel and is subject to noise and interruption. The Facility A EOP individual treatment spaces that are within the group rooms are non-confidential: what is being said can be heard in the adjacent spaces, and other staff and incarcerated persons walk through the space during treatment. There appears to be a disconnect with self-ratings of space and confidentiality by the institution from what we have observed while on-site because group treatment was documented as having occurred in a confidential setting 96% of the time, and IDTTs were documented as held in confidential settings 99% of the time.

Patients frequently arrive late to treatment due to custody and movement barriers: RHU EOP group started 15 minutes late, the clinician reported that this is typical and because they do not have enough officers. RHU CCCMS patients reported during interview that they all go to most of their appointments but that they never get there on time. On Facility C it was reported that patients are not appearing to appointments in a timely manner; reasons identified include officers doing pat downs on the patients prior to leaving their housing unit and waiting up to 15 minutes for the gate to be unlocked upon arrival at the treatment facility. Staff reported in the interview that patients do arrive for services late due to facility shutdowns, and being otherwise held up. These reports are consistent with the Timely Access statistics provided for the reporting period.

Transfers to RHU CCCMS are untimely: Timely transfers to a designated RHU CCCMS program averaged 31%, falling to 5% in January. Delays leave patients in settings already determined inadequate for their needs. The statewide shortage of designated beds is a structural factor; referral processing within institutional control should be maximized while the Receiver addresses bed capacity and increased RHU placements system-wide.

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A high rate of mental health appointments are cancelled due to custody: 13% of all mental health appointments were cancelled due to various custody reasons. The percentage of custody cancellations appears to have decreased in the last two months of the reporting period.

Psychiatry appointment timeliness was consistently well below the threshold: Timely MHMD Contacts in the reporting period averaged 61%, with initial appointments complete 50% of the time and routine appointments completed 63% of the time. Contracts were not renewed for some registry psychiatrists and new psychiatrists were in training within the reporting period.

Structured treatment offerings fell well below requirements in two months: Treatment Offered (non-PIP) averaged 81%, with November at 69% and January at 66%. Other months were approaching at or above the threshold. Movement barriers on Facility C (see Access to Care: Timely Access) and custody-driven cancellations contributed to missed structured treatment hours. The fact that RJD did offer the necessary structured treatment in some months is a hopeful sign that it can achieve consistent compliance.

Safety concerns in treatment areas: The space at Facility B CCCMS, and Facility C CCCMS Trailer is of particular concern, as there are noted safety issues regarding configuration and lack of custody support (see Space by Space Table above). Facility B CCCMS is using the chapel for MH services and MH loses custody support in the afternoon when their shift is over, while MH services are still running. There is no third shift custody allocation for the B-yard chapel so that MH services during that shift could be supported safely.

Recommendations

1. Identify and Remove Barriers to Attending Confidential Mental Health Treatment Services: See Priority Recommendations.
2. Assess current staffing distribution: Treatment modalities in the RHU CCCMS appear to be affected by the staffing allotment in that program. Ensure all programs are staffed to meet program guide requirements of timely clinical care.
3. Implement a weekly access-to-care huddle: This huddle shall be led by psychiatry and mental health leadership. Review overdue MHMD contacts and PC contacts with same-day owner assignment and escalation for custody, scheduling, provider, or patient-refusal barriers.
4. Determine contributing factors for mental health appointments that are not completed due to custody: Institution leadership is encouraged to take a multi-disciplinary approach to determining the contributing factors and address them through corrective action.
5. Maximize delivery of required structured treatment hours: Identify the drivers of the November and January declines and address scheduling and movement barriers so EOP patients are consistently offered ten hours of weekly structured treatment. (Movement-barrier actions are addressed in Access to Care: Timely Access and the related Priority Recommendation.)

Custody and Mental Health Partnership Plan

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

Indicator	Onsite Audits
CMHPP MH Daily Huddles	92%
CMHPP MH Huddle Documentation of Required Attendees	93%
CMHPP MH Huddle Documentation of Supervisor Attendees	100%
CMHPP Monthly Executive Leadership Joint Rounding	100%

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CMHPP Monthly Executive Leadership Joint Rounding Attended by Required Executives	100%
CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH Program	100%†
Custody Staff CMHPP Annual Training	98%
Healthcare Staff with CMHPP Annual Training	95%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours	90%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours with Required Attendees	96%
ML CCCMS and RC CCCMS CMHPP Weekly Supervisor Meetings	100%†
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees	92%
ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings	27%
Quarterly Partnership Round Table Training Completed as Required	58%
Required Staff Attendance of Quarterly Partnership Round Table Training	17%†

✓ Strengths

Many aspects of CMHPP at RJD are compliant: Executive Joint Partnership rounding was completed with all required documentation in all months of the review period. On-site observations of the huddles showed collaborative discussion of patient care.

⚠ Concerns

Review and Revise Local Operating Procedures: See Priority Recommendations

Recommendations

1. Revise the CMHPP LOP to align with statewide policy: See Priority Recommendations.

Psychiatry

There are required timelines for psychiatric response to medication non-adherence notifications, appropriate use of involuntary medication procedures under Penal Code §2602, and systematic monitoring of medication safety and continuity through the Medication Administration Process Improvement Program (MAPIP).¹ MAPIP tracks the percentage of medication doses provided in a timely manner across all transfer types, administration methods (keep-on-person, nurse-administered, directly observed therapy), prescription types, medication categories, and provider types. It also tracks required diagnostic monitoring for psychiatric medications. These indicators assess whether patients receive timely access to prescribed medications and whether prescribing practices include appropriate safety monitoring.

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Timely Response to Critical Non-Adherence Notification (v2.0)	22%†	20%†	44%†	25%†	24%†	50%†	31%	
Timely Response to Non-Critical Med Non-Adherence Notification (v2.0)	38%	18%	15%	31%	17%	22%	24%	
Controlled Use of Force Incidents Required to Administer PC2602 Medication								0%†

¹ See Appendix C

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✓ Strengths

Controlled use of Force incidents required to administer PC2602 medication was at 0%.

⚠ Concerns

Lack of diagnostic monitoring creates a safety gap: Diagnostic monitoring is critical, particularly for antipsychotic EKG/AIMS monitoring, clozapine CBC monitoring, valproic acid levels, lithium levels, antidepressant thyroid monitoring, and medication consents. Reliance on electronic health record messages alone to ensure psychiatrists follow up on medication non-adherence creates vulnerability if prompts are unavailable, delayed, or not integrated into daily provider workflow. Timely response to medication non-adherence notification is substantially below target.

Stacking follow up appointments is causing critical delays: Non-critical non-adherence appointments should not be delayed by stacking them with routine follow-up or consults when this causes the required timeframe to be missed.

Recommendations

1. Introduce Medication Non-Adherence Safeguards: See Priority Recommendations.
2. Discontinue combining non-critical medication non-adherence appointments with routine follow-up when this results in a delay in timely responses to medication non-adherence events: See Priority Recommendations.
3. Ensure providers are aware of current resources for tracking monitoring requirements. Train staff on current available registries and resources (such as electronic health care record messages) to aid in monitoring compliance. Encourage staff to routinely utilize these resources to identify, order and complete laboratory studies and assessments as required. Track individual provider rates of timely follow up and engage individually with psychiatrists as needed.
4. Standardize psychiatry onboarding: This should include medication monitoring expectations, diagnostic monitoring, non-adherence notification closure, medication consent, EKG/AIMS/lab workflows, transfer-medication continuity, and documentation standards.
5. Create a plan for vacancy coverage: Use a coverage plan for psychiatry-related monitoring tasks during vacancies, onboarding, leave, and provider transitions. Assign registry and non-adherence queue coverage to a named provider or supervisor each week.

Patient Safety

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

Indicator	Oct 2025	6-Month Avg	Onsite Audits
Heat Related Illness Incidents for MHSDS Patients Prescribed Heat Alert Medications	0†	0†	
Restraint Duration Incidents Greater than 4 Hours			0%†
Restraint Incidents			1†

⚠ Concerns

Documentation of actions taken during restraint usage was inconsistent: There was one incident of restraint usage during the reporting period. Discrepancies were noted regarding the timing of restraint initiation and the

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RN's initial assessment, which were clarified on-site as stemming from incorrect documentation of timing by the RN. An RN entry incorrectly stated that the restraint was present on admission (10/1/2025); in fact, the restraint was present when the RN arrived at the unit, not upon patient admission.

Recommendations

1. Provide nursing staff training on restraint documentation: To further enhance and strengthen RJD's restraint monitoring procedures, it is recommended that staff consistently document the exact times when actions and interventions occur in the EHRS. Restraint and seclusion documentation should be entered directly into the relevant EHRS sections, rather than relying on the CDCR 7316 paper form.
2. Revise the Clinical Restraint and Seclusion LOP: See Priority Recommendations.

Quality of Care

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

Care Access

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
IDTT Patient Attendance	61%	67%	61%	59%	62%	60%	61%	
IDTT Required Staffing	63%	64%	58%	67%	63%	60%	62%	
IDTTs with Observed Interactive Process								21%

Documentation

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Cases w/doc. of appropriateness of LOC discussed for pts identified by 7388B as potentially requiring HLOC								58%
EOP IDTTs Addressing Accommodations and Clinical Appropriateness for Work and Education								59%†
IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT								92%
IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT								89%

✓ Strengths

IDTTs were patient-centered: Observed IDTTs generally reflected a cohesive, multidisciplinary approach to patient care. Clinicians demonstrated familiarity with their patients and created a patient centered discussion. Patients largely report that they are satisfied with the treatment that they receive at RJD.

