SALINAS VALLEY STATE PRISON

Review Period: Jan 2026 – Jun 2026

Onsite: August 3 – 7, 2026



Receiver's Compliance Team

2026

Statewide Mental Health Program
Continuous Quality Improvement



SALINAS VALLEY STATE PRISON

CDCR

36.4771° N / 121.3744° W

TABLE OF CONTENTS

BACKGROUND 2
GOALS 2
APPROACH TO ASSESSING COMPLIANCE 3
METHODOLOGY 4
RECOMMENDATIONS 5
EXECUTIVE SUMMARY 6
INSTITUTION'S OPERATIONAL PERSPECTIVE 10
ACCESS TO CARE 11
CUSTODY AND MENTAL HEALTH PARTNERSHIP PLAN 16
PSYCHIATRY 17
PATIENT SAFETY 18
QUALITY OF CARE 19
RVRS, SENTINEL EVENTS, AND SPECIALIZED CUSTODY 21
RESTRICTED HOUSING 23
SUICIDE PREVENTION 25
SUSTAINABLE PROCESS AND UTILIZATION REVIEW 28
STAFFING 28
RECEIVER'S SIGNATURE PAGE 31
APPENDIX A: ACRONYMS AND INITIALISMS 32
APPENDIX B: MAPIP 35
APPENDIX C: SUICIDE PREVENTION REPORT 38
APPENDIX D: SUSTAINABLE PROCESS REPORT 47
APPENDIX E: EXCLUDED INDICATORS 60

Background

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

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

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

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

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

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

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

Goals

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

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

Approach to Assessing Compliance

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

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

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

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

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

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

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

Methodology

Data Foundation

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

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

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

Data Collection

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

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

Interpreting This Report

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

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

Indicators Excluded from This Report

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

indicators have been excluded from this report while we work to resolve the issues and can be found in Appendix 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. These include statewide shortages of designated RHU EOP beds, insufficient physical infrastructure for group treatment, and systemwide challenges in recruiting and retaining onsite clinical staff in remote locations. Where the report identifies a structural barrier, the Receiver will take the lead in developing and implementing a resolution, whether through infrastructure investment, population management, policy revision, or coordination with CDCR and DSH leadership. Institutional leadership is not expected to solve problems it does not control, but it is expected to maximize compliance within existing constraints and to document and escalate structural barriers through the channels the Receiver's office establishes.

Where a recommendation touches both domains, for example, maximizing the use of existing treatment space (institutional) while also requesting capital investment for additional space (systemwide), the report identifies the institutional component as a near-term action item and the structural component as an issue the Receiver will address.

Executive Summary

Salinas Valley State Prison (SVSP) is a large, multi-mission, high security institution that includes Mental Health services for patients at the following levels of care: Correctional Clinical Case Management System (CCCMS), Enhanced Outpatient Program (EOP), Mental Health Crisis Bed (MHCB), and Intermediate Care Facility (ICF).

Facility/Unit	Program	Mental Health Level of Care Served
A yard	Non-designated Programming Facility Level III (NDPF-III)	CCCMS, EOP
B yard	General Population Level IV (GP-IV)	CCCMS
C yard	General Population Level IV (GP-IV)	CCCMS, EOP
D yard	Sensitive Needs Yard Level IV (SNY-IV), Restricted Housing Unit (RHU) Overflow, Alternative Housing	CCCMS, EOP, MHCB
Building Z9	RHU	CCCMS
Correctional Treatment Center (CTC)	CTC, MHCB	CCCMS, EOP, MHCB
Treatment Center (TC) 1 and TC2	Psychiatric Inpatient Program (PIP)	ICF

Strong performance was noted in various core areas of clinical operations. Access to Care indicators reflected strong compliance with intake screens, demonstrated awareness among custody staff regarding referral pathways, and efficient transfers to MHCB/EOP. Psychiatry excelled in some facets of diagnostic monitoring, surpassing statewide benchmarks for several performance measures. Primary clinicians consistently exhibited strong clinical expertise and demonstrated a high level of proficiency, particularly in the facilitation of group treatment sessions. In the RHU, PT rounds consistently met audit criteria, RHU screens and pre-screens were thorough, and compliance with basic RHU processes remained high, as evidenced by accurate NDRH identification, prompt ICC processes, and reliable shower access. Suicide prevention initiatives were notably robust, including an effective CIT, collaborative RHU morning huddles, high completion rates for required training, consistently comprehensive MHCB discharge safety plans, and detailed suicide risk management program (SRMP) treatment plans.

Despite these strengths, significant deficiencies persist across multiple domains, which are not attributable to staffing but instead represent ongoing operational workflow gaps. These gaps impede access to timely, adequate, and well-documented care across treatment settings. Access to care performance was adversely affected by inconsistencies in timely psychiatry and primary clinician contacts, as well as insufficient treatment hours offered in PIP, RHU CCCMS, and ML EOP. Psychiatry also exhibited notable shortcomings in responding to medication non-adherence and in completing required diagnostic monitoring for mood stabilizers and clozapine. Suicide prevention efforts were undermined by variability in suicide risk evaluations (SRE) and safety plans, and a lack of clinical follow-up for patients discharged from alternative housing. Additional patient care concerns included suboptimal IDTT quality in ML CCCMS, ML EOP, RHU CCCMS, and MHCB, as well as concerns regarding justifications when not referring patients to higher levels of care.

Several principal themes emerged through the audit. First, operational challenges—such as frequent alarms in D yard, inefficiencies in ducat distribution and patient movement to appointments, and inadequate support from custody—have a more pronounced impact than clinical staffing limitations and substantially impede access to clinical services and treatment. Second, poor cleanliness and overall environment of care undermine patient safety and increase symptom severity. Third, persistent gaps in documentation accuracy continue to present significant challenges.

Priority Recommendations

1. **Implement a Structured IDTT Quality Improvement Initiative:** Only 15% of observed IDTTs demonstrated an interactive process. There was limited and inconsistent discussion regarding case formulation, measurable treatment goals, higher level of care, medications and their side effects, and safety planning. Patient level of care was discussed only 55% of the time, when the patient was identified as potentially requiring a higher level of care. One IDTT space did not have the capacity to accommodate both onsite and remote members who are required to participate. Although the supervisor was present in the room during the IDTTs observed as part of the onsite audit, the supervisor typically participates remotely, negatively impacting treatment planning.

   Implement targeted training for IDTT members and program supervisors institution-wide to promote an integrated and collaborative approach to treatment planning. Require onsite staff to attend IDTT meetings in person rather than remotely to further enhance the treatment discussion. Provide the IDTT field guide to all clinical staff to offer guidance and illustrate the essential elements of an effective IDTT. Establish routine leadership reviews of IDTT meetings to ensure a thorough discussion of treatment planning, level of care, and safety planning when clinically indicated. Engage the regional team to offer further assistance for the IDTT process by providing training recommendations, curriculum resources, or targeted support in specific areas as needed.

2. **Ensure Timely Clinical Contacts and Maximize Structured Treatment Hour Offering:** The data reflects persistent noncompliance in timely clinical contacts and deficiencies in treatment hours, especially in PIP, RHU CCCMS, and ML EOP. During the review period, primary clinician contacts were completed in accordance with required compliance standards 73% of the time. Psychiatry contacts demonstrated a lower completion rate, at only 57%. Timely psychiatry responses to medication non-adherence notifications averaged 28% for critical medications and 62% for non-critical medications over six months. Structured treatment opportunities in both PIP and non-PIP settings consistently fell below the minimum requirements for every month within the review period. Although the PIP provided both core and supplemental treatment, the required minimum hours of treatment were not regularly offered to patients. On average, 31% of patients were offered at least 20 hours of programming, including a minimum of 10 hours of core treatment. The outpatient programs similarly did not consistently deliver the required number of treatment hours; only 17% of EOP patients were offered minimum required treatment hours. Gaps in the provision of clinical care appear to be driven primarily by inconsistencies in patients' ability to access the treatment location and disruptions due to safety and security protocols.

   Establish a custody and clinical joint quality management project specific to the Mental Health Services Delivery System to identify custody related barriers to mental health treatment access. Using a range of activities such as chart reviews, staff interviews, and observational analyses, develop strategies to resolve each barrier. The project should achieve quality control by following the principles of Lean Six Sigma. Implement the strategies and review rates of treatment at least weekly until compliance is achieved to determine if further modifications of the strategies are needed. Ensure that data entry accurately reflects the reasons for missed appointments to support this review and analysis.

Identify contributing factors to the problems with medication non-adherence responses, with a targeted focus on timely responses to critical medication non-adherence. Implement staff training as needed to facilitate understanding of requirements and develop a plan to address any additional identified barriers.

3. **Conduct a Focused Quality Review of Rules Violation Reports (RVR) and RVR-Mental Health Assessments (MHA):** The onsite audits found that clinicians rarely found that a patient's behavior was strongly influenced by symptoms of mental illness, and therefore few recommendations were made to document the behavior in an alternate manner. RVR-MHAs appeared to be conducted in private settings only 46% of the time; unavailability of custody to escort the patients to a private setting was documented by the clinician in five of 32 reviewed instances. Further, RVRs were sometimes issued for behaviors occurring during emergency forced medication administration, which may unfairly penalize patients experiencing acute medical or psychiatric crises.

   Establish clear guidelines and staff training to ensure RVRs are not automatically issued for behaviors exhibited during emergency forced medication administration, especially when physical force is required for emergent clinical intervention. Conduct a case-by-case assessment to distinguish between conduct directly related to psychiatric emergencies and unrelated infractions and provide documentation to hearing officers when behavior is associated with a psychiatric emergency to prevent issuance of discipline. Provide supervisory support and oversight for clinicians conducting RVR-MHAs, particularly for patients in inpatient settings, to ensure documentation of a nexus between symptoms and behavior when clinically appropriate. Ensure patients are offered private settings for the RVR-MHA interview and prioritize escorting patients for these assessments.

4. **Enhance Suicide Prevention Documentation Quality:** Suicide prevention documentation did not meet benchmarks throughout the review period. Chart reviews of patients who experienced emergent and urgent referrals during the review period revealed instances where potential self-harm or intentional overdose was indicated but not explicitly documented as the reason for referral; the required SRE was completed in only 73% of cases requiring one. Clinical follow-ups following discharge from a higher level of care were completed on time (35%) during the review period. Only 67% of patients rescinded from MHCB level of care had clinical follow-ups for each of the five required days following the rescission. In the MHCB and PIP, 45% of the patients on partial issue had the rationale documented, and there were multiple instances of contradictory psychiatry and MHPC progress notes regarding the required level of observation. Daily MHPC progress notes also contained documentation of observation and issue orders without any verification of a corresponding assessment to support the order. Safety plans developed for patients who were discharged from the PIP and rescinded from MHCB level of care were inadequate.

   Adhere to established policy requiring SRE completion for all applicable referrals including those where self-harm or intentional overdose is suspected. Leverage available mental health reporting tools, including the clinical follow-ups report, to systematically track the timeliness of clinical follow-up appointments, aiming to improve completion rates beyond the current 35% and ensuring all patients rescinded from MHCB level of care receive clinical follow-ups for each of the five required days. Require documentation of rationale for partial issue in all MHCB and PIP cases, ensure cross disciplinary communication to minimize conflicting documentation, and conduct regular supervisory reviews to identify and resolve contradictory progress notes between psychiatry and MHPC regarding level of observation. Ensure that daily MHPC/MHMD progress notes include observation and issue orders supported by a corresponding clinical assessment. Strengthen safety

planning for patients discharged from PIP and rescinded from MHCB level of care by developing individualized, comprehensive plans reviewed and approved by a multidisciplinary team.

Institution's Operational Perspective

SVSP has experienced several positive changes over the course of the last year. Most notably is the decline of the clinical vacancy rate. Despite recent successes in staffing rates, many significant challenges remain at SVSP.

PIP Unit Closures

The SVSP-PIP previously accommodated patients in units C5 and C6; however, these units were permanently closed, with the final patient discharged in May 2025. As a result, the PIP's operational capacity decreased by 116 beds.

Staffing

SVSP has historically faced challenges in staffing mental health primary clinicians. Prior to 2025, the combined fill rate for psychologists and social workers in non-PIP programs did not exceed 60%. Since mid-2025, staffing has improved significantly, maintaining rates above 90% for the past six months. Recruitment efforts are ongoing, with regular interviews and new hires in process. Factors influencing staffing include the introduction of psychology and social work intern programs, expanded telemental health placements, and continued reliance on registry staff, particularly for psychiatry. Staffing in the PIP has been less stable, mainly due to allocations being only for psychologists and social workers (not for the broader primary clinician classification) and restrictions on telemental health. Social work roles in the PIP remain more consistently filled than psychology and psychiatry positions.

Treatment Offered

In 2025, the elimination of SVSP's triage plan, originally put in place due to staffing shortages, required clinical and scheduling staff to transition away from the longstanding scheduling practices and retrain on the current Program Guide expectations. Improvements in staffing levels have resulted in a positive trend of compliance with performance indicators including but not limited to timeliness of primary clinician contacts, referrals, and treatment team meetings. Despite progress, challenges remain in maintaining consistent group treatment hours. EOP programs have shown some recent improvement, but ongoing refinements are needed as there continue to be compliance barriers, particularly due to the volume of alarms and alarm response on D yard. Group treatment for RHU CCCMS was not available before June 2026 due to concerns regarding the use of restart chairs. Group treatment resumed and treatment hours offered increased in July 2026.

RHU Overflow and Transfers

SVSP is currently encountering challenges related to RHU overflow placements; accommodating patients in overflow without increased staffing or resources poses significant concerns. SVSP is not an RHU EOP hub and therefore all EOP patients placed in the RHU are required to transfer to a hub. Transfers are not completed on time due to limited EOP RHU beds statewide and the patients awaiting transfer do not receive clinical services consistent with EOP level of care.

Quality of Care

The leadership at SVSP has acknowledged concerns regarding the quality of clinical services, specifically with respect to inconsistencies in IDTTs across the institution. Additionally, there are notable variations in the quality of other documentation, including SREs, safety plans, and treatment plans, particularly in sections addressing higher levels of care.

