SIERRA CONSERVATION CENTER

Review Period: Sep 2025 – Feb 2026
Onsite: April 15 – 16, 2026

Receiver's Compliance Team

2026

Statewide Mental Health Program
Continuous Quality Improvement

SIERRA CONSERVATION CENTER

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. 7283at 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. Most of this work was conducted under the supervision of the Special Master and with input from all parties in the case.

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

Data Collection

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

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

Interpreting This Report

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

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

Indicators Excluded from This Report

Part of the 2026 field-testing phase is designed to identify indicators that are not yet functioning as intended so they can be corrected before the Receiver recommends a final set of indicators to the court. During the audit process, several indicators were identified as producing unreliable results due to technical issues in the CQIT platform, or a need for clarification in instructions or document production. These indicators have been

excluded from this report and are listed in Appendix E. The development team is working to resolve these issues in time for subsequent audit reports.

Compliance Color Coding

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

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

Recommendations

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

Certain deficiencies identified in this report 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 the use of existing treatment space (institutional) while also requesting capital investment for additional space (systemwide), the report identifies the institutional component as a near-term action item and the structural component as an issue the Receiver will address.

Executive Summary

Sierra Conservation Center (SCC) is a Level I - III institution located in Jamestown. It operates four Level I dorms, three level II dorms, a level III 270 design facility, a general population (GP) Restricted Housing Unit (RHU), and serves as a training facility for incarcerated person training in wildland firefighting techniques for the entire state of California. Sierra Conservation Center jointly operates 26 wildland firefighting camps with Cal Fire and Los Angeles County Fire Department. The facility team provides treatment to approximately 237 MHSDS patients across a Non-Designated Mainline and a General Population Mainline facility and a designated Restrictive Housing Unit (RHU) GP with 12 CCCMS patients as of April 21, 2026. SCC does not operate designated RHU CCCMS, RHU EOP, GP EOP, or MHCB programs; patients requiring these levels of care must be transferred to other institutions.

SCC has a limited mental health mission and has demonstrated many strengths in provision of services to its mental health patients. Institutional strengths are concentrated in mental health staffing, training, custody operations, nursing processes, and mental health access to care. The mental health fill rate was 100% at the time of the audit. Compliance with training for CPR (Cardiopulmonary Resuscitation) and Use of Force in 2025 for custody, mental health, and all other healthcare staff was strong. Annual suicide prevention training completion was 99% for custody, 93% for mental health, and 100% for all other healthcare staff.

CPR mouth shields were carried by all officers observed. Cut-down kits were complete and standardized across all housing units except for one unit in one month. Custody staff demonstrated awareness of mental health referral procedures across all yards, and 128-MH5 referral forms were available in all housing units. Timely Transfer to MHCB was 100% throughout the reporting period (N = 49). Custody and Mental Health Partnership Plan (CMHPP) executive leadership rounding was completed at 100% and supervisory program tours met all requirements.

Nursing reception and receiving (R&R) intakes were completed confidentially and thoroughly, as were Restricted Housing Unit (RHU) pre and post screenings. Psychiatric technician rounds occurred with real-time documentation and patient engagement.

Mental health treatment access data reflect that timelines for access to care were met at or above 90% throughout the reporting period for mental health consults (referrals), psychiatry contacts, and Interdisciplinary Treatment Team (IDTT) meetings. Timelines for primary clinician contacts decreased briefly to 85% in October but otherwise met timelines at or above 90% of the time. SCC mental health treatment space was also sufficient, with staff having individual offices for confidential contacts and a group treatment room that is sufficient in size and is confidential.

The deficiencies documented in this report, such as custody documentation of heat plan activation and provision of alternative activities during heat plan activation, are operational factors within institutional control and can be addressed with local institutional custody leadership. The clinical-quality deficits including Institution Classification Committee (ICC) input, quality of safety plans, timeliness of Suicide Risk Evaluations (SRE), and Interdisciplinary Treatment Team (IDTT) meeting content, are supervision and training problems that the facility can resolve.

The priority recommendations below are organized by urgency and target the areas where patient safety, treatment adequacy, or both are at stake.

Priority Recommendations

1. **Elevate clinical substance of encounters.** Across the audit period, treatment encounters at SCC met structural compliance benchmarks (IDTT attendance, staffing, and clinical contact timeliness all exceeded thresholds) while the clinical content within those encounters was deficient. Only 17% of observed interdisciplinary treatment team meetings demonstrated interactive process, safety plans contained stock phrasing, and clinicians attended classification committees but provided no relevant clinical information. This pattern spans Quality of Care, Suicide Prevention, and Restricted Housing, with equally strong alignment across all three sections, indicating a systemic gap between procedural infrastructure and clinical practice that no single section-level recommendation addresses.

   Improve clinical substance across treatment encounters (including interdisciplinary treatment team meetings, suicide risk evaluation safety plans, and institutional classification committee participation) to produce documented clinical content that meets programmatic standards and improves the experience of patients receiving care.

2. **Expedite restricted housing transfers**: Transfers of patients with mental health needs to and from restricted housing units did not meet Program Guide timelines during the audit period. Timely CCCMS transfers averaged 42% across 24 patients, and the single EOP transfer exceeded the required timeline. Transfer delays extend the period during which patients in restrictive settings lack timely placement in appropriate care levels. This finding impacts both Restricted Housing and Access to Care sections, and the contributing structural barriers (including custody investigation timelines and bed availability) are partially beyond the institution's direct control.

   Reduce the elapsed time for transfers of patients with mental health needs to and from restricted housing units, addressing the barriers identified during the audit period to achieve timely placement in appropriate care levels.

   Structural Issue: If local efforts are maximized and SCC still fails to meet Program Guide transfer timelines (which preliminary data suggests may occur due to statewide data), SCC leadership should describe all their efforts to the Receiver, and the Receiver will evaluate options including capital investment, population adjustment, program redesign, or other remedies that are outside institutional control.

Institution's Operational Perspective

Mission and Security Level

Sierra Conservation Center is a Level I through III institution located in Jamestown, California. The institution's primary mission centers on training incarcerated persons in wildland firefighting techniques for assignment to fire camps statewide. SCC jointly operates 26 wildland firefighting camps with Cal Fire and the Los Angeles County Fire Department, serving as the hub institution for California's conservation camp program.