Initial MHPC evaluations were completed prior to IDTT: Nearly all MHPC intake evaluations were completed prior to the IDTT in all programs (92%). Completion of the initial evaluation prior to the IDTT provides an important clinical foundation for treatment planning discussions, including identification of functional impairments, diagnostic considerations, and formulation of measurable treatment goals.

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⚠ Concerns

Quality of IDTTs can be improved: IDTTs are intended to be collaborative, interdisciplinary discussions in which team members develop coordinated plans to address functional impairments and measure progress toward identified treatment goals. However, core elements of this process were not implemented consistently at RJD. Patient attendance at observed IDTTs averaged 61% (range 59–67%), required staffing averaged 62% (range 58 – 67%), and interactive process including the discussion of measurable treatment goals and case formulation was present in 21% of IDTTs observed. During on-site observations, treatment plans and rationales for level of care placement lacked clarity across multiple programs. Measurable, time-bound treatment goals and mechanisms for tracking progress were frequently absent, limiting the teams' ability to evaluate goal attainment and treatment response. IDTTs addressed accommodations for work and education in 59%† of observed IDTTs. Patients reported that they do not know what is in their treatment plans and that the people in their IDTTs change frequently.

Higher Level of Care (HLOC) documentation deficits: Complete documentation supporting the appropriateness of the patient's level of care was present in only 58% of the reviewed cases. These gaps make it impossible to show clinical risks are adequately assessed, nonreferral decisions are supported by reasoned analysis, and functional impairments (central to determining appropriate care and treatment goals) are consistently evaluated.

MHCB IDTT Discussion: During the MHCB IDTT observation, the treatment team did not demonstrate sufficient knowledge of diagnostic criteria necessary to ensure the diagnosis matches the patient's presentation and symptomatology. Additionally, the diagnostic discussion that did occur did not match what was in the patient's chart, and the clinical rationale for the diagnosis was not clearly articulated.

Recommendations

1. Conduct a quality review of IDTT processes across programs: See Priority Recommendations.

Rules Violation Reports

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

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
RVR MH Assessments Conducted in a Private Setting	46%	55%	44%	37%	28%	38%	41%	
RVR MH Assessments where Documentation Requirements were Met	88%	81%†	93%†	91%†	89%†	75%	86%	
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality	100%	100%†	100%†	100%†	100%†	100%	100%	
Timely RVR MH Assessment Request	24%	20%	23%	21%	23%	29%	24%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	61%	82%	81%	47%	76%	63%	67%	

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RVRs Issued								1,356
RVRs Issued to Non-MHSDS Participants								22%
RVRs Issued to Patients at the Acute Level of Care								0%
RVRs Issued to Patients at the CCCMS Level of Care								39%
RVRs Issued to Patients at the EOP Level of Care								35%
RVRs Issued to Patients at the ICF Level of Care								0%
RVRs Issued to Patients at the MHCB Level of Care								3%
RVRs recommended for mitigation that were mitigated								89%†
RVRs Recommended for Mitigation with Custody Documentation								84%†

✓ Strengths

Confidentiality was explained: The limitations to confidentiality in the context of RVR assessments was explained to the patient 100% of the time.

RVRs recommended for mitigation that were not mitigated had supporting documentation: 20 RVRs were reviewed at RJD and the mental health assessment (MHA) recommended mitigation in 19 of 20 cases. Of those 19, the senior hearing officer (SHO) did not follow the MHA recommendation in two cases. The SHO did complete the appropriate follow-up addressing why they did not mitigate in each of those cases, which resulted in 100% compliance.

⚠ Concerns

The RVR process has several areas of deficiency: RVR assessments were documented as taking place in a private setting on average 41% of the time. While a patient may refuse a confidential assessment, it is valuable to offer and encourage participation in the process through a confidential assessment given the potential for mitigating an RVR. RVRs for which a MH assessment was required, the request was submitted on time only 24% of the time. Results of the MH RVR assessment were submitted on time in only 67% of the cases.

Recommendations

1. Address timeliness of RVR-MHA requests: Coordinate with custody leadership to ensure RVR classification triggers timely mental health assessment requests; requests were completed on time in only 24% of cases. There is a discrepancy between custody and mental health RVR MH assessment policies with regards to timeframes. This is a known issue statewide and is being discussed for viable resolution.
2. Provide RVR-MHA assessments in a private setting: Identify and remove the barriers to conducting assessments confidentially.

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 General Population, Correctional Clinical Case Management Services and Enhanced Outpatient Program patients.

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Timeliness

Indicator	Oct 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Timely Transfers to RHU EOP	100%†	100%†	100%†	100%†	100%†	
CCII, Captain, and Warden Reviews of RHU EOP Patients with LOS Over 90 Calendar Days						100%
ICCs with Mental Health Clinicians Present and Relevant Information Provided						100%†
Initial ICCs Reviewed that were Held within 10 Calendar Days of Arrival to Restricted Housing Placement						95%
Required NDRH Transfers that Occurred Within 72 Hours						0%†

Documentation

Indicator	Nov 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Controlled Use of Force MH Assessments Meeting Documentation Requirements	0%†	0%†	0%†	0%†	0%†	
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available						83%
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	100%†
Observed RHU Screening Questionnaire Conducted in Confidential Settings	100%†
Patients in restricted housing with working entertainment appliances	95%
Peace Officers Observed to Carry Their CPR Mouth Shield	100%
RHU CCCMS Out of Cell Time Offered	60%
RHU EOP Out of Cell Time Offered	100%
RHU Shower Access	100%
Staff Who Report Unclothed Body Searches Conducted in a Private Area	100%†
Weeks where NDRH Patients are Offered Required Phone Calls	82%

✓ Strengths

RHU timelines are largely compliant: RJD is 100% compliant with most measures of RHU timeliness.

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Proactive Problem Solving: The facility is commended for implementing initiatives, like setting up a weekend psychiatry line, to ensure patients are seen within timeframes to avoid lapses in treatment.

PT Rounds are 100% compliant: During on-site observations in both RHU units, PT rounding was observed to be well done, and documentation was completed at cell front in real time.

Responsiveness to Deficiencies: Management demonstrated a commitment to improvement by issuing training and daily reminders to staff when data entry or process errors were identified. For example, RJD has been providing targeted monthly trainings to staff working in the RHU hub, based on deficient findings on respective monthly hub certification reviews, and psychiatry created a reference card for the MHMDs working in the unit.

Custodial care functions are largely compliant: Custody staff identified all Non-Disciplinary Restricted Housing (NDRH) patients (100%+), NDRH patients were provided personal property (100%+), RHU screening questionnaires were conducted confidentially (100%+), shower access was compliant (100%), RHU EOP out-of-cell time met requirements (100%), and all observed peace officers carried CPR mouth shields (100%).

Concerns

Controlled use of force mental health assessment documentation was non-compliant: Documentation requirements were met in 0%+ of audited cases in each of the four months with data. Appropriate assessment and documentation of the mental health assessment prior to a controlled use of force provides vital information to staff involved in the use of force when the incidence extends over multiple shifts and to the reviewing officials who assess the appropriateness and may mitigate consequences for the patient.

RHU EOP Hub was inconsistent in meeting some certification requirements: Significant discrepancies were caused by staff unfamiliarity with new Key Performance Indicators (KPIs) and the Automated Restricted Housing Record (ARHR) system, leading to patients being flagged as non-compliant due to incorrect check-out codes rather than a lack of care. RJD RHU EOP did not meet program guide requirements in December 2025 and March 2026. In December 2025, they did not meet expectations due to noncompliance with Timely Mental Health Referrals, Out of Cell Time, and Timely IDTTs. In March 2026, they did not meet expectations due to noncompliance with Timely Mental Health Referrals and Treatment Offered (Structured) non-PIP. RJD did not achieve a rate of 90% or greater for timely mental health referrals for reasons including but not limited to: clinicians saw their patients in a timely manner, but patients who were seen in a non-confidential setting for out-of-cell contact were not checked out as either “patient refused contact” or “medical restrictions/public health,” which are the only two reasons for non-confidential contact that can be selected from a menu of choices by the clinician, which count toward compliance with the metric. These non-confidential contacts may have been a data entry error or true reason for using a non-confidential setting for the contact. There were also issues with after-hours procedures such as lack of available custody escorts and use of confidential treatment spaces.

RHU CCCMS out-of-cell time and NDRH phone calls fell below requirements: Of the patients reviewed for RHU CCCMS, only 60% met the minimum requirements for out of cell time. This has been an ongoing issue at the RHU CCCMS at RJD. During the on-site review, it was noted that staff are aware of these deficiencies and are working to address them. Further, on-site review determined that the RHU CCCMS was non-compliant with the offering of phone calls for NDRH patients. Upon concentrated review of the last two weeks of phone calls, it was noted that drastic improvements were made with ratings of 99 and 100% for the entire population.

Recommendations

1. Review and Revise Local Operating Procedures: See Priority Recommendations.
2. Ensure that clinicians properly resolve appointments to minimize data entry errors: Monitor use of contact location reason for any non-confidential patient contact and address patterns of appointments conducted in nonconfidential spaces for reasons other than patient refusals.
3. Provide training to mental health staff to ensure comprehensive review of Use of Force events: See Priority Recommendations.

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4. RHU CCCMS out-of-cell time and NDRH phone calls fell below requirements: Of the patients reviewed for RHU CCCMS, only 60% met the minimum requirements for out-of-cell time. This has been an ongoing issue that is specific to the RHU CCCMS at RJD. During the on-site review, it was clear that staff are aware of these deficiencies and are working to address them. Further, on-site review revealed that the RHU CCCMS was non-compliant with the offering of phone calls for NDRH patients. Review of the last two weeks of phone calls prior to the date of the on-site review showed that drastic improvements were made with ratings of 99 and 100% for the entire population. RJD should continue the corrective measures that were set in place leading to the compliance improvement demonstrated during on-site review.