Access to Care

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

Environment of Care and Effective Communication

Indicator	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	6-Month Avg	Onsite Audits
Effective Communication Achieved	98%	98%	98%	98%	98%	98%	98%	
Group treatment in a confidential setting	95%	95%	93%	92%	91%	89%	92%	
IDTTs in a confidential setting	99%	99%	99%	99%	98%	100%	99%	
Adequate Group Treatment Spaces								83%
Adequate IDTT Spaces								60%†
Adequate Individual Treatment Spaces								52%

Timely Access

Indicator	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	6-Month Avg	Onsite Audits
IRU Reviews Completed Timely	50%†	44%†	75%†	40%†	60%†	0%†	50%	
MHPC or MHMD Contacts for Patients Returning from a Temporary Departure	0%†	100%†	67%†	100%†	33%†	100%†	65%†	
RHU GP Screens	67%†	88%†	100%†	100%†	100%†	100%†	92%	
RHU Pre-Screen	81%	81%	91%	92%	90%	74%	85%	
Timely IDTTs (v2.0)	67%	77%	79%	81%	87%	94%	80%	
Timely MH Referrals (v2.0)	67%	78%	85%	86%	88%	91%	83%	
Timely MHMD Contacts (v2.0)	55%	56%	52%	59%	57%	61%	57%	
Timely PC Contacts (v2.0)	65%	71%	72%	77%	73%	82%	73%	
Custody MH Referrals								100%
Housing Units Where 128-MH-5s Are Available And Accessible to Housing Unit Staff								100%†

Timely Transfers

Indicator	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	6-Month Avg
Timeliness of Acute/ICF Referral Submission to IRU	88%†	75%†	58%†	67%†	44%†	50%†	65%
Timely Transfer to MHCB (v2.0)	97%	95%†	93%	95%	100%†	89%†	95%
Timely Transfers to EOP (v2.0)	100%†	100%†	100%†	100%†	100%†	100%†	100%
Timely Transfers to PIP	100%†	67%†	83%†	91%†	100%†	60%†	82%
Timely Transfers to RHU EOP	36%†	15%†	50%†	33%†	29%†	13%†	28%

Appointments

Indicator	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	6-Month Avg
Appointments Cancelled Due to Custody [i]	30%	31%	12%	23%	13%	21%	22%
Scheduled MH Appointments Completed or Refused	50%	62%	69%	62%	62%	55%	60%

Treatment Offered

Indicator	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	6-Month Avg
Treatment Offered (Core and Supplemental): PIP	17%	22%	58%	39%	27%	22%	31%
Treatment Offered (Core and Supplemental): PIP Evaluation Period	18%	17%	57%	35%	35%	28%	33%
Treatment Offered (Specified Core Subset and Supplemental): PIP	0%	0%	0%	0%	0%	0%	0%
Treatment Offered (Specified Core Subset and Supplemental): PIP Evaluation Period	0%	0%	0%	0%	0%	0%	0%
Treatment Offered (Structured): non-PIP	8%	9%	27%	19%	16%	19%	17%

Least Restrictive Housing

Indicator	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	6-Month Avg	Onsite Audits
PIP ICF Patients Housed Outside of their LRH	40%	42%	46%	49%	51%	52%	47%	
Timely Review of LRH Housing during the IDTT						0%†		0%

Space-by-Space Assessment

Space/Location	Type	Assessed	Compliant	Primary Deficiencies
ML CCCMS	**IDTT**	4	2	No conference table (N=2), insufficient seating (N=1)
	Individual	6	0	Uncomfortably warm (N=6); Not configured safely, clinician farthest from egress (N=5)
ML EOP	**IDTT**	2	1	Uncomfortably warm; loud and distracting (N=1)
	Group	13	9	Uncomfortably warm (N=4)
	Individual	33	14	Air conditioning not functioning (N=18); not configured safely, clinician farthest from egress (N=6)
RHU CCCMS	**IDTT**	1	0	Uncomfortably warm (N=1)
	Group	1	1	**
	Individual	4	3	Not configured safely, clinician farthest from egress (N=1)
MHCB	**IDTT**	1	1	**
	Individual	3	1	Not configured safely, clinician farthest from egress (N=2)
ICF	**IDTT**	2	2	**
	Group	10	10	**
	Individual	21	17	Not configured safely, clinician farthest from egress (N=4)
TOTAL	**IDTT**	10	6	
	Group	24	20	
	Individual	67	35	

✓ **Strengths**

RHU screenings are largely compliant: Screens for non-MHSDS individuals placed in RHU were compliant on average 92% of the time. RHU pre-screens for MHSDS patients averaged 85% over the review period, with five of six months scoring at or above 80%.

Custody staff demonstrate awareness of the referral process: Custody staff throughout the institution demonstrate knowledge of how to access mental health services for the incarcerated population. Onsite audit findings confirm that 128-MH-5 referral forms are available and accessible across housing units, and all custody staff interviewed demonstrated awareness of their responsibility to initiate mental health referrals.

Timely transfers to MHCB and ML EOP: Patients transferring to MHCB and ML EOP achieved an average timely transfer rate of 95% or higher, based on the six-month average across all transfer types.

⚠ **Concerns**

Clinical contacts across disciplines were frequently noncompliant: Recruitment initiatives during the review period have led to gradual improvement in the timeliness of clinical contacts, though they have not reached the compliance threshold. Timely contacts in response to mental health referrals averaged 83% during the review period, showing an upward trend since January when compliance was at 67%; June reported a compliance rate of 91%. The primary driver of the referral compliance rate is routine MHPC consults, which account for 54% of total consults. Timely MHPC contacts averaged 73% throughout the review period, with improvement from 65% in January to 82% in June. Initial contacts were completed in a timely manner 88% of the time on average, while routine contacts achieved timeliness in only 72% of cases. Timely MHMD contacts averaged 56% compliance over the six-month review period, with initial contacts being compliant 77% of the time compared to 53% for routine contacts. Timely IDTTs also demonstrated an upward trend, averaging 80% during the review period—67% occurring on time in January and 94% in June. During the review period, initial IDTTs were compliant in 69% of cases, whereas routine IDTTs showed 88% compliance. With psychiatry staffing showing a functional vacancy rate of 8% and clinical non-psychiatry staffing averaging a 6% vacancy rate, it appears that workflow or scheduling challenges, rather than staffing shortages, are the main contributors to deficits.

Inaccurate documentation may be masking further timeliness deficits: Staff have indicated that when custody report a patient refused an appointment, custody instructs them to record the appointments as refusals whether or not they can verify, which may inaccurately reflect the underlying reasons why patients do not attend their scheduled treatment. If the reasons for missed appointments are not valid refusals, they should not be documented this way.

Treatment offered was deficient across programs: Treatment offered in the PIP, RHU CCCMS, and ML EOP did not meet minimum requirements for any month within the review period. During the review period ML EOP and RHU CCCMS did not provide the required number of treatment hours consistently; 18% of ML EOP patients were offered the 10 hours of minimum treatment and 4% of RHU CCCMS patients were offered the 90 minutes of minimum treatment. Similarly, within the PIP, 31% of patients were offered at least 20 hours of treatment, including at least 10 hours of core treatment. Multiple patients reported that they are not consistently offered treatment, not consistently given ducats for their treatment, and not consistently released from their cells and units for appointments; this concern was raised on all facilities but was more prevalent on Facilities A and D. Patients also identified concerns with ducat distribution procedures on Facility A, including reports that peer support incarcerated persons handle ducats, a practice inconsistent with policy.

Untimely transfers to RHU EOP: For EOP patients placed in RHU, the average timely transfer rate to RHU EOP hub institutions was 28%, with monthly rates ranging from 13% to 50%.

Untimely transfers to PIP: Of the 56 patients referred during the review period, 10 did not transfer to the PIP within 72 hours of bed assignment. The patients who were overdue for transfer experienced delays ranging from two hours to 74 hours. Half of the patients who were not transferred within 72 hours of bed assignment missed

the requirement by five hours or less. Thirty percent of the patients who did not transfer timely were internal placements from SVSP non-PIP to SVSP ICF.

Cleanliness of alternative housing cells: During the site visit, none of the alternative housing cells located in building D2 were observed to be clean and free of trash and debris. Toilets and sinks were not wiped down and were visibly dirty. It appears that there may be rapid turnover of patients in these cells (the cells are used interchangeably for alternative housing and RHU overflow), raising concerns about whether terminal cleaning protocols are being consistently followed between occupants. This is of particular concern because patients in alternative housing cannot have access to certain items that patients in RHU may have. Incomplete cleaning of the cells between uses could lead to patients having access to items that can be used for self-harm.

Non-functional toilets in D3 requiring maintenance: The audit team observed that several toilets located in the cells of building D3 were inoperative and required maintenance. SVSP Custody leadership was promptly informed, and work orders were submitted to address the issue. However, the repairs were not completed for two days, and the duration of the malfunction prior to the audit team's notification remains unclear. During the period of disrepair, incarcerated individuals in the affected cells were instructed to utilize toilets located on the facility yard. However, access to the yard for restroom use is not consistently available to the population.

Treatment spaces require improvement in configuration and temperature control: The overall adequacy of treatment spaces throughout the institution is insufficient. Ventilation is suboptimal, especially in Facility D, where treatment areas are hot. Both clinical staff and supervisors have reported ongoing air conditioning issues in Facility D treatment areas, which have persisted for over two years despite multiple work orders submitted by the supervisor. Additionally, the current room layouts do not consistently ensure the safety of staff and patients. IDTT spaces achieved 60% compliance with audit standards, while individual treatment spaces met compliance criteria in only 52% of cases. Group treatment areas demonstrated higher suitability, with 83% conforming to established requirements. Individual treatment areas within CCCMS, RHU, and ICF frequently lack proper safety arrangements with patient seating often blocking doorways. The IDTT treatment space on Facility C was insufficient to accommodate all members of the treatment team in person, necessitating remote participation. Although a larger alternate room was available, it lacked adequate connectivity, which would have prevented teleproviders from joining the meeting.

Laundry exchange deficiencies: Individuals housed in the RHU and PIP reported not receiving the required weekly exchanges of clean undergarments, towels, and linens in accordance with established policy. This concern was substantiated by auditors who observed patients wearing soiled clothing. The issue originates from the institutional laundry operation rather than the custody staff responsible for distributing these items and has persisted for years. While laundry access is not a specific item reviewed during CQIT audits, providing adequate clean laundry to RHU and PIP patients supports their welfare and is an important aspect of care. Therefore, the Receiver recommends that the institution resolves any barriers to this long-standing issue.

Recommendations

1. Ensure Timely Clinical Contacts and Maximize Structured Treatment Hour Offering: See Priority Recommendations.
2. Review and optimize treatment spaces for safety and comfort: Conduct a comprehensive review of all treatment spaces to ensure proper configuration for safety. Ensure that IDTT spaces are appropriately configured to support the needs of both onsite staff and teleproviders. Additionally, implement regular monitoring and maintenance of temperature control systems in treatment areas institution wide, to maintain comfortable and safe environments for patients and staff.
3. Strengthen cleaning protocols in alternative housing: Conduct a comprehensive review of terminal cleaning protocols for alternative housing cells. Provide staff with appropriate training on all requirements and reinforce the expectation that SVSP will adhere to established cleaning procedures between occupants. Establish routine audits and clear accountability mechanisms to uphold cleanliness standards and safeguard the health of both staff and patients in alternative housing areas.

4. Address laundry exchange procedures: Conduct a root cause analysis to identify breakdowns in the laundry exchange process—such as delays, missing items, or inventory discrepancies—in order to determine underlying operational deficiencies rather than attributing issues to superficial errors. Identify if alternate means of laundry services would be appropriate. Institute systematic audits of laundry exchange processes to ensure that all individuals housed in RHU and PIP are provided with weekly exchanges of clean undergarments, towels, and linens in accordance with policy. Monitor compliance and address any deficiencies promptly.

Custody and Mental Health Partnership Plan

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

Indicator	Onsite Audits
CMHPP MH Daily Huddles	90%
CMHPP MH Huddle Documentation of Required Attendees	62%
CMHPP MH Huddle Documentation of Supervisor Attendees	92%†
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	98%
Healthcare Staff with CMHPP Annual Training	99%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours	75%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours with Required Attendees	100%†
ML CCCMS and RC CCCMS CMHPP Weekly Supervisor Meetings	51%
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees	100%
ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings	38%
Quarterly Partnership Round Table Training Completed as Required	80%
Required Staff Attendance of Quarterly Partnership Round Table Training	60%†

✓ **Strengths**

Consistent supervisory and executive participation requirements: Review of documentation from a random sample of six weeks during the review period demonstrated that institution-wide, CMHPP huddles are conducted on average for 90% of the required instances and supervisors are attending 92% of the time. Monthly executive joint rounding, ML CCCMS monthly joint program tours, and ML CCCMS weekly supervisory meetings show full attendance by required supervisory and executive staff when they occur, which leads to interdisciplinary coordination, and consistent supervisory engagement and oversight.

High compliance with staff training requirements: Custody and healthcare staff completed annual CMHPP training at and above a rate of 98%. This demonstrates a commitment to competency development, and that

SVSP CQI Report | 2026

SVSP is working toward the alignment of goals across disciplines. Quarterly partnership training was completed 80% of the time during the review period; however, required staff attended only 60% of the quarterly trainings.

⚠ Concerns

Documentation of attendance is inconsistent for CMHPP huddles: Review of documentation from a random sample of six weeks during the review period reflected low performance in the documentation of required attendees during second watch and third watch huddles; 62% of the huddles documented custody and mental health attendance. In addition, housing unit custody staff are not consistently attending the CMHPP huddles in the inpatient setting; instead, these huddles are attended by the sergeant. The intent of the CMHPP huddles is to build and improve communication and teamwork between those working directly with the population. The huddles would be more effective if housing unit custody and mental health staff who are familiar with the population in that unit were present. The insufficiency of documented attendance raises concerns regarding accountability, line staff communication, and compliance with procedural standards.

Inconsistent supervisory meetings and joint supervisory program tours: While attendance at ML CCCMS CMHPP weekly supervisor meetings and monthly joint supervisory program tours are occurring 100% of the time, the occurrence of these functions is inconsistent. ML CCCMS CMHPP weekly supervisor meetings were completed 51% of the time during the review period and monthly joint supervisory program tours occurred 75% of the time. Clinical and custody supervisory engagement with these requirements is below threshold, which may affect oversight, staff coordination, and timely resolution of concerns within the ML CCCMS program.

Recommendations

1. Ensure accurate and consistent documentation of huddle attendance: Provide training for staff on the attendance requirements for daily huddles and the importance of accurate attendance documentation, emphasizing the role of cross-disciplinary communication, procedural compliance, and oversight. These steps will help strengthen accountability, improve communication between disciplines, and support adherence to the standards of the CMHPP.
2. Improve frequency of supervisory meetings and program tours: Establish a standardized scheduling and tracking system for ML CCCMS supervisory meetings and program tours. Assign clear responsibility for meeting and tour coordination.

Psychiatry

There are required timelines for psychiatric response to medication non-adherence notifications, appropriate use of involuntary medication procedures under Penal Code §2602, and systematic monitoring of medication safety and continuity through the Medication Administration Process Improvement Program (MAPIP).[1] MAPIP tracks the percentage of medication doses provided in a timely manner across all transfer types, administration methods (KOP, nurse-administered, directly observed therapy), prescription types, medication categories, and provider types. It also tracks the 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	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	6-Month Avg	Onsite Audits
Timely Response to Critical Non Adherence Notification (v2.0)	0%†	13%†	14%	30%	50%	44%†	28%	

[1] See Appendix B

Timely Response to Non-Critical Med Non-Adherence Notification(v2.0)	54%	51%	54%	57%	76%	75%	62%	
Controlled Use of Force Incidents Required to Administer PC2602 Medication								33%†

**8% of the MHSDS participants at SVSP have an active PC2602 court order for medication.*

✓ **Strengths**

MAPIP monitoring is above statewide average: EKG monitoring by nursing for antipsychotic medications occurred 100% of the time for each month of the review period. Timely nursing monitoring of blood pressure, height and weight was consistently documented across multiple medication classes, with average rates ranging from 96%-100%.