The institution comprises three main facilities: Facility A (Level I, Non-Designated Programming Facility), Facility B (Level II, Non-Designated Programming Facility), and Facility C (Level III, General Population). Facility C includes a general population Restricted Housing Unit designated as C2.

Physical Plant and Housing Capacity

SCC's housing units are organized across its three facilities. Facilities A and B each contain 3 dorm housing units. Facility A includes a firehouse dorm of 10 beds. Facility C contains 4 housing units of 270-design cells. The RHU on C2 has a capacity of 150 beds and serves the general population; patients requiring designated restricted housing programs are held temporarily pending transfer to receiving institutions. SCC does not operate designated RHU CCCMS, RHU EOP, ML EOP, MHCB, or PIP programs.

Facility	Function	Mental Health Population
A (Level I NDPF)	Non-Designated Program Housing; 3 dorm housing units, including 1 firehouse dorm (10 beds)	ML CCCMS
B (Level II NDPF)	Non-Designated Program Housing; 3 dorm housing units	ML CCCMS
C (Level III GP)	General Population Mainline; 4 housing units (270-design)	ML CCCMS
C2 (GP RHU)	Restricted Housing Unit; 150 beds	Pending transfer only
26 Fire Camps	Wildland firefighting camps operated jointly with Cal Fire and Los Angeles County Fire Department	None

Population Demographics

SCC houses approximately 1,214 incarcerated persons on A and B yards (Level I Non-Designated Mainline), approximately 600 on C yard (Level III General Population Mainline), and up to 150 in the RHU on C2. The mental health caseload during the audit period was approximately 237 patients enrolled in the Mental Health Services Delivery System, concentrated on C yard. The RHU housed 12 CCCMS patients as of April 2026. SCC's CCCMS census increased during the reporting period, with the highest single-month increase of 16 patients.

The institution serves classification Levels I, II, and III. Level IV override placements on C yard during the audit period altered the population composition of that facility.

Mental Health Programs

SCC operates a Mainline Correctional Clinical Case Management System (CCCMS) program. The institution does not operate Enhanced Outpatient Program (EOP), Mental Health Crisis Bed (MHCB), or Psychiatric Inpatient Program (PIP) services. Patients requiring these levels of care are transferred to designated institutions.

The mental health program provides individual clinical contacts, interdisciplinary treatment team meetings, suicide risk evaluations, and psychiatric medication management. SCC offers 16 recreation therapy groups per week, distributed between B yard (8 groups) and C yard (8 groups). Additional programming includes a pre-release program and clinician-led mental health groups available to CCCMS patients and interested general population incarcerated people.

Treatment Schedule

Group treatment sessions are scheduled on Tuesdays and Wednesdays on C yard (4 sessions each day) and on Thursdays and Fridays on A/B yard (2 and 4 sessions, respectively). IDTTs convene on Mondays and Fridays on C yard, Wednesdays in the RHU, and Thursdays on A/B yard. Institutional Classification Committees meet on Thursdays in the RHU. Unit Classification Committees are scheduled as needed across all facilities.

Alternative Housing and Intake Cells

Alternative housing cells are located on A yard (Dorms 2 and 4), B yard (Dorms 70 and 72), and C yard (Building 1 and RHU cells 118–132). Intake cells are located on C yard in C2, cells 118–132.

Operational Context

SCC's fire training mission distinguishes its operational environment from most CDCR institutions. The majority of the A and B yard population participates in or trains for wildland firefighting assignments at conservation camps throughout the state. The mental health caseload is concentrated on C yard, which operates as a Level III general population facility distinct from the fire camp training mission on A and B yards.

The psychiatry department consists of the Chief Psychiatrist and a psychiatric nurse practitioner. The institution filled a long-vacant Office Technician position in February 2026, a role that supports appointment scheduling across the mental health program.

Access to Care

This section examines the timeliness and accessibility of mental health services at SCC during the audit period. Access to care encompasses timely clinical contacts, referral pathways, appointment completion, transfer timeliness, and the confidentiality of clinical encounters. These indicators measure whether patients in the Mental Health Services Delivery System receive scheduled and unscheduled services within Program Guide timeframes and in settings that support effective clinical interaction.

Confidential and Effective Communication

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg
Effective Communication Achieved	94%	97%	100%	93%	94%	97%	96%
Group treatment in a confidential setting	100%	100%	100%	100%	100%	100%	100%
IDTTs in a confidential setting	93%	100%	100%	100%	100%	98%	99%

Timely Access

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg	Onsite Audits
RHU GP Screens	93%	96%	91%	99%	100%	98%	96%	
RHU Pre-Screen	88%	86%	90%	87%	88%	88%	88%	
Timely IDTTs (v2.0)	94%	90%	97%	92%	95%	100%	95%	
Timely MH Referrals (v2.0)	89%	90%	90%	86%	92%	94%	90%	
Timely MHMD Contacts (v2.0)	91%	94%	98%	92%	92%	98%	95%	
Timely PC Contacts (v2.0)	98%	85%	100%	97%	96%	98%	96%	
Custody MH Referrals								100%
Housing Units Where 128-MH-5s Are Available And Accessible to Housing Unit Staff								100%†

Timely Transfers

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg
Timely Transfers to EOP (v2.0).			100%†	100%†		100%†	100%†
Timely Transfers to RHU CCCMS	100%†	50%†	67%†	100%†	0%†	22%†	42%

Appointments

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg
Appointments Cancelled Due to Custody [i]	0%	63%	22%	39%	6%	0%	33%

✓ **Strengths**

Timely clinical contact delivery: Timely MHMD contacts averaged 95% and timely PC contacts averaged 96% across the audit period. These indicators measure whether patients receive scheduled clinical contacts within Program Guide timeframes. Sustained rates above 95% indicate the scheduling and clinical availability systems deliver contacts within program timelines.

Custody referral accessibility: All custody staff interviewed were aware of their responsibility to refer patients to mental health when indicated and 128-MH5 referral forms were 100% available and accessible during the onsite audit. Referral form availability is a prerequisite for custody staff to initiate mental health referrals when clinical observations warrant assessment.