Sentinel Events and Specialized Custody

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

Indicator	Onsite Audits
Custody Staff Attendance at UOF Training	94%
Health Care Staff Required to Attend UOF Training	99%
Thermometer Checks completed and accurate	92%†
Use of Force Involving MH Patients	91%

✓ Strengths

Custody Housing Unit Audits were largely compliant: During housing reviews throughout the institution, staff were found to be knowledgeable about cut down kits, updated heat risk lists, MH referral processes, CPR Mouth Shields, etc. Up-to-date informational posters were found in each housing unit reviewed.

⚠ Concerns

Use of Force incidents involve mental health patients at a high frequency: There were 131 immediate Use of Force incidents during the review period. One hundred and nineteen involved mental health patients (91%) and overall at RJD, 59% of the population is included in the Mental Health Services Delivery System.

Recommendations

1. Increase implementation of de-escalation strategies through custody staff training and engagement of peer support and the CIT: Provide custody staff training on communication and de-escalation techniques for working with MHSDS patients, including accessing mental health staff support where possible, to reduce the frequency of use of force involving mental health patients. Increase staff awareness of resources for deescalation including Peer Support and the CIT.

Suicide Prevention

The Program Guide establishes clinical requirements for suicide risk evaluation, safety planning, crisis bed management, post-discharge follow-up, welfare checks, and staff training. These indicators assess whether the institution's suicide prevention processes (from initial risk identification through crisis stabilization and return

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to the general population) function as intended. Detailed findings from the Receiver's Compliance Team and Regional SPRFIT Review are attached as Appendix B.

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Discharges from MHCb with clinician review of discharge summary	50%†	0%†	50%†	100%†	100%†	100%†	70%†	
Documentation of Acute/ICF Discharges with Clinician to Clinician Contact within 5 days	100%†	100%†					100%†	
Emergent and Urgent MH Referrals That Result in SREs	84%	91%	91%	92%	92%	88%	90%	
MHCb Daily Provider Contacts (v2.0)	83%	85%	84%	85%	79%	87%	84%	
MHCb/PIP Supervisory Reviews of Discharge Safety Plans	7%†	7%†	13%†	0%†	0%†	15%	8%	
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training			52%	96%	99%	100%	86%	
Safety Plans Signed Timely	74%	78%	67%	68%	79%	68%	73%	
Timely Clinical Follow-Ups (V2.0)	32%	45%	38%	29%	34%	29%	34%	
Audited Security Welfare Checks in Restricted Housing That Included the Required Visual Observation								100%
Custody Follow Ups, Page 1								93%
Custody Follow Ups, Page 2								51%
Custody Staff with CPR Training								98%
Custody Staff with Suicide Prevention Training								98%
Healthcare staff current with suicide prevention training								92%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories								100%†
Institution SPRFIT Meeting Minutes Reviewed that Satisfy All Audit Criteria								83%†
Institution SPRFIT Meetings Observed that Satisfy All Audit Criteria								100%†
MHCb and Acute/ICF Out of Cell Activities – Phone Calls								100%†
MHCb and Acute/ICF Out of Cell Activities - Showers								100%†
MHCb and Acute/ICF Out of Cell Activities - Yard								10%†
MHCb and Acute/ICF Records with Rationale for Partial Issue								57%†
MHCb Out of Cell Activities								0%†
Observed Initial Health Screenings								100%†
Onsite Review of Patient Orders for Issue and Observation								75%†

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Patients in Alternative Housing with a Bed								100%†
Referrals That Received a SRE When DTS or Suspected Intentional OD was not Marked on the MH Referral								73%†
Restricted Housing Unit Security/Welfare Check Discrepancies with an Explanatory Memo								33%†
RHU Intake Incarcerated Persons Appropriately Housed								50%†
Suicide Resistant Cells								100%†

✓ Strengths

Training compliance rates were consistently high: As of March 2026, SRE Mentoring compliance was 100%, recovering from 52% in December 2025 (period average 86%), and all other required suicide prevention trainings were at or above 90% compliance.

SPRFIT subcommittee functions effectively: The observed meeting met the quorum, with all required voting members present, and the meeting started on time. The facilitator covered all required elements and discussion involved various disciplines, including custody and nursing staff. The committee was thorough, discussed areas of improvement with supported data (detailed drilldowns) and was solution focused.

Alternative housing: Alternative housing, where patients are temporarily housed after being identified as potentially requiring a crisis bed level of care and are awaiting MHCB placement, was extensively used at RJD, with multiple patients placed on the status each day. Patients on RHU status requiring alternative housing remained in designated cells in either B-6 or B-7 units, whereas most non-restrictive housing status patients were held in designated cells (131, 142-150) in Facility C, Housing Unit 15. All IPs were required to be provided beds and observed on a continuous 1:1 basis.

CIT functionality and hours of operation: The CIT is active and initiated several times per day. It is operational seven days a week from 8:00 a.m. through 10:00 p.m. The Review Team observed four CIT responses during onsite assessment. All cases involved full team participation, continuous observation of the individual, a confidential encounter, and SRE completion.

Second watch morning meeting in restricted housing was thorough: The second watch morning meeting for the RHU was observed (combined meeting for both RHU units). All required disciplines were present and the facilitator was adept in ensuring all parties participated and provided relevant information. All new arrivals to RHU and Suicide Risk Management Program (SRMP) patients were reviewed in great detail. The discussion was thorough and interactive.

Holding Cell logs: Examination of Temporary Holding Cell (THC) Logs for the four facilities (A, B, C, and D) that utilized THCs during the review period found that none had any individuals confined in the cells for DTS in excess of four (4) hours.

⚠ Concerns

Urgent and emergent referrals not always completed on time: 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 only 73 percent (11 of 15) of these cases had the SRE completed.

MHCB discharge continuity indicators are substantially below requirements: Timely clinical follow-ups averaged 34% (range 29–45%), safety plans were signed on time 73% of the time, discharges with clinician review of the discharge summary averaged 70%†, and the supervisory-review indicator for discharge safety plans averaged 8%. The onsite review found supervisory reviews completed on time in all 93 cases examined (see Appendix B); this divergence between the automated indicator and the onsite review requires

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reconciliation. Appendix B chart reviews similarly found completed follow-ups in sampled cases, indicating documentation-timing and data-capture issues may be depressing automated scores.

Issue and observation order documentation requires improvement: Onsite review of patient orders for issue and observation met criteria in 75%† of cases, and records with a rationale for partial issue were compliant in 57%†. Appendix B details cases in which partial-issue restrictions were not supported by current behavior or documented justification, and there was one case in which Q-30 observation was paired with partial issue, an inconsistent clinical decision.

Custody and intake documentation gaps: Custody discharge check documentation (Page 2) was 51% compliant and RHU intake patients were appropriately housed in 50%† of audited cases. RHU EOP was compliant in seven of eight instances. The onsite walkthrough found a single case that was not policy-compliant, in that the patient required ADA accommodations but there are no ADA retrofitted intake cells at RJD. This is a known issue involving how to place patients in RHU when they require ADA accommodations. Welfare-check discrepancies had explanatory memos in 33%† of cases.

MHCB Out of Cell Time: Review of a sample of 10 MHCB patients found that none were offered the minimum of 10 hours per week out-of-cell activity (yard and dayroom) during seven-day time periods. Patients were offered between 1 and 4 hours of out-of-cell activity, with an overall average of 3 hours per week. Under the current physical plant configuration, RJD cannot meet the required offering of 10 hours minimum out-of-cell time per week per patient. These deficiencies are driven by structural conditions, wherein the actual yard space is large enough that multiple patients could have out of cell time at once, but the way that it is currently structured, with one large open space and no small management yards for max-custody patients or other separations, only one patient is able to access out of cell/yard time at a time. Facility issues beyond the control of the institution will be addressed by the Receiver's office.

CIT Observation: Although staff made appropriate efforts to address the CIT calls and alternative housing contacts it appears they may not fully understand the goal of the contact which is to clarify the patient's emergent concern and determine if an MHCB referral is needed, as well as how to de-escalate patients who become hostile and difficult to manage during these calls.

Recommendations

1. Strengthen Suicide Prevention Clinical Processes and MHCB Out-of-Cell Access: See Priority Recommendations.
2. Improve the training for all mental health staff on how to handle CIT calls and complete alternative housing contacts: Specific focus on anticipated barriers, treatment options and the goal of the contact is advised. (Please see Alternative housing/CIT observations in Appendix B.)
3. Review SREs for referrals to MHCB for DTS: See Priority Recommendations.
4. Additional training for issue and observation justifications: Ensure that staff understand why clear clinical justifications are needed for observation and issue updates, as well as what constitutes an appropriate clinical justification would be based on a patient's presentation.

Sustainable Process and Utilization Review

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

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Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
MHCB clinical stays within timeframes	86%	92%	83%	78%	97%	88%	88%	
Timely Transfer to MHCB (v2.0)	100%	96%	100%	96%	100%	100%	99%	

✓ Strengths

Mental Health Program Subcommittee (MHPS) minutes: MHPS meeting minutes from January to March 2026 were reviewed. A quorum was met and the IPC was in attendance for all meetings. Table V was embedded in the minutes. The minutes continue to document RJD’s ongoing efforts to improve HLOC documentation, including data analytics, identified barriers, and interventions.

⚠ Concerns

Sustainable process data review: HQ reviewed 60 cases in this quarter’s Higher Level of Care considerations documentation audit: 10% (six cases) were identified as “good” and 90% (54 cases) were identified as “unacceptable.” Percentages were gradually improving in the beginning of 2025 (Q1: 21%; Q2: 34%; Q3: 46%), however, over the last three quarters there was a downward trend. Many were deemed unacceptable because they lacked a Mental Status Exam (MSE). HQ began requiring a MSE for “good” HLOC Considerations documentation a year ago. RJD’s HLOC documentation quality declined by 4% this quarter.