⚠ **Concerns**

Timely responses to medication non-adherence notifications: Timely response to critical medication non-adherence occurred 28% of the time over six months, with a low of 0% in January 2026, and inconsistent month-to-month performance for the remainder of the review period (ranging from 0% to 50%). Timely response to non-critical medication non-adherence occurred on average 62% of the time over six months. Both measures demonstrated a gradual upward trend during the review period.

Medication monitoring is low across antipsychotics and mood stabilizers: The completion rate of the Abnormal Involuntary Movement Scale (AIMS) for patients prescribed antipsychotic medications was 69%. Clozapine monitoring occurred on average 59% of the time. Clozapine complete blood count (CBC) monitoring is below compliance with a concerning downward trend over the last three months of the review period (April 66%, May 64%, June 60%). Depakote therapeutic level monitoring did not occur (0%) for two consecutive months. Valproic acid therapeutic level monitoring occurred 35% of the time and Lithium level monitoring occurred on average 30% of the time with a range of 13% to 43%. Both medications have more narrow therapeutic windows and require careful monitoring to reduce the potential for toxicity.

Recommendations

1. Ensure timely response to medication non-adherence: See Priority Recommendations.
2. Review MAPIP measures to ensure adherence to timelines: Conduct an immediate retrospective review of mood stabilizers to confirm required labs have been completed or are scheduled, identify the root cause of the monitoring gap (ordering failure, lab completion failure, or documentation error), and implement a prospective tracking system to prevent recurrence. Ensure timely CBC monitoring for Clozapine and AIMS assessment for antipsychotic monitoring of patients prescribed antipsychotic medication. Timely CBC monitoring is a mandatory requirement to safely prescribe Clozapine. Demonstrate sustained compliance at or above 90% across all diagnostic monitoring measures within six months.

Patient Safety

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

Indicator	Mar 2026	May 2026	Jun 2026	6-Month Avg
Heat Related Illness Incidents for MHSDS Patients Prescribed Heat Alert Medications		0†		0†

Maximum Number Seclusion Incidents	1†		1†	2†
Seclusion Duration Incidents greater than 8 Hours	0%†		0%†	0%†
Seclusion Incidents	1†		1†	2†

✓ **Strengths**

No heat-related illness occurred for MHSDS patients during the review period: During the reporting period, there were no incidents of heat-related illness among MHSDS patients at SVSP who were prescribed heat alert medications. The onsite audit verified that all custody officers interviewed could clearly explain their duties during a heat alert. The facility's heat plan is up to date, meets statewide requirements, and can be accessed at each post.

⚠ **Concerns**

Non-adherence to seclusion policy and procedure: Two seclusion incidents were reported in the MHCB, one in March 2026 and another in June 2026. A comprehensive debriefing as required by Title 22 Health & Safety Code § 1180.5(b) was not conducted following the March incident. The required documentation to support appropriate clinical justification for the June incident was found to be insufficient.

Recommendations

1. Clarify seclusion procedures and train on clinical indications for use: Ensure debriefings occur after every seclusion, per Title 22 Health & Safety Code §1180.5(b). Provide training to mental health and nursing staff on proper clinical indications and documentation for seclusion events. Review all uses of seclusion over the coming months to assess whether training was effective and follow up as needed.

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	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	6-Month Avg	Onsite Audits
IDTT Patient Attendance	70%	73%	69%	69%	69%	72%	70%	
IDTT Required Staffing	45%	38%	32%	36%	35%	36%	37%	
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available								100%
IDTTs with Observed Interactive Process								15%

Documentation

Indicator	Onsite Audits
Cases w/doc. of appropriateness of LOC discussed for pts identified by 7388B as potentially requiring HLOC	55%
EOP IDTTs Addressing Accommodations and Clinical Appropriateness for Work and Education	33%†
IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT	93%
IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT	93%

✓ Strengths

PIP IDTTs were comprehensive: A total of five routine IDTTs were observed in the PIP, one in TC2 and four in TC1, which included two completed in absentia. Overall, the IDTTs were comprehensive and addressed all required areas. Safety plans were discussed in all cases.

Initial evaluations were completed prior to IDTT: During the observed IDTTs, nearly all PC (93%) and psychiatry (93%) intake evaluations were completed prior to the initial IDTT in all programs. Completing the initial evaluation prior to the IDTT provides a basis for the treatment planning discussion and assists with the formulation of measurable treatment goals.

Quality of mental health treatment groups: Although there are challenges associated with accessing treatment and mental health care, the quality of services delivered was high. Facilitators demonstrated a strong commitment to the group process and possess substantial clinical expertise in the subjects they were presenting. Patient interviews indicate that participants value the available treatment options and would benefit from expanded opportunities for group sessions and increased individual contacts.

⚠ Concerns

IDTT quality did not meet expectations: During all observed IDTTs, it was noted that engagement between participants was strong and the team dynamic fostered a patient-centered approach to treatment. However, despite these positive onsite observations, the IDTT process fell short of compliance requirements due to a lack of comprehensive clinical discussion. Adopting a more comprehensive approach to treatment team discussions will enhance the effectiveness of IDTTs, particularly by ensuring a robust discussion of the most appropriate level of care for each patient. Treatment team members who are located on site should attend meetings in person rather than remotely, to enhance the quality of treatment planning and the interaction with the patient. Institution-wide, 40 IDTTs were observed and only six (15%) met the audit criteria for an interactive process. The following discussions were missed during most of the non-compliant meetings: case formulations, measurable treatment goals, and safety planning. More specifically, observed IDTTs in the MHCB lacked a safety planning discussion and individuals being discharged from MHCB were noted to have documented individualized safety plans with interventions to reduce risk, however these were not discussed during the treatment team meetings. Additionally, the appropriateness of a patient's level of care was discussed 55% of the time when the patient was identified as potentially requiring a higher level of care 55%.

IDTT attendance by assigned clinicians did not meet the established benchmark: Monthly compliance thresholds for IDTT staffing were not achieved during the review period, and the six-month average compliance rate was 37%. The majority of IDTTs in MHCB, ML CCCMS, and ML EOP that were not attended by all members of the assigned treatment team and commonly had alternates attending in place of the assigned clinician, psychiatrist, and/or CCI. In addition to the frequent use of alternate team members at IDTTs 22% of IDTTs in these levels of care had at least one team member absent and they were not represented by an alternate. The PIP IDTTs consistently lacked full attendance, with at least one team member absent from each meeting without alternate representation; the psychiatric technician was most frequently the missing member.

Recommendations

1. Implement a Structured IDTT Quality Improvement Initiative: See Priority Recommendations.

RVRs, Sentinel Events, and Specialized Custody

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

Rules Violation Report

Indicator	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	6-Month Avg	Onsite Audits
RVR MH Assessments Conducted in a Private Setting	48%	56%	39%	34%	40%	49%	44%	
RVR MH Assessments where Documentation Requirements were Met	82%†	96%	95%				93%	
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality	100%†	100%	100%				100%	
Timely RVR MH Assessment Request	43%	25%	31%	35%	28%	29%	32%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	39%	36%	85%	88%	77%	34%	61%	
RVR MHAs where Captain Disagreed with Documenting in an Alternative Manner								0%†
RVRs Issued								3,564†
RVRs Issued to Non-MHSDS Participants								33%
RVRs Issued to Patients at the Acute Level of Care								0%
RVRs Issued to Patients at the CCCMS Level of Care								42%
RVRs Issued to Patients at the EOP Level of Care								21%
RVRs Issued to Patients at the ICF Level of Care								4%
RVRs Issued to Patients at the MHCB Level of Care								1%
RVRs recommended for mitigation that were mitigated								100%
RVRs Recommended for Mitigation with Custody Documentation								100%

**MHSDS participants comprise 58% of the population at SVSP.*

Sentinel Events

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

Use of Force

Indicator	Onsite Audits
Custody Staff Attendance at UOF Training	100%
Use of Force Involving MH Patients	90%

✓ **Strengths**

RVR assessments were conducted with diligence: Comprehensive RVR-MHAs were performed during the review period. The assessing clinicians provided recommendations grounded in mental health considerations. Clinical documentation requirements for RVR MHAs were met 93% of the time; these requirements include documentation of the patient's cognitive and adaptive functioning deficits and clinician collaboration with peers and supervisors in gathering information to draft the assessment.

Clinical recommendation to document behavior in an alternative manner and/or mitigate the penalty was followed in reviewed cases: In a selected sample of cases, collaboration between clinicians and custody resulted in full agreement. Clinicians recommended documenting the behavior in an alternate manner for one patient and in this instance the Captain agreed with the mental health recommendation and reduced the behavior to a counseling chrono. In 18 instances, the clinician assessing the patient recommended that penalties be mitigated. The senior hearing officer agreed with the clinician's recommendation in 100% of these situations.

Use of force training compliance: Custody successfully fulfilled the annual use of force training requirements, with 100% of custody staff completing the training.

⚠ **Concerns**

RVR-MHAs were sometimes conducted in non-private settings due to custody escort unavailability: During the review period, an average of 46% of RVR-MHAs were conducted in a private setting. In a sample of 20 non-PIP cases, the interview was conducted in a private setting six times. Patients refused the interview altogether in 11 cases or 55% of the time. A private setting was not offered due to custody unavailability to escort in three (15%) cases. Similarly, in a sample of 12 PIP cases, the interview was conducted in a private setting three times (25%). Patients refused the interview altogether in six cases or 50% of the time. A private setting was not offered due to custody unavailability to escort in two of the 12 cases.

RVRs were issued to patients for behaviors that occurred during emergency medication administration: Two patients were issued RVRs during an emergency forced medication administration as physical force was used to gain control of the patients during the psychiatric emergency. Because patient behavior during a mental health crisis requiring emergency medication generally has a nexus to the mental health crisis, any RVRs issues for behavior during such incidents should be carefully reviewed for necessity and mitigated or documented through alternative means where appropriate.

Limited correlation identified between mental health symptoms and behavior in RVR-MHAs: While custody consistently agreed with clinical input, clinicians infrequently determined that patient behavior was significantly influenced by symptoms of mental illness, resulting in few recommendations to document such behavior in an alternate manner. Clinicians may benefit from training and mentoring in assessing whether patient behavior is significantly influenced by symptoms of mental illness.

Non-adherence to the alternative housing local operating procedure (LOP): Building D2 is a multipurpose unit, housing RHU overflow, alternative housing patients pending clinical evaluation or placement in a MHCB, and patients who have not been able to find a compatible cellmate. The alternative housing LOP 411 documents cells 101-110 as alternative housing cells. In the OP Addendum 59 to LOP it says that D2 101-105 will primarily be used for Alternative Housing and will have priority over RHU overflow, to include making the necessary bed moves to accommodate the intake of alternative housing placement. There were two RHU overflow patients in cells 101 and 102 at the time of observation. When the officer was asked what happens if cells 101-105 are occupied by RHU overflow and there are more than five patients who need alternative housing, the officer answered that alternative housing patients would go to CTC 114 and 115 and indicated that 101-105 are reserved and designated for RHU overflow (with signs identifying them as Ad Seg) because they are not "retrofitted." Following the LOP and addendum as written, reserving cells 101-105 for patients needing alternative housing ensures compliance with the alternative housing policy and prevents placing patients in unauthorized locations.

Recommendations

1. Conduct a Focused Quality Review of Rules Violation Reports (RVR) and RVR-Mental Health Assessments (MHA): See Priority Recommendations.
2. Reaffirm Alternative Housing Procedures: Provide staff training and clear signage to reinforce the priority and designation of cells 101-110 for alternative housing, as outlined in the LOP and its addendum. Reinforce the current priority for cells 101-105 for alternative housing, moving RHU overflow patients to other cells, to ensure the needs of alternative housing patients are met.

Restricted Housing

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

Timeliness

Indicator	Jan 2026	Feb 2026	Mar 2026	Apr 2026	Jun 2026	6-Month Avg	Onsite Audits
ICC Review of Max Custody ICF Patients Prior to Admission					100%†	100%†	
ICC Review of Max Custody PIP Patients Within 10 Calendar Days of Arrival	100%†	100%†	100%†	0%†	0%†	78%†	
ICCs with Mental Health Clinicians Present and Relevant Information Provided							80%†
Initial ICCs Reviewed that were Held within 10 Calendar Days of Arrival to Restricted Housing Placement							100%

MH Patients on Max Custody Over 150 Calendar Days with a Timely Initial MHCBC							19%
MH Patients on Max Custody Over 180 Calendar Days with Timely Initial LTSCC							89%†

Documentation

Indicator	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Controlled Use of Force MH Assessments Meeting Documentation Requirements	0%†	100%†	0%†	25%†	
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%†
Peace Officers Observed to Carry Their CPR Mouth Shield	100%
RHU CCCMS Out of Cell Time Offered	0%
RHU Shower Access	95%
Weeks where NDRH Patients are Offered Required Phone Calls	65%

✓ **Strengths**

Psychiatric Technician (PT) rounds performed with accuracy: PT rounds are conducted in both the RHU and RHU overflow units. During the observed rounds in RHU, the PT, who was recently assigned to the RHU post, consistently addressed all required assessment questions. The documentation associated with the audited PT rounds fully satisfied all established audit criteria.

RHU structural compliance: Restricted housing structural indicators achieved 100% compliance across identification of NDRH patients, custody officers observed to be carrying their mouth shield, and ICCs occurred within 10 calendar days of arrival to RHU, and required access to showers occurred 95% of the time. Structural compliance establishes the operational foundation necessary for programming in the most restrictive setting.

⚠ **Concerns**

Deficiency in phone calls and out-of-cell time: During the onsite review, a cohort of 10 NDRH patients were assessed over a cumulative 65-week period of placement in the RHU. NDRH patients were provided access to phone calls during 41 out of 65 weeks, equating to a 65% compliance rate with established policy. Additionally, ARHR documentation pertaining to out-of-cell activity was evaluated for a sample of 20 patients housed in RHU across a four-week interval. None of these patients were afforded the required 20 hours of out-of-cell time during the reviewed weeks. The provision of out-of-cell time was adversely affected by recurrent medical emergencies within the RHU, ongoing custody staff vacancies, and the discontinuation of third watch RHU yard coverage in 2025, which collectively reduced the scheduling opportunities for yard activities.

ICC review of maximum custody PIP patients was inconsistent: When patients on maximum custody are being referred for inpatient care, the ICC must review whether the maximum custody restrictions on the patient can be suspended in the inpatient context. Per policy, this review should occur for patients referred to ICF before admission to the inpatient setting and again within ten days of arrival to the endorsed PIP location for any patient designated MAX custody. The latter requirement provides another opportunity for the ICC to consider whether all restrictions are necessary and appropriate. The ICC review occurred for maximum custody patients prior to patient admission to SVSP's ICF in 100% of cases. The ICC review occurred for maximum custody patients within 10 calendar days of arrival to the PIP in 100% of cases in January, February, and March but in 0% of the cases in April and June for an average of 78% compliance over the review period. In both instances of noncompliance, the ICC meetings were conducted beyond the required timeframe, with delays of 16 days and four days, respectively.

Recommendations

1. Enhance opportunities for yard program: Identify ways to reinstate third watch RHU yard coverage. This will help mitigate disruptions caused by medical emergencies and staff shortages, ensuring consistent scheduling of yard activities and adherence to established minimum requirements for out of cell time.