⚠ **Concerns**

Confidentiality reporting inaccuracy: During the audit period, 43 encounters were recorded as confidential despite occurring at cell-front locations. Cell-front locations are rarely, if ever, confidential clinical settings. Separately, group treatment was reported as occurring in a confidential setting at 100%, but the C yard group space failed the visual confidentiality standard. These inconsistencies between reported compliance and observed conditions require institutional follow up.

Custody appointment cancellation rate: Appointments cancelled due to custody averaged 33% (inverse) across the audit period, with a range of 0% to 63%. Analysis of the cancellation pattern indicates the elevated rate was driven by episodic events, including yard incidents and lockdowns, rather than a stable structural barrier, with 24% of cancellations attributable to modified program.

Recommendations

1. Recording treatment confidentiality: Provide staff with the definition of confidentiality, including which spaces can be considered to meet those requirements and ensure staff are knowledgeable of the check in and check out process, including correct selection of confidentiality, to ensure confidentiality is recorded in the clinical record accurately and that contacts are only marked as confidential when they meet the criteria for confidential settings.

Custody and Mental Health Partnership Plan

This section examines the implementation of the Custody Mental Health Partnership Plan (CMHPP) at SCC during the audit period. CMHPP establishes the structural requirements for collaboration between custody and mental health staff, including joint training, supervisory meetings, leadership rounding, and partnership round tables. These indicators measure whether the institutional infrastructure for custody-mental health coordination is in place and operating as designed.

Indicator	Onsite Audits
CMHPP Monthly Executive Leadership Joint Rounding	100%†
CMHPP Monthly Executive Leadership Joint Rounding Attended by Required Executives	100%†
CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH Program	100%†
Custody Staff CMHPP Annual Training	100%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours	100%†
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours with Required Attendees	100%†
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees	100%†

✓ **Strengths**

Partnership training completion: Custody staff completed annual CMHPP training at 100% (828 of 828), and healthcare staff at 100% (86 of 86) during the audit period. These training requirements establish the foundational knowledge base for custody-mental health collaboration. Sustaining 100% training completion across both staff categories with large denominators indicates a reliable institutional training infrastructure capable of scheduling, tracking, and completing mandated requirements.

Monthly Executive Leadership Joint Rounds were conducted as required on all programs and attended by required staff.

Facility and Environment of Care

Treatment spaces used for individual contacts, IDTT meetings, and group sessions should meet standards for confidentiality, safety, adequate size, and environmental controls including ventilation and temperature. These indicators assess whether the physical environments in which mental health care is delivered support therapeutic engagement and protect patient privacy. Compliance is determined through direct observation during onsite audits.

Indicator	Onsite Audits
Adequate Group Treatment Spaces	50%†
Adequate IDTT Spaces	100%†
Adequate Individual Treatment Spaces	71%†

Space-by-Space Assessment

Space / Location	Type	Assessed	Compliant	Primary Deficiencies
ML CCCMS	IDTT	2	Yes	
	Group	2	Partial	C yard non-compliance due to windows compromising confidentiality
	Individual	6	No	Some offices on C yard too small for two chairs
RHU GP	IDTT	1	Yes	
	Individual	1	Partial	Space is shared with custody
	Group	1	No	This space is not currently used for treatment as MH patients in RHU are transferred to designated institutions. If the space is used, approved therapeutic treatment modules would need to be used.

"Partial" indicates the space(s) met some but not all audit criteria.

✓ Strengths

There are designated private offices for individual treatment on B and C yard for mainline CCCMS patients. Although groups are not required for every patient in CCCMS, SCC has group rooms available for ML CCCMS patients who are placed in groups on B and C yard. IDTT spaces are also sufficient as they are appropriately sized with a conference table, sufficient seating, adequate ventilation, controlled temperature, and no distracting noises. The B yard individual treatment space met audit requirements. All individual spaces are configured with the staff member sitting closest to the door, which is the safest configuration that allows clinicians to exit quickly if necessary.

⚠ Concerns

Individual Treatment Spaces on C yard: Two of the offices for mainline CCCMS on C yard are small and do not have space for two chairs except if one of the chairs is placed in front of the door; clinicians in these offices have to move their chairs out of the office so patients can exit. Staff report poor ventilation in these spaces, making them stuffy during summer months.

Group Treatment Space on C yard: ML CCCMS group treatment space on C yard is sound-confidential but visible from the area where patients wait for their individual appointments, failing the visual confidentiality

criterion. Because SCC is not designated as a CCCMS RHU and patients transfer out to other facilities, the RHU is not currently providing group treatment.

Recommendations

1. Increase confidentiality for the group room on C yard: Identify and implement a facility improvement such as frosting the window to make the group room confidential while maintaining necessary safety measures.

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 patients prescribed select medications or classes of medications who received appropriate diagnostic monitoring consistent with clinical guidelines across all transfer types, administration methods (keep-on –person (KOP), nurse-administered, directly observed therapy), prescription types, medication categories, and provider types and provides an overall metric as a composite. These indicators assess whether patients receive timely access to appropriate diagnostic monitoring.

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg	Onsite Audits
Timely Response to Non-Critical Med Non-Adherence Notification(v2.0)	96%	93%†	100%†	80%	92%	100%†	93%	

Aggregate diagnostic monitoring compliance averaged 93% and antipsychotic monitoring averaged 95% across the audit period. These aggregate rates exceed the compliance threshold. The medication-specific rates in Appendix C reflect variability beneath the aggregate performance level. Small denominators for individual medication classes contribute to the month-to-month fluctuations observed.

Involuntary medication activity during the audit period consisted of 1 patient on a PC 2602 court order, with 1 emergency petition initiated and granted.

✓ **Strengths**

No controlled use-of-force incidents were required to administer PC2602 medication during the reporting period. There was one patient on a PC2602. Timely response to non-critical medication non-adherence was high and diagnostic monitoring was completed as required 85% of the time for antipsychotics and anti-depressants.

⚠ **Concerns**

Medication monitoring variability: Medication-specific diagnostic monitoring rates exhibited fluctuations during the audit period. Oxcarbazepine monitoring averaged 73%, oscillating between 0% and 100% across months. Lithium monitoring showed data in only 2 months, December at 0% and January at 100%. Valproic acid monitoring averaged 92%, but December was at 0%. The variability in compliance rates by month suggests that the systems in place are not applied consistently

[1] See Appendix C

Recommendations

1. Review timely response to medication non-adherence requirements.: Implement a system to identify patients who require follow up to address medication non-adherence to prevent extended delays and provide training to staff to clarify the appropriate documentation type and timeframe requirements.