Recommendations

1. Continue concerted efforts in improving HLOC Considerations documentation: The IPC should continue to provide feedback to MHPCs on the quality of HLOC Considerations documentation according to HQ standards, specifically focused on educating staff about the requirement for inclusion of an MSE.

Staffing

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

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Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief Psychologist	2.0	2.0	0%
Chief Psychiatrist	1.0	1.0	0%
Senior Psychiatrist (Supervisor)	1.0	1.0	0%
Senior Psychologist (Supervisor)	8.25*	7.0	15%
Supervising Psychiatric Social Worker I	1.0	0.0	100%
Senior Psychologist (Specialist)	8.25*	6.67	19%
Recreation Therapist	29.25*	32.5	0%
Staff Psychiatrist	16.75*	14.72	12%
Psychologist – Clinical	8.25*	8.25	0%
Clinical Social Worker	2.75*	2.75	0%
Primary Clinician (PC)	*66.75	59.48	11%
PC: Psychologist – Clinical		41.2	
PC: Clinical Social Worker		15.2	
PC: Marriage and Family Therapist		0.95	
PC: Professional Clinical Counselor		2.20	

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

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

✓ Strengths

Increased fill rate during the reporting period: RJD increased the fill rate in most classifications over the course of the reporting period.

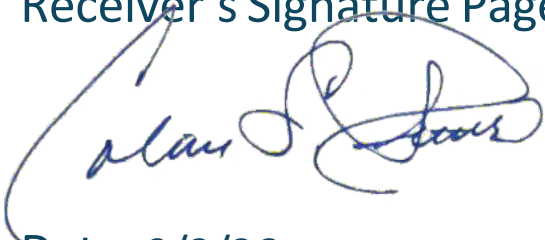
⚠ Concerns

Fill rate vs. Supervision Requirements: Notably, the Supervising Psychiatric Social Worker I position remained unfilled during the entire reporting period, as did a Senior Psychologist Supervisor position. At the same time,, the fill rate for staff positions requiring supervision continued to increase.

Recommendations

1. **Prioritize filling supervisory vacancies:** Continue to work with CCHCS HR to fill the Supervising Psychiatric Social Worker I and Senior Psychologist Supervisor vacancies. Implement an interim supervision coverage plan commensurate with the growing line-staff complement.

Receiver's Signature Page

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

Date: 9/3/26

Appendix A: Acronyms and Initialisms

Acronym List	
ADA	Americans with Disabilities Act
ASP	Avenal State Prison
APP	Acute Psychiatric Program
ARHR	Automated Restricted Housing Record
ASH	Atascadero State Hospital
BPT	Board of Prison Terms
C&PR	Classification and Parole Representative
CAL	Calipatria State Prison
CAT	Chart Audit Tool
CC I	Correctional Counselor I
CC II	Correctional Counselor II
CCAT	Correctional Clinical Assessment Team
CCCMS	Correctional Clinical Case Management System
CCHCS	California Correctional Health Care Services
CCI	California Correctional Institution
CCWF	Central California Women's Facility
CDCR	California Department of Corrections and Rehabilitation
CEN	Centinela State Prison
CEO	Chief Executive Officer
CHCF	California Health Care Facility
CHSA	Correctional Health Services Administrator
CIM	California Institution for Men
CIT	Crisis Intervention Team
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
CMH	Chief of Mental Health
CMHPP	Custody and Mental Health Partnership Plan
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	Correctional Training Facility
D/C	Discharge
DAI	Division of Adult Institutions
DCHCS	Division of Correctional Health Care Services
DDP	Developmentally Disabled Program

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DOT	Direct Observed Therapy
DSH	Department of State Hospitals
DTS	Danger to Self
EHRS	Electronic Health Records System
EOP	Enhanced Outpatient Program
ERRC	Emergency Response Review Committee
FIT	Focused Improvement Team
GP	General Population
HCA	Health Care Access
HCPOP	Health Care Placement Oversight Program
HDSP	High Desert State Prisons
HLOC	Higher Level of Care
HPS I	Health Program Specialist I
HQ	Headquarters
IAC	Inmate Advisory Council
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Interdisciplinary Treatment Team
IPC	Inpatient Coordinator
IRU	Inpatient Referral Unit
ISP	Ironwood State Prison
ISUDT	Integrated Substance Use Disorder Treatment
KOP	Keep On Person
KVSP	Kern Valley State Prison
LAC	California State Prison, Los Angeles County
LOC	Level of Care
LOP	Local Operating Procedure
MA	Medical Assistant
MAPIP	Medication Administration Process Improvement Plan
MCSP	Mule Creek State Prison
MH	Mental Health
MHA	Mental Health Administrator
MHCB	Mental Health Crisis Bed
MHCT	Mental Health Compliance Team
MHMD	Mental Health Medical Doctor (Psychiatrist)
MHPS	Mental Health Program Subcommittee
MHRA	Mental Health Regional Administrator
MHSDS	Mental Health Services Delivery System
ML	Mainline
ML CCCMS	Mainline Correctional Clinical Case Management System
ML EOP	Mainline Enhanced Outpatient Program
MSE	Mental Status Exam
MSF	Minimum Support Facility

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NA	Nurse Administered
NDF	Non-Designated Facility
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 Clinical Case Management System
RHU EOP	Restricted Housing Unit Enhanced Outpatient Program
RHU GP	Restricted Housing Unit General Population
RJD	Richard J. Donovan Correctional Facility
RT	Recreation Therapist
RVR	Rules Violation Report
RVR-MHA	Rules Violation Report – Mental Health Assessment
SAC	California State Prison, Sacramento
SATF	Substance Abuse Treatment Facility
SCC	Sierra Conservation 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
SRMP	Suicide Risk Management Program
SRN II	Supervising Registered Nurse II
SRN III	Supervising Registered Nurse III
SVPP	Salinas Valley Psychiatric Program
SVSP	Salinas Valley State Prison
T4T	Training for Trainers

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

Appendix B: Suicide Prevention Report

Restricted Housing Unit (RHU)

Psychiatric technician rounds were assessed by nursing auditors. Practices were observed to be adequate. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

Intake Cells

The B-6 (EOP Hub) RHU contained 12 retrofitted New Intake Cells, the B-7 (CCCMS) RHU contained 12 retrofitted new intake cells. During inspection of each unit, with one exception, all new intake IPs were housed in new intake cells. The exception was an ADA patient with medical needs requiring a wheelchair on new intake status who was housed in a non-suicide-resistant cell. There are no ADA retrofitted intake cells at RJD. This is a known issue involving how to place patients in RHU when they require ADA accommodations. Of note, B-7 was recently converted into a CCCMS Hub in February 2026. Intake cell compliance was also reviewed by Mental Health Compliance Team (MHCT) lieutenants during this site visit. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

Second Watch Morning Meeting

The second watch morning meeting for the RHU was observed (combined meeting for both RHU units). The meeting started on time and all required members were present with representatives from custody, medical and mental health staff in attendance. The facilitator was adept in ensuring all parties participated and provided relevant information. Additionally, primary clinicians were also present to describe the stability and presentation of SRMP patients. All new arrivals to RHU and Suicide Risk Management Program (SRMP) patients were reviewed in great detail. Individuals on a five day follow up, the current census and alternative housing patients as well as who is assigned to see them for the day were also discussed. The discussion was thorough and interactive; however, mental health staff should be cautious regarding the level of detail provided about patient illnesses in the presence of other, non-clinical disciplines in order to protect health information and therapeutic alliances.

Access to Entertainment Appliances

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

Welfare Check Completion (Guard One)

Guard 1 checks for RHU in March 2026 were within compliance at 90 percent. A portion of RHU Guard 1 checks was observed by MHCT during this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

RHU Pre-Screening (Pre-Placement)

RHU pre-placement screenings were observed by nursing as part of this site review. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of their findings.

RHU GP Screenings (Post Placement)

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

Inpatient Units

Suicide-Resistant Cells

RJD had 14 MHCBs, with all cells previously found to be suicide resistant. Most of the MHCB cells were filled during the onsite assessment.

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Interdisciplinary Treatment Team (IDTT)

The Review Team had the opportunity to observe three (3) IDTT Meetings within the MHCB unit during the onsite assessment (on May 15). During the observed meeting, except for the psychiatrist who was a limited participant, there was good team participation, discussion regarding reason for admission and case presentation, diagnoses, medications, and observation level and issue. Two patients attended and one IDTT was conducted in absentia, despite the team's best efforts to have him participate in a confidential setting. All IDTT meetings reviewed measurable treatment goals. Because all three meetings were initial IDTT sessions, there was appropriate basic discussion regarding safety planning. However, none of the clinicians introduced what an IDTT was to obtain the patient's understanding of the process and establish effective communication.

Quality of Safety Planning

In order to assess the quality of Safety Plans required for patients discharged from the MHCB unit, one reviewer examined the EHRS charts of five (5) patients who were discharged from the unit and who remained at RJD during the review period. The review found that all the cases had SREs completed, and all applicable daily clinical follow-ups were completed for each of the five required days. In addition, the review found that four of five (80%) of the cases had adequate safety plans.

MHCB Supervisory Review of Discharge Safety Plans

Pursuant to CDCR's "Supervisory Review of Mental Health Crisis Bed Discharge Safety Plans" directive (effective March 10, 2020), one reviewer examined data regarding MHCB supervisory review of all discharge SREs and safety plans for patients released from the MHCB unit to a lower level of care between October 2025 and March 2026. The subsequent review found that the supervisory review of MHCB discharge safety plans was completed in all cases (93) of reviewed cases. All the completed supervisory reviews were timely.