Suicide Prevention

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

Indicator	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	6-Month Avg	Onsite Audits
Discharges from MHCB with clinician review of d/c summary		100%†	50%†				60%†	
Documentation of Acute/ICF Discharges with Clinician to Clinician Contact within 5 days	100%†						100%†	
Emergent and Urgent MH Referrals That Result in SREs	94%	96%	96%	98%	97%	97%	96%	
MHCB clinical stays within timeframes	95%	95%†	88%	88%†	83%	87%	89%	
MHCB Daily Provider Contacts (v2.0)	75%	66%	65%	80%	89%	92%	77%	
MHCB/PIP Supervisory Reviews of Discharge Safety Plans	50%†	75%†	35%	67%†	74%†	93%†	65%	
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training	70%	82%	86%	89%	88%	84%	83%	
Safety Plans Signed Timely	77%	83%	64%	73%	89%	87%	79%	
Timely Clinical Follow-Ups (V2.0)	42%	45%	38%	30%	27%	30%	35%	
Audited Security Welfare Checks in Restricted Housing								100%

That Included the Required Visual Observation								
Custody Staff with CPR Training								99%
Custody Staff with Suicide Prevention Training								98%
Healthcare staff current with suicide prevention training								100%
Housing Unit/Incarcerated Person Living Areas with Emergency Response Equipment and Daily Inventories								100%†
Institution SPRFIT Meeting Minutes Reviewed that Satisfy All Audit Criteria								0%†
MHCB and Acute/ICF Out of Cell Activities - Dayroom								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								100%
MHCB and Acute/ICF Records with Rationale for Partial Issue								45%
MHCB Out of Cell Activities								100%†
Nursing Staff Current with CPR Training								100%
Observed Initial Health Screenings								100%†
Observed Initial Health Screenings (PIP)								100%†
Onsite Review of Patient Orders for Issue and Observation								100%†
Patients referred to MHCB on continuous direct visual observation								100%†
PIP Out of Cell Activities								88%
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								0%†
RHU Intake Incarcerated Persons Appropriately Housed								100%†

Suicide Resistant Cells								100%†

✓ **Strengths**

CIT is functioning effectively: SVSP has a robust CIT process, with three clinicians providing coverage seven days a week from 8:00 a.m. until 8:00 p.m. A custody supervisor and nurse respond to the respective yard during each activation. An observed CIT interaction during the site visit demonstrated strong collaboration between all disciplines represented.

RHU second watch sergeant meeting fosters discussion among all participants: The RHU morning huddle was well attended with participants including the clinical supervisor, primary clinicians, custody supervisors, and a psychiatric technician (PT). All of the required daily huddle criteria were covered during the observed huddle.

Temporary Holding Cell (THC) logs demonstrated compliance with suicide prevention policy: Examination of hundreds of THC logs during the review period for the four yards (A, B, C, and D) that utilized THCs found that only five individuals were confined in the cells for danger to self in excess of four hours, with all of those being under seven hours in length. Although only a limited number of patients remained in TTMs for more than four hours, organizational policy strictly prohibits THC placement exceeding four hours when the patient is pending evaluation for suicidal ideation, suicide attempts, and/or self-harm, or an individual is in crisis.

Suicide prevention-related training completion: A review of training records found that with one exception ("Understanding & Assessing Presence, Severity & Risk of Suicidality" training for outpatient clinicians), all mental health, custody, and medical staff had compliance rates over 98% for all court-ordered mental health and CPR training.

Safety plans for MHCB discharges were thorough and clinically meaningful: Reviewed MHCB discharge safety plans scored 100% compliance. All five MHCB discharge safety plans were found to be individualized and contained interventions to reduce risk.

Justification documentation for MHCB rescissions was largely compliant: Results revealed that 14 of 15 reviewed SREs (93%) contained clinical justification for patient rescissions from MHCB level of care.

Patients placed in the SRMP had robust treatment plans: Four of the five reviewed master treatment plans for patients participating in the SRMP included specific goals and interventions to address suicide risk.

Observation orders were compliant for patients in the PIP: Ten charts were reviewed and the review concluded that orders were placed daily and contained adequate justification in all cases.

⚠ **Concerns**

Emergent and urgent referrals not marked for danger to self were inconsistently accompanied by a SRE when clinically indicated: For referrals concerning self-harm or suicidal ideation, 97% of the necessary SREs were completed for emergent consults and 40% of required SREs for urgent consults were completed. In a review of approximately 50 patient charts for emergent or urgent referrals that were not marked as danger to self, there were 15 cases in which danger to self was present and an SRE was required; of these, only 73% had the SRE completed.

Observation and issue orders, justifications, and documentation not completed accurately in MHCB: Patients on partial issue during the on-site audit had the rationale documented for the restriction in 45% of cases. A review of 10 cases revealed multiple instances of progress notes containing contradictory information regarding the required level of observation, referencing both 15-minute checks and 30-minute checks in the same note. Psychiatric notes also contained information regarding level of observation that were contradictory to MHPC progress notes. Finally, there were multiple examples of MHPC daily progress notes that contained documentation of observation and issue orders without any verification the patient was assessed that day.

Five-day clinical follow ups and safety plans for patients in PIP and alternative housing were inadequate: Although safety plans developed for patients discharged from the MHCB were adequate, safety plans

developed for patients discharged from the PIP, as well as MHCB rescissions (alternative housing discharges) were inadequate. Review of 15 rescinded cases from alternative housing found that only 67% (10 of 15) of cases had all daily clinical follow-ups for each of the five required days. In one instance, a safety plan had not been updated at any time during the five days.

Recommendations

1. Enhance Suicide Prevention Documentation Quality: See Priority Recommendations.

Sustainable Process and Utilization Review

This section evaluates the MHCB utilization review processes, including clinical stay compliance with established timeframes and the timeliness of transfers to crisis-level care. Sustainable process indicators measure whether MHCB admissions proceed through acute stabilization and discharge planning at the pace the clinical model requires, and whether patients requiring crisis-level care are transferred without avoidable delays. A comprehensive report containing the detailed findings from the Regional Sustainable Process Review is provided separately and is not attached to this document.

✓ **Strengths**

Leadership actively supports and improves communication and collaboration: SVSP's mental health leadership team demonstrates a commitment to fostering a supportive environment. Leadership has strengthened communication channels among inpatient coordinators (IPCs), supervisors, and staff, and has adopted a more proactive approach in assisting IPCs with requests for IDTTs to update treatment plan documentation.

⚠ **Concerns**

Sustainable Process Data Review: The quality of higher level of care documentation supporting decisions not to refer patients to a higher level of care is reviewed quarterly in the headquarters (HQ) documentation review. The 2026 second quarter audit encompassed 38 cases, with 47% classified as "good" and 53% rated as "unacceptable." The 2026 third quarter audit encompassed 47 cases, with 47% classified as "good" and 53% rated as "unacceptable." Current findings reflect a 13% decrease in HQ review of documentation quality compared to the first quarter of 2026. Across the programs at SVSP, cases deemed "unacceptable" were most frequently attributed to insufficient narrative content, insufficient interventions addressing the reason for non-referral, missing documentation, IPC errors, clinical inconsistencies within documentation, unsigned treatment plans, and copied and pasted documentation without true updates.

Recommendations

1. Enhance support for drafting the higher level of care section of the treatment plan: Establish a structured feedback mechanism among clinicians, supervisors, and the IPC to address areas identified in the headquarters documentation audit and elevate the quality of higher level of care documentation. Progress should be monitored through periodic reviews of documentation and systematic tracking of improvements in documentation standards.

Staffing

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

Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief of Mental Health	1.0	1.0	0%
Chief Psychologist	3.0	3.0	0%
Chief Psychiatrist	2.0	2.0	0%
Senior Psychiatrist (Supervisor)	1.0	0.0	100%
Senior Psychologist (Supervisor)	4.0	4.0	0%
Supervising Psychiatric Social Worker I	1.0	2.0	0%
Senior Psychologist (Specialist)	10.5	9.8	6%
Recreation Therapist	17.0	16.3	4%
Staff Psychiatrist	14.5	13.3	8%
Psychologist – Clinical	14.0	11.4	19%
Clinical Social Worker	7.5	8.6	0%
Primary Clinician (PC)	29.5	28.1	5%
PC: Psychologist – Clinical		10.2	
PC: Clinical Social Worker		17.1	
PC: Marriage and Family Therapist		0.0	
PC: Professional Clinical Counselor		0.8	

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

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

✓ Strengths

Improvement in clinical non-supervisory position fill rates: The staffing of supervisory and non-supervisory clinical positions, including psychiatrists, psychologists, clinical social workers, primary clinicians, and recreation therapists in both PIP and non-PIP settings, has markedly increased, substantially reducing vacancy gaps. With the exception of the senior psychiatrist supervisor and psychologist classifications, all other positions have met or surpassed a 90% average fill rate. As a clinical training site, internship opportunities build a foundation for clinicians to transition to staff positions. SVSP has made considerable progress in filling direct-care positions and is working toward building a foundation for effective clinical service delivery moving forward.

⚠ Concerns

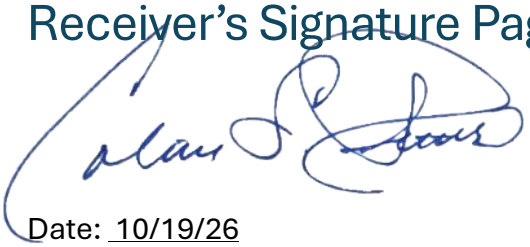
Unfilled psychiatrist supervisor position: The Senior Psychiatrist (Supervisor) classification was vacant throughout the review period. Vacancies in supervisory roles contribute to structural deficiencies in clinical oversight.

Unfilled psychologist positions: During the review period, approximately 2.5 psychologist FTE positions were vacant, resulting in an average 19% functional vacancy rate. Primary clinician classifications of marriage and family therapist and professional clinical counselors are not assigned to the PIP, however there was one additional clinical social worker on staff above the allocation and that offset the effects of the psychology vacancies.

Recommendations

1. Continue to collaborate with CCHCS HR to fill vacant supervisory and psychologist positions: Filling vacant positions will provide additional support for clinical care, further reducing access to care deficits. At the same time, the Receiver is addressing agency-wide challenges to filling certain supervisory classifications.

Receiver's Signature Page



Date: 10/19/26

Appendix A: Acronyms and Initialisms

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

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

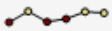
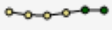
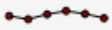
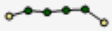
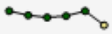
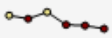
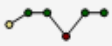
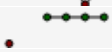
SATF	Substance Abuse Treatment Facility
SCC	Sierra Conservation Camp
SHO	Senior Hearing Officer
SNY	Sensitive Needs Yard
SOL	California State Prison, Solano
SOMS	Strategic Offender Management System
SPRFIT	Suicide Prevention and Response Focus Improvement Team
SQRC	San Quentin Rehabilitation Center
SRASHE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

Appendix B: MAPIP

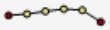
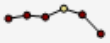
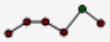
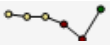
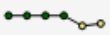
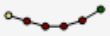
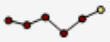
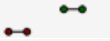
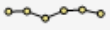
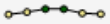
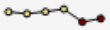
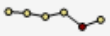
INSTITUTION 6 MONTH TREND

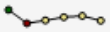
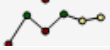
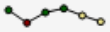
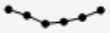
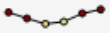
Salinas Valley State Prison (SVSP)

June 2026

Population Health Management	6 Months	Trend	JAN	FEB	MAR	APR	MAY	JUN
Diagnostic Monitoring (All)	**84%**		**83%**	**85%**	**84%**	**82%**	**86%**	**82%**
QT Prolongation EKG 12 Months	100%		100%	100%	100%	100%	100%	100%
Antipsychotics (All)	88%		86%	89%	87%	87%	90%	87%
Lipid Monitoring	75%		68%	80%	69%	72%	80%	79%
Blood Sugar	88%		88%	85%	84%	87%	90%	90%
EKG	100%		-	-	100%	-	100%	100%
AIMS	69%		69%	66%	70%	74%	71%	67%
Med Consent	89%		87%	86%	81%	94%	100%	82%
CBC with Platelets	89%		84%	92%	90%	93%	94%	75%
CMP	93%		100%	93%	90%	92%	100%	78%
Thyroid Monitoring	74%		67%	85%	80%	62%	94%	55%
Blood Pressure	99%		98%	100%	100%	100%	96%	100%
Height	96%		95%	100%	96%	91%	93%	98%
Weight	98%		100%	96%	98%	97%	98%	98%
Pregnancy	-		-	-	-	-	-	-
Clozapine (All)	77%		83%	76%	89%	70%	72%	70%
Blood Sugar	92%		100%	-	100%	67%	100%	100%
Lipid Monitoring	83%		86%	-	100%	67%	100%	67%
CBC	71%		79%	74%	84%	66%	64%	60%
CMP	87%		100%	-	100%	50%	100%	100%
EKG	83%		75%	100%	100%	50%	100%	100%
AIMS	56%		50%	-	80%	67%	0%	50%
Thyroid Monitoring	85%		33%	-	100%	100%	100%	100%
Med Consent	75%		50%	100%	0%	-	100%	100%
Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Height	100%		100%	-	100%	100%	100%	100%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-

SVSP CQI Report | 2026

Valproic Acid (All)	75%		74%	76%	79%	82%	80%	65%
Med Consent	68%		75%	50%	100%	50%	67%	83%
Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Height	97%		88%	100%	100%	100%	100%	100%
Valproic Acid Level	35%		33%	0%	0%	50%	33%	56%
CBC with Platelets	56%		50%	57%	67%	83%	71%	30%
CMP	63%		64%	70%	67%	83%	71%	33%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Lithium (All)	73%		71%	77%	76%	68%	71%	76%
Lithium Level	30%		14%	36%	40%	38%	13%	43%
Thyroid Monitoring	64%		43%	70%	70%	45%	100%	67%
CMP	57%		50%	63%	54%	58%	40%	67%
CBC	73%		83%	75%	75%	50%	0%	100%
EKG	86%		75%	100%	75%	100%	100%	67%
Med Consent	96%		100%	100%	100%	86%	100%	100%
Height	96%		100%	100%	100%	100%	86%	89%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Oxcarbazepine (All)	75%		82%	73%	64%	64%	74%	92%
CBC	69%		67%	57%	73%	40%	70%	89%
CMP	74%		85%	57%	63%	86%	67%	89%
Med Consent	86%		100%	100%	50%	50%	86%	100%
Pregnancy	-		-	-	-	-	-	-
Lamotrigine - Med Consent	78%		50%	50%	-	100%	100%	-
Antidepressants (All)	86%		87%	88%	79%	88%	89%	85%
EKG (Tricyclics)	-		-	-	-	-	-	-
Med Consent	88%		90%	91%	79%	92%	92%	88%
Thyroid Monitoring	70%		70%	75%	58%	71%	80%	65%
Pregnancy	-		-	-	-	-	-	-
Venla Blood Pressure	99%		100%	100%	100%	100%	94%	100%
Medication Management	**6 Months**	**Trend**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**
Medications Received Timely (All)	**80%**		**81%**	**81%**	**78%**	**80%**	**78%**	**80%**
By Transfer Type								
New Arrival to CDCR (RC) – RC	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – RHU	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – MHCB	98%		-	-	-	-	98%	-
New Arrival to CDCR (RC) – CTC	-		-	-	-	-	-	-
Intra-System (Within Institutions) – GP	70%		72%	71%	66%	71%	69%	70%
Intra-System (Within Institutions) – RHU	88%		85%	88%	91%	91%	86%	86%
Intra-System (Within Institutions) – MH Inpatient	78%		80%	78%	81%	84%	67%	72%
Intra-System (Within Institutions) – Specialized Medical	92%		-	-	100%	100%	89%	83%
Inter-System (Between Institutions) – GP	69%		73%	69%	73%	67%	64%	67%
Inter-System (Between Institutions) – RHU	85%		89%	87%	82%	88%	67%	77%