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

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

✓ **Strengths**

Heat plan documentation readiness: The heat plan was current, working thermometers were in place, heat logs were maintained, and zero heat-related illness incidents were recorded among MHSDS patients during the audit period. Heat preparedness documentation, functional equipment, and the absence of heat illness incidents indicate the documentation and equipment prerequisites for heat-related patient protection are in place.

Quality of Care

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

Care Access

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg	Onsite Audits
IDTT Patient Attendance	78%	74%	90%	72%	89%	73%	80%	
IDTT Required Staffing	100%	86%	89%	87%	93%	92%	91%	
IDTTs with Observed Interactive Process								17%†

Documentation

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg	Onsite Audits
Cases w/documentation of appropriateness of LOC discussed for pts identified by 7388B as potentially requiring HLOC								0%†
IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT								100%†
IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT								100%†

✓ **Strengths**

IDTT scheduling and staffing: IDTT patient attendance averaged 80% (range 72%–90%) and required staffing averaged 91% across the audit period. These prerequisites for effective treatment planning were met, or nearly met, across the period, indicating the administrative infrastructure for convening treatment teams is operational.

⚠ **Concerns**

IDTT clinical substance: Of observed IDTTs during the onsite audit, 17% demonstrated interactive clinical process. None of 5 B yard IDTTs included case formulation, treatment goals, or level-of-care justification. On B yard specifically, level of care justification was lacking substantially, with one patient being retained in CCCMS despite no recent symptoms or medication and another being moved to EOP level of care without clear clinical justification (to include discussion of functional impairments, symptom severity, or an indication of any clinical deterioration). In this case, the patient wanted to return to fire camp and, due to the decision to place in CCCMS (without clear clinical justification discussed in IDTT), he was unable to return. Additionally, safety planning was not conducted when indicated. Patients interviewed could not identify measurable treatment goals. RHU IDTTs showed active staff participation, but goals were not consistently measurable.

HLOC documentation gaps: Higher level of care documentation was completed for 0% of qualifying patients during the onsite assessment. Clinical placement decisions for these patients lacked the required supporting documentation.

Recommendations:

Establish quality improvement initiatives to accomplish the following. Workplans should include clear assignments and audits of IDTTs should use statewide audit criteria (described in the Continuous Quality Improvement Tool guidebook) to measure improvement progress:

1. Elevate IDTT clinical quality: Elevate the clinical substance of interdisciplinary treatment team meetings to produce observable interactive process between all the participants, documented case formulation, and measurable treatment goals that patients can identify and articulate. The statewide training regarding level of care decision making is needed to ensure teams have a complete understanding of the clinical indications for each level of care placement and are aware of treatment resources for each level of care.
2. Build HLOC documentation compliance: Improve higher level of care documentation for qualifying patients, ensuring clinical placement decisions are supported by required documentation.

RVRs, Sentinel Events, and Specialized Custody

This section examines sentinel event indicators at SCC during the audit period, including use-of-force training compliance, heat activation response, heat event reporting accuracy, RVR assessment timeliness, and use-of-force involvement of patients with mental health needs. Sentinel event indicators measure the institution's preparedness for and response to high-risk events affecting the mental health population.

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg	Onsite Audits
RVR MH Assessments Conducted in a Private Setting	83%†	83%†	87%†	90%†	67%†	73%†	82%	
RVR MH Assessments where Documentation Requirements were Met		82%†	100%†	100%†			93%	
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality		91%†	92%†	100%†			93%	
Timely RVR MH Assessment Request	80%†	40%†	27%†	17%†	0%†	29%†	29%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	100%†	92%†	100%†	100%†	83%†	91%†	95%	
RVRs Issued								2,375
RVRs Issued to Non-MHSDS Participants								89%
RVRs Issued to Patients at the Acute Level of Care								0%
RVRs Issued to Patients at the CCCMS Level of Care								11%
RVRs Issued to Patients at the EOP Level of Care								0%
RVRs Issued to Patients at the ICF Level of Care								0%
RVRs Issued to Patients at the MHCB Level of Care								0%

✓ **Strengths**

Use-of-force training compliance: Both custody and healthcare staff completed use-of-force training at 100% during the audit period. Use-of-force training establishes the procedural and clinical awareness necessary for safe responses during incidents involving patients with mental health needs. Complete compliance indicates the institution maintains the training prerequisite for competent use-of-force response.

⚠ **Concerns**

Heat activation response: Alternative out-of-cell activities were offered on 0 of 13 Stage I heat activation days during the audit period (0%). Patients lacked access to out-of-cell programming during all documented heat activation events. Physical plant constraints were noted as contributing to this failure.

Heat reporting discrepancy: The institution reported 11 Stage I, 4 Stage II, and 3 Stage III heat activation events on their heat reports sent to headquarters throughout the audit period. Onsite temperature logs show 13 Stage I, 7 Stage II, and 6 Stage III activations for September 2025 alone. The reported information to headquarters does not reconcile with the documentation reviewed onsite.

RVR assessment request timeliness: Timely RVR mental health assessment requests averaged 29% across the audit period.

Recommendations

1. Institute heat activation protections: Institute the provision of alternative out-of-cell activities during heat activation events to ensure patients have access to activities that will support mental health when heat risks are elevated.
2. Reconcile heat event reporting: Reconcile institutional heat activation event counts with supporting documentation to produce accurate reporting of Stage I, II, and III activations.
3. Address RVR assessment request timeliness: Address the timeliness of mental health assessment requests in the RVR process, acknowledging statewide factors that affect timelines while identifying institution-level opportunities to reduce delays.

Restricted Housing

This section examines the delivery of mental health services and conditions in restricted housing units at SCC during the audit period. Restricted housing indicators cover timeliness of transfers, clinical participation at institutional classification committees, documentation, out-of-cell activities, and patient-reported conditions. These indicators measure whether patients in restricted housing receive clinical services, procedural protections, and environmental conditions consistent with Program Guide requirements.