Suicide Watch and Suicide Precaution

Both Suicide Watch and Suicide Precaution statuses were being used in the MHCB unit. In addition, patients not on suicide observation status were observed at 30-minute intervals by nursing staff. During March 2026, the Mental Health Observations Reporting Tool indicated that 33 patients were on suicide observation status in the MHCB unit, with 96 percent compliance with timely observation of patients on Suicide Precaution and 91 percent compliance with timely observation of patients on Suicide Watch.

Observation and Issue Orders

Provider Orders (to include level of observation, patient issue, and privileges) were placed outside each suicidal patient's door on Adaptive Support Forms (CDCR 128 C-2) and found to be current. In addition, almost all patients were granted full privileges upon admission. There were, however, concerns for clinical justification for observation and issue orders found in the medical chart of a current MHCB patient. On May 14, a patient was placed on partial issue, but also Q-30 observation, an inconsistent clinical decision. During his IDTT meeting on May 15, the patient was observed by the Review Team to be continued on Q-30 and remained in partial issue. In addition, the IDTT members stated he continued to be restricted from using pencils, toothbrush, and pen fillers, but remained on Q-30, and such information was not documented in the medical chart until after the meeting when Review Team brought up the issue. These restrictions were based upon a history of swallowing pencils over a year earlier, and not current behavior. If the IDTT believed these restrictions were still warranted, the patient should have remained on Suicide Precaution status. In a second reviewed case, the patient had an order for both partial issue and safety smock for several days, presumably because the May 7 progress note indicated he wore a smock as "his preference." In a third case, the patient had a May 11 order for both partial issue and safety smock.

Privileges

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Regarding Out-of-Cell Time offered to MHCb patients, one reviewer examined the ARHR system for documentation of out-of-cell activity for 10 MHCb patients during seven-day periods of the review period. All had been cleared for out-of-cell activities by providers. The review found that none were offered the minimum of 10 hours per week of out-of-cell activity (yard and dayroom). Patients were only offered between 1 and 4 hours of out-of-cell activity, with an overall average of 3 hours per week. In addition, all patients averaged 4 showers and 5 telephone calls per week.

There continue to be several reasons for the low offering of yard/dayroom. First, the MHCb unit does not have a dayroom. Second, RJD has a local practice of yard only being offered by recreational therapists (RTs), with no involvement by custody officers other than escorting patients to and from the yard. RTs are available in the MHCb unit Monday through Friday, and only one patient is allowed out into the yard at a time and limited to only approximately 60 minutes per day. Under this formula, RJD will never obtain the minimum offering of 10 hours per week per patient.

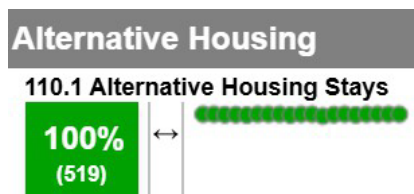
Clinical Discharge Follow-ups

One reviewer examined the EHRS charts of five (5) patients who were discharged from the unit and who remained at RJD during the review period. The review found that all of the cases had SREs completed, and all applicable daily clinical follow-ups were completed for each of the five required days. Reconcile the timely clinical follow-ups data divergence between on-site observations and data input.

Alternative Housing

Alternative housing to temporarily house patients identified as possibly in need of and awaiting MHCb placement due to expressing suicidal or homicidal ideation or identified as possibly SIDDMI, was extensively used at RJD, with multiple IPs placed on the status each day. Patients on RHU status requiring alternative housing remained in designated cells in either B-6 or B-7 units, whereas most non-restrictive housing status patients were held in designated cells (131, 142-150) in Facility C, Housing Unit 15. All patients were required to be provided beds and observed on a continuous 1:1 basis.

An alternative housing contact was observed with two mental health clinicians present as one was training the other (new hire). The contact was conducted at cell front, however, a confidential setting was offered and refused by the patient. There was some training discussion between the clinicians that likely should have occurred before or after the contact, away from the patient's door, however, the clinicians did a good job ensuring the patient's needs were met.



Provided data indicated that 498 patients were placed in alternative housing from November 1, 2025, through April 30, 2026. All were housed under 24 hours. More than half, or approximately 59 percent (292 of 498) of the cases, resulted in the MHCb referrals being rescinded and patients returned to their housing units. Medical chart review of 15 cases of MHCb recissions found that all had SREs completed (100%), but clinicians in two (2) cases incorrectly utilized the abbreviated SRE reassessment form that did not contain the safety plan template. In addition, 8 of 11 (73%) of applicable cases had all 5-day follow-up assessments completed, and only 12 of 15 (80%) had required safety plans completed. Of note, only 6 of 12 (50%) safety plans were of adequate quality.

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Finally, examination of Temporary Holding Cell (THC) Logs for the four facilities (A, B, C, and D) that utilized THCs during the review period found that none had any individuals confined in the cells for DTS in excess of four (4) hours.

Suicide Risk Management Program (SRMP)

RJD's Local Operating Policy (LOP) for the SRMP program was reviewed and is consistent with the most recent SRMP guidelines.

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. All institutional SPRFIT coordinators have been asked to manually track SRMP patients. The manual tracking maintained by RJD's local SPRFIT was reviewed, had all required columns and appears to be accurately tracking SRMP patients throughout the institution as it is organized by housing. This log appropriately tracks patients who "meet criteria but are not included", those that "meet criteria and are currently in SRMP", as well as those that have been "removed" from SRMP. A random sample of 5 patients who were included in SRMP, were reviewed and in 5/5 (100%) of the cases, mental health clinicians had included interventions and goals listed in the SRMP tab of the Master Treatment Plan.

Custody Inpatient Discharge Follow-ups

The process by which patients were provided Discharge Custody Checks at 30-minute intervals following release from either a MHCB or alternative housing placement was reviewed. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of findings.

RJD made the transition from the paper form 7497 to the electronic Observation Tracker on March 2, 2026.

March 2026: Audit Summary for RJD from the Observation Tracker

Institution	Facility	Date Range	
RJD	All	3/1/2026	3/31/2026

Measurement Area	#Pass	#Fail	#Total	%Compliance
3 Timeliness of Mental Health Contact	104	37	141	73.8%
1 Section I Complete	72	0	72	100.0%
4 Checks Discontinued After At Least 24 Hours	63	0	63	100.0%
5 Checks Discontinued After No More Than 72 Hours	56	4	60	93.3%
6 1st Entry Upon Arrival to Unit Complete	44	29	73	60.3%
8 Supervisor Review	44	29	73	60.3%
7 30-Minute Checks	17	56	73	23.3%
2 Section II Complete	0	0	0	
Overall	400	155	555	72.1%

For March 2026, the Timeliness of Mental Health Contacts measure was noted to be compliant in 104 of 141 five-day step-downs, resulting in an overall compliance of 73.8 percent. All checks were discontinued by

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mental health staff (63/63) after at least the 24-hour mark. Additionally, 56/60 of the checks were discontinued by mental health staff after no more than 72 hours, resulting in an overall compliance of 93.3 percent for the month.

Institutional SPRFIT Committee

The SPRFIT Subcommittee at RJD was observed on May 21, 2026, via Microsoft Teams during the larger team's CQIT tour. This meeting met quorum, with all required voting members being present, and started on time. The facilitator covered all required areas including: the new 7497 observation tracker along with a collaborative and qualitative multi-disciplinary discussion, timely clinical follow ups, SRE compliance, safety plans, project pipeline reviewed, high risk patients, intake cell compliance, Guard 1 compliance, SRMP, self-harm review, training, IAC/PAC, CAT audits, LOP review, memo (change in RHU regulations) and more. The facilitator involved various disciplines, including custody and nursing staff, in the discussion. The committee was thorough, discussed areas of improvement with supported data (detailed drilldowns) and was solution focused. The presentation was clear and professional. Overall, this SPRFIT subcommittee's organization and discussion may serve as a model for other subcommittees.

A review of six months of SPRFIT meeting minutes (October 2025 through March 2026) found that meetings had quorums of all required mandatory members or designees for all months except November 2025 (in which there was no inpatient coordinator). Meeting minutes included discussion on compliance data, IAC/PAC meeting attendance (at least once in six months), improvement projects, as well as the status of corrective actions based upon regional SPRFIT audits. In addition, meeting minutes included the tracking and brief review of patients in the SRMP. There were three clinical reviews of serious suicide attempts that had medical severity ratings of "3" that included the seven areas required for clinical case reviews in meeting minutes of November 2025, January 2026, and February 2026. All required suicide-prevention LOPs were current. Overall, SPRFIT meeting minutes during the review period were very comprehensive. In sum, all 5 SPRFIT compliance areas were assessed as adequate.

Policies

RJD has a local suicide prevention policy (Suicide Prevention and Response, LOP No. 17) that addresses required Suicide Prevention trainings, Discharge Custody Check requirements, Suicide Risk Management Program, and documentation of self-harm events, as well as local policies to address receipt of bad news, and Crisis Intervention Team procedures. It was most recently revised in May 2025. Other local policies were reviewed to verify that recent statewide memorandums related to suicide prevention have been incorporated, and policies have been updated annually. The Alternative Housing policy (LOP No. 160) was last revised in March 2025.

Severe Self-Harm

Per the March 2026 SPRFIT report, there was a 23 percent increase in self-harm incidents for February 2026 compared to January 2026 (32 versus 26). The majority of incidents were minor, although there was one suicide attempt by laceration with a moderate severity level. Laceration continues to be the highest trending method of self-harm for several consecutive months. Overall, the rate of self-harm events in February 2026 was 8.2 per 1,000 (33/4009).