Inter-System (Between Institutions) – MH Inpatient	87%		92%	79%	85%	88%	88%	83%
Inter-System (Between Institutions) – Specialized Medical	79%		91%	71%	75%	80%	82%	75%
Return to CDCR – GP	70%		84%	78%	43%	68%	75%	65%
Return to CDCR – RHU	83%		0%	95%	43%	99%	77%	88%
Return to CDCR – MH Inpatient	87%		94%	74%	90%	96%	85%	76%
Return to CDCR – Specialized Medical	73%		-	-	-	54%	86%	100%
Stable Housing	80%		81%	82%	79%	80%	78%	80%
Leaving CDCR	100%		100%	100%	100%	100%	97%	100%
By Provider Type								
Psychiatry	86%		88%	87%	85%	87%	85%	87%
Medications Refused (All)	**8%**		**9%**	**8%**	**7%**	**8%**	**9%**	**10%**
By Provider Type								
Psychiatry - Refused	5%		5%	5%	4%	4%	4%	5%
Non-Formulary by Psychiatrists	**5.9%**		**6.4%**	**5.7%**	**5.1%**	**5.4%**	**6.3%**	**6.7%**

Appendix C: Suicide Prevention Report

Restricted Housing Unit (RHU)

Second Watch Partnership Huddle: The morning huddle in the RHU was observed on August 4, 2026. There was full attendance and participation by the clinical supervisor, four other clinicians, lieutenant, sergeant, four officers, and PT. All areas, including new arrivals, high risk, and SRMP incarcerated patients, were discussed.

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

Intake Cells: There were 10 New Intake Cells (100-110) in the RHU (Z-9 Unit). Review of New Intake Cell usage found adequate practices and all new intake IPs were housed in new intake cells. In addition, D-2 Unit was utilized for RHU Overflow. On August 4, 2026, 23 IPs were observed in the Overflow Unit. No new intake IPs were observed in the unit. Although Guard One surveillance was available in the unit, it was deactivated and paper documentation was completed on each IP. Of note, because of limited custody staffing, IPs in the RHU Overflow did not receive yard if the population was less than 20 IPs, and IPs did not receive yard on weekends regardless of the census.

In sum, although there were problems associated with the lack of out-of-cell privileges for IPs housed in the RHU Overflow Unit, there was significant improvement in the appropriate housing of new intake cell IPs in the RHU since the previous assessment.

Please refer to the CQIR for a further summary of the findings.

RHU Screening (Pre-placement): Please refer to the CQIR for a summary of the findings.

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

Inpatient Housing Units

Suicide-resistant cells: SVSP had 10 **MHCB** cells, and each had previously been retrofitted to be in compliance with statewide policy. During the onsite assessment, there were nine (9) patients in the unit, four (4) of whom were on Suicide Precaution on August 5.

Within the **PIP**, patients were currently housed in either TC-1 or TC-2, with the C-5 and C-6 housing units deactivated in 2025. Patients identified as suicidal and requiring increased observation are not observed in their cells, rather, they are relocated to "observation cells" located within either TC-1 or TC-2. Suicide-resistant cells were designated in each unit as follows: TC-1 (Nos. C-1 and C-2), and TC-2 (Nos. B-14, B-15, B-17, and B-18). During the onsite assessment, there were 51 ICF patients in TC-1 and 70 ICF patients in TC-2. Of those, 1 to 3 patients were on Suicide Watch and Suicide Precaution.

MHCB IDTT Meetings: A total of three MHCB IDTTs were scheduled during the onsite review. One of the three IDTTs was completed in absentia. Both observed IDTT meetings were for patients discharging to a lower level of care. A routine IDTT was held in absentia for one patient. All patients were admitted for suicidal ideation/danger to self. One of the patients was placed in mechanical restraints while the IDTT was being conducted due to being MAX custody level. The IDTTs began on time. The IDTT treatment room

included a table and chairs. The primary clinician and psychiatrist, RN and CCI and psychiatric technician had access to their laptops during the IDTTs.

The primary clinician initiated introductions and stated the purpose for the IDTTs in both cases. All patients were on Q30 observation status and were provided full issue. Appropriateness of issue and observation status were discussed in all cases. The primary clinician in all IDTT meetings provided brief clinical summaries that included current reason for admission, progress toward goals, and strengths and weaknesses. In two cases, adequate case formulations were presented. RVRs were discussed for each patient. Each patient was given an opportunity to provide input regarding their treatment while in the MHCB. Discharge plans were discussed during one of the IDTTs.

Measurable treatment goals were identified and discussed in all cases. Medication and side effects were discussed by the psychiatrist in both cases. The CCI provided pertinent information for each patient. The nursing staff provided information in all cases. Although two IDTTs were for patients discharging, safety planning was inconsistent in both cases. Review of the documented safety plans indicated inconsistencies with the safety planning discussions during the IDTT meetings. Issue and observation levels were discussed and higher level of care and appropriateness of level of care were also discussed for each of the patients.

To assist in the overall structure of the IDTT presentation, it is recommended that the presenting clinicians in the MHCB familiarize themselves with the CQIT audit criteria for IDTTs to guide the presentation and assist in providing succinct clinical information during the team meetings.

PIP IDTT Meetings: A total of five (5) PIP IDTT meetings were completed during the onsite review. One routine IDTT in **TC2** was observed for a patient referred for Significant Impairment/Dysfunction Due to Mental Illness (SIDDMI). The team was interactive and all members participated in the discussion. To assist in the comprehensiveness of the IDTT presentation, the presenting clinicians in TC2 should familiarize themselves with the CQIT audit criteria for IDTTs to guide the presentation and assist in providing succinct clinical information during the team meeting.

Four routine IDTTs were observed in TC1, including two held in absentia. Three of the patients were referred for danger to self and one was referred for SIDDMI. All of the IDTTs began on time. The IDTT treatment room included a table and chairs. The primary clinician and psychiatrist, RN and CCI and psychiatric technician had access to their laptops during the IDTTs.

The primary clinician initiated introductions and stated the purpose for the IDTT. The primary clinicians in all IDTT meetings provided brief clinical summaries that included current reason for admission, current symptomatology, diagnosis, progress toward goals, strengths and weaknesses, and self harm and mental health histories. In four cases, adequate case formulations were presented. RVRs were discussed for each patient. Each patient was given an opportunity to provide input regarding their treatment.

Measurable treatment goals were identified and discussed in all cases. Medication and side effects were discussed by the psychiatrist in all cases. The CCI provided pertinent information for each patient. The nursing staff provided information in all cases. Safety planning was discussed in all required cases. Issue and observation levels were discussed and higher level of care and appropriateness of level of care were also discussed for each of the patients.

MHCB Supervisor Review of Discharging Safety Plans: A review of the On Demand Performance Report for January 1, 2026, to June 30, 2026, revealed that SVSP was 67 percent compliant with timely supervisor review of safety plans.

PIP Supervisor Review of Discharging Safety Plans: According to the On Demand Acute and ICF Performance Report, SVSP PIP compliance with timely safety plans was 61 percent; however, compliance with safety plans reviewed by a supervisor was 37 percent.

MHCB Quality of Safety Planning: A review of five safety plans from patients discharged from the MHCB were reviewed. All five reviewed safety plans were deemed adequate. One safety plan completed on July 22, 2026, which was not included in the audit period, was also reviewed. The safety plan included stock language within the clinical impression sections throughout the safety plan indicating, "Attempted to have IP participate in safety planning, but she repeatedly refused to participate. She said she did not need that." The quality of safety planning is currently on SVSP's Improvement Priorities List and Project Pipeline and will remain open. SVSP's SPRFIT Coordinator conducts monthly audits of safety plans for each MHCB and CIT clinician.

PIP Quality of Safety Planning: Five (5) randomly selected safety plans for patients who were discharged from the PIP during the audit period were reviewed. Only three of five (60%) of the cases were viewed as adequate because the safety plans did not identify any coping skills and/or specific interventions to assist the patient in reducing their suicide risk.

Observation and Issue Orders: A review of 10 patients' daily documentation for patients who were admitted to the **MHCB** for DTS during the audit period was completed. Daily issue and observation orders were present in all of the reviewed patients' charts. Justifications for the issue and observation status are primarily completed by the unit psychiatrist. In all daily notes completed by the psychiatrist, justification for both issue and observation levels was found to be inadequate. Additionally, there were several cases where the justification conflicted with the documentation of the patient's mental status within the note. For example, the mental status section indicated that the patient denied SI; however, justification noted, "Full issue-justification for level of issue: Patient endorses SI and needs close monitoring."

Due to insufficient justification for issue and observation levels in the 10 charts reviewed during the audit period, an additional 10 charts — including patients currently residing in the MHCB — were selected for review during the onsite portion of the audit. During this follow-up, several psychiatric progress notes were identified that contained contradictory information regarding the required level of observation, such as references to both Q-15 and Q-30 within the same note. These same psychiatric notes also contained information regarding level of observation that were contradictory to MHPC progress notes. Finally, there were multiple examples of MHPC daily progress notes that contained documentation of observation and issue orders without any verification the patient was assessed that day. Several of these were found for patients housed in CTC medical beds, but on Suicide Precaution status.

The above concerns regarding observation and issue orders, psychiatric progress notes inconsistently listing both Q-15 and Q-30 observation in the same note, and MHCB patients not always seen on a daily

basis by either a MHPC or MHMD were brought to the attention of the Chief of Mental Health and Chief Psychiatrist for corrective action.

There were no problems encountered with provider issue and observation orders for **PIP** patients. Daily documentation was completed in all cases, and justification was present in all reviewed notes.

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 both the **MHCB** and **PIP** units.

Provider Contacts: During the review period, provider contacts demonstrated an average compliance rate of 77%, with monthly figures ranging from 65% to 92%. Due to the observed variability in compliance across months, an additional review of 10 patient records was conducted for individuals housed in MHCB during this timeframe. Of the 10 patients reviewed, it was found that three (3) patients were not seen on a daily basis by either an MHMD or MHPC.

Privileges: The Automated Restricted Housing Record (ARHR) system was examined for documentation of out-of-cell activity (OCA) for 10 **MHCB** patients during seven-day periods of the review period. All had been cleared for out-of-cell activities by providers. The review found that all but one patient were offered out-of-cell activity (excluding appointments with MH clinicians) during the time period, ranging from 2.5 to 23 hours per week. The average was 15.8 hours per week. In addition, all patients averaged more than 2.6 showers, but less than one telephone call per week.

A review was conducted on a sample of 10 PIP patients to assess whether clinical documentation in the electronic health record confirmed their eligibility for participation in out-of-cell activities. The evaluation determined that all patients had been appropriately cleared by providers for these activities. Each patient was offered unstructured out-of-cell time, which included access to both the yard and dayroom, with total weekly hours ranging from six to 24 and an average of 13.4 hours per week. In addition, all patients averaged 3 showers and 2.7 telephone calls per week.

Clinical Discharge Follow-Ups: A review of the On Demand Mental Health Performance Report for January 1, 2026, to June 30, 2026, revealed that SVSP was 35 percent compliant for completion of 5 Day Follow Ups. A sample of 15 patients' 5 Day Follow Up documentation was reviewed. All reviewed follow ups were completed for at least five days in ten of fifteen (67 percent) cases. All series of follow ups included a safety plan each day except one. The institutional SPRFIT Coordinator reviews and audits all clinical discharge follow up deficiencies each month and reports the findings in the SPRFIT meetings.

Alternative Housing

Cells to temporarily house individuals identified as suicidal and awaiting MHCB placement were used on a daily basis at SVSP. Alternative Housing was located in D-Yard, Building 2 (cells 101-110) and C-Yard, Building 12 (cells 147-150) for RHU (Z-9) IPs. For a six-month period of January 1, 2026, through June 30, 2026, 310 patients were placed in alternative housing, with all released within 24 hours. In addition, 51 percent (158 of 310) of cases resulted in the MHCB referrals being rescinded and incarcerated persons returned to their housing units.

Further, observation of the assessment of three (3) patients in Alternative Housing (D-2) occurred on August 3. Although the required SREs were completed in each case, the safety plans were very poor. Each patient was offered the opportunity for out-of-cell assessments, with one patient refusing the opportunity, thus the assessment was conducted cell front and was very brief, i.e., less than two minutes. Safety planning was not discussed. In the two other cases, each patient requested and was provided the opportunity for out-of-cell assessments.

Medical chart review of 15 rescinded MHCB cases found that all had SREs, and 93 percent (13 of 14) of applicable cases had all daily clinical follow-ups for each of the five required days. Further, the review found that 87 percent (13 of 15) of cases had required safety plans, and only 54 percent (7 of 13) of completed plans were assessed as adequate. Plans were assessed as inadequate if the narrative did not identify any coping skills and/or specific interventions to assist the patient in reducing their suicide risk.

Finally, examination of hundreds of **Temporary Holding Cell (THC) Logs** during the review period for the four yards (A, B, C, and D) that utilized THCs found that only five (5) individuals were confined in the cells for DTS in excess of four (4) hours. Two individuals were housed in A-Yard and three individuals were in D-Yard. No individuals were confined in the cells for DTS in excess of four (4) hours in B-Yard and C-Yard.

Suicide Risk Management Program (SRMP)

During early audits, data discrepancies were discovered between the Mental Health reports and the EHRS. As a result, the Mental Health report has been temporarily suspended and the issue was escalated to the Mental Health Reporting Unit for resolution.

SVSP maintains an internal SRMP list. A review of Master Treatment Plans for five patients enrolled in the SRMP revealed that 80% (4/5) had interventions and goals documented within the SRMP tab of the Master Treatment Plan.

Discharge Custody Checks

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

Local SPRFIT Committee

SVSP has two SPRFIT committees, one for the out-patient program and one for the PIP. With regard to the **outpatient** SPRFIT committee, a review of six months of meeting minutes found that all meetings had quorums of all required mandatory members or designees during the January through June 2026 review period. Minutes included discussion on compliance data, improvement projects, and SRMP data. Although a brief summary of serious suicide attempts that occurred in January 2026 was found in the March 2026 minutes, the summaries did not include the required seven components of a mental health clinical review as outlined in the Update to Enhancements to the SPRFIT memorandum (dated June 14, 2023). A second serious suicide attempt that occurred in April 2026 did not result in a clinical

case review. In addition, the status of corrective actions based upon prior Receiver's suicide prevention expert assessments was briefly included in meeting minutes. In sum, 4 of 5 significant SPRFIT compliance areas were adequate.