Timeliness

Indicator	Feb 2026	6-Month Avg	Onsite Audits
Timely Transfers to RHU EOP	0%†	0%†	
ICCs with Mental Health Clinicians Present and Relevant Information Provided			0%†
Initial ICCs Reviewed that were held within 10 Calendar Days of Arrival to Restricted Housing Placement			100%†

Documentation

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

Out-of-Cell Activities/Care

Indicator	Onsite Audits
Custody Staff who can Identify all NDRH Patients	100%†
Patients in restricted housing with working entertainment appliances	100%†
Peace Officers Observed to Carry Their CPR Mouth Shield	100%

✓ **Strengths**

ICCs were consistently completed within 10 calendar days of arrival: The ICC chair considered both the clinical and custody needs of the patients for program review and the warden routinely ensured effective communication.

PT rounds were conducted as required for all patients in the RHU: Staff demonstrated commitment to patient engagement: mental health screening questions were asked as written, clarified when needed, and staff interacted with patients directly rather than through proxies. Documentation was completed in real time at cell front, promoting accuracy.

Ongoing monitoring: Guard One security/welfare checks were completed and staggered within 30 minutes 100% of the time. During the observed checks, the designated officer conducted visual inspections of the occupied cells.

Custodial care functions in designated RHU programs are compliant: The three patients who were within 72 hours of intake at the time of the audit were housed in designated intake cells and all were in possession of an entertainment appliance (hand crank radio). There were no mental health NDRH designated patients in the RHU at the time of the audit. All peace officers observed in restricted housing were carrying CPR mouth shields. Custody staff were able to describe their process for identifying NDRH patients (100%). These findings indicate that the custodial infrastructure supporting daily living in designated RHU settings is functioning. Staff demonstrated awareness of their responsibilities for patient property, appliance access, and emergency preparedness.

⚠ **Concerns**

ICC clinical content: Mental health clinicians were present at all 4 observed ICCs during the onsite audit but provided no relevant clinical information as defined by the Program Guide, which requires the clinician to provide patient factors such as likelihood of decompensation if retained in RHU, recommendation for alternative placement, effective communication needs, suitability of single or double celling, and any other issues that have an impact on the patient's mental health treatment. The auditor referred 1 patient for emergent evaluation after observing the patient appearing depressed with suicidal risk factors during an ICC.

RHU transfer timeliness: Timely transfers to RHU CCCMS averaged 42% across the audit period (24 patients). Timely transfer to RHU EOP was 0%, though this compliance rate was based on only a single patient (1 patient transferred 3 days past the 30-day timeline).

RHU patient-reported conditions: Patients in restricted housing reported non-functional tablets, lack of in-cell reading and writing materials, limited access to law library and religious services, and a perceived need to report suicidality to obtain urgent mental health attention. Tablet non-functionality is a statewide issue that was acute at the time of the audit during a transition between two tablet vendors.

Recommendations

1. Monitor Symptoms, Track Delays, and Escalate Clinical Concerns: The institution team is responsible for ensuring that patients awaiting transfer receive treatment services available in their current setting, that pending transfers are tracked and prioritized by clinical acuity, and that cases involving clinical

deterioration are escalated immediately through the Regional Mental Health Administrator, who facilitates expedited transfers as necessary.

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

Suicide Prevention

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

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg	On-site Audits
Discharges from MHCB with clinician review of d/c summary		100%†	100%†	100%†	100%†	100%†	100%†	
Documentation of Acute/ICF Discharges with Clinician-to-Clinician Contact within 5 days	100%†						100%†	
Emergent and Urgent MH Referrals That Result in SREs	100%†	100%†	100%†	100%†	100%†	100%†	100%	
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training			18%†	33%†	92%†	100%†	62%	
Safety Plans Signed Timely	75%†	83%†	40%†	86%†	100%†	100%†	78%	
Timely Clinical Follow-Ups (V2.0)	67%†	100%†	25%†	88%†	100%†	100%†	82%	
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								47%†[2]
Custody Staff with CPR Training								100%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories								100%†

[2] *The 47% compliance rate reflects a small sample of 15 discharge follow-up forms. Five documentation errors significantly impacted the overall percentage. SCC has identified this as a priority improvement area and implemented a 7497-audit redesign project. Recent performance shows improvement, with compliance achieved over the last two months.*

Institution SPRFIT Meeting Minutes Reviewed that Satisfy All Audit Criteria								100%†
Nursing Staff Current with CPR Training								100%
Observed Initial Health Screenings								100%†
Referrals That Received a SRE When DTS or Suspected Intentional OD was not Marked on the MH Referral								100%†
RHU Intake Incarcerated Persons Appropriately Housed								100%†

✓ **Strengths**

Completion of Suicide Risk Evaluations and Screenings: SREs that were required for urgent and emergent referrals were completed 100% of the time. SREs upon referral to MHCB were completed in 97% of cases. Chart audits demonstrate that clinician review of discharge summaries for patients returning from inpatient care was conducted in all cases audited. R&R initial health screenings met all audit requirements.

Low self-harm incidence: Self-harm incidents averaged 0.1 per 1,000 MHSDS patients during the audit period, compared to the statewide average of 5 per 1,000. The self-harm rate is a patient safety measure. A rate substantially below the statewide average indicates favorable patient safety outcomes for the audited population.

Emergency response readiness: Housing units maintained emergency response equipment at 100%, peace officers carried CPR mouth shields at 100%, and security welfare checks included required visual observation at 100% during the audit period. Complete compliance across all 3 preparedness indicators demonstrates the physical and procedural prerequisites for emergency intervention are in place.

Suicide prevention training rates: Annual IST suicide prevention training reached 99% for custody, 100% for healthcare, and 93% for mental health staff during the audit period. CPR training reached 100% for custody and nursing staff. High completion rates across all staff categories indicate the training infrastructure supports consistent delivery of mandated suicide prevention competencies.

⚠ **Concerns**

Post-crisis SRE degradation: 30-day post-MHCB suicide risk evaluations were completed at 21% (3 of 14) and 90-day post-MHCB SREs at 50% (5 of 10) during the audit period. Overall SRE compliance reached 74%. Timely clinical follow-ups averaged 82%, improving to 100% in January and February 2026. The post-crisis SRE completion rates indicate that the structured surveillance process degrades after the acute crisis response.