Suicide Risk Evaluations

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Data last refreshed 5/26/2026 2:10:00 PM

	Measurements	Time Overdue (Days)	Compliance
Suicide Risk Evaluation	864	3.5	80%
SRE at ICF Referral for DTS	2	45.1	0%
SRE at MHCB referral for DTS	426	0.1	71%
SRE at MHCB re-referral for DTS	1	0.0	100%
SRE at rescission of MHCB referral for DTS	270	0.3	98%
SRE following MHCB Discharge (CCCMS and Non-MHSDS) - 1st	24	51.0	17%
SRE following MHCB Discharge (CCCMS and Non-MHSDS) - 2nd	19	81.8	32%
SRE prior to discharge IDTT (MHCB)	105	0.5	90%
SRE prior to discharge IDTT (PIP)	1	14.7	0%
SRE upon arrival from StateHospital DSH	16	0.0	100%

Timelines for Suicide Risk Assessment

The Suicide Risk Evaluation indicator on the Performance Report was reviewed in order to access information related to the compliance of suicide risk evaluations for admission to, and discharge from, the RJD mental health crisis bed. It was also utilized to determine the completion of suicide risk evaluations for rescinded MHCB referrals based upon Alternative Housing Placement.

Based on the review, a total of 426 referrals for placement in an MHCB for DTS were completed during the review period. Of those, 299 had suicide risk evaluations completed, resulting in 71 percent compliance. Additionally, a total of 105 clinical discharges from the RJD MHCB required a suicide risk evaluation and 94 were completed, resulting in 90 percent compliance for this measure. Of the MHCB rescissions, 264 of the 269 required Suicide Risk Evaluations were completed, resulting in 98 percent compliance. Overall, the only measure that requires immediate improvement in this area is SREs when a patient is referred for placement in an MHCB.

Urgent and Emergent Consults for Danger to Self (DTS)

A review of the Emergent and Urgent MH Referrals that Result in SREs indicator in On Demand indicated the good compliance rates for referrals in which “self-harm/suicidal bx or ideation/DTS” or “intentional drug overdose” was selected as the reason for emergent referrals. From October 1, 2025, to March 31, 2026, RJD had low compliance for completion of a SRE (two of four cases) after an Urgent Mental Health Consult for Self-harm/Suicidal Behavior or ideation/DTS. Although these SRE’s were ultimately completed, the only contributor to the low compliance was that they were noted to be signed late by the mental health clinicians.

Quick List: RJD

Emergent and Urgent MH Referrals That Result in SREs from 10/01/25 thru 3/31/26

Placement: ASU,ASU EOP Hub,Condemned,IN_TRANSIT,Institution Wide,LTRH,MHCB,ML,ML CCCMS,ML EOP,PSU,RC,RC CCCMS,RC EOP,RHU,RHU CCCMS,RHU EOP,SHU,STRH

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	Measurements	Hour Overdue	Compliance
Emergent and Urgent MH Referrals That Result in SREs	787	38.3	90%
SRE after Emergent MH Consult for Self-harm/Suicidal Behavior or ideation/DTS	781	38.1	90%
SRE after Emergent MH Consult for suspected intentional drug overdose	2	0.0	100%
SRE after Urgent MH Consult for Self-harm/Suicidal Behavior or ideation/DTS	4	98.6	50%

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

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 only 73 percent (11 of 15) of these cases had the SRE completed.

Emergency Response

Cut-Down Kits

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

Quality Improvement Plans (QIPs) Generated by Suicide Case Reviews

There were zero QIPs that remained open from suicides which occurred prior to RJD's last site visit. There have not been any deaths by suicide that resulted in a QIP at RJD during the review period.

Training and Mentoring Compliance

Compliance with the Annual IST Suicide Prevention Training for 2025 was the following: 90 percent of custody staff, 95 percent of medical staff, and 99 percent of mental health staff. Document production numbers differ from on-site review numbers as more training had occurred in the meantime.

Compliance with training requirements is exceptional. Compliance for RJD as of March 2026 is as follows:

- Understanding and Assessing the Presence, Severity, and Risk of Suicidality: 92%
- SRE Mentoring: 100%
- Safety Planning: 95.8%
- Suicide Risk Management Program (SRMP): 96.64%
- Complex Cases: 99%
- Prohibition of safety contracts: 100%
- Nursing CPR: 100%
- Custody CPR: 92%

Annual IST Suicide Prevention Training – Observation

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

Receiving and Release (R&R) Screening

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

Reception Center Processing

RJD does not have a Reception Center.

Crisis Intervention Team (CIT)

The **Crisis Intervention Team** was initiated at RJD in June 2019. The CIT is very active and initiated several times per day. It is operational seven days a week from 8:00 a.m. through 10:00 p.m. The Review Team observed four CIT responses during onsite assessment. All cases involved full team participation, continuous observation of the individual, a confidential encounter, and SRE completion.

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During one observed CIT contact, a clinician conducted a thorough assessment of a patient reporting suicidal ideation under difficult circumstances and ultimately admitted the patient to the MHCB. The observation highlighted a training need for newer staff: the CIT role is to triage the current crisis rather than to make level-of-care decisions in advance, and the decision to admit or not admit should remain fluid based on the contact.

Active Corrective Action Plans (CAPS)

During the previous SPRFIT review, three (3) CAPS were assigned for 1) inadequate safety plans from MHCB rescissions, 2) low compliance with completion of SREs based on mental health referrals not marked for DTS, and 3) low compliance with discharge custody checks. As noted above, during this current review, only 12 of 15 (80%) reviewed MHCB rescission cases had required safety plans completed, with only 6 of 12 (50%) of those plans found to be of adequate quality. In addition, only 73 percent (11 of 15) of reviewed cases of mental health referrals not marked for DTS had SREs completed. Overall, compliance with discharge custody checks has improved, but still not at goal. As such, all three (3) CAPS will remain open.

Conclusion

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

- 1) In order to increase the opportunity for offering out-of-cell activities to MHCB patients, RJD should continue to collaborate with CDCR headquarters for assistance in addressing identified issues with MHCB yard to allow more patients out at the same time.
- 2) Improve the training for all mental health staff on how to handle CIT calls and complete alternative housing contacts, with specific focus on anticipated barriers, treatment options and the goal of the contact.
- 3) Increase compliance with SRE's for referrals to a MHCB for DTS.
- 4) Ensure that staff understand why clear clinical justifications are needed for observation and issue updates as well as what a good clinical justification would be based on a patient's presentation.
- 5) Improve the IDTT process to include ensuring the patient has an understanding of the IDTT process and what it entails.
- 6) Reconcile the data divergence between on-site observations and data input for safety plan timeliness.
- 7) Reconcile the divergence between observation and issue orders with regard to differences between on-site observations of the observation and issue orders posted on patient doors, and documentation of observation and issue orders in the chart.
- 8) Reconcile the supervisory-review data divergence between on-site observations and data input and establish tracking for discharge safety plan reviews.

Appendix C: MAPIP



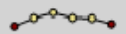
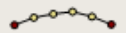
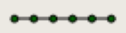
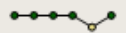
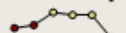
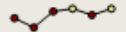
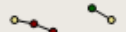
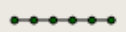
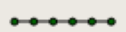
INSTITUTION 6 MONTH TREND

Richard J. Donovan Correctional Facility (RJD)

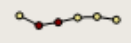
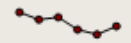
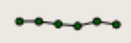
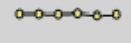
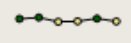
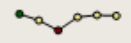
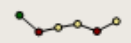
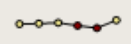
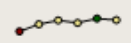
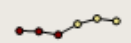
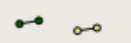
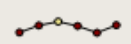
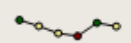
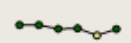
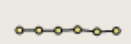
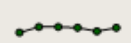
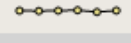
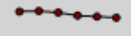
March 2026

Population Health Management	6 Months	Trend	OCT	NOV	DEC	JAN	FEB	MAR
Diagnostic Monitoring (All)	82%		81%	83%	84%	79%	80%	84%
QT Prolongation EKG 12 Months	76%		71%	77%	75%	67%	82%	82%
Antipsychotics (All)	85%		84%	87%	88%	81%	81%	90%
Lipid Monitoring	75%		72%	76%	76%	66%	70%	89%
Blood Sugar	84%		84%	86%	88%	77%	75%	91%
EKG	67%		0%	100%	-	0%	80%	-
AIMS	69%		73%	57%	71%	61%	75%	75%
Med Consent	77%		74%	84%	79%	77%	71%	80%
CBC with Platelets	86%		80%	85%	100%	73%	78%	92%
CMP	88%		81%	86%	100%	80%	76%	100%
Thyroid Monitoring	69%		65%	65%	81%	50%	63%	79%
Blood Pressure	99%		100%	99%	99%	99%	98%	99%
Height	91%		88%	98%	91%	88%	86%	94%
Weight	98%		99%	100%	97%	97%	96%	97%
Pregnancy	-		-	-	-	-	-	-
Clozapine (All)	74%		73%	72%	60%	78%	79%	79%
Blood Sugar	94%		100%	100%	50%	100%	100%	100%
Lipid Monitoring	89%		100%	100%	50%	100%	80%	100%
CBC	63%		62%	58%	56%	69%	73%	63%
CMP	89%		100%	100%	50%	100%	80%	100%
EKG	93%		100%	100%	100%	100%	100%	80%
AIMS	78%		75%	100%	100%	100%	67%	67%
Thyroid Monitoring	50%		0%	100%	-	100%	0%	50%
Med Consent	100%		-	100%	100%	-	100%	100%
Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Height	89%		80%	100%	100%	100%	75%	100%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-