In addition, the SVSP SPRFIT Coordinator and/or designee did not attend any Incarcerated Person Advisory Council meetings during the review period as required. The facility did not currently have a Incarcerated Person Family Council (PFC).

Further, a review of six months of **PIP** SPRFIT meeting minutes found that only the January 2026 meetings had a quorum of all required mandatory members or designees. In the other monthly minutes (February through June 2026), a lieutenant was incorrectly listed as a designee for the associate warden. The policy requires that only a captain is an approved designee. Minutes included discussion on compliance data, improvement projects, and the status of corrective actions based upon prior Receiver's suicide prevention expert assessments were briefly included in meeting minutes. There were no serious suicide attempts during the review period that required clinical case reviews of serious suicide attempts.

Finally, the Review Team was informed that SVSP will combine the outpatient and PIP SPRFIT committees into one entity in September 2026.

Policies: SVSP has a local suicide prevention policy (LOP 400, revised March 2026) that encompassed various issues, including SPRFIT responsibilities. In addition, the Bad News screening (LOP 407, revised April 2026) and SRMP (LOP 401, revised January 2026), and Alternative Housing (LOP 411, revised March 2026) policies were reviewed and each found to be consistent with the statewide memoranda. Finally, SVSP's Crisis Intervention Policy (LOP 402), revised January 2026) was consistent with the statewide memorandum.

Suicide Risk Evaluations in MHCB and Outpatient

During the audit period, SVSP generated 1,058 emergent consult orders for DTS with 97 percent compliance. SRE completion upon MHCB discharge was 98 percent compliant. However, SRE completion upon MHCB referral was noted at 79 percent. SRE completion at the time of a MHCB recission was 96 percent. SVSP had one patient arrive from DSH during the audit period. A SRE was completed timely, resulting in 100 percent compliance. Overall timeliness of suicide risk evaluation completion during the audit period was 85 percent.

Urgent and Emergent Referrals for Danger to Self

During the review period, SVSP was 97 percent compliant for completion of timely SREs for MHPC emergent consult orders and 40 percent compliant for MHPC Urgent Consults orders.

Urgent and Emergent Referrals Not Marked for Danger to Self

Examination of approximately 50 charts for emergent/urgent Mental Health Referrals not marked for DTS found 15 cases that required an SRE during the review period, and only 73 percent (11 of 15) of these cases had the SRE completed.

Crisis Intervention Team (CIT)

The **Crisis Intervention Team** was launched at SVSP in May 2019 and was operational seven days a week from approximately 8:00 a.m. until 8:00 p.m., with other clinicians responding to emergency mental health referrals during other hours. There were three clinicians assigned to cover CIT responses during these hours.

The Review Team observed a crisis response to an emergency mental health referral for DTS during the afternoon of August 4. The CIT included a clinician, yard lieutenant, and RN. The clinician offered the patient the opportunity for a private, out-of-cell assessment in the outdoor recreation yard of his housing unit. The patient's suicidal ideation was secondary to his safety and housing concerns. There were also issues regarding his inability to find a compatible cellmate due to hygiene issues. The yard lieutenant offered the patient a shower, change of clothing, and new housing unit. The patient was assessed by the clinician, denied any further suicidal ideation, and was cleared to return to housing. An SRE was completed as required.

Quality Improvement Plans (QIPs) Generated by Suicide Case Reviews

SVSP did not have any suicides during the review period, and the most recent suicide occurred in November 2025.

Training and Mentoring Compliance in Outpatient and PIP

Compliance with the Annual IST Suicide Prevention Training for 2025 was the following: 98 percent of custody, 100 percent for medical, and 99 percent for mental health staff. Compliance with *Coleman* training requirements has improved significantly since the last review; however, SRE Mentoring and Understanding & Assessing Presence, Severity & Risk of Suicidality remains below 90 percent compliance for outpatient clinicians. Training compliance for SVSP as of June 2026 is as follows:

- Understanding & Assessing Presence, Severity & Risk of Suicidality: 83% for outpatient clinicians and 100% for PIP clinicians.
- Safety Planning: 95% for outpatient and 100% for PIP clinicians
- SRE Mentoring: 80% for outpatient and 100% for PIP clinicians.
- Suicide Risk Management Program: 93% for outpatient and 96% for PIP clinicians.

  <u>CPR Certification</u>

- Custody: 98%
- Nursing: 100%

Receiving and Release (R&R) Screening for Non-PIP Admissions

Please refer to the CQIR for a summary of the findings.

Assignment of Corrective Action Plan and Recommendations

SVSP and SVSP PIP should ensure that all assigned open and previously assigned CAPs, as well as newly generated recommendations, are listed as an Issue and updated audit data included in the comment

section each month on the Improvement Priorities List and Project Pipeline. The project pipeline is to be uploaded to the Suicide Prevention SharePoint site monthly.

	PIP Summary of Concerns	Progress	CAP Status
1	PIP Supervisory Review of Safety Plans	Minimal	Open
2	PIP Safety Planning Documentation	Moderate	Open
3	PIP Mandatory SPRFIT Training Compliance	Substantial	Close
4	PIP Adequate IDTT Presentation & Discussions	Moderate	Open
5	IST Suicide Prevention Training Compliance	Substantial	Close
6	PIP Out of Cell Activities	Moderate	Open
7	PIP SPRFIT Meeting Quorums	Moderate	Open

	SVSP Summary of Concerns	Progress	CAP Status
1	RHU Intake Process	Substantial	Open
2	Safety Planning Documentation	Moderate	Open
3	SREs for Patients Rescinded from MHCB LOC	Moderate	Open
4	Supervisory Review of Safety Plans	Moderate	Open
5	SREs for Emergent Consults for DTS	Minimal	Open
6	5 Day Follow Up Completion	Moderate	Open
7	Justification Documentation for Issue and Observation Status	Minimal	Open

Conclusion

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

1) Ensure that justification for issue and observation orders is present in daily documentation. Justification should include the rationale for placing a patient at a particular level of observation. Justification should also be provided for patients on restricted issue, detailing the patient's unique risk factors and clinical need. General statements of risk and/or providing minimal items without justification are not acceptable.

2) Ensure that MHMD progress notes consistently list the current observation level for the patient on a daily basis and are not pulled forward from previous days' notes.

3) Ensure that MHCB patients are assessed by either a MHPC or MHMD on a daily basis, including patients housed in CTC medical beds on suicide observation status.

4) Ensure that Clinical Follow Ups are completed for a minimum of five consecutive days.

5) Provide refresher training on individualized safety planning to all clinical staff, with mandatory participation for clinicians routinely assigned to MHCB recissions and PIP discharges. Emphasize that safety plans must reflect the patient's specific risk factors, be developed collaboratively with the patient, and not consist of stock phrasing. Initiate monthly reviews of safety plans for rescinded MHCB referrals and PIP discharges who require safety plans, with individual mentoring for plans that do not meet standards.

6) Ensure that all outpatient clinicians have completed the "Understanding & Assessing Presence, Severity & Risk of Suicidality' training, and that over 90 percent compliance is maintained for outpatient clinicians in SRE Mentoring.

7) Increase compliance with SREs required for urgent/emergent mental health referrals not marked as danger to self.

8) Ensure that MHCB and PIP supervisors are reviewing discharge safety plans timely.

9) Ensure that incarcerated persons housed in RHU Overflow (currently in D-2) are provided access to regular yard privileges as required by Title 15.

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

Appendix D: Sustainable Process Report

Site Visit Report for California Department of Corrections and Rehabilitation
(SALINAS VALLEY STATE PRISON)

SITE VISIT DATES

August 3 – 7, 2026
CQIT+ Site Visit

PARTICIPANTS

Regional Mental Health Administrator
Stephanie Neumann, PsyD

Sustainable Process Leads

Senior Psychologist, Specialist (SME) ..... Caitlin Chinn, PhD
Senior Psychologist, Specialist (SME) ..... Shalila Douglas, PhD
Senior Psychologist, Specialist ..... Emily Moresco, PsyD

Program Staff On-Site

Supervising Psychiatric Social Worker ..... Maeve Gormly, LCSW
Senior Psychologist, Specialist ..... Rachael Ohanian, PhD
Senior Psychologist, Specialist ..... Brittany Sawyer, PsyD
Senior Psychologist, Specialist ..... Luz Vargas, PsyD
Associate Health Program Advisor ..... Daniel Stebbins

AREAS REVIEWED

Program Area Reviewed:	Sustainable process data review – Prior review - 47% – Current review - 47%

On this major site visit, all MHCB, EOP, and RHU areas were toured.

The terms "good" and "unacceptable" are utilized in the headquarters documentation review, to determine the quality of the documentation on the higher level of care (HLOC) considerations document. "Good" means that HLOC documentation adequately supports the decision to not refer the patient to a higher level of care even though one or more of the considerations is positive, and that the documentation adequately summarizes the specific treatment modifications that are documented in the treatment plan to improve the patient's ability to function. "Unacceptable" means one or more of the HLOC considerations were positive, but the explanation for not referring the patient to a higher level of care is deficient, and the HLOC documentation does not adequately summarize the modifications documented in the treatment plan to improve the patient's ability to function.

Since the last report, two HQ HLOC audits were completed for Q2 2026 and Q3 2026.

Higher Level of Care Q2 2026 Quarterly Audit: Q1 2026 Data

SVSP identified 53% "good" cases in the HLOC documentation review and HQ identified 47% "good" cases. Six cases had discrepant outcomes between SVSP and HQ; SVSP identified two cases as "unacceptable" but found to be "good" by HQ; and four cases were deemed to be "good" by SVSP but "unacceptable" by HQ. Regional concurred with HQ in all six cases.

HQ reviewed 38 cases: 47% (18 cases) were identified as "good" and 53% (20 cases) were identified as "unacceptable."

ML EOP comprised 63% of the documentation, 11% out of the MHCB, and 26% from RHU. In ML EOP (24 cases total), 50% of the cases were considered "good" and 50% were considered "unacceptable." In MHCB (four cases total), 25% of the cases were "good" and 75% were "unacceptable." In RHU (10 cases total), 50% of the cases were "good" and 50% were "unacceptable."

Program-wide, the reasons why the cases were considered "unacceptable" included: insufficient narrative (35%); insufficient interventions (25%); missing documentation (20%); IPC errors (15%); and copied/pasted documentation without updates (5%).

Reasons why the cases were considered "unacceptable" were further categorized by program. In EOP (12 "unacceptable" cases), the following were the reasons for "unacceptable" documentation: insufficient interventions (42%); insufficient narrative (33%); IPC errors (17%); and copied/pasted documentation without updates (8%). In MHCB (three "unacceptable" cases), the following were the reasons: missing documentation (34%); insufficient narrative (33%); and IPC error (33%). In RHU (five "unacceptable" cases), the following were the reasons and percentage of the identified issue: missing documentation (60%); and insufficient narrative (40%).

Documentation quality declined by 13% from the Q1 2026 audit. Within the individual EOP yard programs, A-Yard EOP declined by 8% to 67% in this current review, and D-Yard EOP declined by 15% to 40%. MHCB declined by 18% to 25% and RHU maintained at 50% since the Q4 2025 review. SVSP was required to complete this HQ documentation audit for Q3 2026 due to not meeting the 85% compliance rate.

HLOC Q3 2026 Quarterly Audit: Q2 2026 Data
SVSP identified 52% "good" cases in the HQ HLOC documentation review and HQ identified 47% "good" cases. Three cases had discrepant outcomes between SVSP and HQ; SVSP identified one case as "unacceptable" but found to be "good" by HQ; and two were cases deemed to be "good" by SVSP but "unacceptable" by HQ. Regional concurred with HQ in all three cases. Regional continues to advise the IPCs to review all associated Sustainable Process Reports (SPRs) to ensure that flagged considerations are endorsed in the Master Treatment Plan (MTP). Additionally, IPCs are to review the prior HLOC document to ensure that the current documentation is not copied and pasted.

HQ reviewed 47 cases: 47% (22 cases) were identified as "good" and 53% (25 cases) were identified as "unacceptable."

ML EOP comprised 75% of the documentation, with 6% out of the MHCB, and 19% from RHU EOP. In ML EOP (35 cases total), 46% of the cases were considered "good" and 54% were considered "unacceptable." In MHCB (three cases total), 33% of the cases were "good" and 67% were "unacceptable." In RHU (nine cases total), 56% of the cases were "good" and 44% were "unacceptable."
Program-wide, the reasons why the cases were considered "unacceptable" included: insufficient interventions (36%); insufficient narrative (32%); missing documentation (16%); clinical inconsistencies (8%); copy/pasted documentation (4%); and MTP not signed (4%).

Reasons why the cases were considered "unacceptable" were further categorized by program. In EOP (19 "unacceptable" cases), the following were the reasons for "unacceptable" documentation: insufficient interventions (42%); insufficient narrative (32%); clinical inconsistencies (11%); missing documentation (5%); copy/pasted documentation (5%); and MTP not signed (5%). In MHCB (two "unacceptable" cases), both cases (100%) had missing

documentation. In RHU (four "unacceptable" cases), the following were the reasons: insufficient narrative (50%); insufficient interventions (25%); and missing documentation (25%).

Documentation quality remained at 47%, the same as the Q2 2026 audit. EOP overall declined by 4%. Within the individual EOP yard programs, A-Yard EOP declined by 9% to attain 58% in this current review, and D-Yard EOP declined by 9% to 31%. MHCB increased by 8% to 33% and RHU increased by 6% to 56%. SVSP will be required to complete this HQ documentation audit for Q4 2026 due to not meeting the 85% compliance rate.

A summary of this information was shared with the Inpatient Coordinators (IPCs), mental health leadership, and program supervisors before the completion of this report. Q3 2026 data was reviewed with the IPCs and Chief Psychologist (CP), along with steps to take in future reviews to improve interrater reliability with the HQ reviewer. Additional resources were provided to assist with tracking various timeframes and timeliness of meeting those timeframes.

Follow-up required: YES _X_ NO____	If YES: Follow-up date: October 19, 2026

Follow-Up Action Plan: 1. Ensure all clinical staff are provided with a summary of the overall results of the audit and areas of focus for continued improvement in the quality of the HLOC documentation. Provide 844s.

Program Area Reviewed:	Mental Health Program Subcommittee Minutes

April 2026

Meeting minutes were posted timely to SharePoint. A quorum was met, with both IPCs in attendance. Part V was embedded in Attachment C of the minutes, along with the "Inpatient Coordinator Report" memorandum that was dated 04-07-26, and the meeting occurred on 04-13-26. The subject was titled "report for February 2026" but in the body it discussed March data. Section E was the only section of Part V that was captured in the narrative. According to the IPC report, there was one Acute referral and seven ICF referrals, for a total of eight referrals. All referrals were submitted within designated timeframes. The Acute referral remained intact and was pending transfer due to a medical hold, one ICF referral was still pending endorsement and acceptance but remained within timeframes, and six ICF referrals transferred timely. HLOC quality of documentation was 52%. Three patients discharged from PIP/DSH to SVSP. Compliance rates were provided for four out of the five required components. Clinician-to-clinician contacts, SREs, and 24-hour evaluations were at 100%; however, 5-Day Follow-ups were at 73%. No compliance rate was provided for discharge documentation review.