Safety plan individualization gaps: Of 3 safety plans reviewed for rescinded MHCB referrals, none contained individualized content; all 3 used copied and pasted stock phrasing. Safety plans were signed timely at 78%. Safety plans lacking individualized content do not reflect patient-specific risk factors, protective factors, or clinical circumstances and are therefore less likely to provide useful information to the patient or staff about how to address future crises.

Discharge follow-up coverage gaps: Safety plans for discharge follow-ups were present in 9 of 14 cases (64%) during the audit period; 5 patients lacked plans.

Custody follow-up documentation deficits: Custody suicide prevention follow-up Page 2 documentation, which covers receiving institution information and custody checks, was completed at 47% (7 of 15) during the onsite assessment, with 5 documentation errors identified. Page 1, which addresses discharge information and clinical evaluations, was completed at 93%.

SRE mentoring training period deficit: Mental health staff SRE mentoring and biennial training averaged 62% across the audit period. The trajectory improved from 18% at the start of the period to 100% by the end. The average for the audit period understates the current performance level; the improvement trajectory indicates corrective action was applied during the audit period.

SRE Compliance by Type	Compliance	N
Emergent consults for DTS	100%	24
Upon rescission of MHCB referral	75%	4
Upon MHCB referral for DTS	97%	38
30-day post-MHCB SRE	21%	14
90 – day post – MHCB SRE	50%	10

Recommendations

1. Strengthen post-crisis SRE completion: Strengthen the completion rate of post-MHCB suicide risk evaluations at 30-day and 90-day required intervals to sustain structured surveillance through the post-crisis recovery window.
2. Individualize safety plan content: Develop individualized safety plan content that reflects patient-specific risk factors, protective factors, and clinical circumstances rather than standardized template language.
3. Extend discharge safety plan coverage: Develop and implement a plan to increase completion of required discharge follow-up safety plans for patients transitioning from an inpatient setting.
4. Improve custody follow-up documentation: Improve custody suicide prevention follow-up documentation by enhancing the accuracy, completeness, and consistency of Page 2 documentation to ensure compliance with audit criteria, support continuity of care, and demonstrate that required welfare checks, safety observations, and clinical communication are being appropriately documented and monitored.

Sustainable Process and Utilization Review

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

Indicator	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	6-Month Avg
Timely Transfer to MHCB (v2.0)	100%†	100%†	100%†	100%†	100%†	100%†	100%

✓ **Strengths**

Timely MHCB transfer execution: Timely transfers to the Mental Health Crisis Bed averaged 100% (49 patients) across the audit period. This indicator measures whether patients in acute crisis are moved to the appropriate higher level of care within required timeframes. Sustained 100% indicates the crisis transfer pathway reliably moves patients to MHCB within program timelines.

Recommendations

See higher level of care documentation recommendation in the Quality of Care, Documentation Section, above.

Staffing

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

Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief Psychologist	2.0	1.0*	50%*
Chief Psychiatrist	1.0	1.0	0%
Senior Psychiatrist (Supervisor)	-	-	-
Senior Psychologist (Supervisor)	1.0	1.0	0%
Supervising Psychiatric Social Worker I	-	-	-
Senior Psychologist (Specialist)	2.0	2.0	0%
Recreation Therapist	0	1.0	0%
Staff Psychiatrist	1	1.05	0%
Psychologist – Clinical	1.5	1.5	0%
Clinical Social Worker	1.0	1.0	0%
Primary Clinician (PC)	3.5	3.5	0%
PC: Psychologist – Clinical		2.5	
PC: Clinical Social Worker		1.0	
PC: Marriage and Family Therapist		-	
PC: Professional Clinical Counselor		-	

*Position held vacant due to other staffing needs across the system

Allocation changed during the reporting period due to January 2026 staffing revisions (*). Vacancy rates are weighted averages. Filled positions for Primary Clinician sub-classifications show the discipline breakdown of the filled PC positions. Telehealth and registry providers are included.

✓ **Strengths**

All clinical positions were filled consistently. The psychiatry position is filled by a contracted nurse practitioner, who is well regarded as a compassionate team player and worked additional hours to meet the needs of the institution. This resulted in a slight overage reflected in the vacancy rate.

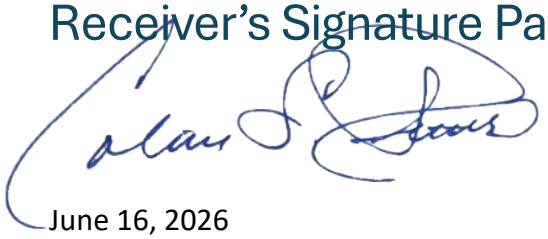
⚠ **Concerns**

At the time of the audit, two clinicians were on long-term leave. At a facility with few staff, this creates an added burden on existing staff to cover all work.

Recommendations

None – at least one staff member was expected to return to work in the coming weeks.

Receiver's Signature Page



June 16, 2026

Appendix A: Acronyms and Initialisms

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

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

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

Appendix B: Suicide Prevention Report

Institutional Changes

No changes in SCC's mission have occurred since the last visit.

Section I: Restricted Housing Unit

***Second Watch Partnership Huddle*:** All required members were in attendance including the unit sergeant and RHU clinician. The discussion included required topics, including patients new to RHU, patients going to ICC, patients leaving RHU, patients who refused medication, and patients with an increased level of care. All disciplines participated in the discussion and all staff appeared familiar with the patients.

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

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

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

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

Section II: Inpatient Unit

SCC does not have any inpatient units; therefore, the below sections are not applicable:

- Suicide resistant cells
- IDTT Observations
- Suicide Watch and Suicide Precaution
- Observation and Issue Orders
- Privileges

Quality of Safety Planning:

Reviews of the MHCB recission data (N=4) found that of the four rescinded MCHB referrals, only three required a safety plan. Of the three cases, all three were completed timely. However, none of the safety plans included adequate, individualized interventions to reduce suicide risk. Additionally, of the three safety plans reviewed, clinicians used cut and pasted information in multiple sections.

Areas for improvement were found in documentation identifying individualized interventions to reduce risk and refrain from using cut and pasted information to complete multiple sections of the safety plan.