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Mood Stabilizers (All)	76%		68%	78%	83%	78%	77%	71%
Carbamazepine (All)	-		-	-	-	-	-	-
Carbamazepine Level	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-
Valproic Acid (All)	78%		69%	79%	83%	86%	80%	70%
Med Consent	76%		75%	71%	50%	90%	50%	100%
Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Height	96%		100%	100%	100%	100%	83%	100%
Valproic Acid Level	44%		29%	40%	75%	50%	43%	25%
CBC with Platelets	60%		50%	56%	80%	75%	75%	30%
CMP	61%		50%	56%	82%	67%	75%	40%
Weight	98%		100%	100%	100%	92%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Lithium (All)	76%		70%	76%	81%	73%	81%	77%
Lithium Level	52%		50%	0%	67%	60%	75%	33%
Thyroid Monitoring	65%		63%	50%	71%	75%	67%	75%
CMP	70%		50%	88%	83%	50%	75%	71%
CBC	71%		67%	50%	67%	100%	0%	100%
EKG	75%		75%	67%	50%	-	100%	75%
Med Consent	71%		67%	100%	67%	67%	100%	50%
Height	100%		100%	100%	100%	100%	100%	100%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Oxcarbazepine (All)	65%		25%	82%	100%	53%	60%	63%
CBC	62%		0%	86%	100%	40%	60%	56%
CMP	62%		0%	88%	-	50%	57%	57%
Med Consent	74%		50%	50%	100%	67%	67%	100%
Pregnancy	-		-	-	-	-	-	-
Lamotrigine - Med Consent	64%		100%	50%	100%	60%	67%	-

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Antidepressants (All)	76%		83%	74%	77%	73%	73%	74%
EKG (Tricyclics)	60%		100%	-	-	100%	0%	50%
Med Consent	77%		81%	70%	74%	79%	80%	77%
Thyroid Monitoring	56%		73%	62%	66%	48%	41%	52%
Pregnancy	-		-	-	-	-	-	-
Venla Blood Pressure	98%		100%	100%	97%	95%	100%	96%
Medication Management	6 Months	Trend	OCT	NOV	DEC	JAN	FEB	MAR
Medications Received Timely (All)	82%		83%	83%	82%	83%	81%	82%
By Transfer Type								
New Arrival to CDCR (RC) – RC	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – RHU	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – MHCB	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – CTC	-		-	-	-	-	-	-
Intra-System (Within Institutions) – GP	73%		75%	72%	66%	76%	75%	72%
Intra-System (Within Institutions) – RHU	89%		90%	91%	87%	87%	90%	87%
Intra-System (Within Institutions) – MH Inpatient	83%		90%	80%	66%	85%	88%	87%
Intra-System (Within Institutions) – Specialized Medical	83%		98%	71%	78%	83%	72%	88%
Inter-System (Between Institutions) – GP	75%		75%	76%	77%	74%	71%	79%
Inter-System (Between Institutions) – RHU	84%		74%	83%	89%	85%	91%	89%
Inter-System (Between Institutions) – MH Inpatient	74%		67%	67%	62%	77%	84%	81%
Inter-System (Between Institutions) – Specialized Medical	94%		94%	98%	-	85%	89%	-
Return to CDCR – GP	70%		63%	71%	75%	70%	63%	71%
Return to CDCR – RHU	83%		97%	88%	76%	72%	93%	87%
Return to CDCR – MH Inpatient	68%		-	-	68%	-	-	-
Return to CDCR – Specialized Medical	91%		97%	97%	92%	92%	83%	91%
Stable Housing	83%		83%	83%	83%	83%	82%	82%
Leaving CDCR	97%		93%	100%	100%	99%	95%	99%
By Provider Type								
Psychiatry	85%		85%	85%	85%	86%	84%	85%
Medications Refused (All)	3%		3%	3%	3%	3%	3%	3%
By Provider Type								
Psychiatry - Refused	2%		2%	2%	1%	2%	2%	2%
Non-Formulary by Psychiatrists	8.4%		8.7%	8.7%	8.6%	8.2%	8.1%	8.0%

Appendix D: Sustainable Process Report

Site Visit Report for California Department of Corrections and Rehabilitation RICHARD J. DONOVAN CORRECTIONAL FACILITY (RJD)

On-Site Review

May 19 – 22, 2026

Review Period

January 1 – March 31, 2026

PARTICIPANTS

Mental Health Regional Administrator (MHRA) – Rosemary Meyers, Psy.D.

Senior Psychologist, Specialist – Diana Couto da Silva, Psy.D.

Senior Psychologist, Specialist – Brian Gotterer, Psy.D.

Senior Psychologist, Specialist – Dina Khoury, Psy.D.

PROGRAM STAFF

Chief Executive Officer (CEO) – Chris Podratz, MBA

Chief of Mental Health (CMH) – Sonia Bahro, Ph.D.

Chief Psychologist (CP) – Christopher Daub, Ph.D.

Chief Psychiatrist (CP) – John Lyszcza, MD

Inpatient Referrals Coordinator (IPC) – Joseph Slimowicz, Psy.D.

AREAS REVIEWED

Program Area Reviewed: Higher Level of Care Considerations HQ Review – Prior Review 27% (Q4 2025)

RJD's first 2026 Sustainable Process review took place this quarter during the CQI+ visit from May 19th to 22nd. Thus, the HQ Data Review of the HLOC Considerations for Q1 and Q2 were reviewed. See the MHRA's Spreadsheet, Tab HLOC, for further details.

For Q1 and Q2 2026, a total of 104 cases were identified as "unacceptable", of which 67 (or 64% of) cases were due to insufficient narrative supporting non-referral (i.e., lack of a Mental Status Exam (MSE)). Per HQ's Reviewer, the expectation of an MSE was introduced within the HLOC Considerations form's "blue text" in April of 2025 and the field was allowed two quarters to begin to follow the updated standards. On April 22, 2026, during the monthly Inpatient Coordinator Teleconference, the HQ reviewer clarified the inclusion of an MSE is an absolute requirement for "good" HLOC Considerations documentation. RJD's effort to address this area has been to provide staff reeducation on the inclusion of an MSE.

For Q2 2026, HQ Data Review audit identified 10% (six of 60) non-referred cases with "good" Higher Level of Care (HLOC) Considerations documentation. The quality of HLOC Considerations documentation declined by 4% (Q1 2026: 14%).

Improvement Opportunities

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▲ RJD's HQ Data Review scores for HLOC Considerations have remained below 85% since Q4 2022, ranging from 14% to 62%. While performance was gradually improving in the first three quarters of 2025 (Q3: 46%; Q2: 34%; Q1: 21%), there has been a gradual decrease since Q4 2025 (27%).

The MH Regional team met with the IPC on 05/21/26 to discuss ongoing efforts and persistent limitations related to improving HLOC Considerations documentation. IPC reported conducting various efforts focused on improving the quality of HLOC Considerations documentation, including providing training and monitoring HLOC Considerations documentation during the audit review period. The MH Regional team will continue monitoring via monthly MHPS minutes and provide additional feedback as needed. No follow-up is required.

Program Area Reviewed: Mental Health Program Subcommittee (MHPS) Minutes

MHPS meeting minutes were reviewed for January to March 2026. Quorum was met, and the IPC was in attendance for all meetings. Table V was embedded in the minutes. The minutes continue to document RJD's ongoing efforts to improve HLOC documentation, including data analytics, identified barriers, and interventions. Feedback was provided to the IPC on-site to revisit data collected over the past year and review any identified barriers and trends, and modify interventions as needed. See the MHRA Spreadsheet, Tab *MH Subcommittee*, for further details. No follow-up is required.

Program Area Reviewed: HLOC Considerations Consistency Audit – Prior Review 100%

A random sample of eight cases was selected from the April 2026 Mental Health OnDemand Acute ICF Non-Referral report. Consistency between MH MTP documentation and EHRS entries from the 30 days prior to each IDTT was reviewed. All eight cases demonstrated full consistency. See MHRA Spreadsheet, Tab *EHRS*, for case-specific findings. No follow-up is required.

Program Area Reviewed: Referral and Non-Referral Log

The On Demand Acute-ICF Referrals and Non-Referrals reports covering January 1st – March 31st, 2026, were reviewed. See the MHRA's Spreadsheet, Tab *MH Subcommittee*, for further details.

Referral Logs

Total referrals: 32 (19 APP; 13 ICF), consistent with last quarter's review (32) and slightly lower to the quarterly ranges over the past year (37–40).

- ✓ 100% of referrals were submitted to the Inpatient Referral Unit (IRU) within required timeframes.
- ✓ Thirty-one referrals were accepted and transferred to PIP/DSH.
- ✓ One was rescinded and re-submitted at a different LOC.

Referral source trends:

- MHCb initiated 100% of APP referrals and 54% (7/13) of ICF referrals.
- Outpatient settings initiated 46% (6/13) of ICF referrals, an increase from or similar to the past four quarters (2026 Q1: 33%; 2025 Q4: 30%; Q3: 38%; Q2: 47%).

The outpatient-initiated ICF referrals remain elevated compared to Q1 2025 (19%). The MH Regional team and IPC continue to monitor outpatient-initiated ICF referrals to ensure appropriate LOC assessment and prevention of avoidable decompensation.

Non-Referral Logs

During the review period, there were 605 IDTT decisions not to refer to HLOC despite meeting one or more HLOC Consideration(s). This number is:

- Consistent with the prior quarter (Q1 2026: 674), and
- Higher than the total of non-referrals across previous years (2025 Q4: 463; Q3: 515; Q2: 480; Q1: 414; 2024 Q4: 441; 2024 Q3: 466).
- Use of multiple considerations: 13%, aligned with prior quarters (2026 Q1: 14%; 2025 Q4: 15%; Q3: 13%; Q2: 18%; Q1: 19%).

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- Most utilized consideration: Consideration #7 (insufficient attendance of structured treatment hours) at 83%. This percentage is consistent with last quarter's percentage (84%) and reflects a maintained increase in percentages of Consideration #7 usage during quarterly reviews since 2024, with percentages ranging from 67% to 81%.