May 2026

Meeting minutes were not posted timely to SharePoint. A quorum was met, with both IPCs in attendance. Part V was embedded in Attachment C of the minutes, along with the "Inpatient Coordinator Report" memorandum that was dated 05-05-26, and the meeting occurred on 05-19-26. Section E was the only section of Part V that was captured in the narrative. According to the IPC report, there were two Acute referrals and eight ICF referrals, for a total of ten referrals. All referrals were submitted within designated timeframes, and all patients transferred timely. HLOC quality of documentation was 71%. Five patients discharged from PIP/DSH to SVSP. Compliance rates were provided for four out of five required components. Clinician-to-clinician contacts, SREs, and 24-hour evaluations were at 80%, and 5-Day Follow-ups were at 92%. No compliance rate was provided for discharge documentation review.

June 2026

Meeting minutes were posted timely to SharePoint. A quorum was met, with both IPCs in attendance. Part V was embedded in Attachment C of the minutes, along with the "Inpatient Coordinator Report" memorandum that was dated 06-02-26, and the meeting occurred on 06-09-26. None of the sections in Part V were fully captured in the narrative. According to the IPC report, there were three Acute referrals and three ICF referrals for a total of six referrals; however, the narrative noted four Acute referrals. All referrals were submitted within designated timeframes. The Acute referrals, and two of the ICF referrals transferred timely. One ICF referral remained pending

but remained within timeframes. HLOC quality of documentation was 64%. Three patients discharged from PIP/DSH to SVSP. Compliance rates were provided for four out of the five required components. Clinician-to-clinician contacts, SREs, and 24-hour evaluations were at 100%, and 5-Day Follow-ups were at 93%. No compliance rate provided for discharge documentation review.

A summary of this information was shared with the IPCs, mental health leadership, and program supervisors before the completion of this report. Possible transcription issues for the narrative of the minutes continue; however, with the added element of the MHPS now being combined with the Q-PIP, the meeting has a specified amount of time in which to cover the information discussed and the committee has less time to discuss all agenda items. IPCs were informed that the priority is to discuss all sections of Part V from the monthly HLOC audit. IPCs should also still be provided with the opportunity to review MHPS minutes before they are presented at the following month's meeting.

Follow-up required: YES _X_ NO___	If YES: Follow-up date: October 19, 2026

Follow-Up Action Plan: 1. All sections of Part V will be captured in the narrative in the body of the minutes. 2. If time allows in the MHPS meeting, discharge documentation review compliance rate will be discussed and captured in the minutes when discussing PIP/DSH discharge returnee documentation compliance rates.

Program Area Reviewed:	Referral and Non-Referral Reports

Referral Reports
The On Demand Acute-ICF Referrals report was run for the review period of April through June 2026.
April 2026
Ten referrals were initiated: two to Acute and eight to ICF.

Of the two Acute referrals, neither was rescinded. MTPs were signed timely in both entries, the Due Process Signed column was complete, and no Vitek hearings were noted as being held. One consult was submitted timely to IRU, and the other was submitted one day late.

Of the eight ICF referrals, none were rescinded. MTPs were signed timely in all eight entries. Two Due Process Signed entries were missing data; both chronos were found scanned in the EHRS under the correct title and it was unknown why the data did not populate. All eight consults were submitted timely to IRU.

Part V of the monthly HLOC audit was not consistent with On Demand data. While the number of referrals to Acute and ICF were correct, Part V reported that all referrals were submitted timely despite On Demand indicating that one Acute referral was submitted late. The referral rate was 10%.

May 2026
Six referrals were initiated: three to Acute and three to ICF.

Of the three Acute referrals, none were rescinded. MTPs were signed timely in all entries. One Due Process Signed entry was missing; the chrono was not found scanned in the EHRS. No Vitek hearings were noted as being held. All three consults were submitted timely, despite On Demand showing one as late due to the MH Consult to MH UM order being dated incorrectly.

Of the three ICF referrals, none were rescinded. MTPs were signed timely in all entries. The Due Process Signed column was complete and no Vitek hearings were noted as being held. All three consults were submitted timely to IRU.

Part V of the monthly HLOC audit was consistent with the On Demand data. The referral rate was 5%.

June 2026
Four referrals were initiated: three to Acute and one to ICF.

Of the three Acute referrals, one was rescinded. MTPs were signed timely in all three entries. The Due Process Signed column was missing data in one entry; the chrono was found scanned in the EHRS under the correct title and it was unknown why the data did not populate. No Vitek hearings were noted as being held. Two entries were missing data in the MH Consult to MH UM Order column: one order was completed and it was unknown why the data did not populate; the other order was not found. Two consults were submitted timely to IRU; one was submitted two days late.

For the one ICF referral, it was not rescinded at the time of the review. The MTP was signed timely, the Due Process Signed column was complete, and no Vitek hearing was noted as being held. The consult was submitted two days late to IRU.

Part V of the monthly HLOC audit was inconsistent with On Demand data. Part V reported the correct number of referrals, three to Acute and one to ICF, but reported that all referrals were submitted timely. The referral rate was 5%.

Referrals were submitted timely for 85% of the referrals (17 of 20) but this information was not noted in the respective monthly audits. The quarterly referral rate was 7%, a 12% decrease from the last data review in Q1 2026.

Non-Referral Reports
The On Demand Acute-ICF Non-referrals report was run for the review period of April through June 2026.
April 2026
There were 105 entries on the report, with 13 entries for patients already referred to Acute/ICF. Forty-four (48%) of the entries for patients who were not already referred to Acute/ICF were reviewed. There were 83 (79%) entries with single considerations, 22 (21%) with multiple considerations, 13 (12%) with subjective considerations, and 96 (91%) with objective considerations. The most common consideration was #7 (56%).

Data errors identified in the reviewed entries included: no SPR saved (four entries); consideration that was flagged but was not endorsed (one entry); and consideration that was not flagged but was endorsed (one entry). The data error rate was 14%.

May 2026
There were 116 entries on the report, with 10 entries for patients already referred to Acute/ICF. Fifty-one (48%) of the entries for patients who were not already referred to Acute/ICF were reviewed. There were 84 (72%) entries with single considerations, 32 (28%) with multiple considerations, 10 (9%) with subjective considerations, and 108 (93%) with objective considerations. The most common consideration was #7 (58%).

Data errors identified in the reviewed entries included: consideration that was flagged but was not endorsed (three entries); consideration that was not flagged but was endorsed (three entries); inaccurate MHI at IDTT (one entry); and MTP was not signed (one entry). The data error rate was 16%.

June 2026
There were 85 entries on the report, with four entries for patients already referred to Acute/ICF. Thirty-eight (47%) of the entries for patients who were not already referred to Acute/ICF were reviewed. There were 57 (67%) entries with single considerations, 28 (33%) with multiple considerations, five (6%) with subjective considerations, and 84 (99%) with objective considerations. The most common consideration was #7 (59%).

Data errors identified in the reviewed entries included: consideration was endorsed when it was not flagged on the SPR (two entries); and associated MTP was not found in the EHRS (one entry). The data error rate was 8%.

The quarterly error rate was 13%, a 6% decrease from the Q1 2026 data review.

A summary of this information was shared with the IPCs, mental health leadership, and program supervisors before the completion of this report. Regional suggested that the IPCs investigate any discrepancies between their internal tracking and the On Demand report.

Follow-up required: YES _X_ NO___	If YES: Follow-up date: October 19, 2026

Follow-Up Action Plan: 1. Determine why there is an inconsistency between what is being reported in Part V and the data that is reflected in the On Demand report. Provide steps taken to either address why the referrals are submitted late to be discussed at MHPS meeting or address those discrepancies in Section D or F of Part V.

Program Area Reviewed:	Documentation Review – Higher Level of Care Tab

Quality

Eight cases were randomly selected from the June 2026 monthly HLOC audit and reviewed for quality of the rationale and intervention sections within the HLOC section of the MTP. Four of the eight cases were found to have unacceptable documentation. In two cases, both sets of the rationale and intervention sections were unacceptable because it was unclear what was driving the endorsed considerations and it could not be determined if the interventions were tailored to the patient's specific needs. Additionally, in one case the patient's current clinical presentation and appropriate level of care was also unclear. In the second case, both intervention sections and one rationale section were unacceptable. In the set where the rationale and interventions were unacceptable, the patient was flagged on the corresponding SPR but not endorsed in the MTP and the discrepancy was not addressed. The second intervention section was unacceptable because no clinical interventions were provided. In the fourth and final case, the rationale and intervention sections were unacceptable because it was also unclear what was driving the endorsed consideration and the patient's clinical presentation and resulting appropriate level of care was unclear.

Regional review of outcomes was discrepant in three cases. In the first case, the institution found interventions acceptable, but Regional's findings noted an unclear cause of the endorsed consideration so it could not be determined if the interventions provided were tailored to the patient's specific needs. In the second case, the institution found a rationale acceptable, but Regional noted that the patient's current clinical presentation and resulting appropriate level of care were not defined. In the third and final case the institution marked "N/A" for the treatment refusal rationale and intervention section despite the patient being flagged on the corresponding SPR. The MTP did not address the flag, so Regional found the document to be unacceptable. Regional also found the second intervention section unacceptable because no clinical interventions were provided while the institution found those to be acceptable.

Consistency

The same eight cases were reviewed for consistency of the endorsed considerations in the HLOC documentation from the MTP, with documentation in the EHRS and corresponding SPR. Seven cases were found to be consistent. In the case that was not consistent, the consideration was flagged on the corresponding SPR but not endorsed in the MTP and the discrepancy was not addressed.

Additional issues with the overall quality of the MTP documentation included: the symptoms, behavior and/or identified cause of the endorsed consideration was not targeted in the problem/symptoms in the treatment plan grid (five cases); aspects of the treatment plan grid were left blank (three cases); the clinical presentation of the patient described in the HLOC section of the MTP conflicted with the patient's assigned diagnosis; a patient was assigned multiple conflicting diagnoses; the medications prescribed to the patient as described in the HLOC section of the MTP

did not correspond with the medications prescribed in EHRS at the time of IDTT; the IDTT type was not identified in the MTP; and, the MHMD initial assessment was not completed prior to the initial IDTT.

A summary of this information was shared with the IPCs, mental health leadership, and program supervisors before the completion of this report. The CP reported that there is now an email distribution list that includes both CPs and the Chief of Mental Health (CMH) and the leadership can more quickly address issues that require their level of attention.

Follow-up required: YES _X_ NO____	If YES: Follow-up date: October 19, 2026

Follow-Up Action Plan: 1. Supervisors will review Regional's feedback on all the identified cases in this review with the respective clinicians and provide accompanying 844s.

Program Area Reviewed:	Attended IDTT in MHCB, RHU, ML EOP

MHCB

Three MHCB IDTTs were scheduled and observed during the site visit. One of the three was a routine IDTT completed in absentia. Both IDTT meetings with the patient present were to discharge to a lower level of care. One patient was in mechanical restraints due to being MAX custody level. The IDTTs began on time, and all staff had access to their laptops during the IDTTs.

The MHPC initiated introductions and stated the purpose for the IDTTs in both cases. Brief clinical summaries were provided but only two cases presented sufficient clinical formulations. RVRs were discussed for each patient and did not require discussions of RVR Mental Health Assessments (MHAs). Additionally, behaviors that led to the RVRs were incorporated into the treatment plans for the two patients who required it. Each patient was given an opportunity to provide input regarding their treatment while in the MHCB.

Measurable treatment goals were identified and discussed in all cases. Medication and side effects were discussed by the MHMD in two cases. The CCI and nursing staff provided pertinent information in all cases. Although two IDTTs were for patients discharging, safety planning was inconsistent in both cases. Reviews of the documented safety plans were inconsistent with the safety planning discussions during the IDTT meetings. Issue and observation levels were discussed and higher level of care and appropriateness of level of care were also discussed for each of the patients.

IDTT outcomes did not appear to be predetermined. Despite meeting the minimal criteria for the audit, and the team being interactive, the structure of the IDTT and information discussed was disorganized and difficult to follow.

RHU

Five RHU CCCMS IDTTs were observed, including three initials and two routines. Three were held in absentia due to the patients declining to attend. IDTTs began timely, and all required disciplines were in attendance; this consisted of the assigned MHPC in four cases and a covering MHPC in the fifth case, the assigned MHMD, the assigned CCI, and a psychiatric technician. The MHPC, MHMD, and nursing representative could access EHRS and used it as needed; the CCI could access SOMS/ERMS and accessed it as needed.

The MHPC stated the purpose of the IDTT in four of the IDTTs. The MHMD and MHPC completed intake evaluations prior to all initial IDTTs observed.

Neither of the two patients who attended their IDTTs appeared to have difficulty understanding the proceedings due to their mental status. They were both asked open-ended questions and invited to participate, but only one of the

patients appeared to have their feedback meaningfully considered regarding their treatment plan, goals, and determinations made.

In all IDTTs, the MHPC attempted to engage all participants, but four of the five contained serial rather than interactive participation. Additionally, in one IDTT, the psychiatric technician's only participation was to ask the patient whether he had any questions. The CCI was engaged and knowledgeable in all IDTTs and appeared attentive when patients in attendance had custodial concerns.

The MHPC offered sufficient case formulation in four IDTTs, and the MHMD provided sufficient information in three of the IDTTs. The treatment team discussed measurable goals in four of the five IDTTs, and all considerations on the HLOC form were discussed in four IDTTs. In the fifth IDTT, objective considerations were discussed, but subjective considerations were not. In one of the two routine IDTTs, there was some discussion of progress toward treatment goals; in the second, this discussion was missing.

In all IDTTs, the treatment team identified any recent RVRs and RVR MHAs. In one case, the behavior was appropriate to address in the treatment plan, and this was included in the patient's goals.

In two IDTTs, resistance was identified as a concern, but individualized interventions addressing this were not developed and custody did not participate in the discussion of resistance. One of the IDTTs appeared predetermined without apparent consideration of the patient's preferences and possible recent changes in symptoms.

ML EOP
A-Yard
Five IDTTs were observed, two routine and three initials. Three of the IDTTs were delayed waiting for custody to call patients. All required members of the IDTT were present including the two respective assigned MHPCs, MHMD and CCI. The program supervisor attended four of the IDTTs. Given the participation from each team member, it was clear that all members of the IDTT were able to navigate the record with ease. One initial MHPC assessment was not completed but the two others and all three MHMD initial assessments were completed.

Each member of the IDTT participated in all IDTTs and the discussion was interactive which led to all the IDTTs not appearing predetermined. All five patients were welcomed to participate in the IDTT process and asked open-ended questions that allowed the opportunity to provide meaningful feedback that was incorporated into their treatment plan. No patients appeared to have difficulty understanding the proceedings or displayed resistance to treatment. The CCI provided thorough and individualized information in all five of the IDTTs in addition to offering encouragement and insight. Similarly, the MHMD discussed all the audit criteria in all IDTTs and appeared to have good rapport with all patients.