Clinical Discharge Follow-Ups:

The OnDemand Performance Indicator noted that SCC overall Timely Clinical Follow Up compliance during the audit period was 79 percent. As of March 2025, the business rule indicates that day one of the clinical follow up

must occur within 24 hours of discharge from the MHCB. Additionally, follow up compliance is now calculated as compliant or not compliant for the entire follow up series, whereas it was previously calculated daily. Currently if one day of the follow up is out of compliance, the entire follow up is deemed out of compliance. Changes to these business rules have significantly impacted compliance for this indicator statewide and are currently in the process of being updated to reflect the spirit of the statewide policy, which mandates daily follow-ups beginning the day following physical discharge, rather than within 24 hours.

Fifteen of the five-day Follow Ups were reviewed. One of the five-day follow ups was completed at a different institution; however, the remaining fourteen five-day follow ups were completed for a minimum of five days following inpatient discharge. Of the fourteen, 64 percent (nine) had the required safety plans. All the five-day follow ups had a mental health clinician complete the first and last day of the follow ups.

Areas for improvement were found in completing the required safety plan for patients discharged from an inpatient setting.

Section III: Alternative Housing

SCC's local operating procedure (LOP) MH04 MHCB Referral/Alternative Housing Admission Procedures outlines the alternative housing process and specifies a prioritized alternative housing location list. Alternative Housing was primarily found in 15 cells in building C2 (RHU). For the purposes of this review, the cells were observed and found to be clean.

During the audit period, there were 49 referrals to the MHCB. The OnDemand performance report indicated SCC was 100 percent compliant with timely transfers to MHCB for all referrals during this time. Only four MHCB referrals were rescinded and all four cases were reviewed. All cases had the required SRE and daily clinical follow-ups for each of the five required days were completed.

There were no patients housed in alternative housing during the onsite audit.

Section IV: Suicide Risk Management Program (SRMP)

At the time of this review, SCC did not have any patients included in the SRMP program and there were no patients who met criteria to be included but were not included, according to the statewide On Demand Performance reports.

Section V: Institutional SPRFIT Committee

SPRFIT committee minutes were reviewed for the audit period. SPRFIT quorum is being met, improvement work, system surveillance topics and corrective actions based on regional SPRFIT audits are being discussed. Additionally, the committee reviewed patients in the SRMP and updating local operating procedures. There were no serious suicide attempts with a medical severity rating of "3" that necessitated a clinical review or root cause analysis.

Documentation within the SPRFIT minutes indicated that the SPRFIT Coordinator or designee attended the Incarcerated Person Advisory Council (IPAC) meetings per policy. IPAC was last attended in January 2026. The Inmate Family Council (IFC) was not attended during the audit period because the council does not have a chairperson and the meeting has not been held.

Section VI: Severe Self-Harm

SCC has very few incidents of self-harm. Per the SPRFIT Reboot report, the six-month average for self-harm incidents is .1 per 1,000, which is well below the statewide average of five. There were no suicides that occurred during the audit period.

Section VII: Urgent and Emergent Referrals for Danger to Self

During the audit period, SCC generated 24 referrals for which the referral was for Danger to Self (DTS). All the referrals were appropriately classified as emergent; all had required SRE documentation, and all were completed timely as noted in the OnDemand Performance Report.

A review of 60 urgent and emergent referrals for reasons other than danger to self/self-harm/suicidal behavior were reviewed for the period September 1, 2025, to February 28th, 2026. There were 35 urgent and 25 emergent consult orders placed. The results of the review revealed that in all cases, patients were seen timely. Regarding the urgent consult orders, all were classified appropriately, and 17 resulted in a SRE completed timely.

Section VIII: Suicide Risk Evaluations

A review of the On Demand Performance Report during the audit period, noted that SCC had an overall compliance rate of 74 percent for completion of required suicide risk evaluations.

There were 38 patients referred to MHCB for DTS during the audit period. The OnDemand Performance Report indicated that 97 percent (37/38) had the required SRE completed. There were 14 SREs due following MHCB discharge for CCCMS and non-Mental Health Service Delivery System (MHSDS) patients within 30 days of MHCB discharge and SREs were completed in 21 percent (3/14) of cases. There were ten SREs due following MHCB discharge for CCCMS and non-MHSDS patients within 90 days of discharge from MHCB and SREs were completed in 50 percent (5/10) of cases. There were four MHCB recissions and SREs were completed in 75 percent (3/4) of the cases. However, the case that was not compliant did not require a SRE because the referral was not for DTS and so SCC was at 100 percent after correction.

An area for improvement was found in completing SREs for CCCMS and non-MHSDS patients within the 30 and 90 day follow ups post MHCB discharge.

Section IX: Emergency Response

Cut Down Kits:

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

Section X: Quality Improvement Plans (QIPs) Generated by Suicide Case Reviews

There were no suicides occurring at SCC during the audit period and there were no open QIPs during the audit period.

Section XI: Training and Mentoring Compliance

The LMS training data is subject to limitations because it does not incorporate the functional vacancy rate captured in the document production data. This omission may result in discrepancies in actual training numbers. Accordingly, the Coleman Court Mandated Trainings SharePoint was used to derive more accurate training figures for February 2026:

- Understanding and Assessing the Presence, Severity, and Riks of Suicidality: 100%
- Safety Planning Intervention: 100%
- SRE Mentoring: 100%
- Suicide Risk Management Program: 100%
- Annual IST Suicide Prevention (End of year 2025):
    - Custody: 99%
    - Healthcare: 100%
    - Mental Health: 93%

Section XII: Receiving and Release (R&R) Screening

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

Section XIII: Reception Center Processing

SCC does not have a Reception Center.

Section XIV: Crisis Intervention Team (CIT)

SCC has not activated a Crisis Intervention Team at this time.

Section XV: Policy

SCC has a policy on suicide prevention (LOP MH01), and it is consistent with the memorandum "Enhancements to the Suicide Prevention and Response Focused Improvement Teams" dated 2-2-2018. SCC also has a postvention policy (LOP MH01). Local policies were also reviewed, and it was found that SCC incorporated recent statewide memorandums related to suicide prevention into local policy.

Section XVI: Assignment of Corrective Action Plans and Recommendations

As a result of this review, no mental health CAPs are assigned and there were no open CAPs at SCC.