Pending APP/ICF Referrals

At the time of the visit: one pending Acute (MHCB), and five pending ICF (two in MHCB; two in ML EOP; one in RHU EOP)

- ✓ All patients are pending acceptance and transfer.
- ✓ HLOC Considerations documentation was adequate in most cases.

No follow-up required

Program Area Reviewed: Interdisciplinary Treatment Teams (IDTTs)

MHCB

Three MHCB Initial IDTTs were observed on 05/15/26 by members of the Receiver's Compliance Team during the Suicide Prevention audit which occurred prior to this on-site visit.

Key Findings

- ✓ The IDTT leader facilitated discussions by attempting to engage all participants, including the patients.
- ✓ Correctional Counselor I (CCI) was engaged in the discussions and contributed relevant information.
- ✓ Level of observation, issue, and privileges were discussed.
- ✓ Safety smocks were appropriately utilized for patients on Suicide Watch or Precaution.
- ✓ All patients not on Suicide Watch or Precaution were in full issue clothing commensurate with the patient's preferred gender.
- ✓ Safety Plan was discussed in one applicable case.
- ✓ All members of the IDTT contributed to the discussion of HLOC Considerations and level of care appropriateness.
- ✓ Treatment goals were discussed in measurable terms.

Improvement Opportunities

- ⚠ The purpose of IDTT was not stated.
- ⚠ Minimal participation or contribution from the MHMD.
- ⚠ Justification of orders for one patient with partial issue was not specifically documented in EHRS.

RHU EOP

Five IDTTs (four initial and one follow-up) were observed. Two were held in absentia due to refusal. Reasons for refusals were not documented.

Key Findings

- ✓ Required staff were present; meetings started on time; IDTT purpose was clearly stated in one case; patients were engaged when present.
- ✓ Clinical summaries and diagnoses were consistently addressed, except one case.
- ✓ Goals were measurable and diagnosis-relevant in most cases.
- ✓ Mental Health Medical Doctor (MHMD) provided varying levels of relevant treatment information.
- ✓ Correctional Counselor I (CCI) engagement was strong.

Improvement Opportunities

- ⚠ Psychiatric Technician's (PT) input was minimal.
- ⚠ HLOC considerations were inconsistently discussed.
- ⚠ Level of Care (LOC) justification/rationale was presented with varying degrees of detail, however, was without input from team members. In two cases, the Mental Health Primary Clinician (MHPC) presented the

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justification/rationale at the conclusion of their portion before the other members had presented; therefore, it appeared as if the recommended LOC was not a team decision.

RHU CCCMS

Five IDTTs (four initial and one follow-up) were observed by a member of the Receiver's Compliance Team, four with the patients present and one held in absentia.

Key Findings

- ✓ Patient-Centered Engagement: Staff consistently spoke to patients rather than about them, actively providing time and space for patients to express opinions and ask questions.
- ✓ Good MHMD Performance: The covering MHMD ensured patient comprehension by asking a patient to restate their care plan in their own words.
- ✓ Collaborative Support: The CCI provided clear rationale for RHU placement/upcoming Institutional Classification Committees (ICCs), and the PT did well in actively encouraging patients to continue participating in rounds.

Improvement Opportunities

- ⚠ Treatment Planning Deficiencies: Plans and rationales for LOC placement lacked clarity. Additionally, treatment goals and progress tracking were missing or unmeasurable.
- ⚠ Missing Clinical Metrics: Functional impairments (or lack thereof) were omitted in nearly all presentations.
- ⚠ Disengaged Team Dynamics: The overall clinical spirit of the meeting was compromised because MHPCs heavily relied on reading from notes or laptops rather than engaging from a place of clinical knowledge about their patients.

EOP Facility A

Five IDTTs were observed (one initial, four routine). Two patients refused.

Key Findings

- ✓ IDTTs were timely and attendance appropriate.
- ✓ Patients were asked open-ended questions and given opportunities to provide input into treatment planning.
- ✓ Diagnosis, strengths, and areas of distress were generally discussed.
- ✓ MHMDs discussed medications and clinical input.
- ✓ Recreation Therapist (RT) provided relevant treatment participation information and observations.
- ✓ HLOC considerations were addressed in all cases.

Improvement Opportunities

- ⚠ LOC justification generally lacked clarity and connection to functional impairments, and in one case with a positive indicator, justification for non-referral was not adequately discussed.
- ⚠ MHPC presentation quality varied, and in some cases discussion of functional impairments, MH history, areas of clinical vulnerability/weakness, prior MH inpatient admissions, HLOC, and suicide attempt history were not consistently reviewed.
- ⚠ Goals were often not measurable and objective indicators of progress were lacking in some cases.
- ⚠ Program assignments were not consistently addressed and in one case continued eligibility appeared to be predetermined without interdisciplinary discussion regarding clinical appropriateness.

EOP Facility C

Five IDTTs were observed (one Initial and four Routines). Three patients refused. All required staff members were in attendance along with a recreational therapist and Senior Psychologist Supervisor.

Key Findings

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- ✓ Purpose of IDTT was clearly stated.
- ✓ MHPCs and MHMD provided thorough clinical presentations for each patient.
- ✓ Discussions amongst all team members were very interactive towards treatment planning.
- ✓ CCI provided relevant custodial information and RVRs were addressed across cases.
- ✓ HLOC considerations were addressed in all cases with overt discussions justifying current LOC.

Improvement Opportunities

⚠ Treatment goals were individualized in all cases, but not fully measurable.

EOP Facility E

Five routine IDTTs were observed. All required staff were present and one patient refused.

Key Findings

- ✓ MHPCs provided clinical summaries, including discussion of diagnosis, strengths and weaknesses.
- ✓ Patients were asked open-ended questions and engaged in treatment planning.
- ✓ HLOC considerations and LOC decisions were discussed and justified in majority of cases.
- ✓ Strong patient engagement and communication practices observed.
- ✓ MHMD participation included discussions of medications, medical, and clinical factors.
- ✓ RT contributed meaningfully regarding treatment attendance and observations.
- ✓ CCI provided appropriate custodial and program information.
- ✓ Eligibility for program assignment was discussed in all applicable cases.

No follow up required

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

PT Rounds

PT Rounds in B6 and B7 were observed by a nursing member of the Receiver's Compliance Team during the on-site review.

Key Findings

- ✓ The PT rounds consistently met all audit standards, with the PT diligently asking every required question and seeking clarification as necessary.
- ✓ The PT rounding in the RHU CCCMS was exceptional, the PT reviewed the scheduled appointments with each patient, explored concerns and provided request for remedy forms when requested.
- ✓ Documentation was completed in real time at the cell front, ensuring both accuracy and compliance.

Morning Meeting

Morning Meeting in the RHU EOP/RHU CCCMS was observed by a member of the Receiver's Compliance Team during the suicide prevention audit which occurred prior to this on-site visit.

Key Findings

- ✓ The meeting started on time and all required members were present from custody, medical and mental health staff.
- ✓ The facilitator did a good job ensuring all parties participated and provided relevant information. Additionally, primary clinicians were also present in order to describe the stability and presentation of SRMP patients.
- ✓ All new arrivals and SRMP patients were reviewed in great detail.
- ✓ Those individuals on a five day follow up, the current census and alternative housing patients and who is assigned to see them were also discussed.
- ✓ The discussion was thorough and interactive.

No follow-up required

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Program Area Reviewed: Patient Reviews

The Sustainable Process report was reviewed for all RHUs and all three non-designated EOP facilities. MHCB Tier Walks were not completed during this visit. Tier walks/housing reviews were conducted with custody/nursing to identify patients with significant MH concerns. Relevant concerns were communicated to the Senior Psychologist Supervisors.

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

⚠ Three patients required an action plan with clinical intervention.

⚠ Three patients required review and consideration of clinical recommendations.

Action Plan Follow-Up

On 12/22/25, the MH Regional team received institutional follow-up for the one patient identified last quarter.

Follow-Up is Required with a due date of July 2, 2026

The CMH or designee shall:

1. Review commentary for six patients listed on the IP Reviews tab, and
2. Submit an institutional follow-up describing actions taken for the three patients requiring clinical intervention to the MH Regional Team.

Site Visit Summary

The Regional MH team conducted the Q2 Sustainable Process review at RJD during the CQI visit from May 19th to 22nd.

Key points

- RJD's HLOC Considerations HQ Data Review identified 10% of the 60 randomly selected non-referred cases to have "good" documentation. The quality of HLOC Considerations documentation has gradually declined over the past three quarters. The major contributor to the decline was the lack of an MSE, which was an updated requirement in documentation.
- All 32 APP/ICF referrals were submitted timely to IRU.
- MHPS minutes continue to document improvement efforts.
- HLOC Consistency Audit showed 100% consistency (8/8 cases).
- Unit-level patient reviews identified no urgent MH or higher-level-of-care needs.
- Six patients require an action plan or follow-up review.
- IDTTs were observed across all RHU and EOP units.

Appendix E: Excluded Indicators

- AC5.2: Monthly Review of EOP Modified Treatment
- QC3: Treatment Plans with Satisfactory Documentation
- QC4: Treatment Plans with Reason for Refusal and Intervention Documented for High Refusers
- 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
- RH24: High Refusers due to Custody Reasons with Documented Plan of Action
- RH25: High Refusers for Whom a 128B was completed
- RH26: High Refusing EOP Patients in Restricted Housing for Whom a Meeting Between MH and Custody was Conducted
- RH27: RHU Incarcerated Persons Who Received an RHU Orientation Guide
- SP3.4: Quality of Safety Planning to Reduce Suicide Risk
- SP23: Quality of Selected SRASHE Documentation