The purpose of the IDTT was discussed in three out of the five IDTTs. Progress in the patient's treatment was provided in both routine IDTTs. Case formulations were attempted in all IDTTs but three were missing crucial aspects including history of mental illness, other relevant historical information and any instances of suicide or self-harm. Measurable treatment goals were provided in all five IDTTs that were well thought out and individualized to the patient's respective needs. Higher level of care considerations were also discussed in all five IDTTs but four of them missed aspects of the considerations. In two of the IDTTs, the subjective considerations were not discussed and in the remaining two the patient's participation in treatment was not clear. One IDTT also did not discuss the patient's RVRs and two did not discuss the patient's relevant MHAs which also did not include potential relevance for incorporation into the treatment plan. Although the patient's assignment was discussed in all IDTTs by the CCI, none of the IDTTs discussed reasonable accommodations.

D-Yard

Five IDTTs were observed, two routine and three initials. The IDTTs started timely and required members in attendance included the MHPC, MHMD, and CCI. All patients were in attendance of the IDTTs. Team members helped ensure effective communication in four of the five cases. In one case, effective communication did not seem to be established where the patient's cognitive functioning appeared to impact their understanding. IDTT leaders stated the purpose in all IDTTs. Prior to all initial IDTTs, the MHPC assessments were completed. MHMD assessments were completed for two of the three initial IDTTs.

In four IDTTs, case formulations were sufficiently discussed. The MHMD provided reasons for all medications but did not include discussion of side effects in the applicable IDTTs. The CCI was engaged and receptive of patients' questions. In one of the IDTTs, reasonable accommodations were not discussed.

The IDTT discussion appeared collaborative and interactive with all participants. The MHPC engaged all treatment team members in discussion. Team members invited patients to participate in the IDTT by asking open-ended questions and giving them an opportunity to provide input regarding their treatment goals.

Measurable goals were discussed in all five IDTTs. The MHPC reviewed progress toward treatment goals in the routine IDTTs. All higher level of care considerations were not discussed for all patients. At the end of all five IDTTS the treatment team briefly discussed the appropriateness of the level of care.

Relevant RVR history was reviewed in each IDTT. However, if the individual's mental health played a role in the RVR, MHA recommendations since the last IDTT were not discussed in two cases. Management of the patient's resistance to treatment was addressed. The outcomes did not appear predetermined in any of the IDTTs. Overall, the IDTTs appeared patient-focused, team members were empathetic, collaborative, and knowledgeable about the patients' overall functioning and treatment goals.

Follow-up required: YES _X_ NO____	If YES: Follow-up date: October 19, 2026

Follow-Up Action Plan:

MHCB: 1. Program supervisor, or team lead, will attempt to help the team streamline the structure of the IDTT, as well as ensure that sufficient case formulations are discussed. Provide 844.

RHU: 1. Program supervisor will ensure the following criteria are met in each IDTT: prompting MHMD for discussion of potential side effects of medications; discussion and explanation of all higher level of care considerations and how that determines level of care; and appropriate language is used to match the patient's current level of functioning ensuring effective communication is reached. Provide 844s.

ML EOP A Yard: 1. Program supervisor shall ensure that any reasonable accommodations related to the patient's work/education assignments are discussed. 2. Program supervisor shall ensure that all aspects of the HLOC considerations including the subjective considerations, RVRs and relevant MHAs are discussed.

ML EOP D Yard: 1. Program supervisor will ensure criteria are met in each IDTT, including discussion of potential side effects of medications, discussion and explanation of all higher level of care considerations, and appropriate language is used to match the patient's current level of functioning ensuring effective communication is reached. Provide 844s.

Program Area Reviewed:	Housing Unit Review

MHCB

Upon entering the housing area, we were advised by a CCI that a patient had just broken a window and there may be a controlled use of force. The patient ultimately came out of their own volition and IDTT was completed. Patients were observed in their cells mostly sleeping and the unit was otherwise calm. One patient was observed in dayroom using the phone.

No patients were maintained on the Regional Spreadsheet who were identified during the previous quarter. No new patients were identified for further review.

RHU

Trash and debris were observed throughout the unit. When staff were asked about how often the unit is cleaned it was reported that it was done at the beginning of each shift, which was just a short time prior to the observation. Multiple cells were observed completely boarded up.

One patient indicated difficulties getting paper and pen fillers. Ants were also observed around the patient's cell, patient indicated he had issues with ants getting into his cell and had just asked for disinfectants to deter the ants.

One patient was maintained on the Regional Spreadsheet who was identified during the previous quarter. After further review, the recommendation was no intervention needed at this time and Regional will continue to monitor the patient. No new patients were identified for further review.

ML EOP

A-Yard

Correctional officers mentioned that the only program running was EOP priority ducats, and no yard or dayroom because of lack of custody staffing. They mentioned that buildings A1-3 (non EOP units) were not running any program with A1 having staff while A2 and A3 only had one officer in each of those buildings. Custody also mentioned that there are a lot of staff out primarily due to workers' compensation claims resulting from getting hurt on the job and then having delays with coming back to work. They mentioned other barriers to having available staff such as call outs, being pulled to other yards and numerous alarms throughout the institution.

The unit was overall clean with patient movement going out to ducats. Some back windows were covered or partially covered. One patient had their front windows completely covered and when approached became verbally aggressive. Custody staff were consulted about the patient who was reportedly upset due to the lack of programming and that reported they would follow up with the patient.

Patients provided a significant amount of information regarding their experience with the program. They reported that there are a lot of staff-on-patient assaults. They also reported that they are receiving minimal program with one reporting that he is locked in his cell for more than 20 hours per day and when they do come out, they are "bombarded" with custody staff yelling orders at them. It was also reported that they will sometimes receive ducats but are not ultimately able to come out for programming. This was observed in various observations throughout the site visit. It was also noted that mental health staff refuse to document when they see problems happening with custody, and that mental health is "overfamiliar" with custody. Patients reported issues with being wrongly marked as absent from groups. It was reported that half of the groups are cancelled and then they get "docked" in IDTT as a high refuser for treatment because they are being identified as refusing their appointment rather than it noting that the patient was not allowed out of the cell by custody. Issues with confidentiality were noted by patients particularly when on lockdowns; telemental health support staff bring a tablet to the door to conduct a follow-up with the patient cell front.

Peer support was on the unit at the time of the visit, and he noted that he has seen 123 peers for intake and has approximately 600 contacts with the people who want to engage with him. He reported feeling the program is positive, noting that it is a good way to help the population identify ways to solve problems that does not solely rely on submitting multiple grievances.

D-Yard

Upon entering the yard, patients were out in the yard for "group" (per the patients' reports when queried) without an RT member present. Custody was consulted regarding the lack of a facilitator, and it was reported that the RT was not present and the patients were alerted to the lack of facilitator but still offered to come out for programming.

A strong odor emanated from D2. C-pod had a distinct and strong smoke smell. A-pod also had the same smell, but it was not as strong. Several cells were observed to have broken windows. Some cells were observed completely boarded up. Most if not all the cells had partial back window coverings. It was noted that multiple toilet and sink problems have been ongoing and not getting fixed. Custody confirmed there were multiple toilets that are broken because patients are using the plug in their cell to light up something to smoke, which breaks the plug, and when the plug is broken, the toilet is no longer able to flush. She indicated that they fix the toilets as quickly as possible, but they often break again shortly after.

While on the yard multiple patients made derogatory comments to staff. They reported several concerns, including that they are receiving very little programming. Patients reported not getting ducats and not getting called out of their cells due to "short of staff" without clarification on if this is custody or mental health staff. Patients reported that they will be scheduled for multiple groups at the same time and then will be reported as a refusal for one. It was also reported that crisis staff are not called when someone reports being suicidal. Patients also indicated that their mail is getting intercepted and not getting sent to the recipients.

Work orders were placed on the first day of the RCT site visit to address the broken toilets, urinals and sinks. Custody reported that the work orders were completed and problems were fixed before the end of the site visit.

This following information was provided to the yard supervisor and MH leadership during the site visit:

Some clinicians reported to the Receiver's Compliance Team that all patients who do not show up for groups are to be noted as a "refusal." Given what had been observed over the past few days, if there is a high likelihood that patients may not be arriving to groups for reasons other than refusing (i.e., patients did not receive a ducat or were not allowed either out of their cell or the housing unit by custody), the concern with this direction is that patients may be getting flagged as a high treatment refuser based on possibly "false" refusals.

With the potential false flags for high treatment refusal, some patients reported that being identified as a high refuser is being used as a reason to consider discharge from EOP even if the patient is not volitionally refusing but is unable to attend for other institutional reasons. They also provided anecdotes of patients who had not left their cells for a lot of their programming who were being considered for discharge simply because they are flagging as a high refuser.

Patient names were posted on the board outside of the D MH building. This is confidential information and it was recommended that the information be removed immediately. The following day Regional confirmed that the information had been removed. Patients were unhappy with this information being removed as they noted that was the only way to know what groups they are assigned to.

No patients were maintained on the Regional Spreadsheet who were identified during the previous quarter. No new patients were identified for further review.

Follow-up required: YES ___ NO__X__	If YES: Follow-up date: N/A

Follow-Up Action Plan: N/A

ACTION PLAN
1. Sustainable Process Data Review – 1. Ensure all clinical staff are provided with a summary of the overall results of the audit and areas of focus for continued improvement in the quality of the HLOC documentation. Provide 844s.

2. MHPS – 1. All sections of Part V will be captured in the narrative in the body of the minutes. 2. If time allows in the MHPS meeting, discharge documentation review compliance rate will be discussed and captured in the minutes when discussing PIP/DSH discharge returnee documentation compliance rates.

3. Referral and Non-Referral Reports – 1. Determine why there is an inconsistency between what is being reported in Part V and the data that is reflected in the On Demand report. Provide steps taken to either address why the referrals are submitted late to be discussed at MHPS meeting or address those discrepancies in Section D or F of Part V.

4. Documentation Review – 1. Supervisors will review Regional's feedback on all the identified cases in this review with the respective clinicians and provide accompanying 844s.

5. IDTTs –
    a. *MHCB*: 1. Program supervisor, or team lead, will attempt to help the team streamline the structure of the IDTT, as well as ensure that sufficient case formulations are discussed. Provide 844.
    b. *RHU*: 1. Program supervisor will ensure the following criteria are met in each IDTT: prompting MHMD for discussion of potential side effects of medications; discussion and explanation of all higher level of care considerations and how that determines level of care; and appropriate language is used to match the patient's current level of functioning ensuring effective communication is reached. Provide 844s.
    c. *ML EOP A Yard*: 1. Program supervisor shall ensure that any reasonable accommodations related to the patient's work/education assignments are discussed. 2. Program supervisor shall ensure that all aspects of the HLOC considerations including the subjective considerations, RVRs and relevant MHAs are discussed.
    d. *ML EOP D Yard*: 1. Program supervisor will ensure criteria are met in each IDTT, including discussion of potential side effects of medications, discussion and explanation of all higher level of care considerations, and appropriate language is used to match the patient's current level of functioning ensuring effective communication is reached. Provide 844s.

6. Housing Unit Review – N/A

SITE VISIT SUMMARY
Region II appreciates the welcome and collaboration with the mental health and executive leadership teams. The terms "good" and "unacceptable" are utilized in the headquarters documentation review, to determine the quality of the documentation on the higher level of care (HLOC) considerations document. "Good" means that HLOC documentation adequately supports the decision to not refer the patient to a higher level of care even though one or more of the considerations is positive, and that the documentation adequately summarizes the specific treatment modifications that are documented in the treatment plan to improve the patient's ability to function. "Unacceptable" means one or more of the HLOC considerations were positive, but the explanation for not referring the patient to a higher level of care is deficient, and the HLOC documentation does not adequately summarize the modifications documented in the treatment plan to improve the patient's ability to function. HQ reviewed 47 cases in this quarter's HLOC documentation review: 47% (22 cases) were identified as "good" and 53% (25 cases) were identified as "unacceptable." ML EOP comprised 75% of the documentation, with 6% out of the MHCB, and 19% from RHU EOP. In ML EOP (35 cases total), 46% of the cases were considered "good" and 54% were considered "unacceptable." In MHCB (three cases total), 33% of the cases were "good" and 67% were "unacceptable." In RHU (nine cases total), 56% of the cases were "good" and 44% were "unacceptable."

Documentation quality remained at 47%, the same as the Q2 2026 audit. EOP overall declined by 4%. Within the individual EOP yard programs, A-Yard EOP declined by 9% to attain 58% in this current review, and D-Yard EOP declined by 9% to 31%. MHCB increased by 8% to 33% and RHU increased by 6% to 56%. SVSP will be required to complete this HQ documentation audit for Q4 2026 due to not meeting the 85% compliance rate.

Regional teams are tasked with observing IDTTs utilizing statewide quality standards determined and agreed upon by several stakeholders, which include plaintiff's attorneys, HQ leadership and staff, and external subject matter experts, which have been vetted and mandated via court processes. This has resulted in the adoption of the Continuous Quality Improvement (CQI) audit criteria for multiple MH program areas, including IDTTs. These standards strive to exceed a constitutional threshold of quality care. IDTTs were adequate and inconsistent in meeting all the CQIT audit criteria. None of the programs provided sufficient case formulations for all patients observed. Minimal measurable treatment goals were discussed for all patients in MHCB, and ML EOP A- and D-yards. MHCB provided sufficient, though disorganized, HLOC discussions for all patients. RVRs were discussed in all IDTTs in MHCB, RHU, and ML EOP D-yard (though not the MHAs). MHCB, ML EOP A- and D-yards were observed to have interactive treatment team discussions and none of the IDTT outcomes appeared to be pre-determined.

On-site observations, documentation reviews, and patient reports indicate several areas in need of attention, including challenges with patients consistently arriving on time for offered treatment; limited clarity around the accuracy of reported patient refusals; and frequent program lockdowns that affect patient movement even when mental health appointments are designated as priority ducats. Patients are disappointed by the lack and quality of mental health treatment that can be provided with the aforementioned barriers.

IDTT discussions of level-of-care decisions were insufficient across programs for all patients and documentation quality was at 47% "good" compliance. Given the documentation and on-site observations, and despite no new patients identified during housing unit observations, barriers to treatment access, limited communication with custody, and new mental health staff make it unclear whether SVSP has the resources to fully identify and address patients' HLOC considerations, specifically related to high treatment refusal (#7) — even for those who do not require a higher level of care.

Dates of the next site visit have not been identified as of this report's submission; SVSP will be notified as soon as possible when the dates are confirmed.

QUALITY IMPROVEMENT FOLLOW-UP
Please refer to the recommended follow-up action plans.

Appendix E: Excluded Indicators

- AC5.2: Monthly Review of EOP Modified Treatment
- AC26.2: Documentation of Clinical Barriers to Patients LRH Placement are Documented in the MTP
- AC26.3: Documentation of Correctional Counselor Review of LRH during IDTT with an Appropriate Response
- QC5.3: MHSDS Patients Released from CDCR with Completed Pre-Release Forms
- 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
- SP12.1: Custody Follow Ups, Page 1
- SP12.2: Custody Follow Ups, Page 2
- SP23: Quality of Selected SRE Documentation
- SP3.4: Quality of Safety Planning to Reduce Suicide Risk