HQ OPEN SPRFIT CAPS	CORRECTIVE ACTION PLAN	REQUIRED SUPPORTING DOCUMENTS
No open CAPS		

As a result of this review, the following action was recommended to SCC:

1) Create a procedure to identify and track CCCMS and GP patients discharged from MHCB and track due dates for the 30- and 90-day requirements for completing clinical contacts.
2) Create a plan to ensure that safety plans are audited to ensure clinical documentation within the safety plan follows CAT audit 14 criteria.
3) Create a plan to ensure required safety plans are being done for clinical discharge follow-ups.

Appendix C: MAPIP

INSTITUTION 6 MONTH TREND

Sierra Conservation Center (SCC)

February 2026

Population Health Management	6 Months	Trend	SEP	OCT	NOV	DEC	JAN	FEB
Diagnostic Monitoring (All)	**93%**		**100%**	**96%**	**93%**	**94%**	**94%**	**88%**
QT Prolongation EKG 12 Months	-		-	-	-	-	-	-
Antipsychotics (All)	95%		100%	100%	97%	100%	100%	85%
Lipid Monitoring	94%		100%	100%	100%	100%	100%	78%
Blood Sugar	94%		100%	100%	100%	100%	100%	75%
EKG	-		-	-	-	-	-	-
AIMS	100%		100%	100%	100%	100%	100%	100%
Med Consent	100%		-	100%	100%	100%	100%	100%
CBC with Platelets	85%		100%	100%	100%	100%	-	50%
CMP	85%		100%	100%	100%	100%	-	50%
Thyroid Monitoring	81%		100%	100%	50%	100%	-	50%
Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Height	100%		100%	100%	100%	100%	100%	100%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Clozapine (All)	-		-	-	-	-	-	-
Blood Sugar	-		-	-	-	-	-	-
Lipid Monitoring	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
EKG	-		-	-	-	-	-	-
AIMS	-		-	-	-	-	-	-
Thyroid Monitoring	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Blood Pressure	-		-	-	-	-	-	-
Height	-		-	-	-	-	-	-
Weight	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-

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Mood Stabilizers (All)	81%		100%	0%	100%	33%	85%	100%
Carbamazepine (All)	-		-	-	-	-	-	-
Carbamazepine Level	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-
Valproic Acid (All)	92%		-	-	100%	0%	100%	100%
Med Consent	100%		-	-	100%	-	-	-
Blood Pressure	100%		-	-	-	-	100%	100%
Height	100%		-	-	-	-	100%	100%
Valproic Acid Level	50%		-	-	-	0%	100%	-
CBC with Platelets	100%		-	-	-	-	100%	-
CMP	100%		-	-	-	-	100%	-
Weight	100%		-	-	-	-	100%	100%
Pregnancy	-		-	-	-	-	-	-
Lithium (All)	75%		-	-	-	0%	100%	-
Lithium Level	0%		-	-	-	0%	-	-
Thyroid Monitoring	100%		-	-	-	-	100%	-
CMP	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
EKG	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Height	100%		-	-	-	-	100%	-
Weight	100%		-	-	-	-	100%	-
Pregnancy	-		-	-	-	-	-	-
Oxcarbazepine (All)	73%		100%	0%	100%	100%	0%	-
CBC	67%		100%	0%	100%	-	0%	-
CMP	67%		100%	0%	100%	-	0%	-
Med Consent	100%		100%	-	-	100%	-	-
Pregnancy	-		-	-	-	-	-	-
Lamotrigine - Med Consent	-		-	-	-	-	-	-

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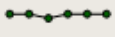
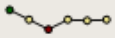
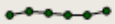
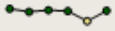
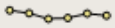
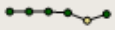
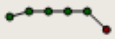
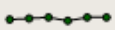
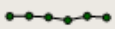
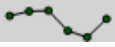
Antidepressants (All)	93%		100%	95%	87%	94%	93%	92%
EKG (Tricyclics)	100%		-	-	100%	-	-	-
Med Consent	99%		100%	100%	95%	100%	100%	100%
Thyroid Monitoring	82%		100%	83%	67%	83%	82%	83%
Pregnancy	-		-	-	-	-	-	-
Venla Blood Pressure	100%		-	-	-	-	100%	-
Medication Management	**6 Months**	**Trend**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**
Medications Received Timely (All)	**96%**		**97%**	**97%**	**96%**	**94%**	**96%**	**96%**
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	95%		93%	97%	95%	93%	93%	98%
Intra-System (Within Institutions) – RHU	96%		100%	96%	98%	97%	83%	97%
Intra-System (Within Institutions) – MH Inpatient	-		-	-	-	-	-	-
Intra-System (Within Institutions) – Specialized Medical	-		-	-	-	-	-	-
Inter-System (Between Institutions) – GP	83%		88%	85%	79%	80%	85%	82%
Inter-System (Between Institutions) – RHU	96%		100%	100%	100%	99%	88%	97%
Inter-System (Between Institutions) – MH Inpatient	-		-	-	-	-	-	-
Inter-System (Between Institutions) – Specialized Medical	-		-	-	-	-	-	-
Return to CDCR – GP	88%		91%	100%	100%	100%	100%	69%
Return to CDCR – RHU	100%		100%	-	-	-	-	-
Return to CDCR – MH Inpatient	-		-	-	-	-	-	-
Return to CDCR – Specialized Medical	-		-	-	-	-	-	-
Stable Housing	96%		97%	98%	96%	94%	96%	96%
Leaving CDCR	99%		98%	99%	100%	96%	100%	100%
By Provider Type								
Psychiatry	95%		96%	96%	95%	92%	96%	95%
By Provider Type								
Psychiatry - Refused	4%		4%	3%	5%	7%	2%	5%
Non-Formulary by Psychiatrists	**1.6%**		**1.9%**	**2.1%**	**2.1%**	**1.1%**	**0.8%**	**1.7%**

Appendix D: Sustainable Process Report

Not Applicable

Appendix E: Excluded Indicators

- AC18: Scheduled MH Appointments Completed or Refused
- AC5.2: Monthly Review of EOP Modified Treatment
- CM2.2: Healthcare Staff CMHPP Annual Training
- MM13: Controlled Use of Force Incidents Required to Administer PC2602 Medications
- QC10: Mental Health Primary Clinician Continuity of Care
- QC11: Mental Health Psychiatrist Continuity of Care
- RH27: RHU Incarcerated Persons Who Received an RHU Orientation Guide